

**NURSE EDUCATION IN CAMEROON: A GROUNDED
ANALYSIS ON SEIZING THE OPPORTUNITY OF THE MOMENT**

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The Power of Knowledge

The tortoise is a small and slow animal. But as shown traditional Cameroon 'fire-side' stories it is a very intelligent animal. In one of these stories, the tortoise challenged the hippopotamus to a tug of war to demonstrate his physical strength. The hippo accepted the challenge and a date was set. The tortoise equally went and challenged the mighty elephant and set a battle on the same day and time as with the hippo. On the set day the tortoise walked to one end of the forest and handed over the end of the rope to the elephant and asked him to start pulling immediately he feels a tug in the rope. He then walked to the opposite end of the forest and did the same with the hippo. The wise tortoise now walked to the middle of the forest and tugged on the rope and the two big animals started pulling. They went on and on for the entire day until failing to win both collapsed at their different ends of the forests. The tortoise now went over to each animal and claimed his victory. All the other animals (gathered at both the elephant and hippo's end) were amazed that the tortoise still looked fresh and energetic after the long battle As he walked home he said "knowledge is power".

DEDICATION

I dedicate this thesis to the unsung heroes of Cameroon's Nursing.

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TABLE OF CONTENTS

DEDICATION	i
ACKNOWLEDGMENTS.....	ii
TABLE OF CONTENTS	iii
SUMMARY	vii
CHAPTER ONE	1
OVERVIEW AND CONTEXT	1
1.0 Introduction	1
1.1 Brief Historical and Political Context	2
1.2 The Cultural and Historical Context of Nursing	3
1.3 Philosophical Basis of Nursing in Cameroon.....	4
1.4 Brief History of Nurse Education.....	6
1.5 Nursing in Cameroon as a Profession	7
1.5.1 <i>The social position of Nursing</i>	9
1.5.2 <i>Regulation of Nursing</i>	10
1.5.3 <i>Educational structure</i>	12
1.5.4 <i>Growth and advancement</i>	14
1.6 The Problem	17
1.7 Research Aim:	19
1.7.1 <i>Research questions</i>	19
1.7.2 <i>Research objectives</i>	21
1.8 Significance of the Study	21
1.9 Operational Definition of Terms	21
1.9.1 <i>Education</i>	21
1.9.2 <i>Professionalization</i>	22
1.10 Conclusion to Chapter.....	23
CHAPTER TWO	24
NURSE EDUCATION DEVELOPMENT: HISTORICAL ORIGINS TO CONTEMPORARY POSITIONS	24
2.0 Introduction to Chapter	24
2.1 Literature Review in Grounded Theory	24
2.2 Nurse Education Development and Evolution	28

2.2.1 A snapshot historical review	28
2.2.2 Trends to note.....	37
2.3 Contemporary Issues in Nurse Education	39
2.3.1 Variations in education policy	39
2.3.2 Access to further education	42
2.3.3 Nursing leadership and power	45
2.3.4 Globalisation and the internationalisation of nursing education	49
2.3.5 Nurse education in higher education	52
2.3.6 Social issues and a whiff of agitation in Cameroon	55
2.4 Conclusion to Chapter.....	57
CHAPTER THREE.....	58
RESEARCH METHOD.....	58
3.0 Introduction to Chapter	58
3.1 The Position of the Researcher.....	58
3.1.1 Ontological and epistemological position.....	58
3.1.2 Researcher reflexivity.....	59
3.2 Method	61
3.2.1 Grounded theory	61
3.2.2 Setting.....	64
3.2.3 Subjects and sampling	65
3.2.4 Data collection and interpretation.....	68
3.2.5 Measures to ensure trustworthiness	76
3.2.6 Ethical Consideration	79
3.3 Conclusion to Chapter.....	86
CHAPTER FOUR.....	87
INTERACTING FACTORS INFLUENCING THE EVOLUTION OF NURSE EDUCATION IN CAMEROON.....	87
4.0 Introduction.....	87
4.1 Nurse Education Policy Decisions from Document Analysis.....	87
4.1.1 Role of physicians and non-nurses.....	87
4.1.2 Role of the nurse.....	88
4.1.3 The status of the nurse.....	90
4.1.4 Education structure	90
4.1.5 Policy making process.....	95

4.1.6 Summary.....	96
4.2 Analysis of Interviews.....	97
4.2.1 Constructing Category One	97
4.2.2 Constructing Category Two	103
4.2.3 Constructing Category Three	112
4.2.4 Constructing Category Four	121
4.2.5 Constructing Category Five	130
4.2.6 Constructing Category Six	136
4.2.7 Constructing Category Seven	146
4.2.8 Constructing Category Eight	156
4.3 Linking the Categories	165
4.4 Conclusion to Chapter Four	166
CHAPTER FIVE.....	168
NURSE EDUCATION IN CAMEROON: SEIZING THE OPPORTUNITY OF THE MOMENT	168
5.0 Introduction	168
5.1 The Framework of the Theory of Seizing the Opportunity of the Moment	168
5.2 Time and National Events: Drivers of Nurse Education Outside the Control of Nursing	171
5.2.1 <i>'Multiple' births and formation and continuing reactive growth and erratic development: the closed loop</i>	172
5.2.2 <i>National agenda – liberalisation and expansion of higher education</i>	181
5.3 Current Opportunity for Nursing to take Control of Development	188
5.3.1 <i>The conjunction of the desire to change and move to higher education</i>	188
5.3.2 <i>Turf wars and intra-professional conflict against opportunity for harmonisation: a force field interaction</i>	192
5.3.3 <i>Realising educational advancement and professionalization of nursing through harmonisation</i>	197
5.4 The Harmonization Project to Achieve Control of Nurse Education: An Opportunistic Model	203
5.5 Conclusion to Chapter Five.....	204
CHAPTER SIX	205
IMPLICATIONS, LIMITATIONS AND CONCLUSION TO SEIZING THE OPPORTUNITY OF THE MOMENT	205
6.0 Introduction	205
6.1 Implications of the Study Findings	205
6.2 Implications for Nursing	206

6.2.1 <i>Implications for government agencies</i>	207
6.2.2 <i>Implications for nurse leaders</i>	212
6.2.3 <i>Implications for professions</i>	214
6.3 Considerations for Further Studies.....	215
6.4 Limitations of the Study	217
6.5 Evaluating the Model	222
6.5.1 <i>Credibility</i>	222
6.5.2 <i>Originality</i>	223
6.5.3 <i>Resonance</i>	225
6.5.4 <i>Usefulness</i>	226
6.6 Conclusion.....	227
REFERENCES.....	230
APPENDIX I: INTERVIEW SCHEDULE.....	258
APPENDIX II: DOCUMENT ANALYSIS PLAN	265
APPENDIX III: INITIAL PhD RESEARCH PROJECT PLAN	267
APPENDIX IV: ETHICAL APPROVAL ESSEX	268
APPENDIX V: ETHICAL APPROVAL UNIVERSITY OF BUEA	270
APPENDIX VI: AUTHORISATION TO COLLECT DATA REGIONAL DELEGATION OF HEALTH.....	271
APPENDIX VII: INFORMED CONSENT STATEMENT	272
APPENDIX VIII: DOCUMENT ANALYSIS RESULTS	277
APPENDIX IX: DESCRIPTION OF STUDY PARTICIPANTS	292
APPENDIX X: SAMPLE NODE EXPORT FROM NVIVO.....	293
APPENDIX XI: EXAMPLE OF MEMO	297
APPENDIX XII: SUMMARY OF RESULTS FOR MEMBER CHECKING.....	298

SUMMARY

Nurse education has moved from apprenticeship models to advanced competency-based curricular in higher education. The bachelor's degree is already becoming the entry level into professional practice. Postgraduate programmes have been developed and there is growing autonomous regulation. Nursing in Cameroon has equally been going through its own evolution from the colonial era to present day Cameroon. However, the absence of empirical data makes it difficult to ascertain the nature of this evolution. The aim of this study was to critically analyse the basis of/and ideological positions of key stakeholders in relation to nurse education in Cameroon. Charmaz's (2006) constructivist interpretation of grounded theory was used to analyse data from official texts and in-depth interviews of nurses involved with education policy. Data sources were initially selected using purposive sampling and subsequently through theoretical sampling.

The results showed that nurse education in Cameroon has been influenced by a series of interacting factors. These included categories that occurred at particular points in time though their influence persist: multiple births and formation; reactive growth and development; liberalisation and nurse education expansion; turf wars and intra-professional conflicts. These were found to interact with fluid categories that represent dynamic current movements whose direction are unclear: change mode; moving nursing to higher education; harmonisation of nursing programmes; and professionalizing nursing. A grounded interpretation of these categories and their relationships led to the development of a theory on seizing the opportunity of the moment. The theory proposes a harmonisation project to move nurse education from a scenario where nursing has no control over the education system to one where nursing seizes control of the nurse education process. The argument is made that turf wars and intra-professional conflicts have the potential to pull nursing education from the unanticipated opportunities suddenly generated by government's policy of liberalization. The current conjunction of the desire for change among nurses and the unplanned inclusion of nurse education in higher education provide the unique opportunity for harmonization if harnessed to advance nurse education and professionalise nursing. The study concludes that nurse leaders must

create a platform that unites nurses towards the adoption and implementation of the harmonisation project or risk another generation of erratic growth and development.

CHAPTER ONE

OVERVIEW AND CONTEXT

1.0 Introduction

Education is one of the most rapidly expanding sectors of national life in Cameroon. It is general, professional or vocational with key players often including the public and private sectors. Cameroon is a country with about 250 ethnic groups located in the “axilla” of Africa bounded by Nigeria to the west, Chad to the North, Central African Republic in the East, Congo in the South East, and Gabon and Equatorial Guinea in the South. Its colonial past was marked first by German then British and French colonisation. According to WHO (2014) in 2012 the population of Cameroon was 21,700,000 with a gross national income per capita of 2,270 USD; life expectancy of 55/57 for men/women respectively; 0.8 physicians and 4.4 nurses/midwifery personnel per 10,000 population respectively between 2006-2013; and expenditure on health at 5.1% of GDP.

I started out on the PhD course in the capacity of nurse, health professions educator and administrator. I had observed in these capacities that nurse education in Cameroon is fraught with lots of inconsistencies including but not limited to: difficulties to obtain diploma to bachelor upgrades; independent policies of different government agencies involved; lack of a professional regulatory body and near absence of postgraduate education opportunities. I could not understand why all the stakeholders could not see that the status quo was not working and consequently the quality of service offered by the nation’s health system. I could not also understand why these stakeholders couldn’t just come together and chart a path forward for the good of the profession and country. So I set out with a simple objective – identify the barriers to education then design a model to solve the problems. It was as simple as that, a problem and a simple obvious solution. However, I have come to learn that problems like the ones affecting nurse education in Cameroon are not simple. They are complex with probably many invisible and imperceptible contributing and/or causal factors. Every stakeholder might hold an opinion/position rooted in some philosophy or ideology, that they

believe is best and should be the guiding philosophy for all. At this juncture I realised that to address this problem one has to go back to get from nurses, their views and beliefs about nurse education. It will be necessary to find out the type of philosophy that influences the policies or actions of the different stakeholders and if there is any overlap. A clear understanding of these deeper issues will make it easier to address the structural manifestation of the problem i.e. the inconsistencies in nurse education.

It will be necessary to briefly review nursing in Cameroon in a bid to provide the context for the evolution of nurse education and factors that might have affected that evolution. This discourse is made even with the consciousness that there is little or no formal documentation on nursing and its evolution in Cameroon. A retrievable documentation of nurse education in Cameroon is hard to find and a lot of this history is handed down orally. Though this might be perceived as some weakness, some nursing research have been built around oral histories from study participants such as Wall et al, 2015; Morrison, 2014; Boschma, 2012; and Miller-Rosser, Chapman and Francis, 2009. The background put forth below is a product of such oral histories aimed at giving the reader an appreciation of the research context. Some of the facts were also enriched from preliminary discussions with study participants. Some nurses who declined to participate in the study volunteered information on the history which also enriched the background below. The history reported here is aimed at nurse education though aspects of this will overlap with the history of the profession in Cameroon.

1.1 Brief Historical and Political Context

Cameroon is a bilingual country with a complex colonial past. Le Vine (1971) observed that “complexity” was the key word to describe the political, social and economic configurations that characterised Cameroon. He noted that no other African country had had such an extraordinarily varied history of political experiences. This history is characterised by the colonial rules of Germany, France and Great Britain and two indirect tutelary rules (mandated territory of the League of Nations and trust territory of the United Nations). East Cameroon was administered by France while West Cameroon was administered by Great Britain. Great Britain managed its part of the territory as part

of Nigeria therefore forging a close political union between Nigeria and West Cameroon. Le Vine (1971) noted that Northern British Cameroons was administered from Kaduna as part of Northern Nigeria while Southern British Cameroons was administered as part of the Eastern Nigerian region with capital at Enugu. So both territories had a completely different set of colonial experiences which probably shaped the political culture of the two regions.

French Cameroon achieved independence in 1960 while Southern Cameroons obtained independence by choosing reunification with East Cameroon over Nigeria in 1961. The system of government adopted at reunification as reported by Levine (1971) was a federal system with a rare type of powerful presidency he described as “a hybrid president who combined the attributes of a British-style governor-general, a Fifth Republic French president and an American chief executive”. He noted that this type of presidency did not appear to have had any parallels at the time or in past constitutional practice. This sort of presidency reflected the desire by some for a strong centralised executive that controlled all powers. Eventually the federal system will be abolished in 1972 and a unitary state created. This phase of the political birth of the country is important as it had potential to influence the development of professions like nursing. In the course of this study an understanding of this political history might be necessary to understand nurse educational evolution in the country.

1.2 The Cultural and Historical Context of Nursing

Before the advent of ‘modern’ nursing during the colonial era, the care of patients in different tribes and villages were in the hands of ‘medicine men and women’. These people who still exist are believed to possess spiritual powers and deep knowledge of herbs and other rituals and their role in diagnosing and treating both physical and spiritual ailments. This ‘traditional medicine’ is believed to have components that could be taught through apprenticeship and others that could only be transferred to a successor spiritually following instructions from the ancestors. Problems of fertility and pregnancy were managed by the traditional doctors, while issues of delivery and postpartum care were handled by traditional birth attendants (TBAs) who were usually elderly women. The TBA received no formal training and may have learned by apprenticeship. They provided care for the mother and neonate, advised on nutrition, hygiene and also carried out circumcision. These women

were also known to treat common childhood diseases and even complex conditions like umbilical hernia through traditional methods. The responsibility of caring for sick persons was usually in the hands of their relatives who were usually guided by the native doctor. This family involvement in care has continued today with hospitals always crowded by patient relatives actively taking over some nursing roles in the care of the patient. In many cases they virtually ‘move in’ with the admitted patient, sleeping and even cooking within the hospital premises.

In this era the profession of nursing did not exist in Cameroon until the arrival of the missionaries and colonialists in the late 19th century. This was similar to the experience of other countries for example China, where modern nursing according to Watt (2004) evolved due to the influence of Western missionaries. In Brazil and other Latin American countries, until the 19th century, family members, healers, and practical midwives were the primary sources of health and illness care in the home while religious, custodial, and philanthropic organizations delivered health care in the major cities (Neves and Mauro, 2001). Thus it can be assumed that while elements of the role of the modern day physician and midwife can be traced back to medicine men and TBAs respectively, the ‘nurse’ figure was not so apparent as nursing roles were carried out by the TBAs, medicine men and family members. Research on the role of this aspect of culture on health care has either not been done or published in Cameroon. At this point it is not known if this is an issue that nursing education planners are aware of and have taken into consideration or not.

The influence of culture and history can therefore not be minimized in the examination of the evolution of nursing because even among the educated class today, there is the belief that certain conditions (especially mental health) can only be treated by the traditional doctors.

1.3 Philosophical Basis of Nursing in Cameroon

Without scientific publications it is difficult to describe the philosophical underpinnings of the nursing profession in Cameroon, and how formal education and/or culture have influenced it. However, it is known that the profession of nursing was a creation of the colonial era as it was in many other countries that experienced colonisation. If this is the case then it will be difficult to

ascertain a philosophical link between the profession and the cultural and traditional roots of the people as opposed to more recognizable roles of the physician and midwife. So to many people today nurses probably are people trained to assist the doctor in taking care of sick people. They are usually ladies always smartly dressed in white uniforms.

In the researcher's personal experience first as a student and then an educator, an acknowledged philosophical link between nursing and the culture and traditions of the people is still to be established. Different authors in countries where nursing is also seen as foreign profession have been able to portray how traditional philosophies have influenced nursing in their countries. Smith and Tang (2004) citing Wong *et al* (2003) stated that Chinese nursing ethos reflects the underlying beliefs of Chinese people and their cultural understanding of health, with a traditional Chinese saying that 30% of healing depends on treatment and 70% on nursing care (Wong & Pang, 2000). So the link between man, his environment and disease has cultural undertones the Chinese people can recognise. This perception is not very different from the philosophies advanced by modern nursing theorists from orientation to fundamental human needs and assisting individuals to meet this needs (Henderson, 1966) through the Neuman systems model (Neuman and Fawcett, 2011) to the assistance of individuals in activities of daily living (Roper, Logan and Tierney, 1996). Nursing philosophy in Cameroon as taught in schools and applied in practice is based on these nursing theorists with no obvious links to any local contextual model. Even without empirical data, the researcher's experience implementing the major undergraduate, post-registration and postgraduate nursing curricular support this assertion.

The points for reflection here will be on whether and how traditional philosophies have influenced nursing education and practice (probably in subtle and imperceptible ways). It might be unreasonable to say there are no such similarities or links, fundamentally because illness, treatment and care existed even before nursing was introduced to the country. If that is the case then it is necessary to assess to what level or extent these have found their way into nursing education design, planning and execution. The fact that nursing professionals and students quickly revert to the philosophies of

nursing as propagated by modern theorists might not necessarily imply that there is no existing traditional ‘philosophy of nursing’.

1.4 Brief History of Nurse Education

Nursing education in Cameroon can be traced back to the start of the colonial era. When the Germans annexed Cameroon in 1884 they trained a type of medical personnel called ‘Dressers’ (Maingeh, 1999). A dresser was a surgeon’s assistant or ‘some sort of male nurse’ whose duty was to dress wounds and sores (Lee, 2005). There is virtually no local literature on what this training entailed and what the role of the dressers were in the health care system. The Germans were followed by the French and the British who partitioned Cameroon between them after WWI. In the French part of the country Dr Eugene Jamot according to the National Observatory for Human Resources for Health Cameroon NOHRHC (2010) opened the first school to train nurse aides in 1930. The training lasted three months and these graduates helped him in his fight against sleeping sickness. According to Kamta (1999) the training evolved to health assistants who were trained for three years and performed both medical and nursing roles. These health technicians were therefore not described as nurses. Kamta goes on to add that it wasn’t until 1959 that a formal curriculum based on the French model was introduced.

In the British Cameroons Maingeh (1999) reported that after the Germans left, the British continued using the services of dressers when they opened the African hospital in Victoria by 1933. During this time training for nurses was only available in Nigeria and since the British managed their territory as part of Nigeria it was easy for Cameroonians to study in Nigeria. The NOHRHC (2010) reported that the first training school in this part of the country was started by the Catholic mission in 1954 at Shisong. The school trained staff nurses in a three year programme. The state owned Bamenda nursing school was formerly opened in 1969 to also train staff nurses. These schools were all hospital based as there was no university based programme at the time. All the nursing programmes at this time were under the Ministry of Public Health.

Graduate education in Cameroon has mostly remained inaccessible to the majority of diploma nurses. The University of Buea (Cameroon's lone Anglo-Saxon state university at the time) began a four-year training programme for the award of a Bachelor's degree in Nursing Science (BNS). The first batch of graduates left in 2001 and were mostly nurses who had previously held diplomas. It must be noted here that the duration of training was the same for both diploma holding nurses and candidates without any nursing background i.e. fresh from high school. The university conferred its first Masters degrees in Nursing Education in 2009, and does not offer any doctoral degrees. The University of Yaounde I which is the oldest in Cameroon also started a Master in Nursing Science degree in the late 2000s.

Entry into practice is still based on the three-year diploma which can now be obtained from both the ministries of Public Health and Higher Education. Preregistration diploma programmes also continue even as undergraduate programmes are now available. However, the pathway to upgrade preregistration and registration diplomas to bachelor degrees is murky.

1.5 Nursing in Cameroon as a Profession

The concept of a profession is copied from the medieval guilds in which the members of the various highly skilled trades bonded together to formulate and uphold high standards, to train neophytes in the particular craft, to socialise these learners into a brotherhood, and to protect their members (Searle, 1982). The process of professionalization across different disciplines was similar. According to Wilensky (1964) in Baird and Szczygiel (2007), firstly early training schools and apprentice opportunities were created with the eventual transformation of their programmes into university curricular; secondly local and national associations were established; and lastly state licensures were established and internal codes of ethics developed and adopted. In a similar argument Searle (1982) in an interpretation of the work of Millerson (1964) said the underlying concepts in the transformation of occupations to professions included the need to ensure professional conformity, maintain development of standards, eliminate competition and improve status of members. To buttress this position Searle (1982) noted that the professional associations argued that professions provided service to the public that at all times took precedence over all else; that proficiency of

members must be based on identifiable skills, attitudes and a body of theoretical knowledge with competence tested by means of examinations; that members have to subscribe to a code of conduct, ethical norms and values; that to this end certain core professional concepts were developed; and that the practitioners profess a distinct specialized service that the public recognises. This functionalist take presents professions as generally good and working for the interest of society (Marshall, 1963) serving as a stabilising force (Carr-Saunders and Wilson, 1933) through guilds guided by ethical codes and practice standards (Parson, 1954). Other authors like Johnson (1972), Larson (1997) have argued against the functionalist view, presenting professions as seeking power and establishing monopolies in pursuit of their own self-interest, maintaining salary levels and raising their social standing. Johnson (1972) even argued from a Marxian angle that professions take away the client's right and establish control over him through claims of specialist knowledge. With legal backing, the client has to depend on the professionals for care. For Illich et al (1977) as cited in Abbot and Meerabeau (1998) professions are disabling because they take away individuals' ability to care for themselves. In support of this argument Minford (1987) cited the role of social workers, arguing their clients come to depend on them rather than learning to solve their own problems.

In recent years the harsh criticism of the Weberian view of professions has been softened to portray the importance of professions. Friedson (2001) in his analysis of organizing work in modern societies argues that professionalism should be maintained as a key principle in organizing work. He argues that due to complexities of work in certain professions, practitioners themselves are the only ones who understand the processes, needs, and procedures to put theoretical knowledge into practice. He adds that professionalism can serve as good strategy for regulating, supervising and rendering certain services to the public especially in contexts where statutory controls and bureaucracy have dampened the quality of work.

In spite of all these arguments the key characteristic of a profession is the full recognition and acknowledgment of its role and relevance by members of the public and subscribers to its services. For as Abbott (1988) stated 'In claiming jurisdiction, a profession asks society to recognize its cognitive structure through exclusive rights; jurisdiction as not only a culture, but also a social

structure'. Thus the assumption here is that society can only grant those rights if they perceive the profession and its service as truly useful and justifiable. Whether we go with the Weberians or the functionalists, the nursing profession offers valuable service to patients and what happens in the process of acquiring the knowledge and skills to render that service as a professional is important to be studied.

In the proceeding paragraphs a descriptive discussion on the situation of nursing in Cameroon within the context of a 'profession' is presented. The goal of this will be to provide information that will determine the professional status of nursing in the country.

1.5.1 The social position of Nursing

After almost 14years of active participation in nursing both as student and professional this researcher is of the opinion that the social position of nursing is constantly evolving. In the days following independence, nursing may have been considered very important because the state provided bursaries for students and guaranteed immediate employment after completion of studies. Nurses were very much respected and there is no evidence that it was associated with any negative stereotype. Over the past two decades the bursaries no longer exist and guaranteed state employment is history. This is happening at a time when guaranteed employment for physicians and teachers from state institutions continue. This fact alone brings to question the position of nursing in government's view. Proponents of the argument that nursing is a profession that is neglected by the state point to the absence of a nursing directorate in the Ministry of Public Health. A counter argument could be whether the other health professions have exclusive directorates in the same ministry and if not why must nursing have one. The argument for this is therefore not clear.

In the domain of education there has been significant increase in both the level and demand for nursing education over the past decade. The number of public and private nursing schools has increased geometrically and so has the number of candidates seeking admission into nursing schools. This may be evidence of recognition and acknowledgement of the profession by members of the public who choose to register as students, sponsor students and demand the services of more nurses.

It could also be related to the increasing worldwide demand for nurses as graduates can easily find better paying jobs in other countries.

In rural communities nurses still enjoy a lot of respect and are usually given preferential treatment by community dwellers. Nurses in these communities have a very wide scope of practice ranging from patient consultation, prescription and minor surgery including circumcision, and remain the predominant providers of healthcare services. This may be one of the reasons for the esteem and respect for the nurse and nursing. However, in comparison, physicians are more respected by the public and many people probably view nurses as assistants to the medical doctors. It will be worthwhile to find out how the public perceives nursing as a profession, whether they see it as autonomous and separate or as a subsidiary of medicine. At the moment while there are no scientific facts to make that conclusion, this public perception might be expected to influence the development of nursing programmes. Whether this happens and to what extent, is again another issue that nurse researchers should address.

In conclusion nurses and all other stakeholders agree that a nurse must receive formal education from a recognized or accredited institution before he/she can be allowed to practice. Thus from this standpoint nursing in Cameroon has met one of the criteria of professions. However, the type, structure, levels and variations of that education are other issues that need further exploration and synthesis

1.5.2 Regulation of Nursing

When Southern Cameroons was colonised by Britain it was administered as part of Eastern Nigeria. Most Southern Cameroonians were educated in Nigerian colonial institutions and our politicians were represented in the Nigerian eastern regional house of assembly. When the region got its independence by reunification with East Cameroon in 1961, the West Cameroon Nursing and Midwifery Council was created. This body was responsible for the recruitment of candidates into nursing schools; supervised nursing programmes and examinations; vetted the end of course certificates; and issued authorisations to practice. Sadly, when the Federal State of Cameroon was

dissolved in 1972 in favour of a unitary state, the role of this body was put in jeopardy. While there are still a few nurses with diplomas bearing the seal of the defunct council, it is extremely difficult to find documents and position papers issued by the council during its existence. Access to such documents would have provided insight to the particular role the council played in the design and implementation of nurse education. This period was the only time in the history of nursing in Cameroon that there was visible professional body regulating the practice of nursing.

The National Order of Nurses Midwives and Health Technicians of Cameroon created by law number 84-010 of 5th December 1984 is umbrella organization for the professions mentioned. Its mission is four fold: to defend the honour, ethics, probity and independence of the professions; the registration of members of the various professions on the national register of the order; hold regular meetings; and collect registration fees into the order as well as annual dues (cf. Constitution of National Order of Nurses Midwives and Health Technicians of Cameroon). This organization registers only nurses with the three-year state diploma in nursing from the Ministry of Public Health.

There also exists, the Cameroon Nursing Society a non-governmental organisation that received official authorization on the 7th of January 1992. Since its creation, it has been struggling to gain admission to the International Council of Nurses and currently has an observer status in the said Council. This association registers all nurses but places those with preregistration diplomas in the category of “associate members”. A similar association in terms of membership structure is the Cameroon Nursing Association. These two groups periodically organise conferences for nurses during which professional issues are discussed and resolutions taken.

The existence of these associations gives a semblance of autonomy for the nursing profession but a crucial weakness is the fact that none of them has the authority to regulate nursing in Cameroon. A typical regulatory body sets and supervises the application of standards from student recruitment through training and entry into practice right through to demonstration of continuing competence of its members. According to Higher Education Better Regulation Group (2011) a regulatory body is one that sets the benchmark standards of entry, and is authorised to accredit programmes leading to

professional qualifications in a particular profession. Such bodies play three roles: they safeguard the public interest which gives them their legitimacy; represent the interest of practitioners (acting as trade unions or as a learned group advancing continuing professional development); and maintaining their privileged and powerful position as a controlling body (Harvey, Mason, and Ward, 1995). None of these groups have attained such a role in Cameroon especially when it comes to regulating and controlling nurse education and practice.

There also exists a national syndicate for nurses which operates as a trade union and lobbies for the interest of nurses. There are equally many other professional nursing associations for different professional levels (e.g. Association of Nurse Educators Cameroon, and many Nursing Alumni Associations) with different goals and objectives.

