

Al Junaibi, Suad Moosa Noor (2016) A Case Study of the Omani Ministry of Health's Approaches to Nursing Education and its Cultural Congruency. PhD thesis, University of Nottingham.

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Chapter One: Background and Context

Introduction

As the study takes place in the Sultanate of Oman, it is important to facilitate the reader's understanding of the context and to appreciate the basis of the cultural values and beliefs that constitute the Omani context. The following chapter offers an in-depth description of the setting in which this study was conducted and is organised into four sections. The first section consists of an overview of the demographical, historical, political, socio-economic and cultural background of Oman, including a section on the relationship between Oman and other Gulf Cooperation Council (GCC) States. The second section focuses on the Omani healthcare system. The third section offers an overview of nursing education in the GCC region, particularly in Oman, with a detailed description of the current MoH basic general nursing programme, the main focus of the study. The final section discusses the rationale for the study, study aims/objectives, and study questions.

1.1 The Omani Context

The Sultanate of Oman is trying to reduce its dependency on expatriate healthcare workforce by educating/training its own indigenous/nationals (Maben, et al, 2010). Despite, the country's tremendous progress made in improving and expanding the national healthcare system, it is still struggling to produce enough nurses to meet its people's needs (Alghemini & Denham, 2008). In order to explore the MoH's approaches to nursing education and its cultural congruency, this point will be fully explored in section 1.4, but before doing so, it is important to provide the context (the Omani context).

1.1.1 The Study Setting: The Sultanate of Oman

The Sultanate of Oman is situated in the southeast of the Arabic peninsula and has a total area of around 310 square kilometres. As shown in the Figure (1.1), Oman is bordered by the United Arab Emirates, the kingdom of Saudi Arabia, and Yemen, and is surrounded by the Oman Gulf, the Arabian (Persian) Gulf, and the Arab Sea. Oman is divided into five regions (Al-Dhakhiliya, Al-Sharqiyah, Al-Batinah, Al-

Dhahirah and, Al-Wusta) and four governorates (Muscat, Dhofar, Buraimi, and Musandam) which are sub-divided into 60 wilayats or districts. According to the mid 2012 census (NCSI, 2013), the total population of Oman is 3.62 million (2.09 million Omanis and 1.53 million non-Omanis). About 53 % of the total population live in Muscat, the capital of Oman (NCSI, 2013). According to the census, the Omani population have a gender ratio of 122 males per 100 females (MoH, 2011). Oman has a young population; the age distribution in the Omani population is 33% aged 0-14 years, 23% 15-24 years, 40% 25-64 years and 4% 65 years and over (NCSI, 2013). Life expectancy at birth was estimated at 72.6 years for men and 76.4 years for women (MoH, 2011).

Figure 1.1: Map of the Sultanate of Oman



***Map of the Sultanate of Oman taken from Oman information centre.

By tradition, most Omanis worked in seafaring and trading, primarily dealing with the local commodity between the Indian Ocean, east Africa, and the Arabian (Persian) Gulf. Consequently, there was a growth of Omani settlements along parts of the East African coast, and coastal lines of India, Pakistan and Iran due to Omani migration to improve or enhance their living standards. Before the discovery oil and gas and its production in 1964, the State was largely reliant on agricultural and

fishing incomes. The accession of his Majesty the Sultan Qaboos bin Saeed to rule in 1970 was a major revolution in the country's development and its people's way of life. The Sultan put Oman on the road to undergoing vast modernisation, particularly in the development of its educational and health infrastructure and programmes. The following section will shed some light on the politics and socio-economics of the Omani context to support the readers' appreciation of the basis for the nature of the MoH's approaches to nursing education and its cultural congruency in the context of Oman.

1.1.2 Political/Socio-Economical Context

Familiarity with the political situation of Oman is extremely important when interpreting and understanding its organisational approaches. As the country is under a monarchical regime, where *"monarchs not only reign but rule"* (Lucas, 2004), leadership is directly linked with the Sultan rather than an organisational leader. Further, Oman is not different to its neighbours. They all have similar regimes to Oman concerning the traditionally based tribal arrangements in their governance or rule approach (Sadiki, 2004). As a result, the decision-making power is in the hands the monarch (the Sultan) instead of a legislative group or institution (Lucas, 2004). The Sultan holds, almost entirely, all the political power, which covers the social and economic concerns of the country. The Sultan makes decrees that establish the main policies that run that country. New decrees override any wider formal policy, which makes decision making centralised above ministerial level. According to Common (2008), this centralisation of authority guarantees that Oman retains a relatively stable government despite the surrounding unpredictable and instable regimes in the Middle East region. Brownlee (2002) indicates that this authoritarian rule enabled the leaders in Oman and other GCC States to shape their organisations *"to support their own aims"*.

Arguably, the authoritarian rule in Oman and other GCC States was reinforced via the prosperity accumulated from petroleum production, which enabled the centralisation of power and control (Gause, 1994). Further, this prosperity protected the Oman and other GCC States from international economic pressure and

encouraged the fast expansion of the public and governmental sector since the 1970s. Ayubi (1992) and Sick (1998) claimed that the government/public sector in these countries attracted their nationals because it is the main focus of economic development, hence, the development of the Ministry of Health Educational Institutes (MoHEIs) in Oman. This has led to the growth of government/ public sector employment for nationals and has created a form of social requirement by the society/ community. In addition, the society saw public sector employment as a means to balance national wealth distribution among its nationals. This holds true in Oman, hence, nursing education and employment is predominantly provided for Omani nationals through the government via the MoH and Ministry of Higher Education (MoHEd). Besides, the main aims of the Omani government are to create employment opportunities for its nationals, which will elevate their socio-economic status and, at the same time, provide the country with the required quantity and quality of its own national manpower to run its facilities.

The following section will shed light on the cultural context in which the current MoH nursing programme is implemented.

1.1.3 The Omani Culture

The culture of a society guides its beliefs and values. It also influences the manner people perceive, create and prioritise issues in their lives. Culture and religion in Oman is very much intertwined and is based on Islamic/Arabic principles and traditions. In fact, all over the Middle East region, the national identity is associated with culture and religion, whereas, in the West, nationality is associated with race and ethnicity (Al-Haj, 1996). In Islam, there is no perceived separation between faith and everyday life. Ronen and Shenkar (1985) argue that because Oman is a part of the wider Arab and Muslim world, therefore, the Omani culture is founded on a wider regional culture. As a result, the Omani culture is a unique blend of an Arabic tribal tradition or custom and an Islamic worldview, which shapes the attitudes, and behaviours of the Omani people.

Islam is the official religion in the Sultanate of Oman. It is centred on five fundamental pillars of practice, which guide all Muslims in their everyday lives,

including educational practices, or approaches, which is the main focus of the study. These pillars assist the individual to develop a virtuous way of life (Barise, 2005). These five fundamental pillars are outlined in Table 1.1. Moreover, the Omani society is diverse and includes different Islamic sects and ethnicities. The two key Islamic sects practiced in Oman are Ibadhism and Sunnism. In addition, a minority of Shia sect exist in Oman. However, different to the other GCC States, Ibadhism is the dominant sect in Oman, which is only practiced in parts of North Africa. According to Riphenburg (1998), Ibadhism has influenced the Omani culture significantly because it isolated Oman from outsiders, including its neighbours, which makes the Omani culture unique. However, the Omani constitution does not ascribe to any particular sect indicative of the impartiality policy/ approach that the Sultan Qaboos has maintained during his rule or leadership.

Table 1.1: Pillars of Islam

1. Declaration of faith (<i>shahadah</i>)	The belief that must be declared that there is no god but Allah and Mohammad is the Prophet of Allah.
2. Prayers (<i>Salat</i>)	Performed five times a day facing Mecca in Saudi Arabia. Frequent sincere prayer, one maintains God-consciousness & discipline. Prayers can be performed individually or communally, but communal prayers promote equality & a strong sense of community.
3. <i>Self & property purification</i> (Zakat)	Muslims are required to pay a fixed proportion of their possessions for the welfare of the whole community & the poor in particular.
4. Fasting (<i>Sawm</i>)	During the month of Ramadan, all adult, able Muslims must abstain from all food, drink & sexual activity from dawn to dusk. Fasting promotes God-consciousness, spiritual growth, self-purification, patience, self-restraint, generosity, sympathy for the poor, communal solidarity & healthy lifestyle.
5. Pilgrimage to Makkah (<i>Hajj</i>)	At least once a lifetime, all able Muslim adults should make pilgrimage to Makkah to perform the Hajj.

*** (Barise, 2005)

There is cultural heterogeneity within the Oman culture. Omanis themselves are ethnically diverse with many originating from East Africa and Baluchistan. As discussed above (in section 1.1), the Omani cultural diversity was enhanced through its historical expansion to East Africa and the Indian Ocean, which made Omani culture different to its neighbours (Al-Lamky, 2007). In addition, Omanis “*tend to hold onto their deeply seated values throughout the transformation of their economy and lifestyles*” (Al-Khatib et al., 2004). According to Peterson (2004), language and religious sects or both define the ethnic boundaries in Oman. Based on the languages, the ethnic groups are indigenous Arabic speaking people, Baluchis, Zinjibaris, Swahili, Mehris, Shehis, and Lawatiyas (Kharusi, 2012). Despite this heterogeneity, the government promotes an all-inclusive Arab identity (Peterson, 2004). Ethnicity and heterogeneity are not topics that are widely discussed in public discourse in Oman, as there is an emphasis on the Arab identity. Hardly any studies have addressed the implications of this policy for ethnic identity. This has a significant relevance to the study findings and how the MoH approaches nursing education.

In conclusion, Islam is a religion not a culture; however, it does play a role in the Omani social structure that affects the expression and practices within a culture (Papadopoulos, 2006). The cultural values of the Omani people are embedded in the values of the Arabic-Islamic culture, with its emphasis on family and community. Omanis tend to derive a sense of self from their role in the greater community. In the Omani culture, decisions are not made by an individual but by a group: the family, community and/or society. Socialised medicine or government-sponsored healthcare for all nationals is reflective of the value placed on collectivism. As a community, oriented society, Omanis believe that every citizen has the right to access free high quality healthcare services that accommodate the needs of local society.

Having addressed the significance of culture and religion, the next section turns to Oman and its political, socio-economic and cultural links with other GCC States. This has significant implications for the overall governmental policies that impact MoH’s approaches to nursing education and practice.

1.1.3 Oman and other GCC States

Oman is a member of the Gulf Cooperation Council (GCC) established on May 25th, 1981. The GCC consist of six countries; Saudi Arabia, the United Arab Emirates, Qatar, Kuwait, Bahrain and Oman. Its main aims are strengthening economic, political, defence, and cultural relations with the vision of achieving complete union based on the European Union model. Contrary to the European Union, where well developed governmental institutions existed prior to the integration process; the GCC States established or created new governmental institutions at the launch of the Council or afterward in order to manage the increasingly complex developmental matters. According to Randeree (2012), all six GCC States have common issues that impact their national policies. These issues include over-reliance on migrant workforce, increasing rates of local unemployment, and developing education systems. The launch of oil production in the mid-20th century led to an increase in wealth across GCC societies. This prosperity created the need for jobs that require various levels of knowledge and skills, which meant the recruitment of foreign workers, mainly from the Indian subcontinent (Halliday, 1977). However, in the mid 1980's, the GCC States realised the need for a long-term strategy to ensure efficient and culturally congruent human resource management in the region. This led to the establishment and implementation of nationalisation policies, which were necessary in order for GCC States to address the socio-demographic imbalances that existed in their workforce. As will be demonstrated, this has significant relevance to the establishment of the Omanisation policy in Oman, which has a major influence on MoH's approaches to nursing education and practice.

The GCC States realised the key foundations to achieving a nationalised workforce consist of proper education and training of their nationals to take over the professions dominated by expatriates (Randeree, 2012). According to Randeree (2012), GCC States acknowledged that foreigners cannot support their long-term development plans indefinitely and that they must rely on their own growing national workforce. This nationalisation process is identified as, Bahrainisation in Bahrain, Kuwaitisation in Kuwait, Omanisation in Oman, Qatarisation in Qatar,

Saudisation in Saudi Arabia, and Emiratisation in the United Arab Emirates (Randeree, 2012). An understanding of the GCC States alliances is important in the context of Oman. GCC States established policies that influence educational and employment practices in their countries. While nationalisation strategies may differ from one GCC State to another, they all face similar challenges. These challenges include the lack of motivation for nationals to participate actively in their national economy, and the limited knowledge and skill levels among nationals required to replace expatriates in various professions. As will be discussed in section 1.2.2, this had significant implications on the establishment of MoH Educational Institutes (MoHEIs) which reflects the implementation of this GCC nationalism agenda.

For the reader to understand fully the MoH's approaches to nursing education and practice, it is important to discuss why the MoH was established in the Oman.

1.1 Healthcare in Oman

In the early 1970's, Oman had limited resources and several defects in its healthcare infrastructures that impacted the quality of the healthcare services provided for the Omani population. After the accession of the Sultan Qaboos (see section 1.1), he directed his efforts to concentrate on improving the healthcare services provided for the public to enable social and economic development of the country (MoH, 2005). This led to a royal decree to establish the Ministry of Health (MoH) in August of 1970, which enabled the creation of a national system that offers all Omani citizens universally accessible healthcare services free of charge. Hence, MoH is the main decision maker concerning the healthcare needs of the country. The MoH developed a succession of five-year plans, which started in 1976, to achieve and sustain a continuous development of the healthcare system (MoH, 2005). Further, the MoH adopted healthcare objectives and reforms based on valid statistics during the 1980's, to facilitate the establishment of well defined, realistic, and achievable policies (MoH, 2010). Currently, the MoH is mainly focused on reaching a high-quality healthcare system that is congruent with the healthcare

needs of the local population by the setting up of a new National Health Policy, to be completed by the year 2050 (MoH, 2010).

1.2.1 Healthcare Facilities and Services

The MoH facilities and services are extended to all regions through a network of healthcare facilities, which consists of regional hospitals and healthcare centres. These facilities provide healthcare services, which are free and accessible to all nationals. At present, the MoH is operating 50 hospitals, of which 14 are considered referral hospitals (MoH, 2011). In order to provide efficient and effective healthcare services to all, the MoH has established, as a minimum, one regional referral hospital in each region to serve the local people living in that particular area (MoH, 2011). Omanis and other non-Omani residents employed in the private sector are covered by their employers, as mandated by Omani law, which mandates all major companies to provide medical insurance for their employees and dependents as a part of their compensation package. On the other hand, all Omanis and other non-Omanis, including their dependent families, employed by the public or government sector can access all MoH healthcare facilities and services free of charge.

Furthermore, the MoH is currently operating 186 healthcare centres, of which 70 have maternity beds, and 24 are extended healthcare centres providing secondary care (MoH, 2011). Primary healthcare institutions refer patients from their catchment area to secondary and tertiary care for specialised care (MoH, 2011). Outside the MoH, there are 5 hospitals and 46 health centres distributed throughout the country under various organisations, such as, the Ministry of Defence, Royal Oman Police, Sultan Qaboos University, and Petroleum Development Oman (PDO). Also, in Oman, the private healthcare sector consists of 10 hospitals, 911 clinics and 442 pharmacies (MoH, 2011). The MoH's approach to management is based on a decentralisation managerial strategy; see Appendix H, which shows the MoH's organisational structure. This strategy allows the autonomous management of the regional healthcare services to enable the efficient operation of all these institutions. This allows the regional general directors to hold large financial and decision-making power over healthcare services management (MoH, 2011).

However, this decentralisation process is still ongoing and main policies remain centralised.

Despite all the MoH healthcare facilities and services growth, the number of healthcare providers available remains a major concern in Oman. According to the MoH census, in 2011 the number of physicians per 10,000 of the population was 12.6, while the number of nurses was 31.6. As will be discussed later in chapters 4, 5 and 6, this led to pressure on the MoH to produce and recruit as many healthcare providers as possible to run its facilities (see Table 1.2).

Table 1.2: Healthcare providers per 10,000 population

Healthcare Providers/ 10,000 population	2012	2011	2010
1. Doctors	19.5	18.0	18.1
2. Dentists	2.2	2.1	2.0
3. Pharmacists	4.6	3.9	3.9
4. Nurses	43.1	40.5	39.7
5. Physiotherapists	1.0	0.8	0.9
6. Radiographers	2.4	2.3	2.3
7. Laboratory Technicians	5.6	5.4	5.3
8. Asst. Pharmacists	5.2	4.8	4.7

*** Annual health report 2012

In conclusion, the expansion of the MoH healthcare facilities necessitated the recruitment of healthcare providers to cover the MoH needs, which made the MoH heavily dependent on expatriate workers and created an unsteady supply of manpower. As a result, the GCC States nationalisation policies, backed by the need for steady supply of skilled workers, led Oman to create the Omanisation policy to resolve these issues.

1.2.2 Healthcare Decision-Making Process

The MoH's directorate of planning (see Appendix H) creates healthcare policies, workforce policies/programmes, and prepares strategic and detailed workforce development plans (MoH, 2010). In order to ensure broad professional involvement of all concerned, the directorate of planning maintains a close relationship with other high-level management personnel in health affairs, planning affairs,

education and training affairs and administrative affairs. The MoH also works closely with all relevant officials within the Ministry, for example regional directors general, director of nursing affairs, hospital executive directors, medical department and nursing heads, and deans of medical schools, nursing and allied health institutes to articulate specific healthcare plans and programmes

According to the MoH, health workforce planning is vital to the development of the Omani healthcare system. Therefore, the planning approaches are based on the need to develop Omani workforces in all key healthcare professions, to ensure sufficient and competent workforce availability in different healthcare institutions/regions, and to achieve best utilisation of the workforce. The shortage of qualified Omani healthcare providers had influenced the MoH to acknowledge the importance of providing medical education and training for Omani healthcare professionals in collaboration with the Medical College at Sultan Qaboos University and various MoH training institutes. Recently, the population of Omani physicians and nurses has grown by about 80% and 64% respectively (MoH, 2010). Despite the MoH being required to follow to the civil service law and other regulations laid down by the Ministry of Civil Service, the MoH is free to develop its own perspectives and approaches in order to enhance its human resources.

The Omanisation policy, which was enacted by the government of Oman in 1988, was aimed at replacing expatriate workers with trained Omani workforces to enable the reduction of the number of expatriates to Omanis (MoH, 2010). For example, in 2012, around 29% of MoH physicians and 54% of MoH nurses were Omani citizens (see Table 1.3).

Table 1.3: Omanisation ratio in MoH

	Omanising %	Omani #	Total
Health Administrators	93%	168	181
Doctors	29%	2,080	7,055
Dentists	20%	159	805
Pharmacists	27%	444	1,657
Nurses	54%	8,413	15,627
Physiotherapists	53%	185	348
Radiographers	53%	453	856
Laboratory Technicians	50%	1010	2,026
Asst. Pharmacists	57%	1090	1,899
MoH Tutors(Teachers)	52%	165	317

*** Annual health report 2012

As a result of political pressure to speed up Omanisation of the healthcare providers, the medical and allied health institutions had to increase their intake capacities; however, the increase was faced with shortages related to teaching/training facilities (Ghosh, 2009). Also, the MoH have not so far been able to address adequately the workforce issues facing the entire nation, due to inadequate interaction with other healthcare providers (Ghosh, 2009). The rapid implementation of the Omanisation policy allowed a high influx of young and less experienced Omanis taking over posts from qualified expatriates, which unfortunately affected the quality of MoH healthcare services provided for the people.

1.3 Nursing Education in the GCC States

This section presents an overview of the nursing education in the GCC States to shed light on the current status of nursing education in the region.

In general, there are three levels of nursing education in the GCC region. These three levels of preparing or training nurses include an associate programme (which consists of a two-year programme post-secondary school and a six-month internship), a diploma programme (which consists of a three-year programme post-secondary school and a six-month internship), and finally, a baccalaureate degree programme (which consists of a four-year or five-year programme post-secondary school and a six-month internship). Some of the GCC States provide master's

degree programmes, such as Saudi Arabia, Bahrain and Oman. So far, none of the GCC States offers doctoral programmes to nurses. The majority of GCC State nurses seeking masters or doctoral degrees usually travel abroad to the United States of America (USA), United Kingdom (UK), Australia or Canada to gain a postgraduate degree. According to Al-Darazi (2003), diploma level education, which is held by the bulk of GCC nurses, contributes to the perceived low academic standards of the nursing profession. He claims that the inadequate existing educational / training resources and the lack of a systematic approach to the accreditation of GCC educational programmes (Al-Darazi, 2003) create the variability in the quality of nursing education.

Despite the surge in indigenous student enrolment in the nursing programmes, there are still several challenges to nursing education in the GCC. Firstly, the history of nursing education in the region reflects the influence of British, French and later American settlement in the Middle East region. The British and American impact on nursing education continues to be present in the design and the development of GCC nursing curriculum and programmes. As a result, the current GCC nursing curriculums are founded on the Western model of nursing education. Al-Darazi (2003) states that *“in most countries of the region, nursing curricula were founded on the Western medical model, stressing individual and curative hospital care.”* However, the GCC States used a Western-based curriculum in the nursing education owing to the lack of an alternative regional healthcare model and the limited number of Arabic nursing textbooks (Al-Darazi, 2003). This clarifies why the healthcare systems in the GCC States and wider Middle East region are largely influenced by the Western-derived models in nursing education.

However, this Western-based nursing model adapted in the GCC States nursing programmes conflicts with their own cultural value and belief system, which is based on Arabic and Islamic values. These local cultural values form the basis of the healthcare needs of local patients and their families (Lovering, 1996). According to Al-Shahri (2002), this imported model of nursing education emphasises the Western viewpoint regarding health and illness, which differs from how the local GCC people view health and illness. In addition, the majority of the

nursing faculty in GCC States are expatriates who come from different cultural and linguistic backgrounds. The current nursing educators/ faculty are recruited predominantly from India, the Philippines, Jordan, Egypt, South Africa and the United Kingdom (UK). As indicated above, the majority of the national faculty gained their advanced degrees in the West (mainly the UK, USA, Canada and Australia) due to limited graduate nursing programmes in the region, thus their advanced theoretical background is derived from the Western perspective. As a result, the nursing curriculum, nursing educators and textbooks all promote a different model of health that conflicts with the one held by the local nursing students and the patients receiving care. This co-existence of the two models of healthcare, Western and Arabic-Islamic, presents a challenge to the GCC States nursing curriculum in achieving a culturally congruent healthcare education. In Oman, the MoH continues to struggle to attain a healthcare education and healthcare service that is congruent with the local religious-cultural views of health.

Secondly, English is the main language of instruction in nursing programmes provided in the GCC States. This move has impacted how the nursing students are educated and trained in the region. As discussed above, the influence of British and American ideology combined with the majority of nursing education resources printed in English has led the GCC States to mandate English language as the main medium of instruction. This is a significant indicator of imposition of the Western-based philosophy on the local education system. In other words, nursing students in GCC States are being instructed in a language other than what they speak at home, which further limits their competency in delivering culturally appropriate care to the local society. Moreover, the majority of students have poor English language skills post-secondary graduation, which limits their ability to use appropriately the education resources, such as nursing textbooks and academic journals. Al-Darazi (2003) claims that, in the Middle East region, most of the nursing programmes do not offer culturally relevant teaching/learning materials, which are written in their own national language. As a result, the local nursing students struggle in their acquisition of essential nursing knowledge and skills,

which may deter some students from entering the nursing profession, as, will be discussed in chapters 4, 5 and 6.

Thirdly, the image of the nursing profession is a key obstacle to nursing education/ profession in the region. GCC States have met resistance from their local societies because nursing is viewed as a dirty, dishonourable job, and suitable only for non-nationals (Al Meer, 1998). Moreover, Al Meer (1998) reported that the GCC people's resistance was based on the perception that nursing is a menial and low rank profession. This negative image was further reinforced by the nature of nursing work, which requires mixing with the public, working with male staff and patients, accepting responsibility for heavy workloads, and enduring hard work schedules (long hours, weekends, night shifts), conflicting with the traditional Arabic/ Muslim family life. Shuriqueie, While and Fitzpatrick (2008), Almalki, FitzGerald and Clark (2011) and El-Haddad (2006) all indicated that negative perceptions dominate nursing's image in the region. This is not unique to GCC countries, nurses from other Arab states, such as Egypt and Jordan, have similar concerns (Lamadah & Sayed, 2014). As a result, this negativity is creating serious challenges for recruitment and retention of nationals in nursing education/ profession.

The following section provides an overview of the development of nursing education in Oman.

1.3.1 Nursing Education in Oman

The expansion of MoH healthcare facilities and services combined with the Omanisation policy, as discussed above in section (1.2), has led to an increased need for well-trained national healthcare professionals. In response to this need, the MoH education programmes were established and designed to meet these healthcare needs of the country. The MoH established the current MoHEIs under the general aim of preparing national professional practitioners in nursing and allied health sciences disciplines in support of its national health policy. According to the MoH, nursing and all allied healthcare programmes were designed to emphasis culture, family, community, and the healthcare system, which shape how

individuals and groups view and maintain their health (MoH, 2008). However, the MoH was faced with a major obstacle in the negative public image of nurses in Oman. The Omani social/cultural image of the nursing profession, as in other GCC countries, remains negative, as discussed above in section (1.3). In addition, the view that diploma level education is technical and low level (El-Sanabary, 2003), has contributed to the public view of nurses as simply helpers to doctors (Al-Sa'd, 2007). Also, the negative media image of nursing and nurses, a social preference for prestigious academic fields of study, and a lack of family support (Al-Omar, 2004), has impacted the lack of awareness about nursing as a career choice in Oman.

Despite all the challenges involved with the recruitment of Omani students, the establishment of MoHEIs with several healthcare programmes has increased the availability of the indigenous human resources in the Omani healthcare system. According to MoH, its educational programmes are also linked to partnerships with higher education institutions abroad (MoH, 2008). At present, the MoH has become the Sultanate's leading human resources provider in the Nursing and Allied Health Sciences disciplines (MoH, 2008). As discussed above in section 1.1, this impressive achievement is a direct result of the renaissance movement started by His Majesty Sultan Qaboos (see Table 1.4).

Table 1.4: The Chronological Establishment of MoHEIs' Programmes

The Decade	Achievements
1950"s	Healthcare education mainly involved training in nursing skills started by the American and British Missions. This type of training consisted of simply teaching basic nursing skills and procedures.
1970's	The first structured training in practical nursing started in 1970, which provided a two-year skill-centred certificate in nursing, and lessons were conducted at the Al-Rahma Hospital in Muttrah. In 1975, a new programme for laboratory technician was initiated in Khoula Hospital and was later moved to Al-Nahdha Hospital in 1978.

	These two programmes set the foundation for MoH nursing and allied health sciences education, which was later established as a formal three-and-a-half-year curriculum for nursing and allied health sciences programmes in 1977.
1980's	The establishment of the Institute of Health Sciences (IHS), which offered secondary school, graduates, for the first time in the Sultanate, the chance to enrol in an organised professional study in nursing and medical laboratory science disciplines. In 1986, two additional programmes were introduced: diagnostic radiography and physiotherapy.
1990's-2002	In 1991, five new regional nursing institutes were established in five different regions (North Batinah, Al-Dhakhiliya, South Sharqiyah and Dhofar) which extended nursing education opportunities to the prospective regional students to study in their own regions. The same year the Oman Assistant Pharmacy Institute and the Oman Institute of Public Health were established in Muscat. In 1993, a dental surgery assistant programme was initiated. In the same year, the nursing programme was transferred from the IHS to a new institute (the Muscat Nursing Institute) set up in Wattayah. Later, more nursing institutes were inaugurated in other regions, such as the Ibra Nursing Institute in North Sharqiyah region, Rustaq Institute in North Batinah region, Al-Dhakhiliya Nursing Institute in Al-Dhakhiliya region, and finally, the Oman Nursing Institute in Muscat. In 1997, MoH began to offer a Post-Basic education to prepare advanced level practitioners in a series of specialties at the Oman Specialised Nursing Institute (OSNI). Finally, in 2002, the Oman Medical Records Institute started its programme.

*** (MoH, 2008)

Initially, the growth of the MoH human resources was slow and only started with 83 practical nurses that were trained between 1970 and 1981 (MoH, 2008). Despite the low numbers of graduates in healthcare professions that decade, many MoH educational programmes were established, which led to a gradual increase in the number of graduates in the following decades. In 2008, the total number of graduates from all programmes accounted for 7079 healthcare professionals, of which 5224 were nurses (MoH, 2008).

In spite of the MoH being a pioneer in nursing education in Oman, it confronts two major challenges:

- Graduating qualified/ competent nurses in knowledge, skills and attitudes (quality).
- Providing the sufficient nursing staff numbers needed to cover the needs of its healthcare facilities (quantity).

The following section will describe the current MoH general nursing programme, which is the focus of the study, to appreciate the nature of the current programme.

1.3.2 The MoH General Nursing Programme

The General Nursing Programme (GNP) functions within the scope of the philosophy and policies of the Ministry of Health together with Ministry of Higher Education that reflect His Majesty Sultan Qaboos bin Said's views and beliefs on self-development of the Omani people in the context of their socio-cultural background (MoH, 2008). The range of practice of the GNP graduates includes hospitals, health centres, outpatient clinics, and school health. According to the MoH, the current programme offers its graduates a foundation for further development opportunities (MoH, 2008).

The current MoH's GNP is free for all Omani students; however, enrolment is only via the central admission centre under the management of the Ministry of Higher Education. The GNP offers many facilities for the students to improve the uptake of nursing students, as mentioned above (see section 1.3) regarding the poor image of the nursing profession. These facilities include free transportation to and from the nursing institutes and clinical allocations providing monetary allowances for the duration of their study, and free of charge study materials, including course books, which they only pay for if they want to keep. Further, the MoH guarantees employment for all GNP graduates after the internship programme's completion. The GNP graduates start internship on average 2-3 months after they finish the programme. All the MoH nursing institutes offer a diploma degree in General Nursing Program (GNP).

The current GNP consists of a 1+3 nursing curriculum. This curriculum consists of a foundation year plus three years focused mainly on nursing and nursing support courses. According to the MoH, the foundation year is designed to improve the preparation of new students to be competent learners, capable of critical thinking and excellent communication skills. Since, English is the main language of instruction at the MoH institutes, students receive support classes in English in the foundation year (first year), with fewer hours being offered in the subsequent semesters (MoH, 2008). The current foundation year programme offers English Language, Mathematics and Statistics, Information Technology courses, First Aid, and an Introduction to Oman's Health System.

The maximum limit for the completion of study is five years. Each year consists of two semesters of 15 weeks each, followed by a period of one to two weeks for examination, and a summer semester ranging from six weeks, inclusive of one week of examinations (see appendix J). The maximum study load for a student is eighteen (18) credit hours for the regular semester and nine (9) credit hours for the summer semester. The minimum study load for a student is twelve (12) credit hours for the regular semester, and not less than six (6) credit hours for the summer semester. However, any student who fails any course has to repeat the whole year. In addition, GNP offers students who fail any course an opportunity to retake an exam up to three times for each subject.

In conclusion, the MoH claims that its healthcare education institutes were created to prepare national graduates who are competent in knowledge, skills, and attitudes. However, if we look at the current MoH nursing programme, the cultural context is not addressed in its current curriculum. Omanisation, culture, and Islam are major concepts that the current MoH nursing curriculum does not address, and inclusion of these concepts is important to graduate culturally competent healthcare providers.

1.4 Rationale for the Study

The MoH has established its educational programme, particularly, the nursing programme to meet the need for highly competent Omani nurses. Over the years,

the programme seemed to focus on the quantity of the graduates and overlooked the quality of the education provided. Despite MoH attempts to improve the quality of the nursing education via collaborating with international universities and professional bodies, and undergoing the programme accreditation process by the Oman Accreditation Council (OAC), concepts such as culture and religion are not accommodated by the current nursing programme. As a result, I was interested to explore how the MoH's approaches to curriculum development impact the nursing education in Oman. I was also interested in exploring how culturally congruent the MoH's approaches to nursing education are. In other words, I was interested in exploring the fitness of the current nursing curriculum for its purpose as stated by MoH, the MoH nursing institutes "represent a tangible reflection and expression of the MoH mission and commitment to enhance healthcare in the Sultanate. These Institutes bear responsibility for the training of healthcare practitioners in tune with the culture, tradition and values of the community" (MoH, 2008, p.6).

Working with the MoH curriculum evaluation committee (CEC) has motivated me to conduct the study because there have been no literature or empirical evidence on MoH's approaches to nursing curriculum development, its impact on nurse education in Oman, and its cultural congruency with the healthcare needs of the Omani population.

1.4.1 Research Questions

1. How do the MoH's approaches to the nursing curriculum impact nurse education in the Sultanate of Oman?
2. How culturally congruent are MoH's approaches to nursing education?

1.4.2 Aims of the Study

- ☐ To review MoH curriculum/educational policy documents to gain insight into nurse education in Oman.
- ☐ To examine the impact of MoH curriculum decisions upon the cultural congruency of nurse education.

- ❑ To suggest recommendations for curriculum development in Oman in light of the research findings.

The following chapter offers an overview and critical analysis of the relevant literature and will discuss a number of definitions of the concepts, common philosophical bases or foundations of education, common curriculum approaches, and nursing theories/models on culturally congruent care. Finally, Lawton's Cultural Analysis Model is discussed as the main theoretical framework for the study.

Chapter Two: Literature Review

Introduction

The second chapter is divided into six sections. The first section includes a discussion of a number of definitions of the concepts of culture; culturally congruent care and curriculum are discussed in relation to nursing education. The second section focuses on the common philosophical bases or foundations of education, particularly in nursing education (curriculum), which is the main focus of this study. It consists of an overview of the common Western educational philosophies and the Islamic philosophy of education. The third section discusses common curriculum approaches in nursing education. The fourth section focuses on the relationship between curriculum and context. The fifth section includes an overview of two common nursing theories/models that emphasise culturally congruent care as a crucial element in the nursing curriculum. The final section discusses Lawton's Cultural Analysis Model, which is the main theoretical framework for the study.

2.1 Definition of Concepts

In this section, the concepts of culture, culturally congruent care, curriculum and profession/professionalism tend to carry numerous meanings, and their definition is important for the purpose of the study.

First, I will start to discuss the search strategies. A systematic way of searching literature was followed to obtain all possible meanings and attributes of the concept of cultural congruency in nursing education in literature. Dictionaries were used to find the usual uses and meanings of the concept, subsequently a search in research literature and textbooks to obtain the meaning of the concept more especially its meaning in the context of the nursing profession.

The search strategy included purposively selected databases using specific keywords and narrowing publications to English only. Initially the search focused on electronic databases. Definitions were searched and extracted, by using keywords such as culturally responsive nursing education, culturally competent

nursing education/curriculum and culturally aware nursing education. The database available on the library website were purposively selected and the following were used: CINAHL, MEDLINE, Ovid Nursing Journals, and PubMed. Proquest was used to find dissertations and theses. Electronic and hard copies of books, journals, theses and dissertations were searched.

2.1.1 Culture

Culture is an important concept for individuals and communities that shape the way health, illness, and quality of life are perceived (Jeffreys, 2010). According to Jeffreys (2010), the quality of life of an individual can only be observed through examining the meaning he or she assigns to “quality of life” based on their perception of health within their own unique cultural context. Denis Lawton (1983), an educationist, argues that the term “culture” is one of the most complicated words in the English language. He claims that the term has a history of shifting meanings and is used by several different disciplines (Lawton, 1983). Leininger (1991), a nursing theorist, defined culture as *“the learned and transmitted values, beliefs, and practices that provided a critical means to establish culture care patterns from the people”*. However, in Leininger’s definition, culture as a broad concept is narrowly applied and perceived to be stagnant. Gray and Thomas (2006), and Gustafson (2005) argue that this definition by Leininger seems to ignore the culture of the nurse, and assumes that increased knowledge and understanding of other cultures would lead to tolerance, respect, and cause prejudiced behaviours to change. In addition, this definition seems to promote the idea of us versus them, which may lead to discrimination.

In anthropology, which uses culture as a central concept, Tyler (1949) proposed the commonly quoted definition of culture. He defined culture as *“that complex whole which includes knowledge, belief, arts, morals, law, custom, and many other capabilities and habits acquired by man as a member of society”* (Tyler, 1949). This definition is more comprehensive because it focuses on the qualities that are acquired through growing up or living in a particular society, rather than the biological heritage (Kottak, 2002). This definition indicates that culture influences

the ways in which people experience and interpret the world, which is largely determined by their cultural contexts. This undoubtedly holds true in Oman, as the Omani culture is based on entwined Arabic and Islamic traditions. However, culture is not a stagnant concept; it is constantly evolving in response to new surroundings and shifting physical, social, economic, and political realities.

Another definition by Lawton (1975) describes “*culture*” as everything that has been created by individuals in a society, which includes tools, technology, language, literature, attitudes and values, or in other words, entire ways of life. This definition proposed by Lawton embraces all the activities experienced by an individual in a particular context, and acknowledges the evolving nature of culture, which is consistent with the study. Culture as a key concept in this study should be flexible and embrace many elements, which create culture. Therefore, Lawton’s definition of culture is used in this study because it provides a comprehensive meaning of the concept.

2.1.2 Culturally Congruent Healthcare

Since one of the key concepts of this study is culturally congruent care, it is important to define concepts in relation to nursing education. There are several concepts similar to cultural congruent care which have slightly different meanings, such as culturally responsive, cultural awareness, and culturally sensitive. Therefore, giving a definition will unpack what is meant by cultural congruency in this study.

Care is an essential element of nursing. The culture care construct is a holistic perspective that involves “cognitively learned and transmitted professional and indigenous folk values, beliefs, and patterned lifeways” (Leininger, 2002, p. 57). “Nurses are expected to get close to people and to establish and maintain intimate caring relationships” (Leininger, 2006b, p. 45). Therefore, culturally congruent care “is defined as those assistive, supportive, facilitative or enabling acts or decisions that include culture care values, beliefs, and lifeways to provide meaningful, beneficial and satisfying care for the health and wellbeing of people or for those facing death or disabilities” (Leininger, 2002, p. 58). Culture care is the broader

philosophical construct, while culturally congruent care refers to the actions and decisions (interventions) one provides that are culture specific for the individual(s) being assisted.

Numerous authors emphasise that a healthcare system that responds to the cultural values, beliefs and traditions patients is crucial (Giger et al., 2007; Leininger, 2002a, 2002b; Rosal & Bodenlos, 2009; Whitt-Glover et al., 2009). According to Leininger (1991), culture care refers to *“the subjectively and objectively learned and transmitted values, beliefs, and patterned life ways that assist, support, facilitate, or enable another individual or group to maintain their well-being, health, improve their human condition and life way, or to deal with illness, handicaps or death.”* Culturally congruent care refers to care that is tailored to fit with the patient’s own values, beliefs, traditions, practices, and lifestyle (Jeffreys, 2006). Jeffreys (2010) describes culturally congruent care as a basic human right, which every individual is entitled to. She continues to say that all healthcare providers and institutions are legally, ethically, and morally obligated to provide culturally congruent care (Jeffreys, 2010). Various authors emphasise culturally congruent care education and practice is accomplished through the complex process of cultural competence (Andrews & Boyle, 2008; Campinha-Bacote, 2003; Leininger, 1991; Purnell & Paulanka, 2008). Therefore, the inclusion of cultural competence in the nursing education programme would provide student nurses with the knowledge and skills essential to serve culturally diverse patients. Indeed, in Oman, people are adamant to preserve their cultural traditions and customs, therefore, it is critical that nurses understand and work effectively within this cultural context. Therefore, it is vital that the nursing programme prepares student nurses to understand the key issues, concerns, and new challenges facing healthcare service users and professionals today within a cultural context in order to provide effective and competent care. In this study, a culturally congruent education refers to an education programme that is customised to fit with the cultural values, beliefs, traditions, practices, and lifestyle of the context where the educational institution is situated (Leininger, 1991). To provide culturally congruent care, nurses need the

proper educational preparation with the knowledge, skills, and attitudes essential to care for people from different cultures.

Since an educational curriculum provides the structure for any education programme, the next section will discuss the concept in reference to nursing education.

2.1.3 Curriculum

The term curriculum is sometimes confused with the term syllabus. According to Stern (1983), curriculum is a programme of studies of an educational institution, while, syllabus refers to an outline of a course of studies. Further, Rodgers (1989) defines a syllabus as the content to be covered by a given course, which is only a small part of the total programme, while, a curriculum refers to wider aspects of an educational programme, which includes the content, the instructional process, and the preparation of teachers (Rodgers, 1989).

The term “curriculum” has different meanings to different people. Even though various authors lack agreement on the meaning of the term, there seems to be consensus that educational institutions have exclusive rights to usage of curriculum (Uys & Gwele, 2005). Further, Apple (1993), Smeyers (1995) and Moore (2000) argue that curriculum is not an unbiased assembly of knowledge, and it signifies a means to promote a particular political agenda. For example, Dewey (1961) believed that an education curriculum is a tool to direct learners to proper learning, while, Freire (1998b) viewed educational curriculum as a political act. Others believe that learners should learn to either fit into the existing social context or recognise their obligation to change the social, political and economic components of their context (Bode, 1937). According to Cuffaro (1994), a curriculum is based on an educational philosophy of its developers; therefore, it represents their values and beliefs about acquisition knowledge. Therefore, an educational philosophy assists in curriculum development through enabling the selection from wide-ranging choices (Uys & Gwele, 2005; Wiles & Bondi, 1998). Therefore, it is important to make clear the philosophical values and beliefs underpinning what the educational institution sees as valuable for learners to learn. In Oman, the main

aims of nursing education are to create qualified national healthcare professionals to fulfil the needs of the healthcare services and maintain high quality healthcare services that meet the needs of the local population.

According to Lawton (1975), curriculum “...*is essentially a selection from the culture of a society*” which includes particular aspects of our way of life, knowledge, attitudes and values perceived as important, and their transmission to the next generation should be entrusted to specially-trained professionals (educators). Lawton’s definition of a curriculum is discussed in section 2.6, however, his definition is disputed in regards to who decided what aspects of the culture should be represented by the curriculum and how the curriculum developers’ perceptions of what is valid knowledge affects the selection process.

In this study, curriculum refers to the planned learning experiences that the educational institution intends to provide for its learners (Uys & Gwele, 2005). This definition does not oppose the existence of hidden curricula, which the educational institution excludes from its written curriculum (Eisner, 1994).

2.1.4 Profession/ Professionalism

The concept of profession refers to an occupational group with a degree of commitment demonstrated by a set of values and behavioural attributes of a specific career identity (Kim-Godwin et al, 2010). According to Black (2014), a profession usually is evolved from a job that originally consisted of tasks but later developed into a specialised educational pathway and publicly legitimised status, such as, law and medicine. Further, a profession is determined by identified work standards, a body of knowledge, and established educational programs in institutions of higher education. Also, profession is promoted by established codes of ethics, effective occupational associations, and established laws to limit practice of their unique skills themselves (Black, 2014). Professionals are generally defined in terms of a particular body of knowledge obtained through formal education, an expanded level of skills, a certification to verify entry to profession, and a set of behavioural norms known as professionalism (Hampton & Hampton, 2000). Moreover, professionalism indicates attitudes that represent high levels of identification with

and commitment to a specific profession (Wynd, 2003). According to Wynd, (2003), professionalism attributes consists of an educational preparation, research, scholarship, and participation in professional organizations, community service, competence and continuing education, the code of nurses, theory, and autonomy. Based on these characteristics of professionalism, professionals can be distinguished from other workers. Professionalism in nursing has focused on the expansion of nursing role in fast changing healthcare setting.

Professionalism in nursing signifies the way nurses perceive their profession, which guides their behaviours in providing quality care and ensuring patient safety. Many factors, such as, social, cultural, and technological, influence the development of nursing as a profession (Black, 2014). The healthcare system is constantly changing due to societal needs, service-user demands, government policies, technological developments, and economical pressures. As well, these changes affect the nature of healthcare establishment. Therefore, the image of nurses reflects their level of professionalism which essential for their public image (Shukri, et al, 2013).

An important question to ask is from where do curriculum developers obtain their basic understanding of education and curriculum. Curriculum developers' thinking does not exist groundless, nor does the curriculum development. There exists a common pool of information from which individuals draw their requirements and this database, which becomes the foundation upon which curriculum conceptualization is built. Thus, curriculum foundation may be defined as those basic forces that influence and shape the minds of curriculum developers and hence the content and structure of the subsequent curriculum. Together these foundation sources provide a background of information upon which the curriculum developers rely to make future curriculum decisions.

Having reviewed the concepts of culture, culturally congruent care and curriculum to establish the basis of Lawton's cultural analysis model, I assert that these alone are not enough to create a nurse education curriculum. A cultural model along with a sound philosophical foundation is required for a sustainable curriculum. Therefore, it was important to conduct a literature review on some current literature

on cultural care and professionalism. Also, review some the fundamental philosophies rooted in grand theories (Lawton, Stenhouse, and Bruner) and contemporary educational perspectives along with Islamic philosophies. Moreover, it was important to review the general approaches to curriculum development and their underpinning philosophies that dominate the literature on nursing curriculum development. Additionally, examining literature on the influence of context in the curriculum development process is most useful.

2.2 The Philosophical Foundations of a Curriculum

The centre of most contemporary educational theories is a particular worldview that reflects certain values and beliefs regarding the purpose of and approach to education. According to Basil Bernstein (1973b), a theorist on curriculum, *“curriculum defines what counts as valid knowledge”*. Therefore, philosophical notions regarding teaching and learning, together with the political, cultural, and economic factors, constitute a particular model of reality, which explicitly or implicitly directs curriculum design and implementation. In order to explore the MoH’s approaches to nursing education and its congruency with Omani culture, understanding the theoretical orientation from which it originates is most useful.

The epistemological foundations of the curriculum are reflected in the various philosophies developed by curriculum experts. Ornstein (2011) says that curriculum differences echo the multitude of ways in which decision makers interpret educational philosophies and their influence on curriculum. The philosophical orientation of the decision makers governs their approach to curriculum development. There are various philosophical orientations, such as realism, idealism, pragmatism and existentialism (see table 2.1).

Table 2.1: Philosophies on the Nature of Knowledge

Philosophy	Definition of Knowledge
<i>Realism</i>	Knowledge is something that may be known, that can be verified through empirical study.
<i>Idealism</i>	Knowledge is the meaning that the learner attaches to what is learnt in the form of ideas.
<i>Pragmatism</i>	Knowledge is achieved through the learner's transactions with the environment and personal experiences that result in a process of knowledge construction.
<i>Existentialism</i>	Knowledge contributes to the self-actualisation of the individual.

*** (Billings & Halstead, 1998; Ornstein & Levine, 1993)

Realism views knowledge as something that may be identified and confirmed through empirical study (Billings & Halstead, 1998; Ornstein & Levine, 1993). In this perspective, the learner learns to describe objectively studied subjects. Idealism views knowledge as the meanings that the learner attaches to what is learnt, which are described as ideas (Billings & Halstead, 1998; Ornstein & Levine, 1993). From this perspective, the learners studied different subjects in order to develop conceptual thought processes that assist them in obtaining a general viewpoint on the world. Pragmatism views knowledge as a process constructed by the learner's transaction with the environment and their personal experiences (Billings & Halstead, 1998; Ornstein & Hunkins, 1998). From this perspective, the learner learns through the interaction with their context and perceived experiences. Existentialism views knowledge as values that contribute towards self-actualisation of the learner. From this perspective, the learner converts objective knowledge about the external world into personal knowledge through a process of internalisation (Billings & Halstead, 1998; Ornstein & Hunkins, 1998).

Education, and therefore curriculum, is essentially concerned with knowledge. Lovat and Smith (1995) claim that an ideology shapes the way we retain knowledge and understand the world. Therefore, ideologies of the curriculum developers regarding epistemology direct their interpretations of the nature of knowledge, which is then reflected in the proposed curriculum. Therefore, an understanding of

some of the most common Western educational philosophies and an overview of the Islamic philosophy of education would be most useful.

2.2.1 Western Educational Philosophies

An educational philosophy guides the curriculum development process. The most common educational philosophies that have influenced the curriculum development process include essentialism, progressivism, and reconstructionism (Ornstein, 2011). Ornstein (2011) presents these philosophical standpoints in relation to curriculum development as traditional philosophy (essentialism), and contemporary philosophy (progressivism and reconstructionism). An overview of these educational philosophies is discussed below.

2.2.1.1 Essentialism

Essentialism, which is embedded in idealism and realism, contends that both body and mind are important in education. According to Gaudelli (2002), essentialists view knowledge and skills as essential features of a successful society because they enable the individual to be an economically productive member of society. Therefore, the aim of education is to equip the learners with the necessary knowledge to establish the “*essential things that a mature adult needs to know in order to be a productive member of society*” (Hearne & Cowles, 2001). From an essentialist’s viewpoint, knowledge is what is real, and reality exists external to the individual and can be observed. Nevertheless, essentialists believe that only certain subjects are capable of cultivating the intellect, and are essential if the educational curriculum is to realise its purpose. Ornstein and Hunkins (1998) assert that essentialists acknowledge that essential knowledge and skills might change over time. This is determined by what is essential to know in order to function as a mature and productive individual, both at present and in the future.