1.5.3 Educational structure

The Ministry of Public Health was the first provider of nurse education in Cameroon before being joined by the Ministries of Higher Education and that of Employment & Vocational Training in the late-1990s and mid-2000s respectively. In the present dispensation the ministries of Public Health and Vocational Training can only issue diplomas by law while the ministry of higher education can issue both diplomas and degrees. This ministry of Higher Education is predicted to emerge as the key provider of nursing education in the future considering the movement towards the bachelor-master-PhD structure of higher education in Cameroon. The current structure of nursing programmes is as follows:

- Preregistration diplomas:
 - Assistant Nurses (1 year of studies) mostly run by the Ministry of Public Health with some under the Ministry of Employment and Vocational Training.
 - Enrolled Nurses (2 years of studies) previously their training was managed by the Ministry of Public Health which stopped running the programme in the early 2000s but now exists under the Ministry of Employment and Vocational Training.
- Registration diplomas/degrees:

- State Registered Nurses SRN (3years of studies) – Ministry of Public Health
- Higher National Diploma nurses HND (3years of studies) – Ministry of Higher Education
- Bachelor degree nurses (4years of studies) – Ministry of Higher Education
- Post-registration diplomas/degrees:
 - State Certified Paediatric Nurses (2years of studies) – Ministry of Public Health
 - State Certified Nurse-Midwives (2years of studies) – Ministry of Public Health.
Since 2011 the training of midwives began separately from nursing. Students no longer needed to complete the three-year diploma programme before going into midwifery for two-year post registration diploma.
 - State Certified Reproductive Health Nurses (2years of studies) and run by Ministry of Public Health
 - State Certified Mental Health Nurses, Nurse Anaesthetists and Nurse Ophthalmologists (2years of studies) – Ministry of Public Health
 - Geriatric Nurses (1year of study) – Ministry of Employment and Vocational Training. Ministry of Public Health launched its own training in 2015.
 - Masters in Nursing (2years of studies) – Ministry of Higher Education

The above structure may probably confound anybody coming from another country with fewer key players. It has also made it challenging for international credential evaluation agencies trying to evaluate nursing certificates from Cameroon. The mechanisms for cooperation and collaboration between these ministries (if it does exist) need to be examined and discussed because of the apparently complex picture the nurse education scenario seems to be. Studying the role and interactions of the different ministries is also important because as shown in 1.4.3 above, a professional regulatory body does not exist thus raising the question of how nurse education is run and regulated in Cameroon.

1.5.4 Growth and advancement

In the immediate post-independence period students in state-run nursing schools paid no fees, rather they received bursaries and accommodation. The graduates were directly recruited into the public service upon graduation. According to NOHRHC (2010) direct recruitment ended sometime between 1987 and 1990, bursaries also ended and tuition fees were introduced. It can be assumed that a key external motivation for candidates to go into nursing had been eliminated. This was not the only challenge the profession was facing. In the same document, the observatory reported that between 1973 and 1985 there was a moratorium on opening state-run schools by the ministry of Public Health, only a few private schools were opened; then between 1985 and 2003 the moratorium was on private schools while more state-run schools were opened. The extent to which these decisions affected the nursing workforce and profession has not been scientifically studied. But one may assume that the decisions would have also had some consequences on the profession.

The recruitment of nurses has also seen decisions that likely influenced the nursing workforce in the public service and consequently the care of patients. The NOHRHC (2010) reported that between 1987 and 2002 there was no recruitment into the public service; between 2002 – 2007 recruitment was done on contract bases under the highly indebted poor country initiative of the IMF and World Bank; and it was only in 2009 that the state recruited directly through a recruitment exam. This recruitment pattern was greatly influenced by the structural adjustment programme introduced by the IMF and World Bank from the late 1980s when Cameroon went into economic crises. During this period the NOHRHC (2010) provided the following data on nursing recruitment

Table 1: Recruitment Data for Nurses into the Public Service from 1990 - 2009

Nurse Category	Eligible Population for Recruitment 1990-2009	Recruitment from 1990-2008	Recruitment in 2009
Nursing Assistants	12517	445	700
Enrolled Nurses	762	338	0
SRN and Bachelor holders	5859	1418	733
Nurse Anaesthetists	149	20	12
Reproductive Health Nurses	221	30	20
Mental Health Nurses	57	13	1
Nurse Ophthalmologists	21	0	0

Source: NOHRHC (2010)

The above data does not include recruitment in the private sector which continued recruitment of nurses even during the almost 15 years that the state did not recruit. However, recruitment data for the private sector is not available.

In spite of the above challenges to training and recruitment of nurses, the profession has still continued growing as evidenced by a number of facts including:

1. The number of nurses in the workforce has grown steadily over the years. According to the NOHRHC (2010) in 2005 there were 6705 nursing personnel (includes assistant nurses and midwives) in the public service and 10714 in 2010. In the Private sector (based on data from the Catholic Health Services, Protestant Churches Council, Ad Lucem Foundation and Social Insurance Fund) the approximate number of nursing personnel in 2009 was about 5596 and midwives about 640. This private sector data doesn't include private-for-profit clinics and hospitals as well as many other faith based health institutions. Therefore while not an accurate representation, the data provides an estimate of the nursing workforce in the country as above 15000 as at 2010.

According to Liese and Dussault (2004) the number of nurses per 100,000 of population in Cameroon was 2.5 in 1960; 6.1 between 1975 and 1977; 8.0 between 1988 and 1992; 7.4 between 1992 and 1998; and 7.4 in 2002. The trends show a steady increase from independence to 1992 and a fall from then unto 2002. This drop coincides with the suspension of bursaries, introduction of tuition fees in nursing schools and suspension of recruitment in the public sector. However, between 2006-2013 WHO (2014) reported an increase to 4.4 nursing and midwifery personnel per 10,000 of population. This again coincides with the resumption of recruitment in the public sector.

2. The number of nursing schools has been steadily increasing over the years making nursing education more available. The ministry of Public Health had by 1990 about 19 schools training nursing personnel (all diploma schools). According to the NOHRHC (2010) the number of nursing schools stood at 23 for three year state diploma and post-registration diplomas and 25 for nursing assistants respectively. The ministry of Higher Education got

into nursing education in the late 1990s and today counts a total of three out of eight state universities with nursing programmes (degree programmes only) and at least 12 private higher institutions offering three year diploma programmes. Some of these private institutions also offer degree programmes.

3. In recent years nurses with the higher education diplomas (HNDs) now have an opportunity to do a one-year top up programme to get a Bachelor of Nursing Science degree.

In another sign of professional growth, nurses are increasingly seeing themselves as scientists and professionals who have a vital role to play in the nation's development. The nursing profession through the Cameroon Nursing Society had organised 16 annual scientific conferences between 1995 and 2011. On the other hand, the Cameroon Nursing Association between 1999 and 2014 had organised five triennial conferences. These conferences serve as venues for nurses to prepare, present and discuss scientific presentations and adopt resolutions to move the profession forward. Articles presented during these conferences are usually compiled in a conference proceedings booklet. The availability of these booklets to nurses nationwide is however, usually very limited. During the 16th scientific conference of the Cameroon Nursing Society in 2011 for example articles presented during the conference of 2011 (cf. Book of Abstracts, 2011) show that nurses are increasingly interested in professional issues and are beginning to carry out small scale research in their different hospitals. There was the active participation of nursing schools both private and public thus giving students an opportunity to participate. The conference also saw the adoption of a resolution on the formation of a commission within Cameroon Nursing Society to look into the problems and issues concerning nursing education in Cameroon (cf CNS 16th Scientific Conference of Cameroon's Nurses Resolutions, 2011). This commission right up to 2016 has not been created.

Employment opportunities for nurses though still characterised by low wages, have also been gradually increasing with the private sector absorbing more nurses. The Ministry of Higher Education in 2011 also announced that nurse educators working with private higher institutions will also see promotions to higher academic ranks like their counterparts in the public institutions. This decision will ensure that private institutions don't lose their faculty because of academic promotion

issues and thus will go a long way to strengthen nursing in the private sector. It will also facilitate the acquisition of prestigious academic titles like lecturer, senior lecturer, professor etc. which will definitely increase the academic profile and social position of nurses.

In conclusion, despite the myriad challenges to the growth of nursing in Cameroon, there has been progress. This is seen in the increasing accessibility of education, increase in recruitment of nurses, and growth in professional associations. Maximizing these has the potential of advancing nurse education in the future. However, this will also be dependent on the substantial analysis of the philosophies that have driven nursing education this far.

1.6 The Problem

The Institute of Medicine (2010) called for nurses to achieve higher levels of education and training through an improved education system that promotes seamless academic progression to ensure the delivery of safe, patient-centred care across settings.

While there has been increase in the variety and number of nurse education programmes in Cameroon over time, it is difficult to comment on how this has affected nurse educational development. Issues of access, quality and orientation to safe patient-centred care delivery need to be examined within the local context. A simple non-scientific observation of the nurse education field as a key participant is not sufficient to produce empirical arguments as to the nature of the evolution of nurse education in the country. ‘Nursing education’ (if dressers and care assistants could be considered nurses) in Cameroon has been traced back to the 1920s and 30s but almost a century later there are still no doctoral programmes and postgraduate options are limited. The educational policy is not clear especially with the involvement of new ministries. The relationship between qualifications from these different ministries is not clearly understood. University education is now available but it is not clear how accessible this education is to students and nurses with existing diploma qualifications. The position of organised nursing on nurse education is also not clear as there is nothing published to that effect. At the same time many nurses who move out of the country for further studies end up not returning therefore perpetuating the lack of a highly educated leadership

corps. Within the public service, there have been enormous difficulties in reclassifying nurses who recruited with diplomas, had gone ahead to acquire degrees while in service. There is still no reward distinction between higher qualifications as all nurses with post-registration diplomas, undergraduate and postgraduate degrees are lumped into the same category. Even with university qualifications nurses in the ministry of Public Health can't be directly recruited in the highest category (A2) of the Cameroon public service. Lewindia (1999) described this as a deliberate attempt [by the authorities] to maintain the domineering attitude of doctors and frustrate any uprising nurse.

This issue of education has become so emotional that ideological camps have appeared i.e. ministry of Public Health trained and ministry of Higher Education trained for example. In the past education has provoked similar reactions in different countries. Lancaster and Lancaster (1982) identified that the amount of education nurses really needed and where they should obtain it were questions that stirred deep feelings in nursing groups, and was another issue where the emotional reactivity got in the way of progress and often precluded any lucid discussion of facts. This might be true for Cameroon since it is likely that with the involvement of different ministries, nurses might argue in preference for one over the others. How nurses are receiving the changes in educational control and what their arguments and aspirations are with respect to the issue will determine the kind of recommendations that can be made towards advancing nurse education. Operating within nurse education in the country exposes the researcher to some of the differences in positions and ideas from nurses with different educational experiences. However, an argument cannot be made on what is not working and what strategies can work for nurse education in the future. A critical analysis of nurses' positions on the evolution of nurse education is the one major way for getting empirical evidence on what is actually happening as well what projections can be made from those findings.

In local conferences where nurses present papers reflecting their opinions and ideas, there has been evidence of the desire for more accessible education. Junang (1996) called for the institution of master's and doctoral programmes for the nurses arguing that the dynamic nature of care requires constant research which in the case of Cameroon was made difficult by the low level qualifications in nursing education. He saw the advanced programmes as an accessory for health professionals

including nurses to advance their professions and improve the quality of care rendered to clients. In tandem with this proposition, it is a fact that the higher the level of education of nurses, the better their awareness of the need for research (Karkos & Peters, 2006; McCleary & Brown, 2003) and evidence-based practice. The role of education in advancing a profession cannot be overemphasized. So while some countries like the UK have moved all nursing education to university based degree programmes and the US plans to implement measures to increase to 80% the number of nurses with bachelor degrees and double the number of nurses with a doctorate in the US by 2020 (IOM, 2010); the position of Cameroon's nurses and policy makers vis-à-vis such issues has to be analysed to provide clarity on nurse education in the country.

Thus the issue that needs to be addressed is the basis of the evolution of nurse education to its present state and whether such an analysis can provide a clear sense of direction for the future. The inconsistencies identified above are evidence of the fact that stakeholders in nurse education probably have varied views, perceptions, beliefs and expectations on what nurse education should be based on, what it should look like and who should be involved. This can also be perceived as a quest into existence and nature of guiding frameworks or models influencing the different stakeholders in nurse education. The goal of this will be to generate a theory that demonstrates the interrelationships between concepts fundamental to nurse education in Cameroon.

1.7 Research Aim:

The goal of this study is to undertake a critical analysis of the basis of/and ideological positions of key stakeholders in relation to nurse education in Cameroon.

1.7.1 Research questions

As indicated in the introduction above, the desire for the PhD was oriented towards a problem-solving model. I was interested in addressing issues which I found during my research for a Master's degree in Nursing Education. One of the key findings of that study (which has not been published) demonstrated nurses' desire for better access to further education. So the initial goal was to explore

the difficulties and obstacles to further education so as to design a model that makes further education conveniently available for working nurses.

With this aim I asked two fundamental questions:

What are the impediments to further education for nurses? And

What educational models or approaches can be developed to make further education more accessible to nurses?

With these questions I set out for a PhD seeing it as a means to provide an empirically convincing approach to make further education possible. The period of study, and reflection that typically characterizes the earlier part of PhD studies helped me to understand that the issue could be more complex than just having access to further education. I realized in the process of reflexivity that I had not examined my own positions and assumptions and as such was in danger of conducting a highly biased study. Grounded theory was the method of choice for my initial research questions for reasons that will be explained further in chapter three. But as I studied the method, I began to reconcile it to my ontological and epistemological orientation. This gradually led to fundamental change in my perception of the research area and issues of nurse education in Cameroon. The humbling moment came when I acknowledged that though I was an active participant in nurse education in Cameroon I had never reflected on nurse education in Cameroon.

At this point I could see that a structural solution as I first envisaged was at best a symptomatic relief with no guaranteed effectiveness. The profession had to be analysed from a very open and unbiased perspective so that its true nature and story can emerge. To accomplish this new research questions were designed not necessarily with the aim of seeking answers but to give the study its starting point. The questions were therefore markers to guide this journey into nurse education in Cameroon. So the following questions were crystallised:

1. What are the major education policy decisions/rationales of the different ministries since independence?

2. What is the basis of nurse education?
3. What beliefs/ideologies influence the present status quo?
4. What educational model can be developed to incorporate and unify the different ideological positions?

1.7.2 Research objectives

1. To analyse the major nurse education policy decisions from independence to present of the different ministries involved in nurse education
2. To establish the basis of nurse education in Cameroon
3. To analyse beliefs/ideologies that have influenced the status quo
4. To develop a national nurse education model that unifies the different ideological positions

1.8 Significance of the Study

Most often differences and arguments arise from a lack of understanding of the basis on which others make decisions or arrive at conclusions. This study is expected to analyse the fears, beliefs and aspirations of different stakeholders in nurse education and use these findings to develop a model to guide nurse education policy development in the future. Such a model if grounded in the data will likely be acceptable to all stakeholders and eliminate inconsistencies that might hinder the growth and advancement of the nursing profession in Cameroon. The results will be published in journals, presented to stakeholders in seminars, workshops and conferences.

1.9 Operational Definition of Terms

Although appearing as part of this first chapter, the key terms of the study were only arrived at in the course of the study. They include education and professionalization.

1.9.1 Education

Education has traditionally been defined as ‘initiation to practice’ (Smeyers and Burbules, 2006). The authors hold that in this view the learner is ‘initiated’ into the belief systems, thought, understanding

and cultural values and activities of ‘civilized life’. This definition portrays education as a process involving the transmission of a particular content to a learner.

In another more complex definition, the international standard classification of education (ISCED-97) presents education as “*organised and sustained communication designed to bring about learning*”. Schreyer (2010) expounds that in the context of this definition: communication deals with the exchange of information between persons; organised communication refers to a planned structure as would be defined in a curriculum with an organisation or teachers responsible for it; sustained communication involves establishing time frames and continuity in the learning process; and learning is considered change in ‘*behaviour, information, knowledge, understanding, attitudes, skills or capabilities which can be retained*’ and is not due to natural physical growth and development of the individual. This definition portrays a more familiar picture of education as we recognise it in formal settings.

Building from the above literature this study considered education as the formal, curriculum based training of nurses within academic establishments with the goal of producing professionals who can practice within their prescribed scope in healthcare and health related settings. The term ‘nurse’ education is preferred in the context of this study to ‘nursing’ education in order to avoid the ambiguity with the nurse’ patient teaching role as could also be implied by the latter.

1.9.2 Professionalization

Professionalization has been usually described as the process by which occupational groups used formal education, code of ethics, practice rules and conduct, and the formation of associations to define their identity and raise themselves to the level of independent professions (Wilensky, 1964; Meerkerk, 2010). In addition to the educational system, code of ethics and professional associations Merten (1999) added regulated access to labour markets as a characteristic of professionalization. So as implied by (Fröhlich, 2005: 600) professionalization is achieved when the professional rules are laid down, a professional education system is in place, professional ethics clearly defined and the specific role of institutions identified.

In this study professionalization was not only considered within the terms of these definitions but is equally a measure of how much nursing in Cameroon has lived up to the standards of the nursing profession. Professionalization was thus seen from the context of an education driven process.

1.10 Conclusion to Chapter

In this chapter a contextual background of the study setting have been presented. This included a historical perspective of the political history of the country. Cameroon is presented as a complex country with very unique colonial past that has probably influenced the development of the modern state of Cameroon. The historical narrative of care in Cameroon is presented from a predominantly oral history perspective. The argument is made that nursing in its current form was introduced during the colonial era to a society that had been operating under traditional forms of health care. The history of nurse education in both parts of the country was briefly explored to provide a clear background of its known history. The present educational system is described with the nature of nurse education programmes and regulating authorities explained. In a similar vein available data on the nursing manpower in the country is presented showing both workforce strength and recruitment trends over the years. The research problem was introduced demonstrating not a particular problem *per se* but rather the lack of evidence of an empirical analysis of nurse education in Cameroon. The research questions that would serve as broad markers for the direction of the study were also crystallized. The next chapter will deal with a global review of key issues in nurse education.

CHAPTER TWO

NURSE EDUCATION DEVELOPMENT: HISTORICAL ORIGINS TO CONTEMPORARY POSITIONS

2.0 Introduction to Chapter

This chapter covers an exploratory review of literature. The first section discusses the literature review from the grounded theory perspective, the second part deals with literature on nurse education development and evolution across the world, and the third part covers a brief review of contemporary issues in nurse education.

2.1 Literature Review in Grounded Theory

The place of the literature review in a grounded theory study has always been one of controversy, which could be a source of confusion and anxiety for novice researchers (McGhee, Marland and Atkinson, 2007). There have been arguments both for and against the initial review of literature. Glaser and Strauss disagreed on this aspect as well. Strauss in later works advocated for an early review of literature to stimulate theoretical sensitivity, find a secondary source of data, generating questions, direct theoretical sampling and getting supplementary validity (Strauss and Corbin, 1990). Glaser (1992) on the other hand argued against this position, rather proposing a multilevel review with detail review on study area delayed until when codes and categories have begun emerging from the data.

The position of Glaser or Strauss might influence a researcher's approach to the subject but in a PhD study like this one, a literature review is needed to meet the requirements of ethics committees as Strauss and Corbin (1998) observed. Apart from this, the early exploratory review of literature according to McGhee et al (2007) can be taken before the final decision on the focus of the study is made. Such a review is aimed at increasing awareness of the existing knowledge base and identifying gaps (Hutchinson, 1993; McGhee et al, 2007). From this position it is therefore not advisable for the researcher to get into the field in an 'atheoretical' state, rather he/she should be aware of extant

literature and use it objectively (May, 1994). It is thus important to be familiar with extant knowledge so to outline the research phenomenon (Backman & Kyngas, 1999). However, Strauss and Corbin (1998) cautioned that this familiarity can ‘enhance sensitivity to subtle nuances in data, just as it can block creativity’ (p. 49). The argument for an initial review of literature is necessary to give the researcher an orientation to the area of study because McGhee et al (2007) raised the point that if one of the arguments for grounded theory is paucity of research or knowledge in the study area, then an early literature review is the only way to justify that point. This is not the position of some other researchers who argue against the initial review of literature.

Hickey (1997) countered the argument against the importance of using an early literature search to establish the paucity of literature on a study area. He argued that in the event where there is a paucity of literature, there may be insufficient information from the process and the researcher risks focusing on areas highlighted in the literature rather than on emerging data. In other words there is the risk that the emerging theory is less likely to be ‘grounded’ in the case where an initial review is carried out (Cutcliffe, 2000). So rather than ‘telling it as it is’ the researcher just might be importing categories from literature (Glaser and Strauss, 1967). Glaser (1992; 1998) also insisted on avoiding the review of literature in the study area and staying uncontaminated by extant literature. The reason for this is to prevent the researcher from being ‘constrained’ or ‘contaminated’, or from being inhibited from generating categories from the data (McGhee et al, 2007). However, Glaser’s position seems to be confusing because in his writing on ‘Theoretical Sensitivity’ he posited that ‘it is necessary for the grounded theorists to know many theoretical codes in order to be sensitive to rendering explicitly the subtleties of the relationships in his data (Glaser 1978:72). To Charmaz (2006), the researcher can only use these codes if he/she is knowledgeable about them, and such knowledge cannot be dissociated from the major literature from which they have been drawn. So though this raises some ambiguity Glaser (1978) goes on to argue for a delayed literature review. In the constructivist interpretation of grounded theory on which this study was based, Charmaz (2006) upholds the argument of the delayed review. She argues that delaying the literature review allows the researcher to articulate their position since it prevents the risk of importing preconceived ideas and imposing

them on the research. She however, suggests that if the early literature review is demanded then the researcher should conduct a review but let it lie dormant. After developing categories from the data, the researcher can now start locating their emerging categories within the relevant literatures.

In the current study, it was necessary to present a literature review as part of the research proposal for ethical approval. So the literature review was divided into two: an initial exploratory review and a later robust review during data collection and analysis. The first part of the review focused on getting literature on nurse education issues within the Cameroonian context. This process revealed that there is a paucity of published literature on nurse education in Cameroon as shall be seen in 2.3 below but it also served to provide the reader with the researcher's perspective as well as justification for launching the grounded theory (McGhee, 2007; Antle May, 1986). The paucity of local literature reinforced the need for global literature in the broad study area. The purpose for this initial review was twofold: firstly, a general scoping of the research area i.e. the evolution of nurse education across the world; and secondly to explore the trends in countries that might have some general similarities with Cameroon. The kind of similarity considered here was countries that also saw 'modern nursing' introduced in them by other countries. The review could potentially reveal some 'sensitising' characteristics but this remained mostly at the level of awareness. A synthesis of concepts was not done at this stage to keep in line with Glaser's recommendations. In conducting the review, the electronic search started from google scholar then to CINAHL and JSTOR. The search started with general key terms like "nurse education policy", "nurse education development", "trends in nurse education" "nurse education in Africa" "history of nurse education". These key terms were carefully selected to generate the information being sought (Cronin *et al*, 2008). The selection of articles after these key terms were used was based on the relevance of the content in addressing general issues in nurse education and how dated the article was. An age range of 5-10 years is usually recommended for articles with the exception of seminal works and also depending on the availability of information in the area under study (Paniagua, 2002; Cronin *et al*, 2008). A 10year time frame was considered generally, while at the same time considering quite dated articles which contained relevant historic information. Articles that explored historical and/or contemporary trends in nurse

education were retained. Articles dealing with nurse education policy and its evolutionary trends were also considered. This electronic search was complemented with manual search of selected print journals, for example “Nurse Education Today”, “International Journal of Nursing Education” that were available in the Essex University Library. Even though the electronic search is considered more effective and accessible (Younger, 2004), Hick and Moule (2006) argue that a manual search though slow can also be very rewarding in sourcing articles. So the initial review included both electronic and manual searches for relevant articles. During the manual search relevant topics addressing the same key terms were isolated from the table of content, the abstract read and from it a decision to read the entire article. Generally, the review of the articles selected followed a similar pattern which was adapted from Cohen’s (1990) PQRS system. This system recommends a preview, question, read and summarize systematic approach (Cronin *et al*, 2008). The review was kept light with a critical analysis of the articles considering their methodology, theoretical framework, key questions and findings avoided. This process helped the researcher to get familiar with nurse education development across the world since nurse education in Cameroon was the area of interest. Keeping this initial review ‘light’ was a balancing act meant to meet the requirements and illuminate the research area on the one hand and the desire to go with the emerging data to develop a theory ‘grounded’ in the data (Hickey, 1997 Cutcliffe, 2000; Charmaz, 2006) on the other hand.

The second review of literature was more robust than the initial and started after initial coding of the first interviews. This review was aimed at linking the concepts, constructs and properties of the emerging theory with extant theories (Hutchinson, 1993). During this phase search terms were guided by the emerging categories such as “harmonising education”, “professional evolution”, “change theories”, “marketization of education”, “academisation of nursing”. Using the same databases articles and books were selected that dealt with these themes. The emerging theory was then discussed drawing similarities and differences with these extant literatures. To avoid reading through the hundreds of articles preselected at each stage of the review, the researcher made use of NVivo 10. NVivo is a software package for qualitative analysis but it was used to identify common themes in the articles imported into it. After importing the articles and running word frequency and

text search queries (Wiredu, 2014) (during the initial and second review respectively) articles showing a high concentration of the search theme were prioritised. The researcher then went back to the prioritised articles for a more detail analysis. The use of the software for this seemingly ‘unlabelled’ purpose was taking advantage of its ‘Queries’ property. This property allows qualitative researchers to ‘explore different uses of words, phrases, and their different contexts and guides coding broadly until later when meanings become clearer’ (Wiredu, 2014)

This two phase approach to the literature review was helpful in revealing the gaps in extant literature and how the emerging grounded theory linked with the gaps as well as exposing the contributions and positions of the theory (Charmaz, 2006).

2.2 Nurse Education Development and Evolution

2.2.1 A snapshot historical review

The evolution of nurse education across the world was limited to countries that share some similarities or have a shared history with Cameroon. The similarities considered here is principally colonialism, that is countries that experienced colonisation or those that had nursing introduced to them by foreigners. The countries considered here include Iran, China, South Africa and Brazil. With respect to shared history, Nigeria is a country with close historical links with Cameroon and its nursing education evolution will be considered here. The purpose of this review was to become familiar with the paths of development of nurse education across the world. Being blank in this area will be precarious considering the current study is about studying that process in Cameroon.

South Africa

South Africa is the country in Africa that seems to have one of the oldest experiences with nursing education. According to Mekwa (2000), nursing education in South Africa dates back to 1899 with several programmes that have evolved and have been modified according to pressures and needs. These first programmes were run by reverend sisters first and then other organizations before the first university-based diploma at Witwatersrand University in 1937 (Howitz, 2011). This university diploma was a post-basic, two-year part-time programme towards a diploma in nursing education

(Howitz, 2011; Alexander, 1995). The programme was apparently a sort of specialisation aimed at preparing nurses for a teaching role. Therefore nurses should have acquired their basic training out of the university setting. The first basic programme leading to bachelor's degree was a bachelor of arts in nursing and started in 1959 (Ehlers, 2002). So basic nurse education at university level only came in 20 years after the introduction of nurse education at the university. The development of nurse education seems to have been influenced by demand for nurses, professionalization projects, and race.

The shortage of nurse teachers precipitated a shortage in nurses and was one of the main reasons why the tutor-training programme was set up at the university (Searle, 1965; Howitz, 2011). It was also hoped that once education moved to the university it will attract more women into the nursing profession to meet the shortage. Even with such a strategy Digby (2006) posited that even when the diploma course was brought into the university many white women still perceived nursing as inferior to teaching. This was an opposite perception to that of black women. Howitz (2011) observed that many black women perceived nursing as an esteemed career and it was the only professional role (with teaching) available to them throughout the apartheid years. This shows how race played a role in the development of nurse education with whites looking down on the role while the blacks looked up to it. The expansion into the university was meant to attract these white ladies into the profession. Howitz (2011) noted that during consultations in 1935, South African Medical Council and the South African Trained Nurses Association decided to start the tutor training programme for interested white ladies at the Witwatersrand and Cape Town universities. She observed that even when these courses became open to black students, most of them could not meet the entry requirements. In addition black students were required by the law to obtain ministerial permission through a difficult and tedious process before getting admission to the university (Howitz, 2011). However, since blacks continued being trained in segregated schools they gradually assumed influential positions in hospitals for blacks where they worked leading to deliberate effort from nursing leaders to raise qualifications for white nurses in the 1950s (Marks, 1994).

Moving to university level training programme was influenced by race but also the desire for professionalization. Nurse leaders in the South African Trained Nurses Association in the 1920s and 30s argued for the nurse tutor programme as a means of increasing the quantity and quality of nursing training thus fostering recognition of nursing as a profession in the health care system (Marks, 1994; Howitz, 2011). When the undergraduate bachelor degree programmes were started later in 1955 (Ehlers, 2002), nursing leaders saw the difficult nature of the courses as fitting with international norms of professionalization and also supported the initiative because according to Howitz (2011) they found the healthcare environment was getting more complex with modern units for intensive care, tissue transplants, neurology and plastic surgery. The degree courses were also expected to produce highly skilled nurses to relieve some of the pressure on doctors and raise the status of nurses by lengthening training duration and so attract candidates from 'better backgrounds' (Marks, 1994). Since programmes at this time were restricted to whites, it can be inferred from the above that race was used as a quality to raise the status of nurses. Where nurses with higher qualifications were seen to be only whites, it will create a distinction that increases the profession's value and exclusivity. So though nursing shortage played a role in the expansion of nurse education into the university, as Marks (1994) observed it failed to meet the shortages because of racial discriminations in training. This discrimination ensured that it was only in 1985 that the first black student graduated with a nursing degree from the university (Howitz, 2011).

The control of nursing education in South Africa was in the hands of the South African Medical and Dental Council (SAMDC) but there were conflicts because nurses felt they were underrepresented in the council (Marks, 1994). This changed when the South African Nursing Council (SANC) was created. Ehlers (2002) reported that SANC was created by Act no. 45 of 1944 and became immediately responsible for nursing education standards.

Nigeria

Nigeria is the most populous nation in Africa and was a British colony until it got its independence in 1960. By 1930, formal apprenticeship training started in Nigeria in some mission and government

hospitals with standard six and secondary class four as entry qualifications for Midwives grades II and I respectively with 1 year training period (Adebanjo and Olubiyi, 2008). Ayandiran et al (2013) pointed out that the educational system started out in informal structures then onto ‘ad hoc institutions’ (at independence) that were designed to meet the need of trained nurses and generate additional funds for hospitals. The additional funds cited here probably came from the income hospitals made from running nursing schools. University based education for nurses started five years after independence. Adebanjo and Olubiyi (2008) reported that the University of Ibadan was the first university in the country to start training nurses at bachelors’ degree level in 1965. The programme was aimed at producing nurse educators and nurse administrators and by 2013 was being phased out as having outlived its usefulness (Ayandiran et al, 2013). The programme was being phased out firstly because the Nigerian University Commission in 2010 considered basic nursing as the benchmark programme and the realization that basic nursing education at the university level would have a better impact on meeting the health needs of population (Ayandiran et al, 2013). The basic bachelor of nursing programme designed following North American models was started by the University of Ile-Ife (also called Obafemi Awolowo University) in 1973 (Adebanjo and Olubiyi, 2008), and became the nationally accepted standard nursing programme by the National Universities Commission in Nigeria (Ayandiran et al, 2013).

The development of nurse education in Nigeria has not been very smooth and straightforward as the description above seems to suggest. Unlike what we see in the case of China and Iran below, Nigeria’s Federal Ministry of Education (2005) observed that traditional systems of education in precolonial Nigeria were easily replaced in favour of western education models during the colonial era. It is possible to assume from this fact that nurse education was probably not indigenised since the colonial system of education was mostly embraced. In later years as the education system was reformed and restructured with standard certificates for different levels of education, nursing was left out. Ayandiran et al (2013) observed that while clearly defined qualifications like the ordinary national diploma and higher national diploma were being established for professional programmes, nurse education remained hospital based without a clearly defined status or ‘quantified certificate

face value'. This situation they argue is not unrelated to the fact that historically nurse education was within the ministry of health making it challenging for it to align with national education reforms. The effect of this they concluded is that there is a slow pace of academic progression for hospital based programme graduates. Their RN qualifications according to Ndatsu (2002) and experience were not considered valuable in obtaining admission into universities. Attempts to address the problem included the affiliation of nursing schools with universities. However, as Ayandiran et al (2013) observed this strategy was not very successful because universities placed stringent rules for affiliation and insufficient number of nurses with qualification to teach at higher education level.

So while many universities have started basic nursing programmes towards a bachelor's degree, nurses with diplomas from hospital-based programmes still have challenges to upgrade their diplomas. Innovative solutions that have been attempted here include part-time and distance learning programmes. Adebajo and Olubiyi (2008) describe the part-time programme started by the Obafemi Awolowo University in 2004 targeting the diploma nurses. In addition the national open university of Nigeria also started distance learning programmes to help these nurses stay on their jobs and obtain education to upgrade their diplomas (Ayandiran et al 2013). In the process of nurse education development in Nigeria, Ayandiran et al (2013) observed that the Nursing and Midwifery Council of Nigeria (NMCN) has been instrumental in the process of regulating practice and education. They cite NMCN policy of 2010 that recognised part-time education for practising diploma nurses and the establishment of clear entry requirements to ensure that all candidates in nursing programmes meet university entry requirements.

Iran

Nursing education began in Iran in 1916 with the establishment of a nursing school by American missionaries training mostly to meet the needs of hospitals with focus on practical skills (Khomeiran and Deans, 2007). The model of training was American and Nikbahkt et al (2003) posited that the graduates from these programmes at the time were simply called 'doctor assistants' because they were perceived as handmaids to the doctor. Over the years this model was gradually changed as the

influence of British trained nurses grew within Iran (Khomeiran and Deans, 2005). The educational system started with an American model but later changed to a British model. The literature doesn't seem to mention a local model but after the Iranian revolution of 1979, Nikbahkt et al (2004) reported that this British model was replaced by a reconstructed model. The new model saw the integration of religious beliefs into the nurse education system with the goal being to prepare nurses to meet the spiritual needs of the communities they will serve (Khomeiran and Deans, 2007).

Another part of the change was the recommendation that the care of patients should be provided by a nurse of the same gender as the patient (Nikbahkt et al, 2003), a change which according to Khomeiran and Deans (2007) encouraged males to seek a career in nursing. Khomeiran and Deans (2007) also noted that the growth and development of nursing schools over the years were greatly directed by government legislation. A case in point is the policy that required all students to take a national entrance examination into universities. Nikbahkt et al (2004) argued that the implementation of the policy meant that students with the highest scores got admitted into more prestigious programmes (medicine, dentistry and pharmacy) while those with less stellar performance either chose nursing or were forced into nursing. This means that such candidates ended up studying nursing not as a matter of choice but as their only option of getting a university-based education and a professional role. Apart from the Islamic revolution another aspect that has influenced the development of nurse education in Iran is war. The Iraq-Iran war created such a high demand for nurses that the traditional 3-year programmes were reduced to 2-years to rapidly meet this demand (Khomeiran and Deans, 2007). They added that subject to meeting admission conditions, these two-year and three-year diploma holders could do a two-year or one-year programme respectively to get a degree, but after 1987 the education system was consolidated to four-year degree programmes.

The control and regulation is in the hands of the state through its ministry of health and higher education, which provides a national plan including aims, scopes, and content of nurse education programmes (Khomeiran and Deans, 2007). They add that all schools are expected to follow the national plan though schools could design their own curriculum strategies (teaching and learning methods, assessment, examinations and evaluation) to achieve those guidelines. Such a plan thus

gives schools enough wiggle space to introduce their unique characteristics into their nursing programmes. For institutions in the public sector Khomeiran and Deans (2007) observed that the state paid for their education and the students were entitled to grants and loans. The role of an autonomous nursing professional body in the nurse education is not clear. Khomeiran and Deans (2007) indicated that the national education plan is drawn up by the nursing council of the ministry of health and higher education which though providing education right up to doctoral levels recognises only one professional rank – the registered nurse. It can thus be assumed that the nursing council is more or less a council within that government ministry that is responsible for issues of nurse education and not a professional body. Today the nurse education system in Iran considers the four-year bachelor programme as the entry to practice programme and as indicated by Khomeiran and Deans (2007) expanded to Masters' programmes in 1988 and Doctoral programmes from 1995.

China

The first school to train nurses was opened in China's Fuchou in 1888 by an American Ella Johnson (Chan and Wong, 1999). Education of nurses quickly expanded and by 1915 Hong and Yasushiro (2003) reported that there was already a well-established professional certification system culminating in Asia's first 5-year bachelor of nursing degree programme in 1920. All the educational institutions at this time were probably all in the private sector because Smith and Tang (2004) observed that the Chinese government only started its own nursing schools from 1930. They considered that tertiary education had been a reasonably successful project in China by that time. Xu et al (2000) observed that between 1924 and 1952, China's first institution to offer the bachelor's degree in nursing (the Peking Union Medical College) had graduated 264 nurses with bachelor degrees. This growth and progress was not to last. By 1952 the communist party which came to power following a 1949 revolution brought in a soviet model of education that saw the abolition of all post-secondary nursing education (Xu et al., 2000). Only the 3-year training programmes which followed 9 years of primary and secondary school were now available (Hong & Yatsushiro, 2003). So an advancing nurse education system was suddenly relegated back to basic training as a result of a cultural revolution.

The backward trend continued with the final suspension of even the 3-year diploma training. Chan and Wong (1999) observed the Cultural Revolution that lasted from 1967 to 1977 saw the effective suspension of nurse education with the government closing most of the nursing schools. Bachelor level education in nursing was only revived in 1983 after a 30-year gap that affected the educational advancement of nursing as a respectable profession (Chan & Wong, 1999). Even with this development, they remarked that 95% of all Chinese nurses at the time trained in 3-year programmes in nursing schools attached to hospitals. Within the same period a higher university diploma in nursing was also reintroduced (Hong and Yatsushiro, 2003). Graduates from both types of diploma programmes obtained registration by passing a licensure exam while those graduating from the bachelor degree programmes obtained direct registration (Smith and Tang, 2006). The five-year bachelor degree programme was considered the elite programme because of its duration and the fact that it was the highest qualification at the time (Chan and Wong, 1999).

One of the interesting things about Chinese nurse education development is the fact that a local model of nursing care was incorporated into the system. Xu et al (2000) noted that the local model trains students to be familiar with the principles of Chinese medicine with many graduates choosing to work in that field. The other track is usually taught in English or Japanese and prepares candidates for an international career (Smith and Tang, 2006). This is an interesting case where a country has been able to develop a nurse education that takes into consideration its culture and at the same runs a parallel 'modern' nursing education programme. Wong et al (2003) reported that the ethos of Chinese traditional nursing is closely linked with the local beliefs of what illness and disease are. This paradigm according to Smith and Tang (2006) has its roots in Confucian thought and the theoretical foundations of traditional medicine central to which is the concept of 'yin-yang' and the five phases. In their analysis of these concepts, Wong and Pang (2000) suggested that in Chinese traditional medicine, man interacts with his environment and the five phases of wood, fire, earth, metal and water. Illness and disease results when there is disharmony between the human body and its environment. So focus of treatment is on restoring this balance with the individual's total environment and in this process they believe that 30% of healing depends on treatment and 70% on

nursing care. This is the basis of the philosophy of Chinese traditional nursing and as seen above, nurses are trained on this philosophical basis and go ahead to practice in this area. However, this has not prevented nurse education from going beyond the bachelor degree level. The first postgraduate programmes were introduced in 1992 (Hong and Yatsushiro, 2003).

Brazil

Prior to the establishment of nursing schools in Brazil nursing care were delivered by priests and nuns as well as slaves, Indians and later untrained personnel including men and women (Paixão 1951; Oguisso and Freitas, 2015). The beginning of formal training is linked to US nurses who came to the country in the early 1920s as part of an agreement between the government and the Rockefeller Foundation to fight the yellow fever epidemic of the time (Carvalho, 1976). These nurses stayed on to help establish the first school of nursing in 1923 whose first graduates went on to create the Brazilian Nursing Association in 1926 (Oguisso, 1996). The school was named the Anna Nery School for Nurses (currently part of the Federal University of Rio de Janeiro) in 1926 (Oguisso, 2007) and in 1931 it was set up as the standard official nursing school after which all other nursing schools had to be modelled (Oguisso and Freitas, 2015). This school was considered the second official school within the modern system because back in September, 1890 a school for nurses was opened by French-educated psychiatrists at the National Insane Asylum (Moreira and Oguisso, 2005). But they reported that this training did not follow the Nightingale model of nursing and was opened to any literate man and woman. The first school of nursing following the Nightingale model was started for young women at the Samaritan hospital around 1894 by a group of English nurses who were part of a group of English, German, and American doctors (They started the hospital – which later became part of the University of Sao Paulo – in 1890, practising and keeping all patient notes in English right up till the early 1960s) (Cavarlho, 1965; Oguisso and Freitas, 2015). At this point the influence of two different models of nurse education i.e. the American and English models are both operating within the Brazilian system.

One thing to note is that apparently, the first people to carry out nursing services in Brazil were volunteers who were not paid. Moreira & Oguisso (2005) seemed to make allusions to this when they indicated that professionalization in terms of a remunerated activity came with start of the school of nursing at the Insane National Asylum in 1890 (renamed Alfredo Pinto nursing school). So the catholic missionaries who dominated prior to this time apparently did not consider nursing a paid activity. Even during the period from 1930-45 Gomes et al (2005) noted that the Catholic Church established a strong alliance with the state which resulted in vocational awakening and compulsory religious education in school curricular. This they observed was fostered by the presence of religious women as managers of nursing schools.

Apart from this another key influence on the evolution of nurse education in Brazil is the Brazilian Nurses Association (BNA). According to Oguissa and Freitas (2014) the BNA worked hard for many years to get the government pass a law in 1949 to regulate nursing education in the country. This law made mandated that the creation of new nursing schools must be attached to university centres or colleges of medicine without autonomy (Silva and Batista, 2007) thereby effectively placing nurse education within the university. The status of nursing as a higher level profession within the Brazilian public was further strengthened with the consolidation of education within the university system by another law in 1960 (Carlos et al, 2014; BNA, 1980). The BNA was also responsible for more actions that led to the state authorising in 1973 the 'Cofen' as the national nursing regulatory body with mandatory membership for all nurses. Carvalho (1976) also reported that the BNA carried out Brazil's first nursing research project - 'Survey of Needs and Resources in Brazil, 1956–58' with funding from the Rockefeller Foundation.

2.2.2 Trends to note

The common characteristic of the countries reviewed above is that all of them had nurse education introduced by foreign powers. The key trends show that nurse education is foreign to most colonised states across the Americas, Africa, Middle East and Asia. In each of these countries nurse education was introduced by missionaries or colonial governments and so its model remained largely foreign. China presents an interesting scenario where two strands of nurse education have evolved, one

following 'modern' nursing and the other following Chinese traditional health beliefs and philosophies. Such models have the potential to enrich nursing philosophy and strengthen nursing's professional status. Another example similar to China is Iran which introduced Islamic religious beliefs into its nurse education model. These cultural modifications of nursing reflect the national contexts of countries that simply adopted or had formal nurse education imposed on them. The literature on Nigeria, South Africa, and Brazil do not show evidence of cultural models impacting or being incorporated into nurse education. These countries embraced foreign models and though over the years have passed nurse education policy to meet their public health needs, they have not developed cultural models as clearly seen in the China example. Researchers have to consider this particular issue and assess if nursing is losing or gaining by not considering local care models in each country's nurse education development. Researchers also have to establish how the inclusion or exclusion of local models impact nurse identity, output, and status.

Another key influence is that of the state and revolutions. In all the countries the state is responsible for enacting policy that also includes nurse education policy. The state determines where nurse education is going to take place and who is going to be responsible for it. State policy will determine which government agency will be responsible for nurse education or how nurses will be trained and deployed to meet national health policy goals. State priorities like meeting man power shortages, health needs and budgetary needs also were shown to influence government policy on nurse education. These policies are usually affected radically during revolutions as can be seen in the Chinese experience when nurse education was brought to a complete halt during the Cultural Revolution. In Iran the Islamic revolution led to the integration of religious beliefs and values into nurse education curriculum. In South Africa the fall of apartheid ushered in a new era of nursing eliminating racial discriminations that had characterised the development and evolution of nurse education. Professional associations were also shown to have influenced the development of nurse education especially in countries like Brazil and South Africa where the literature shows the nursing associations were instrumental in lobbying government to issue laws promoting nurse education advancement.

This snapshot review of historical trends in nursing education aimed not at a critical analysis of factors that have been inherent in that process across different countries. The goal was to pick out from the different regions in the world, general trends that have influenced historical development of nurse education in countries that saw nursing introduced as a foreign profession. Nigeria and West Cameroon were once administered together by the colonial British administration and so its evolution of nurse education is of particular interest. These general trends identified from country-specific literature will provide a comparative lens to assess findings from the study with respect to nurse education. The decision not to explore any factors in great detail was also to avoid looking at the emerging data through a lens of such factors thereby avoiding the risk of not picking out sensitive emerging data from the local setting.

2.3 Contemporary Issues in Nurse Education

2.3.1 Variations in education policy

There have been significant efforts to adopt common policies for nurse education across the world with respect to entry level qualifications, programme qualifications and advanced education. A good example of this is the Bologna process which was born out of a desire to establish a common higher education area to adapt education and research in Europe to the changing trends and advancing scientific knowledge (European Ministers of Education, 1999). From this initiative, several European nursing organisations and the International Council of Nursing (ICN) recommended in 2008 that basic nursing programmes should be at bachelor level, guarantee the acquisition of required competencies and last for a minimum of three years with a research and skills-based curriculum (Salminen et al, 2010). The implementation of these changes has been challenging for most European countries (Spitzer and Perrenoud, 2006; Sztembis, 2006; Davies, 2008; Bahçecik and Alpar, 2009; Patelarou et al., 2009) and these are not unrelated to the variations in national legislation, culture, healthcare needs, philosophies and economic condition of member countries (Salminen et al., 2010).

In an analysis of the variations in implementation Lahtinen et al (2014) used nursing education system; duration; title of nursing graduate; postgraduate degrees; entry qualification and practical

training; and registration, specialization and tuition, to compare the countries that were signatory to the Bologna Process. They found the following variations:

1. *Nursing education system:* 68% of nursing programmes were offered at higher education level while up to 32% were still offered at diploma level. 60% of the countries offer a single point of entry (with 74% of these being the bachelor degree), while 29% offer two points of entry (54% of these offer either at the diploma or bachelor degree level while 38% offer two entry points but both leading to a bachelor's degree).
2. *Duration:* full-time programme duration ranged from two – four years with 58% lasting for three years and 31% for four years. For the schools within higher education 51% offer three-year programmes while 42% offer four-year programmes.
3. *Title of nursing graduate:* 82% of the countries offer higher education programmes leading to a bachelor's or equivalent. But when all the education systems are considered 68% of programmes lead to bachelor's degree while in 23% of the countries, studies lead to a diploma. The bachelor degrees are generally awarded by universities, colleges, university colleges and universities of applied sciences or polytechnics.
4. *Postgraduate degrees:* Master's and doctoral programmes are offered in 60% of the countries while in 27% of the countries postgraduate studies are not yet available. Six of the 45 countries have the master's degree as the highest level of education for nurses.
5. *Entry qualification and practical training:* all the countries meet the set directives in terms of minimum number of years of general education required prior to nursing education and the minimum number of practical hours.
6. *Registration, specialization and tuition:* countries are allowed to determine the registration authority for nurses. In 52% of the countries the title of registered nurse is awarded by government and by a regulatory body in 38% of them. Only five countries (Austria, Germany, Ireland, Malta and the United Kingdom) offer undergraduate specialisation programmes. For tuition fees, 48% of the countries charge tuition fees in state-owned

schools. All the countries that charged tuition fees offered programmes towards the bachelor's degree except for France which offered diploma level programmes.

The above variations are outstanding because all the countries studied are members of the European Higher Education Area (EHEA) and are supposed to be running a harmonized system of higher education. In the USA inconsistencies are still observed in nurse education. Rich and Nugent (2010) observed that as far back as 1965 the American Nurses Association called for the 4-year baccalaureate (BSN) degree to be the entry into professional practice but by 2007 54% of nursing students were in two-year associate degree programmes, 42% in BSN programmes and 4% in three-year diploma programmes. This shows that the USA still has multiple levels of entry into nurse education. Rich and Nugent (2010) citing the National League of Nursing observed that 57% of all entry-level nursing programmes in the US were the associate degree programmes. It is in recognition of such trends that the IOM (2010) proposed that the US plan to implement measures to increase to 80% the number of nurses with bachelor degrees and double the number of nurses with a doctorate in the US by 2020.

The requirement for training nurse educators is another area that reflects variations even within a harmonized area like the EHEA. Jackson et al (2009) observed that nurse educators should at least have a university degree but the career pathways for this was poorly defined and varied across Europe. In fact there is no consensus on what the minimum qualifications or experience of nurse educators should be (Salminen et al, 2010). They observed that doctoral-level preparation is the desired level for nurse educators in order to ensure that the profession develops its own research leaders for the future. The variation may have an impact on the quality of training and probably the number of nurses that can be trained. In the USA, the American Association of Colleges of Nursing (AACN) in 2005 drew attention to the critical shortage of nurse educators in the US and that it was contributing to the overall nursing shortage (Rich and Nugent, 2010). The shortage of educators was attributed to growing opportunities outside health care, emphasis on long clinical careers before entering academia, low salaries as compared to clinical practice and administration, high cost of required education, high workloads and low salaries for educators, fluctuations in nursing school

enrolment, and lack of funding to recruit educators (Yordy, 2006). These factors add to the complexities already associated with the preparation of nurse educators. Yordy's (2006) factors may have been based on the US but it is likely that some of the factors might resonate with other countries as well. In such cases countries will adopt different approaches to addressing the issues thus leading to more variation in the educational preparation of nurse educators.

Cameroon's nursing education system reflects some of the inconsistencies that have been shown in other countries. The variety of pre-registration diploma programmes with varying entry qualifications give people many different entry levels into nursing. The existence of hospital based nursing school diploma programmes, higher education based diploma programmes and university based bachelor's degree programmes also introduce variations in duration and exit qualifications. Master's and doctoral programmes have not become common as Cameroon is still to offer its first doctoral programme in nursing. However, Cameroonian nurses had expressed desire for graduate and postgraduate studies many years back. Junang (1996) called for the institution of master's and doctoral programmes for the nurses arguing that the dynamic nature of care requires constant research which in the case of Cameroon was made difficult by the low level qualifications in nursing education. He saw the advanced programmes as an accessory for health professionals including nurses to advance their professions and improve the quality of care rendered to clients.

2.3.2 Access to further education

Access to further education in this context refers to diploma to bachelor degree upgrade programmes that can facilitate access to postgraduate studies for diploma level nurses. The movement from diploma programmes to bachelor degree programmes are still ongoing in many countries. Bridging or upgrade programmes have been designed in different countries to facilitate diploma nurses' acquisition of the bachelor's degree. As Andrukaitis (1995) noted, the admission requirements differ across states, national and international boundaries. In Australia, Hutchinson, Mitchell and St. John (2011) observed that in some states like Queensland, enrolled nurses are automatically granted one year of credit to a university bachelor degree programme. While in other states enrolled nurses have

to apply for accreditation of prior learning, have a minimum of one year working experience or complete a mandatory bridging programme (Phillips, 2008).

Suva, Sager, Mina, Sinclair, Lloyd, Bajnok and Xiaol (2015) define bridging as an academic pathway that takes into consideration the past experiences and existing skills and knowledge of the student. Such programmes are necessary because countries are increasingly adopting the bachelor's degree as the entry point of professional practice. The argument for this is that bachelor degree is essential to preparing nurses to adequately meet the expanding scope of RN practice and the needs of a constantly changing environment (Dean, 2009). Other authors have argued that the employment of bachelor's degree nurses has been associated with decrease morbidity, mortality and failure-to-rescue rates in hospitals (Aiken, Clarke, Cheung, Sloane, and Silber, 2003; Estabrooks, Midodzi, Cummings, Ricker, and Giovanetti, 2005; ; Friese, Lake, Aiken, Silber, and Sochalski, 2008; Altman, 2011). Higher percentage of bachelor's degree nurses have also been linked to shorter lengths of stay, lower rates of 'nurse-sensitive outcomes' like pressure ulcers, congestive heart failure mortality, postoperative deep vein thrombosis or pulmonary embolism (Blegen, Goode, Park, Vaughn and Spetz, 2013) as well as decreased rates of medication errors (Chang and Mark, 2009). In Europe, Collins and Hewer (2014) observed that one of the most significant changes from the Bologna process was the adoption of the three-cycle higher education degree structure i.e. bachelor's, master's and doctoral levels. As a result, participating countries either changed (or are changing) their programmes to three-year bachelor's and two-year master's based on the European Credit Transfer System (ECTS) (Adelman, 2009).

Bridging programmes usually come with a series of challenges that could serve as a barrier for nurses wanting to enrol in them. A common observation is that the students were usually not aware of the academic demands, time, and the level of knowledge required to succeed in the programme (Cook, Dover, Dickson, and Engh, 2010; Hutchinson et al, 2011; Ralph, Birks, Chapman, Muldoon and McPherson, 2013). The use of self-directed learning and grasping the conceptualisation of knowledge in the bridging programmes is challenging for nurses who had been used to directed learning and ready-made knowledge for application (Hylton, 2005). Rapley, Nathan and Davidson (2006) also

observed that in clinical placements these students felt that the nurses expected more from them in terms of knowledge and skills because of their diploma background. Social structures within the student's environments constitute barriers as well. This occurs in the form discouragement from peers, insufficient community resources and inadequate support from employers in terms of allocating time for studies (Melrose and Gordon, 2008; Porter-Wenzlaff and Froman, 2008). The differences in standards with respect to accreditation of prior diploma-level nurse experience and knowledge (between institutions and between countries) is seen as another deterrent (Ralph et al, 2013). In some cases diploma nurses have to compete for the same space as prospective basic bachelor-level entry students because universities don't have any special allocations for them thus posing admission barriers (Suva et al, 2015).

To overcome some of these challenges at the personal level, encouraging candidates to reflect on the past experiences as second-level nurse, the features and expectations of the bridging programme prior to seeking admission will help them get what works best for them (Porter-Wenzlaff and Froman, 2008). At the institutional level, Suva et al (2015); Miller and Leadingham (2010) proposed that staff should assist students develop their planning, writing, comprehension and literature search skills. They also propose curricular modifications in the areas of teaching and learning methods. Curricular modifications could also include online delivery of programmes (Rapley et al, 2006; Ralph et al, 2013) flexible and efficient class schedules (Hutchinson et al, 2011) which can all greatly facilitate learning for the student. Incorporating and validating the student's past experience as second level nurse, was also found to facilitate adaptation to the programme (Melrose and Gordon, 2008; Hylton, 2005; Adelman, 2002). This acknowledgment of prior knowledge and skills should also have credit value. In other words, the student should be given 'advanced standing' or credit waivers based on the assessment of these prior knowledge and experiences (Brown, Falkingham, Fischback, Nerud, and Schmidt, 2005; Porter-Wenzlaff and Froman, 2008; Ralph et al, 2013;). Also, the use of peer and staff mentorship by institutions helped students in bridging programmes overcome challenges of handling multiple roles, adapt to the academic environment and to acquire the necessary skills

required for success (Rapley et al, 2006; Porter-Wenzlaff and Froman, 2008; Hutchinson et al, 2011; Ralph et al, 2013; Suva et al, 2015).

Bridging programmes has relevance for nurse education in Cameroon because of the vast majority of pre-registration diploma programmes. The commencement of bachelor's degree nursing programme in 1997 in Cameroon with the subsequent increase in the number of such programmes alongside diploma programmes indicate that bridging programmes could be part of education discourse in the country. There might be nurses who entered practice through diploma programmes who might want to pursue the bachelor's degree qualification. There could also be younger generation of nurses who might have been forced to register for diploma programmes instead of direct entry to bachelor's degree programmes for one reason or the other. They all might be interested in bridging programmes

2.3.3 Nursing leadership and power

According to Welford (2002) the Department of Health (1989) defined leadership as setting the pace and direction for change, facilitating innovative practice, ensuring that policy is up to date, that professional standards are set in relation to care and that a comprehensive service is developed over time. It is about unifying people around values and then constructing the social world for others around those values and helping people get through change (Stanley, 2006). In summary, leadership is a process built around the ability to influence and motivate individuals or groups towards common goals (Vroom and Jago, 2007). Whether considering leadership within the individual or group context, the concept is a complex one. The health care environment constantly changes; the social environment changes; government policies change and political revolutions come and go. All of these have an impact on nursing as a component of society and as such the profession has to be able to function effectively in such a changing context. In this light, leadership within the profession is an important issue to analyse. The development of future nursing leaders is an obligation of current professional leaders (Dyess, Sherman, Pratt, and Chiang-Hanisko, 2016) especially because in spite of the recognized need for succession planning, the lack of an adequate leadership pipeline has become one of nursing's key challenges (Thompson, 2008; Sherman & Pross, 2010; Sverdlik, 2012). It can be assumed that nursing having come this far in its evolution has been because of hard work

from nurse leaders across the world, making it necessary to prepare a generation of new leaders to tackle the challenges of the future. Most of these leaders belong to a generation that is currently retiring from the work force. This generation is referred to as baby boomers and were born between 1946-1964 (Zemke, Raines and Filipczak, 2000). Their retirement according to Dyess et al (2016) will place huge demands on already challenged health systems. The American Hospital Association (AHA) in 2014 observed that the replacement for this generation of nurses will be a large cohort of nurses born between 1980 and 2000 and who will constitute 50% of nursing workforce by 2020.

The need for leadership goes beyond the fact that older generation of nurses are gradually retiring from the workforce. The changes taking place constantly within healthcare systems pose challenges for the nursing profession raising the need for leadership. Maccoby and Scudder (2011) asserted that organizations [professions] need leaders who can stimulate innovation and the development of knowledge, manage change and provide strategic direction. The constant changes taking place and the need to adjust to them can become frustrating because it creates a sense of uncertainty and instability. Effective nurse leadership can help the profession navigate such a scenario. The new generation of leaders according to Thorne (2006) must help the profession avoid passivity and victim mentality that nurses are powerless to do anything about some of the bad decisions that arise from the environment and impact the profession. Leadership must not be reactive because that could create a sense of 'running uphill' for the profession. Nursing leaders have to study current trends and predict direction of future trends and prepare the profession to influence the process and not just react to it. So, preparing for leadership will give young nurses a unique opportunity to collaborate with other healthcare professionals to actually lead improvement and new designs for healthcare systems and the practice environments (IOM, 2010). Meeting these challenges require a number of strategies including ensuring that there is a significant cadre of young nurses who are keen and are ready to take up the mantle of leadership (Scott and Yoder-Wise, 2013; American Organization of Nurse Executives [AONE], 2014). A key aspect of preparing nurses for leadership seems to be through educational preparation. In the past, nurse leaders kind of stumbled into leadership without any academic preparation so projects targeting young nurses like the master's in nursing administration

and financial leadership aiming to prepare them for leadership positions reflect a clear paradigm shift in recent times (Dyess et al, 2016; Sherman, Bishop, Eggenberger & Karden, 2007).