In conclusion, essentialism emphasises that a curriculum cannot be based on learners’ needs and wants, but rather on what those in authority believe is essential for the learners to know. Therefore, the main purpose of education is to equip the student with the essential knowledge and skills required for the assigned work, in this case, nursing. However, this approach totally disregards learners’ needs and

interest in education. Progressivism may offer a better approach to nursing education.

2.2.1.2 Progressivism

Progressivism is associated with a dissatisfaction with the traditional education approaches, which focus on content. There are two views on progressive education discussed in the literature of educational philosophy (Billings & Halstead, 1998; McNeil, 1996; Ornstein & Hunkins, 1998; Ornstein & Levine, 1997). The first is the European view, often referred to as “child-centred” education, which goes against controlling the learner’s experiences by means of the conservative principles of traditional education (Tanner & Tanner, 1995). The basic idea of this European view is that children have the potential to become distinct and individual if not untainted by societal influences and thinking. The second view is existentialism, which is based on the view that the world is not objective and therefore, individuals must discover their own meaning for existence (Noddings, 1995). So, meaning for individual’s existence is merely established by freedom of choice and reflection.

Despite the differences between the broad views of progressivism, a number of similarities exist regarding ideologies of education. According to progressivism, knowledge is not stagnant but dynamic. Also, the learner’s interests and needs are just as significant as the learned content. Progressivism perceives that experience is the best source of knowledge, not the textbook; therefore, learners learn best by doing, experimenting and finding meaning in their own actions and in the consequences of their decisions. From this perspective, an educational curriculum needs to focus on the learner’s experiences and interests rather than on predetermined forms of knowledge.

In Oman, the general approach to education, as in other countries the region, is similar to what Freire (1970) calls the model of “banking education”. In this model, the learner-teacher relationship is centred on the viewpoint that the teachers hold all the knowledge and the learners know nothing. The teacher lectures and the

learners passively listen. As a result, nursing educators and learners became resistant to the notion of learner-centred approaches (Emenyeonu, 2012).

2.2.1.3 Reconstructionism

Reconstructionism views education as a method of producing essential social change, especially in the areas of socio-politics, economics and culture. According to Kilgour (1995), reconstructionism centres on the belief that societal change can be achieved through education. From this perspective, the aim of education is to reconstruct society through learners' attainment of problem-solving skills (Stern & Riley, 2002). Reconstructionists perceive that problem-solving skills can resolve social and economic inequalities. There are two views within reconstructionism. The first is ideological reconstructionism, which emphasises theory development. The second is methodological reconstructionism, which emphasises the use of research-based strategies for achieving social change in education (Weltman, 2002). In this view, the basis for making decisions about educational curriculums should be based on data gathered on the learner's needs, interests and characteristics, context and the views of subject experts (Tyler, 1949). Undoubtedly, this is missing in the current MoH's approaches to nurse education (Emenyeonu, 2012).

Having explored some of the prominent works on Western-based philosophical foundations of curriculum, I turn to the Islamic philosophy of education to explore further the conflicts that surround nursing curriculum development in the context of Oman, which is fundamental to this study.

2.2.2 Islamic Philosophy of Education

The Islamic philosophy of education is mainly derived from the Quran (Abdullah, 1982). According to Dabashi (1993), Maududi, (1980), and Nasr (1985), Islam is a comprehensive system covering and incorporating the political, social and economic together with personal, moral and spiritual aspects of existence. Therefore, the purpose of education is the holistic development of the individual. Education in Islam is concerned with the ways individuals develop knowledge to enable them to follow the path of virtue and become valuable members of society.

Various authors such as Tibawi (1972), Al-Attas (1979) and Ashraf (1995), claim that in Islam learning is a religious duty, which is “*compulsory for every Muslim male and female*” (Karim, 1938). In Islam, education’s role is perceived as giving meaning to existence, introducing discipline, maintaining human values, and advancing societies. Therefore, Omani culture, as part of the Islamic world, approves that education should be based on holistic development of the learner in regards to knowledge, skills and attitudes. Furthermore, Islamic educational philosophy states that the educational curriculum is obligated to provide knowledge that enables the holistic development of the individual, and it should not be based on individual choices or market needs. These perceptions add to increased expectations of the learners and the society from educational institutions to provide a holistic education and not only focus on the acquisition of knowledge and skills (Emenyeonu, 2012).

In conclusion, the Islamic approach to education attempts to produce a well-rounded individual. However, as discussed in Chapter One (section 1.3), the lack of nursing models that are founded on the Islamic values and the predominance of the Western-based education ideology in the region has limited the adaption of these values into nursing education, which might create an educational system in conflict with the local value system.

After exploring the educational philosophies, which are the foundation of the curriculum development process, I move to explore and understand the most prominent curriculum approaches in order to explore the MoH’s approaches to curriculum development in nursing education.

2.3 Curriculum Development Approaches

There are three different and conflicting approaches to curriculum development. These include content-driven, competency/outcomes-based, and process-based. These three approaches continue to dominate the literature on nursing curriculum development. Table 2.2 depicts these three broad approaches to curriculum development and their underpinning philosophies. Each approach places a great

value on a particular aspect of the curriculum, such as content, outcome or process, which is also implied by the name.

Table 2.2: Curriculum approaches in the context of nursing

Curriculum approaches	Content-based approach	Competency-based approach	Process-based approach
Philosophy	Essentialism	Reconstructionism	Experimentalism
Purpose of nursing education	Transmission of worthwhile nursing knowledge.	Understanding of social, political & economic factors of health & disease.	Understanding of the world of nursing as complex.
Curriculum purpose	Core nursing subjects	Social, economic, & political issues affecting the health of the people.	Learners' experiences of the world of nursing, health & disease
Nature & role of the teacher	Expert in the discipline; identifies, selects, organises & transmits worthwhile knowledge to the learner.	A critical mediator of knowledge through creating spaces for critical reflection & action.	A mediator of knowledge via questioning & experiences that facilitate the students' understanding of their professional role.
Nature & role of the learner	A passive & willing recipient of information.	Atone with their community. Questioning & challenging the status quo.	Need to make connections between their experiences in nursing & the world.
The teaching/ learning process	Teacher-directed with emphasis on knowledge acquisition methods	Issue-based learning with emphasis on a preference for socio-cultural approaches, e.g. debates	Experience-based learning with emphasis on methods that promote active learning.

*** (Uys & Gwele, 2005)

2.3.1 Content-Driven Curriculum

A content-driven curriculum is embedded in the essentialist view of education. This approach to curriculum views that most disciplines have knowledge bodies which are essential for the learners to understand. The content-focused approach is the most commonly used approach in designing nursing curriculum. Fraser and Bosanquet (2006) assert that this approach views the curriculum as “product” and is entirely discipline-focused. Therefore, a content-driven curriculum allows the industry requirements to control the structure and content of the educational

programme. This notion of curriculum development is similar to the MoH approach to its educational programmes, particularly nursing.

A content-driven curriculum starts with a list of content that must be taught, often starting with the sciences. Despite the integration of courses and the use of multidisciplinary teams, the basic approach to curriculum in most nursing programmes remains content-based. Wellard and Edwards (1999) describe this type of curriculum as a traditional curriculum model. The teaching/learning process is predominately lectures combined with discussions. As a result, the learners are expected to embrace the learned material and be able to recall it when required or during exams. The current MoH nursing curriculum is unquestionably entirely a content or discipline-based curriculum. Hence, all the courses are core-nursing subjects with few biomedical support courses. In addition, the current curriculum is inflexible and rigid due to the limitations of the duration of study. As a result, the curriculum is teacher-centred and emphasises the acquisition of knowledge for the purpose of passing exams. The aim of the teaching/learning process has become focused on the acquisition of knowledge; however, how much of the knowledge is retained after graduation is questionable. To overcome this issue, a competency-based curriculum offers a solution through using identified observable and measurable competencies, in which the learner is expected to accomplish; he/she is deemed competent. This leads to the competency-based curriculum discussed in the next section.

2.3.2 Competency or Objective Based Curriculum

Outcome, objective or competency based curriculum (CBC) is based on various philosophical foundations, which makes it difficult to affiliate to a specific one. Watson (2002) defines a learning outcome as “*being something that a student can do now that they could not do previously ... a change in people as a result of a learning experience*”. From this perspective, educational curriculum should use learning outcomes to assist the learner to accomplish desired changes through the teaching/learning process. Similar to the essentialist perspective, CBC is based on identifying specific outcomes, which are considered crucial for all learners to

achieve to be considered competent and gain a particular qualification. If appropriately applied, the CBC approach to curriculum can create critical learners who perceive education as a holistic process rather than one merely concerned with the acquisition of knowledge and skills, and gaining the appropriate attitudes to be deemed competent professionals (Slattery, 1995).

According to Carey and Gregory (2003), Ralph Tyler is the pioneer of the “*objectives-based*” approach to curriculum development. He proposed four essential questions that curriculum developers should address while designing a particular curriculum (1949). These basic questions are:

1. What is the purpose of the curriculum?
2. What educational experiences can be provided to attain these purposes?
3. How can these educational experiences be organised effectively?
4. How can we determine whether these purposes are being attained?

These basic questions represent a framework for designing a curriculum and provide a tool that simplifies the complex task of curriculum development (Tanner & Tanner, 1995). Although Tyler’s principles were widely criticised, it remains a helpful framework for designing a curriculum.

Another well-known contributor to the development of outcomes-based curricula was Benjamin Bloom. In 1956, he published a book titled “*A Taxonomy of Cognitive Objectives*”. He offered a framework for classifying the learning process in terms of students’ cognitive development. The cognitive development process consists of five levels: knowledge, comprehension, application, analysis, synthesis and evaluation. Bloom’s taxonomy has influenced the design of numerous outcomes-based educational curricula (Coates, 2000). In the UK, recent educational reforms in higher education (HE) prompted by the Dearing Report (1997) have resulted in a significant increase in awareness and use of Bloom’s taxonomy.

According to While (1994), a key disadvantage to CBC is that it is concerned with the learners’ activity rather than their knowledge. CBC assumes that competencies are easily identifiable (While, 1994). Although it is easier to evaluate competencies that can be reproduced, assessed, and measured, it is difficult to assess others, such

as problem solving skills and interpersonal skills (Chapman, 1999). Also, CBC is open to the subjectivity of the assessors, particularly in clinical performance, since nursing educators come from various education/clinical backgrounds. According to Chapman (1999), the nursing educators' expectations of clinical education and the student-teacher role are likely to be vastly different. Further, CBC approach is misused by reducing the learning competences into sets of skills, for example, how to administer an intramuscular injection. When students are able to demonstrate certain skills, they are deemed to have completed the process. When students are able to demonstrate certain skills, they are deemed to have completed the process. Whether or not students are able to apply the skills to make sense of the world around them is somehow overlooked. With the limited duration and resources of the current MoH nursing programme, how much the learners are expected to accomplish for them to be deemed competent is debatable. This leads to the next section where the process-based curricula, on the other hand, focuses on helping learners learn how to learn.

2.3.3 Process-Based Curriculum

From the perspective of process-based approach, educational institutions, including nursing programmes, have a limited time to prepare students for a wide range of knowledge professional work. Therefore, educators can assist and support learners learn how to find, analyse and interpret information to enable them to problem solve. This view on curriculum development is in contrast with the content-based approach, which prioritises content (Knight, 2001). The process-based approach offers a broader and more holistic understanding of curriculum, which embraces a far more dynamic approach, focusing on the teaching/learning context (Fraser & Bosanquet, 2006).

Lawrence Stenhouse (1975), in his book *"An Introduction to Curriculum Research and Development"*, argues that objective-based curricula proposed by Tyler (1949) is too narrow in focus, teacher-centred, and insensitive to the complexities of the teaching/learning process. He claims curriculum development depends neither on particular content nor on particular learning objectives, but instead on teacher–

learner interaction (Stenhouse, 1975). According to Stenhouse (1975), the objective model is “*an ends-means model which sets arbitrary horizons to one’s efforts*”. He asserts that curriculum development should focus on the actual interaction between learners and teachers instead of the written objectives and content. Further, Stenhouse (1975) argues that “curriculum development” is equivalent to “professional development”. He emphasises that the effectiveness of curriculum development is highly dependent upon the quality of the teachers (Stenhouse, 1975). Yet, the model proposed by Stenhouse is not faultless. First of all, he uses the concept of professionalism to indicate that teachers should be aware of whether or not they are performing well, however, he does not give an explanation for what is involved in “*a detailed analysis of the nature of the professional knowledge*” (Carr, 1989). The second issue revolves around Stenhouse’s argument that the strength and weakness of the process-based approach is totally reliant on the quality of the teacher, which prompts questions regarding the types of teachers required to implement the process-based approach. In addition, what qualities deem one to be labelled a strong or a weak teacher? Is the process-based approach supportive of those teachers deemed too weak to achieve the quality needed to teach? According to Stenhouse (1975), the teacher is the researcher in his or her own practice, which makes them responsible for their own professional development. Also, he claims that teachers’ work is a fundamental and crucial drive of any educational reform (Stenhouse, 1985). In nursing education, problem-based learning has become a dominant factor derived from the process-based approach. The benefit of this approach to curriculum puts teaching/learning at the centre of the educational process. As a result, learners acquire the knowledge and skills to deal with both current and future professional situations.

In conclusion, curriculum development in any educational programme, including nursing, proceeds from particular philosophical foundations (Uys & Gwele, 2005). Without doubt, no ideological perspective is used in isolation, but the clarifications of values and beliefs about the purpose of nursing education, the nature of knowledge, and the roles of the teachers and learners in the educational process

would allow the educational institution to monitor its own practice regarding meeting its established aims.

In order for the process of nursing curriculum development to proceed effectively and efficiently, the context in which it is carried out must be considered. This study examines the MoH nursing approaches to nurse education in the context of Oman; therefore, examining literature on the influence of context in the curriculum development process is most useful.

2.4 The Context of the Curriculum

The perception of the curriculum as a social and political construction appears in the work of authors such as Ahier and Ross (1995), Apple (1988, 1996, 2000), Goodson (1988, 1994), and Lawton (1980, 1996). Curriculum development can be isolated from the influences of the context, which it occurs in. The concept context refers to any combination of historical, political, social, cultural, religious, or economic factors. Many education theorists recognise the huge impact of the political aspect of any context on the curriculum development process (Harden, 1986; Pratt, 1980; Posner & Rudnitsky, 1997). Stenhouse (1975) asserts that curriculum is a field of ideological and political conflict that occurs in all societies to create and provide a meaning to the concept and process of education. Curriculum is also a reflection of any society's culture (Reynolds & Skilbeck, 1976; Lawton, 1983; Goodson, 1994; Mel, 1996). Therefore, choices and decisions about a curriculum should be based on thorough understanding of the educational ideologies behind the curricula, and culture or context is central to these pedagogical practices.

According to Emile Durkheim (1922), education is a replica and reflection of any society. Consequently, education enables a society to prepare its subsequent generations to meet its own cultural ideals. Lawton and Gordon (1996) assert, "*All societies have the task of passing on to the next generation the knowledge and skills regarded as particularly worthwhile; ...societies achieve this by means of education*". Similarly, Talcott Parsons claims that education is a reflection of the social structure, and the role of the education institution is to maintain the social

order (Parsons & Platt, 1973). Young (1971) argues that curriculum is constructed socially because education is based on knowledge selected at a particular time and administration. According to numerous educationists, education is not a neutral process (Bode, 1937; Moore, 2000; Smeyers, 1995). Freire (1998b) asserts that education “*demand from educators that they take it on as a political act*”. Paul Willis (1977), in his well-known work “*Learning to Labour-How Working Class Kids Get Working Class Jobs*”, has provided an insight in to the role of cultural practices within an educational institution. Willis (1977) highlights that the process of social reproduction in an educational institution is based not only the predominant institutional determinants, but also on the cultural practices shaped by institutional contexts.

Jerome Bruner (1996), in his book “Culture of Education”, sheds more light on the role of culture in a curriculum. He asserts, “*Culture shapes the mind*” and provides us with the tools by which we construct not only our worlds but also our conception of ourselves (Bruner, 1996). For Bruner (1996), education and learning involves the consideration of their situated cultural context. Bruner (1996) argues that the surrounding social environment shapes mental activity. He states that “*mental life is lived with others, is shaped to be communicated, and unfolds with the aid of cultural codes, traditions, and the like*” (1996). Therefore, it is important to explore what function education serves in a particular culture. According to Rogoff (2003), when developing an educational programme for the members of a society, it is essential to understand the cultural values and practices of its context. Bruner (1996) asserts that human experiences are social and shaped by culture. Therefore, individuals create meanings in their own cultural contexts. This view of learning acknowledges that meaning-making processes and human action is largely influenced by the cultural contexts. As a result, cultural contexts shape our thinking, which subsequently shapes our learning.

Educational aims or “*ways of knowing*” are formed by the interaction with a culture (Bruner, 1996). Bruner presented the ideas of *computationalism* and *culturalism* (1996). *Computationalism* is the data handling aspect of thought and memory, which includes storing learned facts in a memory location (Bruner,

1996). However, meanings of facts cannot be interpreted without a context, which requires *culturalism* (Bruner, 1996). *Culturalism* is the idea that all knowledge and meaning is situated within a particular set of symbols, so meaning is assigned to things in the context in which they are introduced and used (Bruner, 1996). From this perspective the meaning-making process is dependent upon the set of cultural “tools”, which include verbal and non-verbal language, that are used to interpret it (Bruner, 1996).

Bruner (1996) argues that education is significant to the maintenance and replication of the culture as a whole. Therefore, it enables new societal members to be introduced into their cultural norms. Bruner (1996) asserts that the idea of uniformity in instruction will not meet the needs of all learners because each person understands the world in a unique way that reflects the cultural environment in which they exist. Thus, culture offers overall frames of reference for individuals to create meanings of daily events and classroom lessons (Bruner, 1996). This implies that educators need to assess the existing values and beliefs of the learners to modify their instruction in light of them, instead of assuming that learners absorb classroom lessons as presented.

Despite Bruner’s discussion on how cultural influence affects how we come to understand the world around us, and consequently effects the educational system, he failed to illustrate how other cultural factors such as politics and socio-economics affect decisions about education. Moreover, Bruner’s work did not offer a comprehensive view of the role of culture and its context in the development and implementation of an educational curriculum. Instead, Bruner spends a lot of time arguing that culture plays an integral role in the way we construct our own realities based on our shared cultural beliefs and values. Moreover, the learner focuses on the how to learn, rather than what to learn.

In conclusion, Bruner emphasises that “*learning without meaning is not learning and can never be retained*” (1996). Therefore, education should reflect its cultural context, which is an important aspect to understanding the learners’ needs and societal needs,

After exploring the different aspects of the curriculum development regarding philosophical foundations, approaches and the role of context, it is essential to explore the most common nursing theories/models view cultural congruency in nursing education.

2.5 Culturally Congruent Care in Nursing Education

There is an established need to include cultural aspects of care in nursing curricula (Brathwaite & Majumdar, 2006; Dyson, 2007; Leininger, 1991; Papadopoulos et al., 1998; Purnell & Paulanka, 2003). Various models exist that assist in developing the essential cultural competent knowledge and skills in nursing (re). According to Schon (1987), professions such as medicine and nursing that involve making judgement in a complex situation, may cause conflict between their own values and those of their patients. Therefore, a key aim of culturally competent education involves providing the learner with sufficient knowledge and skills to adapt to various situations and environments. Jeffreys (2006) asserts that a culturally congruent care is a consequence of nursing care provided by a culturally competent nurse.

Cooper (1996) claims that “good care” is a culturally based phenomenon. While caring for various patients, nurses may project their own culturally based values onto patients from backgrounds different to their own (Thiederman, 1986). To avoid such situation, there are numerous cultural competence models in nursing which include the Purnell (2005) model for cultural competence and the process of cultural competence in the delivery of healthcare services (Campinha-Bacote, 2005). According to Mahoney and Engebretson (2000), cultural care involves proper communication skills, which are vital to building a strong nurse-patient relationship. Culturally competent education minimises the effects of ethnocentrism, a belief that the individual’s way of life is superior to others (Leininger, 1978). According to Greipp (1995), ethnocentrism can compromise the nurse-patient relationship, and result in misdiagnosis, mistreatment, and undertreatment of patients. Consequently, identifying ethnocentric attitudes and behaviours is crucial to providing culturally competent nursing care (Harris &

Cummings, 1996). However, nurses exposed to largely homogeneous cultural contexts may experience difficulty in identify unique characteristics of their own culture (Habayeb, 1995).

Generally, nursing education has been influenced by biomedical models that can be reductionist and contrary to the holistic nature of nursing. Therefore, nursing curriculum developers must recognise the impact of the biomedical model on a nursing student, which tends to be “*culture of no culture*” (Taylor, 2003a). An alternative is offered by the transcultural nursing approach, which advocates a more comprehensive, multicultural pedagogy in curriculum development (Clark & Robinson, 1999). Furthermore, it is essential for nursing education to emphasise the importance of learning ethics (Doane, 2002).

Table 2.3: Summarising key current empirical literature regarding transcultural nursing from an international perspective.

Source	Summary
1. Chenoweth, L., Jeon, Y.-H., Goff, M. & Burke, C. (2006). Cultural competency and nursing care: an Australian perspective <i>International Nursing Review</i> ; 53, 34–40.	Cultural diversity is a feature of the Australian healthcare system and is affecting significantly on nursing care quality. Cultural insensitivity in care practices leads to poor quality outcomes for the healthcare users and their families. Strategies This paper offers a process that will facilitate cultural competence in Australian nursing practice by proposing to reverse the current practice and promote culturally competent nursing care and that locates overseas-qualified nurses in this process. According to the authors, nurses must pay attention to interpersonal relationships and develop respect for the health user’s value systems and ways of being, in order to protect their rights and avoid the tendency to stereotype individuals from particular cultures. Similarly, the expertise of qualified nurses from different cultures can greatly contribute this process.
2. Gebru, K., Khalaf, A., & Willman, A. (2008). Outcome analysis of a	This study aimed at describing and analysing to what extent promoting culturally competent nursing care through education have been achieved from a student perspective. The Swedish society has changed into a

research-based didactic model for education to promote culturally competent nursing care in Sweden– a questionnaire study. <i>Scandinavian Journal of Caring Sciences</i>; 22; 348–356.	multicultural society over the last 50 years, therefore, there a need to for the nursing programmes to introduce transcultural concepts for proper healthcare for patients. In this paper, a research-based didactic model was designed for the nursing programme in Malmö University and this was followed by examination of its outcome. The study was a prospective cohort study with an outcome analysis. A descriptive research study with a longitudinal design was performed, with the focus on Swedish nursing students' experiences of transcultural nursing knowledge and their attitudes before and after implementation of the didactic model. The students were evaluated highly on their competence to meet demands of multicultural health and medical service. Additionally, their ability to recognise and understand the consequences of international migration on health also received a high mean. In conclusions, the study revealed that knowledge and experience acquired by Swedish students in transcultural nursing. The assumption was that a visible development of knowledge should occur during the three years of education. Interpreting the findings, such effectiveness can be found and hopefully the students will be able to give holistic nursing care based on a person's individual culture.
3. Kardong –Edgren, S. & Campinha-Bacote, J. (2008). US Bachelor of Science Nursing students. <i>Contemporary Nurse</i>; 28: 37–44.	This study evaluated the effectiveness of four different nursing program curricula in developing culturally competent new graduates. Four methodologically and geographically diverse groups of graduating BSN students in the United States were given the Inventory for Assessing the Process of Cultural Competency Among Healthcare Professionals-Revised (IAPCCC-R®) prior to graduation and after completion of course work. Varieties of curricular methods for achieving cultural competency were included. Two programs utilise a theory or a model developed by recognised transcultural expert nurses, Madeline Leininger and Josepha Campinha-Bacote. One program utilised an integrated approach employing no specific model. One program utilised a freestanding two-credit culture course within the curriculum, taught by nursing faculty with strong cultural preparation. Results indicate that these 212

	graduating nursing students scored only in the culturally aware range, as measured by IAPCCC-R®.
4. Torsvik, M., & Hedlund, M. (2008). Cultural encounters in reflective dialogue about nursing care: a qualitative study. <i>Journal of Advanced Nursing</i>; 63(4), 389–396	This paper a report of a study to explore how students developed reflective nursing practice through cultural encounters between students from Tanzania and Norway. According to the authors, nursing students need to develop cultural care competence to care for patients in a globalised world. To achieve this goal may be through international practice experience. Previous studies have shown that students visiting developing countries matured personally and intellectually more than those who experienced encounters between developed countries. The study was exploratory, using qualitative data about nursing practice and cultural encounters experienced by nursing students from Tanzania and Norway. Three main themes were identified. The Norwegian students emphasized nurse–patient relationships, individualized care, direct communication and emotional involvement. The Tanzanian nursing students demonstrated a collectivist approach in nursing characterized by nurse–relative–patient relationships, and they emphasized curing attributes with focus on competency in skills. According to the study, cultural encounters between students from different culture is a way to share thoughts, reflect on value systems and personal practice through dialogue with students from a different culture. Therefore, contribute to cultural competence, reflexivity and consciousness of various ways practising nursing.
5. Mixer, S. (2011). Use of the Culture Care Theory to Discover Nursing Faculty Care Expressions, Patterns, and Practices Related to Teaching Culture Care. <i>The Online Journal of Cultural Competence in Nursing and Healthcare</i>; 1(1), 3-14.	In this study, ethnonursing method was used to discover nursing faculty care practices that support teaching students in providing culturally congruent care within baccalaureate programs in urban and rural universities in the Southeastern United States of America. Participants consisted of twenty-seven Anglo- American and African American faculty. The main four themes were revealed were the following: ○ Participants’ care is embedded in religious values, beliefs, and practices. ○ Participants’ taught culture care without an organizing framework. ○ Participants ‘provided generic and professional care to nursing students.

	○ Care is essential for participants' health and wellbeing to teach culture care. According to the study, culture care action and decision modes offer insight into teaching students to provide culturally congruent care. This study supported Leininger's (1991) culture care theory. The study contributed to the practice of nursing through understanding the complex nature of teaching culture care and added to the body of transcultural nursing education knowledge.
6. Koskinen L, Campbell B, Aarts C, Chassé F, Hemingway A, Juhansoo T, Mitchell MP, Marquis FL, Critchley KA & Nordstrom PM. (2009). Enhancing cultural competence: Trans-Atlantic experiences of European and Canadian nursing students. <i>International Journal of Nursing Practice</i> 2009; 15: 502–509.	This paper describes the enhancement of cultural competence through trans-Atlantic rural community experiences of European and Canadian nursing students using critical incident technique (CIT) as the students' reflective writing method. The data generated from 48 students' recordings about 134 critical incidents over a 2-year project were analysed by qualitative content analysis. Five main learning categories were identified as cross-cultural ethical issues; cultural and social differences; healthcare inequalities; population health concerns, and personal and professional awareness. Four emergent cultural perspectives for the health sector that became apparent from the reflections were health promotion realm; sensitivity to social and cultural aspects of people's lives; channels between the health sector and society; cultural language and stories of local people. CIT was used to foster European and Canadian undergraduate students' cultural reflections resulting in considerations and suggestions for future endeavours to enhance cultural competence in nursing education.
7. Ayaz, S., Bilgili, N. & Akin, B. (2010) The transcultural nursing concept: a study of nursing students' in Turkey. <i>International Nursing Review</i>; 57, 449–453.	According the authors, Turkey is comprised of different cultures, which creates some difficulties in patient care. Cultural sufficiency while providing healthcare to the patients contribute to satisfactory care delivery. The study looked at the cultural diversity that the students experienced between the patients and themselves while providing care to patients and their knowledge of transcultural nursing. The study was a descriptive study, included total of 622 undergraduate students (out 665) attending the nursing schools of three universities, and a survey was used for data collection. Most of the students (85.5%) had experienced cultural differences while giving care to their patients and 73.8% did not know the

	definition of this concept. Cultural differences were experienced to the highest degree were differences in dialect and pronunciation (53.4%), differences of language (37%), traditions and customs of the individual (30.7%), and religious belief and sect (30.2%). The significant effect on the experience of cultural differences ($P < 0.05$). In conclusion, the majority of students experience cultural diversity while providing patient care. Therefore, the study supports that transcultural care should be placed in curriculum even as a separate course to guide nursing students in all stages of patient care.
8. Taylor, G., Papadopoulos, I., Dudau, V., Maerten, M., Peltegova, A. & Ziegler, M. (2011). Intercultural education of nurses & health professionals in Europe (IENE). <i>International Nursing Review</i>; 58, 188–195	The study aimed to explore the perceived learning and teaching needs of students and practitioners of healthcare professions in relation to preparation for working in another European country and/or in a multicultural environment. The study included the following countries Belgium, Bulgaria, Germany, Romania and the United Kingdom. Questionnaires, consisting of open questions, were completed by total of 118 participants. Data analysis adopted both a priori and inductive approaches. The predetermined constructs of cultural awareness, cultural knowledge, cultural sensitivity and cultural competence were used to structure suggestions for theoretical input and practical activities and experiences. Inductive analysis revealed other emergent themes that underpin all four of these constructs. The study concluded that healthcare practitioners need to be adequately prepared for such experiences, explore values and beliefs, and to practise intercultural skills within the safe environment of an educational establishment, facilitated by skilled teachers.
9. Shattell, M., Nemitz, E., Crosson, N. Zackeru, A., Starr, S., Hu, J. & Gonzales. C. (2013). Culturally Competent Practice in a Pre-Licensure Baccalaureate Nursing Program in the United States: A Mixed-Methods Study. <i>Nursing</i>	This study examined how one pre-licensure baccalaureate nursing program at a public university in the south-eastern United States integrated concepts and issues of culture and culturally competent practice into its curriculum. A mixed-methods case study approach was used and data were collected from student surveys ($n = 111$), student focus groups (three groups, $n = 9$), faculty interviews ($n = 14$), and school of nursing documents, including the mission statement, faculty and student handbooks, and course syllabi. Data were analysed using descriptive

<i>Education Perspectives</i>; 34, 6.	statistics and content analysis. The study revealed that cultural competence is crucial for deeper engagement with care. The findings suggest teaching/learning strategies and curricular design may lead to greater student and faculty cultural understandings.
10. Hawala-Drury, S. & Hill, M. (2012). Interdisciplinary: Cultural competency and culturally congruent education for millennials in health professions. <i>Nurse Education Today</i>;32 (7), 772-778,	The increasingly diverse multicultural and multigenerational student population in the United States requires that educators at all levels develop cultural knowledge, awareness, and sensitivity to help diverse learners fulfil their potential and to avoid cultural misunderstandings that can become obstacles or barriers to learning. The purpose of this study was to design and implement eclectic, creative, evidence-based interdisciplinary educational activities, along with culturally congruent teaching strategies, within a semester-long university course that promoted positive and culturally competent learning outcomes for culturally diverse, largely millennial students. The interdisciplinary course would prepare health professional students with the requisite knowledge and skills, through transformative learning that produces change agents, to provide culturally congruent and quality team-based care to diverse populations. This was a qualitative and quantitative study, which measured students' level of cultural awareness, competence, and proficiency pre-and post the educational intervention. Instruments used for data collection included the Inventory for Assessing The Process of Cultural Competence-Student Version (IAPCC-SV) by Campinha-Bacote, course evaluations, students' feedback, and portfolio reflections. The study was conducted at a private academic institution located in the Mid-Atlantic region and the sample population included inter-professional students (N=106) from various health professions including nursing, pharmacy, and allied health sciences. Results from the pre- and post-test IAPCC-SV survey revealed that mean scores increased significantly from pre-test (60.8) to post-test (70.6). Thus, students' levels of cultural competency (awareness, knowledge, skills, desire, and encounter) improved post-educational intervention, indicating that the teaching methods used in the course might be applied on a larger scale across the university system to cater to the nation's increasingly multi-cultural population.

11. Al-Kandari, F., Vidal, V. & Thomas, D. (2009). Assessing clinical learning outcomes: A descriptive study of nursing students in Kuwait. <i>Nursing and Health Sciences</i>; 11, 252–262.	This study examined the perceptions of 202 nursing students, 14 faculty members, and 32 clinical instructors in the achievement of nursing students' clinical learning outcomes during their different clinical placements. The participants were involved in the bachelor of science in nursing and associate degree in nursing programs. Nine dimensions were studied using the Kuwait Clinical Learning Outcomes for Nursing Students tool. These were knowledge, nursing process, communication, student role, accountability, teaching/learning, organization, caring, and psychomotor skills. The perception of achievement of the clinical learning outcomes was 72% for the students, 77% for the faculty members, and 75% for the clinical instructors. The scores of both the faculty members and the clinical instructors for the student role were significantly higher than the scores of the students. The findings confirmed that the quality and type of clinical placement have a significant impact on the achievement of clinical learning outcomes and provide a strong base for students' development as future professionals.
12. Serizawa, A. (2007). Developing a <i>Culturally Competent Health Care Workforce in Japan: Implications for Education. Nursing Education Perspectives</i>; Vol. 28 No.3	According to author, in the past few years, the population of foreign nationals from diverse cultural, racial, ethnic, and linguistic populations has steadily increased in Japan. There has been an apparent failure by the healthcare system to deliver culturally congruent care services, which resulted in dissatisfaction with the healthcare system on the part of foreign nationals and increased potential for adverse healthcare outcomes. The paper highlighted that the chief causes of lack of a culturally competent healthcare workforce are include limited exposure to foreigners, cultural factors, and language difficulties. Therefore, it proposes strategic educational actions to address these obstacles.
13. Schrinier, C. (2007). The Influence of Culture on Clinical Nurses Transitioning into the Faculty Role. <i>Nursing Education Perspectives</i>; Vol. 28 No.3	The purpose of this qualitative study was to describe how cultural differences and similarities affect the transition of nurses into the faculty role from professional clinical practice. Components of culture (e.g., values and beliefs) of seven nurses new to the faculty role were examined using multiple methods of document review, interviews, and observations. Results demonstrated that cultural dissonance creates conflict in new nurse faculty as the values they bring from clinical practice influence their transition into academe. Cultural dissonance can be

	improved through formal education, mentoring, and socialization to the faculty role. It is recommended that schools of nursing adopt the values inherent in the nursing profession.
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There has been much discussion in the literature on what and how to cultural competence in nursing education and practice (Campinha-Bacote, 1999; Giger & Davidhizar, 2004; Leininger, 1991; Papadopoulos, 2006; Papadopoulos et al., 1998; Purnell and Paulanka, 2003). The healthcare professional literature supports a growing consensus that cultural competency curricular content should focus on attitudes, skills and knowledge. Yet, the best practice or approach to teaching/training students, faculty and healthcare workforce have received little attention in the transcultural healthcare literature. Teaching and learning about culturally competent practice in pre-licensure nursing programs are essential to ensure a culturally competent healthcare workforce (Campinha-Bacote, 2008).

There is evidence that achieving high-quality care and positive health outcomes is mainly dependent on effective communication between patients and their healthcare providers (Gerrish, 2000). Achieving communication competence requires more than just speaking the same language, or making provision for interpretation, it entails understanding of and sensitivity to the patient's social and cultural context. Therefore, cultural competence must be supported through appropriate education on the healthcare needs of the target population.

2.5.1 Leininger's Cultural Care Diversity and Universality Theory/ Model

According to Madeleine Leininger, the founder of the field of transcultural nursing, providing culturally competent care entails customising care to fit with the patient's own cultural values, beliefs, traditions, practices, and lifestyle (Leininger, 2002; Leininger & McFarland, 2002, 2006). Leininger's "Sunrise Model" portrays her theory on culture and health (Leininger & McFarland, 2006). This theory draws from anthropological observations and studies of culture, cultural values, beliefs and practices. The principal theme of Leininger's theory is cultural care, and she regards care to be an essential concept in nursing (Leininger, 1991). The aim of the Culture Care Theory is to provide culturally congruent care to individuals, families,

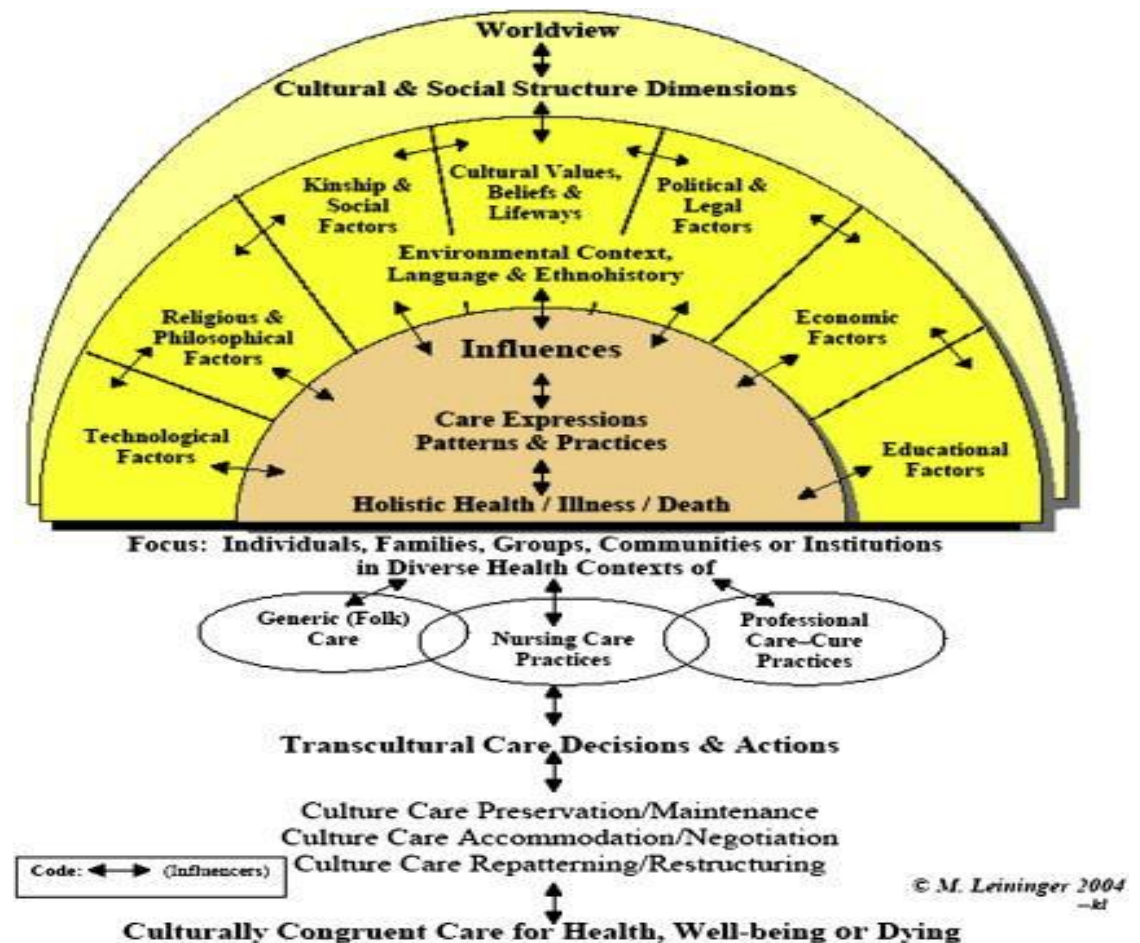
groups, communities and institutions. Culturally congruent care is defined as *“those cognitively based assistive, supportive facilitative, or enabling acts or decisions that are mostly tailor made to fit with an individual’s, group’s, or institution’s cultural values, beliefs, and lifestyles in order to provide meaningful, beneficial, satisfying care that leads to health and well-being”* (Leininger, 1995).

This theory encourages better understanding of both universally held understandings of care, as well as culture-specific beliefs regarding care. Leininger (2002) argues that this theory of cultural care diversity and universality is holistic. In this theory, culture refers to the specific pattern of behaviour that distinguishes a society from others and gives meaning to human expressions of care (Leininger & McFarland, 2006). The following are assumptions about care/caring based on Leininger’s theory:

- Care/ caring is essential to curing and healing, for there can be no curing without caring.
- Every human culture has lay (generic, folk, or indigenous) care knowledge and practices and usually some professional care knowledge and practices as well, which vary transculturally.
- Cultural care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological ethno-historical, and environmental contexts of cultures.
- A client who experiences nursing care that fails to be reasonably congruent with his/her beliefs, values, and attitudes towards caring will show signs of cultural conflict, noncompliance, stress and ethical or moral concern.
- Within a culture care diversity and universality framework, nurses may take any or all of these culturally congruent action modes including cultural preservation, maintenance of patients’ and families’ existing patterns of care and health behaviours, cultural accommodation/negotiation to modify patterns of care, and cultural restructuring/repatterning to change or repattern cultural care behaviours.

Leininger recognises the comparative aspects of caring within and between cultures, hence the acknowledgement of the similarities as much as the differences in caring across diverse cultures. The model has implications for how we assess, plan, implement, and evaluate care for people from diverse cultural backgrounds. This model has been used in a wide range of nursing specialties and across cultural groups.

Figure 2.1: Leininger's Sunrise model



*** Source: Dennis N. Munoz (2011)

According to Leininger (2002), nurses who understand and value the practice of culturally competent care are able to effect positive changes in healthcare practices for patients of designated cultures. Sharing a cultural identity requires knowledge of transcultural nursing concepts and principles, along with an awareness of current research findings. Culturally competent nursing care can only occur when patients'

beliefs and values are thoughtfully and skilfully incorporated into nursing education. Caring is the core of nursing; therefore, a culturally congruent education would guide the nurse to provide optimal holistic, culturally based care. Moreover, this educational practice would also enable patients to receive care that is familiar, supportive, and meaningful in their own cultural context. Continual improvement and expansion of modern technologies, nursing, and general science knowledge are integrated into practice if they are appropriate to the setting context. Today, nurses, on a daily basis, are faced with unprecedented cultural diversity because of increasing population migration, and Oman is no different. Nursing curriculum decision makers must realise that a culturally congruent nurse education will provide holistic supportive care to all patients (Leininger, 2002, 1991).

However, in recent decades nursing scholars and scientists have extensively critiqued the concept of transcultural nursing. Culley (1996) argues that cultural difference, with a large focus on communication difficulties, has been conceptualised in nursing discourse using a culturalist framework, thus tending to ignore some aspects of the issues of race, ethnicity and health. She criticises Leininger's model for its assumption that care and services will be improved by knowledge of different cultures. According to Culley (1996), there is a need to recognise "the very complex ways in which race, socio-economic status, gender and age may intersect." As Betancourt, et al. (2003) argue, cultural care is based on attitudes, including "humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences on the patient". He correlates this foundation with "cultural sensitivity/awareness" approaches instead of the focus on knowledge of diverse cultural traditions.

The structural and political aspects of inequality for minority ethnic people are not given primacy within this culturalist approach; moreover, the approach tends to promote culture in a negative manner, with potential contribution towards stereotypical attitudes and propagating power unbalances (Mulholland, 1995). Serrant-Green (2001) offers more reflection on the criticism of Leininger's work as minimising the roles of racism and social inequality in the health status of minority ethnic groups. She further recommends that nursing education stress the diversity

within all ethnic communities. Furthermore, Leininger's approach, especially the Sunrise Model, is too abstract to implement in practice, and adoption of such works may lead to imposition of Western values, which in turn may result in cultural incongruence.

In the next section, the Campinha-Bacote model emphasises that cultural competence is a process whereby providers gradually build cultural awareness, knowledge and skills that result in changing attitudes toward different cultures and eventually cultural competence. Learners can progress toward cultural competence through drawing on knowledge and skills to adapt to situations.

2.5.2 Campinha-Bacote Model of Cultural Competence

Campinha-Bacote et al.'s (1996) model was developed for nurse education and initially identified four elements: cultural awareness, cultural knowledge, cultural skill, and cultural encounters; later, a fifth component, cultural desire, was added to the model (Campinha-Bacote, 1999). Similar to Leininger's Sunrise model, the Campinha-Bacote model reiterates that culturally congruent nursing education should emphasise a continuum of cultural competence that is threaded throughout the curriculum (Campinha-Bacote, 2002; Kripaiani, Bussey-Jones, Katz, & Genao, 2006). Campinha-Bacote (2004) advocates a focus on becoming culturally competent as a lifelong undertaking, grounded in "cultural desire," characterised by humility, curiosity, the seeking of cross-cultural encounters, and the building of cross-cultural skills. According to Campinha-Bacote (2008), individuals and organisations begin the process to cultural competence by first demonstrating an intrinsic motivation to engage in a cultural competence process.

Cultural desire is defined as the motivation of the nurse to 'want to' engage in the process of becoming culturally competent not the 'have to' (Campinha-Bacote, 2003). Campinha-Bacote (2005) describes "cultural desire" as one's aspiration. She goes on to say that "cultural desire" includes a genuine passion and commitment to being open and flexible with others; a respect and understanding of differences, yet a commitment to build upon similarities; a willingness to learn from others as cultural informants; and a sense of humility (Campinha-Bacote, 2003a).

According to Campinha-Bacote (2008), the building blocks of cultural desire are caring and love, sacrifice, social justice, humility, compassion, and sacred encounters.

The central concepts in this model are:

- *Cultural Awareness*

The first element requires self-reflection to understand that one's own culture is not neutral, but socially constructed, i.e., the student nurse's values, assumptions, perspectives and biases about all matters, which are shaped by his or her own cultural influences. This will allow the student nurse to become sensitive to the values, beliefs, lifestyle, and practices of the patient/client. However, the student nurse needs to go through this process in a conscious, deliberate, and reflexive manner, otherwise he or she will risk imposing her/his own cultural values during the encounter (Campinha-Bacote, 2005).

- *Cultural Knowledge*

The second element incorporates an understanding of the patient's beliefs, values and worldviews with particular regard to the relevant service provided. Here the student nurse finds out more about other cultures and the different worldviews held by people from other cultures. Understanding of the values, beliefs, practices, and problem-solving strategies of culturally/ethnically diverse groups enables the student nurse to gain confidence in her/his encounters with them.

- *Cultural Skill*

The third element relates to the ability to make 'cultural assessments' (Campinha-Bacote et al., 1999). This notion is informed by Leininger's model (Leininger, 1978), which advocates evaluation of the individual patient's personal cultural beliefs, values, practices and views about (medical) interventions to avoid relying on generalisations about particular cultures. Based on the cultural knowledge gained, the student nurse is able to conduct a cultural assessment in partnership with the patient.

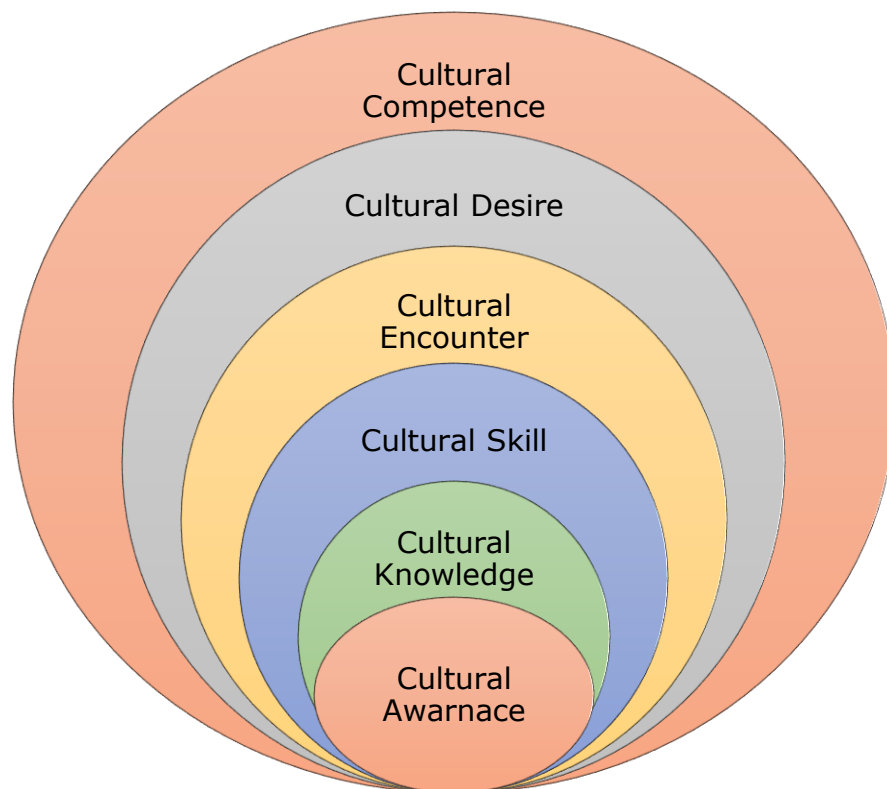
- *Cultural Encounter*

Campinha-Bacote (1999) maintains that in order for student nurses to understand truly a particular cultural group and the diversity within it, they must actively look for opportunities to participate in cultural encounters with members. This will provide primary and experiential exposure to cross-cultural interactions with people who are culturally/ethnically different to oneself.