The emphasis on preparation for current and future leaders points to education. Education is an important way to produce the next generation of leaders. When this training is combined with succession planning there is a chance for group success (Minnick, Norman, Donaghey, Fisher, and McKirgan, 2010:504). When emphasis is placed on education then the role of nurse educators becomes essential to this process. Nurse educators have the primary responsibility to prepare nursing professionals and consequently its leaders. To achieve this, educators themselves need leadership knowledge and skills to adequately prepare undergraduate and postgraduate students for the current and future challenges (Patterson and Krouse, 2015). A good number of current leaders in academia – 63% actually, acknowledged in a study by Adams (2007) that they had no interest in administrative or leadership positions. Many of them who had this role thrust upon them did not have adequate leadership education or experience (Young, Pearsall, Stiles, Nelson and Horton-Deutsch, 2011). It is possible to assume that people who did not actively seek leadership will likely not be ready to make the necessary sacrifice of time, commitment and self that may be necessary at times. It is also possible to assume that such leaders will not perform well in their new roles. These assumptions are linked to the understanding that people seek to prepare themselves in various ways for the things they are interested in. Therefore if they are interested in leadership they will try to prepare themselves for it. However, these issues are not raised in Young et al (2011). Rather they point out that for most of the leaders who had leadership ‘thrust’ upon them by circumstances, they were usually the most qualified nurses with postgraduate degrees at the time of need. So though they were not academically prepared their level of education was perceived as conferring upon them a certain degree of leadership ability. Education and other qualities were thus seen in Young et al (2011) as factors that led some nurses to be called to leadership when need arose. These leaders act on their instincts and follow their personal qualities and traits to execute leadership roles. The level to which this is sufficient to meet the array of challenges that come with leadership is highly debatable. With the increased regulation, accountability, costs and changes to nurse education curricular within the

current higher education atmosphere, nurse educators are expected to develop leadership skills necessary to sustain policy, effectiveness and growth (Patterson and Krouse, 2015). This issue has a lot of relevance because higher education is fast becoming the domain of training for nurses as hospital-based programmes are being phased out in many countries. In such scenarios, it is possible to expect that leadership and change strategies will be led by the universities i.e. nurse educators. It will be their responsibility to prepare the students to take on leadership roles to advance professional growth and prepare the profession for current and future challenges. If most of the current leaders of the profession, just found themselves in leadership, it is possible to assume that not having been educationally prepared might have impacted their capabilities as leaders.

Academic leadership is not only going to bring about increase staff satisfaction, retention and healthier work environments (Brady, 2010; Siddique, Aslam, Khan and Fatima, 2011) but will also ensure graduates have skills necessary to seek and function in leadership positions. In defining competencies for training nurses in leadership the National League for Nursing (NLN) (2006) emphasised evidence-based teaching and evaluation; mentorship of new educators; advancing the profession; identifying with the academy; curriculum design, implementation and evaluation; leadership to transform and re-envision nurse education; and building the science of nurse education (Patterson and Krouse, 2015). Obviously, the NLN considers that applying these components in their role is a quality that makes good academic nurse leaders. Their suggestion is asking future nurse leaders to embrace educational advancement and the trappings of academia as well as be ready to adapt curricular to meet both current and future changes in practice. There is also the focus on preparing nurses to contribute to the knowledge base of the profession thereby encouraging research. This last bit requires that nurse educators readily assume leadership roles (Patterson and Krouse, 2015). Preparing nurses then just for their clinical role is insufficient to give the profession that kind of leadership it should have. That will be insufficient to prepare them to take on research roles, identify academic and social strategies to advance professional growth and develop adaptability qualities. In their work on leadership competencies Patterson and Krouse (2015) identified four core competencies for leaders in nursing education: articulating and promoting a vision for nursing

education; functioning as a steward for the organization and nursing; embracing professional values within higher education; and developing and nurturing relationships. These competencies are similar to the emphasis from the NLN (2006) and show a trend towards dynamism, competence, foresight and visionary capacity as individual qualities.

Looking at the above competencies, there is an indication that leadership is not limited to leading or being at the top or being in charge. It is also about skills, knowledge and qualities every nurse must develop. Keeping the profession dynamic, being ready to assume leadership in an administrative position, advanced teaching and learning practices, evidence-based patient care and research are thus essential competencies that nurse educators must help nursing students to achieve. Leadership in nursing is therefore not only dependent on role or title, limited to the academic or professional environment, limited to formal or informal positions, but includes all these as well as a capacity to develop a vision for the future and creating and sustaining environments to achieve that future (Patterson and Krouse, 2015). Reflecting on leadership and the education of nurses for leadership is something for Cameroon nurses to consider. In a study like this one it is worth reflecting on how education has influenced leadership and vice-versa in the evolution of nurse education in Cameroon. Nursing is a powerful professional group with tremendous power that has to be harnessed as a social force to influence social change only if nurses can work together and support each other from their different visionary positions (Thorne, 2006). Therefore nurse educators and administrators must 'hold a mirror' to future leaders (Young et al, 2011) with every nurse collaborating with present leaders through shared governance to promote positive outcomes (Reilly and Morin, 2004). Under such conditions it can be assumed that young nurses will confidently rise up to assume leadership roles in various levels of institutional governance and advocate for nursing and nurse education in the political environment (Halstead, 2007).

2.3.4 Globalisation and the internationalisation of nursing education

In the quest for education many nurses (just like this researcher) are going beyond national boundaries. In the assessment of challenges to contemporary nurse education the issue of globalisation and internationalisation must be considered because if nurses are not moving for

educational purposes, they will be moving for work purposes. Globalisation in broad terms has been used to describe the ongoing integration of societies and economies as well as the ever increasing mobility of capital, labour, technology, goods and services (International Monetary Fund, 2008; Smith & Smith, 2002). On the other hand internationalization is a term that has been very common in politics and international relations but is now used sometimes as a synonym to globalization (Beumann and Blythe, 2008). In education the term has been used to depict the process of “integrating an international, intercultural, or global dimension in the purpose, functions, and delivery of postsecondary education” (Knight, 2003). Linking the two, globalization is seen as the driving force behind the internationalization of education (Knight, 2003; Beumann and Blythe, 2008). Other factors behind the internationalization of higher education include the increasing global demand for highly skilled professionals including nurses (Beumann and Blythe, 2008). Institutions are capitalising on these trends to market their programmes globally in many different ways. Some provide admission to international students, provide distance learning, and yet others establish annex campuses and/or franchises in different countries (King, 2006; Knight, 2006). These trends are relevant to nurse education as nursing is one of the programmes being offered at various levels by universities globally.

In recent years, institutions and governments are adopting internationalization as a deliberate policy for economic reasons. The Philippines for example adopted a policy of training nurses for export to the US especially as far back as the 1950s (Brush and Solchalski, 2007). This is happening despite the differences in international education and practice (Baumann and Blythe, 2008). These differences are addressed through curricular modifications for international practice. In the Philippines the nurses are educated in English using US-based curricular (Baumann and Blythe, 2008) which gives them the necessary proficiency needed to work within the US healthcare system. The Indian government copied this approach with a policy that Khadria (2007) described as ‘a comprehensive training-cum-recruitment-cum placement’ programme that prepares nurses for destinations like the US and UK through an agency system. While states are seemingly using deliberate strategies to encourage educational migrations, some students who move also consider

personal reasons before seeking education opportunities abroad. While the socioeconomic situation might be a strong individual factor, Buchan (2002) in Dyson (2005) observed that the lack of health care services in some countries is a factor. According to them poorly developed healthcare services imply that clinical placement experience of student health professionals will be lacking in quality thus moving students to making the decision to study abroad. These personal and state factors reflect the complexity in the internationalisation of higher education. However, states like India and the Philippines for example that have adopted an economic angle to internationalisation have considered the increasing demand for higher education by their citizens and the increasing competition for jobs among the graduates. According to Baumann and Blythe (2008) such ever growing populations and expanding higher education markets in these countries will facilitate the education of nurses for export. Governments support such initiatives because it is a source of income for the country in the form of remittances. A number of authors pointed out that educated but underutilized people are always the first to seize migration openings, and countries encourage this because these ‘surplus human resources’ will contribute to economy through remittances to family members (Baumann, Blythe, Rheame, & McKintosh, 2006; Blythe and Baumann, 2008).

The implication of internationalisation of nursing education requires that nurse educators and education policy makers examine how the concept affects nursing in their countries. Thorne (2006) argues for a modification to training such that nursing students are prepared for a global career and the complexities therein rather than just for a local setting. She adds that these curricular adjustments are even more necessary because diseases that were once considered to plague just a certain part of the world are now everywhere. For a third world country like Cameroon, internationalization will be an interesting consideration because it might be possible that nursing students are considering working abroad. If this is the case then it might be possible that nurse education programmes are being affected by this global outlook. Without studies to cite it is difficult to say with any certainty how nurse education in Cameroon is influenced by internationalisation trends. At the same time, considering that the country is apparently quite open to the global community, it is likely that such trends will be affecting the nurse education system. The argument here is not on the merits or

demerits of internationalisation but rather an understanding of the concept as an aspect of nurse education with potentially significant ramifications for different countries.

2.3.5 Nurse education in higher education

It is commonly acknowledged that nurse education evolved from apprenticeship hospital based models historically to higher education and university based programmes today. This transition is still going on as nurse education still occurs out of higher education setting in many countries including Cameroon. With respect to the current study, this transition is worth exploring due to its relevance to the study setting with its variety of programmes. Reviewing literature on the process will be helpful in gaining insight from some of the issues about nurse education settings that might arise from the findings of this study.

From a historical perspective the commencement of nursing education in higher education was not smooth and straightforward. During the early years of the debate in the US, Yoakum (1931) made a case for nurse education in the university. She argued that there was a variety of things a nurse had to do which required adequate training creating the need for a particular form of education. The university seemed to be the place for that kind of education but she warned that the history of the university in the US was characterised by resistance to new courses such that courses had to come in at the fringe and start pushing against that resistance until they get to the centre. This was a warning for nurse leaders at the time to brace up for the resistance that may characterise the introduction of nursing in the university. The fact that nursing education had been in existence out of the university created a scenario where freshmen students and nurses with diplomas might both be seeking bachelor's degrees in nursing. In this situation Yoakum (1931) suggested that nurse leaders should prepare for both groups by considering those who were capable of becoming administrators and teachers at the university (and so become the leadership of the profession) and those who are satisfied with remaining in hospitals or working under the direction of physicians.

This sounds like creating two types of nurses, those who will advance to represent the profession as full professionals and those who want to operate under the physician's direction. However, it could

also be a pragmatic approach to an issue which must have evoked different arguments and controversies among stakeholders at the time. In apparent reference to acquiring a credible knowledge base for practice, she further argued that university level education should go beyond the traditional preparation that allowed nurses just to follow physician orders and carrying out simplistic acts to complex training that reflects the level of intellect nurses have. The education should provide the same fundamental training given to doctors or something even better so that nurses can stand at the same level as physician. From her arguments it can be perceived that raising nurses' status vis-à-vis physicians wasn't of inconsequence in the case for nurse education at the university. By giving nurses the same kind of education or better than physicians had, the status of nurses will be higher since the assumption seems to be that physicians' high status and power isn't unrelated to their quality and type of education. Yoakum (1931) also recommended that the nursing professors must meet the same standards as their peers in the university, suggesting that they too must acquire PhDs to back their position. She felt the profession in addition had the responsibility to prepare candidates considering nursing as a career, by giving advance information on what studies will look like, expectations of students, and what they should know before seeking nursing education. In other words, candidates should know what kind of pre-university general education will best prepare them for nurse education and also be oriented to the requirements and expectation of nurses. This was surely meant to prepare a qualitative screening process to get the best candidates into the profession.

Forty years after Yoakum's arguments the rationale for nursing education in the university was still a point of controversy. Pellegrino (1968) made a strong argument for nursing's place in the university. He noted that some stakeholders at the time felt that what was needed was numbers, a high number of nurses for bedside care and not nurses with degrees. Some felt that the university was already too involved in professional education and was at a risk of deviating from its academic and scholarly goal with another professional programme like nursing. Yet some others felt that the 'intellectual substance and academic credentials' of nursing did not meet the requirements to join those involved in scholarly endeavours. After acknowledging these arguments, he pointed out that the nursing profession had come of age then and academically merited the same support and consideration given

to medicine when it started moving into the university in the late middle ages. He argued that the 'acculturation' of medicine in the university was still ongoing and its dependence on the university was no longer being questioned. So nursing too should be given just such a chance as at the time it was barely 50 years into its university experience. Another forty years later nursing education in the university had come a long way and had played out differently across different countries.

Nursing departments in universities have grown in prominence while at the same time in some universities it is being subsumed within other departments or schools. Thompson (2009) observed that in the UK many departments had replaced 'nursing' with words like 'health', 'healthcare' or 'health sciences'. He observed at the same time that other departments like medicine and psychology had never done that. Apparently this is a criticism of sorts related to some inferiority complex or conflicting identities. While no reasons for this change to more general names seem to have been published, it is an indictment of nursing leaders failing to project nursing within the university as their counterparts in medicine and psychology have done. This identity crisis is characterised by a persistent introspection and internal bickering whether nursing is a science or art or both even as other professions avoid such focus (Edwards, 1999; Thompson, 2009). Thompson (2009) reported that the US on the other hand projected nursing better by having schools, faculties or colleges of nursing as the norm. He added that even after achieving a place in academia, nursing was still weak in visibility, political astuteness and academic performance, and often withered under external pressure as compared to other professions. Research which is a strong characteristic of academe has been an area where nursing is still to dominate.

At the start of the 21st century, Rafferty, Traynor, Thompson, Illot and White (2003) observed that the research base of nursing was still comparatively weak requiring training and capacity building in this important area. The research culture was also perceived as not being fully promoted by nursing academia (Thompson, 2009). Solutions to strengthening nursing's research capacity included building cross-disciplinary networks that reflect the characteristic complexity of current health issues affecting individuals and communities, but with the contribution of nursing clearly visible and acknowledged (Watson, McKenna and Thompson, 2007). In similar historic comments Pellegrino

(1968) had recommended that nurses should relate with the ‘languages and techniques’ of physical scientists, biologists, social scientists, engineers or statisticians because those professions have knowledge that is potentially valuable for nursing. He added that developing the scholarly and research capacity of nursing will require that at the time the doctoral programmes that bridge nursing and other science subjects like Physiology; Biochemistry; Behavioural Sciences; and Sociology and Anthropology was a good strategy to develop research knowledge in nursing. He argued this will lead to the development of ‘sophisticated curricular’ for nursing since at the time the nursing knowledge base was still too weak to sustain doctoral research only in nursing. Obviously if Pellegrino’s recommendations were still being echoed in 2007 then the perceived weaknesses of nursing in higher education in the mid-20th century were still relevant at the start of the 21st century. Nursing academics should therefore strengthen their positions on the ‘high table of research policy and decision making’ (Watson et al., 2007), because there is still strong need for a deliberate and well planned scheme to build substantive and lasting research based programmes in nursing which can also reap advantages of collaborative research enterprises (Thompson, 2007; 2009).

2.3.6 Social issues and a whiff of agitation in Cameroon

Nursing in Cameroon has a significant feminine representation but it is majority masculine. According to the NOHRHC (2010) females constituted 49.64% and males 50.34% of nursing workforce in the public sector. This does not include data from the confessional, para-public and private sectors. Contrary to these statistics, it is a strongly held popular view that there are actually more female nurses in Cameroon. Cantrell and Dickens (1982) raised the argument that nursing was a predominantly feminine profession and that was a key contributor to the disorganisation that they argued characterised the profession. To them nursing was an excellent embodiment of the female gender. Going by the statistics, nursing in Cameroon should be spared from this gender-related disorganisation because of its strong masculine numbers. How the gender ratio influences nursing and nurse education in Cameroon can only be a matter of speculation due to lack of empirical evidence. However, some nurses in Cameroon like Lewindia (1999) have argued without statistical evidence that government deliberately recruits more female than male nurses because females were

more pliant to physician domination. People who support this argument point to the fact that the physician profession apart from being politically powerful is also male dominated (75.64% of the total physician workforce according to NOHRHC (2010) is male). This feeds cultural paradigms where women are expected to be deferent to males in most Cameroonian tribal customs. In such situations visionary deficiency which typically characterises female positions in such male dominated contexts (Cantrell and Dickens, 1982) may influence political and diplomatic savvy of the nursing profession in the country.

In a study by Maboh (2009) nurses identified their lack of sufficient knowledge as one of the barriers to effective clinical teaching. In the same study, nurses complained that the lack of a Directorate of Nursing in the Ministry of Public Health makes it difficult for nursing issues to be adequately addressed in that Ministry. Perhaps one of the most dramatic issues raised by the nurses in this study was the fact that they had no opportunity for further studies after their professional diplomas. They illustrated this point by pointing to medical doctors who came to them as students, went on to complete their programmes and even went on for specialization while they marked time on the same spot. This situation according to the nurses can be remedied by leadership and education. In a conference presentation Maingeh (2011) observed that it was very imperative that nurses in Cameroon take leadership roles to close gaps and to improve access and equity in health care by designing education to meet societal and professional changes. Such an educational system should consider a platform where the bachelor's degree becomes the point of entry for professional practice within a ministry of health led nurse education initiative (Shishu and Junang, 2011). Though they recognised the value of higher education, their proposal fails to say how that can be achieved since higher education is in the domain of the ministry of higher education and not health. In Cameroon the award of degrees is the prerogative of the ministry of higher education, so recommending something different is a radical shift from the status quo with highly unpredictable outcomes if implemented.

The above arguments are very descriptive and demonstrate the state of awareness of nurses with regards to issues of nurse education. However, they don't reveal anything about the more complex factors and their interactions that might be influencing nurse education development. The substantial

lack of empirical evidence on nurse education in Cameroon also makes it difficult to carry out a convincing academic discourse on nurse education vis-à-vis contemporary trends. This is a key factor that has influenced the design of this study and even the review of literature. For a country whose nurse educational system has not been the subject of scientific studies it is wiser to avoid approaching this research with strong theoretical assumptions. Such an approach will complicate the study's potential to pick out the unique characteristics of the context for an original contribution to the body of knowledge on nurse education development. Rather it will subtly cause data to be seen in the light of extant concepts with just the value of comparing and contrasting with such concepts. Therefore the more 'general' review of literature covered in this chapter was meant to serve as an orientation to contemporary educational issues in a more global context.

2.4 Conclusion to Chapter

In this chapter a general review of contemporary issues in nurse education has been made. The rationale for this approach has been made on the basis of Glaser's (1978) and Charmaz's (2006) arguments for the delayed literature review. However, to meet the requirements of a student PhD research project, a lighter pre-data collection review has been done here to serve also as evidence of awareness of contemporary issues in nurse education. The historical context of nurse education evolution in selected countries from different regions of the world (but with the common characteristic of having nursing as a foreign introduction) has also been presented. In the next chapter a more detail discussion on the grounded theory methodology and its application in this study is presented.

CHAPTER THREE

RESEARCH METHOD

3.0 Introduction to Chapter

This chapter covers the method used in the study. It begins with the articulation of the position of the researcher before delving into the study design. Ethical issues are also discussed before ending with the data analysis plan

3.1 The Position of the Researcher

3.1.1 Ontological and epistemological position

My ontological position leans more towards the naturalist paradigm than to the positivist paradigm. Positivism is an epistemology that subscribes to a unitary scientific method consisting of objective systematic observation and experimentation in an external world with the goal to discover and to establish general laws that explain the studied phenomena and from which predictions can be made (Bryant and Charmaz, 2007). The naturalistic paradigm or postmodernism on the other hand is described by Bryant and Charmaz (2007) as a theoretical turn that challenges the foundational assumptions of the Enlightenment with its belief in human reason, belief in science, and belief in progress through science. Postmodern thinking emphasizes the value of deconstruction (i.e. taking apart old ideas and structures) and reconstruction (i.e. putting ideas and structures together in new ways) (Polit and Beck, 2004). I believe in multiple realities and the fact that reality is subjective. A half-filled glass will be described by some as ‘half empty’ and others as ‘half full’. People experience the same phenomena in different ways and arrive at different truths which may or may not be ‘objective’. However when the researcher attempts to understand the meaning of the phenomena as each individual perceives, and examines that individual’s position with respect to his context (holism), he can then grasp the deeper meaning, a better understanding of the phenomena. It is thus helpful to deconstruct the perceptions of study participants on the research problem if the goal is to construct a model that is based on the understanding of these different perceptions.

Epistemologically, I believe that knowledge is evolving, what you know and believe about a subject usually changes with increase exploration and deeper analysis of the subject. The study of a phenomenon should not only give us knowledge about that phenomenon, but should extend to identifying patterns in the structure and evolution of that phenomenon. Considering the contextual nature of naturalistic research, patterns identified within a particular context might be different in another context therefore the researcher's goal should not be generalization. No matter the evidence generalizations are based on, the bottom line is that there are usually exceptions. Generalizations are closely linked to what is common with the majority and it doesn't really matter if that majority is 51% or 99% of the population. In a classic example of the problem with generalization, Munhall (2012) said most treatment protocols are based on what is best for the average person – which she describes as a mathematical concept – and this may explain why there are so many complications in healthcare delivery.

The above line of thinking has influenced my choice of qualitative approach in conducting this study. I believe that nurses have different views and beliefs about nurse education which they may be very passionate about. So to fully understand the problem it will be necessary to study each participant's experience within their particular context, then with rigorous analysis we can articulate a position that reflects the nature of the problem and how this could be considered in designing a nurse education model.

3.1.2 Researcher reflexivity

As a nurse and nurse educator in Cameroon I am carrying out a study within a context I have been very actively involved in. Qualitative researchers are usually expected to ensure the quality of the research process in such situations (Dyson, 2010). This makes it necessary for me to address the issue of reflexivity. Reflexivity in simple terms is the 'open acknowledgment' of the nature of relationship between the researcher and study participants as well as the research problem (Dyson, 2010). Charmaz (2006) defined it as:

the researcher's scrutiny of his or her research experience, decisions and interpretations in ways that bring the researcher into the process and allow the reader to assess how and to what extent the researcher's interest, position and assumptions influenced inquiry. A reflexive stance informs how the researcher conducts his or her research, relates to the research participants and represents them in written reports (2006: 188-189).

I began my PhD studies with the desire to find a research based solution to further education (post-graduate) barriers for nursing. The question then was what plan can be designed to make higher education more accessible? My whole focus thus was on problem solving. Over the past months I stopped thinking and started reflecting on the issue and my position within the research. I tried to find and study every bit of information on nursing in Cameroon (a very difficult task since scientific publications are rare) from unpublished theses, conference papers, opinion pieces, government texts to scientific publications. With all these my perception began to change and evolve. I soon realized that the observed inconsistencies in nurse education were the symptoms of something probably more complex and nebulous than the manifestations and did not just affect postgraduate education alone but nurse education in general. I assumed a more reflexive position, acknowledging my own personal views so that I could understand the views of other stakeholders. At this point, I now believe that stakeholder's positions and arguments are based on their perceptions. These perceptions are greatly influenced by their ideologies which are enshrined in a certain mind-set. These mind-sets have been built over the years from a myriad of subjective and objective experiences, internal and external factors as well as subconscious beliefs and aspirations that might not even be obvious to the individual. I also found that nursing did not evolve from cultural persona like the medicine man and the TBA and was apparently imposed on the local context. This raises questions as to the basis of national philosophy of nursing if at all it exists. This should have affected the way nursing has been internalised by different stakeholders and thus its educational evolution. Consequently, the problem is not the simple structural shortcomings that fuelled my desire for a PhD. It is becoming more an issue that might go back to the very origins of nursing in Cameroon, capturing every possible influencing

factor in a bid to first understand what is happening and then crafting a model to guide the future trajectory.

As I progressed I began questioning the basis of my own positions on nursing education. I realized that I have thought about it but not reflected on how I came to hold those views. I sought to discover in the process the subtle and subconscious experiences that have helped shaped my views. I then got into the field with a frame of mind that asked a genuine question: “who are we and how did we get here?” Therefore my research evolved to become also a voyage of self-discovery as I could hold open and honest conversations (interviews) with my colleagues. So reflexivity did not ‘paralyse’ and set me on ‘self-destruct’ (Neil, 2006), mode it actually liberated me to question myself. As Glaser (2002: 47) himself argued from a grounded theory point of view researcher impact on data is just one more variable to consider whenever it emerges as relevant. Without reflexivity I would have entered the field from a biased angle but as I reflected more, I could see how it gave me according to Mruck and Günter (2007: 519) the chance to rethink, reground, or justify my own decisions and to communicate the process of theory development to my supervisors and later to research participants.

3.2 Method

3.2.1 Grounded theory

Grounded theory was developed by Glaser and Strauss through the publication of the *Discovery of Grounded Theory* in 1967. The authors were interested in shifting focus from the dominant theory verification philosophy among social researchers at the time to one focusing on theory generation. It was their perception that efforts to close the gap between theory and research have been too focused on improving methods aimed at verifying theory while little emphasis had been placed on the theory generation. That context meant that social researchers were focused on empirical verification of ‘grand theories’ rather the generation of theory from data systematically obtained from social research (Glaser and Strauss, 1967). The basic ideas or notions of grounded theory did not begin with the *Discovery of Grounded Theory*. According to Goulding (1999) the roots of grounded theory could be traced back to symbolic interactionism. Symbolic interactionism mentioned above, is

theoretical perspective which according to Charmaz (2006) assumes that individuals construct their reality, selves, and society through interactions, focusing on meanings and actions and as such addresses the active processes through which individuals construct meaning. Similarities have been drawn between symbolic interactionism and grounded theory. Bryant and Charmaz (2007) pointed out that both methods assume that people act as individuals and as collectivities with symbolic interactionism emphasising meaning and action while grounded theory adds more value by posing questions about what was happening in the empirical world. Bryant and Charmaz (2007) equally added that the underlying emphasis on the agentic actor and action in both methods lead researchers to focus on studying process instead of assuming structure. An elaborate discussion on the link between symbolic interactionism is not a key issue with the current study but brought up just to highlight what has been presented as the similarities between the two theoretical views.

Glaser and Strauss (1967) acknowledge the similarity between their work and earlier works while demonstrating the fundamental differences therein. In their notes they observed that earlier researchers like Merton in his work on theoretic functions of research had come close to the concept by talking about “serendipity” which described the ‘unanticipated, anomalous or strategic’ find which provokes a new hypothesis. However, they concluded that Merton ended at the level of ‘grounded modification of theory and not grounded theory. The focus then is generating new theory from data as opposed to getting data to modify existing theory. Their work was aimed at overcoming the dominant positivist research paradigm of their day even though they came from varied backgrounds – Glaser from positivism and Strauss from pragmatism field research (Charmaz, 2006). The core components of grounded theory as emphasised by Glaser and Strauss (1967; Glaser, 1978; Strauss, 1987; Charmaz, 2006) include the concurrent implementation of data collection and analysis; the construction of analytic codes and categories from data; applying the constant comparative method; theorizing at each stage of data collection and analysis; memo-writing; theoretical sampling and literature review after developing an independent analysis.

The constant comparative method typically consists of: comparing incidents in each category; integrating categories and their properties; delimiting the theory; and writing the theory (Glaser and

Strauss, 1967). Emerging codes and categories are thus compared with each other, with categories, concepts within the data as the theory is being developed. Theoretical sampling on the other hand according to Glaser and Strauss (1967) is a method where the researcher makes a decision on what data is to be collected based on the findings from simultaneous collection coding and analysis of data, in order to develop the emerging theory. Glaser and Strauss (1967) thus produced a method that challenged previously held views of qualitative research as ‘impressionistic and unsystematic’ and only valuable as prelude to quantitative research and validated qualitative research as a credible methodological approach in its own right capable of generating theory (Charmaz, 2006).

In later years Glaser and Strauss developed contradictory views on grounded theory methodology and went ahead to articulate significantly divergent arguments on the method and its application. Their original work had been focused on theory discovery and generation against theory verification. Strauss started working with Corbin and moved towards a more theory verification and positivist orientation (Strauss and Corbin, 1990; Corbin and Strauss, 1990; Strauss and Corbin, 1998). Their work favoured new technical procedure rather than emphasizing the comparative methods that distinguished earlier works (Charmaz, 2006). Glaser (1992) on the other hand remained true to the earlier focus of the method’s discovery orientation and argued that Corbin’s new emphasis on systematic procedures went contrary to the fundamental tenets of grounded theory by forcing data into preconceived categories.

This study was based on a contemporary reading of the grounded theory method (Charmaz, 2006) a qualitative approach. It is an approach to the study of social processes and social structures (Polit and Beck, 2004) with the aim of systematically generating social theory through a sequence of analytic procedures (Haddan, and Lester, 1994), in other words the generation of comprehensive explanations of phenomenon that are grounded in reality (Politt and Beck, 2004). According to Charmaz (2006), grounded theory methods consist of systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories ‘grounded’ in the data themselves. In a brief description of the method’s application, Charmaz (2006:3) indicates that the researcher begins studying the data early ‘separating’, ‘sorting’, and ‘synthesizing’ through qualitative coding. By making and coding

numerous comparisons the researcher's analytic grasp of the data begins to take form. She continues that preliminary analytic notes called memos about the codes, comparisons and other related ideas are also written during this process which leads to tentative categories. The analytic categories and the relationships the researcher draws between them provide a conceptual handle on the studied experience. She concludes that levels of abstractions are thus built directly from the data and subsequent additional data is collected to check and refine emerging analytic categories culminating in a 'grounded theory' or an abstract theoretical understanding of the studied experience. This method thus lends itself perfectly to the goal of the research to develop a model of education based on aspirations of stakeholders.

In addition to the above arguments Mullen and Reynolds (1978) posited that grounded theory presentations are generally easily applicable; provide succinct understanding of processes which are vital in health education; and also allow the problem to emerge from the data couched in the perspectives of the informants who are the actors in the situation under study. These means that using grounded theory in this study will make it possible for professionals to understand the findings without any complex interpretations because they can relate them to their own experiences and thus apply it readily. This and the fact that the definition of the problem is from the informants' angle including the analysis of processes implicated in the evolution of nurse education, contributed to my choosing this method.

In summary, grounded theory enables the researcher to study processes, explicate what is happening in the field setting, stay focused on the data and emerging analysis and supports the researcher in developing an original theoretical analysis (Charmaz, 2006).

3.2.2 Setting

The study was conducted in Cameroon and participants were met in both local and urban settings. Some were met in their offices and workplaces while others were met at home. Documents like those used in this study typically are found in archives at regional offices of different ministries, with the main archives found in the capital city. The archiving system is purely manual meaning everything

will be mostly in paper form. The following characteristics of the study setting provide a basis for understanding the context.

Accessibility

Access to all institutions required proof of authorisation to collect data and in some cases ethical clearance. The same requirement was needed to access official document archives. Document archives were not orderly so it was challenging to trace relevant documents. Also some documents were acquired from the private collection of individual nurses who authorised the researcher to photocopy the documents. In some offices the researcher was only allowed to take photos of the relevant documents as excessive physical handling was discouraged. It was not possible in some of the cases to take the documents out of the premises of the institutions where they were found.

Communication

English and French are the two official languages which imply that the researcher had to be prepared to deal with both languages. Fortunately, all participants even those who were French-speaking were ready to communicate in English so there was no need to translate the interviews. Their responses were fluent and relevant indicating that the language wasn't a barrier. The researcher had to seek the services of a bilingual translator with certain documents which were in French. However, a number of documents studied surprisingly had available English versions.

3.2.3 Subjects and sampling

The initial population for this study included nurses and major nurse education policy documents (issued by the ministries of Public Health, Higher Education, and Employment and Vocational Training). Purposive sampling was the initial technique used to select both nurses and documents to be studied. Further sampling was to be determined by the principle of 'theoretical sampling' - Glaser and Strauss (1967).

Purposeful sampling is characterised by the selection of information-rich cases from whom the researcher can learn a great deal about the central issues relevant to the purpose of the study (Patton,

1990). So it is about selecting the ‘excellent informant’ (Spradely, 1979:25-26) who in a grounded theory must be expert in the phenomenon being studied, be willing to participate, have the time to share their experience, be reflective, willing and able to articulate their experience (Morse, 2007:231). In this study the ‘excellent informants’ were nurses who had been involved in nurse education issues usually by virtue of their roles.

The recruitment strategy was very practical because of the absence of any formal registry of nurse leaders, educators or trainers. The researcher had to count on professional networks to gain access to nurses who fit the selection criteria. During this process the researcher discovered that access to potential participants was greatly influenced by who the researcher knew and what role these connections were ready to play in the recruitment process. This is an important aspect to consider in participant recruitment across different cultures. Most often interpersonal relations and recognition tend to facilitate all forms of work and interactions in the local study setting. In presenting a conceptual model for recruiting transcultural participants in qualitative studies, Eide and Allen (2005) argued that in some cultures, (like those of Aboriginal Hawai’ians and Micronesians in their study) ‘knowing and being known are crucial to every activity’. They went on to defend their model which build on penetrating cultural networks and building trust that makes it easy for community members to participate in a study. To them, in such cultures being known and trusted by the community is an essential ingredient for success in the recruitment of study participants.

During this study, the researcher had to call on some colleagues who though not being part of the study could introduce the researcher to the target potential participant. This was important to get access because in many cases potential participants worry about the true purpose of a study especially where their responses are recorded and when issues being discussed touch on government policy. With an introduction from someone they trust potential participants were ready to receive and listen to the researcher. The potential participants could have faith that the researcher will respect his obligations, behave reliably, and exhibit integrity (Eide and allen, 2005). In similar arguments, LynnMcHale & Deatrck (2000) identified communication respect, competence, knowing one another and negotiation as essential preconditions to trust. In this study professional networks were

mostly used to facilitate access to the potential study participants and not as a form of snowballing. While colleagues who knew the researcher were able to facilitate these contacts, most of the eventual research participants were not personal contacts of the researcher, therefore eliminating any potential for bias. Once contact was made, the potential participants were told about the study and the method of data collection. Those that indicated interest agreed to appointments to explore the informed consent statement with the researcher. After reading the informed consent statement some of the potential participants declined to participate while others gave their consent.

Generally the nurses were found in nursing schools, administrative services and hospitals. Most of them had worked in positions where they were able to take part in the policy making process, while others were involved in the implementation of nurse education policy. Thus it is their experience and not their place of work or position that determined their selection. This decision eliminated the idea of representative sampling which would have required comparing different groups of nurses and is not part of the research question.

After the first interviews with the purposive sample, theoretical sampling at the level of individuals and data came in. Theoretical sampling is 'the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges' (Glaser and Strauss 1967:45). It means seeking important data to develop the emerging theory with a purpose to elaborate and refine the categories constituting the theory (Charmaz, 2006:96). So it is not sampling for representativeness but sampling aimed towards theory construction (Charmaz, 2006:6). The researcher had to seek some nurses who fit the study criteria but who were not initially targeted for the study. Some of these nurses were sought because they had better grasp of some of the emerging categories in the data. For example some participants were sought when it became obvious that there was an emerging definition of a 'francophone perspective' on nurse education. Others were sought when there was emergence of 'hospital-based' and 'higher education' model of nursing education. Some participants were visited twice to explore some emerging categories that emerged from analysis of their previous interview as well as interviews of others. In the course of this however, the

new questions developed were generated from the data and sought to explore in depth, issues arising from the answers to the original exploratory research questions. In other words all new questions remained within the context of the research objectives as spelt out in the research proposal.

Theoretical sampling also occurred at the level of data. This happened when an emerging category caused the researcher to go back to previous interviews to identify data to fill out its properties. Theoretical sampling remains one of the core components of grounded theory methodology and not including it risk generating according to Charmaz (2006:96) categories that are intriguing but thin with much still remaining assumed unknown or questionable.

The sample size for this study was initially set between 10 and a maximum of 20 nurses. The decision was guided by the fact that qualitative sample sizes are usually small while interviews generate large volumes of data. Morse (2007:233) argues that collecting too much data results in a state of conceptual blindness because the researcher will be scanning rather than cognitively processing the data – “unable to see the forest for the trees, or even the trees for the forest for that matter”. The informants for this study were information rich and provided very good information on the issues raised. So the key categories emerging from the data were saturated after 10 primary and three follow up interviews.

For official texts and papers, only those that were relevant to nurse education were considered for analysis. Texts from 1960 (year of independence) right through 2015 that met the criteria were included in the study.

3.2.4 Data collection and interpretation

Data was collected through document analysis and in depth interviews of nurses. Coding and categorisation of data occurred simultaneously with data collection.

Document analysis

Document analysis is a systematic procedure for reviewing or evaluating documents both printed and electronic (computer-based and internet-transmitted) material (Bowen, 2009). He adds that

documents contain text (words) and images that have been recorded without a researcher's intervention. Document analysis requires that data be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge (Corbin and Strauss, 2008). The analytic procedure entails finding, selecting, appraising, and synthesising data contained in documents (Bowen, 2009) and generates data as excerpts, quotations, or entire passages that are then organised into major themes, categories, and case examples specifically through content analysis (Labuschagne, 2003 in Bowen, 2009).

There are typically two types of written records i.e. the episodic and the running records (Buttolph and Reynolds, 2012). They describe the episodic record as 'records that are not part of an ongoing, systematic record-keeping programme but are produced and preserved in a more casual, personal, and accidental manner'. While to them the running record is more likely to be produced by organizations and is carefully stored and easy to access even over long periods of time. Document analysis will be relevant to meet objective one of this study because they describe a historical underpinning of the contemporary ideas, practices and identities that subtly affect our present (Rapely, 2007).

The documents that were targeted included texts on issues related to nurse education from government sources. Policy documents from the defunct West Cameroon Nursing and Midwifery Council (WCNMC) were also targeted but none was found. Documents from other associations were not considered because none of them has assumed the powerful regulatory role once played by the WCNMC. In its time the WCNMC regulated entry into and exit from nursing schools and maintained a register. The aim of studying these records was to get insight to the historical and evolutionary basis of nurse education in the country – the 'history of our present' (Rapely, 2007). Documents from government agencies usually come in two forms – policy statements and texts of application. Policy statements usually announce major policy decisions and are signed by the President of the Republic or by a Minister. Texts of application on the other hand usually explain how a policy statement will be implemented. For example a policy statement might announce a new level of training or qualification for nurses while its text of application will provide details on curriculum structure,

student selection criteria, programme management etc. In the past there have been instances where a policy statement is made and text of application only comes out some months or years later. This study took both types of documents into consideration. Excluding all other types of texts and from more diverse sources reduces the risk of being overwhelmed with substandard data and conceptual blindness (Morse, 2007:233) thus weakening the conclusions that could be drawn from the findings.

Prior (2008) suggest four ways to approach documents in research: focusing on the content; focusing on how the document ‘comes into being’; focusing on how the document is used for purposeful ends; and focusing on how documents function independently of their producers. Using any of these approaches will definitely depend on the purpose of the research. Prior (2010:419) explained that focusing on content has been the common approach in sociology, social science and health research with the goal of ‘scouring for evidence’ by concentrating on what is in the text using content, thematic or grounded theory approaches to analysis. The primary focus was on the content of the texts in an attempt to get from them the philosophies underpinning nurse education policies over time. To give the process more structure, the researcher also made use of Charmaz’s (2006:39-40) approach to studying texts. So the focus on content was fine-tuned by establishing the context of the text (i.e. how it was produced, the authors, their purpose and assumptions they seem to be based on), categories within the text (including how they change in sequential texts over time and meanings they imply), any unintended information and meanings and who benefits or is the target of the text. Document analysis was thus expected to provide background and context, additional questions to be asked, supplementary data, a means of tracking change and development, and verification of findings from other methods (Bowen, 2009). Appendix VIII shows a summary of documents analysed during this study and their detail descriptions.

Semi-structured interviews

Fitzpatrick and Boulton (1994) contend that the primary advantage of in depth interviews is that they allow the investigator to focus maximally on the participants’ perceptions of the issue under study

and responses to them, rather than imposing his own categories. This they say leads to a new and more meaningful typology of participants' concerns.

The interviews in this study were semi-structured and in depth with the initial questions derived from the research questions and then the follow up questions derived from participant's response and emerging data. Follow up questions were not new questions but questions that probed or explored emerging categories further. Interviews were tape recorded and later transcribed verbatim. The interviews typically lasted between 40-60minutes. Memo writing (Goulding, 2002) also influenced the development of further questions. Appendix I shows a copy of the initial interview schedule designed for the primary interviews in this study.

Analytical process

Once interview transcripts and scanned copies of documents were ready, they were imported into NVivo 10 software for data analysis. The researcher conducted the interviews, transcribed and typed the transcripts personally, all of which offered the opportunity for prolonged engagement with the data. The whole process was guided by Charmaz's (2006) constructivist approach.

Once documents and transcripts were imported into NVivo, the coding process was immediately initiated. The initial coding was characterised by line-by-line coding (Charmaz, 2006; Glaser, 1978). Charmaz (2006) argues that this approach keeps the researcher open to the nuances in the data. This initial coding started giving the first indications of what was in the data and resulted in over 600 codes. It also pointed to new questions that will be needed to make later interviews richer. Without applying any coding frame (Glaser, 1978) this process was guided by the desire to identify what the data was actually saying or not saying as well as the first signs of any trends within the data. An example here was '*administering treatment*' was used to label data describing this activity as a nursing function. The choice of label was determined to cover aspects of the nurse's expected activity that captures issues of treatment. For example:

"Organising and administering nursing care" (Chap I MINSANTE Order 22, 1980)

“To control the effective daily application of all treatments, diets, and care given to patients”
(Chap I MINSANTE Order 22, 1980)

“To supervise and control the rate of medication consumption...” (Chap I MINSANTE Order 22, 1980)

Another example of a line by line coding was *“conducting health education”* which captured data describing teaching expectations of the nurse for example:

“Give consultants and their family elementary notions about individual and collective hygiene...” (Chap I MINSANTE Order 22, 1980)

“Organise and carryout in collaboration with the local authorities and personalities, health and nutritional education campaigns amongst the population...” (Chap I MINSANTE Order 22, 1980)

“Teach the principal notions of sanitation particularly to young people of the country...”
(Chap I MINSANTE Order 22, 1980)

At times *in vivo* codes were generated during this phase of coding. For example ‘*conceptualising nursing*’ and ‘*protecting your turf*’ emerged from the participants own words to describe certain aspects of the data:

“...we begin to see a change in mentality, in conceptualising nursing...this is at the level of education, university, uhmm conceptualising nursing” (Int3:1)

“Of course there is no rationale, there is no rationale! Again it has to do with what we call protecting your turf, enh protecting your turf!” (Int7:1)

From this first coding new questions still within the objectives of the study were generated and the process continued on to focused coding. Focused coding is about using the strongest or most significant codes to categorise data incisively and completely (Charmaz, 2006:57). Focused codes were thus considered primarily as those that could be applied to data across the different sources and

were generated from initial codes. For example, a number of initial codes demonstrated the itemised functions of the nurse in different settings. During focused coding, *‘describing the nurse’s role’* emerged as a focused code that increasingly captured data describing expectations of the nurse across data sources. It absorbed many initial codes for example *“administering treatment”* and *“conducting health education”* (seen above) as more data was found to strengthen the code as an emerging subcategory. Based on the amount of evidence present in the data, codes were raised to subcategories and categories as will be demonstrated in the results chapter. In another example, *in-vivo* codes rose to become focused codes and eventually sub-categories. The code *“conceptualising nursing”* was fleshed out with data from different interviews capturing participants’ expressions of a more scientific approach to educating nurses:

“There become a need to adequately train people in this domain so that we shouldn’t only train people who will come and give physical care, but it should be broad based, have a multidimensional approach” (Int1:2)

“We want them to understand if you are carrying up you have the principles that are backing you up and we insist on that...because we need you to show a difference between the one that you call a senior nurse and you. And so you cannot just sit there and wait for the doctor to come and order a nasogastric tube you should be able to assess and see that the patient needs a nasogastric tube yes!” (Int10:1)

“Conceptualising nursing is a way of nursing education that says that when you are giving that injection what does it mean for the patient?... When you were doing that dressing, you have done it so well but then what does it mean for the patient? What have you done for that patient? How has that patient conceptualised your practice during the dressing? This is where there is a big problem” (Int3:5)

Evidence was collated by comparing data, codes and even the categories which resulted in the merging of some focused codes and the elimination of certain initial codes. The rejected codes were mainly generated from initial coding and were not supported by sufficient evidence from the data to

strengthen them. Some of the rejected codes included: “*categorising from public service*”, “*uplifting nursing*”, and “*compromising quality of care*”.

The constant comparison and the use of theoretical sampling helped to move some focused codes to categories as their properties became more complex and demonstrated viable links between subcategories. Theoretical sampling means finding important evidence to support emerging categories and clearly define their properties (Charmaz, 2006). As certain codes moved from initial codes to categories e.g. ‘*harmonising nursing programmes*’ both the data and study participants were sampled to find more data explicating this category. The process did not lead to selecting different study participants but led to follow-up discussions with participants to address the emerging categories in more detail. As will be shown in the discussion chapter, theoretical sampling was done to establish the meaning, method and goals of harmonising nursing programmes. Appendix X shows an example of code and its supporting data as exported from NVivo to facilitate analysis and discussion. The process continued until theoretical saturation was achieved. This is the point at which ‘fresh data no longer sparks new theoretical insights nor reveals new properties of emerging categories’ (Charmaz, 2006). It is questionable whether such a point can be literally reached prompting Janice Morse (1995) to argue that most researchers just proclaim it, rather than proving it. In similar arguments Dey (1999) says the term can be easily misinterpreted as it does not truly fit a process that continues until all data is coded. It is easy for ‘saturation’ to be declared after coding the first few interviews if the researcher is just looking for a point where no new insight is emerging. Dey’s point therefore is that the researcher proves saturation by actually doing the work. Thus he adds, the researcher should talk of categories generated by data rather than saturated by data and proposed ‘theoretical sufficiency’ (p.257) as a better term for grounded theory. Charmaz, (2006) concurred by warning against the risk of ‘foreclosing analytic possibilities’ resulting in ‘superficial analyses’. In this study the point of theoretical saturation was that point at which the categories had sufficient supporting data to demonstrate their properties and the links between them.

Coding was greatly facilitated by the use of memos from the onset of the coding process. The initial memos picked up ‘surprise’ elements in the data and questioned their occurrence and their

implications. It allowed the researcher to put down his thoughts with respect to the emerging codes in a reflexive manner while identifying directions being evident by the codes. For example a memo titled 'stopping ministry of health training' reflected the researcher's astonishment at the emergence of what was perceived as a very radical and entirely unanticipated position. Notes were made on how this will play out and how it will be received by other participants thus provoking questions for follow up interviews. While some of the memos were short, others were comparably elaborate defining the direction for theoretical sampling in some situations. In Appendix XI an example of one of the analytical memos is shown. This memo explored the researcher's thoughts on the emerging 'Role of the nurse' sub-category generated from document analysis. The highly itemised description of the nurses' functions revealed a mostly technical competence expected of nurses. These expectations were compared with '*Conceptualising nursing*' a sub category emerging from interviews for the links between the two. As the memo shows, the need for conceptualising the nurse education system could be linked to practical skill orientation at the conception of formal nurse education. Seeking training that only prepared the nurse to carry out specific task may have contributed to what participants in the interview described as a very basic and technical training orientation. Questioning this further link required theoretical sampling in subsequent interviews as well as already collected data.

As analysis progressed, memos and theoretical sampling gradually helped to 'flesh' out the emerging categories. The links between the categories were sought as well as that between the subcategories within the same category. Looking for these connections and weaving them towards a theory is what Charmaz (2006:115) describes as theoretical sorting. Using this process, the links between the categories was established as shown on figure depicting the summary of results. The analytic process did not stop at seeing these clear links as more questions were now asked of the results. The goal was to transform those links into a defensible model that demonstrate a more complex interaction between the categories. A sort of theoretical coding was applied at this point. This expression was used by Glaser (1978) to describe the process of conceptualizing the relationship between substantive codes to incorporate them into an emerging theory. Charmaz (2006) noted that if skilfully used these

codes could add a ‘sharp analytic edge’ to the research. Glaser (1998; 1978) presented coding families that could be used in the process of theoretical coding. While these were not applied to this study directly, they influenced the search for the link between the eight major categories that emerged from the analysis. From this process the complex link was gradually constructed linking the categories such that some categories emerged as ‘central points’ and others became the links between these points in the emerging theory as demonstrated in chapter five.

3.2.5 Measures to ensure trustworthiness

According to Lincoln and Guba (1985) trustworthiness is a method of ensuring rigor in qualitative research without sacrificing relevance. The process they add involves establishing credibility, transferability, dependability and confirmability.

Credibility

Lincoln and Guba’s (1985) model guided strategies to ensure credibility. Firstly, the time allocated to data collection and analysis should be adequate to answer the research questions. During the interviews participants were allowed to share their views and given time to explain their arguments. The constant comparative characteristic of the grounded theory method also requires that the researcher immerses himself in the collection and analysis of data i.e. a kind of ‘prolonged engagement’. Lincoln and Guba (1985) recommended “prolonged engagement” between the investigator and the participants in order both for the former to gain an adequate understanding of an organisation and to establish a relationship of trust between the parties. In this study the researcher was working within a very familiar context. Also beginning analysis concurrently with data collection and going back to participants to further explore emerging categories increased the engagement between researcher, participants and data. However, Shenton (2004) analysing Lincoln and Guba’s (1985) side effects of prolonged engagement warned that the researcher could become so immersed in the context of the participants that it clouds their professional judgment. Continuous reflexivity on the researcher’s part throughout this study helped to avoid this danger. Throughout the study the researcher constantly wrote down his reflections on emerging data noting areas were

findings were unexpected or ‘surprising’. The researcher also questioned his own positions on the issues emerging and noted how his opinions were gradually changing with emerging data.

The second strategy used here was triangulation – a method which according to (Patton, 1990) helps the research guard against the accusation that a study’s findings are simply a product of a single method, source or single investigator’s bias. Thus triangulation gives a ‘confluence of evidence that breeds credibility’ (Eisner, 1991). Here triangulation of data sources as opposed to method was implemented. The use of interviews and document analysis to obtain data and compare emerging codes and categories in this study achieved the goal of triangulation of data or information sources. Shenton (2004) in support of such an approach posited that supporting data from documents provide a background to help explain attitudes and behaviours of participants. To him, the researcher should seize the opportunity to analyse any documents participants may mention in the interview. In this study, documents were found to improve the quality of questions (as they provided vital information that would have been otherwise missed in the interviews) and served as verifiable source of information in their own right. Thus the use of documents and interview participants as data sources for the same research questions lends more credibility to the study.

Thirdly, member-checking was done after initial analysis with different but similar groups to those that took part in the study. Carcary (2009), Shenton (2004), recommended giving participants an opportunity to verify the emerging theories and inferences being made by the researcher. Nurses who met the same criteria as the initial sample (but did not take part in the study) as well as some study participants were invited to assess and comment on the emerging findings of the study. Using these two groups was planned because it was not possible to guarantee at the start of the study that study participants will be conveniently accessible at the end of the study for member checking. All those involved agreed with the researcher’s findings and some added bits of information to support the results. Having these two groups identify with the researcher’s findings confirmed that the interpretations were credible and truly reflected the data.

Transferability

The objectives of this study did not include generalization of the findings but by ensuring transferability the researcher is making it possible for other researchers to determine according to Talbot (1995) whether the findings of the study could be applied to other settings. Thus efforts have been made to provide a detail description of the entire research process as well as the rationales for decision making during the process so that researchers and professionals can fully understand the process and context. A thick description (Holloway, 1997) of the research context brings out key characteristics that researchers in other settings can use to determine if there are any similarities in the settings. These make it easier for other researchers to make decisions on the relevance of the study to their own settings. The clear description of the research problem, context and background, processes and decision making throughout the research have also been provided to help the reader ascertain the extent to which the findings reflect the setting, and how well it might be transferable to another context. For as Shenton (2004) argued it is left for the reader to determine how far they can transfer the results and conclusions to other settings after studying the researcher's description.

Dependability

According to Lincoln and Guba (1985) dependability has to do with ensuring that the findings of an inquiry will be repeated if the inquiry was replicated with similar participants in the same context. They also argue that credibility and dependability are closely related so demonstrating credibility to some extent demonstrates dependability. A detailed description of the methodological processes, as well as sample population and sample documents, all determined through purposive sampling have been be provided. The descriptions have been provided both within the thesis and as appendices to the thesis. These ensure that researchers can determine the characteristics of participants and assess their relevance to providing answers to the research questions. It also provides enough information on participants for a repeat study in the same setting or in another setting. The fact that during member-checking nurses who had not taken part in the study could identify with the findings also demonstrated the level of dependability of the findings.

Confirmability

It is the degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest (Lincoln and Guba, 1985). They recommended that the researcher keeps an audit trail of the raw data, data reduction and analysis products, data reconstruction and synthesis products, process notes, materials relating to intentions and dispositions and instrument development information. Miles and Huberman (1994) also consider the extent of researcher's reflexivity as a way to measure confirmability. In this study the researcher clearly defined his ontological and epistemological beliefs with a reflexive account of his views and predispositions. This in addition with description of the study method including reasons for its selection, decision making at different levels of the study, notes and memos, Gantt charts, and project plans, have been provided to give readers insight to the entire study process thus ensuring confirmability.

3.2.6 Ethical Consideration

The UK Economic and Social Research Council ESRC (2010) recommend guidelines based on six principles which will broadly fall under research integrity, respect for persons, and beneficence. In the light of this and other ethical recommendations the proceeding discussion demonstrates the ethical measures maintained during the study.

Justification of the Study

At least 95% of research is indeed research for things that have been found long ago and many times since (Andreski, 1974). Based on this assertion, the researcher will need to show that a particular research is necessary. Iphofen (2009) suggested the following three questions to help a researcher make this decision:

Can the required information be found elsewhere?

Could the project be carried out as a secondary research?

Does existing research answer the research question adequately?

If the researcher can answer 'No' to all these questions, then the research is viable as a primary research (Iphofen, 2009). In this case, no previous study had examined the development of nurse education in Cameroon and if such a study has been carried out it has never been made public through any scientific publication. For this same reason the study could not be carried out as a secondary research. Similar studies may have been carried out in other countries but such studies do not address the particular situation of Cameroon.

Research Quality and Design

It may be an accepted maxim that a poorly or improperly designed study involving human subjects...is by definition unethical (Rutstein, 1972). Therefore poorly designed research is inherently unethical since it wastes the researcher's and participants' time and energy if the results are less than useful, likely producing more dis-benefits such as contamination of the field by discouraging participants from future research engagements, which may be of better quality (Iphofen, 2009). This study was well designed with the goal of identifying the best method to achieve the research goal. The research methodology finally adopted was found adequate to meet this purpose by the principal and co-investigators and the University's research ethics committee. The choice of methodology was thus determined not so much by researcher's preferences as by its potential to answer the research questions.

Application for Approval

As a research student the authorization to conduct this study was obtained from the School of Health and Human Sciences, University of Essex. Ethical clearance was also sought from the Faculty of Health Sciences, University of Buea and the Regional Delegation of Public Health for the South West Region in Cameroon. Appendix IV, V and VI show respectively, the ethical approval from the University of Essex, the ethical approval from the University of Buea and the authorisation to collect data from the South West Regional Delegation of Health in Cameroon. Applications for access to archive services were also made and submitted to the relevant authorities for the collection of document samples.

The Principle of Beneficence and Non-maleficence

This principle obligates the researcher to do no harm (non-maleficence) and to maximize possible benefits as much as possible (Tappen, 2011). According to Polit and Beck (2004) most researchers consider that this principle contains multiple dimensions including the following:

a. Freedom from harm

The ESRC (2010) states that harm to research participants must be avoided in all instances. Researchers according to Iphofen (2009) have to be aware of the range of ways in which their activities can cause distress [harm] to others. Such harm could be physical (e.g. injury, fatigue), psychological (e.g. stress, fear), social (e.g. loss of friends), and economic (e.g. loss of wages) (Polit and Beck, 2004). No form of economic, social or physical harm to participants was anticipated in this research. The questions did not address overtly controversial issues that may criticize any person or organization and also did not include any experiments or activities that could lead to physical harm. That notwithstanding it's necessary to heed Oliver's warning (2003) that, participants can have very strong feelings when it comes to certain issues of/ or at work. To guard against this, interviews were conducted in a manner that did not challenge the participants or put them in embarrassing or stressful positions. Participants' views and positions were neither criticised nor rejected. Interviews were conducted at the convenience of the participants to avoid any chance of fatigue or other physical discomfort.

b. Freedom from exploitation

Exploitation according to Polit and Beck (2004) could be overt and malicious (e.g. sexual exploitation, use subjects' identifying information to create a mailing list, ...etc.), or more subtle (e.g. subjects agree to participate in a study requiring 30mins of their time and the researcher goes back to them 1 year later for a follow up. He might be accused of not respecting the previous agreement and of exploiting the participant – researcher relationship). This researcher adhered to the terms of the consent agreement and did not attempt to take any form of advantage of the participants. No

promises of rewards were made, no subtle or overt threats were made and no rewards were given to influence participation.

c. Maximizing benefits

It is always worthwhile to consider if there are ways in which participants may gain anything from taking part in a research, though it is not usually essential that the participants gain something tangible from it (Oliver, 2003). Participants in this study earned no direct benefits from taking part in this study. However, it is possible that the adoption of the recommendations of this study could end up being beneficial to all stakeholders including nurses. The community will benefit from better care services because of the strong potential of the recommendations to improve nurse education and therefore care delivery.

The Principle of Respect for Human Dignity

According to Tappen (2011) individuals should be treated as autonomous agents, meaning the ability to make decisions. Other individuals are therefore expected to respect such a decision unless they as Tappen (2011) continues are detrimental to others. This principle is again subdivided into two according to Polit and Beck (2004):

a. The right to self-determination

Research participants must take part in research voluntarily, free from any coercion (ESRC, 2010) without risking any penalty or prejudicial treatment (Polit and Beck, 2004). Participants therefore have the right to answer or not answer the researcher's questions or not to participate or to withdraw without fear of any form of reprisals. Despising this right means not respecting the dignity of a person. According to the National Institute of Health NIH (2009), a lack of respect for persons is shown when a person is denied freedom to act on his or her decisions or when information needed to make a decision is withheld without a compelling reason to do so.