- *Cultural Desire*

Finally, in order to deliver culturally appropriate healthcare services, student nurses must have an inherent curiosity or drive to ‘*want to*, rather than *have to*’ (Campinha-Bacote, 1999, p. 182) undertake the processes that enhance cultural (self) awareness, knowledge and skills, and be interested in actively seeking opportunities to engage in encounters with those from other cultures. It is seen as a self-motivational aspect of individuals and organisations to want to engage in the process of cultural competence.

Figure 2.2: Campinha-Bacote Model of Cultural Competence



According to Campinha-Bacote, while there has been some consensus in the transcultural healthcare literature on what to teach regarding cultural competence, there is no consensus on how to teach it, particularly concerning affective or attitudinal constructs (Campinha-Bacote, 2008). According to Campinha-Bacote, nurse educators must acquire an in-depth knowledge of the concept of cultural desire before they are able to teach it. Additionally, she identifies that caring, love, sacrifice, social justice, humility, compassion and sacred encounters are salient components of cultural desire that must be addressed in the teaching of this construct (Campinha-Bacote, 2008).

The Campinha-Bacote model is a process whereby providers can gradually build cultural awareness, knowledge and skills that may result in changing attitudes toward different cultures and eventually create cultural competence. Therefore, students and educators can progress toward cultural competence through encounters with other cultures and by drawing on knowledge and skills to adapt to the situation. Tortumluoglu (2006) regards the model as useful in caring for all people, because in reality we all have the same basic needs. However, the model continues to guide the student to learn descriptive information about the other and to use that information to adapt care from the dominant culture, the Western model of healthcare, to the individual client from another culture (Duffy, 2001). Hence, students learn to account for culture as a contextual variable in the development of health and disease interventions. Nursing education and care remain focused on changing the individual rather than society, despite the existence of known structural variables that can be oppressive and dominating (Phillips, 2001).

In conclusion, culturally congruent care is a stated value of nursing and nursing education. However, some institutional and traditional practices in nursing education can unintentionally impede nurses from achieving cultural competence. The literature shows that to ensure that the nursing profession reflects the composition of the patient population it serves, nurse educators must first acknowledge the Eurocentric culture of nursing education and, then, work to change the environment in which students are recruited, learn, and take on the role of practicing nurses (Debrew, Lewallen, & Chun, 2014).

According to Lawton (1983), many curriculum models fail to acknowledge the contextual nature of a curriculum. Lawton developed a model based upon the assumption that the proposed curriculum is relevant to the society that the graduate will serve. Therefore, it is imperative that curriculum decision makers understand the social contexts of a particular curriculum.

2.6 Lawton's Cultural Analysis Model

Any decision that educators make about a curriculum is influenced by their philosophical assumptions about epistemology (the nature of knowledge), society/culture, the individual (particularly the learner), and learning (how a person learns and what learning theories the curriculum should be based upon). Curriculum structure refers to the various components of a curriculum. These components are aims/goals/objectives, content, learning activities, and evaluation. Lawton (1983) developed a cultural analysis model that is based upon the assumption that the main purpose of a curriculum is to initiate learners into the cultural heritage of society. Curriculum development involves making appropriate selections from culture. To facilitate such selections, it is imperative to understand the social contexts of a particular curriculum. Such understandings are pursued by means of the technique of cultural analysis.

Denis Lawton is the founder of a growing body of educationalist theorists arguing the case for a common core curriculum relevant to all students. Developing his theory in three very influential texts, *Social Class, Language and Education* (1968); *Class, Culture and the Curriculum* (1975); and *Social Change, Educational Theory and Curriculum Planning* (1983), Lawton argued that in Britain the education system itself was based on misguided understandings of culture and attitudes, which lead to prejudice against students (Lawton, 1983). This was the main reason for underperformance of these students, because consequently they did not receive the support needed to perform (Lawton, 1983). In this study, Lawton's cultural analysis model is used as a theoretical framework; it facilitates the attainment of the aims and objectives of the study. Lawton emphasises that the model works as a systematic process of examining a particular society in its social and historical

context. Such an analysis in full would involve an examination of a society's culture, language, technology, knowledge, beliefs and values, in order to make better judgements about what ought to be transmitted to the next generation; in other words, what is worthwhile to teach and learn (Lawton, 1975). According to Lawton, cultural analysis is the missing link in curriculum development. He went on to state several important questions that should not be ignored in curriculum planning; these questions include:

- What are the underlying values of this curriculum?
- Do they agree with the prevailing values of the target society?
- What role does the language of the curriculum play in teaching and learning?
- What are the consequences, for example, of English or French predominating as the language of instruction when another language is used by the learner at home and for socialisation?
- Finally, what important knowledge, skills and values are to be exemplified or expressed in the new curriculum?

According to Lawton, answers to these questions would assist curriculum developers with planning; providing them with a better idea of how teachers and learners might react to any new materials that are to be introduced (Lawton, 1983). Lawton's cultural analysis model is based upon the assumption that the main purpose of a curriculum is to initiate learners in the cultural heritage of society (Lawton, 1983). He proposed a five-stage model of curriculum planning: "*Cultural Universals; National Culture; Cultural Analysis; Selection from Culture; and Curriculum Objectives*" (Lawton, 1983). Curriculum development involves making appropriate selections from culture. To facilitate such selections, it is essential to understand the social contexts of a particular curriculum. Such understandings are pursued by means of the technique of cultural analysis. If cultural analysis is applied to nursing education, the following questions could be asked:

- What is the current status of nursing?
- In what ways is healthcare provision developed?
- How do members of the profession wish nursing to develop?
- What kind of values and principles will be involved when deciding how nursing should develop and how future nursing should be prepared to meet people's needs?

According to Lawton, it is necessary to sub-divide culture in a way, which is manageable yet meaningful; to achieve this he posited a set of nine *cultural invariants*, categories or systems that he claimed are universal to all societies. These are the socio-political, economic, communication, rationality, technology, morality, belief, aesthetic, and maturation systems (see figure 2.3). Cultural analysis involves asking questions about the extent to which an educational system already matches the needs of society; as well as the kinds of curriculum change that will be necessary to achieve certain changes regarded as desirable (see figure 2.4). Lawton (1983) claims the sociological questions are concerned with the social, technological and ideological changes, which impact society. He argues that both philosophical and sociological issues should influence the selection from culture.

Figure 2.3: Lawton's Cultural Analysis Model (Nine Cultural Systems)

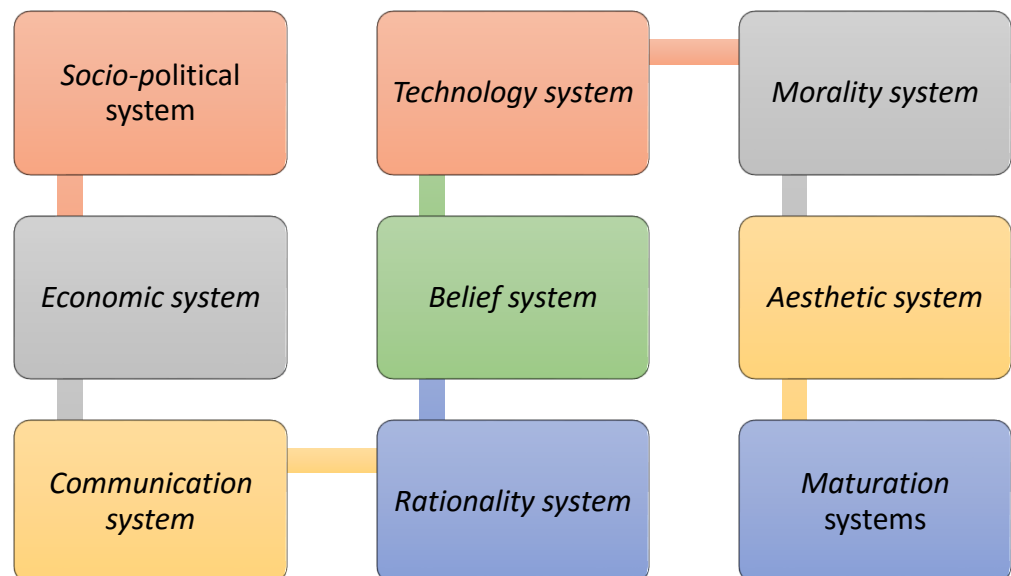
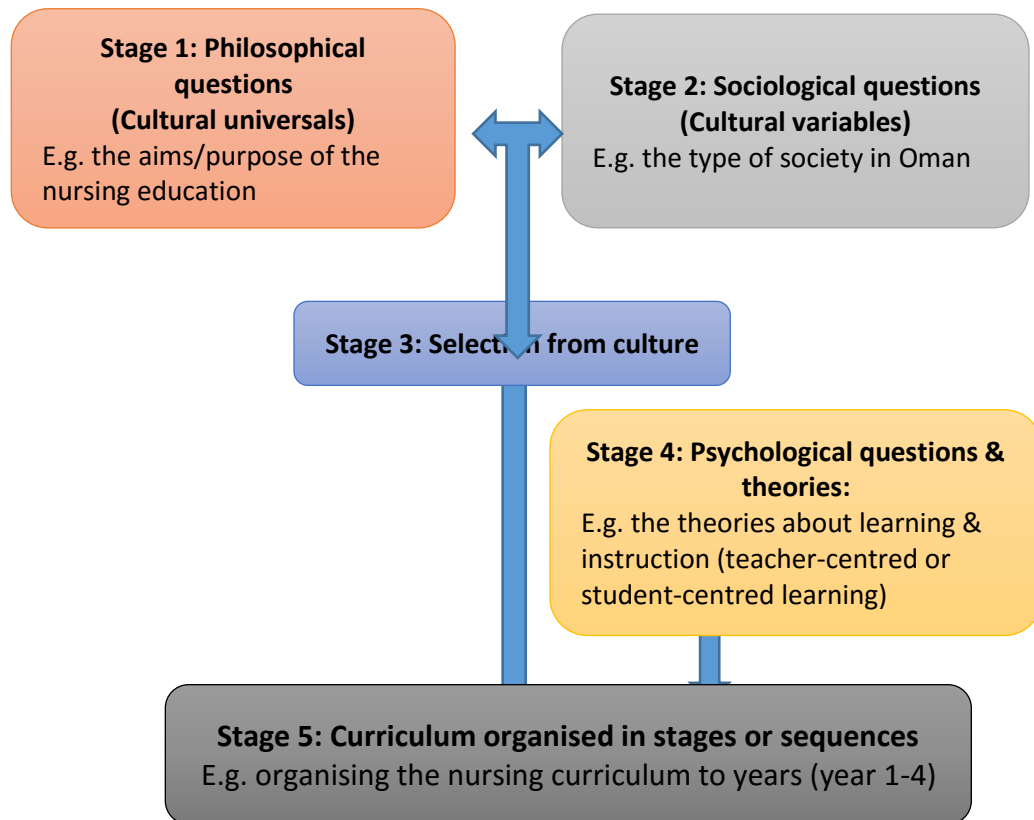


Figure 2.4: Lawton's Curriculum Planning (1975)



A critique of Lawton's cultural analysis model is that selection from the culture of the society is not an easy task, even after all the philosophical and sociological questions are answered. While it is important to study society and see its problems, values and needs at any particular time, it is essential to consider the students' interest, needs and level of development. Moreover, societal needs are not static; thus, society will have different needs at different times. However, Lawton's model exposes the cultural features common to all societies. His view was that the compulsory curriculum should ensure that these aspects of culture are transmitted. Lawton's nine cultural systems do help to develop the full extent of possible curriculum and indicate what may be missed by over specialisation. An important contribution of Lawton's model is that it demonstrates how wider cultural issues and political ideologies shape curriculum thinking.

Further, Lawton's cultural analysis model, being a comprehensive approach in assessing the society before planning a curriculum, has been criticised on several

grounds. Firstly, even though, an educational theorist, Lawton provides an explanation for the role of culture in the educational curriculum, he tends to lack depth in exploring how culture affects our learning abilities. Secondly, problems arise with the process of selection; it is clearly not possible to teach the whole mass of human knowledge, so selections have to be made; but by whom? Despite epistemological attempts to define essential knowledge or to select from essential culture, such decisions remain fundamentally political and ideological, which raises questions of alienation and relevance. This also raises key issues, such as how a selection is made from a society's culture to be included in the curriculum, what is chosen, by what processes, by whom, with what intent, and with what result. According to Basil Bernstein, how a society selects, classifies, distributes, transmits and evaluates knowledge reflects both the distribution of power, the principles of social control (1971a), from which list the selection, classification, and evaluation of particular knowledge is central to the definition of a curriculum. Therefore, this is not a simple or deterministic model of social and cultural reproduction of the dominant ideology. There are numerous studies regarding the growth of particular disciplines within the curriculum that suggest the processes are considerably more complex (e.g. Goodson, 1984a; Whitty, 1985). Thirdly, it has been well documented for many years (Pring, 1976) that curricula based upon the selection of content tend to encourage didactic teaching and passive study. Fourth, society is no longer possessed of a clear culture; there are ranges of cultural identities from which individuals make their own selection. The plurality of society means that students come from a range of cultural backgrounds, different ethnic origins, faiths, attitudes, beliefs and experiences.

In this study, Lawton's cultural analysis model was selected as a theoretical framework for the reason that it acknowledges that a curriculum is socially constructed, as individuals and societies decide what constitutes a curriculum. Also, the model emphasises that the local context plays a key role in the curriculum development process. Moreover, this model involves an examination of a society's culture, language, technology, knowledge, beliefs and values, in order to make better judgements about what is worthwhile to teach and learn. Lastly, the model

acknowledges that there are differences between what an individual learner might want from a curriculum and what a much wider social grouping might want, and furthermore, what a more influential group, such as a curriculum authority, might want. Further, the core professional values in nursing are evidently represented in the MoH current nursing curriculum, however, the cultural congruency on the curriculum is in question. Using Lawton's cultural analysis model will enable the study to explore the issue of cultural competency/ congruency more in depth.

In conclusion, Lawton argued that education is concerned with the transmission of middle-class values and that this explains the relative educational failure of the working class. Consequently, every culture needs a different kind of education that is congruent with its own values and beliefs. His cultural analysis model analyses cultural differences from a sociocultural viewpoint and considers the views of those applying the sociology of knowledge to educational issues. Also, Lawton acknowledges the prevalent sub-cultural differences in society but maintains that education should ideally transmit knowledge, which is relatively class-free. As a result, curriculum should be defined as a selection from the culture of a society and this selection should be appropriate to all learners. Therefore, a clear description of the issues and pressures involved in developing a common culture curriculum is a necessary step towards achieving a culturally congruent curriculum.

Although no other studies of this nature exist, the literature review has provided critical insights into some grand educational theories and perspectives pertinent to culturally congruent curriculum, the focus of this thesis. The next chapter addresses the methodology to answer the research questions and aims.

Chapter 3: Methodology

Introduction

This chapter sets out the justification for the use of a qualitative multiple case study design as a methodological framework for the study. The chapter presents a detailed description of the research process sequence, starting with a description of qualitative research in relation to research design and approach, case definition, selection of the cases, selection of the participants, data collection, and data analyses. Furthermore, the chapter describes the ethical considerations and the measures taken to ensure rigour in the research process. Finally, to better organise this chapter, I looked at various multiple case study based theses, in particular, Kaewasari, A. (2012).

3.1 Research Design

According to De Vaus (2001), “the function of a research design is to ensure that the evidence obtained enables us to answer the initial question as unambiguously as possible.” The main purpose of the study is to review the MoH’s approaches to nursing education and its cultural congruency in the context of the Sultanate of Oman. There are two research questions:

1. How do the MoH’s approaches to curriculum development impact nurse education in the Sultanate of Oman?
2. How do the MoH’s approaches to nursing education maintain cultural congruency with the local healthcare needs in the Sultanate of Oman?

Researchers have various views and beliefs regarding how their research studies are performed. Nevertheless, their views and actions should be guided by a research paradigm, which provides the rules and principles of conducting the research study (Lincoln & Guba, 2000). According to Creswell (1998), a research paradigm or worldview is required to help understand the phenomena being studied. Researchers hold beliefs, which might lead to preference for a particular research approach in their studies, such as a qualitative, quantitative, or mixed methods approach. To gain a better understanding of why I chose the particular research

design in this study, it was essential to discuss the philosophical assumptions behind quantitative and qualitative research designs to appreciate the paradigm most suitable for the purpose/ aim of the study.

Consistent with Creswell (2003), quantitative research is founded on positivist assumptions, which have represented the traditional form of research. This worldview is also referred to as post-positivist research and/or empirical science (Creswell, 2003). Positivists hold a deterministic philosophy. Thus, the phenomena researched should identify cause and effect relationships, such as those found in experiments. In addition, this approach aims at the reduction of ideas into small and isolated concepts to test. In addition, in a positivist view absolute truth can never be found (Phillips & Burbules, 2000). According to a positivist perspective, knowledge is developed through observation and measurement of objective realities. Thus, developing numeric measures of observations, data and evidences collected through instruments shape knowledge and understanding of the world. Scientific methods are the preferred technique with which to conduct research by positivists, whereby an investigator starts with a theory, gathers data that either backs or contradicts the proposed theory, and processes modifications before further tests are made.

Consequently, selecting a quantitative approach to explore my study would have facilitated the identification of a cause and effect relationship between the MoH's approaches to nursing curriculum, nursing education and cultural congruency, but it would not have allowed an in-depth exploration of the experiences and perceptions of the MoH nursing administrators, educators, nursing students and service users (the public). The study focus is on the process of how the MoH's approaches to curriculum development impacts nursing education and its cultural congruency. Therefore, a quantitative research approach would not support the attainment of the research aims and answer the research questions.

Alternatively, qualitative research holds a different worldview, which is based on constructivist philosophy. A constructivist perspective views that people seek an understanding of the world around them. Therefore, qualitative research is

concerned with understanding how people construct meaning or make sense of their world (Merriam, 2009). In contrast to the positivist approach, constructivist researchers look for varied and multiple meanings, which lead to complex interpretations, rather than narrowing meanings organised into simple ideas. Therefore, the purpose of the research is to explore the participants' views of the phenomena being studied. These views are shaped through interaction with society (social constructivism). Thus, constructivists focus on a particular context in order to understand the influence of the settings on the participants. Therefore, they recognise that people's own backgrounds shape their interpretation; also, they acknowledge how their interpretation of the gathered data reflects their personal, cultural, and historical experiences. Qualitative research leads to the generation of a theory or pattern of meaning (Crotty, 1998). This approach is valuable because it facilitates a close interaction between the investigator and the study participants, which allows participants to share their stories (Crabtree & Miller, 1999). According to Lather (1992), and Robottom and Hart (1993), qualitative research enables a better understanding of the participants' actions through their stories, in which the participants describe their views of reality.

The purpose of this study is to explore how the MoH's approaches to curriculum development impact nurse education and its cultural congruency in the context of the Sultanate of Oman. After conducting a literature review, and based on my years of practice in nursing education, I acknowledge that there are social, economic and political factors that influence nursing education practices, consequently, the assumptions underpinning such practices are complicated. The nursing curriculum philosophy, aims, processes, and the selection of knowledge is an expression of an educational policy, and is directly interlinked with the government: the political and normative composition of the educational system. Educational curriculum is a product of cultural, political, and economic conflicts and compromises. Consequently, it is evident that nursing education is a complex phenomenon that takes place within diverse social and cultural environments.

In this study, qualitative research was chosen because it is based on an approach, which assumes that people through their experiences of the phenomena socially

build different realities. For that reason, in this study a qualitative research will enable the acquisition of insight into MoH nursing education practice in Oman by exploring the complex experiences of participants and gaining data through many different techniques, for example, documents and interviews.

3.2 Research approach: Case study design

A case study design is a research approach, which facilitates the study of a phenomenon within its context via multiple sources of data (Yin, 2009). There are two main approaches to conducting case study research. One offered by Robert Stake (1995), and the other by Robert Yin (2009). Both Stake (1995) and Yin (2009) found their approach on a constructivist paradigm. According to Yin (2009) a case study design should be used when the main aim of the study is to answer “how” and “why” questions, the study participants’ behaviour cannot be influenced, the study context is relevant, and the boundary between the phenomenon and context is not clear.

A case study approach was selected based on its usefulness and appropriateness for this study. According to Yin (2009), a case study is a special kind of qualitative work that investigates a contextualised, contemporary phenomenon within a specified boundary. Also, Merriam (1988) presented examples of a bounded phenomenon in education as “...a program, an event, a person, a process, an institution, or a social group” (p. 13). Case study characteristics include examining a particular subject bounded in time and space, providing a detailed description of contextual material about the case setting, gathering extensive material from multiple sources to provide an in-depth picture of the case, and using the researcher as an instrument of data collection (Creswell, 1998). For that reason, a case study design was chosen as it is considered most suitable design for this study given the aims of the research and research questions. Moreover, in the study it is essential to understand the nature of the MoH’s approaches to nursing education in the context of Oman. Also, case study was chosen because the phenomenon could not be considered without its context, more specifically the Sultanate of Oman, MoH and nursing institutes. In addition, in these settings nursing education decisions

were made and implemented and it is difficult to gain a true picture of a decision-making process without considering the context, which it occurred in. Furthermore, the phenomena pertaining to the MoH's approaches to curriculum development impact on nurse education and its cultural congruency could not be manipulated or controlled, however; in order to gain an understanding of this issue the study needed to take place in its natural environment. As a result, a case study approach was chosen. This was the most appropriate method to examine the research questions in order to gain insight and explore how the MoH's approaches to nursing curriculum impact nursing education and its cultural congruency in the Sultanate of Oman.

According to Yin (2009), once the research question(s) and its boundaries were determined, a type of case study must be considered. To select a particular type of case study design, it is important to refer to the overall purpose of the study. Whether, to describe a case, explore a case, or compare between cases. Both Yin (2009) and Stake (1995) use different terms to describe the various types of case studies. Yin (2009) classifies case studies into explanatory, exploratory, or descriptive. An explanatory case study is applied to explain the assumed causal relations between interventions that are too complex for the use of a survey or experimental strategies (Yin, 2009). An exploratory case study is applied to explore situations in which an intervention that is evaluated has no clear, single set of outcomes (Yin, 2009). A descriptive case study is applied to describe an intervention or phenomenon including the context in which it occurred (Yin, 2009). Further, Yin (2009) distinguishes between single, holistic case studies and multiple-case studies. A single case study is conducted using a single case study, while a multiple case study is used to understand better a phenomenon through conducting multiple case studies. While Stake (2005) classifies case studies into intrinsic, instrumental, or collective. An intrinsic case study is conducted to better understand or learn about a particular case, which could be a problem in a particular work situation. An instrumental case is a tool mainly used to learn about a particular issue or to support understanding of an issue. A collective case is used to find out about a particular phenomenon using a number of different cases, which is similar to Yin's (2009) account of multiple case studies.

The case study type selected was a combination of Stake's (2005) and Yin's (2009) approaches using an instrumental and multiple case study design. According to Stake (2005), an instrumental case study would accomplish an understanding of a particular phenomenon through providing insight into an issue, and facilitating understanding of the particular phenomenon in depth within its contexts. Therefore, an instrumental case study would provide emphasis on exploring the wider issue of the MoH's approaches to nursing education and its congruence in the Omani context. As well, Yin (2009) argues that a multiple case study design allows the researcher to explore differences within and between cases.

To conclude, this study is based on a qualitative multiple case study approach which falls within the constructivist paradigm. This design is chosen to seek explicitly out the multiple perspectives on how the MoH's approaches to curriculum development impact nurse education and its cultural congruency in the Sultanate of Oman. The aim is to explore an issue (MoH's approaches to curriculum development and their impact on nurse education and its cultural congruency) within its context (the different stakeholders in Oman). A qualitative multiple-case study was chosen to promote the richness and depth that is drawn from multiple cases that would help understand and explore the MoH's approaches to curriculum development's impact on nurse education and its cultural congruency in a way that pays attention to the individual's point of view, and the nature of nursing education in an Omani context.

3.3 Multiple-case study design

In this study, a multiple case approach was the logical methodology as it allowed the research to focus on the complex forces and relationships that impact on the nurse education under MoH within the context of Oman (Stake, 1995). A case study is a methodological approach that involves systematically gathering enough information about a particular person or group and situation to permit the researcher to understand effectively how the subject operates or functions (Berg, 2004). The aim of this research is to explore beginning teachers' use of digital technologies in their first year as a teacher by concentrating on individual teachers within the context of a complex schooling system. The detail that can be included in case

studies allows the reporting of complex dynamic and unfolding interactions or events, human relationships and other factors in unique situations. This aligns with underpinning ideas from complexity theory.

3.3.1 The Case Definition

The definition of a case or the unit of analysis is a central concept in understanding, preparing and implementing a case study design (Yin, 2009; Patton, 2002). Stake (1995), Merriam (1988), and Miles and Huberman (1994) describe the case study as an analysis of a phenomenon, such as a person, a programme or an event in a bounded system. Further, a case is important for what it reveals about the phenomenon and for what it might represent (Merriam, 1988). Further, Creswell (2007) described a case as a bounded system (for one case) or multiple bounded systems (for two or more cases). A bounded system or context is clarified by the researcher's statements in the research objectives about the focus and extent of the research (Creswell, 2007).

Yin (2009) maintains that the unit of analysis is identical with the case. He says that an event or a person could be the case being the studied; therefore, the event or the person is the primary unit of analysis (Yin, 2009). Yin (2009) proposes using "propositions" to guide the research process, while Stake (1995) suggests considering "issues" which involve political, social, historical, and personal contexts, and are important in studying cases. Both Yin and Stake suggest that the propositions and/or issues are essential elements in a case study research in that both lead to the development of a conceptual framework that guides the research.

Regarding this study, the issue under investigation is how MoH's approaches to curriculum development impact nurse education and its cultural congruency in the Sultanate of Oman based on the view of each of the different stakeholders. The boundary between the phenomenon and the context is not clearly apparent due to the complexity of the topic. So, the view of each of the different stakeholders is regarded as the case (Yin, 2009). It is also an unbounded phenomenon (Merriam, 1988; Miles & Huberman, 1994; Creswell, 2007), as the boundary between the issue (MoH's approaches to nursing education and its cultural congruency) and the

context (the different stakeholders in Oman) are not clearly defined. To properly describe the issue (MoH's approaches to nursing education and its cultural congruency), four instrumental cases were selected and grouped into the following: MoH nursing administrators case, MoH educators case, MoH nursing students case, and MoH service users case (the public). The rationale for this is that each group will provide a different viewpoint, which could further explore the issue in a multiple-case study. Each case will provide insight into how the MoH's approaches to curriculum development impact nurse education and its cultural congruency in the Sultanate of Oman, and together will add to the holistic understanding of the phenomenon.

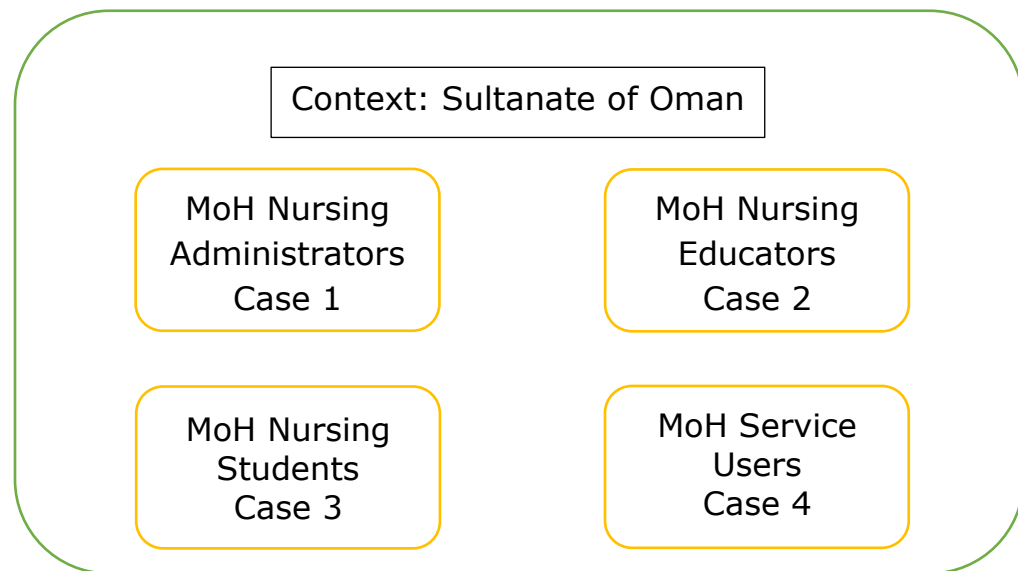
3.3.2 The Number of Cases

The number of cases is an important aspect in case study research. There are no specific guidelines as to the number of cases to be selected in a multiple case study research. According to Miles and Huberman (1994), the number of cases selected depends upon the richness and complexity of the study. Eisenhardt (1989) proposes that four to ten cases work well. She believes that fewer than four cases make it difficult to generate a theory or a model. In highly complex case studies, Miles and Huberman (1994) suggest a maximum of 15 cases. According to them, more than 15 cases will make the study unmanageable due to excessive amounts of data and variations to explain (Miles & Huberman, 1994).

In order to maximise learning and "preserve multiple realities" (Stake, 1995, p.12), participants were selected based on their unique perspective. Stake asks, "which cases are likely to lead us to understandings, to assertions, perhaps even to modifying of generalizations?" (1995, p. 4). In order to allow for an in-depth study four cases were selected for the purpose of this study based on the discussion above and considering the availability of resources. Each case is the main unit of analysis. Two research questions were established with the intention of exploring how the MoH's approaches to curriculum development impact nurse education and its cultural congruency in the Sultanate of Oman. Therefore, the phenomenon being investigated is the impact of the MoH's approaches to curriculum development on

nurse education and its cultural congruency, and thus, participants' viewpoints on the phenomenon were the main unit of analysis in the context of the Sultanate of Oman (see Figure 3.1).

Figure 3.1: The Study Design: Multiple-case Study



3.3.3 Case Selection

Patton (2002) identifies various sampling strategies in qualitative research design, including 2 for random sampling and 16 for purposeful sampling. Selection of cases in a multiple case design implicates purposeful strategies instead of random sampling (Patton, 2002). Purposeful sampling involves the intentional selection of cases rich in data; therefore, the precise number of cases depends on the study purpose and availability of resources (Patton, 2002). Eisenhardt (1989), Perry (1998), Stake (1995) and Yin (2009) point out that purposeful sampling in a case study methodology maximises the richness, validity and depth of the information obtained. In addition, purposeful sampling is necessary to ensure that the case objects are keen and open to interact, and to share information in relatively long and in-depth interviews.

The purposive sampling technique allows the participants to be selected to serve a specific purpose. The purpose of it is to maximise the value of data for theory development by gathering data rich enough to uncover conceptual relationships.

Each sampling unit may be distinctive by deliberate selection (e.g., two students at a nursing programme, one from the capital and one from the regions). Alternatively, they may be selected because they share a common characteristic (e.g., third-year students). Simply, the sample selected depends on its purpose. Therefore, purposeful sampling is chosen as the appropriate technique for this study. The purposeful sampling strategies selected for the study are a combination of the purposeful sampling strategies proposed by Patton (2002). The following are the case selection strategies:

- **Criterion sampling** involves studying cases that meet predetermined criterion of importance (Patton, 2002). This approach is frequently used to construct a comprehensive understanding of all the studies that meet certain pre-determined criteria. This strategy entails stating explicit inclusion/exclusion criteria. The participants were grouped into four groups: nursing administrators, educators, nursing students, and service users. All participants were identified through a purposive sampling strategy. The inclusion criteria were as follows:
 1. A nursing administrator should be a MoH curriculum evaluation committee (CEC) member (main or subgroups).
 2. A nursing educator is someone who has worked in MoH nursing institutes for at least two years teaching theory and clinical components.
 3. A nursing student is a student enrolled in the third year of the current MoH nursing programme (2012/13).
 4. A service user is someone who has full access to all MoH healthcare services, does not work under the MoH, and is not directly related to MoH staff.

The rationale for this is that perceptions regarding the study questions might be influenced by exposure to prior knowledge regarding the phenomena under study. Also, to allow the cases to represent and illustrate a range of advantages and challenges associated with curricula. The main goal of this study was to explore how the MoH's approaches to curriculum development impact nurse education and its cultural congruency in the Sultanate of Oman,

in addition to developing recommendations and a practical model for cultural congruency in nursing education. Therefore, all selected cases represent the perspectives of the MoH's main stakeholders (MoH administrators, MoH educators, MoH nursing students, and MoH service users) in order to make the most of data-rich cases.

- **Maximum variation sampling** is constructed by identifying key aspects of variations and then finding cases that vary from each other. As a result, this approach can assist in constructing a holistic understanding of the studied phenomenon (Patton, 2002). Therefore, utilising this approach can help identify important variable aspects of a phenomenon (how MoH's approaches to curriculum development impact nurse education and its cultural congruency in the Sultanate of Oman) as experienced by diverse stakeholders (MoH administrators, MoH educators, MoH students and MoH service users).
- **Convenience sampling** is selecting participants at low cost who are easily accessible (Patton, 2002).

3.4 Ethical considerations

Ethical considerations are a critically important aspect of ensuring that the research process and findings are trustworthy and valid. So, the protection of human subjects or participants in any research study is vital (Orb, Eisenhauer & Wynaden, 2000). In any research, ethical aspects are considered in the context of justice, preventing harm, honesty, dignity, privacy, anonymity, and confidentiality of the research participants (Beachamp & Bowie, 1983; Hammersley & Atkinson, 1995; Patton, 2002). Consequently, these ethical aspects were addressed in the ethical application form submitted to the Medical and Health Science Ethics Committee at the University of Nottingham (see appendix A), MoH Research and Ethical Review and Approval Committee in the Sultanate of Oman (see appendix B) which included the case setting for this study.

The ethical issues covered throughout the research process included:

- Informed consent by which each participant may choose whether to participate in a study. I have made sure that all participants have a complete understanding of the purpose and methods to be used in the study, the risks involved, and the demands placed upon them as a participant. Each participant was aware and understood that he or she has the right to withdraw from the study at any time. In the study, all participants were given informed consent (see appendixes D & E), and each received a full explanation of the research purpose and their potential role within it. I also provided each participant with an information sheet (in English/Arabic). In the case of illiterate participants, I provided a verbal explanation. Then, I asked that the two signed informed consent forms that were to be returned to me. Those who chose not to participate in the study were not contacted any further.
- Privacy: All the individual and focus group interviews were conducted in a private, secure and comfortable setting to reduce any psychological stress, personal embarrassment or humiliation that may adversely affect the participants in a significant way.
- Confidentiality and Anonymity was maintained for all data collected from the participants during the interviews. All participants are given a code title and number, which was applied in the field notes and interview transcripts (e.g. Service User 1, Teacher 2). To maintain anonymity in the study. Further, no one was aware or had access to the names the participants. Those whose data they were reviewing (my supervisors and a bilingual reviewer) reviewed the data, and they were aware only of the group types (administrators, educators, students or service users). Any data gathered during interviews via audio recordings or field notes was kept in a locked cupboard, while soft data was saved in my computer with a protected password. All data collected for this study will be destroyed within four to five years.

3.5 Data collection process

The concept of reflexivity was essential to ensuring the integrity of this study. Reflexivity refers to the researcher's ability "*to keep track of one's influence on a setting, to bracket one's biases, and to monitor one's emotional responses*" (Hatch, 2002 p.10). The researcher's personal experiences in the MoHEIs negative or positive had to be identified. These experiences included working as a nursing tutor at one of the MoH nursing institutes for ten years dealing with teaching (classroom/clinical), course coordination, supervision of staff and students, members of the examination committee, and member of the curriculum committee. These roles exposed me to specific aspects of the role of the MoH in nursing education. Also, some of these responsibilities had caused me some concern regarding the MoH's approaches to nursing education and its cultural congruency, therefore, to control for any bias, bracketing was used.

According to Patton (1990), the researcher should be completely aware of his/her personal bias and control this bias to gain clarity or eliminate preconceptions. The fact that a researcher may have shared with participants' certain experiences within the field of proposed research might have a positive influence (Crotty, 1996). However, the challenge for the researcher is to understand accurately essentially, what the research participants mean in their personal accounts expressed through the data collection methods. This obligates me as the researcher to separate any past knowledge or experience I might have had in the MoH nursing education and curriculum development approaches and not to connect that knowledge interpretatively to the meanings of the participants. Qualitative data collection is subject to the biases of the people involved, both in collecting the data and in providing it. Researchers may have a preconceived notion about the evidence they are likely to find in their investigation. Unconsciously they may ask questions phrased in such a way as to heighten the chance that the participants will answer as expected. Likewise, the respondent may have biases about either the researchers or their topic and may not be willing to disclose personal ideas or feelings. This is likely to occur when issues connected to power, sensitive feelings, or cultural values enter the topic under study.

3.5.1 Negotiating access

Negotiating access to the research setting is a key part of the early stages of the research. However, gaining access to organisational contexts requires patience and sensitivity. Bryman (2001), Hammersley and Atkinson (1995), and Patton (2002) indicate that efficient engagement with the research context can be supported in a number of ways:

- Being sensitive to the hierarchy or organisational structure: particularly getting clearance from senior people and providing clear information about the aims and purpose of the study and why that setting has been selected.
- Being open and consistent about what is required, in terms of the number of visits, the amount of time required, and the variety of individuals the research would include.
- Being clear about how the study findings will be utilised.
- Being flexible about shaping the study approach in anticipating and being responsive to concerns and sensitivities that may arise.
- It is important to have a single point of contact within the organisation to avoid duplication or gaps in communication.

Therefore, negotiating access to the study setting was appreciated through the good relationship I had with the Director General of Education and Training (DGET) and deans of the MoH nursing institutes due to my work experience within MoH. This relationship was vital in gaining access to possible participants and MoH nursing education documents. Moreover, it was essential to gain ethical approval from the MoH and University of Nottingham, which enabled me to contact the DGET to gain access to the nursing administrators, nursing educators and students. I also asked relatives and friends to advertise my study to gain potential participants from the public. In the early stages of the study, DGET and the nursing deans expressed interest in the study aims and purpose. They were keen to understand how the study findings would be used. Following this initial meeting, I had access to different workshops through which I had the opportunity to meet potential nursing administrators and educators. This was my first opportunity to encounter potential

participants in my study. At this meeting, I was introduced as a colleague who is currently a PhD student studying at the University of Nottingham in England with authorisation to collect data from the MoH nursing administrators, MoH educators, MoH nursing students, and MoH service users. During the meetings, I shared my experiences as a MoH nurse, a lecturer, and a service user and I described the aims of the research and the proposed methods of data collection. There were many questions regarding the reasons for undertaking this particular topic and the potential benefits of the study. In addition, they expressed hesitation and reluctance to being recorded during the interviews and wanted more details about what the interview might involve. I explained that the participants will remain anonymous and the recordings will only be used for the purpose of the study. This seemed to help gain their trust and confidence in my study. These meetings with the MoH nursing administrators and educators lasted about 10-15 minutes.

3.5.2 Recruiting case participants

I selected participants for the four case studies who met the inclusion criteria. Then I contacted the participants to explain the purpose and potential advantages of the study for nursing education. I provided detail regarding the study and an information sheet (see appendix C). Also, I provided them with my contact number and email to contact me within the next two days to indicate if they are interested to participate in the study. The majority of those contacted stated that they were willing to participate, and each signed the consent form as required (see appendixes D & E). Figures 3.2, 3.3, 3.4 and 3.5 illustrate the recruitment procedures.

Figure 3-2: Research Sites

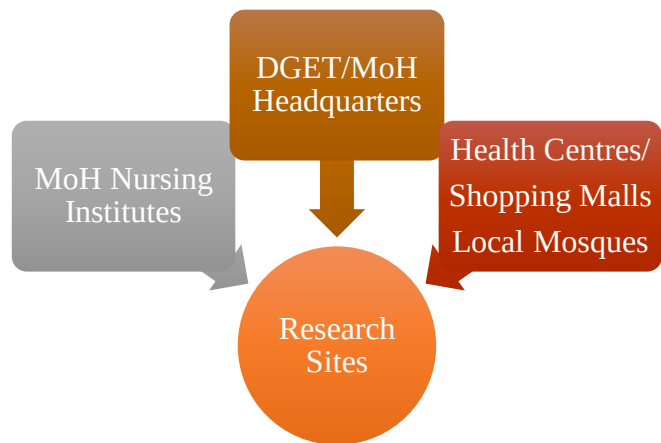


Figure 3.3: Recruitment of MoH Nursing Administrators & Educators

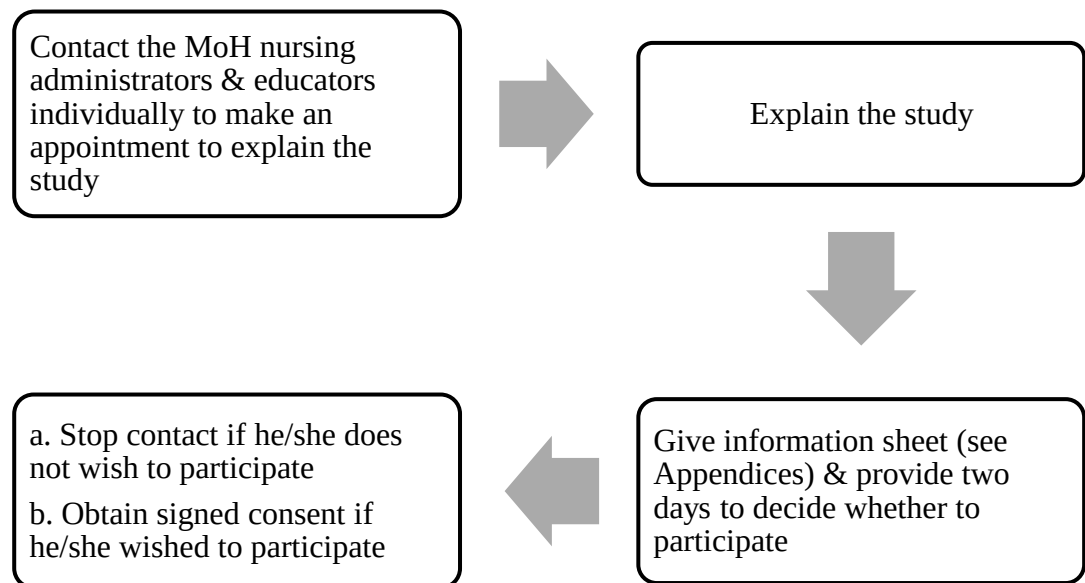


Figure 3.4: Recruitment of the MoH Nursing Students

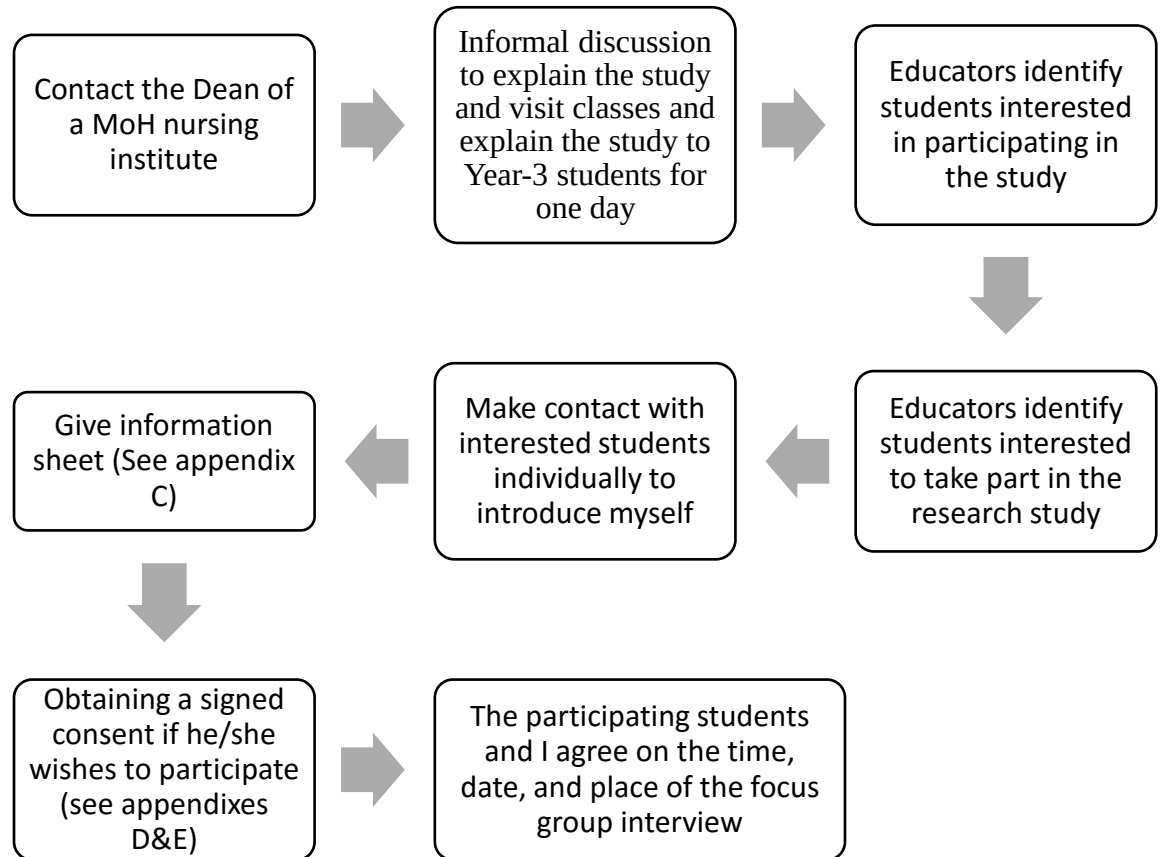
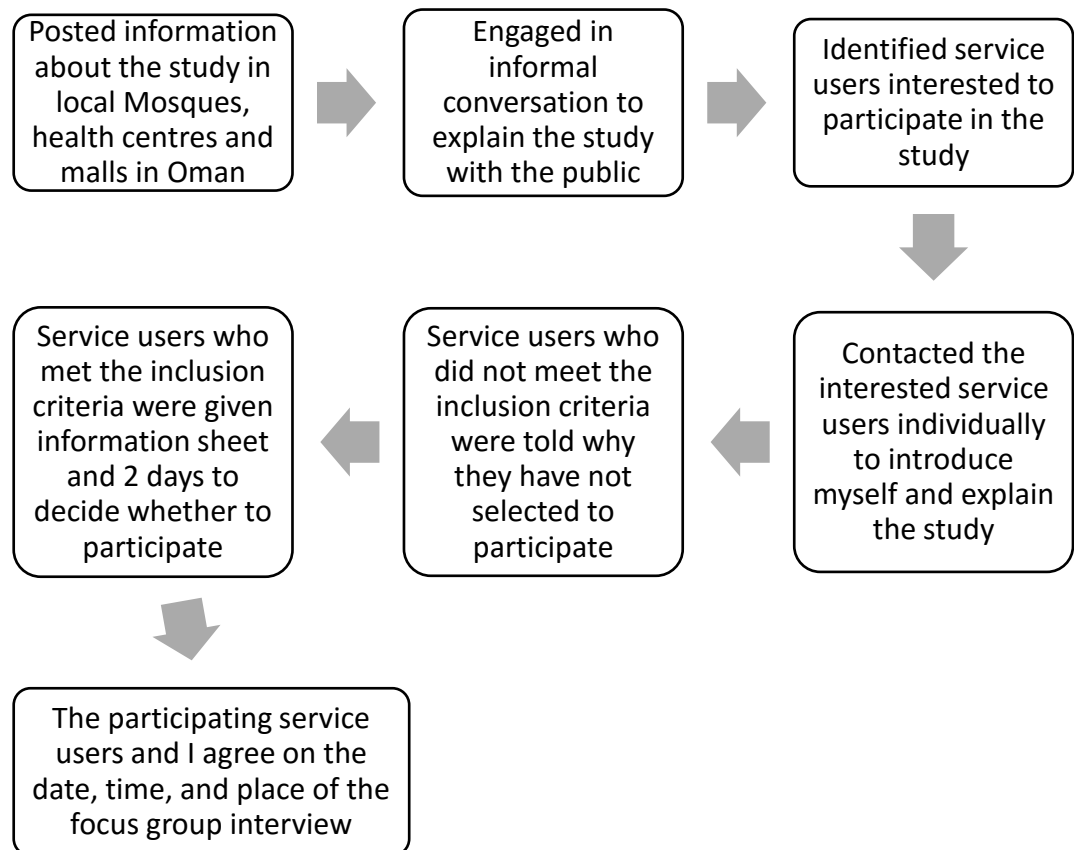


Figure 3.5: Recruitment of the MoH Service Users



Although no potential participants declined to take part in this study, there was an issue with some of the participants being late or their phones ringing during the interview. I felt very uncomfortable about this situation and discussed this with my supervisors. Following this, I decided to ask the participants to call me if they would be late and switch their phones off during the interview.

3.6 Data Collection Methods

Data collection commenced by collecting and reviewing all the MoH nursing curriculum documents in December 2011 and concluded with the focus group interviews in September 2012 (see Table 3.1).