In this study the participants were informed in very clear terms that they had the right to not participate in the study, to back out of the study, to have their questions answered and their doubts

clarified etc. They were no threats of punishment for refusal to take part in the study, and neither was any form of coercion applied. No form of reward was also promised or given to the participants.

b. The right to full disclosure

Full disclosure means that the researcher has fully described the nature of the study, the person's right to refuse participation, the researcher's responsibilities, and likely risks and benefits (Polit and Beck, 2004). It is this definition that makes this right and the right to self-determination inseparable. You can't expect an individual to objectively and freely make his own decisions if some information is hidden from him or her. This contributes to why the ESRC (2010) explicitly stated that research staff and participants must normally be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved. However, the ESRC recognizes exceptions due to the nature of the research and provides specific guidelines in such situations. In this study, the participants were given information on the goal of the study, why they are selected, their other rights, and the researcher's responsibilities before, during and after the collection of data. Their questions were also answered and those who decided not to participate after full disclosure had their decisions respected.

The Principle of Justice

This principle according to Tappen (2011) addresses both the denial of a benefit without a good reason or imposing a burden unequally. The principle is divided into the right to fair treatment and the right to privacy.

a. The right to fair treatment

Fair treatment includes features like: fair and non-discriminatory selection of participants based on research requirements; respect for cultural and other forms of human diversity; non-prejudicial treatment of those who decline to take part in the study; honouring of all agreements between researchers and participants; access to research personnel at any point during the study; participants access to professional assistance for any harm incurred during the study; debriefing if necessary;

courteous and tactful treatment at all times (Polit and Beck, 2004). This extensive list shows the magnitude of the researcher's responsibility towards the participants.

Fairness was guaranteed during this study according to the prescription of this principle. Participants who met study criteria were selected based on their availability and consent and no other subjective or discriminatory reason. They were given the researcher's address and contact information of the University of Essex in case they needed to verify any of the information the researcher gave them.

b. The right to privacy

When people accept to take part in any research they are opening up their lives to varying levels of scrutiny. They may be expected to share their deepest and most secret thoughts with researchers they may not know, express their views and positions on controversial issues, sacrifice the privacy of their homes, their health situations, their family lives etc. depending on the type of study. They will therefore want to be assured and reassured that this 'private' information is not made public. This can be ensured either through anonymity or through other confidentiality procedures (Polit and Beck, 2004).

In this study, participants' identifying information was not used during interviews. During the interview, transcription and presentation of data, participants were identified by false names which had no link to their real identities. The citations from the data were also made using labels that protected participants' identity. Documents carrying participants' information like the signed informed consent form were carefully locked away in a cabinet and shared with no one else. If for any overarching ethical reason someone else has to see these documents, they must sign a confidentiality pledge. Such documents however, will be destroyed as soon as possible after the research process is concluded. The research results were also released in the aggregate (Polit and Beck, 2004) and not individually.

Informed Consent

This has to do with the researcher obtaining the participants agreement to participate in the research. According to Polit and Beck (2004) informed consent means that participants have adequate information regarding the research, are capable of comprehending the information, and have the power of free choice, enabling them to consent to or decline participation voluntarily. This consent according to Pera and Van Tonder (2005) should be sought within a moral framework to ensure autonomy, confidentiality and anonymity; telling the truth and guaranteeing non-coercion and non-exploitation of the individuals concerned. These two positions clearly indicate that for a participant to decide to participate in a study he must have been given full information about the study and his role in it in an atmosphere that is free, cordial and non-coercive. Iphofen (2009) emphasizes the phrase ‘voluntary informed consent’ implying the participant was able to choose freely to give consent and subsequently participate in the research. The researcher has to equally ensure that the participant is competent and mentally fit enough to give consent after receiving information.

To obtain informed consent in this study, the researcher provided the potential participants with the full address of the supervisory institution and the researcher’s own address as well. They were equally told why and how they were selected for the study. The purpose of the research, the type of data and data collection method including the approximate amount of participant’s time to be taken during the interviews (maximum one hour per interview) was communicated to the participants. They were informed that there were no potential risks and no benefits involved in taking part and how their rights were to be respected. Considering that this study was qualitative with a grounded theory methodology, it was difficult to predict the flow of questions, the duration and frequency of interviews because these will all be determined by the emerging data. To circumvent this issue there should be an informed consent statement at the beginning with as much information as possible as well as adoption of the process consent (Polit and Beck, 2004) i.e. the researcher will continually renegotiate consent with participants during the course of the study as necessary. However, during the study the researcher explained to the participants that there was always a potential for subsequent interviews as the analysis was going. They were asked to give permission to be interviewed a number

of times as necessary and at their convenience. The informed consent document used in this study is shown on Appendix VII.

When the above information had been given and participants had their questions answered, a number of them declined. Of those who gave consent, one preferred not to take part in a second interview if it became necessary. However, all study participants expressed satisfaction with the study and complemented its potential to positively impact nurse education in Cameroon.

3.3 Conclusion to Chapter

In this chapter the argument for the study design was made. The researcher argued that grounded theory methodology was the most appropriate method to analyse nurse education development in Cameroon. In line with the researchers ontological and epistemological position the researcher demonstrated the rationale for the selecting Kathy Charmaz's constructivist interpretation of grounded theory. The researcher argued that the reality of the nurse education experience in Cameroon and its future direction could be created by the interaction between nursing and its environment thus presenting potentials for unique context-specific differences from international trends. The discussion on the application of the method in the study was also made with the goal of providing rich descriptions to demonstrate trustworthiness of the study process. Ethical considerations applied before, during and after the study process were also described. The next chapter provides a constructivist grounded theory interpretation of the study results. It shows how the subcategories and categories were created from the emerging data and establishes the link between the emerging categories.

CHAPTER FOUR

INTERACTING FACTORS INFLUENCING THE EVOLUTION OF NURSE EDUCATION IN CAMEROON

4.0 Introduction

A constructivist interpretation of grounded theory is applied in the presentation of the study results in this chapter. The data was collected from document analysis and in-depth interviews of study participants. The results are presented in two parts. The first part deals with results from document analysis and end with a summary model leading into the second part. The second part is based on data from the interviews which also builds from and incorporates the document findings and ends with a more elaborate model. This model shows the emerging categories and the interrelationship between them.

4.1 Nurse Education Policy Decisions from Document Analysis

4.1.1 Role of physicians and non-nurses

The role of non-nurses in nurse education is reflected in some policy documents from the different ministries involved. With the goal to promote social inclusion through involvement of relevant groups in programme development, the ministry of higher education gives non-nurses an undefined role in nurse education:

“...to promote social inclusion with participation of national structures and the competent socio-professional groups particularly regarding the definition of programmes and the organization of theoretical courses , practical work and internships” (Law No 005, 2001)

The broad inclusion allows different groups to be part of a higher education process that also includes nurse education.

In some cases physicians are explicitly allowed to head nursing schools:

“The director of a cycle B school has to be a holder of degree in medicine or the advanced nursing diploma from CESSF” (Article 10 Decree No.80/198, 1980)

Physicians are listed before nurses though it is unclear if the listing is in order of preference. The order thus gives physicians room to manage the day-to-day activities of nurse training programmes.

Training should prepare the nurse to perform nursing roles alone or under supervision of a physician. The physician has authority to supervise nursing care and students trained under this philosophy will see their role as subordinate to medicine. The decision goes on to add that the SRN holder should:

“...participate in the training and further training of personnel and ensuring the supervision of probationary students under medical authorities or paramedical personnel specially trained for this purpose (instructors and supervisors)” (Ch1:4 Order No.22, 1970)

The physician can teach nurses without further training but the nurse teacher should get further education.

The involvement of physicians and non-nurses in nurse education was enshrined in nurse education policy thus influencing the orientation of training.

4.1.2 Role of the nurse

The law expects graduates:

“...to contribute within the national and international scientific and cultural communities to the exchange of ideas, the advancement of research and the meeting of cultures” (Law No.005, 2001)

Promoting research, advancing, science and knowledge, and cultural exchanges go beyond just playing a unique professional role. By implication, nursing graduates will be expected to work with the scientific community to advance knowledge and progress of science in relevant areas. Thus nurse education must not be focused only on clinical skills development.

The structure of undergraduate studies must build on professional competences:

“...professional training within the university system should include professional practices directed towards the acquisition of the required competencies. It should also permit the acquisition of the quality of reasoning, the attitudes and behaviours as well as develop a sense of responsibility by progressive adaptation to the exigencies of the profession.” (Order No.06/0014 MINESUP, 2006)

Professional competencies and values of each profession (including nursing) must be the basis of higher education. Graduates should also have the capacity to adapt to a changing work environment.

The purpose of training in the ministry of health is to produce nurses for the health system:

“The general aims are the training of state registered nurses...who are generally qualified and are capable of fulfilling the various responsibilities devolving on them in the implementation of the health policy defined by the government on the one hand as regards the development of the basic health services and on the other within hospital shifts” (Ch1:3 Order No.22, 1970)

The nurse is being trained for certain roles towards achieving national health policy goals. Training here is for consumption and has nothing to do with organising an autonomous profession. The role is mainly focused on disease prevention and treatment:

“...observing, recognising and interpreting physical and psychic, emotive and mental signs of illness; participating in the various methods of action to prevent diseases with a view of promoting the health of the public...to practice laboratory examination for current investigation, to make out medical prescriptions, to observe the effects of various therapeutics and to keep the medical files up to date; etc.” (Ch1 Order No.22, 1970)

Training is focused on clinical skills development, but critical thinking and problem solving skills are not mentioned. The expectation to practice in the laboratory points to a more polyvalent role.

4.1.3 The status of the nurse

Higher education does not define any status for nurses however; nurses working under that ministry are bound by its general staff statutes:

“The professional grading of lecturers in institutions is the same as in public universities... The conditions for change of grade for full time lecturers in higher institutions are fixed by order of the minister of higher education” (Ch3 Law No.005, 2001)

The nurse educator doesn't have a special status but receives the same, privileges and conditions for promotion as all other staff in that sector.

Documents from the ministry of health show that levels of nurse qualifications were linked to categories in the public service:

“Training schools for health personnel will comprise three cycles: B, C, and D....Cycle ‘B’ constitute schools training nurses...at the category ‘B’ level of the public service. Cycle ‘C’ constitutes schools training assistant nurses...at the category ‘C’ level of the public service...” (Decree No.80/198, 1980)

The status of nurse qualifications is designed to suit the classification of personnel in the civil service. It is not based on an independent professional profile built for the profession.

4.1.4 Education structure

Creation of schools

The opening of schools to train health personnel was the prerogative of the president of the republic:

“The creation of training schools for medico-sanitary personnel created by decree of the president of the republic is placed under the authority of the minister of public health” (Order No.22, 1970)

Creation of schools by the president reflects a centralised approach to governing and the level of state control over nurse education at the time. The minister of health only had the responsibility to

supervise or manage the schools. Ten years later the Minister will have authority to extend the programmes of the school in further evidence of control:

“....New sections can be created within the training schools for health personnel by decision of the ministers of public health and finance” (Decree No.80/198, 1980)

The input of the ministry of finance was probably related to funding since the state at the time funded nursing studies. Decisions on nurse education were therefore in the hands of political administrators.

The exception here was the centre for higher nursing studies which was the highest centre for nursing studies at the time:

“The centre for higher nursing studies (CESSI) in Yaounde an integral part of the university centre for health sciences (CUSS) opened its doors in 1972 to respond to the need in France Africa for a cadre of nurses, nurse-midwives and midwives at a higher level in the areas of administration, community health care and teaching in nursing and obstetrics” (CESSI Curriculum)

The school was created as an international project for not only Cameroon but other French-speaking African countries.

Law No.005 of 2001 liberated higher education and recognised the role of private institutions:

“Higher education is made up of all programmes and post-secondary education provided by public higher education institutions and private higher institutions authorised as higher institutions by the state” (Law No.005, 2001)

And of private individuals:

“Private higher institutions are created by the initiative of private individuals or by international organisations under conditions specified by regulatory texts” (Law No.005, 2001)

Private higher institutions are fully recognised and the right of individuals to open such schools is established. There is no expectation that only a nurse can open a nursing school. The law deals with institutions and not individual programmes and as such applies to every programme in an institution including nursing.

Entry requirements

The ministry of health spells clear measures to admit students:

“Students of cycle B2 are recruited by entrance exam. No candidate can attempt the exams more than three times. Candidates who are civil servants must hold the SRN diploma, be aged at least 40years...and must have been working in their present grade for at least two years” (Decree No.80/198, 1980)

Similar conditions are set for different levels (cycles) but the emphasis is on controlling the process. Age and work experience were part of the determinants of entry depending on the programme. The number selected was determined by the ministry of public service:

“The minister of public service sets the number of places, as well as the number of places reserved for candidates from under-scholarised regions in consultation with the minister of public health” (Decree No.80/198, 1980)

This process points to training being motivated by the government’s health care needs and the funding available. Age restrictions were likely made for public service recruitment purposes rather than academic potential.

For higher education the admission process is left at the discretion of the institutions:

“Access to these institutions may be through a written test or through the assessment of candidate’s application documents following modalities defined by the regulations.” (Law No.005, 2001)

Institutions can admit as their capacity permits, but respecting the minimum entry requirements and prescribed guidelines. This means number of nurses trained is no longer predetermined by the government.

School administration

Policy also sets up the administrative functioning of schools.

“The administration of training schools is ensured by a common administrative council for the creation of schools; an administrative structure for every school; an academic council for each school and a disciplinary council for each school” (Decree No.80/198, 1980)

The central administrative council is led by the minister of public health and includes representatives from other ministries. It also sets the budget for each school. This reflects the political control of nurse education as major decisions are made by public administrators at the central level.

At the level of higher education each school proposes its administrators:

“The head of the school and the academic dean are designated by the proprietor for approval by the board of the school following conditions laid down by the minister of higher education” (Order No.02/0035MINESUP, 2002)

Private institutions have to nominate their officials for confirmation by the minister of higher education but have autonomy in managing their schools. In both ministries, the administrative set up is such that non-nurses have significant room to influence nurse education as members of different councils or committees.

Teacher selection

Teacher qualification is an aspect that is clearly defined by government texts:

“Personnel teaching in [private higher] institutions must have the same academic qualifications expected of lecturers of the same level in public universities. They must teach

within their specialty and an authorisation to teach for every teacher in the institution must come from the minister of higher education” (Decree No.2001/832/PM, 2001)

A nurse educator in the private higher institute must meet the minimum requirements to lecture as at the public university level. So students in both sectors are exposed to the same quality of teachers. The minister of higher education endorses the staff list of each school.

The ministry of health has its own teacher recruitment formula:

“The teachers for cycle B come from staff at level of category A and B specialised in the specific discipline;...for cycle C staff should be from category A and B specialised in the specific discipline and teachers for cycle D come from staff at the level of category B specialised in the specific discipline” (Decree No.80/198, 1980)

Personnel have to be of a higher grade from the level they teach at. Category A personnel are holders of the national advanced diploma (highest at the time) and so can teach at all the other diploma levels.

Student funding

In the early years of nurse education the state provided funding for student nurses:

“The students admitted on the state’s account benefit from a bursary whose amount is fixed by particular texts” (Decree No.80/198, 1980)

“Students of Cameroonian origin sponsored by public or para-public institutions or private organisations benefit from their sponsors, a training bursary that must not be less than what student’s on the government’s bursary receive for the same level” (Decree No.80/198, 1980)

Private organisations were expected to provide comparable bursaries to those on state funding for their own candidates. Nurses were thus not expected to pay for their education.

Awarding diplomas

The award of qualification diplomas is in the hands of the state:

“The award of titles and diploma and national qualifications from higher education is the responsibility of the government” (Law No.005, 2001)

Institutions provide training as authorised by the state, but all diplomas and certificates are issued by the state. Validation of the education process is made by the state when a minister endorses exit certificates.

Suspending training

Data showed that training of SRN nurses was at some point suspended:

“Within the context of rationalising our system of training, I have the honour to inform you that the training of state registered nurses... and specialist nurses from now on will be done in a sporadic manner per batch. Consequently there shall be no entry exam this year for the said cycles” (MINSANTE Fax, 2005)

This document shows a decision in 2005 but the suspension of nursing education is commonly placed at the end of 1980s right through the 90s. However, no document was found explaining the decision then or in 2005.

4.1.5 Policy making process

Studied documents do not indicate the process behind their making. Typically policy documents begin with authority references and earlier decisions (where they exist):

“Mindful of the constitution of 1 September 1961 as amended by Law No. 69/LF/14 of 10 November 1969...Mindful of decree No. 69/DF/71 of 26 February 1969 concerning the creation, organization and functioning of paramedical personnel training establishments” (Order No.22, 1970)

This preamble is where you can find processes or organs that have contributed to the policy to be elaborated. However the documents reveal nothing about the people, processes, or justifications of the policy.

There was evidence that nurses may have had input in the process:

“I have the honour to inform you that a seminar on the revision of the training programmes for medico-sanitary personnel will take place in Yaounde from the 14 to the 25 of February 1994” (MINSANTE Invitation, 1994)

Invitations to such gatherings give nursing school directors an opportunity to debate on nurse education issues. Their proposals might find their way into policy decisions but this is not acknowledged in any of the documents studied.

4.1.6 Summary

Nurse education has essentially remained within government control through different ministries. The nurses’ role and the structure of education are clearly set forth in policy documents. However, the role of non-nurses and the status of the nurse are two factors that are implicit in policy documents and have a subtle influence on nurse education. This can be summarised in the following model:

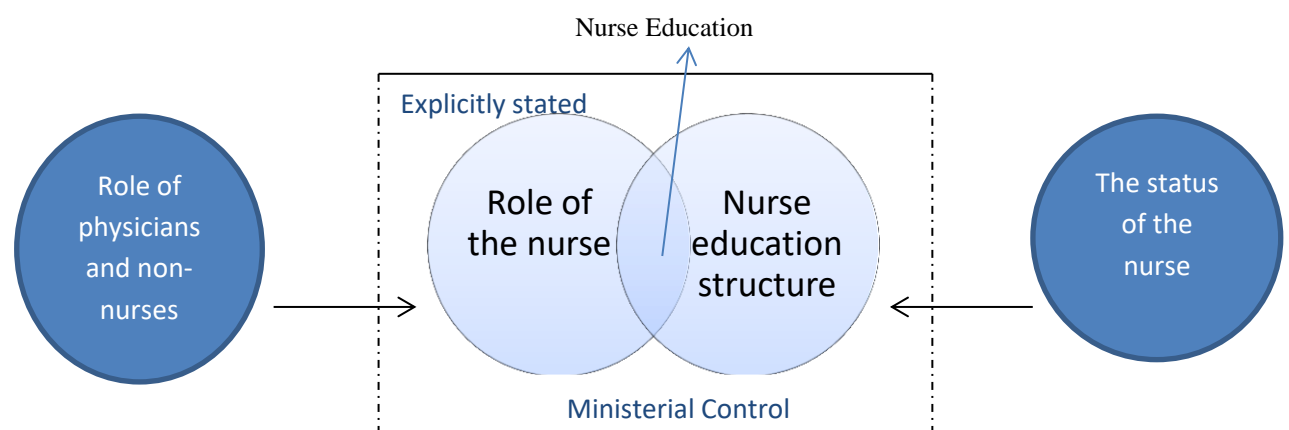


Figure 1: Influence of government policy on nurse education.

This summary now leads to the interview analysis and provides a backdrop to understand certain facts that could come up from interview responses.

4.2 Analysis of Interviews

4.2.1 Constructing Category One

The history of nurse education in Cameroon as emerging from the data provides a context that fosters understanding of other emerging categories from the data.

The origins and conception

Formal nurse education was introduced by the colonial powers:

“In fact you can’t separate it from colonialism” (Int1:2)

Nursing practice and training was thus established as part of the western-styled health care system. Its ‘modern’ format was not based on indigenous practice rather it was an imposed model.

The ‘nurse’ at this time learned by assisting the doctor or nurse. In the French section of the country the ‘nurse’ learned under the doctor:

“Somebody coming to stay with a doctor or so and then eventually learning a few things, acquiring knowledge, you know, in dispensing drugs, in dressing a wound and in...other simple situations of care” (Int4:2)

In the English section the ‘nurses’ trained under nurses who came from Nigeria.

“...they were the Nigerian nurses, staff nurses who were running our hospitals” (Int4:23)

The apprenticeship model was used to train the dressers. In East Cameroon apprenticeship took place under the doctor while in West Cameroon it also took place under nurses thus giving it a ‘nursing’ touch.

Formal training in East Cameroon is linked to the work of Dr. Eugene Jamot a French physician:

“The first nursing programme that started in East Cameroon was in 1930 in a small town called Ayos...It was a nursing aide school, recruiting mostly men and again the main actor in those days was Dr Jamot” (Int7:2)

The doctor needed assistants to help him with his practice. The choice of males may be a reason why there were more males than females in nursing. This situation established an early physician influence on nurse education.

In West Cameroon training was styled after the British model introduced in Nigeria.

“So the British again started the first training school, I think was in Victoria around the 1930s. Again I think it was a state registered type of nursing program or midwifery program based on the British system” (Int7:5)

So formal training started with an actual nursing programme thanks to colonial administrative structure. The French, British, Nigerians, and foreign physicians all influenced the creation of the nursing profession. Here also, the root of two fundamentally different orientations to nursing is seen.

Contextualisation

The code ‘*contextualising nursing practice*’ was used to capture how nursing was adapted to local needs. Further analysis changed it to ‘*evolving contextualisation of nursing education*’ to show that it occurred over time.

Nursing was part of western-oriented healthcare system:

“the local context was such that of course health systems in those days were meant to serve the white establishment and the colonial masters who were there and those who were working in the big cities” (Int7:1)

The health system was for the foreigners and those locals who worked with them. Nurses were trained to be part of such a system implying that the training was not based on local care approaches.

Traditional models were considered ‘unscientific’.

“...when the western medicine came, they rejected them, they relegated them to the background on the basis that they were not scientific so involved their own” (Int1:6)

The implication is that ‘modern’ nursing built from that system failed to incorporate local models in practice and training. Therefore the inherited system of nurse education at independence was a very foreign system.

Overtime the contextualisation of nursing programmes occurred gradually especially in the area of primary health care where nursing students learned about traditional health practices.

“...the things that have value...we try to readapt them, so this new practice – formalised practice is not all just abstractions but contextualised.” (Int1:16)

Community health nursing courses were the principal way in which nurse education validated aspects of indigenous care. Some programmes include courses that focus on culture and indigenous practices

“There are some courses dealing with traditional medicine, influence of traditional medicine, aspects of cooperation between traditional medicine and orthodox practitioners so it is a synergy yes!” (Int1:20)

There is therefore no evidence that indigenous care models have been integrated into nursing programme designs. Learning about the practices and their value is different from incorporating the indigenous models into the curriculum for nursing.

Early education structure

Initial codes here included ‘*describing education structure,*’ ‘*entering nursing programmes*’ and ‘*funding mechanism*’.

In the English subsystem the GCE Ordinary Level certificate with a pass in the science subjects was the entry requirement:

“In our own time we entered with the GCE ordinary level to the state registered nursing and...with that qualification you must be a holder of the science subjects...” (Int12:1)

A significant level of general education was required including knowledge of the sciences. Thus basic sciences were seen as an essential pre-requisite to study nursing. In East Cameroon the entry requirement for the nursing aide programme was the First School Leaving Certificate

“You know that Ayos is the first centre of training of nurses it started training nurses then...at the level of – first school leaving certificate and then you have nine months”
(Int6:3)

Staff nursing candidates in addition had to pass through a pre-training probationary course:

“...for you to go and have a knowledge of just the environment, the practical work in the hospital before you go...some people decided to even run away because when you talk of uhm a bed pan enh! A patient is going to stool you carry the bed pan to go and empty, you are there to go and wash the toilet, you are there to go and bathe the patient.” (Int5:5)

Probationary training was therefore a kind of apprenticeship that was also used to gauge the candidates' readiness for a nursing career. After reunification the entry requirements were modified according to the variety of programmes:

“...After that there was a system that there are nursing assistants who are doing nine months training...breveté nurses who were entering with O-level or breveté in the French system and who are doing 2 years and there were diplome nurses who were training with probatoire or A-level. I think 2 paper and they were doing three years” (Int6:1)

There were now two levels of pre-registration practice before the SRN programme seen as the professional entry level. This established a number of pre-registration training options.

After the introduction of these different levels of training there was a transition scheme from the enrolled to the state registered nursing programme:

“...at first it was that when you did two years and you put in two years of service you could go directly into the diploma course otherwise at the second year of studies you could now

enter next year for the diploma course. But then later on they asked that we should work for two years then sit in for a concours to enter to do the diploma course...” (Int10:2)

The transition scheme allowed enrolled nurses to get reduced study period in the SRN programme. There could be direct continuation upon completing the enrolled nursing training or after two years of working. Eventually this transition scheme was abolished.

After the SRN programme, it was possible to pursue specialisation studies:

“...you specialised in midwifery ...psychiatry ...periculture...pharmacy and all the rest. And that training was for two years, two academic years. After the two academic years now you had to go to the field and work and then after, to go...higher in what they used to call in our time the advanced nursing school in Yaounde CESSI” (Int12:1)

Clinical specialization programmes were available as post-registration programmes after two years of working. There is persistent emphasis on clinical experience as a precondition to further studies.

Physician domination

This subcategory emerged as evidence showed physician domination of nurse education. The main code here was ‘*setting nursing as assistants to physicians*’. Historical events set the doctor above the nurse from the very onset:

“Although we are not having back-up documents, the truth is that the nursing profession at the beginning in Cameroon...during the colonial period – who was the doctor? The doctor was the colonel or the well, the highly grade officer of army. He was the one who was called doctor. And the person, I can say the body guard of that colonel was the one that was called the nurse. So that is when our problem start in this country” (Int6:1)

Nursing was thus conceived not as an autonomous profession but as a supporting role to physicians. This is an aspect recognised as a key underlying obstacle to nurse advancement in the country. The physicians were already established in the healthcare system:

“Get this point very well! ...the first stakeholder, the people who we may call – they were the doctors na! And so therefore they were simply looking for people to carry out as robots their instructions, and so therefore the nursing concept in the practice was never their boredom.”

(Int3:2)

Physicians were most influential in designing nurse training and so focused on skills that will make nurses useful to physicians. The focus was therefore on skills development and execution of instructions. So the conception did not perceive nursing as autonomous.

This perception continued with the introduction of the SRN programme in East Cameroon:

“The people graduating with SRN were simply called doctors - in fact they were assistant doctors in East Cameroon” (Int4:1)

“...Why called assistant doctors? Because the conceptual framework of nursing as a specialty was never their call...” (Int4:2)

The trained nurses saw themselves as assistant doctors because their training lacked the nursing professional framework to see themselves as autonomous professionals with a collaborative but distinct role from that of physicians.

The passage of time saw the strengthening of this physician domination:

“Up till now nursing profession is, I can say is conceived in Cameroon as a basic, as a support of medical profession which is not true enh! It is not true! That is where the problem is” (Int6:7)

The era of liberalization of higher education further strengthened physician influence in nurse education:

“The present scenario is that physicians have money to open their nursing schools and employ teachers who are there to come up, so the qualification is never their problem.”

(Int3:8)

Serving as proprietors of nursing schools gives physicians, significant influence on both the training programme content and staff recruitment. These two factors increase their influence on nurse education in the recent era.

Category One: Multiple Birth and Formation

The history of nursing education in the country emerged from the data as one that was born out of colonialism and not indigenous practices. An emerging pattern linking the history, the beginning of formal training, the structure of training through the influence of physicians from the early days is seen to be influencing the evolution of nurse education. The pre-educational apprenticeship model dominated by physicians, the French and English colonial influences, are all part of a narrative that show how nursing was conceived, born and groomed in its early years. It shows a profession that was created and influenced by others as well as historic events like the reunification of Cameroon.

4.2.2 Constructing Category Two

After its birth and early years of nurse education, key subcategories were identified showing the evolution of the profession

External influences

The growth of the nurse education system was influenced subtly and overtly by external forces. The focused code '*recognising external influences*' developed from '*identifying external individual influences*' and '*projecting collective external influence*' helped to capture data showing this.

Some nurses were able to travel abroad for both undergraduate and postgraduate studies:

“Most people who had the first degree were trained outside, either in Nigeria or in London”

(Int2:1)

Foreign exposure would have influenced their perception of nursing, style of practice and content for advocacy. If not at macro-level such exposure would surely have influenced at the micro level.

There was also elaborate influence from other countries:

“I cannot really say what happened but I know that Nigerians were here and everything we did here was more of Nigeria. So even the nurses were trained from Nigeria and sent here. Some started here...But most of them were trained in Nigeria” (Int5:1)

Foreign models influenced pioneer educators and programmes. This influence caused nursing programmes in West Cameroon to be designed exactly after the Nigerian format. Nurses who studied in England came back to teach in the early nursing programmes:

“...teachers came from the old nurses who had been trained in England and those who had been trained in Nigeria...” (Int7:5)

The culture from Britain and Nigeria emerged as one of the dominant external influences on nurse education in West Cameroon.

Candidate selection

Initial codes like: ‘*questioning candidate’s motivation*’ and ‘*screening unsuitable candidates*’ were used to capture relevant data. The codes were later merged during focused coding into ‘*visiting entry into nursing programmes*’ from which the sub-category ‘candidate selection’ emerged.

As already seen in 4.2.1 entrance to nursing school was by written and oral exam. A final screening exam took place just after start of school:

“It was a written exam, it was like you have studied for these 3months nah, and you were writing the exams...they are going to test for all the things you have done. So if you pass then continue, if you don’t you...go out of the school.” (Int10:2)

The selection process was multi-layered after which the successful candidates were allowed to continue their nursing studies.

In recent years candidates just take a single entrance examination:

“I remember even here there was a time in this hospital we had some...a disabled student or girl who had to join the nursing field (Int5:1)... But if they were interviewing as they did in

our own days they will see that this student, this girl or student cannot be a good nurse because she cannot run physically.” (Int5:2)

Nurses think that taking off the interview part of the process makes it difficult to screen candidates whose physical capabilities are unsuitable for nursing. This is thus perceived as dilution of the standards and status:

“So one of the reasons that made nursing not to be regarded was that the entry qualifications were not well defined” (Int1:7)

A consequence of this is the perceived lowering of the status of nursing in the country.

Polluting nurse education

‘Polluting nursing education’ emerged as an *in vivo* code representing data on nurses’ perception of the creation of pre-registration certificates. The ‘pollution’ is associated with the francophone influence on nursing education:

“...But is just after that that this people brought this thing of 2years and 1year, that was around 1964. That is when they started talking about nursing aide and brevete nursing.” (Int5:1)

The creation of nursing assistant programmes was therefore not appreciated by nurses at the time. It threatened the professional value of nursing:

“We told them that nursing was being polluted and that we will lose meaning that we had acquired from the British training via Nigeria. The British training was being polluted by these Francophones” (Int4:2)

The inherited Anglo-Saxon approach to nurse education was a source of pride for Anglophone nurses. The introduction of lower programmes was taken as an affront on this culture. Nurses tried to convince the authorities against pre-registration programmes:

“We...wrote a memoir to inform the ministry of health that we were spoiling nursing with this multiplicity of training, and...growth in nursing will be hampered. We were envisaging a single cadre that SRN cadre...” (Int4:3)

The SRN diploma was perceived as the right minimum level training for professional practice.

Hospital-based training

From birth through its early years nursing programmes remained under the ministry of health and were run from hospital-based schools:

“These diploma programmes or hospital based programmes are meant to train those nurses who will much more stay at the bedside...the main focus is to train that person who will nurse at the bedside” (Int9:2)

This location facilitated a training model where students easily moved from the classroom to the ward for clinical sessions. There was a strong focus on bedside practice or clinical skills as compared to other important non-clinical nursing skills:

“I will tell you that even when we receive them here they are still lacking in the research work” (Int10:5)

This focus on clinical skills presented challenge for nurses who pursued further education. They had difficulties in acquiring knowledge and skills in research.

Another characteristic of hospital-based training is the use of a national curriculum:

“...health has one programme for all the schools of the same category, everything and they the ones supervising you see from beginning, from competitive exam until they are going out...so that all of you come out with the same standards and everything.” (Int8:1)

A national curriculum enforced by the ministry of health was seen to guarantee a similar learning experience for every student nurse. In addition the programme is seen to be ‘professional’ by some nurses

Keep the SRN level, that level brings – starts bringing professional nursing” (Int3:5)

The argument is that the programme is valuable and should be retained because it is an acceptable level for entry into professional practice. Its strong focus on multifaceted clinical skill and professional values development is its main strength.

The francophone perception

This subcategory developed from the initial code ‘*a limiting francophone perception of nursing*’ to represent data showing how the politically dominant francophone subsystem see nursing. This perception of nursing never saw nursing developing beyond the diploma level

“There is still one francophone driven ideology that does not see nursing beyond the diploma level. That is one, and that is very, very fundamental, and given that they are in the majority they are holding everybody back. It’s a big problem” (Int7:5)

Nursing is not seen as an autonomous profession that can train its members, right up to doctoral levels.

“They don’t see the nurse capable of doing research, they don’t see the nurse even becoming a PhD, doing research and improving the quality of nursing.” (Int7:6)

“They don’t see nursing influencing and setting the pace for the role of nursing in the overall health policy and in the overall policy of providing health care services to the rest of the country.” (Int7:7)

The nurse’s potential to become a researcher who can use research evidence to contribute to improving healthcare quality and health policy development is not recognised in this view. This view point also supports the strong emphasis on clinical skills development at the expense of other skills needed by the nurse.

If the Anglophone perception was dominant, participants predict that the profession would have advanced at a faster pace.

“If we were only Anglophones we would have been like Britain and America. It is because we are joined to them and most of them in the ministry are those in policy making. So they are the ones who are tying us down, and to fight through them – we are in the minority – it’s difficult.” (Int8:6)

Changing the perception of the politically dominant culture is a challenging prospect for nursing. So moving nurse education forward will include changing the perception of not only the majority but also of the dominant political culture.

Advanced education at CESSI

There was significant data on CESSI which was created as the most advanced institution for nurse education in Cameroon in the mid-1970s.

The programme content revolved around administration, teaching and research methods. However, research is not mentioned in the curriculum documents of the school as a main objective:

“During the CESSI programme there were three important courses: research methodology, administration and teaching methodology.” (Int12:2)

So the programme was directed at training teachers and administrators of nursing schools and nursing services. It did not have an academic orientation even though it was domiciled at a university campus:

“It was not really academic it was basically administration again opening in university level!” (Int7:8)

The university lodging added the sense of higher education but the award remained a diploma which was uncommon for typical university based programmes. The school was created to meet the needs of French Africa and did not take into consideration the English-speaking nurses in Cameroon:

“Training there was, was purely in French, so you can imagine! You must give credit to some of our candidates who left Bamenda in those days who are nurses and were able to cope in that school without necessarily having a French background.” (Int7:5)

For Anglophone nurses, succeeding in CESSI required that they overcame the hurdles of studying in language they did not master.

Some years later, without explanations training for Cameroonian candidates was later suspended

“You know...they came and closed it down for Cameroonians. I don’t know, it looks like they say the school is still going but not for Cameroonians” (Int8:1)

The reason for the suspension of this training remains unclear as until the university came no other programme prepared nurses for advanced roles CESSI was created to achieve.

Suspension of training

The suspension of SRN training occurred at some point in the growth process:

“...that gap was almost 10-15years eh!” (Int10:3)

“Now before the bachelors program there was a gap in training in Cameroon. Precisely between 1987 and 1997 yes, about a ten – year gap” (Int7:1)

The University of Buea stepped in in 1997 but the SRN training was probably still under the moratorium. The reason for this moratorium was not evident even in studied documents. However it was associated with the economic crises that started in the late 1980s and early 1990s:

“So for some reason they said there was an economic crisis and as such they could not operate nursing schools and train the nurses that were required. However, the...sole medical school in the country in the University of Yaoundé continued to train medical doctors but no nurses were trained for this ten year period.” (Int7:2)

Suspending nurse training and maintaining physician training, is perceived as discriminatory against nursing.

The consequence of the suspension is that there was a manpower shortage:

“...this lack of training led to an incredible shortage of manpower. A decade is too long!”

(Int7:3)

The shortage of nurses generated a need for more nurses, a need aggravated by the reduction in mentorship opportunities:

“The gap was too much because when we were in school we met old nurses who had been training, who had been working and they trained us and we picked at least our models from them. Now you go there the person that is there had no training from an older nurse, no experience, so she is working with what she has.” (Int10:2)

There is therefore an added value associated with the opportunity to work with experienced nurses for young nurses. This was lost during the suspension because newly recruited nurses had fewer nurses to mentor them.

The suspension also led to a situation where nursing assistants became the dominant force within nursing and assumed leadership positions.

“They were doing only...nurse assistants...many years like that. Finally now before that they were managers of places, health centres, they were the chiefs of post and all what not”

(Int8:2)

So there is a scenario where nurse managers were actually nursing assistants and not nurses. With their training based on taking instructions these nurses being in charge of nursing services were thus acting beyond their competence and would have strengthened physician domination.

Training for consumption

This emerged as a subcategory covering data reflecting how nursing education was driven by healthcare needs. Codes used here included ‘*increasing need for quality healthcare*’ and ‘*meeting nursing shortage*’.

The basis of development of nursing was the need for healthcare

“the basis of this development has been the increasing need, the ever increasing need to render high quality health care especially in this era of increasing human health needs”

(Int1:1)

There was need for people to carry out certain health activities to meet the needs of the population:

“In the francophone area because we were not having too much...health facilities, we were limited (Int6:2)... And then later on there is need of qualified personnel to carry out some activity and they started training of nurses” (Int6:2)

In private practice, doctors opened training centres to train their nurses during the period when training was suspended:

“...doctors in particular decided to train their own nurses in their clinics for their use....when they finish they cannot hire all of them, the rest go into private practice...and we don’t even know whether to qualify them as the nurse’s aide, nursing assistants or even the qualified registered nurses that we know.” (Int7:3)

The idea was to train for private use but gradually they could not use all the nurses and the others went into private practice. This training posed difficulties because the level of nurses trained could not be ascertained.

Training of nurses at all times was influenced by needs: either physicians’ prior to formal training, the healthcare needs of the colonialists, the healthcare needs of the public health system, or of physicians in private practice.

Category Two: Reactive Growth and Development

From formation through its growth into ‘adolescence’ the evolution of nurse education has been influenced by many factors that make it difficult to define its ‘shape’. External influences defined the structure and implementation of the first programmes. The reunification of the two Cameroons brought together two very different perspectives (Anglophone and francophone) bearing on the young profession. The former saw nursing more as an autonomous profession while the latter saw it more as a ‘supporting’ profession to medicine. Training was built on a hospital-based model which emphasised clinical skills development as opposed to research and other non-clinical skills. Nursing training due to the economic crises was later suspended in favour of training assistant nurses. The overarching goal of training was for consumption i.e. meeting healthcare needs in public and private practice. These subcategories reflect a growth pattern that is not organised or planned over the long term. It rather reacted to surrounding circumstances hence the name reactive growth and development.

4.2.3 Constructing Category Three

Liberalising nurse education

This subcategory emerged from data showing how government liberalization policies of the late 1990s and early 2000s affected nurse education in Cameroon. Primarily it was the key factor in the expansion of education

“...what I think is that the liberalization of higher education in this country is a very big factor” (Int9:1)

It came along with a general change in thinking:

“That in as much as scientific profession is coming on, in as much as different pathologies are coming up, in as much as different fields of specialties are coming up for the wellbeing of the patient, people should be given the opportunity to excel in whatever domain they want and not to have limiting factors.” (Int12:2)

The fundamental change in thinking was that every professional should be given an opportunity to seek the maximum level of career and educational development possible without any inhibitions. This shift in thinking increased educational opportunities for the nurse

“Formerly the nurse could not go beyond the so called CESSI advanced nursing diploma...But opportunities since the decree of uhm 1990 and all what not, when things were liberalised, it seem as if many people understood that no profession should be held ransom.”

(Int12:1)

Liberalization removed the limitations to access higher education giving room for advancement beyond the existing higher national diploma as the highest qualification.

It also ushered in a variety of players in the area of running nursing schools:

“...when the government uplifted the suspension, yes there was this liberalization and people felt that it was good market to get into” (Int9:2)

So, entrepreneurs got into nurse education to take advantage of the high demand for nursing education and not necessarily to advance the profession.

Influence of physicians and non-nurses

The data revealed the strong influence of physicians and non-nurses on nurse education. Two codes ‘*identifying influence of physicians*’ and ‘*identifying influence of non-nurses*’ where used to construct this subcategory.

At the administrative or policy level, the key players are not nurses:

“The people who plan policies have no nursing orientation” (Int3:1)

Administrators of ministries are usually political appointees and may not be professionals. In such scenarios they become the key decision makers on professional issues of which they have no background.

“The first problem is that the training of nurses in this country is in the hands of people who are not nurses and they don’t understand how nurse training should be like” (Int9:1)

Non-nurses don’t master the concept and philosophy of the profession but are actively involved in training. This involvement is fostered in the opening and running of nursing schools.

“...if I could say the last thing on the scenario of nursing practice – it’s the quest for economic power by the doctor. They know that to get rich quick, open a nursing school of course, you will have all prospective girls. One cannot open a nursing school behind you know, at his back yard and will lack prospective willing candidates and enrolling them. No! So therefore the financial aspect of it by the people opening nursing schools, override nursing care practice.” (Int3:3)

The ability to open nursing schools gives physicians and others undue influence on nurse education. It gives the impression that nursing is an occupation without any restrictions so its training can be organised by just anyone for financial gain. The use of the expression ‘at his back yard’ demonstrates how degrading nurses perceive the ease with which people get to run nursing schools.

Increased access to education

Initial codes like: ‘*increasing access to education*’, and ‘*opening of universities*’ were used to code data that led to the refining of this subcategory.

The increasing access after the period of suspension was seen by nurses as an opportunity:

“I was opportuned I say opportuned because at the time when they announced the concours entry into the BSc section for UB in 1997, they considered the new entry and the old or experienced nurses...so the professionals who were ready and had more than five years’ experience were opportuned to get in. and so I used the opportunity and I got in and so succeeded and got in to do my BSc nursing.” (Int10:1)

The University of Buea which started university-based training made provision for experienced diploma nurses to be admitted into the undergraduate programme. This consideration did not include accreditation of prior learning.

The ministry of higher education also brought in the higher national diploma programme (HND) designed to facilitate an upgrade to bachelors:

“So around 2003 or so...launched its HND program to train again nurses again at the diploma level but this time using a higher education model not a hospital based type of model with the hope of giving those nurses the opportunity to advance in the higher education system becoming bachelor of nurses, masters...etc.” (Int7:2)

This increased access to nurse education was facilitated by the opening of many private higher institutes which though not universities operated on the university system. This is combined with the increasing number of universities:

“There are other universities that have also come up both public and private that are also training at the bachelors’ level. We can take the Christian university...the Catholic University in Yaoundé; and also the University of Bamenda...just to name a few. Those are the ones that are actually delivering a Bachelor of Science programmes in nursing, straight four years program” (Int7:1)

The universities go straight into the four year bachelor of nursing programme. They don’t run the HND programmes.

The increasing access has also led to increasing recognition of the bachelor’s degree in the ministry of health:

“I think things have ameliorated themselves, once you want to go to school now you ask for authorization you are given the authorisation. When you come back and give your report and hand in your papers you will be placed” (Int10:2)

A procedure has been set out for nurses to follow if they want to pursue further education and have those qualifications acknowledged. This is a change from previous years when only the advanced nursing diploma was recognised.

Increasing access has seen the multiplicity of nursing programmes emerging:

“...there is a lot of multiplicity in our nursing as we move to higher education, which is a good thing anyways – the nurse was not meant to stagnate” (Int3:3)

Though this multiplicity seems worrisome, nurses think it is good in that it now gives room for academic growth and progression for the nurse who for many years had stagnated.

Policy controversies

This subcategory is constructed from data showing the murky nature of nurse education policies in recent years. The data was captured through codes like ‘*training policy confusions*’, ‘*upgrading diplomas*’ and ‘*existing silent policies*’.

The key controversies are generated by the different training policies of the ministry of health and that of higher education:

“Ministry of public health continues with its trajectory of training nurses in its hospitals based again on a different type of curriculum while the ministry of Higher Education is using the LMD or the Bachelors, Masters, PHD model to train nurses along the University curriculum. So the problem is what will be the fate of the nurses who are continuing to be trained by the ministry of public health.” (Int7:3)

The two parallel models: hospital-based, and BMP (Bachelor-Masters-PhD) show no signs of coalescing. The situation is worrisome because the SRN has no clear upgrade pathway in the university system even though that training continues.

The variation in curricular is also perceived as a problem:

“...there is no control everybody has his own independent training programme, curriculum. Curriculum goes with duration of training meanwhile everybody should be on the same footing” (Int8:2)

The autonomy of academic institutions to implement variations of the curriculum is seen in a negative light by some nurses. This is quite different from the national curriculum policy implemented by ministry of health.

The absence of a clear policy on recognising previous learning and skill of SRN nurses is one of the problems facing nurse education:

“Well without any written policy some private schools now, private schools I must say private higher education institutions are giving those nurses now the opportunity to convert their SRN diplomas to a degree after one year” (Int7:1b)

Private higher institutions are trying to accommodate the problem without any national policy to guide the process. As making it possible, there is no clear policy guiding that process.

The contradiction also occurs within higher education itself.

“...candidate with the HND...since it is a university based education, they can... and- again is only the private universities doing it...after one year conversion they get their bachelor's degree. But...the state universities are not doing it. That is interesting [laughs], one would think that it would have been automatic now for HND students to just enrol in the university system and get their degree since it is the same university but the university is not doing it” (Int7:4)

Private higher institutes are affiliated to state universities through which they offer the one year upgrade for HND holders. The universities don't offer the upgrade directly which presents another education policy controversy that affects the profession.

Advocacy

Advocacy emerged from data indicating that at different times nurses have tried to influence the government to consider certain policies. In 4.2.1 the efforts of nurses to convince the government against pre-registration programmes was reported.

In recent years, nursing groups and their leaders perceive government intervention as the key to addressing nurse education controversies:

“The government needs to help. I don’t know we need to lobby the government, we need government support to help the advancement of nursing education in this country...” (Int9:1)

This shows a strong dependence on the government for every policy decision on nurse education. It also shows that without lobbying the government on its own might never come to address the issues.

Expansion anxieties

This subcategory was built from initial codes like: ‘*worrying about educational expansion*’, ‘*watching for proliferation of schools*’ were used to capture data showing the worries that came with liberalization.

The first worry is involvement of different government ministries.

“Somebody comes from the ministry of health, another goes to the ministry of professional training and gets his own programme the ministry of higher education sets its own programme HND” (Int1:11)

This involvement fosters variation in training programmes without any inter-ministerial coordination. It also causes some diplomas not to be recognised in certain quarters even though they are government authorised:

“People become confused on what to do, this is a government programme but is not recognised in some places so it is more at student risk, and it creates a dilemma.” (Int1:12)

The third type of anxiety is related to the demand for nurse education and the type of candidates being allowed into nursing schools:

“...there is an influx, there is an influx enh! People are flocking into nursing education but ask why! Is it that they are looking for a job, an occupation, do they know that it could be a job or an occupation with a vocational content that is the giving out of self to that occupation.” (Int3:1)

The perception here is that most of the candidates are not aware of the vocational aspect of the profession. They thus lack the potential to become good nurses because they only see nursing as a as an occupation

Another worry is the fact that the increasing demand for nurse education has caused schools to implement weak teacher recruitment policies:

“Because of the too many schools and institutions or whatever...the schools are now recruiting teachers not for the qualification but rather those who can easily come and bulldoze you that technical...training.” (Int3:3)

The teachers lack the ability to help students develop genuine passion for nursing and changing their view of it as just another occupation.

For some nurses expansion is not going properly:

“It’s good for a country to have nurses that are trained at bachelor’s degree level...master’s and why not PhDs, but how they get that qualification is very, very important so I think there is a problem with how that expansion is going.” (Int9:1)

It needs to be regulated:

“Much has to be done especially as it concerns health, because I can say there is some laxity by the government. We are dealing with human beings not paperwork” (Int5:1)

Regulation is necessary because poor education mechanisms will produce nurses whose practice will put patients at risk. Seeking regulation of the process is a strategy that retains the gains of expansion while eliminating the negative effects on nurse education.

Positive reception

As the category was being further explored, data showed that there was evidence of the expansion being seen in a positive light. The codes ‘*being thankful at education expansion*’ and ‘*appreciating education expansion*’ were created to capture the evidence.

Nurses expressed varying degrees of happiness at the expansion of education:

“I think we can really applaud what is happening now because as I told you formerly the nurse could not go beyond the so called CESSI advanced nursing diploma.” (Int12:1)

The opportunity to now go beyond the advanced nursing diploma has become a reality with the current expansion.

“We now realise there was something we were missing now they are going for it to expand the scope of these disciplines” (Int1:1)

Expansion provoked realisation of what was being lost prior to liberalization. Nurses see an opportunity to grow their abilities and expand the scope of their practice.

Some nurses are beginning to take credit for present expansion:

“We fought for this, fought for it seriously, seriously, seriously so we are very happy with what is happening today” (Int6:1)

Taking credit for expansion indicates that it is positively perceived and desired. Nurses want to be associated with the positive aspects of the process.

Category Three: Liberalization and Education Expansion

This category reflects the impact of the government’s liberalization policy on the nursing profession. Liberalisation broke ministry of health’s monopoly over nurse education with the entry of other ministries. A proliferation of schools and increase demand for nursing education ensued. Non-nurses and physicians could legally open and run nursing schools thus having a direct say in nurse

education. Increase access to further education was a highly appreciated aspect of liberalization although it created need for stricter regulation to guarantee quality of education. There is also need to address intra- and inter-ministerial policy controversies. The era is thus characterised by positive and negative consequences on the profession but the results show a desire for improvement and regulation rather than a return to the pre-liberalisation status quo. The impact of liberalisation has thus been very significant.

4.2.4 Constructing Category Four

The entry of the university

The start of university education for nurses is inextricably linked to the history of the Faculty of Health Sciences of the University of Buea and certain individuals at the time:

“There was consensus, the think tank got together and... proposed to start with nursing and medical laboratory sciences in this medical faculty, got the blessing of the minister of higher education and the ministry of public health and many stake holders and leading stakeholders in health in Cameroon” (Int7:3)

The start of nursing at the University of Buea was thus not a decision from the government but from certain individuals. The individuals included medical professors and nurses but according to some nurses the pioneer dean of that faculty merits extra credit:

“[Professor] McMoli came in from Nigeria, she had learned Nigerian system, the English system, trained in both systems and then when she came in...she broke ground...by saying that nursing education can also be elevated and forcefully by her you know enthusiasm...charisma she woke up from Yaoundé and single handedly...against all controversy introduced the faculty of health sciences training two types of cadre, the nursing cadre and the medical laboratory cadre.” (Int4:4)

Nurse education in the university is one positive impact that a physician has had on the profession. She led the initiative even against resistance from different quarters in the country.

Welcoming the university

The code ‘*welcoming the role of the university*’ was coined after data emerged showing nurses’ positive perception of the university’s role. Participants saw that the coming of the university has increased the number of home-grown nurses with bachelor degrees

“In those days...there were very few people with the first degree. Most people who had the first degree were trained outside, either in Nigeria or in London. Now you have first degree schools training first degree everywhere.” (Int2:2)

Some nurses describe their opinion of the role of universities as giving them personal opportunities to achieve a long held career dream:

“I think...instead of nursing being sporadic, it is actually escalating in its measures and height and I think it’s only a thing to hold onto because if I see myself and I calculate what has happened to me if – I took the administrative concours, I did not pass the first time, the second time I tried the results never came out and they closed the school. So you can imagine that from 1985 that I left school I could only earn a BSc in maybe 2003, or had the opportunity to even enter 1997.” (Int10:1)

Aborted personal advancement ambitions led nurses to appreciate the current opportunity. The value of university education is appreciated by considering its impact at personal level.

University education has enhanced professional status:

“Now nursing evolved up to now the university level, it is at that level we really could have started talking about professionalism in nursing” (Int3:1)

University education infuses new levels of confidence in nurses about their status as a profession. So the discourse on professionalism is linked to level at which education is taking place.

Higher education model

The code *‘using a higher education model’* was used as a focused code to build this subcategory. The emerging data attempts to articulate the higher education model.

The strong emphasis on the scientific basis of the nursing profession is the central element in this model:

“Ministry of Higher Education thinks that when you have that scientific base...because the first years are spent on the sciences doing chemistry, doing physics, maths...to give it that scientific base before you now get up to the practice.” (Int13:2)

Studying the pure sciences facilitates understanding of nursing as an applied science. The nurse in this model is expected to distinguish her practice by the application of scientific principles and rationales. The use of scientific rationales to back skills during practice is seen as a mark of competence:

“But I begin to ask myself whether a nurse with skills without the scientific knowledge is a good nurse. You need to have a good scientific knowledge of what you are doing, a rationale for what you are doing to be able to be considered a competent skilled person.” (Int9:1)

The model also emphasises broad development of the nurse

“the bachelor degree programmes come with extra skills like management, like research, like teaching, and what that means is that the programme in as much as it is training the nurse at the bedside is also preparing them to be in managerial positions, to go onto teaching, to go into research and things like that.” (Int9:2)

The nurse is prepared for a wider role beyond bedside care. The abilities to teach, lead and conduct research are some important expectations of the nurse at professional entry level.

Teacher qualification at university level is higher:

“...when you have masters and doctoral teachers taking them, at least there is little input more than they will have down there” (Int10:1)

The perception is that better qualified teachers will give better quality education than teachers at diploma schools. The university thus requires teachers to have at least the Master's degree.

Criticism of higher education model

'*Faulting higher education model*' and '*resisting higher education*' were the initial codes used in the making of this subcategory. The data showed that there were strong criticisms of the perceived weaknesses of the higher education model.

The key criticism of the model is that it is too 'academic' with insufficient practical training:

"There they know the theory but strength in practice is a little bit negligent and they don't really get back to the nursing. In fact there are not very practical that's what it is...they only have the theoretical approach, they are not very practical, but their own nurses, those of ministry of health, those ones are practical" (Int13:3)

The model is too focused on theory and students are not given sufficient practice exposure. Graduates are seen as weak in clinical skills as compared to SRN diploma.

The candidate selection process is not rigorous:

"These are people who are just taken in they don't go through any selective examination. They just forward documents and documents are treated, whether how many thousands of people have to be in class it's no problem and those are still some of the weaknesses in training" (Int1:12)

The entry exam method is considered a better tool to select candidates than the application documents assessment being used by some schools in higher education. The large number of students in class affects the quality of teaching and learning.

Curricular variation is another perceived weakness:

"You find out that in the universities the syllabuses are different, they are not having the same curricular and their duration of training is different" (Int8:8)

Higher education institutions have certain level of autonomy over their curricular which affects programme requirements. This introduces programme diversity that is seen as a weakness of the higher education model.

There is also doubt as to the overall quality of the curricular in this model:

“The problem is that from the word ‘go’ there was a problem in the conception of the programme...If ministry of health had sat there to assist in conceiving that programme then I don’t think that there should be any reason why this situation should be” (Int13:1)

Participation of the ministry of health in programme conception would have elicited their credibility. Data in 4.2.7 will show that nurses had some input at the conception of HND programmes. However, the argument about credibility seems to be based not on competence of programme planners but rather on the ministry involved.

There is perceived weakness in teacher competence:

“First of all the teachers too they are not, they themselves are not strong in the profession, if you work with them you find out that they themselves they are empty. Doing research and looking into books does not mean that you are a professional, you are empty” (Int8:13)

The teachers are more involved in teaching and research roles than in clinical practice. This projects an image of weakness in their clinical skills and thus a weakness in their ability to teach well.

Phasing out ministry of health training

A surprise finding was the proposal to end nurse education at the ministry of health. The data was coded at ‘*stopping ministry of health training*’

The ministry of health should voluntarily relinquish training of nurses to the ministry of higher education:

“So basically the ministry of health should say “wow! Let nursing training be liberalized and be directed by higher education then we hire the products” (Int7:1)

Or be called to stop:

“...somebody should come out and clearly tell them but nobody has been able to say that because when they just go to the meeting they say “no, bring your this thing to this, this, this”. But who are there? Who are there to bring what to what? Because doctors are in the ministry of public health they are not in higher education. They have obtained a doctorate they don’t even have a master’s...they don’t have PhD. So how will they now sit down and be drawing curricular for higher education, do they know what it involves?” (Int10:3)

Attempts at inter-ministerial collaboration will be futile because the Ministry of Health lacks competent nurses to address curricular issues raised by higher education.

Further theoretical sampling of this emerging subcategory revealed that moving to higher education completely will be best for the profession:

“I think that that’s going to be best thing that can happen for nurse education in this country because so far the programmes that the ministry of health is running for me they are not well designed. They are not just the best and I feel that it’s high time Cameroon should also stand on the line as other countries are doing” (Int11:1)

The weaknesses of health’s model over decades are an argument against its continuous role in training. Global trends showing the move to university education constitutes another reason to expect the same in Cameroon.

This perception also is influenced by the belief that letting ministry of health to train in the first place was a flawed model and a key cause of problems facing nurse education

“The problem here is that the ministry of health is not supposed to be a trainer that is why we are having difficulties. The ministry of health is supposed to be a consumer!” (Int8:1)

Higher education has potential to provide high quality training for nurses and should take over the role while health focuses on hiring. This is a challenge to the historical precedent that placed training in the ministry of health which is perceived as provider of healthcare and professional education.

Transitioning to higher education

Theoretical sampling to further explore the move to higher education revealed evidence through codes like *‘phasing out mechanism’*, *‘dealing with personnel issues’*, *‘seeking compromise’*, and *‘identifying challenges’* leading to the focused code *‘preparing transition to higher education’*.

The process is seen as a battle:

“I see a very tough battle, I see a very tough battle because given the situation at hand in this country, just talking about- ministry of health is first of all not happy that higher education is training because they think that it is their place to train nurses in this country” (Int11:4)

Health monopolised training for close to 40years before higher education came and perceives this as its exclusive territory. So changing something this entrenched is not going to be easy. At the same time health is training other paramedical personnel:

“I think that that is not going to be easy because...it’s not only nurse training that is in the hands of the ministry of health, we have other health professions programmes that are being run by the ministry of health and they will just think that a lot will be taken away from them” (Int11:9)

Health has a training portfolio that includes other health professions and as such might not welcome this kind of change as it may eventually lead to giving up the entire training portfolio.

The concerns of the ministry of health must be addressed:

“maybe higher education can also start by showing to health how they are going to ensure that the products are professional enough for them to consume and that they are going to

uphold the good values that the ministry of health is uhmm, the values of those programmes that they are holding onto” (Int11:12)

Higher education has to recognise the values of hospital-based model and demonstrate how it will incorporate these to produce highly qualified nurses. It also has to demonstrate what is in it for health, how its interests will be protected.