Table 3.1: Schedule for Data Collection

	Case 1 Nursing Administrators	Case 2 Nursing Educators	Case 3 Nursing Students	Case 4 Service Users
Month/ year	Dec 2011- Sept 2012	Dec 2011 - Sept 2012	Sept 2012	Sept 2012
Method	Curriculum Documents Dec 2011-Sept 2012			
	Individual interview	Individual interview	Focus group interview	Focus group interview
Site	Sultanate of Oman			

A multiple case study design employs multiple data sources as a strategy to increase data credibility and facilitate reaching a holistic understanding of the phenomenon being studied (Patton, 1990; Yin, 2009). According to Yin (2009), possible data sources include documents, archival records, interviews, physical artefacts, direct observations, and participant-observation. In the case study, data from multiple sources are combined in the analysis process rather than handled individually. Therefore, each data source becomes one part contributing to the researcher's understanding of the whole phenomenon. The selection of the research methods depends on the research aims, questions, actual context and availability of resources (Yin, 2009). Therefore, in this study I have selected documents and semi-structured interviews (individual and focus group). I started by reviewing the MoH documents then conducted the semi-structured interviews (individual and focus group).re

3.6.1 Documents

According to Lincoln and Guba (1985), a document refers to any written or recorded material that is not prepared for the purpose of evaluation or at the request of the researcher. There are varieties of documents that can be used in research, such as letters, memos, agendas, reports, newspapers or any items that could add to the database (Yin, 2009). Also, documents can be used in many different ways. They can provide historical information about how certain issues were perceived or dealt with in the past and provide a way for understanding current issues. Therefore, searching for documents significant to the study enables the

confirmation and adds insight to the phenomena under study (Yin, 2009). Documents can be helpful in validating evidence gathered from other sources, such as interviews, and verifying correct spelling or organisational names/titles (Yin, 2009). However, the validity of these documents is an important issue that should be carefully considered (Yin, 2009). Therefore, the researcher should review and examine the context within which the documents were produced (Punch, 1998; Yin, 2009). In light of this, a precise guide for identifying documents relevant to this study was developed (see appendix K).

One of the study aims was to review the MoH nursing curriculum/education policy documents relevant to nursing education to provide insight in to the nature of nursing education in under the MoH. Therefore, to access such documents, it was important to contact directly the head of the nursing curriculum development committee (CEC) to enquire about their possible location. I was informed that the documents were placed at the DGET office and that some soft copies were available for the CEC members. Therefore, I asked the head and other members of the committee to send me all the available soft copies of the documents, and asked them to identify those that were currently used in practice. I identified ten relevant documents, and these included DGET mission/vision/objectives, curriculum competences, the nursing programme, foundation programme, Omani midwifery and nursing council codes of ethics, the student handbook, the MoH five-year plan, and MoH mission/vision/objectives. I spent a total of three weeks reviewing and analysing these documents.

3.6.2 Interviews

Interviews are considered one of the most important sources of case study research (Yin, 2009). There are three different types of interviews: structured, unstructured, and semi-structured. Structured interviews involve asking every participant the same questions with no variation in the questions between participants, whereas unstructured interviews involve no fixed set of questions for the participants (Crabtree & Miller, 1999; Patton, 2002). Semi-structured interviews involve a balance between a structured and an unstructured interview. They involve questions

that are open ended, thus not limiting the participant's choice of responses (Gubrium & Holstein, 2002). Moreover, semi- structured interviews provide an environment that enables the researcher and participant to converse about the issue in detail. The researcher can also use prompts to help and direct the participant towards the research topic focus to enable the gathering of more in depth and detailed data (Creswell, 2003; Patton, 2002).

For that reason, interviews were chosen as the appropriate method for the purpose of this case study to provide detailed descriptions of the phenomena under study (Yin, 2009). This case study is concerned with the MoH's approaches to nursing education and its cultural congruency in the context of Oman; therefore, interviews would be valuable in gaining insight into the phenomena and increasing understanding of the phenomena. Further, I selected semi-structured interviews to enable exploration of the topic in detail and allow the study participants to discuss their experiences using their own choice of words while also being able to prompt them through a pre-set guide.

3.6.3 Semi-structured interviews

The interview guide was based on Lawton's cultural analysis model, which is based upon the assumption that the main purpose of a curriculum is to initiate learners into the cultural heritage of society (Lawton, 1983). With cultural analysis applied to nursing education, the following questions could be asked:

1. What is the current status of nursing education?
2. In what ways is, nursing education provision developed.
3. How do members of the profession wish nursing education to develop?
4. What kind of values and principles will be involved in deciding on how nursing education should develop, and how should future nursing graduates prepare for their role?

The semi-structured interview guide is presented in the appendices (F/G). In order to identify how these aforementioned factors were included in the participant interviews, the participants were made aware of the nature of the questions during

the recruiting process (see Section 3.5.2) in order to help them to decide whether to participate or not.

In this study, ten nursing administrators and twelve nursing educators were interviewed individually. Further to this, two focus group interviews were conducted. The first focus group included six third year nursing students, and the second focus group interview included ten service users. The main purpose of focus group interviews was to draw upon respondents' attitudes, feelings, beliefs, experiences and reactions in a way, which would not be feasible using other methods, for example, through one-to-one interviews. Compared to individual interviews, which aim to obtain individual attitudes, beliefs and feelings, focus groups elicit a multiplicity of views and emotional processes within a group context. The individual interview is easier for the researcher to control than a focus group in which participants may take the initiative. A focus group enables the researcher to gain a larger amount of information in a shorter period of time. Focus groups are particularly useful when one wants to explore the degree of consensus on a given topic (Morgan & Kreuger, 1993).

In the semi-structured individual interviews, all the participants were interviewed privately in their offices or at a pre-arranged location. In the semi-structured student interviews, a classroom at the Oman Nursing Institute was booked to conduct the focus group interview. Similarly, in the semi-structured service user interviews, the home of one of the participants was used to meet all the participants and conduct the focus group interview at the request of the homeowner. The majority of the interviews were conducted in English, with the exception of the two focus group interviews, which were conducted in Arabic. I was keen to maintain a good relationship with all the participants during the individual and focus group interviews to alleviate any discomfort and ease any stress. Each individual interview lasted 20-45 minutes, and the focus group interviews lasted 40-60 minutes.

Each interview began by eliciting general information from each participant. Furthermore, each participant was probed for detailed responses in order to explore

particular issues in more depth (Merriam, 1988). During the course of the interviews, careful attention was given to what the participants said. They were also encouraged to explain and expand on the details of their experiences through the use of phrases such as ‘please expand’, ‘explain’, or ‘please give me an example’. At the end of the interviews, a summary of the main points of information was provided and the participants were asked to verify that their views had been accurately collected. All interviews were audiotape recorded using two high quality-recording devices; one digital recorder and a normal tape recorder. This approach provided a contingency should one of the devices fail. In addition, field notes were taken after the interviews to summarise the feelings and perceptions about each interview and to record initial thoughts about each interviewee.

Although an interview schedule was developed, two questions proved problematic during the pilot individual interviews (two) and focus group interview (one). Therefore, supplementary questions were asked to generate improved responses to the study questions and reduce the number of missed opportunities. As a result, the questions were adapted and used as a guide to promote continuous discussion whilst listening and responding to emerging topics or new ideas on the topic of interest. Overall, the pilot interviews have improved my confidence as an interviewer and enabled me to anticipate issues, which may arise during the interview process, such as telephone calls. Moreover, some minor difficulties were experienced when certain participants were interviewed. Some spoke about issues that were not related to the topic being studied. For example, when they were asked about the current status of nursing education in Oman, the participants talked about it in general terms referring to nursing services, but not specifically in relation to nursing education. Thus, to ensure that the participant was encouraged to focus on nursing education, statements such as ‘please tell me more about how you see the current nursing education in Oman’ were used.

3.7 Reflexivity

Given the complexity nature of qualitative research, it is anticipated that novice researchers feel apprehension at the onset of their first study. According to Cole

(1992), reflexivity involves being able to think critically about the self and others, with a robust and open curiosity about how we are situated in different contexts and interpret the behaviour of other people and ourselves. Further, reflexivity is a process of self-reference, self-awareness about the relationship between what we know, and how we know it (Davies, 1999). This relationship between a knower and knowledge is highly influenced by perceptions in a particular moment. Consequently, what we know and how we use knowledge is a result of our experiences, which frames the references we use to interpret events (Bonner, 2001). In reflexivity, awareness of the self in relation to others offers the freedom to transform ourselves through thinking and acting differently.

Although there are guidelines in the literature, the emphasis on interpretation provides no precise formula on how to proceed. As the researcher is the primary instrument of data collection and analysis, reflexivity is considered essential (Merriam, 1998; Stake, 1995). Reflection allows the researchers to give careful consideration to the phenomenon under study, as well as the ways their own assumptions and behaviours may be impacting or influencing the study. According to Patton (2002), reflexivity allows the researcher to be aware of the cultural, political, social, linguistic, and ideological origins of their own assumptions in addition to the viewpoints of the study participants. Therefore, it was essential to reflect on my experience as first time researcher and increase my awareness of my behaviour and thoughts in relation to my role in the study.

The first concern that became apparent in the study was my link with the MoH as an employee and service user. Another concern was my existing knowledge of the academic and professional framework of nursing practice in Oman. Both of these concerns had desirable and undesirable effects on the study. I had thought carefully about how to position myself in this research. I knew that I had to separate myself from the participants' stories. However, interviewing colleagues (nursing teachers and administrators) was a challenge because within few minutes of the interview, I found myself listening to contradicting details of what they had said or communicated in prior discussions. While maintaining sense of my role as the researcher, there were moments when I identified with colleagues concerns and

experiences. Keeping field notes enabled me to keep track of theoretical perspectives and assumptions, as well as, keeping track of my emotional reactions (Gilbert, 2001). According to Kleinman and Copp (1993), keeping field notes may enable understanding through self-reflection. This process helped me in to keep track of different events, which were useful when looking for codes during analysis phase. I carefully completed field notes every time I went in to conduct an interview. I was not having regular supervision meetings during my period of fieldwork. On the other hand, as a MoH employee, the participants felt at ease and were willing to open up and share information regarding the topic and the context (the MoH in Oman). Moreover, this good relationship has a desirable influence on my research because it facilitated data collection, encouraged the potential participants to take part in the study, and facilitated organisational support.

In contrast, being an employee of MoH created some undesirable influence during the data collection. Some of the study participants were so keen on helping me; they were only concerned with providing answers to the pre-set interview questions. This created difficulty in getting their real viewpoints on the topic. Furthermore, non-Omani participants seemed to be wary of me as an Omani researcher; therefore, I might expect them to share information that is within the legal and professional framework of nursing under the MoH, not their true viewpoints. Looking back at my actions, and thinking about their effects on the participants in the interviews, I became more aware of how I might have responded in a way that had a different effect on what the participant was able to tell me. This understanding of the effects of my behaviour allowed me to understand better what motivates the participants to respond in particular ways, and avoid stories.

Creswell (1998), Merriam (1998), and Stake (1995) point out that a case study design allows the investigator to create a comprehensive description of the case and includes the context. Therefore, it was important to be aware of my personal assumptions and beliefs throughout the study because these will have significant effects on the trustworthiness of a study. Therefore, keeping reflexive field notes to document my concerns and impressions was important during the data collection

and analysis. Further, these notes were incorporated into the charting and indexing of codes and themes.

3.8 Preparing the Data for Analysis

After I concluded the data collection process for each of the case studies and the curriculum documents, I started preparing the collected data for analysis. Each case database consisted of the data from the two sources (documents and interviews). Figure 3.6 illustrates the datasets for each case.

Figure 3.6: Illustration of Each Case Dataset

Case 1	Case 2	Case 3	Case 4
10 Documents			
10 Individual interviews	10 Individual interviews	1 Focus Group	1 Focus Group

All data were collected and tape-recorded in either English or Arabic. Each tape recording was carefully labelled and later transcribed. Next, all the Arabic documents and transcripts were translated into English. After double-checking all tape-recorded interviews with their transcripts for any inconsistencies, all the interview transcripts and field notes were typed and saved into Microsoft office files. In addition, demographic data was added to each transcript and, to retain anonymity of the process, each participant was assigned a code name, for example, Admin 1, which refers to a participant in Case 1, Teacher 1 refers to a participant in Case 2, Student 1 refers to Case 2, and Service User 1 refers to Case 4. Later, the transcripts were transferred to an NVivo programme, which was used to organise, date and facilitate the coding process (Yin, 2009).

3.9 Translation

Qualitative research represents the various perspectives of participants and the richness of their experiences, through a variety of approaches and methods (Denzin & Lincoln, 1994; Flick, 1998). Maintaining accuracy when representing participant's viewpoints and perspectives is essential but very challenging when the research study is conducted in one language and then analysed and synthesised in another. Since understanding of meaning is central in qualitative research analysis,

Jootun, McGhee, and Marland (2009) therefore suggest that researchers must engage with meanings to come up with accurate and valid translations. Esposito (2001) indicates that translators must use good vocabulary and grammar to ensure that the composition is correct and the meaning of the translation is comprehensible to everyone. Also, the translator should consider the cultural context of both languages to develop a translation that is understandable (Larson, 1998). Therefore, fully understanding the participants' culture and language will decrease potential concerns about the validity of the data.

Furthermore, professional translators may be fluent in a language but not the nuances embedded in cultural expressions, and this may add to the challenge of producing meaning-based translations instead of word-for-word translations. According to Jones and Kay (1992), not all expressions can be easily translated because not all concepts are universal. As a result, I had to translate all the interviews conducted in Arabic into English to avoid issues related to translation discrepancies, and because my thesis will be submitted in English (Twinn, 1997). Nevertheless, to save time and resources I accessed the English versions of the MoH nursing education documents.

3.9.1 Editing of the Translated Transcripts

Despite the translation process being very challenging and time consuming, it enabled me to grow very familiar with the data and maintain organisation. I started the translation process by reading each of the interview transcripts in Arabic, and then translated the sentences one by one into English. However, I realised that the translation process is not just about direct translation of the words; it is difficult to fully develop accurate and meaningful transcripts because the exact equivalence or meaning may not exist. Therefore, I had to carry out some editing of the transcript material. For example, one participant in the service users' case stated that:

Before editing: *"Nurses do not give the face you like"*

The exact verbatim meaning is not comprehensible in English. Therefore, I had to reflect on the context of this statement instead of its verbatim meaning.

Consequently, I developed a phrase to explain this sentence in order to make it more comprehensible, which can be transposed by saying that:

After editing: *“Nurses do not pay attention to us as we like them to do”*

Moreover, grammatically speaking, Arabic sentences are of two types: nominal and verbal, whereas English sentences are usually nominal because they begin with a noun. Most verbal Arabic sentences become nominal sentences when translated into English. Therefore, when translating I was required to modify some sentences in order to make them understandable to a non-Arabic speaker. The following is an example of such an instance:

Arabic language: “يُحسوا انه نحن اقرب لهم من الاجانب”

Before editing: “Feel they that we closer them from the foreigners”

After editing: “They feel that we are closer to them than foreigners”

As stated above, in this case, because the sentence states with a verb, I needed to change “feel they” to “they feel”. Also, a noun of a nominal clause in Arabic is usually identified by the definite article (ال), meaning “the” in written as well as spoken Arabic. Therefore, when translating an Arabic text into English I had to remove the definite article “the” because the English nouns require no definite articles in a given linguistic situation.

Thirdly, unlike Arabic, an English adjective usually goes before the noun. An adjective in English can be translated into Arabic; the order of words is usually reversed.

Arabic language: “في ممرضات زينات”

Before editing: “there are nurses good”

After editing: “there are good nurses”

Lastly, the Arabic language is part of a culture that exists in hot and dry climates, whereas English is generally spoken in cold and wet climates. Therefore, some Arabic expressions are associated with cold weather to express positive and favourable connotations of joy and delight.

Arabic language: “يبردوا الفؤاد”

Before editing: “cool they the heart”

The equivalent expressions in English, in order to have positive connotations, are usually associated with warmth rather than cold, such as a warm welcome or a warm-hearted person.

After editing: “They warm the heart”

A bilingual translation checker was used as a strategy for ensuring the accuracy of the translation process and to check for translation errors (Smith et al., 2006). Also, providing the translation checker with key information regarding the research study, including the aims of the study, is essential to producing accurate transcripts (Temple & Edwards, 2002). The translation checker reviewed the translated version of the transcripts and compared them to the original Arabic transcripts to ensure accuracy. There were no significant differences between them, and only a few mistakes were found due to word choices related to participants' different dialects, resulting in different words being used to describe the same concept.

The transcripts were sent to the translation checker via email in password-protected files to maintain the confidentiality of the participants. In addition, code names were used to identify the participants. During the checking process, the translation checker added and/or changed words, phrases, and sentences to ensure that the interview flowed and the meaning remained the same before and after editing. In conclusion, minor changes were made to the translated transcripts to ensure their accurate depiction of the original transcripts.

3.10 Methods of analysis: Qualitative case study data

Qualitative analysis of text is often accompanied with other sources of data to fulfil the principle of triangulation and increase the validity of the study's findings. Therefore, it is common to analyse transcribed interviews along with documents. The purpose of multiple sources of data is the validation of evidence. Qualitative researchers keep journals that describe their approaches to data analysis. A recording of ideas and decisions also enables another person to evaluate the

conclusions reached based on its logical consistency. Retracing thinking is important; for example, describing the reasons for the pre-established categories for initial coding is useful in building an argument to explain why a conclusion is based on categories that emerged only after older theories or models did not fit the data. This is why qualitative researchers rely on written ideas, as they occur to help sort data into categories, define their properties, and make sense of them by discovering the relationships among categories.

Qualitative data analysis eventually reaches a point called saturation, often signaling completion of the study when there is a judgment of *diminishing returns* and little need for more sampling. This is the point where new data and their sorting only confirm the categories (often numbering between three and six or so), themes, and conclusions already reached. Perhaps data analysis yields a conclusion that is best described by reference to a metaphor (e.g., teachers as orchestra leaders, contractors, or mediators). This conclusion will be strengthened by a description of how and why saturation was reached. For example, journal recordings of the reasoning behind major decisions over time and evidence that supports both the saturation and the concluding argument build a solid case for your conclusion.

Conclusions in qualitative research are typically derived from identified patterns and uncovered conceptual, not statistical, relationships. The discovery of connections in the data may support a theory, revise one, or generate a new one. As described earlier, this type of analysis is inductive, with thinking moving in the direction of specific observations to a more general theory or explanation (often referred to as “bottom-up”). The exploration of data is flexible in the sense that the researcher is open to new constructs (ideas) and explanations (theories), given that existing variables are often unknown. Entirely new questions may evolve from the analysis, potentially answerable from the same data sources. The task is often described as *iterative*, meaning there is repeated movement back and forth between raw data (narrative text), codes, categories, and plausible explanations that emerge. The process ends with a reasonable conclusion. The task is also “interpretive” because it requires “sense making” as meanings emerge. Ultimately, the qualitative data analyst aims to create a shared understanding that forms a coherent structure,

a unified whole. Each level of analysis, from codes to categories to themes, reaches higher levels of abstraction.

Qualitative researchers often seek relationships between conceptual ideas generated from the narrative data. For example, presume that teachers' interviews about stress are transcribed and their major ideas coded (e.g., emergence of "compassion fatigue," "resource issues," and "creative illness," among others). Later in the interviews, teachers refer to an idea coded as "protective barriers." Across several interviews, a pattern emerges: references to compassion fatigue co-occur with mention of codes ultimately categorized as "protective barriers," a major category with several subcategories (home remedies, seeking mentorship, reducing home visits, use of humour, etc.). Further analysis may reveal that protective barriers are associated with less commitment to the profession (another category). From this analysis, a theory of teacher attrition may emerge, one that posits the central role of compassion fatigue as opposed to more tangible influences such as low pay or lack of resources.

Connections between ideas that form a whole often reveal themselves via visual aids such as matrices, tables, concept maps, charts, boxes, and cross tabulations (categories of a critical dimension suggested by theory). The power of visual tools to reach less-than-obvious conclusions is illustrated by Wainer (2000) in *Visual Revelations*. Bullet-ridden planes returning to aircraft carriers during World War II were mapped by the location of their holes so that the manufacturer could strengthen the armor plates where there were the *fewest* holes, the reasoning being that planes damaged in those areas were likely not airworthy (they did not return). Often these visual displays highlight contrary evidence—instances that do not fit your proposed category structure. Data that "jump out" in contradiction may lead to a revision of the scheme initially imposed on the data. Sometimes counter evidence or perplexing gaps lead to new research questions. Qualitative researchers always consider alternative explanations as they "re-enter" the data and wrestle with it to locate supporting or refuting evidence. Further, there is often a need to access additional sources of data for evaluation of a particular interpretation. Finally, qualitative researchers guard against "confirmation bias," or seeking out

evidence that supports their initial conclusion or personal view while other data are filtered.

In qualitative research, collected data consists of in depth descriptions of circumstances, people, interactions, observed behaviours, attitudes, thoughts and beliefs, and direct quotes from individuals who have experienced or are experiencing a phenomenon (Patton, 2002). Additionally, it includes personal or organisational documents such as correspondence, records/diaries, and case histories (Patton, 2002). Therefore, qualitative data is typically presented in the form of text, such as interview transcriptions or documents; nevertheless, it may also include non-textual data such as tables, pictures, audio and video recordings (Patton, 2002; Strauss & Corbin, 1998). Thus, different researchers have proposed various methods of analysing qualitative data (Bryman & Burgess, 1994; Merriam, 1998; Miles & Huberman, 1994, Yin, 2009; Thomas, 2011). Several guiding principles and specific steps can be easily found in many qualitative analytic techniques; for example, grounded theory (Corbin & Strauss, 1990), frameworks (Ritchie & Spencer, 1994), and many others (Bryman & Burgess, 1994; Cresswell, 1997; Denzin & Lincoln, 1998; Silverman, 1993).

Generally, there are some common procedures in the analysis of qualitative data. The qualitative researcher looks for categories or themes from the raw data to describe and explain phenomena. The aim is to identify the relationship patterns between these categories or themes. An example of a qualitative analysis technique, suggested by Miles and Huberman (1994), consists of the following three steps:

1. Data reduction, which refers to the process whereby the mass of qualitative data obtained, such as interview transcripts, field notes, observations, are reduced and organised (coding).
2. Data display which refers to drawing conclusions from the mass of data, for example, displaying the data in the form of tables, charts, and other graphical formats. This is a continuous process that is carried throughout the data collection process.

3. Conclusion drawing which refers to starting to develop conclusions regarding the study. These initial conclusions can then be verified, that is, their validity examined through reference to the existing field notes or further data collection.

Another approach, developed by Ritchie and Spencer (1994), is framework analysis. I have used this approach to analyse the multiple case study data collected in the form of document and individual and focus groups interviews. Framework analysis is a flexible analysis process in that it allows the research to choose to either collect all the data and then analyse or perform data analysis during the collection process. In the analysis stage the gathered data is filtered, charted, and sorted in accordance with the main themes. This involves a five-step process:

1. **Familiarisation with the data.** This included whole or partial transcription and reading of the data (Ritchie & Spencer, 1994).
2. **Identifying a thematic framework.** This included the initial coding framework, which is developed both from *a priori* issues and from emerging issues in the familiarisation stage (Ritchie & Spencer, 1994).
3. **Indexing.** This included the process of applying the thematic framework to the data using numerical or textual codes to identify specific pieces of data, which correspond to differing themes (Ritchie & Spencer, 1994).
4. **Charting.** This included using headings from the thematic framework to create charts of the data so that it can easily be read across the whole dataset. Charts can be either thematic for each theme across all respondents (cases), or by case for each respondent across all themes (Ritchie & Spencer, 1994).
5. **Mapping and interpretation.** This includes the analysis of key characteristics as laid out in the charts. This analysis provided a schematic diagram of the phenomenon, thus guiding the interpretation of the data set. It is at this point that the researcher is aware of the objectives of qualitative analysis, which are: “defining concepts, mapping range and nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies” (Ritchie & Spencer, 1994). Once

again, these concepts, technologies, and associations are reflective of the participant. Therefore, any strategy or recommendation made by the researcher echoes the true attitudes, beliefs, and values of the participants.

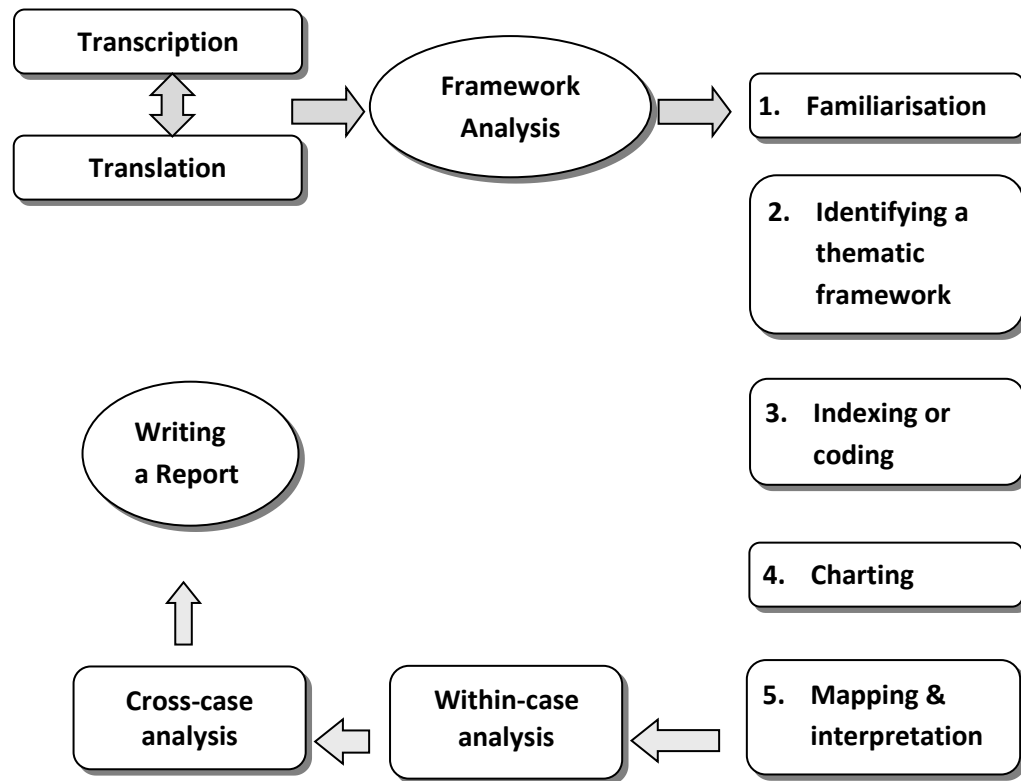
According to Thomas (2011), analysis of a case study research may take multiple shapes depending on the nature of the phenomena being studied. Moreover, Yin (2009) indicates that it is dangerous to treat each data source and the findings reported independently or separately during the analysis phase. He points out that the case study data should be combined in order to understand the whole case, not the various parts of the case or the contributing factors that influence the case.

In this multiple case study, I have applied Ritchie and Spencer's (1994) five step analytical framework to identify themes in the data collected from the documents and interviews (focus group and individual). Furthermore, two phases of multiple-case study analysis were used: within-case analysis, and cross-case analysis. According to Eisenhardt (1989), within-case analysis would allow the unique patterns of each case to emerge prior to generalising the patterns across cases and provides the researcher a rich familiarity with each case, which increases proficiency of cross-case comparison. Also, the purpose of cross-case analysis is to push the researcher to go beyond initial impressions and improve the likelihood of accurate and reliable findings (Eisenhardt, 1989; Yin, 2009).

3.11.1 Case Study Analysis Procedures

Subsequent to finalising the transcription and translation processes of the collected data sets, I started the analysis process of each case separately. For each case, I began by analysing all the collected documents, then I analysed the interview data (individual and focus group). Once I completed the within-case analysis of the four case studies, I initiated the cross-case analysis process. The phases of the qualitative multiple case study analysis process are illustrated in Figure 3.7.

Figure 3.7: Phases of Qualitative Multiple Case Study Analysis



The following details the multiple-case study analysis applied in this study:

Phase 1: Familiarisation with the collected data

The data collection process allowed me to become familiar with the data collected. It was vital to immerse myself in the data to become more familiar with the depth and scope of the content (Ritchie & Spencer, 1994). This involved repeated reading of the documents and interview transcripts while searching for meanings, patterns and so on (Ritchie & Spencer, 1994). I read the entire data set three times before I started coding ideas for the identification of possible patterns in the data. The MoH documents offered data regarding the aims of the MoH nursing education. Whereas the interview transcripts offered information on what MoH nursing administrators, educators, nursing students and service users (public) thought about the MoH's approaches to nursing education and its cultural congruency in the context of Oman.

Phase 2: Developing a thematic framework

Identifying a thematic framework, the second phase, occurs when the researcher recognises emerging themes or issues in the data set (Ritchie & Spencer, 1994). These emerging themes may have risen from a priori themes or issues; however, it is at this stage that the researcher must allow the data to dictate the themes (Ritchie & Spencer, 1994). To achieve this end, I have used the notes taken during the familiarisation stage. The key issues, concepts and themes that have been expressed by the participants now form the basis of a thematic framework that can be used to filter and classify the data (Ritchie & Spencer, 1994). During this phase, I began to generate an initial list of ideas about what is contained within the data and what is thought provoking about them.

Phase 3: Indexing data (coding)

Indexing refers to identifying portions or sections of the data that relate to a particular theme. This process is applied to all the textual data that has been gathered (i.e. transcripts of interviews). Ritchie and Spencer (1994) suggest that a numerical system be used for indexing references and notes in the margin beside the text. I have used analysis tools such as NVivo to help me with this process. To ensure accuracy in the process of coding, I have spent 10 months coding ten documents, the twenty-two individual interviews, and two focus group interviews. The main difficulty I encountered during the indexing process was finding the word or term that best fitted the meaning of each part of the collected data. I have discussed this problem with my supervisors, and we decided that a useful approach was to code one or two interview transcripts and then meet to discuss the process, which facilitated my understanding of the process. Table 3.2 illustrates an example of interview indexing

Table 3.2: An Example of Interview Indexing

Data	Preliminary theme	Refined theme
“Nursing is a public service, and being trustworthy is important. We take care of people and it is a big responsibility. We should be competent in what we are doing. If I was interviewing, you for a teaching position I could have asked you how ready are you to be able to teach when just graduated? I had people who chose to start in the clinical first to gain the experience and then went back to teach. I believe to be a teacher; you have to be a practitioner first. Our profession is not based on theory alone” Admin 5 (p5)	1.6 Characteristics of nursing teachers	1.2.2 Teacher competencies
“I do not feel the time or the duration students’ spend studying nursing (3 years) is enough for someone to care for patients. Maybe more years in study will give them more maturity and experience to deal better with patients” Service User 1	• 4.8 Extending the programme duration • 4.2 Improving the students	4.2.2 Quality of the graduates

Phase 4: Devising a series of thematic charts (Grouping and classifying across two sets).

Charting consists of arranging the specific pieces of data that were indexed in the previous stage in charts of the themes (Ritchie & Spencer, 1994). This means that the data is lifted from its original verbatim context and placed in charts that consist of the headings and subheadings that were drawn during the thematic framework (Ritchie & Spencer, 1994). However, it is important to remember that the pieces of data lifted from their context still clearly identify what case they came from (Ritchie & Spencer, 1994). According to Ritchie and Spencer, for accuracy, cases should always be kept in the same order in each chart (1994).

Table 3.3: An Example of a Case Chart

Case 1	Theme 1	Theme 2
	<i>MoH approach to nursing education</i>	<i>The impact of MoH curriculum decisions</i>
	<i>“There was very little acceptance of nursing ... there were a very limited number of applicants coming to the nursing programme... which was a problem due to the number we needed for the healthcare service” Admin 3.</i>	<i>“I believe that the nurse is supposed to be a more independent practitioner, therefore the preparation should be different to meet the community needs” Admin 9.</i>

Phase 5: Mapping and interpreting data

Mapping and interpretation involves the analysis of the key characteristics organised in the charts. This analysis should be able to provide a schematic diagram of the phenomenon, which guides the researcher’s interpretation of the data set. According to Ritchie and Spencer (1994), at this stage the researcher should be aware of the objectives of qualitative analysis, which involve defining concepts, mapping of phenomena, creating typologies, finding associations, providing explanations, and developing strategies. In addition, the concepts and associations should be reflective of the real attitudes, beliefs, and values of the participants (Ritchie & Spencer, 1994).

I began by reading and reflecting on the documents, transcripts of the interviews, and reviewing all the charts and research notes. Then, started comparing and contrasting the different perspectives, searching for patterns and connections within the data as a whole. I devoted a lot of time thinking about what the participants meant and how this could be presented in a meaningful way in the study. Once I identified the initial themes from the codes across the two data sets, I started refining the themes. Each theme was checked by reflecting on the coded data generated and I verified that the themes fitted with coded data. The process was documented carefully and I double-checked the whole data sets. External auditing was performed by my supervisors to examine how the codes and themes were generated, also to ensure the thoroughness of the process. At the end of this process,

the final themes and sub-themes were clearly defined and described to reflect the components of each theme. Table 3.3 illustrates an example of defining/describing a theme.

Table 3.4: Defining/Describing the Theme in Case 1

Theme	Defining theme	Components
Nursing in Oman	How the participants perceived the current status of nursing in Oman, mainly, the nursing education.	1. Omanisation of the Nursing Cadre 2. Quantity versus quality in nursing education

3.12 Reporting the case study findings

3.12.1 Within-case Analysis

I started this first phase of the multiple case study analysis with the identification of the finalised themes and sub-themes of each case. Then, I started to write a report on the findings of each case, beginning with Case 1 then progressing to Case 2, Case 3 and then Case 4 (see Chapter 4). The results of the within- case analysis were utilised in the next phase of analysis: the cross-case analysis.

3.12.2 Cross-case Analysis

In this final phase analysis, I made use of the themes and sub-themes generated from the within-case analysis (see Chapter 4). In addition, I used the identified codes generated from each case (see appendix L) to contemplate the findings to create a common theme across the four cases. To illustrate the process of comparing and contrasting the within-case findings of the four cases, I created a table to validate any similarities and differences between the cases (see table 5.2 in Chapter 5). Subsequently, I created another table presenting the newly established across-case themes and sub-themes, demonstrating the full picture of how the MoH's approaches to curriculum development impacts nursing education and its cultural congruency in the context of the Sultanate of Oman. Each new theme was named and defined based on the new sub-theme components. To verify that the new themes and sub-themes were a true representation of the cases, I re-checked with

the within-case findings in Chapter 4. In addition, I shared the findings with my supervisors to confirm all the themes and sub-themes accurately represented findings across the four cases.

3.13 The Quality of Case Study Research Design

Patton (2002) asserts that the validity and reliability are the two features, which any qualitative researcher should be concerned about while designing a study, analysing results and judging the quality of the study. Alternatively, others indicate that the concept of reliability is deceptive in qualitative research since qualitative and quantitative researches belong to different paradigms (Stenbacka, 2001). As a result, some researchers emphasise that the quality of a study in each paradigm should be judged by its own paradigm's positions (Healy & Perry, 2000). For instance, the terms reliability and validity are crucial criterion for quality in quantitative paradigms, while in qualitative paradigms the terms credibility, confirmability, dependability and transferability are necessary criteria for quality (Lincoln & Guba, 1985). Several authors on research methods have established how qualitative researchers can incorporate measures that deal with these issues (Lincoln & Guba, 1985; Silverman, 2001). Two such authors are Lincoln and Guba (1985), who propose four criteria that are thought to ensure the trustworthiness of the study through addressing these issues:

3.13.1 Credibility

According to Merriam (1998), credibility is the equivalent concept in qualitative research to internal validity in quantitative research. She goes on to say that, credibility deals with the question of *“how congruent are the findings with reality?”* Lincoln and Guba (1985) claim that ensuring credibility is a key factor in establishing trustworthiness.

At the start of the study, it was important to develop familiarity with the culture of participating organisations prior to data collection (Lincoln & Guba, 1985). This was achieved through exchange of ethical approval documents and preliminary visits to the MoH offices, DGET, and several nursing institutes. This contributes to the establishment of a trusting relationship between the potential participants and

me (the researcher). However, Silverman (2000) indicates that immersion in the context under study may influence the researcher's judgement.

Secondly, using triangulation, this involved the use of different methods, particularly documents, focus groups and individual interviews, to ensure the credibility of the study. The use of different methods compensated for the individual limitations of each research method, therefore, it was essential to obtain MoH documents to provide a background to help explain the attitudes and behaviour of the interview participants and verify particular details that participants have provided (Brewer & Hunter, 1989). Also, during the actual individual and focus group interviews, I have referred to the MoH documents to allow the participants to shed light on their individual viewpoints and experiences that can be verified against others and, ultimately, a rich picture of the attitudes or values can be constructed.

Thirdly, according to Lincoln and Guba, (1985), peer scrutiny of the research study increases credibility. I have welcomed scrutiny and feedback offered on the study by colleagues, peers and academics during presentations in conferences and in school meetings. This has provided me with an alternative perspective that such individuals are able to bring, which allows me to challenge my assumptions, refine my methods, develop a better understanding of the research design, and strengthen my arguments in light of the comments made (Lincoln & Guba, 1985).

Fourthly, reflexivity allows that the researcher to evaluate the project again as it develops, which may include the effectiveness of the techniques that have been employed (Guba & Lincoln, 1989). The reflexive notes may also be used to record the investigator's initial impressions of each data collection session, patterns appearing to emerge in the data collected and theories generated. This can play a key role in establishing credibility. Ultimately, reflexivity becomes an informative part of the emerging patterns in the findings and discussion. Also, reflexive notes can be used in the research report as part of the research analysis.

Fifthly, Guba and Lincoln (1989) consider member checks the most important step to strengthening the credibility a study. Checking the accuracy of the data may take

place during or at the end of the data collection. Participants may also be requested to read transcripts of their interviews to verify that the words match what they actually intended to say in order to accurately capture their perspectives.

2.13.2 Transferability

Transferability or generalisability is related to the extent to which the findings of one study can be applied to other contexts (Lincoln & Guba, 1985). Some authors are doubtful that generalisability can be achieved in qualitative research (Creswell 1998; Lincoln & Guba, 1985). According to Wainwright (1997), the context-specificity of qualitative research limits its generalisation to other contexts. As a qualitative study results are specific to a small number of individuals in particular environments, it is difficult to demonstrate that the results and conclusions are applicable to other contexts. Stake (1994) offers an opposing view and suggests that despite the uniqueness of each case, it remains a sample within a broader context, so transferability is possible. Similarly, Lincoln and Guba (1985) indicate that the researcher should ensure that sufficient contextual information about the study is provided to enable the reader to make such transfer. Therefore, it is essential that a sufficiently dense description of the phenomenon under study is provided to allow the readers to have a good understanding of the study and enable them to compare the features of the phenomenon as described in the research report with other situations. According to Guba (1981), there is a need for a complete description of all the contextual factors affecting the study.

As a result, I have used an in-depth description of the study process, including study aims, purpose, context, literature review, methodology, data analysis and discussion in the thesis report to enable the reader to see the whole picture and draw comparison that can be generalised or transferred to other contexts. Moreover, I used purposive sampling techniques in the selection of the research participants to enhance the importance of context for a case; the use of precise cases allows the reader to draw comparison between this research results and their contexts (Flyvbjerg, 2006). Also, according to Stake (1994), the use of multiple case studies consisting of different participants, and applying the within-case and cross-case

analysis techniques would support the reader in comparing and contrasting cases, recognising connections between cases, and to draw inferences from the findings.

3.13.3 Dependability

Dependability is related to showing that the results are consistent and could be repeated (Lincoln & Guba, 1985). Lincoln and Guba (1985) argue that there is a link between credibility and dependability, as demonstrating dependability ensures the credibility of the study. This can be achieved through the use of triangulation processes, such as focus group and individual interviews. In order to address the dependability issue directly, the study process was reported in detail, thereby allowing researchers to repeat the process to gain similar results in the future. Therefore, in-depth reporting allows the reader to evaluate what appropriate measures were followed during research. To allow the readers of this research study to develop a thorough understanding of the methods and their effectiveness, I have incorporated comprehensive details of the research process in the methodology chapter.

3.13.4 Confirmability

Confirmability relates to the extent to which the study results are formed by the participants and not based on investigator bias, or interest (Lincoln & Guba, 1985). The concept of confirmability in qualitative research is similar to objectivity in quantitative research. Remenyi et al. (1998) indicate that the main issue or criticism of the case study design/approach is the absence of rigour and objectivity. Miles and Huberman (1994) consider the researcher's acknowledgement of their own predispositions a key criterion for confirmability. Therefore, triangulation of research methods is a valuable technique to confirm that the study results are a true representation of the experiences and perceptions of the study participants instead of the investigator's views, therefore reducing the effects of researcher bias and promoting confirmability. Hence, I have included the reasons behind decisions made regarding favouring one approach, design, methods and limitations in the techniques employed in the study report. Most of these issues are acknowledged in the field notes (see section 3.7).

Chapter 4: Results of the Individual Case Analysis

Introduction

This chapter describes the study findings of the within-case analysis of each of the four case studies. Therefore, the chapter consists of four sections. Each section starts with a profile background of each case and its context followed by an in-depth description of the findings.

The analysis is based on Ritchie and Spencer's (1994) framework process (see Chapter 3 Section 3.11.1), the themes and sub-themes reflect the evidence and information gathered from the raw data. All the findings are supported by example quotations from the two datasets: MoH nursing education documents, which showed the intentions, the policies and the execution process of nursing education under the MoH; and the interviews (individual and focus group) data, which showed the perspectives of the MoH nursing administrators, MoH nursing educators, MoH nursing students, and MoH service users regarding MoH's approaches to nursing education and its cultural congruency in the context of the Sultanate of Oman. The quotations were used to provide evidence for the interpretations, to give participants a voice, offer the reader greater depth of understanding, and maintain objectivity (Corden & Sainsbury, 2006).

- **Providing evidence**

Quotations helped to provide evidence for the interpretations, so that, so that the work did not appear unscientific or subjective.

An example:

The original words: *"There was very little acceptance of nursing ...there were a very limited number of applicants coming to the nursing programme... which was a problem due to the number we needed for the healthcare service" Admin 3.*

What this participant appears to be suggesting (interpretation) that the nursing administrators believed that there was a need to encourage the community to accept first nursing as a proper profession for their children.

- **As illustration**

Quotations could be useful to show how something affected an individual by using their own words. For example, a service user explained their experience with the MoH healthcare providers using their own words:

“When you are there at clinics or hospitals the nurses do not make you feel welcome, and we are not happy with the way they treat us as patients”
Service User 3.

- **Provide deeper understanding**

Quotations could offer readers greater depth of understanding. Spoken words sometimes show the strength of individual’s views or the depth of feelings in ways that the researcher’s own narrative could not. An example, a nursing educator describes her views regarding upgrading to degree programme:

“I believed that nurses with a degree are more attentive to issues that diploma nurses think are less important, such as vital signs... therefore, I feel the B.Sc. in nursing will make a difference in nursing education”
Teacher 2.

- **Enabling voice**

Spoken words of the participants sometimes make more impact than the researcher’s narrative in conveying experiences to readers. An example, a nursing administrator views regarding the qualifications of nursing educators: *“I believe to be a teacher you have to be a practitioner first... our profession is not based on theory alone”* Admin 5.

4.1 Case 1(MoH nursing administrators)

4.1.1 Case 1 Background

Case 1 is based on ten MoH nursing administrators who represent MoH nursing education decision makers. The case consists of two datasets: MoH nurse education documents, and ten semi-structured individuals (face-to-face) interviews with MoH nursing administrators. Each participant was given a code name to protect his or her identity and maintain confidentiality. All the interviews took place at the

nursing administrators' work offices. The participants' characteristics are listed in Table 4.1.

Table 4.1: Participant Characteristics

#	Gender	Country	Work in Years	Edu.
Admin1	Male	Omani	6-15	Master USA
Admin2	Male	Omani	6-15	Doctorate USA
Admin3	Male	Omani	15+	Master UK
Admin4	Male	Omani	6-15	Master UK
Admin5	Female	Omani	15+	Master UK
Admin6	Male	Omani	< 5	Master USA
Admin7	Female	Omani	15+	Master UK
Admin8	Male	Non-Omani	< 5	Master UK
Admin9	Male	Omani	15+	Doctorate USA
Admin10	Female	Non-Omani	15+	Doctorate

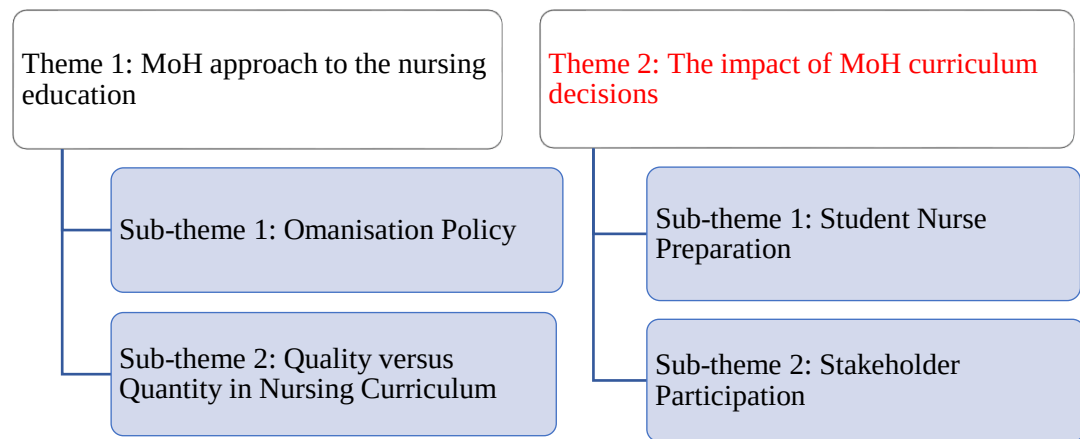
The governance of the MoH nursing institutes is complex and has multiple levels. The MoHEIs are administered by the MoH through the MoH Undersecretary for Planning Affairs. Nursing institutes in Muscat report to the MoH Director General of Education and Training (DGET), while the regional nursing institutes report to both the MoH DGET and their regional Director General of Health Services (DGHS) for administrative and financial aspects (see appendix I). Furthermore, mainly two bodies govern the MoHEIs: The Higher Council of Educational Institutes, and the Technical Committee. Both bodies are led by the undersecretary of planning affairs and create all the rules and regulations that regulate the MoHEIs. The higher council of educational institutes subdivide into nursing and allied health councils. At the nursing institute level, the council of nursing institutes manages all MoH nursing institutes and is chaired by one of the deans, and all the other nursing institute deans are members. This council mainly formulates operational policies on administrative and education/academic issues. Also, the council is a decision-making body regarding the implementation of policies approved by the MoHEIs higher council.

4.1.2 Findings

Analysis of MoH nurse education documents and the individual interviews with the MoH nursing administrators (decision makers), provided a wealth of data that was

subjected to analysis using the Ritchie and Spencer framework approach (1994) and organised into main themes and sub-themes. Two themes with four sub-themes were generated to represent MoH nursing administrators' perception of how the MoH's approaches to curriculum development impacts nurse education and its cultural congruency in the context of Oman. Each theme and sub-theme is presented separately (see figure 4.1).

Figure 4.1: Themes and sub-themes in Case 1



4.1.3 Theme 1: MoH approach to nursing education

This theme describes the MoH nursing administrators (decision makers) viewpoints on the MoH approach to nursing education and how they have influenced MoH's decisions regarding establishing the nursing programme and quality of nursing education. The theme has two sub-themes: Omanisation policy and quality versus quantity in the nursing curriculum.

4.1.3.1 Sub-theme 1: Omanisation policy

This sub-theme describes the participants' perceptions regarding MoH implementation of the Omanisation policy and how it impacted nurse education in Oman.

4.1.3.1.1 Raising community acceptance

According to the MoH, the main aim of the establishment of the MoHEIs was to increase the human healthcare resources to achieve Omanisation and best utilisation

of healthcare forces (MoH, 2012). All the nursing administrators believed that Omanisation of the nursing profession/education provided the country with Omani graduates who were better able to respond to the healthcare needs of the local population. Further, they believed that the graduates were able to respond to the mental, physical, and social needs of the community because they knew the local language and understood the local culture. They went on to say that the MoH needed to start its own nursing programme because of the growing need in the healthcare service for qualified human resources and to reduce the dependency on non-Omani workers. However, the nursing administrators believed that there was a need to encourage the community to accept first nursing as a proper profession for their children. A high-ranking participant at DGET stated that:

“There was very little acceptance of nursing ...there were a very limited number of applicants coming to the nursing programme... which was a problem due to the number we needed for the healthcare service” Admin 3.

They expressed that the community viewed the nursing profession as a dirty, disreputable job, suitable only for foreigners (here they refer mainly to Indian and Filipino nurses). Moreover, the community perceived nursing as an unskilled and low status profession. The nursing administrators believed that the nature of nurse’s work and working conditions, which requires them to mix with the public, work with men/women, take on heavy workloads and difficult work schedules (long hours, weekends, night shifts), conflicted with traditional Muslim/Arabic family life in Oman. Furthermore, the nursing administrators stated that many Omanis associated nursing work with maid work and helping with domestic tasks, such as fixing beds, changing bedding, house cleaning, and preparing and serving meals. One of the participants stated:

“We are used to having expatriates, of which the majority were from India... so, the concept the public had... because of a lack of education or ignorance... they look at the nurses as maids... or housemaids or servants... and therefore, nursing was not looked at as a noble profession” Admin 4.

They believed that the Omani community did not appreciate the contribution of the nursing profession in promoting and maintaining health. According to the nursing administrators, the Omani community only viewed nursing in relation to bedside

care. Consequently, they believed that political influence was needed to encourage the locals to enter the nursing profession. One of the participants stated:

“Definitely within our region, specifically in Oman, politics play a big role ... there was a need for political involvement to move nursing education to the community ... without political involvement there will be no nursing education until today” Admin 3.

Also, the nursing administrators believed that socio-economic pressures drove the expansion of the nursing programme to other regions (outside the capital, Muscat). They indicated there were limited applicants for the MoH nursing programme due to the fact that it was based in the capital; which meant that students from outside Muscat had to travel a long way to attend the programme. Furthermore, they pointed out that social factors such as family cohesion, and economic factors such as travel expenses put many families off encouraging their children to join the MoH nursing programme. Therefore, the MoH’s decision to move the nursing programme to the regions (outside Muscat) was a good one because it helped the MoH to achieve its target number of students for the programme. A high-ranking participant at the MoH stated that:

“The good thing about it (the nursing programme) is it not being concentrated in the capital, Muscat... but it is distributed all over the different regions or governorate, which gives the opportunity to students who are living in these regions to start studying close to their homes” Admin 6.

The nursing administrators believed an advantage of expanding the nursing institutes all over the different regions was that when students completed the programme the graduates would start working in their local hospitals and health centres. They went on to say that, this contributed to social stability, as well as good distribution of the healthcare facilities and health manpower in the country.

4.1.3.1.2 Current admission criteria

Additionally, the nursing administrators highlighted that nursing was not the top choice for the majority of Omani students; therefore, their interest in the nursing profession was questionable. According to them, the Omani students selected nursing as their third or fourth choice, and only for socio-economic reasons, such as offering a guaranteed job upon graduation and the ability to study at a nursing

institute close to their homes. They believed that many of these students were low achievers who tended to drop out of the programme or struggle in the nursing programme. One of the participants experienced in student admissions stated that:

“We realise that many Omanis are coming into nursing not because it is their first choice... we can see from the admission applications that nursing was not their first choice ... sometimes nursing is their fourth” Admin 3.

Others believed that nursing was still a choice due to the guarantee of employment and a salary, which is why many of the secondary school graduates were coming to the MoH nursing programme. They point out that many Omani students enter nursing due to encouragement or pressure put on them by their families, because nursing provides a secure job upon graduation, unlike other professions whereby you may have to search for years before finding a job. Furthermore, they stated that many of the students came to nursing because they were unable to get into other programmes, for example, medicine or teaching (education). They went on to say that these students tended to display an unprofessional attitude towards the nursing profession. The nursing administrators expressed that the current entry criteria for students did not assess the students’ values and beliefs regarding the nursing profession upon entry. A high-ranking participant at the DGET expressed that:

“We do not look at their values and attitudes... and the reasons why they are coming to the profession” Admin 4.

Further, the nursing administrators believed that the Omani culture, based on Islamic and Arabic culture, had affected nursing education in Oman. They went on to say that, currently, female students comprised the majority of the applicants to the nursing programme because the Omani culture perceives the female role as a caretaker of family members, and as home managers. Therefore, the nursing administrators stated that Omani culture contributed to higher female admissions to the nursing programme because as a role it was easier for a female to adapt and pursue as a career. Nevertheless, this created problems with females working in a male context, which was unacceptable to Omani culture. One of the participants stated that:

” In some places we experience resistance from the families regarding the mixing of females and males in the work environment... and they do not want the (female) student nurses to even touch patients from the opposite sex” Admin 10.

However, the nursing administrators believed that the Omani cultural roles differed between rural and urban areas. Some of the participants stated that, despite the number of male nursing students being small, male nurse graduates had made progress towards being accepted by the community.

In conclusion, the nursing administrators believed that Omanisation was a positive move towards meeting the healthcare needs of the population. They stated that Omanisation allowed the MoH to achieve self-sufficiency in producing their own human resources. The nursing administrators described the nursing profession image in the community as a barrier to recruiting or attracting students. They believed that the MoH had to accommodate the Omani community by expanding the nursing programme to the regions (outside the capital) and offering graduates guaranteed work.

4.1.3.2 Sub-theme 2: Quality versus quantity in the nursing curriculum

This sub-theme describes the participants’ views regarding how the MoH approached the issue of quality versus quantity in nursing education.

4.1.3.2.1 Nursing Staff Shortage

According to the student handbook (2009/2010), the MoH nursing institute’s main aims and objectives are *“to meet the needs of hospital and health institutes of qualified nurses” (MoH, 2009)*. The majority of the nursing administrators stated that the quality of the nursing programme was not the main concern of the MoH. They believed that covering its manpower needs for the MoH healthcare facilities and services required was more important to the MoH. They went on to say that, the quality of nurse education was stagnant because the main focus of MoH was to graduate as many healthcare providers as possible within a short period of time. A high-ranking official at the ONMC stated that:

“He (the minister) wanted to create a cadre ... have numbers... and he was establishing new nursing institutes... so he needed to fill the institutes... so that is a major problem here with nursing education” Admin 5.

Others went on to say that the current nursing curriculum was designed to enable the graduation of as many nursing students as possible. They believed that the current nursing curriculum permitted pushing students to pass all the required courses. They stated that repeating exams allowed incompetent nursing students to pass and graduate, which affects the quality of the graduates. A head of one of the MoH nursing institutes said:

“Repeating exams twice or more is not appropriate if we want better nurses... we need a better, rigid system that is able to filter graduates ... we do not have to have 100 percent graduation, or even 90 percent” Admin9.

4.1.3.2.2 Degree level entry to nursing

According to the MoH health institute catalogue purpose statement, the MoH acknowledged that there was an increasing need for well-trained health professionals, and claimed that the current MoH education programmes were designed to meet the healthcare needs of the country at international standards (MoH, 2008). Based on this, the nursing administrators believed that the MoH had the determination to move the current diploma-nursing programme to a degree level. They believed that this was an important step because it would improve the healthcare services in the country, particularly nursing services. Furthermore, they believed that all professional nurses should have a degree. According to them, the W.H.O advised that entry to the nursing profession should be at a degree level. Further, they went on to say that in Oman only about 3% of nurses were considered professionals, the remainder were considered technical nurses. They believed that a degree-holding nurse would wield better theoretical knowledge and skills.

Some of the nursing administrators expressed a belief that the nursing profession needs to move away from the MoH to the Ministry of Higher Education to allow nursing to be exposed to other professions and to improve the public image of nursing. However, they stated that they understood that the government regulations in Oman were not yet ready to facilitate this move. Despite the nursing administrators’ support of a degree level entry to nursing, they still believed that

the diploma graduates demonstrated better technical skills. A high-ranking participant from the MoH stated that:

“Moving to a degree programme does not mean we are not happy with the current graduates of the diploma programme... they meet the MoH objectives” Admin2.

The nursing administrators believed that a degree programme in nursing would put the nurse in a better position to stand up to other healthcare professions. Moreover, they believed that a degree programme in nursing would allow the students to develop leadership skills. Additionally, they stated that a degree programme would enable nursing students to widen and expand their scope of knowledge and skills. One of the participants stated that:

“In the diploma now there are around 90 credits, and later on it will be more-than 120 credits of teaching ... and definitely that will broaden their knowledge, broaden their clinical skills, and as a result of that we will have better patient care and healthcare services” Admin 6.

Further, the nursing administrators believed that degree level nurses would have a better education, which meant more knowledge and advanced skills, and this would therefore lead to improvements in patient care. Two of the nursing administrators pointed out that the move from the current three-year diploma programme to a degree programme or BSc would also help improve the quality of nursing education. Additionally, some of the participants expressed that specialised degree programmes would be better than general degree programmes; for example, a BSc in paediatric or critical care. A high-ranking participant at the MoH stated that:

“We should have a general nursing programme for people who still are unsure where they want to go... but we should encourage and have more specialised nurses to be ready to work in clinical settings” Admin 6.

4.1.3.2.3 Culturally relevant curriculum

Furthermore, the nursing administrators stated that the community conveyed that current nursing students needed further education on topics such as Islamic values and Arabic culture. They highlighted that MoHEIs had recently taken this point and implemented these courses in the nursing curriculum. One of the participants explained:

“We included the Islamic civilisation in the curriculum as a course called Islamic Culture, which is a compulsory course... and related it to health, the role of the nurse, and the nursing profession” Admin 10.

However, the nursing administrators believed that it was easier to teach students a skill than train them to acquire the appropriate values and attitudes. Moreover, the nursing administrators claimed that the nursing educators did not demonstrate the appropriate attitudes considering they were role models for the students. They went on to say that, some nursing teachers exhibited poor communication and interaction with the patients, families, nurses and other healthcare providers during their clinical teaching, and that this influenced their students’ attitudes and behaviour. Some of the participants added that nursing teachers should monitor student behaviour and give feedback to identify the students that required more training. A head of a nursing department stated:

“We have a lot values within our Islamic religion... but we are not effectively utilising them... such as, a smile and greeting our patients... teachers need to emphasise these values from our religion, this will help the student nurses to be aware of their behaviour” Admin 8.

The nursing administrators acknowledged that the Islamic culture had a huge influence on nursing education; for example, female students’ uniforms and how they interacted with male patients. Moreover, they believed that rules and regulations in Oman were based on an Islamic and an Arabic culture, for example, nursing students were never assigned night shifts, which made it difficult for them to adjust when they graduate. Also, the MoH claimed to incorporate concepts of caring and ethics based on Islamic and Omani cultural values at all levels of practice in all MoHEI programmes (MoH, 2008). However, the nursing administrators indicated that a great deal of the public complaints were not associated with the medical treatment they received, but rather how the treatment was delivered. They believed that teaching how to build and maintain good communication and interpersonal relationship with patients was essential in nursing education. One of the participants pointed out:

“We need to include Omani culture... I mean our Arabic and Islamic cultural values and beliefs... also, teaching ethics is very important... we need to expose students to different issues, for example, dying in Islam” Admin 5.

In contrast, many of the nursing administrators believed being Omani and a Muslim should be sufficient to guide the students' behaviour and attitudes with patients and their relatives. Also, they stated the curriculum should reflect the needs of all nationalities and religions served in recognition of the variety of patients in Oman. One of the participants stated:

"Our culture as Arabs and Muslims... even without the code of ethics, we have the code of ethics of our religion... our Islamic laws... which guide us in how to behave and act... how to respect and listen to others" Admin 10.

In conclusion, the nursing administrators described that the MoH approach to nursing education was based mainly on graduate numbers, not the quality of education. Also, they claimed that the MoH was not ready to relinquish ownership of the nursing programme to higher education. They believed a degree entry to the nursing profession would provide the country with professional nurses. However, they indicated that the current diploma programme graduates were efficient in meeting the healthcare needs of the country. Moreover, the nursing administrators acknowledged that the current nursing programme lacked emphasis on cultural values, and claimed that the nursing educators contributed to the issue by demonstrating inappropriate attitudes toward service users and other healthcare professionals.

The theme described the nursing administrators' viewpoints on how the MoH approach to curriculum development impacts nurse education and its cultural congruency in the context of Oman. They described the Omanisation policy to be an effective way for the MoH to become self-reliant. They indicated that the negative image of nursing was a major hurdle for the MoH nursing programme, which compelled the MoH to expand the nursing programme to the regions (outside the capital) and offer guaranteed work. Moreover, nursing administrators highlighted how graduate quantity not quality was the main concern of the MoH. Also, they believed that a degree entry to nursing would enhance the quality of the MoH nursing education while providing the country with professional nurses. Despite this, the nursing administrators' acknowledgement of culture care concepts should be incorporated and enforced in nursing education.

4.1.4 Theme 2: The impact of the MoH nursing curriculum decisions

This theme describes the nursing administrators' viewpoints regarding how the MoH's approaches to curriculum development impact decisions regarding how nursing students are educated and the involvement of stakeholders' in nursing education. The theme has two sub-themes: student nurse preparation, and stakeholder participation.

4.1.4.1 Sub-theme 1: Student nurse preparation

The sub-theme describes the nursing administrators' views regarding how the current MoH nursing curriculum approaches educating Omani nursing students.

4.1.4.1.1 Hospital-focused training

Based on the DGET mission statement, *"DGET is committed to producing and training Omani healthcare professionals who will deliver efficient, safe, competent and culturally relevant care to the population"* (MoH, 2012). The nursing administrators stated that the majority of MoH healthcare services were institutionalised, and as a result, students were trained to work in a hospital or health centre. They went on to say that the main focus was on ensuring the Omani nurses were capable of working in any of the MoH healthcare facilities and specialities, for example, medical, surgical, paediatric, or maternal. Some of the nursing administrators believed that in order to create very good graduate nurses and highly competent clinical practice, the training had to be carried out in a hospital setting. Other nursing administrators disagreed; they believed that this approach limited nurse education and training and created a nurse that was limited to hospital-based care. One of the nursing administrators stated:

"I believe that the nurse is supposed to be a more independent practitioner, therefore the preparation should be different to meet the community needs" Admin 9.

All the nursing administrators indicated that general nursing graduates do not consistently possess the necessary knowledge, skills and attitudes. They felt that the current graduates were inadequately prepared upon graduation for employment in the clinical settings due to a lack of available allocations.

4.1.4.1.2 Nursing educator competency

Furthermore, the nursing administrators stated that the current MoH nursing institute faculty body were not trained properly. They went on to say that the current nursing faculty did not have the requisite clinical skills and that their knowledge was not up to date. They believed that most of the nursing educators had a Master's degree, which was not in a nursing speciality, such as adult nursing or paediatrics, but in education or professional practice development. A head of a nursing department stated that:

"I do not know anything about the clinical teachers or when was the last time they practiced in a clinic to assess their nursing skills... since they are away from clinical practice for many years" Admin 8.

Moreover, the nursing administrators stated that the current programme for training the faculty should be reconstructed to improve the competency of the nursing faculty. A high-ranking female participant stated:

"I believe to be a teacher you have to be a practitioner first... our profession is not based on theory alone" Admin 5.

Some of the participants stated that the MoH has started to place the nursing educators in the hospitals to train them in different skills. Also, they said that the MoH has started to recruit more clinical teachers from hospitals by providing them with incentives to help the nursing institutes with teaching these students in the clinical allocations. Others highlighted that the MoH was tackling the issues regarding the training of the nursing educators with the application of Omanisation policy. According to the participants, there was a very good Omanisation level in the nursing tutors and academic staff in all institutes. A high-ranking participant stated:

"The MoH is engaged in sending many of the MoH nursing graduates who will be potential academics ... we send them abroad, particularly to universities in the USA, the UK, and others... to finish either their BSc or Master's degrees" Admin 6.

Moreover, the MoH claimed that its educational philosophy reflected the current trends in nursing education, with focus on self-directed learning, creativity, and the development of critical thinking (MoH, 2008). The nursing administrators stated

that the nursing courses adhered to the concept of critical thinking, but the application and implementation of the nursing course objectives by the faculty was incorrect. They believed that the nursing faculty was spoon-feeding students as a teaching method. One of the nursing administrators stated:

“I believe that critical thinking is not a skill learned through power point slides, we have to put them (students) in a learning experience... where situations are given, and students are given time to analyse... to come up with solutions with rationales so gradually we build this ability... but this is not fully implemented by all teachers... this is the problem” Admin 10.

Further, the nursing administrators stated that the nursing teaching faculty were unfamiliar with the student learning objectives, specifically after changes had been made to the curriculum. However, they blamed the nursing teachers for their lack of knowledge of the curriculum.

In conclusion, the nursing administrators believed that the students’ preparation was geared toward working in healthcare facilities, which limited the student nurses’ skills. Also, the educators’ knowledge and skills were uncertain, since they have been out of practice for a long time. Some of the participants stated that Omanisation of the nursing educators might be a solution.

4.1.4.2 Sub-theme 2: Stakeholder participation

This sub-theme describes the nursing administrators’ views regarding how the current MoH nursing curriculum approached stakeholder participation in nurse education.

The nursing administrators believed that nursing was a major part of healthcare and that this made it everybody’s business; therefore, every stakeholder should have input into the development of the profession. They went on to say that that the community needed to be involved and participate in the development of nursing education. They believed that community involvement in nursing education would improve the quality of nursing services. One of the nursing administrators stated:

“Nursing education should consider the patients’ cultural needs and issues while developing curriculum by involving the public in the decision-making process though surveys or having representatives” Admin 7.

Also, the nursing administrators stated that nursing education should work closely with the service sector to identify its needs and issues. Moreover, they stated that collaboration with all the stakeholders, bench marking with other institutions, transparency of resources, and using the expertise and knowledge of the experienced staff would develop an appropriate nursing curriculum. Additionally, the nursing educators believed that curriculum development should make sure that both the academic and clinical content were in tune with current trends in other countries. One of the participants went on to say:

“We have to also remember... what is happening in the United States might not be culturally applicable to us here... we have to make sure the provisions of the nursing curriculum do not only change as a result of the introduction of the national policies in the country... or the political situation... it should be based on some kind of formative assessment... this needs to be carried out... at the moment... not many studies have been done to check if we are meeting what is expected of the graduates” Admin 4.

The nursing administrators believed that the nursing curriculum should involve all stakeholders, which includes the community, students and teachers, to develop a curriculum that reflects their needs. Moreover, they believed the current nursing curriculum included some courses that addressed the Omani culture. They acknowledged that nursing graduate attitudes are a problem, but they believed that Islamic rules should guide the students’ behaviour.

In conclusion, the nursing administrators perceived that the MoH approach to nursing education should be directed toward producing the required nursing staff to work in its healthcare facilities. Furthermore, they described the MoH nursing educators to be incompetent in terms of their knowledge and skills, which negatively affected the implementation of the nursing curriculum. The nursing administrators acknowledged that not all stakeholders were involved in the development of the nursing curriculum. Moreover, they recognised that nursing graduates’ attitudes are a problem; however, they believed that Islamic laws should guide the students’ conduct.

4.2 Case 2 (Nursing Educators/Teachers)

4.2.1 Case 2 Background

Case 2 is based on MoH nursing curriculum documents and twelve semi-structured, individual (face to face) interviews with MoH nursing institutes educators. The participants were from several countries, including Oman, India, Philippines, Jordan, and South Africa. Each participant was given a code name to protect their identity and ensure confidentiality. The interviews were conducted in various venues, such as educators' offices, booked rooms or coffee shops. The characteristics of these participants are listed in table 4.2.

According to the MoH, the faculty in each nursing institute consists of highly qualified and experienced educators (MoH, 2008). The educators work under the supervision of the institute dean, who is responsible for the management of the institute and reports to the DGET.

The nursing institute faculty consists of: Senior Tutor, Tutor, Assistant Tutor, clinical teachers, English teachers, science teachers, and Information Technology (IT) teachers. The MoH declares that it is working hard to ensure that the institutes have the required number of qualified teachers (MoH, 2008). The ratio between faculty and students in different courses is 1 faculty: 9-12 students (MoH, 2008).

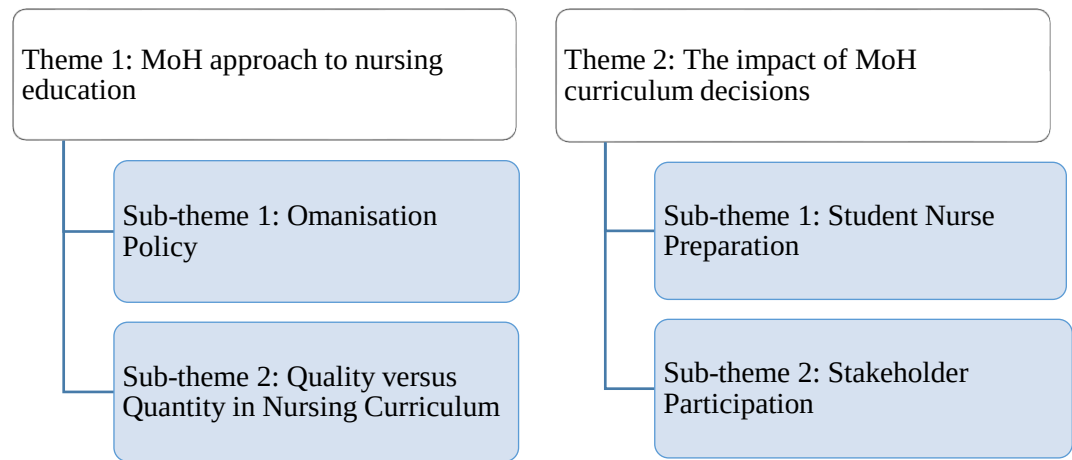
Table 4.2: Participant Characteristics

#	Gender	Country	Titles	Work / years	Edu.
<i>Teacher1</i>	<i>Female</i>	<i>Omani</i>	Tutor	10+	Masters USA
<i>Teacher2</i>	<i>Female</i>	<i>Omani</i>	Assistant Tutor	2-5	Masters USA
<i>Teacher3</i>	<i>Female</i>	<i>Omani</i>	Senior Tutor	10+	Masters USA
<i>Teacher4</i>	<i>Male</i>	<i>Omani</i>	Assistant Tutor	6-10	Masters USA
<i>Teacher5</i>	<i>Female</i>	<i>Non-Omani</i>	Clinical teacher	10+	Masters
<i>Teacher6</i>	<i>Male</i>	<i>Non-Omani</i>	Clinical teacher	2-5	Masters
<i>Teacher7</i>	<i>Male</i>	<i>Non-Omani</i>	Clinical teacher	10+	Masters
<i>Teacher8</i>	<i>Female</i>	<i>Non-Omani</i>	Clinical teacher	10+	Masters
<i>Teacher 9</i>	<i>Female</i>	<i>Non-Omani</i>	Clinical teacher	6-10	Masters
<i>Teacher 10</i>	<i>Female</i>	<i>Non-Omani</i>	Tutor	6-10	Masters
<i>Teacher 11</i>	<i>Female</i>	<i>Omani</i>	Tutor	6-10	Masters USA
<i>Teacher 12</i>	<i>Female</i>	<i>Omani</i>	Assistant Tutor	2-5	Masters UK

4.2.2 Findings

Analysis of MoH nurse education documents and the individual interviews with the MoH nursing institute educators provided a wealth of data that was subjected to analysis using the Ritchie and Spencer's framework approach (1994) and organised into main themes and sub-themes. There are two themes with four sub-themes generated to represent MoH nursing educators' perceptions of how the MoH's approaches to curriculum development impacts nurse education and its cultural congruency in the context of Oman. Each theme and sub-theme is presented separately (see figure 4.2).

Figure 4.2: Themes and Sub-themes of Case 2



4.2.3 Theme 1: MoH Approach to Nursing Education

This theme describes the nursing educators' viewpoints on how the MoH's approaches to curriculum development impact the nurse education regarding Omanisation of the nursing education/service and the quality of the current nursing programme. The theme has two sub-themes: Omanisation of policy, and quality versus quantity in the nursing curriculum.

4.2.3.1 Sub-theme 1: Omanisation policy

This sub-theme describes the nursing educators' views on how the Omanisation policy influenced the current MoH nursing curriculum/education.

The nursing educators believed that Omanisation was a positive thing and that introducing more Omanis to the nursing profession would allow the MoH to be more self-sufficient. Furthermore, many of the nursing educators believed that Omanis were the future nurses and educators in Oman. They went on to say that the current nursing programme was designed to implement the government's Omanisation policy, which is directed toward replacing the expatriate workforce in the nursing profession. According to many of the nursing educators, the MoH was focused on achieving 100 % Omanisation of all the hospitals and educational institutes. However, some of the participants disagreed and believed that Omanisation was being implemented too rapidly. One of the Omani nursing educators stated:

“We are Omanising at a fast rate... we are replacing experienced nurses with new graduates just to show we have reached a good level of Omanisation... and that is affecting the quality of the nursing care for the patients in the hospitals... and there are many incidents that I have seen... related to a lack of quality experience on the nurses' side” Teacher 1.

4.2.3.1.1 Nursing Image in the Community

In addition, the nursing educators believed that despite the slight improvement of the nursing image, the community still did not view nursing as a proper profession. According to the nursing educators, nurses were considered by the public to be the least important, or less important than other healthcare professionals. They pointed out that through their experiences and interactions with the community members, nurses were considered servants of patients in the hospital. They went on to say that Omani culture assumes that nurses are there to serve the patients not as a healthcare professional, but as a maid. Moreover, the nursing educators believe that many people think nurses are assistants to the doctors, and do not respect nursing as a profession. They stated that many people see nurses as helpers that simply follow doctors' orders. One of the Omani educators stated that:

“When I enrolled in nursing I saw that nurses were the ones giving and taking care of patients... the community beliefs and awareness started to change, but again, the majority are not looking at nursing as a profession” Teacher 3.

Further, the nursing educators believed that generally the public did not know the scope of the nursing profession. They believed that the media did not enhance the role of nursing in the community. Also, they stated that many of the students that enrolled in the first year did not even know what nurses did. One of the nursing educators went on to say:

“The Omani culture still sees nursing as a low job and regards the mixed (female/male) working environment as unfavourable, which means nursing is not seen as a reputable profession” Teacher 2.

In conclusion, the nursing educators viewed the Omanisation of nursing education as a positive step toward self-reliance; nevertheless, some believed it was happening too fast. They described the Omani community as generally perceiving nurses as subordinate to doctors.

4.2.3.2 Sub-theme 2: Quality versus Quantity in Nursing Curriculum

This sub-theme describes the nursing educators’ views regarding the MoH’s approaches to the issue of quality versus quantity in nursing education.

The MoH claimed that the institutes were equipped with a wide range of laboratories and equipment that assisted in teaching different clinical skills, and encouraged the student to use critical thinking and problem solving skills (MoH, 2008). The nursing educators stated that the fact that nursing institutes were under the remit of the MoH and not the Ministry of Higher Education like other colleges played a role in nursing education. According to the nursing educators, the MoH’s main focus was to produce the largest number of Omani nurses in a short period of time for the purpose of Omanisation. One of the non-Omani nursing educators stated:

“I believe the current nursing programme was only designed to meet the needs of the country... there are many hospitals & health institutions that need a number of health professionals... in general; we need to fulfil these needs” Teacher 5.

All the nursing educators stated that the current nursing institute facilities did not match higher education standards. They believed that higher education institutions had access to better facilities, for example, teaching aids and equipment, which many MoH nursing institutes still lacked. One of the nursing educators stated:

“The resources that are available for the nursing institutes are not enough... compared to SQU and technical colleges ... we lack proper libraries and laboratories for our students to practice” Teacher 2.

Moreover, the nursing educators stated that the lack of appropriate personnel to install and maintain equipment in each institute was a problem. Moreover, the different institutes scattered all over the Sultanate had variations in staffing levels. The nursing educators went on to say that the resources available to the nursing institutes were insufficient. They believed that in the capital (Muscat) there were enough specialist hospitals to accommodate student needs, whereas the regional institutes lacked specialities, such as mental health, oncology, cardiac and orthopaedic wards. Moreover, the nursing educators believed that the educational resources available were dependant on the location of the nursing institute. One of the nursing educators stated:

“Currently, we have to deal with limited clinical allocations for the students... we are increasing our intake of nursing students and we do not have enough clinical placements for all of them” Teacher 12.

In conclusion, the nursing educators indicated that the MoH was increasing the student intake yearly despite the limited healthcare facilities available to post students. They believed that the limited clinical allocations for their students had inhibited their learning. Also, unequal distribution of facilities and resources between the different nursing institutes; particularly in the regions (outside the capital), affected the students’ opportunities and clinical experiences due to the limited specialties available in the local hospitals and health centres.

The theme described the nursing educators’ views on the MoH approach to nursing education, the impact of Omanisation, and the nursing shortage. They described Omanisation to be a positive move towards the MoH becoming self-reliant. Moreover, nursing educators discussed how graduate numbers were the main concern of the MoH, in spite of concerns about limited clinical allocations and facilities available for student training.

4.2.4 Theme 2: The Impact of MoH Curriculum Decisions

This theme describes nursing educators' viewpoints on how the MoH curriculum approaches to nurse education impact student nurse training and the extent of stakeholder involvement in nursing curriculum/education. The theme has two sub-themes: student nurse preparation, and stakeholder participation.

4.2.4.1 Sub-theme 1: Student Nurse Preparation

This sub-theme describes nursing educators' views regarding the current MoH nursing curriculum approach to preparing Omani nursing students.

4.2.4.1.1 Rigid Curriculum

According to the MoH nursing programme goals, the programme is directed towards assisting the student in developing the knowledge, skills and attitudes required to provide effective care to patients (MoH, 2008). All the nursing educators believed that the nursing curriculum needed to change the view that patients only existed within hospitals. They stated that the nursing curriculum needed to acknowledge that community health is very important. Moreover, the nursing educators believed that to create innovative nurses, nursing education needed to be broadened and not just focus on the nursing profession. They believed that the nursing curriculum should create an educated nurse whose knowledge is not limited to nursing. Moreover, some of the nursing educators stated that the current curriculum did not stimulate the students to learn. One of the nursing educators stated:

“We need to change the curriculum to something more stimulating for the students... to think critically and analyse... and be creative in problem solving”
Teacher 5.

Further, the nursing educators stated that the current nursing programme did not match international standards, because there were no pre-requisites for nursing education like there are in other colleges around the world. Besides, the current foundation programme did not include courses such as communication skills, introduction to psychology, or introduction to sociology. They believed these

courses provide the students with the knowledge and skills required to deliver the appropriate care for their patients.

4.2.4.1.2 Degree Entry to the Nursing Profession

The nursing educators believed that a degree entry to the nursing profession would improve the nursing care services. They stated that a degree programme would create nurses who are better at communicating with patients, their families, and other healthcare personals. They also believed that the degree programme would increase student competencies in knowledge and skills. One of the nursing educators stated:

“I believed that nurses with a degree are more attentive to issues that diploma nurses think are less important, such as vital signs... therefore, I feel the B.Sc. in nursing will make a difference in nursing education” Teacher 2.

Moreover, the nursing educators believed that a degree curriculum would include courses which were not limited to nursing courses. Also, the nursing educators believed that the move to degree curriculum would provide the students with access to good academic advisors and counsellors. An experienced nursing educator stated:

“A B.Sc. curriculum or entry level will make our nursing education more compatible with other countries... so we need to work harder to upgrade the curriculum” Teacher 1.

The nursing educators stated that at the time the MoH curriculum was developed the country was tackling enormous healthcare needs. Therefore, they believed that the MoH nursing curriculum was primarily focused on teaching fundamental nursing skills to cover the basic healthcare services required by the public. They went on to say that with our community becoming more aware and more knowledgeable of their healthcare needs, the nursing curriculum should reflect this.

A new nursing educator stated:

“We need to prepare our nurses to meet the needs of the current community ... the curriculum needs to be flexible to add or remove courses ... to adapt and be tailored for the needs of the community, and we need to be culturally oriented ... and be aware of the global issues... also, politics and socio-economic issues have an impact on healthcare services and education... the curriculum should be able to address these issues” Teacher 12.

A more senior nursing educator stated that:

“Our graduates will be serving the public, and we need to prepare them for the realities of the workplace... this will increase the quality of healthcare services, increase patient safety, ... which all depends on nursing education” Teacher 11.

According to the educators, nursing education under the Ministry of Higher Education would be better than staying under the MoH, because the MoH has limited resources available for nursing education. They believed that the MoH is a service oriented organisation, and its priority is healthcare services over education. Moreover, they believed that nursing education suffered under MoH from a lack of facilities, such as an advanced medical library and fully equipped laboratories. Some of the nursing educators stated they were still using references and textbooks from Western countries that were not suitable for the Omani culture. An Omani nursing educator stated:

“We need to modify the material to fit our needs... we do not have our own references because we do not have a good research committee here to initiate research which can give us good feedback to incorporate in our curriculum” Teacher 4.

Also, the nursing educators believed that even when the research was carried out, it was not disseminated through proper communication to the teaching staff. They stated that the outcomes of different research projects should be accessible to educators so that they can incorporate the new data into their teaching. One of the educators stated that:

“When I am teaching about diabetes, all that is in the text is related to the American population, not the Omani population... if I go and search the MoH website I will not be able to get clear statistics on the number of patients, risk factors or complications related to diabetes” Teacher 1.

4.2.4.1.3 Cultural Diversity

Another issue the participants highlighted was that the Omani community comprised of diverse sub-cultures and languages. They believed that the nursing curriculum should reflect these issues to increase student awareness. They went on to say that students were not able to interact or communicate with patients who had different customs or languages. They believed the curriculum should cover this issue to improve nursing care. A non-Omani nursing educator stated:

“Sometimes during clinical practice I have encountered students who told me they did not speak Swahili ... which affected their care... the students would avoid these patients because of the language barrier... although the Swahili speaking people are a part of the Omani community” Teacher 8.

In addition, the nursing educators stated that the MoH healthcare services were provided for Omanis and expatriates, however, the current nursing curriculum did not cover care for people of different cultures in Oman. They went on to say that, compared to other countries, for example the United States, there were no courses or even sections of courses that accommodate these issues. They stated that the curriculum needed to address cultural diversity and accommodate the community needs. One of the nursing educators stated:

“We have courses on modern society or Omani modern society... the courses provide with them an idea of changes that occurred in the Omani society and how to accommodate for these changes... however, the course does not discuss the diversity in the Omani population” Teacher 6.

Others highlighted that despite the majority of the patients being Muslims, there was no mention of religion or Islam in the current curriculum. Moreover, they stated that through their experience they realised the importance of cultural values and beliefs in the lives of Omani people. They went on to say that traditions like celebrating the weaning of a child, caring for the young and elderly, and visiting the sick, were practices the curriculum needed to embrace. An Omani nursing educator stated:

“We teach our students to start an IV therapy, but we never mention to them that these patients may want to stop the IV to pray ... we need to teach our students to be aware of the religious needs of our patients” Teacher 2.

An experienced non-Omani nursing educator stated:

“As a foreigner I did not realise how important it was for Omani families with relatives in the hospitals to be there... visiting and caring for the sick... they said it was required by their religion” Teacher 8.

4.2.4.1.4 Student Attitudes

The nursing educators acknowledged that many of the nursing students displayed inappropriate behaviour towards patients and their relatives. They believed that the nursing curriculum should provide the students with knowledge and skills which

will increase awareness of their behaviour and actions around patients, thus improving patient care in hospitals. One of the nursing educators stated:

“We know for a fact... that we have a problem with our students’ attitude... and how they approach and interact with patients in hospital when it comes to issues such as confidentiality and the rights of the patients” Teacher 7.

The nursing educators believed that caring could be learned and that nursing students should be taught the concept. Also, they stated that caring should be evaluated not only in theory but also in practice in order to maintain consistency between teaching and practice. Furthermore, the nursing educators believed that nursing was a caring profession and that the value of care should be emphasised in the nursing curriculum. Also, the value of professionalism should be a focus in nursing education so that nursing practice is better respected.

4.2.4.1.5 Ethics

According to nursing educators, the current nursing curriculum only incorporated the MoH code of conduct. They believed that ethics should be implemented throughout the curriculum in different courses. They went on to say that they recently started teaching ethics to the second-year students, and believed that this would help the students deal with the different ethical issues that might arise. Moreover, the nursing educators believed that the introduction of the principles of beneficence, justice, and other principles developed by the Oman Nursing and Midwifery Council (ONMC), such as patients’ rights to dignity, confidentiality, and patient safety, would improve nursing education and practice in Oman. One of the nursing educators stated:

“We have a problem addressing ethical issues ... we never expose our students to the ethical issues that are there in the healthcare setting” Teacher 9.

The nursing educators went on to say that the decision makers had begun to acknowledge the need for ethics in nursing education, however, the current course was an elective; they believed it should be a compulsory course for all students. They stated that the way nurses cared for patients were influenced by their values and beliefs. Consequently, a course in ethics would help the students to be aware

of the dilemmas and issues that arise while caring for patients with different values and beliefs. One of the nursing educators stated:

“It is essential to teach the students how to deal with issues and dilemmas that arise while caring for patients with different views than themselves and other healthcare professionals” Teacher 5.

In conclusion, the nursing educators described the current nursing curriculum as rigid. They believed that moving to a degree programme would improve nursing education and equip students with better knowledge and skills. Further, they believed that the nursing curriculum should accommodate Omani culture so that it is able to meet the healthcare needs of the people it serves. Moreover, they stated that caring is a concept that can be learned, and the nursing curriculum should incorporate ethics to improve nursing education.

4.2.4.2 Sub-theme 2: Stakeholder Participation

This sub-theme describes the nursing educators’ views regarding stakeholder participation in the current MoH nursing curriculum.

The MoH nursing educators stated that the individuals involved in teaching were not involved in the decision-making process. They went on to say they were not involved in the curriculum meetings, and neither did they know what was going on at the top levels. According to the nursing educators, the curriculum changes were unclear and courses were moved around, for example, some electives became compulsory courses and vice versa. One of the expatriate nursing educators stated:

“Since we have multicultural teachers here... most decisions are made at a higher level ... all these positions include Omanis, not expatriates, and we are not involved much in these decisions, that is a reason for the poor communication I think sometimes... what they need from us... should be communicated clearly” Teacher 5.

Others went on to say that students should be a part of the curriculum decision making process, as they could contribute to the curriculum. However, they believed that students were not currently included in the decision-making process. One of the senior educators stated:

“I think that students should be involved not at the novice level, but certainly at the third-year level... to involve them in the planning of the curriculum for the first

levels... because they have gone through the process, and are familiar with the required courses and what is practiced in the clinical in the hospitals and health centres here in Oman” Teacher 10.

Moreover, the nursing educators believed that the service needs should be addressed by the nursing curriculum. They stated that there is ineffective communication between nursing education and nursing service divisions, despite both sectors operating under the same organisation. They believed that the problem was caused by the nursing services’ lack of information regarding the nursing curriculum and courses. One of the nursing educators stated:

“The ward in-charges or senior nursing staff in the hospitals keep asking us ‘what are the objectives of your students and what are they coming here for?’” Teacher 7

According to the educators, to reduce the gap between the nursing education and service areas, members from the nursing service should be included in the curriculum development process. One of the nursing educators suggested:

“During course orientation we need to invite people from the hospitals to discuss what to expect when we go there, or when the students are allocated to the different hospitals and wards... at least they will feel included, and teachers will also not feel alienated and isolated in the clinical” Teacher 7.

Furthermore, the nursing educators believed that involving the nursing service in the decision-making process was important because they were employing the students upon graduation. They stated that the nursing service should be oriented around the content of the different courses being taught to the students; for example, the competencies the students needed to accomplish at the end of their clinical exposure. One of the nursing educators stated:

“If they are involved in the design of the curriculum and in the orientation of the students ... they will be aware of the objectives that have to be achieved by the students... this might reduce the gap between nursing service and education” Teacher 9.

However, some of the nursing educators disagreed, and believed that the nursing service personnel were involved in the development of the nursing curriculum.

4.2.4.2.1 Inter-professional Education

The nursing educators said that mixing the nursing students in a multidisciplinary environment would improve the image of nursing and orient other healthcare professionals towards the nursing profession. They went on to say that the foundation programme allowed the nursing students to mix with all students from allied health specialities, such as physiotherapy, pharmacy, and radiology. They supported an interdisciplinary approach in the nursing curriculum which would allow the nursing students to be exposed to more than just the main nursing courses.

Some of the non-Omani nursing educators stated that foreign teachers from various parts of the world had enriched the current nursing education in Oman. However, they believed that when dealing with issues such as culture, language, and religion in a course, for instance a community nursing course, Omani teachers were better equipped to handle these issues.

In conclusion, the nursing educators believed that the MoH nursing curriculum should reflect the local cultural and religious values. Also, they believed that the MoH should involve all the stakeholders, including teachers, students, the nursing service and the public, in the decision-making process. They believed that the nursing curriculum would be enriched by incorporating feedback from all the stakeholders.

This theme described the nursing educators' views regarding the MoH's approaches to the nursing curriculum. They believed that the current nursing curriculum was not motivating the students to be innovative and that it did not address the Omani culture so as to effectively meet the healthcare needs of the people. Moreover, they believed that the MoH should involve all the stakeholders, including teachers, students, the nursing service and the public, in the decision-making process.

4.3 Case 3 (Nursing Students)

4.3.1 Case 3 Background

Case 3 is based on MoH nursing curriculum documents and six third-year (2012/13) female students who were interviewed as part of a focus group. Each student was given a code name to protect their identity and ensure confidentiality. The focus group interview was conducted in a booked classroom in one of the nursing institutes. The characteristics of these participants are listed in table 4.3. For MoH nursing institute applicants to be considered for admission to a basic General Nursing Programme (GNP) they must first satisfy the following requirements: Be of Omani nationality, possess a General Secondary Education Certificate (Science Section) or equivalent, their age should not be less than 17 years or over 25 years on the date of admission, they must be medically fit, and they must pass and fulfil the professional requirements; employees may be admitted if they meet the admission requirements and are recommended by the concerned authorities (MoH, 2008).

Table 4.3: Participant Characteristics

Participant	Age	Reason for entering the MoH nursing institute	From the capital or regions
<i>Student 1</i>	20	First choice with family supporting her decision	Capital
<i>Student 2</i>	24	First choice after MoD nursing assistant program	Regions
<i>Student 3</i>	20	Not first choice but family persuaded her to apply	Regions
<i>Student 4</i>	20	Not first choice but family persuaded her to apply	Capital
<i>Student 5</i>	20	Not first choice but family persuaded her to apply	Regions
<i>Student 6</i>	20	Not first choice but family persuaded her to apply	Capital

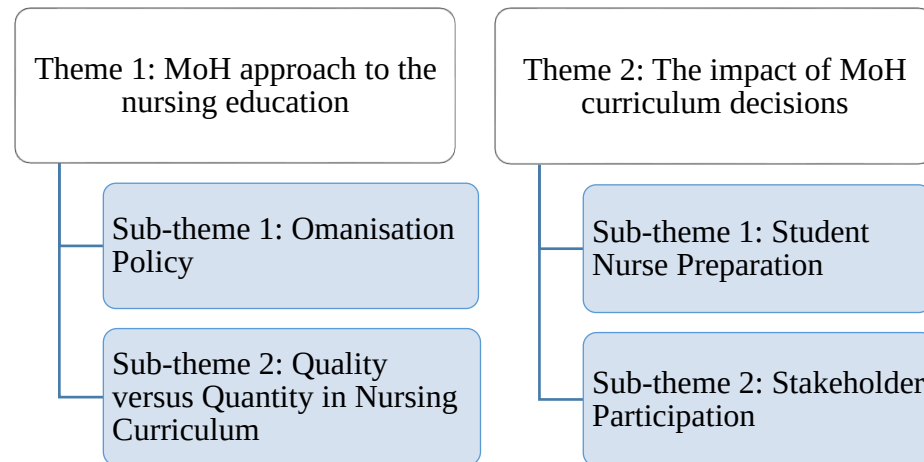
As by law, all the government supported educational programmes are obligated to only intake new graduates from the secondary diploma of that year; therefore, Nursing Student 1, Nursing Student 3, Nursing Student 4, Nursing Student 5, and Nursing Student 6 enrolled in the MoH GNP upon secondary school graduation

through the Higher Education Admission Centre under the Ministry of Higher Education. The only exception was Nursing Student 2, who has come via a Ministry of Defence (MoD) medical assistance programme. This is a two-year programme which allows the three top students to continue to study nursing. These students are a part of the current 1+3 nursing curriculum adapted by the MoH, which comprises of a foundation year plus a three-year nursing programme. The students are offered free transportation from and to the nursing institutes and clinical allocations; they also receive allowances during their study. Also, free accommodation is available for students who qualify. All the study materials are provided free for the students, including the course books, which they only pay for if they want to keep. The programme consists of two semesters (16 weeks) and a summer session (6 weeks) (see Chapter 1). The MoH employs the graduates after the completion of the internship programme, which begins upon completion of the GNP. The graduates start internship on average 2-3 months after the end of the programme.

4.3.2 Findings

Analysis of the focus group interview with the student nurses and MoH nursing documents provided a wealth of data that was subjected to thematic analysis using the Framework Approach (Ritchie and Spencer, 1994) and organised into main themes. Two themes with four sub-themes were generated to describe nursing students' perceptions of how the MoH nursing curriculum maintains congruency with the healthcare needs of the population, and how MoH curriculum decisions impact nurse education in Oman. Each theme and sub-theme will be presented separately (see figure 4.3).

Figure 4.3: Themes and Sub-Themes Case 3



4.3.3 Theme 1: MoH Approach to Nursing Education

This theme describes the nursing students' views on the impact of the MoH approach to nursing education and how it impacts the current nursing curriculum. The theme has two sub-themes: Omanisation policy, and quality of nursing education.

4.3.3.1 Sub-theme 1: Omanisation Policy

This sub-theme describes the students' perception of the MoH implementation of Omanisation policy on nursing education.

4.3.3.1.1 Nursing as a Career Choice

Based on the nursing students' handbook (2009/2010), the MoH claimed that students admitted that the nursing institutes improved the chances of achieving Omanisation targets for the nursing workforce (MoH, 2009). The nursing students believed that Omanisation was a positive step by the government, as they believed that there was a need for Omani nurses to help their community because they understood the language and the culture better than the expatriate nurses. Also, according to the students' handbook (2009/2010), the MoH would provide opportunities for prospective candidates to secure a job in a profession of their choice. All the nursing students acknowledged that what attracted them to the

nursing profession was the guarantee of employment upon graduation, which meant financial security for their families. One of the students stated that:

“Even parents started to encourage their children to go into nursing... because nursing is secure work which is guaranteed upon graduation” Nursing Student 4.

Despite the job security offered by the MoH nursing programme, only two of the participants said that the MoH nursing programme was their first choice when they applied through the higher education admission centre. The other four participants expressed that nursing was never their first choice. Even though they all had relatives who were nurses, nursing was not their ambition. Further, they stated that they had “negative views” regarding the working environment of nursing. According to one of the students:

“There are seven women in my family who are nurses... but still I did not think nursing was a career for me because of the long hours and different shifts... I saw how hard they had to work” Nursing Student 3.

The nursing students believed that nursing interfered with family life because of the work long hours and the different shifts. One of the students was quick to say that:

“Nursing is a hard job... which is not suitable for a woman” Nursing Student 6.

The nursing students went on to say that the Omani community did not view nursing as a proper job. Also, the students believed that despite the nursing profession becoming more acceptable as a career, families were still reluctant to encourage their children to commit to the nursing programme. One of the students explained:

“Nursing in Oman is still resisted by parents as a career choice for their children... it is difficult for them to allow their daughters to be nurses... because of the mixed environment (males & females working together)” Nursing Student 2.

The nursing students stated that the nurse’s job involved dealing with the opposite gender while performing nursing care tasks, and that this is not acceptable to their religion (Islam) and Omani customs/traditions. They felt that a mixed environment and the necessity of dealing with male patients caused them a lot of discomfort. Moreover, the mixed gender workplace had prevented many Omani families from allowing their daughters to enter nursing. One of the students stated that:

“Working night shifts and giving bed baths to men is not acceptable in our religion and traditions... it is not suitable for a woman to work in a male ward” Nursing Student 5.

Despite the negative views the nursing students had of the nursing profession, they acknowledged that there were some positive aspects to nursing. They stated that during their clinical experiences as students they had felt respected by patients and their relatives, and they welcomed their involvement in their care. The nursing students went on to say that they had observed that Omani families were appreciative of healthcare providers who were knowledgeable of their language and culture. Therefore, they believed that there was a need in society for Omani nurses to replace expatriate nurses in a healthcare setting. One of the students stated:

“The patients in the hospitals tell us: we hope or wish all the nurses were Omanis (male/female) ... which indicates that society has started to accept the Omani nurse” Nursing Student 1.

Additionally, the nursing students described nursing as a profession that helped others become well. They believed that nursing was a noble profession that brought them closer to Allah (God), because helping people in need was a religious calling. One of the students stated:

“Nursing is a profession which makes them closer to Allah (God), because helping people in need is a religious duty and “Allah rewards us when we help others in need” Nursing Student 1.

In conclusion, this sub-theme described the nursing students’ perceptions regarding the Omanisation of the nursing profession. They indicated two main negative issues regarding the nursing profession; one being the issue of a mixed work environment clashing with religious tradition and the Omani culture, and the other being the issue of the nursing profession being linked to long working hours which interfere with family life. Equally, the students described their positive perceptions of the nursing profession in Oman and how families have recently changed their view regarding their children, and particularly daughters, joining the nursing profession. This shift in attitude has been motivated by the improved image of nursing and by the guarantee of a job upon graduation.

4.3.3.2 Sub-theme 2: Quality versus Quantity in Nursing Curriculum

This sub-theme describes the nursing students' views regarding how the MoH approached the issue of quality versus quantity in nursing education.

4.3.3.2.1 Degree Entry to the Nursing Profession

The nursing students expressed their disappointment that the programme they enrolled in had been extended by an additional year, but yet they still receive a diploma like previous batches. The nursing students stated that the current MoH nursing curriculum was designed to be upgraded to a B.Sc. (degree) programme; however, the MoH plans were changed because the MoH had to cover a shortage of staff nurses, therefore, the graduates were awarded a diploma degree because it was a faster way of obtaining new staff. Further, the nursing students stated that the MoH still awarded a diploma degree instead of the BSc which was awarded by the Sultan Qaboos University (SQU) and other private universities. They went on to say that this made them feel less worthy than graduates with a degree. The nursing students expressed that the MoH decision to award them a diploma was unfair because they had a similar curriculum and better clinical practice which started earlier than others. One of the students stated:

“MoH nursing institute graduates are better in practice than university graduates with a BSc” Nursing Student 1.

Another student stated that:

“We are only missing some general courses to get a BSc degree... however; we have more clinical practices... we even start our clinical practice earlier than others” Nursing Student 4.

Furthermore, the nursing students believed that upgrading the nursing programme to a degree level would deal with many of the issues they encountered with the current programme. They believed that the upgrade to a degree level would allow students to reflect and practice what they learned in the classroom and clinical. One of the students stated:

“They (MoH) need to upgrade us to B.Sc. curriculum and increase the years of study, then we will not have the shortage of time to study and practice” Nursing Student 5.

In conclusion, the sub-theme described the students' views on the impact of nursing shortage on MoH decisions regarding the current nursing curriculum. The students stated that the nursing shortage led the MoH to continue the diploma programme. They believed that despite adding a year to the current curriculum, the MoH continued to award a diploma, which was unfair to them.

This theme describes the nursing students' views on the MoH's approaches to nursing education. The students stated that Omanisation allowed the community to be served by nurses that speak their language and understand their culture. However, the students stated that what primarily attracted them to nursing was the guaranteed job upon graduation. Moreover, they stated that the nursing shortage caused the MoH to retain the diploma programme. They felt that the current diploma programme was rushed in order to cover many theories and skills, so that students graduate to fill the various healthcare needs.

4.3.4 Theme 2: The Impact of MoH Nursing Curriculum Decisions

This theme described the nursing students' views regarding the MoH management of the nursing curriculum and how it impacted nurse education in Oman. The theme has two sub-themes: student nurse preparation, and stakeholder participation.

4.3.4.1 Sub-theme 1: Student Nurse Preparation

This sub-theme describes the nursing students' views on how the current nursing curriculum prepares them for their role as a nurse in Oman.

Based on the student's handbook (2009/2010), the nursing institutes were committed to preparing nurses to be able to function efficiently and effectively as members of the healthcare team, and who were qualified to meet the nursing needs of the people in Oman (MoH, 2009). Yet, the nursing students stated that the current nursing curriculum was overloaded with coursework, which did not allow them time to reflect on what they had learned. They stated that the current curriculum did not allow them time to comprehend the material. Similarly, the nursing students believed that passing exams with high grades/marks was the main aim of many of the students. One of the students stated:

“Passing the exam is the main focus of everyone, not the linking... analysing the learned material or developing a caring attitude” Nursing Student 6.

They went on to say that, if asked about any course a few weeks after the final exam, many students would not be able to answer, because they had merely memorised the answers in order to pass the exam. Moreover, the nursing students believed the rush in the current nursing curriculum was affecting their knowledge and skill competencies. The students expressed that the MoH decision makers want to improve the curriculum, however, change was occurring too fast for them to handle. One of the students stated:

“When we took the course of ethics... they (MoH) gave us the course despite it needing a lot of improvement... they just wanted to introduce the concept according to the new plan in the nursing curriculum” Nursing Student 1.

4.3.4.1.1 MoH Nursing Educators

Another issue raised by the students was regarding the nursing teachers; they felt that they did not help the students develop critical thinking skills. They believed the nursing teachers were concerned only with the students passing their exams, practical skills, and answering questions related to disease process and medication. One student stated:

“If we pass the exam the teachers will say ‘good student’ ... but if we fail they will only say the exam was easy and we told you everything coming in the exam... no one cares about the quality of the student” Nursing Student 4.

Several students expressed that some teachers asked questions while in clinical practice to encourage them to link and think critically about different issues, however, some students felt that other teachers asked questions only to humiliate the students. In addition, the nursing students believed many of the nursing teachers were limited in their knowledge and skills, which made them unable to teach the students effectively. One of the students stated:

“I believe some teachers have the skills to teach us, but many do not have any skills or have limited skills to teach us ... so how can we learn to apply critical thinking?” Nursing Student 2

4.3.4.1.2 Quality of the Nursing Service

Moreover, the nursing students believed that patients had rights and they had to be treated with care and safe practice. Also, they believed that nursing was caring, and that this was more important than treatment because care is holistic. They related their views to their religious affiliation and described caring as an important part of Omani culture as an Islamic country. The nursing students said they did not take a particular course in caring, but they can apply what they have studied. Also, they stated that respecting and caring for patients in accordance with their religious values was important to them, because the ability to provide comfort and care to patients is emphasised by Islam. Therefore, the nursing students believed that being honest and treating patients with dignity, care, and warmth is very important. One student said:

“If a nurse cares for her family, she should be able to give care to others... as Muslims we should take care of others in need” Nursing Student 2.

All the students believed that nursing education had improved in many ways, but that the nursing service was still weak. They stated that nurses practice some of what they learn but ignore other aspects. They also believed that not all the nurses practiced what they learned. They believed that time constraints were an important factor in nurses’ bad practice. One of the students stated:

“The care that is missing is not by accident; the nurse is caring for 6-8 patients in a ward during a shift... in some peripheral hospitals up to 13 patients... will she be able to give every patient the same care? ... if she spends more time with one patient, she will be neglecting the others... the care they imagine is difficult to achieve under these circumstances... to have better care we need more staff nurses in the wards” Nursing Student 5.

On the other hand, the nursing students expressed concern regarding nurses’ lack of a caring attitude. The students felt that there was a major issue involving lack of care in the current state of healthcare in Oman. One student stated:

“I noticed sometimes, nurses are doing nothing... just sitting at the nursing station... no one moves to check on their patients... only waiting for the patients to press the button to call them” Nursing Student 6.

The nursing students described that the nursing staff’s personal attitudes might be the reason for the lack of care. They believed carelessness and a lack of conscience

was the main reason for the bad attitudes. According to the students, the personality of the nurses affected their approach to patient care. They believed that care should include tending to the patients' physical needs as well as psychological needs. The nursing students acknowledged that workplace realities, such as time constraints, shortage of staff, and limited resources affected the nursing practice. One of the students explained:

"We have the professional education to make us professional nurses, but when we join the service (reality) we do not practice the different skills and knowledge we have learned because some nurses do not like nursing" Nursing Student 5.

They believed that nurses' lack of interest in the nursing profession was the reason for their uncaring attitude toward patients and their relatives. One of the students stated:

"I believe that some nurses only care about their salary at the end of the month... not the patients and their needs" Nursing Student 3.

4.3.4.1.3 Mentorship Programme

Another point highlighted by the nursing students was the role of a mentor in helping with the facilitation of their development. They stated that a mentorship programme would prevent the students and new graduates from feeling lost. The nursing students believed that the mentorship programme would allow them to practice the skills they learned earlier, and therefore they would not lose their acquired skills. According to the students, a lack of nursing skills was related to the fact that some skills learned in the first year were never practiced again and there was no following up on the matter. One of the students stated that:

"I believe providing mentorship for nursing students and new graduates will help us... and guide us in clinical practice." Nursing Student 5

In conclusion, the nursing students believed the current nursing curriculum was overloaded with courses which did not give them any time to reflect on what they had learned. Moreover, the students believed that caring came from within the nurse, and therefore it could not be learned. According to the students, the current nursing curriculum did not offer them any opportunities to follow up on their learned knowledge and skills, which consequently affected their competency.

4.3.4.2 Sub-theme 2: Stakeholder Participation

This sub-theme describes the nursing students' views regarding stakeholder participation in the current MoH nursing curriculum.

The nursing students stated that the MoH decision makers started to include them in the decision-making process by taking on board their views. However, they felt they were not fully involved in the decision-making process regarding the current nursing curriculum. According to the students, there were continuous changes in the current curriculum which they were not consulted or informed about. They believed that the MoH nursing education decision makers, despite including students in the decision-making process by allowing them to voice their views and concerns about the nursing programme, did not implement these views when making curriculum decisions.

In conclusion, the sub-theme explored the nursing students' views regarding the MoH management of the nursing curriculum. They stated that the MoH did not involve them in the decision-making process regarding the current nursing curriculum. Also, they stated that a mentorship programme would guide students and new graduates to develop their knowledge and skills, and would bridge the gap between education and service.

This theme explored the students' views on the issues of the MoH nursing curriculum and education. They believed the current nursing curriculum was overloaded with courses, and therefore did not give them any time to reflect on what they had learned. They perceived that mentorship would ensure the nurses' competency in knowledge and skills. Moreover, the students believed that caring could not be learned. The nursing students believed that upgrading the current nursing curriculum to degree level would improve the nursing practice and meet the needs of the nurses and public.

4.4 Case 4 (Service Users)

4.4.1 Case 4 Background

Case 4 is based on a focus group semi-structured interview of ten MoH healthcare facilities service users (public). The participants were all Omani. Each participant was given a number to protect their identity and to ensure confidentiality. The characteristics of these participants are listed in table 4.4. All the participants were interviewed in a focus group at the home of one of the participants.

4.4.2 Findings

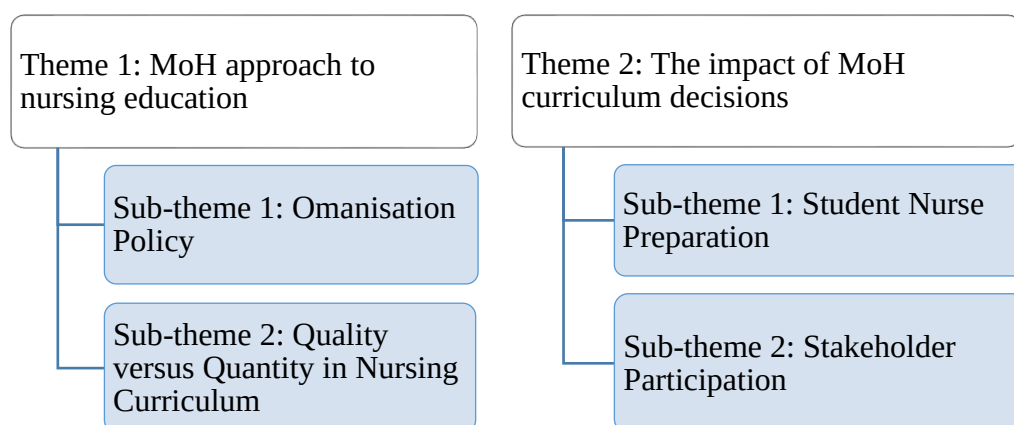
Analysis of the focus group interviews with service users (public) provided a wealth of data that was subjected to thematic analysis using the Framework Approach (Ritchie and Spencer, 1994) and organised into main themes. Two themes with four sub-themes were generated to describe nursing service users' perception of how the MoH nursing curriculum maintains congruency with the healthcare needs of the population, and how MoH curriculum decisions impact nurse education in Oman. Each theme and sub-theme will be presented separately (see figure 4.4).

Table 4.4: Participant Characteristics

#	Age	Gender	Marital Status	Work	Health History
Service User 1	26	Female	Single	Primary school teacher	Ovarian cyst removed in Thailand
Service User 2	29	Female	Single	Works for the royal court	No health issues
Service User 3	56	Female	Divorced with three children	Housewife	High blood cholesterol
Service User 4	80	Female	Widow with seven children	Housewife	Hypothyroidism & high blood pressure
Service User 5	22	Female	Single	University student	No health issues
Service User 6	30	Female	Married mother of four	Works for an oil company	No health issues
Service User 7	25	Male	Married with one child	Works for a bank	No health issues

Service User 8	40	Male	Married with seven children	Works for a government	No health issues
Service User 9	52	Male	Married with six children	Works for a private company	Diabetic for 10 years
Service User 10	70	Male	Married with ten children	Retired	Knee replacement & cataract surgeries

Figure 4.4: Themes and Sub-themes of Case 4



4.4.3 Theme 1: MoH Approach to Nursing Education

This theme describes the service users' views on the MoH's approaches to nursing education and how it impacts their healthcare needs. The theme has two sub-themes: Omanisation policy, and quality versus quantity in nursing curriculum.

4.4.3.1 Sub-theme 1: Omanisation Policy

This sub-theme describes the service users' (public) views regarding Omanisation policy of the nursing profession and how that has impacted their care through their experiences and interactions with MoH graduates.

All the service users stated that Omanisation of the nursing profession was a positive thing and that the process would benefit the country. However, the service users stated that many of the Omani nurses did not meet their healthcare needs nor make them feel comfortable and welcome. They said that the MoH graduates did not understand their cultural or physical needs. One of the service users stated that:

“When you are there at clinics or hospitals the nurses do not make you feel welcome, and we are not happy with the way they treat us as patients” Service User 3.

Moreover, the service users group appeared to link the lack of care with the attitudes of the MoH nurses they interacted with during their visits to the hospitals or health clinics. They believed that a simple gesture, such as a smile, would make the patients feel cared for and comforted. According to the service users, nurses would refuse to care for patients, make them wait, and never tend to their needs. They believed that these behaviours were caused by lack of knowledge or carelessness on the nurses’ part. One of the service users stated:

“The way they (MoH nurses) behave toward us and their attitude is wrong” Service User 6.

Another gave a description of her experience:

“I was ill with fever and I went to the health clinic... I was told to go the A&E... at A&E there were two nurses and one doctor attending another patient... I was very ill so I asked for help because I was very dizzy... I was told to wait for my turn... the nurses did not even move to check me or to explain in a polite way... they just talk to you from a distance... they do not check the needs of the patients or the severity of illness... they only care about the turn in a queue” Service User 2.

There was consensus between the service users that “bad attitudes” were not limited to nurses, but that it was a problem with the MoH healthcare providers in Oman in general. The service users stated that the healthcare provider’s attitudes were the worst problem they faced. One of the service users stated:

“In general, the MoH healthcare providers had no smile, no warmth, no care, no compassion... that is the problem with the current healthcare” Service User 8.

In conclusion, the sub-theme described the service users’ (public) views on the impact of the Omanisation policy on the healthcare services they received, particularly nursing care. They described the healthcare providers, particularly MoH nurses, as uncaring and uncompassionate because of their “bad attitudes”. They linked the “bad attitudes” to a lack of knowledge and carelessness of the healthcare providers regarding their work.

4.4.3.2 Sub-theme 2: Quality versus Quantity in Nursing Curriculum

This sub-theme describes the service users' views regarding how the MoH approached the issue of quality versus quantity in nursing education.

The service users believed that there were huge shortages of nurses and other healthcare providers in MoH healthcare facilities. They went on to say that they had all experienced long waiting hours for healthcare. One of the service users stated:

“When we go to the health centre or hospitals for appointments or emergencies... they (healthcare providers) keep us waiting... and waiting for a long time... they (MoH) need to hire more nurses and doctors to serve us... we are not getting efficient care” Service User 6.

All the service users agreed that, in the Sultanate of Oman, the nursing profession did not establish itself as an independent profession. They stated that nurses in Oman were always waiting for the doctors' orders. They believed that the nurses were incompetent and dependent on doctor's orders, which wasted a lot of time. Moreover, the service users stated that nurses from abroad had a protocol on how to deal with different issues while caring for patients. They said that these nurses used their own judgement and did not wait for the doctor to make the care based decisions all the time. One of the service users stated:

“I believe the healthcare providers are lacking the correct knowledge to deal with patients... they do not care for the patients' needs... some patients dislike coming to hospitals” Service User 3.

The service users linked “correct knowledge” with nurses explaining the care to the patient. They went on to say that the healthcare providers needed to be sensitive to the patients' worries and anxieties. In addition, the service users believed that Oman lacked qualified healthcare providers who were able to provide proper care. One of the service users said:

“Everyone tells us Oman has the best equipment, but we lack the manpower to use this equipment...when we travel abroad for treatment people tell us that your country has the newest equipment, but ... we do not have the people who know how to use it” Service User 8.

The service users believed that the Qaboos (the Sultan) was spending a lot of money on healthcare facilities; however, the healthcare providers were not providing the care the patients needed. They went on to say that the bad service was not limited to nurses, but pervaded healthcare providers in general. Furthermore, the service users compared the healthcare services provided at home (Oman) to the healthcare services they experience abroad. One of the service users stated:

“When they (nurses) are providing care they need to explain or show some regard to the patients’ ... when we compare their care to the care outside Oman (Thailand) we get a proper explanation about our care” Service User 5.

The service users believed that the fact that nursing was a new profession to Omanis caused the issues they experienced. They went on to say that nursing education seemed to miss out a lot of important factors, and that the MoH needed to review nursing education by looking at public issues and concerns.

In conclusion, this sub-theme described what the service users thought about nursing education in Oman. They perceived that MoH Omani nurses needed to obtain the “correct knowledge” to enable them to care for the patients. The service users believed that the Omani healthcare services lacked healthcare providers which were qualified to provide the appropriate care. They also felt that the MoH nursing education needed to be reviewed in order to amend the shortcomings that might be caused by nursing being a new profession in Oman.

This theme describes the service users’ views on the MoH approach to nursing education and how it impacts the current nursing curriculum in the Sultanate of Oman. The service users stated that the Omani healthcare system lacked care and compassion because of the healthcare providers’ “bad attitude”. They believed that the uncaring attitude was related to the providers’ carelessness and lack of knowledge.

4.4.4 Theme 2: The Impact of MoH Nursing Curriculum Decisions

This theme describes the service users’ views regarding the impact of MoH curriculum decisions on nurse education in Oman. The theme has two sub-themes: student nurse preparation, and stakeholder participation.

4.4.4.1 Sub-theme 1: Student Nurse Preparation

This sub-theme describes the service users' perceptions regarding how the graduates of the MoH nursing programme meet their healthcare needs.

4.4.4.1.1 Nurses Attitudes

According to the MoH mission for healthcare institutes, the nursing institutes bear responsibility for the training of healthcare practitioners in tune with the culture, tradition and values of the community (MoH, 2008). The service users (public) stated that the nursing services provided by these graduates of the MoH nursing programme needed to improve. The service users believed that the MoH graduates should be sensitive to the needs of the patients and their relatives. They stated that nurses were uncaring toward patients who were experiencing severe stress and anxiety due to their illness. They said many of the nurses raised their voices when communicating with patients and their relatives. They went on to say that simple gestures like a smile, paying attention to the patients' concerns, and proper communication would help ease their anxiety. One of the participants stated:

"I feel, first of all... a smile and care are important... if the patient feels they are cared for, they will feel better." Service User 1

The service users stated that nurses in Oman lacked professionalism in caring for patients. They believed that student nurses needed education on communication methods and attitudes because this was an important aspect of Omani culture. According to them, it was very important to show respect through the language the nurse used when talking to patients during their interactions. One of the participants stated:

"I think nurses need to be trained in the way they communicate with the public"
Service User 10.

4.4.4.1.2 Culturally Competent Care

Based on the purpose statement of the MoH health institutes, nursing focused on factors such as culture, family, community and the healthcare system, which influenced individuals and groups in their attempts to meet the health needs of the

people (MoH, 2008). The service users did acknowledge, however, that some of their cultural needs were met by the MoH, such as the provision of separate female/male care wards. Nevertheless, they indicated that there was no regard for patients' needs such as rest and sleep, due to the noise created. Equally, they felt that their religious needs were also disregarded during their care. One participant described his experience:

“Once, I had a fracture in my left leg and I was admitted to the hospital ... they did not allow my son to stay to help me, and they said the nurses are there to provide assistance... but when I needed to pray... I just wanted someone to bring water to me so I could wash for prayer time... no one came to help me... I have called them many ...many times... to answer” Service User 10.

According to the MoH, the general nursing programme taught students ethical, legal, socio-cultural and professional standards for providing nursing care (MoH, 2008). Yet, the service users stated that nursing education needed to focus on teaching nurses a code of ethical conduct in order to improve the nurses' behaviour and attitude. Further, the service users believed that MoH should educate the student nurses in how to care for patients ethically. They stated that students needed a lot more clinical experience and study time before they began to practice.

4.4.4.1.3 Degree Entry to the Nursing Profession

The service users indicated they had little understanding of nursing education, but they believed that nurses in Oman needed more time in training before they cared for the public in order to acquire the required “correct knowledge” Service User 2. Moreover, the service users believed that student nurses needed more time in education before graduating. According to the service users, the duration of the nursing programme was too short for them to learn how to properly care for patients. They stated that more time studying would provide the students with more maturity and experience to better deal with patients. Moreover, the service users stated that the clinical experiences for the students were not enough, and therefore the MoH should increase the number of study years and focus on communication skills. Others believed that the nursing students should be exposed to other healthcare systems from abroad in order to acquire the proper skills and experience and improve their attitude. They stated that student nurses should be able to classify

patients according to the urgency of their care needs, and that they should be trained on how to work under stressful conditions with patients and their families. One of the service users suggested that:

“I think sending Omani student nurses to other countries will give them exposure to different systems... this might help improve their attitudes and ways... I suggest in the final year the top students should be sent abroad to learn and train... so, when they are back others could do like them” Service User 1.

4.4.4.1.4 Language of Instruction

According to the student handbook (2009/2010), the language of instruction was English, and English courses were extended throughout the programme to enhance the student's competence in learning other courses (MoH, 2009). The service users believed that the use of English language in the nursing programme, which was the second or third language of the students, might be a hurdle to their nursing education. One of the participants stated:

“My cousin is a nursing student... she says they have a lot to cover in a short amount of time ... making it difficult to fully comprehend it all... their English language is not great after graduating secondary school” Service User 2.

As Arabic is the main language in Omani education prior to higher education, the service users believed it was difficult for the nursing students to comprehend all the subjects in a new language in such a short time.

4.4.4.1.5 Mentorship Programme

The service users felt that student nurses needed to be guided after graduation through a mentorship programme to foster their transition from the education to service. The service users stated that student nurses needed a mentorship programme after graduation because they would need to be guided in practice.

In conclusion, the service users (public) believed being sensitive to the needs of the patients and their relatives through application of proper communication and attitude would improve their care. Also, proper communication between healthcare providers regarding patient care, as well as employing more healthcare providers, would improve services.

4.4.4.2 Sub-theme 2: Stakeholder Participation

This sub-theme describes the service users' views regarding stakeholder participation in the current MoH nursing curriculum.

The service users stated that they were not involved in the current nursing curriculum. Also, they stated that they did not know anything about the nursing programme. They believed that the MoH should involve them in the nursing education decisions process because they were the recipients of the care; allowing them to voice their concerns would improve the nursing service. One of the service users stated:

“They (MoH) should have a committee with new members every few years to allow for new ideas... also, allow members from the new graduates and the public to raise concerns and participate in the decision-making process... so the new programme can meet our needs” Service User 6.

In conclusion, the service users expressed that the length of the current nursing programme should be extended to improve the students' experiences and attitudes through maturity. According to the participants, extension of the nursing programme would provide more time for the students to be taught a professional code of ethics for the nursing profession and skills in communication and classifying patients' needs. Also, the participants felt that sending students or nurses abroad for further training would expose them to other healthcare systems from which they would gain experience and learn new skills/knowledge. The participants believed that the use of the English language might be a problem for the students, and as a consequence lead to them not fully understanding the new concepts and teachings. They believed the nursing profession in Oman was not portrayed as an independent profession, and that the healthcare provided seemed to be dependent on doctors' orders, with nurses rarely using their own judgement. The participants felt that the MoH needs to involve the public in decisions made regarding nursing education so that they can voice their concerns and communicate their needs.

Theme Summary

The theme described the service users' (public) thoughts on how to improve the healthcare service in Oman, particularly nursing care and nursing education. Proper

communication and proper attitude of healthcare providers would improve the experiences of patients and their relatives. Increasing the number of healthcare providers and collaboration between them will improve the standard of care. The service users felt that the current nursing programme is too short to accommodate the time needed to teach a professional code of ethics, skills on classifying patients' needs, and communication. Also, the participants felt that students are graduating very young, and need time in the programme to mature. Also, sending students or nurses abroad for further training would expose them to other healthcare systems from which they could gain experience and learn new skills/knowledge. The participants believed that using the English language might be a challenge for the students since it is not their first language, and as a consequence the students may not understand the newly learned concepts fully. They believed that the MoH needs to involve the public in the decision-making process in order to communicate the concerns and needs of the public.

Chapter 5: Results of the Cross-Case Analysis

Introduction

This chapter presents the cross-case findings from the four study cases which emerged from the process of cross case analysis (see Chapter 3 Section 3.11.2). First of all, the four case studies are presented in terms of number of participants, demographical data, relationship with MoH nursing institutes, and method of interview (see table 5.1).

Table 5.1: Characteristics of all Four Case Studies

Characteristics	Case 1	Case 2	Case 3	Case 4
Number of participants	10	12	6	10
Gender:				
Female	3	9	6	6
Male	7	3	0	4
Age:				
20-35	0	3	6	3
36-45	5	7	0	3
46-60	4	2	0	2
60+	1	0	0	2
Relationship with MoH	Nursing Admin	Nursing Educators	Nursing Students	Service Users
Interview method	Individual		Focus group	
Documents	10 documents			

Lastly, a table consisting of all four cases studies (see appendix L) was developed to detect similarities and differences in the themes and sub-themes from the within-case analysis (see table 5.2 and Chapter 4) to generate a new table (5.3) illustrating the findings of the cross-case analysis. The generated cross-case analysis led to two main themes describing how the MoH's approaches to curriculum development impact nursing education and its cultural congruency in the context of the Sultanate of Oman.

Table 5.2: Within-case Themes and Sub-themes from the Four Cases

Within case themes & Sub-themes	Case1	Case 2	Case 3	Case 4
Theme 1: MoH Approach to Nursing Education				
Sub-theme 1: Omanisation Policy	Agree	Agree	Agree	Agree
• The country needed to be self-reliant & meet the healthcare needs of their community	A	A	A	A
• Omani nurses were familiar with the indigenous language & culture	A	A	A	A
• Expanding the nursing programme to regions to accommodate the students' needs	A	A	A	N/A
• Job security attracted students to nursing	A	A	A	A
• Omani culture deterred Omanis from nursing (mix work environment)	A	A	A	A
• Majority of the applicants were females	A	A	A	A
• Many nursing students were not interested in nursing as a career	A	A	A	A
• MoH lowered scores required for admission to increase the intake, mostly for male students	A	A	N/A	N/A
• Nursing was not viewed as a proper profession by the public	A	A	D	D
• Bad attitudes of nurses were related to lack of interest in nursing as a career	A	A	A	A
Sub-theme 2: Quality versus quantity in nursing education	Agree	Agree	Agree	Agree
• MoH was concerned with dealing with the shortage of nurses	A	A	A	D
• The current curriculum was designed to start students at work as soon as possible	A	A	A	D
• The current diploma programme meets the needs of the MoH	A	D	D	D

• The programme duration was too short to cover all the required knowledge & skills	A	A	A	A
• A degree programme would increase students' competency in knowledge & skills	A	A	A	A
• Entry to the nursing profession should be at the degree level	A	A	A	A
• Mentorship would provide guidance and support for the students & new graduates	A	A	A	A
• Ethics were an important issue to cover in the nursing curriculum	A	A	A	A
• Students' attitude was not assessed by the current nursing curriculum	A	A	A	A
• Omani cultural values were not emphasised in the current program	A	A	A	A
• Nursing graduates exhibit unprofessional attitudes	A	A	A	A
• English could be a barrier to student learning	D	A	A	A
• Cultural competency was not covered in nursing education	A	A	A	A
Theme 2: The Impact of MoH Curriculum Decisions				
Sub-theme 1: Student nurse preparation	Agree	Agree	Agree	Agree
• MoH was focused on preparing students to work in hospital-based facilities	A	A	A	A
• Nurses were not encouraged to be independent practitioners	A	A	A	A
• Critical thinking & innovation was not encouraged	A	A	A	A
• Nursing educators were not competent in their knowledge & skills	A	A	A	N/A
• Some faculties did not have the qualified training to teach	A	A	A	N/A
• Lack of appropriate teaching/learning facilities e.g. libraries, laboratories	A	A	A	N/A
• Students should be sent abroad for further studies	A	A	A	A

• Teaching/learning methods were an issue in the current curriculum	A	A	A	A
Sub-theme 2: Stakeholder participation	Agree	Agree	Agree	Agree
• Not all the stakeholders were involved in the development of the nursing curriculum.	A	A	A	A
• MoH decision makers did not communicate well with all the stakeholders	A	A	A	A
• Stakeholders' needs & concerns were not reflected in the current nursing curriculum	A	A	A	A
• Involvement of all the stakeholders would improve nursing education	A	A	A	A

*(Note: Agree= A, Disagree= D, Not applicable= N/A)

Table 5.3: The Generated Cross-case Themes and Sub-themes across the Cases

Cross-case themes	Cross-case sub-themes
Cross-case theme 1: Providing a culturally congruent nursing service	Cross-case sub-theme 1: Omanisation of the nursing profession
	- Advantages of Omanisation - Self-sufficiency - Culturally competent nurses - Jobs for Omanis - Challenges of Omanisation - Omani culture - Lack of interest in nursing profession
	Cross case sub-theme 2: Meeting the public healthcare needs
	- Responding to the nursing shortage - Employing qualified nurses - Providing culturally competent nursing care
Cross-case theme 2:	Cross-case sub-theme1: Competent nursing education

Providing a culturally congruent nursing education	• Teaching/ learning style • Educator competency • Availability of educational facilities
	Cross-case sub-theme 2: Community involvement in nursing education
	• Involve all the stakeholders in the decision-making process • Improve communication with the stakeholders

5.1 **Theme 1: Providing a Culturally Congruent Nursing Service**

This theme describes the impact of the MoH's role as the main healthcare service provider and employer in Oman, and how this role has influenced its decisions regarding the current nursing curriculum. Two sub-themes were found that signified the key aims of the MoH as a service provider; these were: Omanisation of the nursing profession, and meeting the public healthcare needs.

5.1.1 **Sub-theme 1: Omanisation of the Nursing Profession**

This sub-theme describes all the case views regarding the MoH's implementation of the Omanisation policy and how this decision has impacted the nurse education/service in Oman. Table 5.4 summarises the characteristics of this sub-theme across the four cases.

Table 5.4: Cross-case findings for Omanisation of the nursing profession

	Case 1	Case 2	Case 3	Case 4
• The country needed to be self-reliant & meet the healthcare needs of the community	A	A	A	A
• Omani nurses were familiar with the indigenous language & culture	A	A	A	A
• Expanding the nursing programme to regions to accommodate the students' needs	A	A	A	N/A
• Job security attracted students to nursing	A	A	A	A

• Omani culture deterred Omanis from nursing (mixed work environment)	A	A	A	A
• The majority of the applicants were female	A	A	A	A
• Many nursing students were not interested in nursing as a career	A	A	A	A
• The MoH lowered the scores required for admission to increase the intake, mostly for male students	A	A	N/A	N/A
• Nursing was not viewed as proper profession by the public	A	A	D	D
• The bad attitudes of nurses were related to a lack of interest in nursing as a career	A	A	A	A

As revealed in Table 5.4, all cases stated that the government's Omanisation policy was a positive move towards ensuring self-reliance on indigenous manpower. Hence, all the cases agreed that the MoH nursing programme was a good outcome for the Omanisation policy. Moreover, all cases were in agreement that Omani nurses were better than foreign nurses because they were familiar with the local language and the culture, which meant they understood the cultural healthcare needs of the population. However, all the cases acknowledged that there were issues with Omani nursing graduates' attitudes and behaviour towards the public and other healthcare team members. Cases 1, 2 and 3 described their observation of the issue, whereas Case 4 described their experiences with the Omani nurses as unwelcoming and unfriendly. Further, all cases believed that the nurses' bad attitudes were linked to their lack of interest in nursing as a job or a career.

Socially, nursing has been perceived as an unacceptable occupation choice in Oman. Therefore, Cases 1 and 2 identified that political influence was needed to enlist more nationals in the nursing profession, because the MoH experienced difficulty doing so in the past since many nationals consider it a demeaning profession. Cases 1, 2 and 3 stated that the public considered nursing to be an improper job, fit only for foreigners. Case 4 described that many Omanis did not like nursing because it was a dirty job. Yet, all cases agreed that increasing unemployment rates in other professions made the MoH nursing programme more attractive due to the guarantee of a job upon graduation. All cases believed that the

increasing unemployment rate among graduates of other academic specialities and its associated economic pressure had a major influence on the uptake of less socially favourable specialities in Oman, such as nursing. All cases mentioned that socio-economic reasons had motivated the Omani students to enter the MoH nursing programme. Case 1 indicated that the MoH's decision to guarantee employment had led many Omanis to enter nursing simply to earn a living and support their families. There was a consensus among cases that nursing was a challenging occupation, causing a great deal of family and social stress. Cases 1, 2 and 3 described the social and family issues associated with nursing and how nurses were not considered as important members of the healthcare team. Professionally, nursing continues to pursue a recognised professional identity among the healthcare specialities. Case 4 believed that nurses did not establish themselves as an independent profession and that they were always dependent on doctors' orders.

Moreover, Cases 1, 2 and 3 described that cultural customs, specifically in rural areas, forbid Omani women from working in a mixed-gender environment; instead they sought work in female-dominated sectors such as teaching. In traditional Omani society, women were not allowed to work outside their home. Therefore, the emergence of nursing as an occupation for women has been perceived as a challenge to the social norms. All cases stated that working long hours in mixed-gender settings was socially unacceptable. According to the participants, the public views were formed by work-related issues which had social and religious associations. Regarding the gender issues in nursing education, the participants pointed out that Omani culture was based on Islamic and Arabic values which viewed females as the main caretakers of the family; hence, nursing was an easier career choice for Omani females. They believed the majority of nursing students in Oman being female had limited their interaction with patients of the opposite gender due to their cultural and religious beliefs. According to the participants, cultural beliefs regarding the mixing of genders were more evident in the rural areas.

Despite the support for the Omanisation of the nursing education and service, there was a disagreement on the rate of Omanisation in nursing. Case 1 and 2 participants

stated that the implementation of the policy was taking place too quickly. They said that replacing experienced nurses with new graduates had affected the quality of nursing care. According to the cases, the main focus of the MoH was to produce as large a workforce as possible in order to meet healthcare demands and achieve workforce self-reliance.

In conclusion, all the cases recognise the importance of the MoH being self-reliant in respect to manpower, because Omanisation will lead to the employment of culturally congruent healthcare providers. On the other hand, the cases recognise the difficulties created due to the pressure to implement the Omanisation policy in the current MoH nursing education/ service.

5.1.2 **Sub-theme 2: Meeting the Public Healthcare Needs**

This sub-theme describes the case views regarding how the MoH focus on meeting healthcare needs impacted nurse education/service in Oman. Table 5.5 summarises the characteristics of this sub-theme across the four cases.

Table 5.5: Cross-case findings for meeting the public healthcare needs

	Case 1	Case 2	Case 3	Case 4
• The MoH was concerned with dealing with the shortage of nurses	A	A	A	D
• The current curriculum was designed to start students at work as soon as possible	A	A	A	D
• The current diploma programme meets the needs of the MoH	A	D	D	D
• The programme duration was too short to cover all the required knowledge & skills	A	A	A	A
• A degree programme would increase students' competency in knowledge & skills	A	A	A	A
• Entry to the nursing profession should be at a degree level	A	A	A	A
• Mentorship would provide guidance and support for the students and new graduates	A	A	A	A
• Ethics were an important issue to cover in the nursing curriculum.	A	A	A	A
• Student attitudes were not assessed by the current nursing curriculum	A	A	A	A

• Omani cultural values were not emphasised in the current programme	A	A	A	A
• Nursing graduates exhibit unprofessional attitudes	A	A	A	A
• English could be a barrier to student learning	D	A	A	A
• Cultural competency was not covered in nursing education	A	A	A	A

As revealed in Table 5.5, cases 1, 2 and 3 agreed that the MoH was a service oriented organisation; consequently, the allocation of resources had been directed toward healthcare services first and education second. Also, all the cases agreed that the current nursing curriculum facilitated passing students due to the shortage of nurses in MoH healthcare facilities. The existing shortage of nursing staff in MoH healthcare facilities was restricting care. The ratio of the healthcare workforce in Oman was nowhere close to that of developed countries. Cases 1 and 2 believed that the curriculum was set to pass students, whereas Case 3 believed that the programme was focused on passing exams.

According to all the cases, the MoH concerns about insufficient nursing staff had amplified pressure on the current nursing programme to graduate as many nurses as possible. Consequently, the new Omani graduates were not sufficiently prepared to provide culturally congruent care to the population. All the cases acknowledged that Omani nursing graduates exhibited poor attitudes and behaviour toward patients and their families. Furthermore, all the cases stated that the current programme did not provide the students with courses on cultural competency.

5.1.2.1 Degree Entry to the Nursing Profession

Despite the MoH being the largest producer and employer of nursing graduates in the country, it continued to offer diploma programmes in general nursing. All MoH nursing institutes share an identical curriculum with some slight course plan variations to ensure uniformity of nursing education throughout the country. According to the cases, the MoH claimed to ensure the preparation of highly educated nurses to improve the quality of nursing care. All the cases agreed that moving nursing to a degree programme would improve the quality of the nursing services. Moreover, all the cases believed that a BSc prepared nurse would have more knowledge and skills than a diploma graduate. All the cases indicated that the

current programme graduates were too young and needed to mature before they started practice. This could be achieved by increasing the programme duration. Maturity was linked with better attitudes and competency in knowledge and skills. Case 1 acknowledged that the MoH would benefit from the move; however, the current programme was sufficient and met the needs of the MoH. Cases 2, 3 and 4 indicated that the current nursing programme did not meet the healthcare needs of the population in terms of cultural needs, physical needs and psychological needs.

5.1.2.2 Cultural Congruency

All cases stated that the current programme did not emphasise the importance of Omani cultural values and beliefs in the curriculum. All the cases mentioned personal experiences with the MoH Omani nurses that were indicative of their perceptions. Further, all cases indicated that healthcare providers imposed their own values and beliefs while caring for patients. Cases 1, 2, and 4 stated that patients experiencing nursing care, which was incongruent with their own values, norms and customs, might not comply fully with recommended treatment and may experience cultural conflict, stress and ethical or moral dilemmas. Additionally, all cases agreed that ethics was not emphasised in nursing education. The cases mentioned the importance of including an ethics course in the nursing curriculum to prepare the graduates for the ethical dilemmas of the healthcare system. Cases 1, 2 and 3 mentioned that ethics was introduced in the current curriculum as a course for second year students. Case 1 and 2 stated that the course needed to be expanded and emphasised throughout the nursing curriculum. Case 3 indicated that the course was rushed and was not properly introduced, and therefore the students struggled to comprehend its importance. Case 4 indicated that nurses needed the course to improve their nursing care and cater to their moral needs.

Another issue raised by the cases was the use of English as the medium of instruction in the nursing programme. The official language in Oman is Arabic; therefore, most of the nursing students received their primary and secondary education in Arabic. All the cases described that there was an automatic shift from Arabic to English when they enrolled in college, as the medium of instruction was

English. All cases pointed out that the students' weak English language skills affected their performance in the programme. According to Cases 2, 3 and 4, the students hardly spoke English, thus, they were unable to effectively learn in the class. Case 2 acknowledged that the students' level of participation in class was linked to their language levels. Moreover, they stated that the students' performance improved dramatically when both English and Arabic were used because they understood the concepts better. Case 3 and 4 agreed that students had difficulty comprehending nursing concepts in English, which hindered their competency in learning nursing knowledge and skills.

5.2 Theme 2: Providing Culturally Congruent Nursing Education

This theme describes the impact of the MoH's role as the main nursing education provider in Oman and how this role has influenced its decisions regarding the current nursing curriculum. Two sub-themes were found to signify the key aims of the MoH as a nursing education provider: competent nursing education, and community involvement in nursing education.

5.2.1 Sub-theme 1: Competent Nursing Education

This sub-theme describes the cases' views regarding how MoH curriculum decisions impact nurse education in Oman. Table 5.6 summarises the characteristics of this sub-theme across the four cases.

Table 5.6: Cross-case findings for competent nursing education

	Case 1	Case 2	Case 3	Case 4
• The MoH was focused on preparing students to work in hospital-based facilities	A	A	A	A
• Nurses were not encouraged to be independent practitioners	A	A	A	A
• Critical thinking & innovation was not encouraged	A	A	A	A
• Nursing educators were not competent in their knowledge & skills	A	A	A	N/A
• Some faculties did not have the qualified training to teach	A	A	A	N/A

• Lack of appropriate teaching/learning facilities e.g. libraries, laboratories	A	A	A	N/A
• Students should be sent abroad for further studies	A	A	A	A
• Teaching/learning methods were an issue in the current curriculum	A	A	A	A

As revealed in Table 5.6, all the cases described that nursing curricula were not relevant to the Omani population, but instead exported from Western countries. Consequently, the course contents were not as relevant to the culture of the students. Case 2 described the current nursing curriculum as culturally insensitive. The case went on to describe that the examples and illustrations used in the exported curricula were unreflective of the community being served by the students. Cases 2 and 3 stated it was difficult to follow such examples when applied to the Omani population. According to Case 2, nursing students would benefit from teaching using local examples and illustrations. However, Case 1 disagreed and indicated that the implementation of the current curriculum by the nursing educators was the problem and that the current curriculum was well balanced and reflected the required knowledge and skills. Despite this disagreement on the curriculum content, all cases agreed that the current nursing curriculum did not reflect the culture of the students or the population that the students served.

5.2.1.1 Teacher Competency

The MoH nursing educators were described as incompetent in terms of their knowledge and skills. Cases 1, 2 and 3 described the current MoH nursing educators as being improperly trained. They went on to say that the current nursing faculty did not have the requisite clinical skills and their knowledge was not up to date. Case 1 stated that most of the nursing educators were trained in a master's programme which was not related to a nursing speciality, such as adult nursing or paediatrics, instead of general education. Moreover, cases 1 and 2 stated that the current programme for training the faculty should be reconstructed to improve the competency of the nursing faculty. Also, the MoH has started to place nursing educators in hospitals in order to train them in different skills. Case 1 stated that that MoH started to recruit more clinical teachers from the hospitals by providing

them with incentives to help the nursing institutes with teaching these students in the clinical allocations. Cases 1 and 2 indicated that the MoH was tackling the issues regarding the training of nursing educators through applying Omanisation policy. According to all cases, Omanisation of the nursing tutors and academic staff in all institutes would be a positive move. Case 1, 2 and 3 stated that the rate of Omanisation of the nursing educators was good.

5.2.1.2 Teaching/Learning Approach

Moreover, the MoH claimed that its educational philosophy reflected the current trends in nursing education, with a focus on self-directed learning, creativity, and development of critical thinking (MoH, 2008). The nursing administrators stated that the nursing courses adhered to the concept of critical thinking, but the application and implementation of the nursing course objectives by the faculty was lacking. They believed that the nursing faculty was spoon-feeding students as a teaching method.

Cases 1 and 2 stated that some teachers' teaching methods were too limited and dependent on lectures as a teaching method. Cases 2 and 3 stated that nursing students would simply depend on teachers and did not read course materials or go to the library to borrow books on the topics. According to all cases, most of the students believe in the traditional method of teaching, where teachers are the sole authority in the classroom. The teachers were seen as a reservoir of knowledge, and would hence transfer this knowledge to the open minds of the students. Case 2 described that the current nursing curriculum enabled nursing students to sit, listen and take information from the teacher.

In conclusion, all the cases believed that the students' preparation was geared toward working in healthcare facilities, which limited the student nurses' skills. Also, the educators' knowledge and skills were questionable since they had been out of practice for a long time. Some of the participants stated that Omanisation of the nursing educators might be a solution.

5.2.1.3 Educational Resources and Facilities

The availability of educational resources in the MoH educational institutes was perceived as a major issue by all the cases. According to Cases 1, 2 and 3, there were poor libraries and practice laboratories and a lack of access to electronic books and journals, which were barriers to the teaching and learning process. Furthermore, they mentioned that the educational resources were not well equipped in terms of books, and that there was hardly any access to electronic materials. Case 2 stated that students did not engage in reading because the materials were not available in the library. Furthermore, Case 2 pointed out that a more serious problem was the lack of culturally relevant material, and that most of the materials used in teaching in Oman are ready made and sourced from Western countries. Cases 1 and 2 pointed out that the nursing students rely heavily on teachers and that PowerPoint material limited the development of their critical thinking skills. Despite the limited resources allocated to nursing education, all cases indicated that the MoH was providing a lot of facilities and resources for nursing education, such as free education, accommodation, transportation and monetary incentives for the students. Also, the MoH had provided students with free books, computers and uniforms. They believed that the MoH was trying its best to meet the needs of both education and service.

5.2.2 Sub-theme 2: Community Involvement in Nursing Education

This sub-theme describes the cases' views regarding how the MoH approached community involvement in decisions regarding nursing education in Oman. Table 5.7 summarises the characteristics of this sub-theme across the four cases.

Table 5.7: Cross-case findings for community involvement in nursing education

	Case 1	Case 2	Case 3	Case 4
• Not all the stakeholders were involved in the development of the nursing curriculum	A	A	A	A
• MoH decision makers did not communicate well with all the stakeholders	A	A	A	A
• Stakeholders' needs & concerns were not reflected in the current nursing curriculum	A	A	A	A
• Involvement of all the stakeholders improves nursing education	A	A	A	A

As revealed in Table 5.7, all cases described that the community had little understanding of the nursing profession. Moreover, the community was oriented to nursing education being grounded in a unique body of knowledge and nurses being autonomous professionals with their own scope of practice. All the cases acknowledged that the MoH did not involve all the stakeholders in the nursing curriculum decision making process. Cases 2, 3 and 4 described their lack of involvement in the current nursing curriculum decision making process. Cases 2 and 3 went on to say they were not involved in the curriculum meetings and that they did not know what was going on at the top levels of the MoH. Also, the nursing curriculum changes were unclear and the courses were moved around; for example, some electives became compulsory courses, and vice versa.

All cases described that community involvement in nursing education would improve the quality of nursing services. All cases agreed that nursing students and graduates should be a part of the curriculum decision making process, as they could contribute their experience of the nursing curriculum. Moreover, the cases acknowledged that service needs should be addressed by the nursing curriculum. Case 1 and 2 described that there was ineffective communication between the nursing education and the nursing service divisions, despite both sectors operating under the same organisation. Cases 1, 2 and 3 agreed that the problem was caused by a lack of information regarding the nursing curriculum and courses.

Furthermore, Case 1 believed that nursing was a major part of healthcare and that this made it everybody's business. Therefore, every stakeholder should have input into the development of the profession. All cases went on to say that the community needed to be involved and participate in the development of nursing education. They believed that community involvement in nursing education would improve the quality of nursing services.

Cases 1 and 2 also stated that nursing education should work closely with the service sector to identify its needs and issues. Moreover, they stated that collaboration with all the stakeholders, bench marking with other institutions, transparency of the resources, and using the expertise and knowledge of the experienced staff would develop an appropriate nursing curriculum. Additionally, Case 2 believed that curriculum development should ensure that both the academic and clinical content is in tune with current trends in other countries.

5.2.2.1 Inter-Professional Education

Case 2 stated that mixing the nursing students in a multidisciplinary environment would improve the image of nursing and orient other healthcare professionals towards the nursing profession. Case 2 went on to say that the foundation programme allowed the nursing students to mix with students from other allied health specialities, such as physiotherapy, pharmacy, and radiology. Case 2 supported an interdisciplinary approach in the nursing curriculum which would allow the nursing students to be exposed to courses other than the main nursing courses.

In conclusion, the cases indicated that the MoH nursing curriculum should reflect the local cultural and religious values through involving all the stakeholders, such as teachers, students, the nursing service and the public in the decision-making process. They believed that the nursing curriculum would be enriched by incorporating feedback from all the stakeholders.

Chapter Six: Discussion

Introduction

This study was conducted to investigate the MoH's current approaches to nursing education and its cultural congruency in the context of Oman. The study sought to answer two questions:

1. How do the MoH's approaches to the nursing curriculum impact nurse education in the Sultanate of Oman?
2. How culturally congruent are the MoH's approaches to nursing education?

The main aims of the study were:

- To review MoH curriculum/educational policy documents to gain insight into nurse education in Oman.
- To examine the impact of MoH curriculum decisions upon the cultural congruency of nurse education.
- To suggest recommendations for curriculum development in Oman in light of the research findings.

These aims were met through the collected data (documents and interviews) analysis, which included a variety of participant sources (MoH nursing administrators, MoH nursing educators, MoH student nurses, and MoH service users).

In this chapter, the main themes described in chapters 4 and 5 will be discussed in the context of previous literature. This leads to a discussion of a framework for a culturally congruent nursing curriculum in the Omani context. Finally, this chapter will conclude with an overall study conclusion, discussion of study's strengths and limitations, and recommendations in light of the study.

6.1 Omanisation of nursing education

6.1.1 Meeting the Omani Healthcare Needs

Using Lawton's cultural analysis model as a framework, the four case studies revealed that the current nursing programme was intended merely to realise

Omanisation policy and generate the required national manpower needed to fill the expanding healthcare facilities. This may explain why the current nursing programme is based on discipline-focused curriculum. Thus, as revealed by the documentary analysis, the main focus of the curriculum content is core nursing courses, with some biomedical supporting courses such as anatomy and physiology, biochemistry, and nutrition. Also, the interview findings support that the MoH nursing curriculum is conceptualised as a product which is almost entirely nursing discipline-focused, and acknowledge that the main focus of the current MoH nursing curriculum is to produce hospital-based nurses. Also, the findings reveal that the MoH approach is based on an essentialist philosophy which advocates the view that a curriculum is not to be based on student nurses' needs and requirements, but rather on what those in power or authority think is necessary for the students. According to Null (2003), this is in line with the essentialist philosophy of education, which proclaims that other philosophies focus on the process of learning rather than curriculum content. Further, the case study findings indicated that this essentialist approach in the current MoH nursing curriculum has led to the general belief that nursing education should be strictly discipline focused and rich in content. As well, this approach has led to the exclusion of important content, such as Omani culture and Islam, in the current curriculum. As a result, the current nursing education is not culturally congruent to the nursing students' context.

Furthermore, the case studies point out that delivering both good clinical outcomes and service user-centred care can be achieved with high quality and effective nursing education which ensures both the availability of the right numbers of healthcare providers and the attainment of the right skills, values and competencies. However, the MoH approach to nursing education seems to put emphasis on the nursing graduates' numbers (quantity) rather than the quality of the nursing education provided for the graduates. This approach by the MoH defeats the main aim of the Omanisation of the nursing profession, which is to minimise misunderstanding between the healthcare providers and service users. In addition, many authors (Campinha-Bacote, 1999; Giger & Davidhizar, 2004; Leininger, 1991; Papadopoulos, 2006; Papadopoulos et al., 1998; Purnell & Paulanka, 2003)

argue that concepts such as cultural awareness, cultural sensitivity, and cultural competence are essential in nursing education. They view these concepts to be related to important nursing concepts like health, illness and care, which signify different things to different cultures or people. Therefore, familiarity of cultural traditions would allow the healthcare provider to deliver better care and avoid misunderstandings between themselves and other healthcare providers, patients, and their families.

Moreover, the study revealed that the current MoH nursing curriculum focus on ensuring that the students pass the courses and graduate as soon as possible, which affects the ability of the graduates to acquire the appropriate knowledge and skills. According to the MoH's nursing documents, the pass level was lowered recently from the former level (cumulative GPA of 1.75, equivalent to an overall grade of 65%) to the present level of 1.50 (equivalent to an overall grade of 60%). The interviews indicated that the reason behind this change was the need to respond to workforce requirements and pressure from students. Further, the case studies acknowledged concerns about the possible negative effects of this decision on the quality of graduates. Therefore, based on the findings, Omani nurses lacked competence in cultural care and appropriate communication skills that are essential for culturally congruent care.

Further, the socio-political policy of Omanisation seems to influence participants' views supporting the interpretation that values such as nationalism are constructed by culture. Hence, the case studies described that Omanisation of nursing education and practice is beneficial because it reduces the reliance on expatriate nurses and lessens the cultural incongruences in healthcare services. This is supported by the view that a culturally congruent education would allow the nurse to provide the best care in a holistic, culturally based manner. According to authors such as Campinha-Bacote (1999), Giger and Davidhizar (2004), Leininger (1991), Papadopoulos (2006), Purnell and Paulanka (2003), a culturally congruent nursing education would facilitate nurses to provide patients with care that is familiar, supportive, and meaningful in their cultural context. Nevertheless, the Omanisation of nursing

education may make nursing too parochial and inward looking by excluding international nursing staff.

Moreover, the case studies revealed that the current MoH approach to implementing the Omanisation policy was not effective in reducing the service users' communication difficulties with the healthcare providers. The study findings indicated that the bulk of service users and their families were Omanis who speak mainly Arabic, and most healthcare providers, including Omani nurses, converse in English. Further, the study findings revealed that even Omani patients who speak other common locally used languages such as Swahili and Baluchi were not accommodated. Therefore, the current MoH nursing education does not offer the nursing graduates the cultural or linguistic competence necessary for communicating with local service users, which indicated the inability of the MoH as a healthcare organisation to respond effectively to the needs of the public. Gerrish (2000) indicated that high-quality care cannot be attained without effective communication between patients and their healthcare providers; therefore, to improve communication competency nursing education should embrace the Arabic language and other languages spoken by Omanis. Also, the nursing education/ curriculum should involve content regarding understanding the social and cultural context of the served community to enhance the graduates' awareness of cultural and traditional needs. Therefore, to achieve culturally congruent nursing care, the MoH's approaches to nursing education need to encourage the students to use their native language/ languages while providing care to facilitate understanding of the cultural and linguistic needs of the target populations.

The case studies findings are in line with other studies' findings that all the GCC countries adapted nationalisation policies encouraged by the vision that local indigenous nurses are more appropriate or suitable for providing nursing care for their local population (Alamri et al., 2006). Local nurses are perceived to provide better patient care because they understand the culture and language of the local people. This is in line with findings from a study by Mebrouk (2008), conducted in Saudi Arabia, which highlighted the positive impact of using the Arabic language for communication between service users and local nurses in increasing satisfaction

of service users and their families, as well as improving the outcome of nursing care. Another study, by Aldossary et al. (2008) in Saudi Arabia, found that conflict developed between nurses, patients, and families when nurses were not able to communicate in Arabic. Therefore, language problems between the nurse and patient may result in miscommunication that could negatively influence their relationship (Halligan, 2006). This failure to communicate with the healthcare providers not only creates a hurdle to accessing healthcare, but also challenges trust in the quality of healthcare provided (Weinick & Krauss, 2000; Woloshin et al., 1995). Hence, language is vital to how culture operates, so, a nurse's ability to speak a few words or phrases of the patient's language may reduce communication barriers by encouraging trust (Green-Hernandez et al., 2004). According to Mebrouk (2008), culturally sensitive care based on service user and family values is fundamental to effective nursing services.

According to the case study findings, the MoH's approaches to nursing education do not reflect the cultural values and beliefs of the local population. This aspect of the findings suggests that nurse education in Oman fails short of what Lawton (1983) considers a culturally competent curriculum. According to Lawton, the main purpose of a curriculum is to initiate learners into their cultural heritage of society. Furthermore, my case study findings confirm that due to the lack of a culturally congruent focussed curriculum, new graduate nurses did not have sufficient knowledge about the local culture. This impoverished understanding of local culture means that their practice is most likely to overlook the importance to their service users of Islamic beliefs and values, a recurrent theme from the perspectives of users in this study confirmed. Further, the documentary analysis suggests that the current curriculum seems to assume that Omani nursing students have sufficient knowledge of their own culture, and therefore strategies are not in place to provide additional education regarding Omani culture or any cultural care content. This is in line with other studies which suggest culturally competent nursing education will improve the quality of nursing services, because providing culturally competent services has the potential to improve healthcare outcomes, increase the efficiency

of staff, and result in greater service user satisfaction with services (Anderson et al., 2003; Brach & Fraser, 2000; Leininger, 1995a).

Leininger (1995a) indicates that culturally congruent care is possible if cultural values, expressions or patterns are recognised and appropriately utilised while providing care. Therefore, a culturally competent nursing education should include culturally diverse nursing educators that reflect the communities served, encourage students and educators to speak the service users' language(s), and content on the cultural values and traditions of the served communities (Anderson et al., 2003).

Further, the study findings indicate the poor image of nursing as a profession in Oman, together with gender norms, which include women choosing to work only in female wards. This issue has lead Oman and other GCC countries to heavily rely on expatriate nurses in healthcare organisations to cover the rapid population growth. As a result, the majority of nurses employed in these countries are expatriates with professional, cultural and linguistic backgrounds that vary from each other and the local context they are serving (Almutairi & McCarthy, 2012). This heavy reliance on expatriates as nurses and nurse educators has consequently compounded the problem of cultural incongruence in nursing based on local culture and traditions. Numerous studies highlight similar problems in the context of culturally sensitive care. Astle (1993) and Halligan (2006) indicate that expatriate nurses come upon difficulties understanding and meeting their service users' cultural requirements. Nevertheless, the presence of expatriate nurses in healthcare facilities and education is not a new issue in all Gulf countries. Percentages vary among the GCC countries. For example, in the United Arab Emirates (UAE), local nurses comprise only 3% of the total number of nurses employed in their healthcare institutes (El-Haddad, 2006), whereas in Oman, expatriate nurses comprise 46% of the total number of nurses (MoH, 2012). India and the Philippines are the most common recruitment sites for expatriate nurses by the MoH. Others include Malaysia, North America, the United Kingdom, South Africa, and other Middle Eastern countries.

In conclusion, although the present case studies' concerns about reliance on expatriates in nursing and nurse education and its impact on culturally congruent curriculum resonates with the findings of other studies; my findings are unique to Omani nurse education. However, there is evidence from the literature that a cultural competent education would help the students provide efficient care using cultural assessment, which is essential to planning and implementing care (Andrews & Boyle, 2008; Campinha-Bacote, 2003; Giger & Davidhizar, 2008; Leininger, 2002a; Purnell & Paulanka, 2008; Spector, 2009). Also, creating nursing education that provides culturally congruent care requires continuous learning based on theory and empirical evidence (Jeffreys, 2006). The insights derived from multiple case perspectives lend support for adopting Lawton's cultural analysis model to reconfigure the current MoH nursing curriculum to be culturally congruent, so that it is in tune with the values and beliefs of the local context. In Section 6.6, a culturally congruent nursing curriculum based on Lawton's model is proposed.

6.1.2 Attitudes and Behaviours of Nursing Graduates

The case study findings revealed that the current image of nursing as “a dirty job” posed a challenge for the MoH in finding applicants to the nursing programme, and led to a lowering of the admission criteria (see Section 5.1.1, p. 194). According to the case studies, the lack of interest in the nursing profession involved the poor image of nursing in Oman, a lack of awareness about nursing profession prospects, the nature of nursing work that clashes with the traditional Omani family lifestyle (high workload, long working duties, night shifts, and working over public holidays and weekends), low wage compared with other occupations, limited professional growth, and absence of support for working mothers, which is in line with other Middle Eastern literature (Abu-Zinadah, 2004; Al-Sa'd, 2007). This in turn affected the quality and type of applicants to the MoH nursing programme.

The documentary analysis indicates that the current MoH nursing curriculum does not address the negative impact of the poor image of nursing on the nursing students' attitudes and behaviours toward the nursing profession. Instead of

addressing students' attitudes and values, the curriculum focussed on tangible matters such as uniform and submitting assignments on time. Moreover, cultural care and professional ethics are not part of the clinical competence requirements. As a result, the nursing students' negative attitudes and behaviour were not assessed and evaluated in the programme. According to Fletcher (2007), most nurses do not hold a positive sense of worth or think highly of themselves. Certainly, this holds true in Oman and other GCC countries, where the social image and professional status of nursing is still negative due to cultural beliefs regarding women working outside their homes. However, the case studies highlighted positive aspects of the nursing profession in Oman, such as regarding assisting a person in need as a religious duty and a way to be close to God (Allah). Similar findings in other studies reinforced the vision of the nursing profession as a "calling" (Prater & McEwen, 2006). Other studies indicate many students select nursing driven by a desire to help others (Zysberg & Berry, 2005).

However, according to the case studies, not all students who choose nursing express a calling or even a desire to pursue nursing as their first choice. Many of the MoH nursing programme applicants came into nursing for the job security, free education, limited career options elsewhere, and family pressure. This is in line with a Jordanian study which indicated that 69% of Jordanian nursing students came into the profession because of family or economic pressures (Jrasat et al., 2005). Similarly, in Turkey many nurses enrolled in nursing as a last option because they did not make the grade for other university courses (Baykal et al., 2005). For that reason, a concentrated effort to represent the nursing profession in a positive light would improve its image and status, and consequently attract a better calibre of students to nursing in Oman.

The poor image of nursing and the lack of interest in nursing as a career is not an Omani phenomenon, it is a global issue. The study findings are in line with many studies that addressed the image and perceived status of the nursing profession (Kalisch & Kalisch, 1987; Waterhouse, 1988, Grossman et al., 1989; Mendez & Louis, 1991; Kiger, 1993; Spouse, 2000; Coombs et al., 2003; Ward et al., 2003). According to a study by Al-Omar (2004), only 5.2% of a sample of high school

students in Saudi Arabia intended to pursue nursing after graduating secondary school. Another study in Tanzania showed that of all the allied health professions, nursing was the least popular, with only 9% of students indicating an interest (Kikwilu et al., 2000).

Despite the MoH's acknowledgement that the poor image of the nursing profession influences nursing students' attitudes and behaviours, the case studies revealed that the current MoH nursing programme did not emphasise or teach professional ethics as an important aspect of the current nursing curriculum. According to Dimond (2008), the nursing graduate is accountable ethically, professionally, and legally for their actions and errors. He/she is accountable and liable to their organisation, their patient, their society, and to themselves. However, the study findings revealed that the current MoH nursing curriculum does not enable the students to be fully accountable for their attitudes and behaviours because there is no formal assessment to address the issue. Many literatures indicate that nurse education should enable nursing students to become professionally accountable and responsible for their actions (Plant, Pitt & Troke, 2010). However, nursing education should provide the knowledge and skills that facilitate the nursing student to develop an understanding of the structures which hold them accountable, so that they can practice in confidence within the scope of their competence to provide professional care for their patients and society.

Another issue the case studies highlighted was that the current higher education policies in Oman mandate the enrolment of recent secondary school graduates, therefore, there is no diversity in the age group of the students. As a result, the case participants described the new Omani nursing graduates to be immature due to their age, which reflects another culturally constructed value (Omani value), linking age to level of maturity (wisdom), which was linked to the new graduates' poor attitudes and incompetence. Also, the study participants indicated that professional maturity is enhanced through the healthcare provider's exposure to a wide range of experience in different settings and diverse patient groups, which is similar to McGee and Castledine's (2003) study findings. Unfortunately, the current MoH nursing curriculum does not support students' exposure to a wide range of

healthcare settings or diverse patients due to the limited clinical allocations and facilities available. Therefore, promoting diversity in the student population by widening access to more mature candidates may help to achieve a culturally congruent curriculum. Mature students may bring a wealth of life experience and cultural awareness, which in turn may beneficially impact on culturally sensitive care.

Currently in Oman, the culture values and beliefs of the nursing profession/ education reflect many of the dominant societal values and beliefs held in many of the Western or European value systems predominant in the USA and UK universities. As a result, the Omani nursing students become enculturated into these foreign nursing values and beliefs, which may lead to dismissal and alienation towards their own non-western Omani culture. Leininger (2002a) defines *Enculturation* as a learning process whereby students learn to take on or live by the values, norms, and expectations of the nursing profession. Nonetheless, this creates a conflict between the Omani nursing students' cultural values and beliefs and those of the Western-based nursing curriculum/ education (Lawton, 1983). As a result, the Omani student nurses must choose which cultural values and beliefs better fit the Omani culture and society, their own or those of the nursing education (AbuGharbieh & Suliman, 1992). This aspect of the findings suggests that nurse education in Oman is inconsistent with what Lawton (1983) considers a culturally competent curriculum.

The study findings indicate that Omani students come from and hold different cultural values before entering professional education. These various patterns of learned values, beliefs, and behaviours are transported by the students into the academic and professional setting. These personal values have meaning and importance to the students, and these values guide their behaviour. According to Leininger (1995a), cultural values are the “*powerful directive forces that give order and meaning to people's thinking, decisions, and actions*”. Many cultural theories propose that students' cultural assumptions and stereotypical ideas should be challenged through self-awareness and value clarification exercises in the classroom (Narayanasamy & Narayanasamy, 2012). Such opportunities for

challenging pre-conceived ideas and assumptions would lead to better self-awareness and cultural sensitivity, ultimately achieving a culturally congruent curriculum.

6.2 Caring: An Omani Perspective

The case study findings validate that the current MoH nursing curriculum did not give emphasis to the concept of caring as an essential value in nursing education. According to the case studies, Islamic rituals such as prayer times were not part of the nursing care. The participants of the case study interpreted the concept of “caring” to involve compassionate care and effective caring communication with patients and their families. The participants’ interpretation of caring is attributed to their cultural understating of the meaning of care. Hence, they stressed that caring involved respecting the spiritual and religious needs of the patients and their families. According to the case studies, patients appreciate nurses’ caring approach and presence more than their nursing knowledge and skills in providing care. Schwein (2004) indicates that when nurses make an effort to care for their patients, it positively impacts the nurse–patient relationship. The study findings showed that caring nurse characteristics involved being physically present with his/her patient, having a conversation with the patient with active listening, avoiding prejudice, maintaining confidentiality, flexibility in patient care, and optimism. In Islam, caring consists of the intention to be responsible, sensitive, and concerned about others with the drive and commitment to act rightfully (Salleh, 1994a). Therefore, caring in Islam is to understand what, when, who to care for and why (Salleh, 1994a). So, the nursing education should provide the students with the right knowledge, skills and resources to enable them to be accountable and responsible for their patient caring process. The Holy Prophet stated that:

“Each of you is a guardian and is charged with a responsibility, and each of you shall be held accountable for those who have been placed under your care”.

As with all religions, Islam embraces caring as an essential aspect of human relationships. Caring from an Islamic perspective emphasises the dignity of the person and puts high value on direct human contact and interaction. Kasule (1998) indicated that despite the use of technological developments which enable the nurse

to provide comfort and care to patients, Islam maintains that direct interaction between the nurse and the patient is imperative.

There is compelling evidence from the case studies that the MoH's approaches to the nursing curriculum are incongruent and do not meet the needs of the local context. The current MoH nursing curriculum defines the value of caring as "*continually demonstrating feeling and exhibiting concern and empathy for others, coupled with respect, fairness and transparency*" (MoH, 2008). This definition of caring does not reflect the Omani culture or context, which is very problematic. It does not help the graduate or educators to make culturally sensitive and appropriate decisions, actions, and innovations. Furthermore, the case studies revealed the need for a culture specific model for the Arab Muslim context to develop culturally specific concepts to guide the practice and education of Omani nurses. According to Shin (2001), within non-Western nursing educators there is recent acknowledgement that while nursing theory has universal aspects, the differences in philosophy and culture that are unique to each country need to be reflected in the nursing education. Cultural blindness is a major hurdle to the required changes in the current MoH nursing education. In the context of nursing education, *cultural blindness* is the failure to recognise the diverse cultural values and beliefs that exist among cultures and populations (Jeffreys, 2010). As a result, the current MoH nursing education imposes its dominant Western nursing education values and beliefs on Omani students because the MoH does not recognise that differences exist. According to Jeffreys (2006), this cultural imposition can inflict cultural shock, and lead to cultural clashes among students whose cultural values and beliefs are incongruent with the dominant nursing cultural values and beliefs.

In Oman, parallel to the Islamic perspective on nursing care, care is defined from various perspectives which reflect the Western Judeo-Christian values and beliefs with a notion that nursing has a common value system (Holden & Littlewood, 1991; Narayanasamy & Owens, 2001; Rassool, 2000). Holden and Littlewood (1991), Leininger, (1991) and Kyle (1995) indicate that caring is culturally established. The nursing image of assisting individuals is a strong theme held in the literature (Beck, 2000; Rheame et al., 2003; Sand-Jecklin & Schaffer, 2006). According to Price

(2009), many people choose nursing as a career based on a pre-held idealistic view of caring and influencing others to get better. The present case studies' findings about concerns about caring are in line with another study by Eman, Seamus and Edgar (2012) of Bahraini nursing students, which found that the majority of participants perceived nursing as a caring profession. In many of the studies (Foskett & Hemsley-Brown 1997, Beck 2000, Mills & Blaesing 2000, Duffield et al., 2004, Day et al., 2005, Coombs et al., 2007; Williams et al., 2009), caring for others is a constant factor which reinforces the long believed stereotype that nursing is a "caring profession".

A nursing model that reflects Arabic /Islamic cultural health values and beliefs is necessary to reflect the cultural values of the local nurses and their patients. Rassool (2000) acknowledged the need for an Islamic model of nursing based on the Islamic perspective of caring and spirituality. He described that the concept of caring is embedded in Islamic theological framework and is articulated at three stages: intention, thought, and action. He claimed that nursing models from the Judeo-Christian belief are missing the core of spirituality and religious promise, which render them improper for meeting the holistic needs of the local Omani population. Further, a model of nursing based on Islamic beliefs would ensure congruence between the Arabic/ Islamic nursing identity and the practice of nurses (Lovering, 1996).

The study findings indicate that caring should be the main focus of nursing education and practice. This is in line with Watson's (1979) definition of nursing as *"the science of caring, in which caring is described as transpersonal attempts to protect, enhance, and preserve life by helping find meaning in illness and suffering, and subsequently gaining control, self-knowledge, and healing"*. The case study findings pointed out that poor attitudes, uncaring behaviour, and lack of proper communication with service users and their families are a crucial issue with Omani nursing graduates. This is supported by a study in Kuwait which found that service users' measurement of quality nursing care was based on the personal qualities of the nurse rather than his/her technical skills (Al-Kandari & Ogundeyin, 1998).

Brilowski (2005) asserts that caring has three important attributes: relationship, action, and attitude. Within these, Brilowski claims that nursing care (action) involves the responsibility to maintain competence, and to use a therapeutic touch in communicating with patients to enhance the healthcare. Similarly, Finfgeld-Connett (2006) found caring to be an interpersonal process which involves sensitivity and close relationships between the nurse and their patients. Furthermore, Finfgeld-Connett (2006) asserts that caring includes the idea that professional maturity incorporates competence and knowledge, as well as emotional maturity. This is another aspect of the study findings which suggest that nurse education in Oman falls short of what Lawton (1983) considers a culturally competent curriculum.

6.3 Competent Nursing Educators

According to the case study findings, the MoH nursing educators come from diverse cultural and educational backgrounds due to insufficient well-prepared Omani nursing educators. As a result, the current nursing faculty in Oman holds different values and beliefs regarding nursing education and nursing practice, which further contributes to the cultural incongruence of nursing education with the local context. Stenhouse (1975) viewed curriculum as flexible and open to teachers' interpretations. This is an issue the MoH's curriculum decision makers had to face. In Oman and other GCC countries, nursing education is heavily dependent on expatriate nursing educators who have different cultural, linguistic and educational backgrounds. The majority of expatriate nursing educators are from India, the Philippines, Egypt, Jordan, Sudan, Iraq, Pakistan, South Africa, and the United Kingdom. Each educator has their own understanding and interpretation of what the focus of the nursing curriculum should be and how to conduct their classroom/clinical teaching, which is complicated by the current rigid, discipline-focused nursing curriculum, limited duration of the programme, and the pressure to graduate Omani nurses to cover the MoH healthcare facility needs. As a result, this has created conflicts in meeting the Omani students' learning needs because culture was not linked to pedagogy, which, in turn, caused the students to become academic under-achievers or incompetent in providing culturally congruent care.

According to the findings, the current nursing curriculum predominately emphasises a teacher-centred approach to learning to ensure uniformity in what is taught due to the multicultural and multinational teaching faculty. Additionally, the MoH's essentialist approach, as discussed above (see Section 6.1.1), has also encouraged this approach. The study findings revealed that this approach motivates teachers and students to focus on passing exams instead of meaning-making and critical thinking. As Stenhouse (1975) asserts, this approach treats learners as objects rather than subjects, and he suggests the use of a process-based model (see section 2.3.3). However, the current MoH nursing curriculum is based on a set of pre-established objectives and competences that direct the nursing educators. As a result, nursing knowledge is reduced to sets of skills, for example, how to administer medication and change a dressing. When students are able to demonstrate certain skills, they are deemed to have completed the established curriculum objectives. As the study findings reveal, the majority of the MoH nursing graduates exhibit poor attainment knowledge and skills beyond the course work, which indicates that the current nursing curriculum has caused severe limitations to student learning and made educators incompetent.

Moreover, the findings described the current MoH nursing educators as improperly trained, and lacking the requisite clinical skills and up to date knowledge. Further, the current programme for training the faculty should be reconstructed to improve the competency of the nursing faculty; therefore, the MoH has started to place nursing educators in hospitals in order to re-train them in different skills. The theory–practice gap is universally recognised as a major problem within nursing education (McSharry, 1995). It was highlighted by AbuGharbieh & Suliman (1992) when they reported that, although faculty members in Jordan were well-prepared theoretically, they lacked training and experience in clinical nursing. As a result, nurses in practice settings regard them as theoreticians rather than “real” nurses. According to the findings, the MoH nursing educators' knowledge and skills were questionable since they had been out of practice for a long time. As well, the findings indicated that the current nursing faculty was not a good role model to their students and negatively affected the students' knowledge, skills and attitudes. This

is in line with Johnson et al.'s (2007) and Miers' (2007) findings, which show that the concept of altruism has become less important to students, reflecting a less spiritual approach, as a result of observing role-modelling behaviours that do not always reflect and value the importance of compassion. Firth-Cozens and Cornwell (2009) advocated that acting as a role model for the delivery of compassionate care will demonstrate its importance as a fundamental value to students. Therefore, in order for nursing educators to act as role models for their students, they should have advanced clinical preparation in their areas of expertise. The Carnegie study of nursing education, in the USA, found that some nursing educators did not practice for years, and in some cases, students complained that the faculty were not current in their understanding of clinical practice (Benner et al., 2010). While faculty members surely cannot be experts in everything, they should still have advanced experience in clinical nursing knowledge. Advanced education at the master's level in clinical practice facilitates the educator with the necessary background to teach and supervise in clinical practice.

Further, faculty prepared at the graduate level in clinical practice possess skills that are valuable for teaching within the context of clinical practice. Phillips and Duke (2001) identified four high-level questioning skills necessary for the nursing educator to possess: application, analysis, synthesis, and evaluation, and they found that these were important elements for stimulating learning in the clinical setting. According to several studies, a graduate prepared faculty will be able to teach and role model. Riner and Billings (1999) conducted a study to identify perceived needs for faculty members. They found that faculty with bachelor's degrees, or those with master's degrees in other fields, had significantly higher needs than those with master's in nursing degrees or doctorates. The findings of the study supported this notion, despite the current MoH nursing programme faculty predominantly holding BSc and master's degrees in nursing. Carnegie's study of nursing education (Benner et al., 2010), Riner and Billings (1999), and Bartels (2007) all go a step further and support doctoral education of nursing faculty members. Riner and Billings (1999), for example, found that nursing faculty members without doctoral

preparation had significantly greater developmental needs in almost all items on their scale.

Despite some of the study participants' notion that a specialised advanced nursing course is important, a graduate course in the science of teaching/learning is as important. This is because the nursing educator takes the role of director of student learning. He or she must understand the science of education, which would include an understanding of learning styles, including diverse learners; education theory; evaluation and assessment of learners, curriculum and programme outcomes; curriculum design; and diverse teaching strategies (Bartels, 2007; Tanner, 2007; Zungolo, 2004). Riner and Billings (1999) support the inclusion of education coursework in graduate nursing education. In their study of 352 nursing faculty members, they found that faculty with no formal teacher education had significantly higher needs for the following items: understanding how what is taught fits into the curriculum, establishing an effective teaching/learning environment, planning clinical experiences, and using simulations that provide experience in critical thinking and problem solving, which is in line with the study findings. What constitutes appropriate educational preparation for a nurse educator has been debated for many years; nurse educators remain responsible for creating an environment in the classroom, laboratory, and clinical settings that facilitates student learning and the achievement of the desired cognitive, affective, and psychomotor outcomes.

In conclusion, nursing educators need to act as a role model to their students in terms of delivering high-quality compassionate nursing care (Firth-Cozens & Cornwell, 2009; Madhavanprabhakaran et al., 2013). Bandura's (1977) social learning theory states that individuals learn in the social environment through observation of others' actions. Alain (1989) asserted that, when learners are unable to discriminate positive from negative role modelling, there is a risk they may perpetuate negative behaviours. Schon (1983) identified that, when a student works with a mentor in the clinical environment, they reflect on and internalise the behaviour patterns observed. Illingworth (2006) suggested that student nurses undergo a process of professional socialisation, involving the transfer of values,

attitudes and beliefs from an experienced nurse to a less experienced nurse. Role models can best demonstrate to student nurses that compassion is a core behaviour by showing their own commitment to the concept. This is another aspect of the findings which suggests that nurse education in Oman falls short of what Lawton (1983) considers a culturally competent curriculum.

6.4 Teaching/Learning Approaches

The case studies revealed that the current nursing curriculum limits the innovation of teacher and student due to limited programme duration and resources allocated for educational usage. The limited budget allocated for nursing education and MoH priorities as a healthcare service ministry hinders the teaching/learning in nursing. According to the findings, there are inadequate libraries, training laboratories, and a lack of access to electronic books and journals, which limits the teaching and learning process. Furthermore, the case studies revealed the inflexibly and rigidity of the nursing programme that adheres to specific course content and teaching style. Therefore, many of the study participants viewed the current curriculum to be ineffective in improving the students' learning capabilities. This is in line with Bruner's (1996) idea that uniform instruction will not meet the needs of all learners adequately, because everyone understands the world in their own unique way. This has to do with the cultural environment in which they exist, which the current nursing curriculum does not accommodate.

According to Bruner (1996), learning is an active process in which the learners construct new ideas based upon their current or past knowledge while interacting with new information. In this the learner selects and transforms information, constructs hypotheses, and makes decisions, relying on a cognitive structure. Hence, the learner "focuses on the 'how' to learn, rather than 'what' to learn" (Craig & Reed, 2002). However, the findings revealed that the current nursing curriculum facilitates nursing students to rely heavily on teachers' lectures, which limited the development of their critical thinking skills. While, culture provides general frames of reference that permeate the meanings people impose on classroom lessons (Bruner,1996), educators must engage students in ongoing dialogues, assessing

existing beliefs and understandings rather than assuming that students will absorb classroom subject matter exactly as it is presented. Yet, the current nursing programme focuses on learning content and achieving objectives rather than enabling the students to learn.

The case study findings acknowledge the need to move away from the teacher-centred approach and toward a learner-centred one. It has been long advocated by theorists and researchers of education to replace teacher-centred pedagogies with learner-centred ones (Bruffee 1984; Hillocks 1993; Rubin & Herbert 1998; Edens 2000; Hansen & Stephens 2000; Villaume 2000). In teacher-centred approaches, judgments about appropriate areas and methods of inquiry, legitimacy of information, and what constitutes knowledge, rest with the teacher. By contrast, learner-centred approaches derive from constructivist views of education, in which the construction of knowledge is shared and learning is achieved through students' engagement with activities in which they are invested. However, education in Oman, including higher education, is based on the teacher knowing everything and the students knowing nothing, which is similar to Freire's (1970) "*banking education model*". This leads the educators and students resistant to the learner-centred approach. Gregory (1997), and Hansen and Stephens (2000) mention a number of factors that contribute to students' resistance to the intellectual work of learner-centred learning. The study findings reveal that the focus is on passing exams, as mentioned above. According to Hansen and Stephens (2000), society's emphasis on success leads to students seeking easy answers and to count on high grades, to avoid difficult work, and to develop inflated perceptions of their abilities. Teaching to students' comfort levels has become so much the norm that students expect it (Gregory, 1997). Similarly, Hansen and Stephens (2000) suggest that students have "*low tolerances for challenge*", and that they, as well as some faculty members, have become "*risk averse*" in the classroom because of the educational institution's focus on assessment, and have discomfort in dealing with diversity issues in classrooms. For learner-centred learning to be effective, the philosophy of learning in nursing education should be reassessed.

Furthermore, the case study findings reveal that a major issue in the Omani higher education system, including nursing, is the language of instruction. The use of the English language was endorsed because the majority of nurse educators were multinational. Similarly, Omani nursing educators who had been sponsored to obtain a postgraduate education from the USA, UK and other Western countries assumed educational posts, and were highly influential in the continued influence of the Western model of nurse education in terms of structure and faculty training (Shuriquie, 2006). The appropriateness of the content for the Omani context shows the incongruity between the reality of nursing practice and the models described in the classroom. For example, student nurses are taught the unique functions of nursing that emphasise individualism, science and secular rationality. In contrast, Omani culture places greater emphasis on religion and family ties. As this relationship is inevitably and fundamentally influenced by cultural norms, the way that nurses relate to service users in Oman will be different from the way that nurses relate to service users in the USA (Hijazi & Al-Ma'aitah, 1999). This is still the case, as Shuriquie (2006) raises similar concerns regarding the appropriateness of the American nurse education system for the Arabian/Muslim context. As well, the textbooks and printed material in Oman is culturally biased, because most nursing course materials are imported from the West. There is a lack of educational resources in Arabic, the national language of most of Eastern Mediterranean countries, and Oman is no different. Educational resources, such as evidence-based scientific medical and nursing books, journals and research reports, are mostly inaccessible in Arabic. The lack of educational resources in the national language of nursing programmes continues to compromise the quality of nursing education in the region.

In conclusion, the teaching/ learning approach of the current MoH nursing curriculum has created a conflict between the local cultural values and beliefs and those of Western-based nursing education (Lawton, 1983). Therefore, the current nurse education in Oman falls short of what Lawton considers a culturally competent curriculum.

6.5 Stakeholders and Nursing Education

The study findings acknowledge the limited stakeholder involvement in the current MoH nursing curriculum. This is a challenge in Oman because of issues regarding lack of transparency in the decision-making process. According to the case study participants, nursing curriculum decisions should involve all stakeholders, which include the community, students, and teachers, to develop a curriculum that reflects their needs. These findings are consistent with Roberts et al.'s (2010) study findings, which highlighted that stakeholders are consumers of healthcare, and so are well-placed to contribute to decisions relating to the appropriate qualities and skills needed in the graduate nurses. Further, Simpson (2006) claimed that stakeholders bring a unique perspective to the process which can positively complement the perspectives of academics and clinicians. This perspective arises from the ability of stakeholders to discern good quality compassionate care as a direct result of their personal experiences of nursing care. This is consistent with the study findings that nursing education should work closely with the stakeholders to identify its needs and issues. In addition, Cook and Walsh (2007) identified that stakeholders should also be involved in nursing curriculum planning, design, and teaching/learning strategies. Simpson (2006) suggested that such involvement should be integral to the strategic direction of higher education institutes, ensuring that stakeholders are willing and active participants in curriculum planning, development and delivery.

The study findings reveal that not all stakeholders are equally involved in the decision-making process regarding the current nursing curriculum. Therefore, efforts must be made to ensure fairness and equity of representation to avoid potential doubt relating to the stakeholder involvement. Indeed, stakeholder involvement in curriculum development may help to illustrate the importance of values such as compassion and cultural care, embedding the concepts as core values of nursing (Firth-Cozens & Cornwell, 2009). Therefore, stakeholder participation in healthcare education is central to meeting the healthcare needs of the population competently. Overall, many researchers agree that stakeholder involvement has also been identified as beneficial in terms of enhancing the quality of the education

process (Wykurz & Kelly, 2002; Flanagan, 1999). Similarly, the WHO identified the importance of stakeholder involvement in healthcare education (Flanagan, 1999). Moreover, the study findings reveal that collaboration between all the stakeholders, bench marking with other institutions, transparency with the resources, and using the expertise and knowledge of the experienced staff, would develop an appropriate nursing curriculum that fits the needs of the nation. However, stakeholder involvement should be translated into meaningful, active partnerships, rather than simply remaining at the level of rhetoric (Maslin-Prothero, 2000) or “tokenistic consultation” (Forrest et al., 2000).

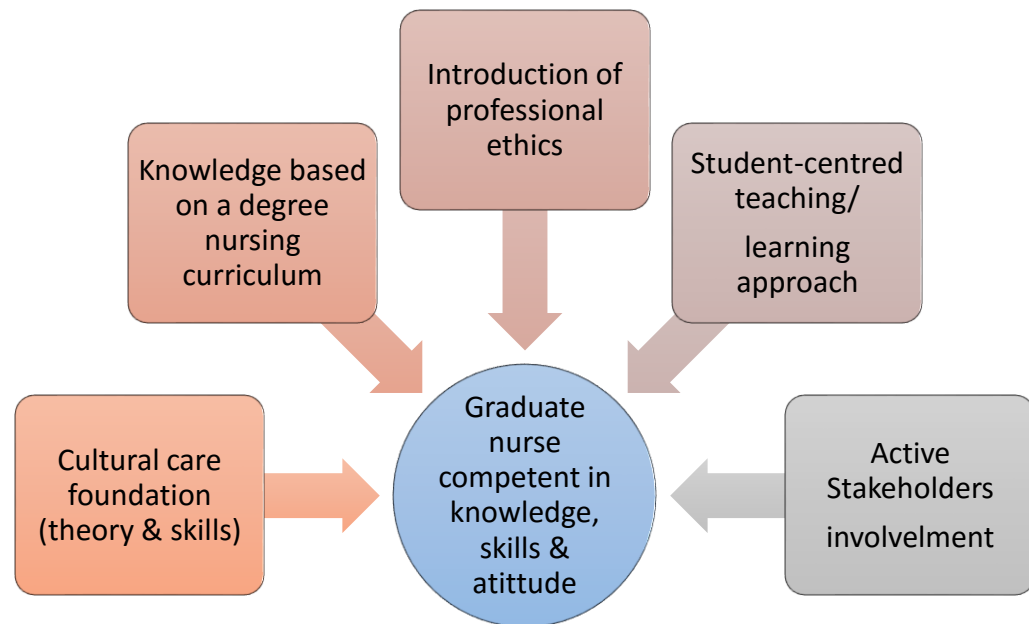
In conclusion, nursing education should continue to put emphasis on the importance of involving all stakeholders in enhancing the quality of the nursing education process. As Masters et al. (2002) have highlighted, stakeholder involvement is crucial in nurse education. However, the current MoH nursing curriculum fails to involve all stakeholders in the decision-making process, and consequently, the unique Omani cultural beliefs, values and practices are not expressed in the current MoH curriculum. Therefore, the current nursing curriculum fails to be culturally competent according to Lawton (1983). In the following section I propose a model based on the findings and Lawton’s cultural analysis model that will ensure that nursing education in Oman is culturally congruent.

6.6 Proposed Approach for a Culturally Congruent Nursing Curriculum

This study was conducted to explore the MoH’s approaches to nursing education and its cultural congruency with the Omani population’s healthcare needs using data collected from a variety of participant sources (MoH administrators, MoH nursing educators, MoH nursing students and service users), together with a thorough analysis of documents and interviews. The study is unique and makes a significant contribution to knowledge and understanding of the MoH’s current approaches to nursing education in Oman. It has further extended the literature by illustrating the curriculum approaches to nursing education found in Western studies, but which remain unexamined from an Omani perspective. The overall findings demonstrate the MoH’s approaches to nursing education, which are

presented through perceptions of the participants and interactions with the MoH healthcare system and nursing education, all of which occur within the context of Oman.

Figure 6.1: A Model for a Culturally Competent Nursing Education



As shown in Figure 6.1, a culturally congruent curriculum will be able to prepare an Omani nurse that is competent in knowledge, skills, and attitudes. However, a single approach to developing culturally competent care is not enough, i.e. it's not just about learning outcomes that reflect culture and seek to engender cultural competence, it is also about the other factors identified in the proposed figure. The figure involves five components of a culturally congruent curriculum: cultural care foundation (theory and skills), knowledge based on a degree nursing curriculum, introduction of professional ethics, a learner-centred teaching/learning approach, and active stakeholder involvement. These elements cover the notion of competency in knowledge, skills, and attitudes, which are identified as aspects of professional practice (Gonczi et al., 1990). This model is based on the study findings (chapters 4 and 5) and literature, for example, cultural care, professional ethics and learning approaches. Also, the model is structured around Lawton's Cultural Analysis model (1983).

6.6.1 Cultural Care Foundation (Theory & Skills)

People belonging to different cultures may have different needs in terms of health, therefore, their cultural values should be respected by healthcare providers. In the study, all the cases stated that the current nursing programme did not provide the students with courses on cultural competency and the current programme did not emphasise the importance of Omani cultural values and beliefs in the curriculum. Further, all cases indicated that healthcare providers imposed their own values and beliefs while caring for patients. Transcultural nursing education will provide a good guide for Omani nurses in getting acquainted with the cultural structure of society and in evaluating it. Leininger and other nursing scholars, such as Purnell, Campinha-Bacote, Giger and Davidhizar, building on Leininger's ideas, contributed greatly to the studies in the field of culture/cultural care.

Nowadays, nurses are expected to be sensitive to and knowledgeable about cultural differences and similarities while providing care (Dowd et al., 1998; Duffy, 2001; Leininger, 2002). Also, nurses should be aware of the values of different cultures, races and ethnic groups to respond appropriately to these differences (Dowd et al., 1998). Professional nurses are required to provide holistic and culturally competent nursing care (Ryan et al., 2000). To be culturally competent, nurses must initially be aware culturally and sensitive when dealing with patients with different cultural values (Fletcher, 1997). It is essential for nurses to utilise knowledge gained from conceptual and theoretical models of culturally appropriate care to provide culturally competent care in a dynamic and continuous process (Giger & Davidhizar, 2002b).

6.6.1 Knowledge based on a Degree Nursing Curriculum

This component refers to upgrading the current nursing programme to a baccalaureate nursing programme which encompass all of the course work taught in the current diploma programme, plus a more in-depth study of the social sciences, nursing research, community health, nursing management, and the humanities. The added coursework would improve the student's professional development, prepare the graduates for a broader scope of practice, and provide

them with a better understanding of the cultural, political, economic, and social issues that affect patients and influence healthcare delivery. According to the study findings, all the cases agreed that moving nursing to a degree programme would improve the quality of the nursing services. Moreover, all the cases believed that a BSc prepared nurse would have more knowledge and skills than a diploma graduate. The findings indicated that the current programme graduates were too young and needed to mature before they started practice and this could be achieved by increasing the programme duration.

The baccalaureate student can assimilate a wider variety of abstract concepts over a longer period of time than a student of diploma education. Baccalaureate programmes also require high level course work in such subjects as research, management, theories and leadership that is limited or non-existent in diploma degree programmes. Moreover, the educational foundation in the baccalaureate curricula provides a basis for nursing beyond direct care of individuals to including care of families, groups and the community. Bachelor of Science in Nursing (BSN) students have access to faculty involved in research and a broader educational experience than undergraduate students. This is important if nurses are expected to interact with a broad spectrum of human conditions.

Furthermore, a highly educated nursing workforce is essential to assure safe, high quality healthcare for all people. Nurses prepared with the baccalaureate provide better patient outcomes (Aiken et al., 2003), have lower levels of medication errors and procedural and practice violations, stronger critical thinking and leadership skills (Goode et al., 2001), and stronger communication and problem solving skills (Johnson, 1988). Also, a study by Phillips et al. (2002) found that degree prepared students demonstrated higher competency in nursing practice, communication, leadership, professional integration, and research/evaluation. Therefore, adapting a degree nursing programme would provide the MoH with graduates who exhibit better skills in communication and nursing process implementation. In addition, the majority of other professionals in the healthcare field require a minimum of a bachelor's degree as an entry level into practice; so, raising educational requirements for nursing would promote more collegial relationships with other members in the

healthcare profession. Fagin and Lynaugh (1992) state that "asserting the baccalaureate as the norm for nursing practice recognises the reality of nursing as an occupation, as well as a profession". Furthermore, BSN requirements meet the obligation of the nursing education to produce safe, competent, and productive nurses (Fagin & Lynaugh, 1992).

As well, the education of professional nurses must take place in higher education institutions providing a Bachelor of Science degree in nursing, which is required for beginning professional practice. Nurses educated in these academic settings would be socialised as professionals with a value system that is compatible with this role. This education should be flexible, diverse, and directed toward providing the nurse with a solid base for general, professional nursing practice.

6.6.2 Professional Ethics

This component refers to the professional values and their associated behaviours as foundational to the practice of nursing. In the study, all the cases acknowledged that Omani nursing graduates exhibited poor attitudes and behaviour toward patients and their families. Also, the findings indicated that patients experiencing nursing care, which was incongruent with their own values, norms and customs, might not comply fully with recommended treatment and may experience cultural conflict, stress and ethical or moral dilemmas. Additionally, the study showed that ethics was not emphasised in nursing education and the cases pointed out the importance of including an ethics course in the nursing curriculum to prepare the graduates for the ethical dilemmas of the healthcare system.

Professionalism also involves accountability for one's self and nursing practice, including continuous professional engagement and lifelong learning. Also, inherent in accountability is responsibility for individual actions and behaviours. In order to demonstrate professionalism, nursing education should emphasise the fundamental set of accepted behaviours for a particular society/culture upon which a nursing programme is based (Hammer, 2003). One definition of accountability is offered by Caulfield (2005): "A wider view of accountability is that it is an inherent confidence as a professional that allows a nurse to take pride in being transparent

about the way he or she has carried out their practice.” Yet, Griffith and Tengenah (2005) found that despite its common usage in professional practice and its inclusion in nursing texts, organisational policies, and regulatory bodies, the concept of accountability is frequently misunderstood, and often ambiguous. Therefore, it is essential that accountability be clearly understood (Griffith & Tengenah, 2005).

When a nursing curriculum sufficiently addresses professional ethics, it provides graduates with the tools to help them reflect critically on what nursing care implies. By stimulating critical reflection on nursing practice, education in professional nursing ethics aims to encourage a virtuous attitude in nurses, forming the basis from which to provide good care. According to Tronto (1993), good care entails care acts that express an attitude of caring. The essence of nursing is the precise integration of expert activity (knowledge and skills) and caring (virtue); nursing can therefore be considered a moral practice (Gastmans et al., 1998). Graduates must be prepared for the numerous dilemmas that will arise in practice. Professional ethics will enable them to make and assist others in making decisions within a professional ethical framework.

Inherited in the professional practice is an understanding of the historical, legal, and contemporary context of nursing practice. Professionalism refers to the consistent demonstration of core values evidenced by nurses working with other professionals to achieve optimal health and wellness outcomes in patients, families, and communities by wisely applying principles of caring, professional ethics, respect, communication, and accountability. Professionalism also involves accountability for one’s self and nursing practice, including continuous professional engagement and lifelong learning. Also, inherent in accountability is responsibility for individual actions and behaviours. In order to demonstrate professionalism, nursing education should emphasise the fundamental set of accepted behaviours for a particular society/culture upon which a nursing programme is based (Hammer, 2003).

Caring is a concept central to professional nursing practice. Caring encompasses the nurse's empathy for, and connection with patients, as well as the ability to translate these affective characteristics into compassionate, sensitive, and patient-centred care. The professional nurse must ensure care is performed competently, at least to the standard of the ordinarily competent practitioner (Scrivener et al., 2011). Professional nursing requires a balance between evidence based knowledge, skills, and attitudes and professional confidence, maturity, caring, and compassion to care competently for diverse patient populations. Therefore, professional ethics would provide the student nurse with an understanding of a wide variety of physical, psychosocial, cultural, and spiritual needs, health/illness decisions, and life challenges that will facilitate cultural competency.

6.6.3 Learner-centred Teaching/Learning Approach

Students are the centre of the educational establishment, and their cognitive and affective learning experiences should guide all decisions as to what is done and how. The study findings indicted that the teaching methods were too limited and are dependent on lectures as a teaching method. Also, the findings revealed that nursing students would simply depend on teachers. The teachers were seen as a reservoir of knowledge, and would hence transfer this knowledge to the open minds of the students. The findings described that the current nursing curriculum enabled nursing students to sit, listen and take information from the teacher.

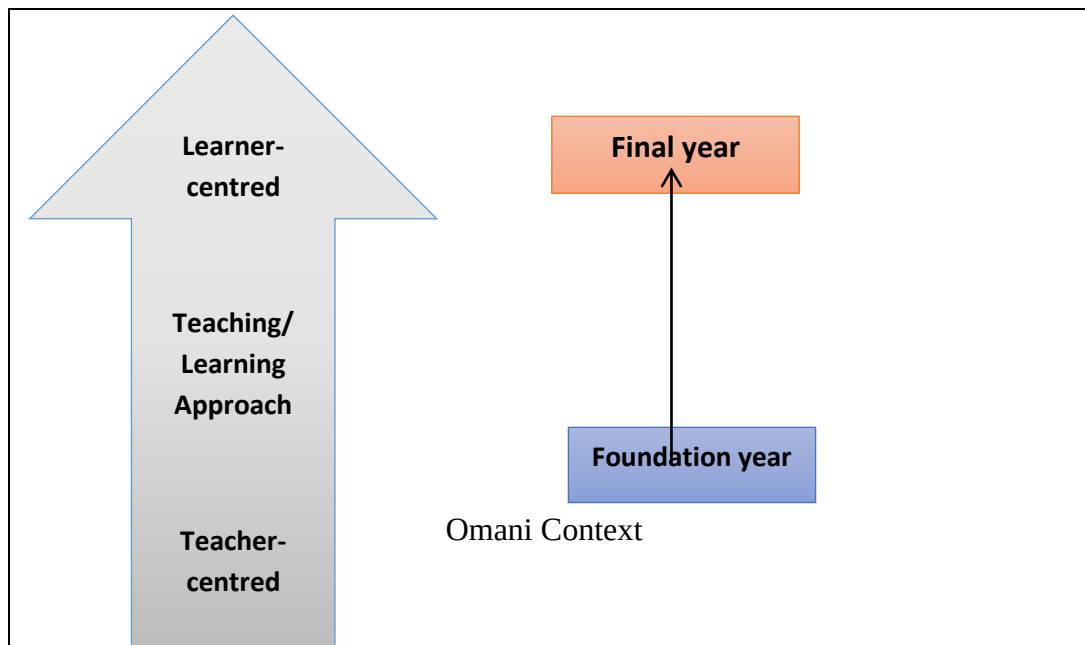
Most of the learning activities for the class are traditionally carried out by the teacher: choosing and organising the content, interpreting, applying the concepts, and evaluating student learning, while the students' efforts are focused on recording the information. Weimer (2002) points out that in the learner-centred approach the roles of teacher and student change. Students are no longer viewed as empty vessels to be filled with knowledge, but as seekers to be guided along their intellectual developmental journey (Weimer, 2002). Therefore, students learn by doing, and so involving them in the learning activities promotes learning.

Similarly, Baxter and Gray (2001) state that to achieve effective learning it is desirable to move toward a model in which students are actively engaged in the

learning process. No longer is the student expected to be a passive absorber of information; instead, the teacher acts as a facilitator and does not need to be an expert in the particular content (Tärnvik, 2007). As Weimer (2002) points out, the responsibility for learning naturally shifts to the student in a learner-centred setting. Neither students nor teachers are proficient at making this shift. However, the duty is on the faculty to redesign and conduct the course in a way that requires students to hold up their end of the educational contract. The faculty should follow through on consequences instead of making adjustments to accommodate students' failure to accomplish agreed upon expectations of the course. According to Weimer (2002), today's students are "unable to function without structure and imposed control", and have "little or no commitment to learning." Their concern is, mainly, to get a good grade, and when this does not occur the blame is placed with the teacher. Accompanying this has been an increase in incivility toward both teachers and peers.

Learner-centred methods of content delivery allow students the opportunity to control their learning, since they require students to take responsibility for their learning by being actively involved in the learning process rather than simply passively receiving information from a lecture (Slunt & Giancarlo, 2004). Kennedy (2009) found that after participation in a debate, positive rating of the experience as an instructional strategy increased from approximately 75% to about 85%, including students who were initially reticent to participate. In the case of Oman, student-centred methods should be incorporated into traditional delivery formats in the foundation year and increasingly used as students' in the nursing programme. This will allow the students to better adapt to this approach which differs from the previous traditional approaches they are used to.

Figure 6.2: Teaching/Learning Approach in the Context of Oman



6.6.4 Active Stakeholder Involvement

To achieve a culturally congruent curriculum in nursing it is essential to involve all stakeholders, such as patients, policy makers, educators, graduates (alumni), and students. The study findings revealed that the public had little understanding of the nursing profession. They were not oriented to nursing education being grounded in a unique body of knowledge or nurses being autonomous professionals with their own scope of practice. The study acknowledged that the MoH did not involve all the stakeholders in the nursing curriculum decision making process and there was lack of transparency at the top levels of the MoH. Also, the nursing curriculum changes were unclear and the courses were moved around; for example, some electives became compulsory courses and vice versa. The findings indicated that community involvement in nursing education would improve the quality of nursing services.

Stakeholder involvement in nursing curriculum planning and design would improve the quality of the nursing education and better meet the healthcare needs of the population. A study by McGarry and Thom (2004) explored the experiences

of user and carer participation in nurse education from the perspective of the key stakeholders involved in the process. The study findings showed that to achieve meaningful involvement of service users and healthcare providers in nurse education is not simply a matter of including them in the process, but requires careful consideration and partnership at every stage of the development process. Simpson (2006) suggested that such involvement should be integral to the strategic direction of nursing education institutes, ensuring that stakeholders are willing and active participants in curriculum planning, development and delivery. However, efforts must be made to ensure fairness and equity of representation. This approach would enable nursing education to reflect the cultural values and beliefs of the local population in the curriculum, as the main purpose of a curriculum is to initiate learners into the cultural heritage of society (Lawton, 1983). Consequently, these new graduate nurses would have sufficient knowledge about the cultural healthcare of the local context. Culturally congruent care can only occur when cultural care values, expressions, or patterns are known and used appropriately (Leininger, 1995a), and stakeholder involvement would deepen the understanding of service users' perspectives.

In conclusion, this model offers an empirically based pragmatic framework for a culturally congruent curriculum discussed above, but contextualises it into a specific environment. Therefore, this model is feasible and appropriate for the Omani culture. Firstly, this model acknowledges the role that the context – in this instance the Omani cultural context – has on the nursing education/ curriculum, which the current curriculum does not do. Secondly, this model illustrates the key elements that the MoH's nursing education is currently lacking in order to maintain competent and safe nursing education/practice. Recently, the quality of higher education in Oman prompted the Sultan to issue in 2010 a Royal Decree (No. 54/2010) to establish the Omani Academic Accreditation Authority (OAAA). The OAAA role is to develop and implement institutional and programme accreditation systems. Therefore, the MoH is currently looking to improve the quality its educational institutes to comply with the new system. On the other hand, a criticism of this model may indicate that this framework is too specific to the nursing

education in Oman; however, the main aim of the study was to develop a culturally congruent nursing education in Oman.

6.7 Overall Conclusion

The Ministry of Health (MoH) in the Sultanate of Oman plays a major role in healthcare education because it is the main employer and producer of healthcare professionals in the country. The MoH's educational programmes are designed to meet the healthcare needs of the country to international standards. As nursing is the main profession that the MoH invests in, produces, and employs, the purpose of this study is to examine the MoH's approaches to nursing education and its cultural congruency in the context of Oman. Therefore, this study sought to answer three research questions:

1. How do the MoH's approaches to the nursing curriculum impact nurse education in the Sultanate of Oman?
2. How culturally congruent are MoH's approaches to nursing education?

The main aims of the study were:

- To review MoH curriculum/educational policy documents to gain insights into nurse education in Oman.
- To examine the impact of MoH curriculum decisions upon the cultural congruency of nurse education.
- To suggest recommendations for curriculum development in Oman in light of the research findings.

A qualitative multiple-case study design was used to answer the research questions. Educational policy documents, semi-structured qualitative individual interviews and focus groups have been used to collect data from the MoH's nursing education decision makers, educators, students and service users (public) over a period of six months. Ritchie and Spencer's (1994) framework analysis consists of five phases/stages: familiarising, identifying a thematic framework, indexing, charting, and mapping and interpretation. The analytical framework was used to analyse the collected data in two phases: within-case and cross-case analyses. The within-case

analysis identified the individual cases themes of how the MoH's approaches to curriculum developments impact nursing education and its cultural congruency in the context of Oman. In contrast, the cross-case analysis provided a broader picture of phenomena through comparing and contrasting the similarities and the differences between the cases. The rigour and trustworthiness in the study was maintained through using triangulation (two data sources), cross-case analysis, and reflexivity.

Using Lawton's cultural analysis model as a framework for the study, the study revealed that MoH's approaches to nursing education were based on creating the manpower to meet its healthcare facilities' needs, which affected the quality of the nursing education. Secondly, the Omanisation policy added pressure to the MoH to graduate as many nurses as possible in order to achieve the national policy projections. Consequently, the MoH nursing curriculum was a discipline-focussed curriculum and hospital oriented. Also, the current nursing curriculum was based on Western values which conflicted with the local cultural values and beliefs. The study revealed that the current nursing curriculum did not emphasise professional ethics to address students' negative attitudes and behaviours. Additionally, the poor image of nursing in Oman has led to the recruitment of non-Omani nursing educators with different cultural values and beliefs, which has as a consequence added to the cultural incongruence of the MoH nursing curriculum. Also, the competency of the current nursing educators' knowledge and clinical skills was questionable. Finally, the study found that stakeholder involvement was limited in the current nursing education. This study also resulted in the development of a model for a culturally congruent nursing education in the context of Oman. The model views the nursing graduates as culturally competent nurses who are able to provide culturally congruent nursing care to their patients and families. A culturally congruent curriculum consists of cultural care content, knowledge based on a degree nursing curriculum, professional ethics, a learner-centred teaching/learning approach, and active stakeholder involvement. These elements cover competency in knowledge, skills, and attitudes. Therefore, firstly, knowledge of the cultural heritage, beliefs, attitudes and behaviours of the local context is essential to develop

cultural competency. Secondly, the education of professional nurses must take place in institutions of higher learning with a bachelor of science in a nursing degree required before beginning professional practice. Thirdly, professional nursing requires a balance between evidence based knowledge, skills, and attitudes and professional confidence, maturity, caring, and compassion. Fourthly, the responsibility for learning should be shifted to the student in a learner-centred setting. Lastly, to achieve a culturally congruent curriculum in nursing it is essential to collaborate with all stakeholders, including clients, policy makers, educators, graduates (alumni), and students.

Conclusion

The findings illustrate that there is a low level of cultural content in the current MoH nursing programme, which has affected the learning of graduates of the programme. Also, the current programme needs to focus on developing student-centered learning rather than the didactic teaching techniques currently practiced. The nursing faculty also needs to critically examine their preparation for implementing current or new strategies for teaching transcultural nursing. This research study showed that cultural knowledge is a critical component of a culturally congruent curriculum. It is important to prepare Omani nurses to care for patients in an increasingly diverse society that demands that their level of cultural nursing knowledge be increased. This increased understanding will enable them to be more effective in providing care that is within the cultural context of individuals, families and communities from diverse cultural backgrounds. However, the researcher acknowledges that although the study has been robust it is not possible to exclude other reasons for the findings such as the culture of nursing in Oman, the hidden curriculum, and the community perceptions of nursing and its effect on nursing education.

6.8 The multiple case study strengths and limitations

6.8.1 Strengths

A case study design is a valuable method of investigating complex issues, particularly context-dependent issues, which generate knowledge appropriate in

social sciences (Flyvbjerg, 2006). This multiple case study strength is based on its originality in exploring the phenomena of how the MoH's approaches to curriculum development impact nurse education and its cultural congruency in the context of Oman. According to Eisenhardt (1989), the multiple-case study approach pursues phenomena bringing together multiple perceptions and experiences from a range of different sources (documents and interviews). Therefore, this study highlighted how the MoH's approaches to curriculum development impact nursing education and its cultural congruency in Oman from multiple perspectives. In addition, the use of purposive sampling in the selecting study participants facilitated comparing and contrasting the findings (cross-case analysis) of the four cases to develop a framework for a culturally congruent nursing curriculum. Lastly, triangulation of data (document analysis, and semi-structured interviews) in the context of this multiple case study provided differing data sources to satisfy verification of the findings (Patton, 1990).

6.8.2. Limitations

There are many criticisms of case studies regarding generalisability, credibility, and confirmability of data (Flyvbjerg 2006). This refers to the view that case study findings are irrelevant to other contexts. In this study, the following limitations have been encountered:

Primarily, this study was conducted in the context of Oman, which limits the generalisability of the findings of the study. However, generalisability was never intended, as the study aims indicated.

Secondly, the nature of political office may have influenced the statements of the MoH nursing administrators in not presenting opposing viewpoints to MoH policies. Also, non-Omani participants may have been cautious of making negative statements against MoH policies and policy makers. In addition, the focus group participants may have been reluctant to make statements that were too negative or critical of the MoH as an organisation, due to their potential impact on the dynamics of the group.

Finally, time and resource restrictions impacted this study, particularly regarding the number of participants recruited, which may have presented or contributed different viewpoints and insights to the phenomena.

6.9 Recommendations

This study has revealed that the MoH's approaches to nursing education need to emphasise cultural congruency to enable the graduate nurse to better serve Omani society. Based on this, a number of recommendations can be made so as to improve practice in this area.

1. Cultural care or transcultural education must be included in the nursing undergraduate curriculum to develop culturally competent graduates (Chapter 4 & 5). This will equip the students with:
 - A wide range of cultural diversity.
 - Knowledge of cultural differences and similarities and knowledge of patient culture.
 - Knowledge of one's own cultural values and identity.
 - Communicate effectively across cultural groups.
 - Use of knowledge to adapt services and skills.
 - Develop lifelong learning and reflection that includes examination of attitudes and values of cultural groups.
2. Upgrade the current nursing programme to a baccalaureate degree programme (Chapters 4 & 5) to prepare nurses to:
 - Provide a holistic, caring framework with evidence based research.
 - Use critical thinking to address simple to complex situations.
 - Practice in a variety of healthcare settings.
 - Reflect on one's own beliefs and values as they relate to professional practice.
3. Apply a learner-centred approach in nursing education (Chapter 4 & 5).
 - Provide educational resources to support the learner-centred approach.

- Allow the student some independence by giving more guidance at the beginning of the placement (foundation year), then stand back and let the student show initiative and self-motivation as they progress to the final year.
 - Less emphasis on grades and more encouragement to become competent in knowledge, skills and attitudes.
4. Stakeholder involvement in nursing education (Chapters 4 & 5).
- Collaborate with all stakeholders, including service users, policy makers, educators, graduates (alumni), and students.
 - Multiple and diverse approaches to seeking and using feedback should be developed.
5. Recommendations for future research:
- Study the benefits of including transcultural care course into the nursing programme
 - Explore different teaching/learning approaches to training nursing students and faculty in cultural competency.

In conclusion, the study findings have certain implications for the MoH nursing curriculum, teaching/learning methods, and nursing educators' professional development, in order to combat the cultural incongruence of the current nursing curriculum. The recommendations are aimed at improving nursing education in two key ways; first, by developing a curriculum that facilitates students' competency in nursing knowledge and skills, enabling them to make judgments and decisions about nursing care issues in a multicultural world; and second, by revising the current curriculum and textbooks in order to reflect the values and traditions of Omani culture, nursing education would better fit its purpose. As a result, this will reduce negative attitudes and behaviour which are based on bias and misconceptions of the nursing profession. Overall, these actions will improve the quality of nurse education and enhance the graduates' competency in knowledge, skills and attitudes to better serve the local context.

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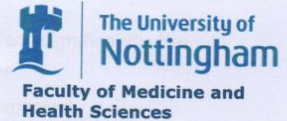
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Appendixes

Appendix A

Direct line/e-mail
+44 (0) 115 8231063
Louise.Sabir@nottingham.ac.uk



18th October 2011

Ms Suad M Al Junaibi
Nursing Tutor
Oman Nursing Institute
Directorate General of Education & Training
Ministry of Health
Sultanate of Oman

Medical School Research Ethics
Committee
Division of Therapeutics &
Molecular Medicine
D Floor, South Block
Queen's Medical Centre
Nottingham
NG7 2UH

Tel: +44 (0) 115 8231063
Fax: +44 (0) 115 8231059

Dear Ms Junaibi

Ethics Reference No: SNMP24052011 –please quote on all correspondence

Study Title: A Critical Evaluation of the Current Nursing Curriculum Cultural Congruency to the Omani Population Health Needs.

Student Researcher: Ms Suad M Al Junaibi, PhD Student, School of Nursing Physiotherapy and Midwifery, University of Nottingham.

Supervisors: Dr Aru Narayanasamy, Associate Professor & Dr Derek Chambers, Associate Professor School of Nursing, Midwifery and Physiotherapy.

Duration of Study: 1/10/2011 – 31/01/2012

Thank you for your application dated 24th May 2011 and the following documents were considered:

- Application form dated 5/24/2011
- Information sheet version 1 dated 24/05/2011
- Revised information sheet version 1 dated 18/10/2011
- Volunteer Consent Form dated 25/05/2011
- Hierarchical Focusing Interview Method 24/05/2011

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below are followed.

Conditions of Approval

You must follow the protocol agreed and any changes to the protocol will require prior Ethics' Committee approval.

This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review.

You promptly inform the Chairman of the Research Ethics Committee of

- (i) Deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subjects.

- (ii) Any changes that increase the risk to subjects and/or affect significantly the conduct of the research.
- (iii) All adverse drug reactions that are both serious and unexpected.
- (iv) New information that may affect adversely the safety of the subjects or the conduct of the study.
- (v) The attached End of Project Progress Report is completed and returned when the study has finished.

Yours sincerely

Dr Clodagh Dugdale
Chair, Nottingham University Medical School Research Ethics Committee

Appendix B

<i>Sultanate of Oman</i> <i>Ministry of Health</i> <i>Directorate General of Planning</i> <i>Directorate of Research & Studies</i>		سِلْطَنَة عُومَان وَزَارَة الصِّحَّة الْمَدِيرِيَّة الْعَامَّة لِلتَّحْطِيط وَالْبَحْث وَالرَّسَالَة
Ref. : MH/DGP/R&S/PROPOSAL_ APPROVED/13/2011		الرقم :
Date : 27.12.2011		التاريخ :
To, Suad Mossa Al Junaibi - Principal Investigator, " A Critical Evaluation of the MOH's Governance of Curriculum Development & Its Impact on Nurse Education in the Cultural Context of Oman "		الموافق :
After compliments.		
We are pleased to inform you that your research proposal " A Critical Evaluation of the MOH's Governance of Curriculum Development & Its Impact on Nurse Education in the Cultural Context of Oman " has been approved by Research and Ethical Review & Approve Committee, MOH.		
Regards,		
		
Dr. Ahmed Al Qasmi Director General Of Planning, Chairman, Research and Ethical Review & Approve Committee MOH, Muscat, Sultanate of Oman.		
Cc Day file		

P.O. Box : 393, Postal Code : 100, Muscat E-mail : research-cord@moh.gov.om ص.ب: ٣٩٣ - الرمز البريدي: ١٠٠ - مسقط
Tel. : (968) 24697551 - Fax : (968) 24696702 هاتف: ٢٤٦٩٧٥٥١ (٩٦٨) - فاكس: ٢٤٦٩٦٧٠٢ (٩٦٨)

UNIVERSITY OF NOTTINGHAM MEDICAL SCHOOL ETHICS COMMITTEE

Information sheet for Normal Healthy Volunteers

The guidance which follows applies primarily to multi-centre pharmaceutical studies and encompasses the ICH Good Clinical Practice guidelines. However, the principles and much of the content will be of use to researchers writing information sheets in their particular fields, for trials involving normal healthy volunteers. You will find it helpful to refer also to other guidelines produced for writing patient information sheets (The Association of the British Pharmaceutical Industry: Guidelines for Medical experiments in Non-patient Human Volunteers March 1988).

Potential recruits to your research study must be given sufficient information to allow them to decide whether or not they want to take part. An Information Sheet should contain information under the headings given below where appropriate, and in the order specified. It should be written in simple, non-technical terms and be easily understood by a lay person. Use short words, sentences and paragraphs.

Use headed paper of the institution/research unit where the research is being carried out. Please use the format laid out below. Un-headed paper is not acceptable.

Address of Unit

B Floor
South Block Link
Queen's Medical Centre
Nottingham
NG7 2HA

Title of Project:

A Case Study of the Omani Ministry of Health's Approaches to Nursing Education and its Cultural Congruency

Name of Investigators: Ms Suad M. Al Junaibi

Healthy Volunteer's Information Sheet

Invitation paragraph

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with colleagues if you wish to. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. If you decide to take part you may keep this leaflet. Thank you for reading this.

Background

Curricula have been used as means of social, economic, cultural control and development. It is also as a mechanism for the reproduction and generation of norms and ideologies. There is an extensive literature focusing on the influence of social, economic and political factors on the curriculum (Apple, 1993; Cooper, 1984; Goodson, 1988; Ball, 1990). The tendencies and orientations of curricula manifest the dynamics of their time (Lawton, 1983). The curriculum's philosophy, aims, processes, and the selection of knowledge is an expression of an educational policy, and is directly interlinked with the state, the political and normative composition of the educational system. According to Apple (1993), it is a part of a selective practice, someone's selection, and someone's vision of legitimate knowledge. It is produced out of the cultural, political, and economic conflicts, and compromises. Therefore, it is not a neutral assemblage of knowledge, appearing in the texts and classrooms of a country (Apple, 1993). The Ministry of Health (MoH) in the Sultanate of Oman has been the chief graduator and employer of health professionals in the country. Since; nursing is the main profession that MoH

invests in; the purpose of this study is to explore how the MoH nursing curriculum governance maintains congruency with the Omani culture. Also, describe how the current MoH approaches to curriculum development impacts on nurse education in the cultural context of Oman. Qualitative case study design will be used to answer the research question. Educational policy documents and semi-structured qualitative interviews using a hierarchical focusing method will be used to collect data from the MoH's nursing education decision makers over a period of four to six months in the Sultanate of Oman. Discourse analysis will be used to analyse the data collected from the documents and interviews. A purposeful sampling will be used to select study participants from the MoH nursing education decision makers. Implications of the study are to suggest recommendations for curriculum development in Oman in the light of the research findings.

What does the study involve?

The volunteer will be part of the MoH curriculum development decision makers regarding nursing education in the Sultanate of Oman. He/she will be interviewed for about 30 to 45 minutes and will be tape recorded. The researcher will use an interview protocol sheet to guide the interviewees through the questions and take notes about them. The interviewees' responsibilities are to answer the questions in their own words. The length of time for the data collection will be four to five months.

Why have you been chosen?

You were chosen because you are a staff/faculty under MOH and your work is relates to nursing education. There will be other staff/faculty that will be interviewed in the study at the same time.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

You will be asked to be interviewed regarding the nursing curriculum development in the Sultanate of Oman in 30-40 minutes interview. Your input regarding this topic will be appreciated.

What if something goes wrong? /Who can I complain to?

In case you have a complaint on your treatment by a member of staff or anything to do with the study, you can initially approach the lead investigator. If this achieves no satisfactory outcome, you should then contact the Ethics Committee Secretary, Mrs Louise Sabir, Division of Therapeutics and Molecular Medicine, D Floor, South Block, Queen's Medical Centre, Nottingham, NG7 2UH. Telephone: +44 (0)115 8231063. E-mail louise.sabir@nottingham.ac.uk."

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results of the study might be published in nursing journals and the data will be used mainly for the purpose of PhD thesis. Your name in the study will not be identified in any report/publication.

Who has reviewed the study?

This study has been reviewed and approved by the University of Nottingham Medical School Ethics Committee.

Contact for Further Information

Ms Suad M. Al Junaibi
PhD Student, Division of Nursing
B Floor
South Block Link
Queen's Medical Centre
Nottingham
NG7 2HA
Tel: (UK) + 44 (0)7984704924, (Oman) +968 99455354
Email: ntxsma@nottingham.ac.uk

Appendix D

**University of Nottingham,
School of School of Nursing, Midwifery &
Physiotherapy, Division of Nursing**



Title of Project: A Case Study of the Omani Ministry of Health's Approaches to Nursing Education and its Cultural Congruency

Name of Investigator: Ms Suad Al Junaibi

Healthy Volunteer's Consent Form

Please read this form and sign it once the above named or their designated representative, has explained fully the aims and procedures of the study to you

- I voluntarily agree to take part in this study.
- I confirm that I have been given a full explanation by the above named and that I have read and understand the information sheet given to me which is attached.
- I have been given the opportunity to ask questions and discuss the study with one of the above investigators or their deputies on all aspects of the study and have understood the advice and information given as a result.
- I agree to the above investigators contacting my general practitioner [and teaching or university authority if appropriate] to make known my participation in the study where relevant.
- I authorise the investigators to disclose the results of my participation in the study but not my name.
- I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 7 years after the results of this study have been published.
- I understand that I can ask for further instructions or explanations at any time.
- I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing.

Name:

Address:

Telephone number:

Signature: **Date:**

I confirm that I have fully explained the purpose of the study and what is involved to:

.....

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: **Date:**

Investigators Name:

Study Volunteer Number:

Appendix E

(Form 5.3)

سلطنة عمان
وزارة الصحة – دائرة الدراسات والبحوث
لجنة مراجعة و اجازة البحوث من الناحيتين العلمية و الأخلاقية

نموذج استمارة موافقة المبحوث على المشاركة في البحث Certificate of Informed Consent

أقر أنا /
الإقامة: النوع: السن:
بأنني اطلعت على بيان مفصل عن البحث المقدم من الطبيب/الباحث Suad Al Junaibi

بقسم مستشفى/دائرة/معهد Omani Nursing Institute
الذي يهدف إلى دراسة : -

- To review MoH curriculum/educational policy documents to gain insights into nurse education in Oman.
- To examine the impact of MoH curriculum decisions upon cultural congruency of nurse education.
- To suggest recommendations for curriculum development in Oman in the light of the research findings.

و على خطوات البحث وهي :-

- Individual face to face semi-structured interview
- Tape recorded
- Duration 30-45 minutes

وأنه قد تم اطلاعي على احتمالات المتاعب التي قد يرد حدوثها من الدراسة وأنه سوف لا يترتب على عدم موافقتي على الاشتراك في البحث حجب أي خدمة طبية عني..

لقد قرأت المعلومات السابقة أو قرأت علي وكانت لي الفرصة للسؤال عما أريد وأجيببت جميعها وأنا مقتنع بذلك. والمعلومات التي تم الحصول عليها مني تعتبر سرية ولن تستخدم لغير أغراض البحث. أوافق بكامل اختياري على المشاركة في هذه الدراسة وأفهم أنه من حقي التوقف عن المشاركة فيها في أي وقت لاحق دون أن يؤثر ذلك على الخدمة الطبية المقدمة لي .

اسم المشارك :
العنوان :
الهاتف :
التوقيع :
التاريخ :/...../.....

اسم الشخص الذي حصل على موافقة المبحوث: Suad Moosa Al Junaibi

وظيفته: Nursing Tutor

* وعند عدم اكتمال أهلية المشارك يوقع ولي أمره وذلك لغير البالغين والفاقدين للوعي أو التمييز .

Appendix F

Interview Guide (in English)

Semi-structured Interview Questions

1. As you see it, what is the current status of nursing education?
 - What about nursing education in the Sultanate of Oman?
 - What does nursing education involve?
 1. Would you say it involves political forces?
 - What do political forces involve?
 2. Would you say socio-economic context?
 - What does socio-economic context involve?
 3. Would you say cultural context?
 - What does cultural context involves?
 4. Would you say technological innovations?
 - What does technological innovations involves?
2. In what ways is nursing curriculum provision developed?
 - How does it affect nursing education?
 - What is/are the effects of these provisions on nursing curriculum?
3. From your view point, how do members of the profession wish nursing to develop?
 - In the Sultanate of Oman
4. In your view, what kind of values and principles will be involved in deciding on how nursing should develop?
 - What part these play in the nursing profession development:
 - The Global/international standards
 - Omani culture (values and beliefs)
5. Can you elaborate on how future nursing should be prepared for their role?
 - How the future nursing on meeting the Omani population health needs?
 - What is expected of nursing education in Oman?

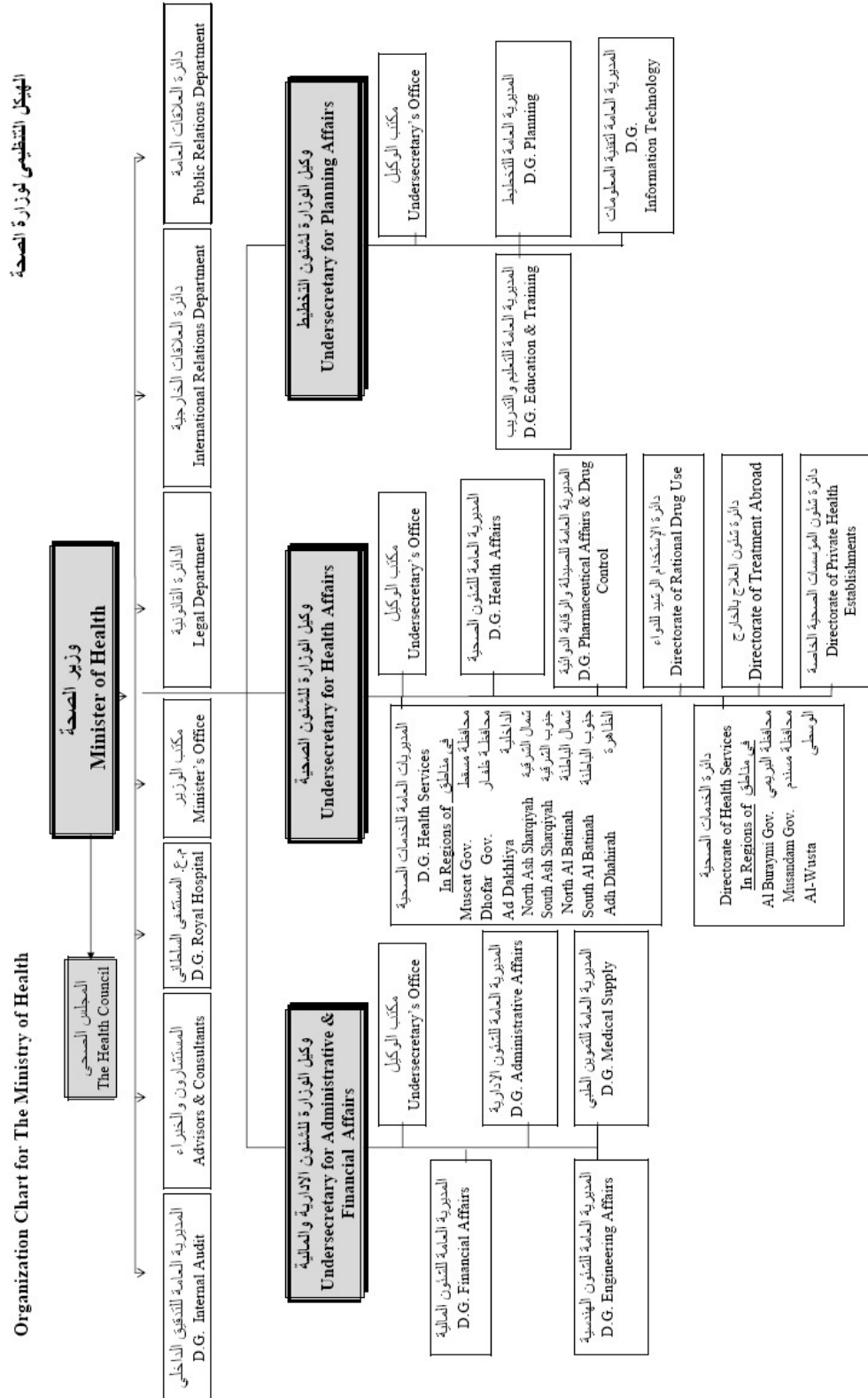
Appendix G

Interview Guide (in Arabic)

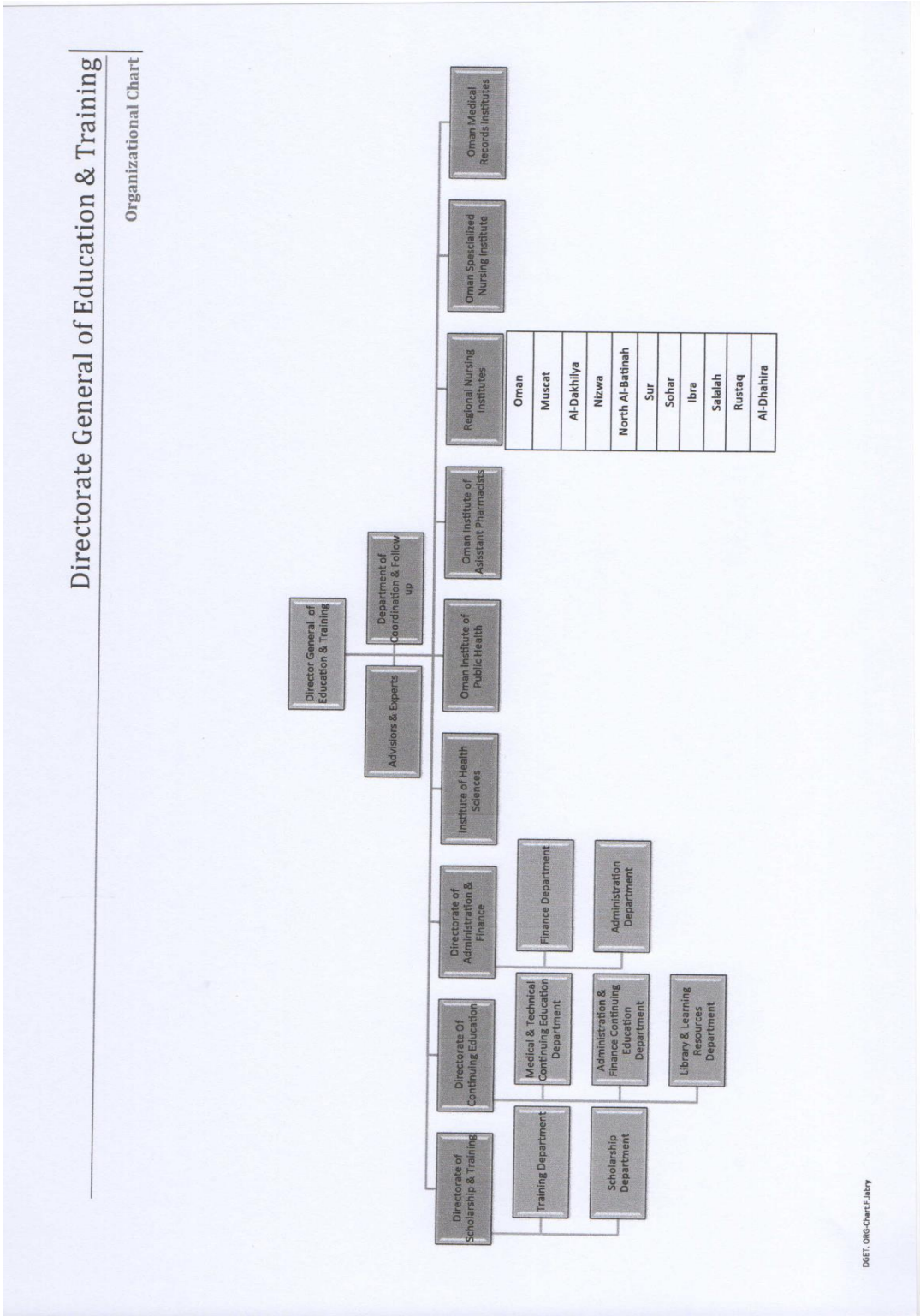
أسئلة المقابلة شبه المنظمة

1. كما تراه، ما هو الوضع الحالي لتعليم التمريض في سلطنة عمان؟
2. ما هو تأثير العوامل التالية على تعليم التمريض؟
 - القوى السياسية (الخطط الخمسية لوزارة الصحة، السياسة العامة للبلاد “التعمين”)
 - السياق الاجتماعي والاقتصادي
 - السياق الثقافي المحلي
 - الابتكارات التكنولوجية
3. كيف يتم تحديث مناهج الدراسية للتمريض؟
 - وما هي الآثار المترتبة من تحديث المناهج الدراسية للتمريض؟
4. من وجهة نظرك، كيف ترغب أعضاء مهنة التمريض في تطوير تعليم التمريض؟
 - في سلطنة عمان
5. في رأيك، ما هي القيم والمبادئ التي ينبغي أن تشارك في اتخاذ القرار بشأن كيفية تطوير تعليم التمريض؟
6. من وجهة نظرك، ما الذي يجب أن يلعب دوراً هاماً في تطوير مهنة التمريض؟
 - المعايير العالمية / الدولية
 - الثقافة العمانية (القيم والمعتقدات)
7. في رأيك، كيف ينبغي أن تكون مهنة التمريض مستعدة لدورها في المستقبل؟
 - تلبية الاحتياجات الصحية للسكان العماني
 - وما المتوقع من تعليم التمريض في سلطنة عمان؟

Appendix H: MoH Organisational Chart



Appendix I: DGET Organisation Chart



Appendix J: Curriculum Structure

Foundation Year Cohort A/Y 2011-2012 (GNP Cohort A/Y 2012-2013)

Year One - Semester One (15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Anatomy & Physiology I	4	0	0	4	60	0	0	60
2	Biochemistry	3	0	0	3	45	0	0	45
3	Communication skills	2	0	0	2	30	0	0	30
4	Islamic Culture	2	0	0	2	30	0	0	30
5	English for Health Professions	2	0	0	2	90	0	0	90
	Total	13	0	0	13	255	0	0	255

Semester Two (15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Anatomy & Physiology II	4	0	0	4	60	0	0	60
2	Microbiology & Parasitology	3	0	0	3	45	0	0	45
3	Fundamentals of Nursing I (Th)	2	2	0	4	30	60	0	90
4	Fundamentals of Nursing I (Practice)	0	0	2	2	0	0	90	90
5	Elective	2	0	0	2	30	0	0	30
	Total	11	2	2	15	165	60	90	315

Summer Session 6 Weeks

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Fundamentals of Nursing II (Th)	2	2	0	4	30	60	0	90
2	Fundamentals of Nursing II (Practice)	0	0	2	2	0	0	90	90
	Total	2	2	2	6	30	60	90	180

Total # of credit hours of year I (34)

Year Two - Semester One
(15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Adult Health I	3	1	0	4	45	30	0	75
2	Adult Health I (Practice)	0	0	4	4	0	0	180	180
3	Pharmacology	3	0	0	3	45	0	0	45
4	Nutrition	2	0	0	2	30	0	0	30
	Total	8	1	4	13	120	30	180	330

Semester Two
(15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Adult Health II	3	1	0	4	45	30	0	75
2	Adult Health II (Practicum)	0	0	4	4	0	0	180	180
3	Professional Ethics	3	0	0	3	45	0	0	45
4	Psychosocial	2	0	0	2	30	0	0	30
	Total	8	1	4	13	120	30	180	330

Summer Session
6 Weeks

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Mental Health	3	0	0	3	45	0	0	45
2	Mental Health (Practice)	0	0	3	3	0	0	135	135
	Total	3	0	3	6	45	0	135	180

Total # of credit hours of year II (32)

Year Three - Semester One
(15 Weeks)

Sr #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Maternal Health Nursing	3	1	0	4	45	30	0	75
2	Maternal Health Nursing (Practicum)	0	0	4	4	0	0	180	180
3	Introduction to Research	3	0	0	3	45	0	0	45
4	Elective	2	0	0	2	30	0	0	30
	Total	8	1	4	13	120	30	180	330

Semester Two
(15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Community Health Nursing	3	0	0	3	45	0	0	45
2	Community Health Nursing (Practicum)	0	0	3	3	0	0	135	135
3	Child Health Nursing	3	1	0	4	45	30	0	75
4	Child Health Nursing (Practice)	0	0	4	4	0	0	180	180
	Total	6	1	7	14	90	30	315	435

Summer Session
6 Weeks

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Comprehensive Clinical Practicum	0	0	3	3	0	0	135	135
2	Introduction to Leadership & Management	2	0	0	2	30	0	0	30
	Total	2	0	3	5	30	0	135	165

Total # of credit hours of year III (32)

1 Credit Hour of Theory	= 15 hours
1 Credit Hour of Laboratory	= 30 hours
1 Credit Hour of Clinical	= 45 hours
1 Credit Hour of English	= 45 hours

Total Number of credits for the diploma (98)

Cohort 2010/2011 - GG 2013

Year One - Semester One (15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	English I / English II	3	0	0	3	135	0	0	135
2	Study Skills	3	0	0	3	135	0	0	135
3	Information Technology	0	2	0	2	0	60	0	60
4	Mathematics	2	0	0	2	30	0	0	30
5	Introduction to Health	3	0	0	3	45	0	0	45
	Total	11	2	0	13	345	60	0	405

Semester Two (15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Anatomy & Physiology I	3	0	0	3	45	0	0	45
2	Microbiology & Parasitology	3	0	0	3	45	0	0	45
3	Fundamentals of Nursing (Th)	2	2	0	4	30	60	0	90
4	Fundamentals of Nursing (Practice)	0	0	2	2	0	0	90	90
5	English II	3	0	0	3	135	0	0	135
	Total	11	2	2	15	255	60	90	405

Summer Session 6 Weeks

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Anatomy & Physiology II	3	0	0	3	45	0	0	45
2	Biochemistry	2	0	0	2	30	0	0	30
3	Elective	2	0	0	2	30	0	0	30
	Total	7	0	0	7	105	0	0	105

Total # of credit hours of year I (35)

Year Two - Semester One
(15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Adult Health I	3	1	0	4	45	30	0	75
2	Adult Health I (Practice)	0	0	4	4	0	0	180	180
3	Pharmacology	3	0	0	3	45	0	0	45
4	Nutrition	2	0	0	2	30	0	0	30
	Total	8	1	4	13	120	30	180	330

Semester Two
(15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Adult Health II	3	1	0	4	45	30	0	75
2	Adult Health II (Practicum)	0	0	4	4	0	0	180	180
3	English III	2	0	0	2	90	0	0	90
4	Elective (Professional Nursing Ethics)	2	0	0	2	30	0	0	30
	Total	7	1	4	12	165	30	180	375

Summer Session
6 Weeks

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Mental Health	3	0	0	3	35	0	0	45
2	Mental Health (Practice)	0	0	3	3	0	0	135	135
	Total	3	0	3	6	45	0	135	180

Total # of credit hours of year II (31)

Cohort 2010/2011 – GG 2013

Year Three - Semester One (15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Maternal Health Nursing	3	1	0	4	45	30	0	75
2	Maternal Health Nursing (Practicum)	0	0	4	4	0	0	180	180
3	Introduction to Research	3	0	0	3	45	0	0	45
4	Psychosocial	2	0	0	2	30	0	0	30
	Total	8	1	4	13	120	30	180	330

Year Three - Semester Two (15 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Community Health Nursing	3	0	0	3	45	0	0	45
2	Community Health Nursing (Practicum)	0	0	3	3	0	0	135	135
3	Child Health Nursing	3	1	0	4	45	30	0	75
4	Child Health Nursing (Practicum)	0	0	4	4	0	0	180	180
	Total	6	1	7	14	90	30	315	435

Year Three – Summer Session (6 Weeks)

Sr. #	Course Title	Credit Hours				Actual Teaching Hours			
		Theo	Lab	Clin	Total	Theo	Lab	Clin	Total
1	Comprehensive Clinical Practicum	0	0	3	3	0	0	135	135
2	Introduction to Leadership & Management	2	0	0	2	30	0	0	30
	Total	2	0	3	5	30	0	135	165

Appendix K: Document record guideline

Producer of documents	Type of document	Criteria for collected data from documents
Ministry of Health	• The MoH five-year plan • The MoH mission/ vision/objectives • Organisational chart • Educational Institutes Catalogue • Annual health report 2012	All documents will be examined in relation to: 1. Contents that have the word of MoH nursing institutes/ education. 2. Contents that show references to nurse education or training under MoH. 3. Contents that show decision related to MoH general nursing programme/ curriculum.
DGET	• DGET mission/vision/ objectives • Organisational chart • The nursing programme structure • Curriculum competences • Foundation programme objectives • The student handbook	
ONMC	Omani midwifery and nursing council codes of ethics	
Oman Academic Accreditation Authority	Report of an Audit of the Ministry of Health Educational Institutes (2013)	

Appendix L: Matrix table of two data sets from Case 1-4

Codes across the data sets	Documents	Semi-structured interviews			
		Individual		Focus Groups	
		Nursing Administrators	Nursing Educators	Nursing Students	Service Users
1. MoH Approach to Nursing Education • Omanisation of nursing	• Ministry of Health's education programmes are designed to meet the health care needs of the country at international standards	• The country needs locals to meet the healthcare of their community. • Established nursing institutes. • They know the language & the culture	• The country needs locals to fill the healthcare facilities need. • They know the language & the culture	• The country needs locals to care for their own community. ✓ They know the language ✓ They know the culture	• The country needs locals to care for their own community. ✓ They know the language ✓ They know the culture
	• Raising community acceptance	• Establishing 12 nursing institutes in the capital and regions. • Guaranteed employment upon graduation • 20% of admissions reserved for male students • Male students are exempted from doing the obs/gyn clinical & using female wards for clinical practice.	• Guaranteed employment upon graduation • Move the nursing education closer to students' home • Provide free education to all the nursing students (free uniform, books, transportation etc. • Attracted students who were not interested in nursing as a profession.	• Guaranteed employment upon graduation • The community is still resistant to nursing despite the change. ✓ Hard job ✓ Long hours ✓ Interferes with family life ✓ Mix environment	• Guaranteed employment upon graduation • Attracted students who were not interested in nursing as a profession. • Limited opportunities for new secondary school graduates.

Admission criteria	- MoH nursing education is offered to Omanis only. - Age 16-25 years - Recent graduate with a secondary school diploma of the current year.	- Nursing is not their first choice - Increase the student intake by lowering the admission grades - Low achievers need more time - Admitted students not interested in nursing	- Increase the student intake by lowering the admission grades - Low achievers need more time - Admitted students not interested in nursing	- Nursing is not their first choice - Admitted students not interested in nursing	- Nursing is not their first choice - Admitted students not interested in nursing.
Nursing shortage	40.5 nurses per 10,000 of total population - Total population = 3,519,000 - Total nurses in Oman = 14,238	- Shortage in the healthcare professional particularly nurses - Pressure to Graduate - Life style changes increased healthcare needs	- Shortage in the healthcare professional particularly nurses - Increased healthcare needs of the population - Pressure to Graduate	- Shortage in the healthcare professional particularly nurses - Pressure to Graduate	Shortage in the healthcare professional particularly nurses
2. Nursing Education under MoH Governance					
Student Nurse preparation	- Student-centred learning - Library - Laboratories	- No critical thinking - Lack of appropriate teaching/learning facilities e.g. libraries, laboratories - Limited funds /budget available to run the nursing institutes	- No critical thinking - No room for innovation - Lack of appropriate teaching/learning facilities e.g. libraries, laboratories - Limited funds /budget available to run the nursing institutes	- No critical thinking - No room for innovation - Lack of appropriate teaching/learning facilities e.g. libraries, laboratories	No critical thinking
Institutionalised training	Ministry of Health aims to train a diploma level	Training students to work in hospital facilities	Training students to work in hospital facilities	Training students to work in hospital facilities	Training students to work in hospital facilities

	indigenous nurse who will deliver a high standard of nursing care to patients in hospitals and other health care facilities and to people in the community.	• Dependant of doctors' orders	• Dependant of doctors' orders	• Dependant of doctors' orders	• Dependant of doctors' orders
• Educators' competency ✓ Faculty selection ✓ Knowledge ✓ Skills ✓ Continuing education	• Omanising the nursing faculty (trained abroad) • Well qualified nursing multicultural faculty • Continuing education programmes & workshops	• Knowledge & skills are not updated. • Some Omani faculty did not have the qualified training to teach. • Omani faculty are sent abroad for further studies.	• Knowledge & skills are not updated. • Spoon-feeding teaching style • Some Omani faculty did not have qualified training to teach. • Limited clinical allocations • Limited clinical experience esp. in the regions	• Knowledge & skills are not updated. • Some faculty are qualified training to teach. • Focused on passing the exams • Limited clinical experience	• Dependant of doctors' orders
• Graduates competency ✓ Knowledge ✓ Skills ✓ Attitudes	• Provide learning opportunities, technical resources of the highest order • Informed faculty • High standard education & training in a conducive environment for learners	• Limited clinical experience due to limited allocations. • Loaded programme • Limited guidance or mentorship • Limited training time • The programme duration is too short • Our students' attitudes are a problem.	• Limited clinical experience • Loaded programme • Limited guidance or mentorship • Limited training time • The programme duration is too short • Graduates' attitudes are a problem. • No courses on local	• Limited clinical experience. • Limited guidance or mentorship • Limited training time • The programme duration is too short • Graduates' attitudes are a problem. • Need to learn local	

		- problem. - Limited emphasis on cultural values but we still need to improve - We need to emphasise on the code of ethic - Using English is not a problem. - Students expect teacher centred teaching style	cultural values or customs - We need to expand the ethic course - Using English is a barrier to learning. - Students expect teacher centred	cultural values or customs - The ethic course was too short. - Using English is a barrier to learning.	cultural values or customs - They need to have ethics course - Using English is a barrier to learning.
Stakeholders participation - E.g. ✓ Community ✓ Nursing service ✓ Educators ✓ Students ✓ Graduates	Formulate committees or taskforces to address identified curriculum needs.	- We do not involve all the stakeholders. - We started to involve the students, educators and graduates. - We in the process of surveying the public. - To improve, we need to involve all the stakeholders.	- Decision makers are not involved in teaching - Teachers are not involve in making decisions, we only implement - Top-down management & communication is a problem - They do not involve all the stakeholders. - To improve, we need to involve all the stakeholders.	- They started to asks us but we still not involved in the decisions making process - Continuous changes - They do not involve all the stakeholders. - To improve, they need to involve all the stakeholders.	- We do not know anything about nursing education - They do not involve all the stakeholders. - To improve, they need to involve all the stakeholders.