The issue of personnel handling training at the ministry of health has to be addressed:

“They need to educate the current educators who are working in the schools because people may be losing their jobs. Something that has to happen because most of those who teach in these schools are not qualified to teach in higher education institution because they don’t have the right qualification... And what that means is that some of them will be losing their jobs, some of them will be expected to go back to the hospital, I wonder whether that will do. There will obviously going to be some kind of tension which will require [sic] to be adequately managed.” (Int11:2)

A personnel plan should be designed to prepare nurse teachers who will be affected by the change. Redeployment of personnel to hospitals might be necessary because their teaching qualifications may not meet higher education standards.

There should be time for all those who are in the programmes to get to the completion of their courses. The schools should not be closed down but should be used by higher education:

“These schools because of course resources are not there, higher education...can still train in facilities owned by the ministry of health. But it’s the ministry of higher education that has control and in some way health will still – like they are a partner in that training because their facilities are being used and of course their personnel...if they are qualified enough to each at the demands of higher education, then those people should also be preserved, they should be kept and let health also have some kind of a hand inside training.” (Int11:17)

The transition should identify relevant roles for both ministries and make ample use of all existing resources that can apply to higher education programmes. Retaining qualified personnel in their roles as well as infrastructure strengthens such cooperation.

Potential change agents have to be identified:

“You will notice that most of these teachers, the people who are being sent to teach in these ministry of health schools are graduates from higher education. And because they are going there with that philosophy and I am sure they are well educated to understand that training in that sector is not needed, maybe such an advocacy needs to be put forth, then those are the people that should be channelled through it.” (Int11:7)

Change agents could be ministry of health personnel who were trained by higher education. Their training gives them the resources required to lead change from within the ministry of health schools.

Category Four: Moving Nurse Education to Higher Education

The university role in nurse education which came during the period of suspension of training was not a government or nursing led move. It was led by the pioneer Dean of the School of Health Sciences at the University of Buea. The university made it possible for nurses to get degrees for the first time with a model that also emphasised the development of non-clinical alongside clinical skills in nurses. The higher education model was a departure from the hospital based model and is criticised for insufficient focus on practice and being too ‘theoretical’. Emerging properties show that many nurses welcome the educational opportunities brought in by higher education in spite of the controversies it has generated. Data also revealed an unexpected call for training to move completely to higher education making ministry of health solely a consumer. The process for this to occur include articulating what is in it for ministry of health, handling issues of personnel and incorporating certain values in the training process. So connecting these subcategories reveals how nursing is gradually moving to higher education and the kind of unexpected turn this move might take.

4.2.5 Constructing Category Five

Control of nurse education

The data revealed that there was significant tension over the control of nurse education.

“These are health personnel, in some settings there can be no health personnel who will not train within the...ministry of health context...But now they just diffuse the whole thing, in the final analysis all those who are being trained be trained so the patients will not suffer. Because we imagine what type of certificates ministry of professional training gives them. So those things...there’s really a mix up somewhere needing synthesis” (Int13:1)

Training being given by ministries of vocational training and higher education are ‘out’ of the health context and so may not meet the required standards for patient safety. This is influenced by opinion that the other ministries have less stringent rules for programme accreditation:

“when we were in the ministry of health, there were many applications from people who wanted to open schools, economic operators, but when you look at their profile, they were not qualified so they now went them into vocational education...and opened schools, got their authorisation from there” (Int1:1)

Some nurses are not comfortable that the law allows entrepreneurs to open schools but other nurses argue against such resistance. The position is seen as territorialism:

“Of course there is no rationale, there is no rationale. Again it has to do with what we call protecting your turf” (Int7:1)

Rejecting other ministries is perceived as an effort by health to return to the old era where they monopolised training:

“The ministry of health who is the employer feels that they should follow its ideology, unfortunately times have changed. We cannot be following your ideology when you are

ending at the diploma level and some of us are ending at the bachelor's level. Something, somebody, something has to give.” (Int7:3)

The contrary view is that nursing education has evolved and qualifications are going beyond the diploma to university degrees. The implication is that the ministry of health has to rise and accommodate these changing trends in nurse education rather than opposing them.

Employment controversy

The data also revealed tensions also arise from the area of employment. Nurses who hold certain diplomas are discriminated against:

“When we train these people there are some people they call higher nursing diplomas and there are others they call state registered nurses, in a country like our own which is not determined, in the public service okay, during recruitment they take both higher nursing diploma with state registered nurses. But if the ministry of health has to organise its recruitment it doesn't take into consideration the higher nursing diploma, you see!” (Int12:1)

National recruitment recognises the HND only when the recruitment is organised by the ministry of public service. When ministry of health recruits it considers only its SRN holders. This creates tension and puts pressure on higher education by forcing students to choose ministry of health programmes for employment reasons. However, the data also suggests that some other nurses from higher education are recruited by the ministry of public health

“They are not willing to let go at the basic training level, they are not even willing to let go even when people have been trained now in terms of even how you hire. But you are hiring their products with mixed feelings, and there are many out there who have not been hired because of the same reason” (Int7:4)

When hiring takes place it is done grudgingly and the policy leads to a situation where many nurses are not employed because of where they are trained. This policy is perceived to be contributing to a nursing shortage:

“The nursing shortage still continues, it has not been resolved and this one is deliberate and policy driven because I think the nurses have been trained whether in the private or public sector, they have been trained they just need to be hired. But you see because of these conflicting ideologies and protecting turfs and so on, there is no harmonized policy to say fine let’s take these nurses at this entry level and then they will continue with their careers, it is simple. It’s still the problem.” (Int7:5)

Conflicting ideologies around training is increasing the nursing shortage even when nurses are available to be employed. The lack of a harmonised education policy perpetuates the turf wars and ensures that trained nurses will not always be employed to meet the nursing shortage by virtue of their higher education training.

Personal prejudices

Data revealed conflicts which arise not from policy but rather from personal prejudices.

“you always find those people who are in charge and who had to take decisions that when they look at themselves they are not at the level or unit, they may be seeing you as a stumbling block on their way and they will not want you to advance” (Int10:1)

Nurses at the ministry of health with advanced diplomas blocked the recognition of those with higher qualifications in order to protect their status and positions.

“They somehow feel threatened that if they allow this young people to go into universities or they allow training to move into the universities, what that means is that young people will come out with higher qualification and that may jeopardize their job and their position.” (Int9:1)

Personal insecurity is a hindrance to advancing nurse education. Some nurses already in service see advancing education opportunities as a direct threat to their careers especially because they have lower qualifications than the new ones that are now available.

There is the feeling that people are protecting themselves not the profession:

“I think that people are protecting their diplomas, they are not protecting the profession. They are protecting the kind of training they got, because I am a state registered nurse, I have to make sure that state registered nursing stays on the market, because I did HND let me protect HND, no!” (Int9:3)

There seems to be little objectivity in addressing nurse education issues. The observed tendency is for nurses to back their form of training perpetuating a perception of ‘us against them’. This subjectivity is revealed in the data as follows:

“I have not been able to look at their programme [higher education programmes] but I think that it is really, it does not have that flesh” (Int8:4)

Strong arguments are made against other models without an objective assessment of the content of those programmes. There is more passion than reason in arguments and nurse leaders are failing to assess each programme model on its merits before taking a position for or against it. This demonstrates the strong influence of personal prejudices on nurse education.

Professional membership tensions

Another area of tension emerging from the data has to do with membership to professional nursing associations.

“...the prerequisite to register in the association is a diploma in your profession of three years consecutive training, academic training” (Int8:1)

Membership is only for those who have a three-year professional diploma implying that only SRN holders can be admitted as the HND is not seen as professional enough.

Some associations still reject even those nurses with bachelor degree qualifications:

“...you’re A-levels and you go and start doing a degree course when you have not yet been a professional. There is a jump, and that is why shows in the field. And that is why we are not registering them” (Int8:2)

Bachelor degree holders must begin first with the three-year SRN programme before they can be registered into the association. So going directly from high school into the degree programme disqualifies nursing graduates from registering with some professional associations within the country.

Resistance to higher qualifications

Elements in nursing have always resisted colleagues coming in with higher qualifications. From the early days of formal training, the first group of nurses were rejected by the dressers:

“Those who grew from the dresser profession claimed that there were more practical than the new nurses. They could do things in a more practical way and claimed nursing professionalism.” (Int3:4)

The dressers had better dexterity in technical skills than the incoming trained nurses and saw this as evidence of their superior abilities. Professionalism here is linked to dexterity in technical procedures. The resistance and misrepresentation of professionalism slowed down the growth of the profession:

The resistance emerged again when the university started training nurses. The existing SRN holders who took over from the dressers now argued that university trained nurses were not ‘professional’

“...they went studying theory and not the practical part of nursing and so problems between the two contesting factions –the factions that [had] people who were not university trained and...who were still at the level of SRN and the faculty nurses” (Int3:9)

So just like back in early years it is again about skills. The more experienced nurses who over time became very skilled resist the new highly qualified nurses because they are not as skilled:

“I think that it’s this tension ‘this child, why is this child trying to...have a bachelor’s degree while I am here I have worked for 10, 15, 20years and I don’t have a bachelor’s degree. When she comes here with a bachelor’s degree can she inject?...can she deliver a baby? I am here I can deliver 100 babies, I can do this but I don’t have a bachelor’s degree” (Int9:2)

The perception seems to be that a higher qualification is not necessary as long as you are skilful in performing nursing tasks. Some nurses argue that every novice nurse needs time to perfect their skills:

Tension is also increased by the fact that the older nurses hold lower qualifications:

“This...war...exists...because those who are in the hospital-based schools, the trainers there are not having higher qualifications in nursing like bachelor degree or master’s degree.”

(Int9:2b)

Having lower qualifications poses risk of potential loss to incoming highly qualified nurses and thus perpetuates resistance and conflict from the less qualified nurses. Making available advance education opportunities for this group may reduce these insecurities and promote collaboration.

Tension over title

The data revealed that nurses are not satisfied with the rampant use of the title ‘nurse’:

“You see that you will train as an auxiliary for six (6) months or nine (9) months - I am a nurse, for what? Eighteen (18) months I am a nurse; this this this- I am a nurse.” (Int3:3)

‘Nurse’ should not be applied to auxiliary care staff to facilitate recognition of the nurse. By presenting themselves as nurses, auxiliaries’ shortcomings affect professional status because stakeholders can’t make the out the difference.

Another area of tension is the use of the word ‘infirmière’ for nurse by the Francophones

“For them ‘infirmière’ means nurse. But then, the duties of the infirmière were simply dispensing medication and doing minor treatment. It never from the primary stage ever meant...a conceptual framework wherein people can enrol, get trained and become professionals. Never! Never! Never!” (Int4:4)

Anglophones translate ‘infirmière’ as ‘infirmarian’, a role they perceive as auxiliary. Use of the francophone appellation is seen as representing the perception of the nurse as a skilled care assistant rather than a professional.

For some nurses there has to be redefinition of who a ‘nurse’ is.

“You need to redefine a nurse in this country. If we redefine a nurse in this country we need to now ask ourselves what a nurse should do in this country, with what training, then we need to go into the curriculum documents and look at them and ask ourselves whether it is going to give us that nurse that we want in this country.” (Int9:2c)

There is a search for a new identity for the nurse at this point in the evolution of the profession. This identity should be defined in curricular and education should aim at establishing and consolidating that identity. The emphasis on what the ‘country wants’ can be seen as indication for a national identity in addition to internationally accepted nurse identities.

Category Five: Turf Wars and Intra-Professional Conflicts

The category started from initial codes like ‘*protecting your turf*’, ‘*continuing conflicts within nursing*’, ‘*resisting more qualified nurses*’ and ‘*using the title nurse*’. Data was studied to refine these into focused codes that generated the subcategories reflecting the kinds and areas of tension in nurse education. The conflicts over control of nursing, employment controversies, professional membership tensions, resisting more qualified nurses, personal prejudices infringing on the profession as well as conflict over appellation revealed the tensions that affect the profession. It all boils down to a conflict between two major ideologies or models with nurses taking sides against each other. The category thus elaborates evidence of turf wars and intra-professional conflict.

4.2.6 Constructing Category Six

Data revealed perceived need for something different. The word ‘change’ did not necessarily come up but the expressions of ideas indicating an expectation or desire for something different was

considered an expression of change. The initial code ‘*accepting change*’ was used to label such data. Focused coding on the concept of change yielded even more data.

The call for change

There was recognition that policy issues have to be addressed to move nurse education forward.

“I think the profession is going down the drain on a daily basis, training is in the hands of the wrong people and then people are beginning to market nursing, nursing is a commodity, becoming a commodity, everybody is rushing for it. So I think that there need to be a change as far as nurse education is concerned and as far as nursing practice is concerned.”

(Int11:3)

The need for change is justified by the perceived unregulated influence of non-nurses over nurse education and the apparent commercialisation of nurse education. There is strong emphasis on regulation:

“We need a nursing organisation in this country and we need nurse education to be controlled, we need a model that everybody should follow.” (Int11:4)

A nursing organisation can address discrepancies in nurse education and set out a guiding model to provide direction and regulate nurse education. This is also evidence of the lack of a nursing regulatory body.

There is a call for nurses to reflect on the education process:

“I think that we need to go back to the roots... people have to come back together and I think we have a think about how this nursing education in this country is structured.” (Int9:1)

Nurses must objectively reflect on the education system and come together to address the findings of such a reflection. There is the expectation that such a process can lead to a united position on what the organisation and implantation of nurse education in the country will be like.

The data also revealed that nurses have in the past tried to obtain change in nurse education.

“In fact this is really something that we have been clamouring for since because I can remember that even with the syndicate for nurses and health technicians and with the nursing association, we have been clamouring for expansion in nursing education in order to meet international standards.” (Int2:1)

Change was sought by lobbying through professional groups. The present expansion is seen by some as an outcome of that effort. However, from document analysis there is no evidence of the input of nursing groups in education policy.

Silent change

‘*Creeping change*’ was the main code here because the data pointed to an insidious change already taking place in the direction of nurses’ expectations:

“But gradually we - at all levels people have now equalised that...and as those who came up as dressers through the backdoor are learning from the change we begin to see a change in mentality, in conceptualising nursing” (Int3:1)

Nurses with lower qualifications just like dressers before them are quietly acknowledging the importance of new and higher qualifications to advancing their practice. They might not be saying it openly but the very quest of easier access to further education is evidence.

Within the educational establishment this quiet change is occurring:

“It is happening silently! Interesting enough the ministry of health does not train teachers and the CESSI program has been closed a long time ago. So most, in fact almost all the graduates that are hired from the University of Buea have been sent to their schools. They are the ones running the schools now.” (Int7:1)

Without any formal change in policy the ministry of health is gradually recruiting and deploying university graduates to its schools as teachers and leaders. This silent process could be a quiet acknowledgment of the graduate’s competence and the relevance of university-based education.

Another indicator of the gradual change taking place is the ongoing consultations between the ministries of health and higher education on a bachelor's programme for midwifery.

"...let me give you an example. You know that the students who have entered the midwifery schools nowadays, now in the first year are going to come out with the first degree and they are affiliated to Buea University. They have affiliated all the midwifery schools...to the Buea University, this is the recent development, and this one is after a consultation talks between the ministry of public health and the ministry of higher education" (2:4)

The consultations are therefore a reflection of a desire to do things differently and acknowledge the importance of university-based education for health professionals. While there might be many factors pushing these consultations, it is a reflection of change and could serve as a model for consultations on nurse education.

Career limitations

The code '*limiting nursing advancement*' was used to capture data indicating perceived barriers to nurse advancement and how it could be linked to the change concept.

There exist limitations to further education.

"...in fact even with that diploma [advanced diploma] in nursing that was the highest qualification you could have in nursing in this country at that period, and that is why most people after that they didn't forge ahead because they know that they had attained the summit of nursing education so remained at that level at that time." (Int12:2)

The failure to obtain further education and higher qualifications is directly linked to lack of local opportunities. Nurses with a desire for advanced qualifications were forced to contend with the advanced diploma in nursing. This in itself might not justify a need for change but then reflecting a desire for something different nurses who could afford travelled abroad for further education:

“A good number went to Nigeria since training in this country was never evolving...so individuals were finding their way out to Nigeria to the US” (Int4:2)

The ‘stagnation’ was therefore not acceptable to nurses they simply resigned themselves to it or found ways to travel abroad. So change in that situation was a desire among nurses who felt trapped in the situation.

“So you can imagine that from 1985 that I left school I could only earn a BSc in maybe 2003, or had the opportunity to even enter 1997. Look at the waste, the gap! [Significant sadness in voice and watery eyes] Why, because there were no opportunities, there were no opportunities” (Int10:8)

Many years of no educational advancement opportunities were perceived as wasted years. It demonstrates how general issues affected nurses at the individual level. That policy has left a lot of sadness and regret in many nurses.

The lack of education opportunities meant nurses could not get to the highest categories in the public service.

“In the beginning...in the public service there is a limit, even if you have a PhD, you cannot go into category A2, only category A1. This discouraged nurses going further” (Int1:1)

Nurses achieved A2 only by longevity in service:

“So that A2 now is longevity because they did not want in-service people they wanted external people” (Int8:1)

That policy based on nurse education system at the time probably discouraged some nurses from seeking further education even out of the country. Those who seized the opportunity to get degrees when the university came were not reclassified:

“Many of us graduated [retirement] without reaching our, our credential mark for the service because they won’t allow us to go there because they said they didn’t send us to school. So you will not advance.” (Int10:5)

Authorities refused to reclassify nurses who acquired degrees because they were not authorised to go for further studies. Nurses who acquired such education were disciplined by non-recognition of their new status thus discouraging others from taking similar steps.

“They said “no the nursing education was limited at this level so whatever thing you’ve done cannot be integrated” and that is why most of them left the ministry of health joined the ministry of higher education which accepted them. That’s what happened!” (Int12:4)

Moving to Higher Education meant going into mainly academic roles and receiving recognition for academic qualifications. It also meant that the Ministry of Health lost the added value these nurses would have brought into their practice.

The expression of dissatisfaction with the status quo can be considered as a desire for something different. This will thus constitute a call for change.

The search for leadership

The initial code ‘*seeking trained nurse leaders*’ was first used before later concluding that the data will fit the emerging ‘justification for the need for change’ during focused coding.

There is evidence of nurse leadership limitations:

“...let me say there were bottlenecks and some people who did not want others to advance....so they do nothing with your papers.” (Int9:1)

Nurse leaders at the time failed to advance the case for reclassification of their colleagues for subjective reasons related to securing their own position. Leadership was influenced by personal rather than professional interests.

Leadership failings are also attributed to having inadequately qualified nurses in high positions.

“You find people with portfolios and empty heads. They are just there because we complained of our absence in high positions.” (Int8:2)

Some leaders were not qualified and may have been appointed to give nurses a sense of representation at high levels. So they lacked the competence to make sound decisions for nurse education.

In some cases the leaders were not even nurses:

“Look at like in the ministry now there’s just one person and that’s the sub-director of training, she is alone and the others surrounded by teachers. We cannot be having educationists in the ministry of public health to run affairs of training that they do not understand!” (Int10:8)

Educationists are non-nurses and as such lack the competence to lead nurse education policy development. The sense among nurses is that there are no academically qualified nurses to lead education policy development:

“I am sure one problem you would have come across throughout your study is that policy is just enacted, nobody is there – no I should just make this statement! – Nobody is there to think through policies now like this! To design policy, nobody is there to plan policy. The people who plan policies have no nursing orientation. What should policy be in nursing education?” (Int3:2)

A well-educated leadership is needed to plan education policy that will directly influence nurse training:

“I think we need to develop that you know the cadre. The cadre that...is specifically in nursing planning, in nursing education and then reinforce, again once more...the practice of emotional thinking of a patient’s problem” (Int3:3)

Deficiency in critical thinking ability in nurses is being linked to the lack of proper education policy. So the improvement of nursing education lies in having nurse leaders who can help to conceptualise nursing.

The kind of leadership nurses seek can only be had through higher academic qualifications.

“nurses can only be empowered if they continue to move to the highest height not only to limit themselves at that base level but to continue to study to attend heights where they can be now decision makers, decision makers themselves, not only to depend on others to take decisions on behalf of their profession” (Int12:1)

Nurse leaders had been limited by the diploma level education and higher qualifications will provide justification for nurses getting into even higher positions and taking complete control of their profession.

Working together – the change process

The code ‘*working together*’ came up as one of the earlier codes during data analysis. At some point it looked like it will fit into the emerging ‘harmonising nursing programmes’ category. However, there were ideas that suggested they could be more linked to a slightly different process.

Data showed tacit acknowledgment of the authority of different ministries to run nursing programmes.

“...the ministry of health cannot do anything because that authorisation is also given by a minister who has the same rank with the minister of health so he cannot do anything” (Int1:3)

There are different aspects of government policy being legally executed by different ministries apart from ministry of health. Though there is resistance there is recognition that they are acting legally. These can all work together to address nurse education issues:

“so far the key actors should come together in a common front as to what kind of personnel are trained, what they should do after the training without which there could be some confusion in the job” (Int1:6)

Working together will clarify the type of personnel being trained by different ministries. So this is not about harmonisation but about coordination.

Coordination is expected to consider the French and English subsystems:

“I think that we need to start seeing how we can...get our francophone brothers to understand that these days this is the international trend. It's not by us, the international nursing council will tell them and I think some of them know.” (Int7:2)

The changes being required go against the francophone perception of nursing so it will be necessary to convince them that nurse education has to respond to the changing international trends.

Working together indicates a process that will bring stakeholders together to coordinate their nursing efforts. It emphasises understanding each other and recognising what each is doing in nurse education.

Leading change

As the change concept expanded theoretically sampling participants' views on who should lead change initiatives was revealing. The initial code used here was '*identifying change agents*'.

The desire is for nurses with higher qualifications to lead change at the professional level:

“...the nurses should lead such an initiative and I think that we have had a good number of nurses who are educated to at least a master's degree level they should stand at the fore front. And nurse educators, advanced practice nurses – when I say advanced practice nurses I am talking about nurses who have at least a master's degree in other specialties because I think that these people are educated enough and they understand the problem and they have been able to do comparative analysis of nursing in Cameroon and nursing in other countries

and see where the gaps are. So those people stand in a better position to lead this, this – should I call it a fight – they stand in a better position to do that” (Int11:1)

The assumption of respondents is that nurses with postgraduate qualifications are equipped to carryout critical analysis of related issues locally and compare them with global trends to identify where and what has to be done. This shows a connection with the assertion that nurses need to get further education to be able to change and manage their own profession.

Nurses believe that the profession now has an emerging core of educated potential leaders

“I think we have come of age, I think we have enough nursing and a growing number of nursing intellectuals again especially at the bachelors and masters level. They are still very, very young but they are showing their worth and playing their own role effectively” (Int7:4)

Unlike in the past, there were insufficient nursing intellectuals to lead change in nurse education. The emerging generation of nurses with postgraduate qualifications are seen as qualified to lead change efforts. These leaders have to operate through a ‘nursing board’:

“...all our doctorates of nursing, all our masters will become think tank that they will form a new board of nursing” (Int7:8)

The “think tank” reinforces the perception of an educated cadre that has the academic credibility to lead change. The idea of a board provides a forum and structure for planning and decision making.

At the institutional level, the university should lead change:

“So a key proposition is that the university should lead it. The university should come up with a position paper on which that policy will be based on or the policy will be changed completely. Yes!” (Int7:5)

Universities are usually seen as great centres of learning and research which gives it credibility and respect. A position paper from a university will be taken seriously by stakeholders because of this status:

“Policy people like to listen to what academics have proposed, they do because they are coming from a position of authority [laughs]. Yes and people who have a vision. They will not be neglected, that position paper will bring them together” (Int7:9)

The authority of the university will help overcome the subordinate perception of nursing that policy makers might hold.

At the ministerial level higher education should lead.

“...higher education has to take the lead but that does not exclude the hospital or the clinical aspect of nursing training” (Int9:1)

Higher education should lead but must take into account health's positions and values to ensure sustained collaboration and high quality training.

Category Six: The change Mode

Change as a concept emerged from the data as recognition of failures in the status quo. Focused coding and constant comparison between data sources helped to establish facts justifying the need for change. Nurses' descriptions of what didn't work even when not explicitly stated were seen as a justification of the need for change. The limitations to academic and professional advancement for nurses, its expressed impact on the evolution of their careers as well as individual measures taken by nurses to circumvent limitations helped refine the emerging change category. Leadership failures and the description of leaders, players and processes for the planning and implementation of change filled out the category. The nurses want change to correct past mistakes and equip nursing with an educated leadership to conceptualise nurse education and lead coordination with stakeholders in order to move nurse education forward.

4.2.7 Constructing Category Seven

As participants tried to address the issue of diversity in nursing programmes, one of the first codes to emerge during initial line-by-line coding was *‘standardising nursing programmes’*

“...formal healthcare programmes should be standardized, some for 3 months, someone doing it for one year, what are they really up to?” (Int1:1)

‘Standardization’ in this context was addressing the varying lengths of nursing programmes. It aimed at having programmes with similar durations.

A search for similar data led to another initial code ‘*synchronising programmes*’:

“We set it like a committee to sit together and synchronise these uhmm if there are two or three actors to synchronise these programmes and come up with single one which they will all apply “ (Int1:2)

The context of ‘synchronisation’ is to merge the programmes. Standardisation was also used in the context of uniform entry requirements:

“...if we could cut off this one year training and this you know doing things like that and then...make a standard point that nursing training must be at the level of the institution or the university; entry requirement used to be O levels, the normal one should be GCE Advanced level yes, good GCE in the sciences.” (Int3:1)

There must be a singular entry requirement that should apply to all institutions. At this point standardisation therefore was emerging to mean similar programme duration, one programme, and one entry requirement. It was therefore moving beyond an initial code to a focused code as more data was sought to identify further properties of the code.

‘Harmonisation’ looked like a better description for focused coding because of its easier recognition and less likelihood for misunderstanding as opposed to standardization. It was first identified during initial coding to address the diversity of qualifications:

“They harmonise the qualifications such that any person who has that qualification should be the same” (Int1:5)

Meaning of harmonisation

Data was critically explored to find the meaning of harmonisation. Some participants explained harmonisation by examples:

“...for the schools in the ministry of public health, if you are doing SRN, it is the same programme everywhere. If you are doing nursing assistant it’s the same programme”
(Int1:3)

One programme being implemented without any changes by all schools offering it is an example of harmonisation. This sounds like setting a national curriculum for nursing programmes.

It was also seen as having similarly structured programmes:

“We are looking at harmonization in terms of the structure of the program, the nursing program itself rather than the linguistic orientation.” (Int7:4)

Structure here is likely in the context of entry, programme duration and exit qualifications because these are the some of the things that constitute the ‘*structure*’ of a programme. It does not refer to merging the French and English cultures.

Harmonisation is also seen in the context of competencies:

“by harmonization, I mean basically the – an agreed competencies or skills that every nurse that is leaving a bachelor’s degree programme for example should acquire or must have acquired” (Int9:4)

Narrowing harmonisation to a set of “competencies or skills” that defines each professional level gives a more succinct description than a broad reference to ‘programme harmonisation’. A competency framework thus proposed was not seen to necessarily mean a national curriculum:

“I don’t really mean that the curriculum must be the same or that the institutional philosophy or whatever, it’s not at that level. But what I expect is that there should be a competency set for bachelor degree nurses, for diploma level nurses, for assistant – nursing assistants, masters and PhD levels in this country so that we can have people transiting from one level

to the next. So we know that somebody has a diploma in nursing being the HND or whatever diploma they have in nursing, that person can move to a bachelor degree for a certain number of – maybe one year, and within that, these are the additional competences that a person should acquire to be able to be in that level. Yes I think that that is where we need to focus. If we come out with a set of competencies for nurses in this country, then it would go a long way to solve a lot of problems”. (Int9:5)

The competency framework defines what people can do at each level and spells out what competencies have to be achieved to progress to the next level. So the curriculum in this context is not the generator of the competency framework but rather becomes a product of it. This definition also recognises the fact that institutions should have different philosophies and missions which could be reflected in their curriculum, but the caveat is that that curriculum must deliver professionals who meet the competences defined in the harmonised framework.

Justifying harmonisation

The reasons for harmonisation were identified in the data using the initial code ‘*giving reasons for harmonisation*’. As more data was found during constant comparison the focused code ‘*justifying harmonisation*’ was created

Comparison of findings from different interviews showed that harmonisation is necessitated by an array of factors. The first is the existence of multiple views on nurse education:

“There are many views because higher education they have their view, ministry of public of health, they have their view. The association they are also clamouring, they also have their view” (Int2:3)

Different viewpoints create a need for a comprehensive process to address the differences. It also indicates the recognition that every stakeholder has something to offer.

The second is related to curricular differences across the schools:

“We have the SRN curriculum, we have the HND curriculum that the ministry of higher education has given, we have the bachelor’s degree curriculum that are developed...and are hosted by the universities. If you look at those curriculum they are all different...they have their strength in some other things and they are weak in some other things. So there needs to be some harmonisation – what a diploma nurse can do, what a bachelor degree nurse can do, what a master’s degree level nurse is expected to do and PhD and all of that and where that person can fit into the system when they come back to practice.” (Int9:13)

Variations in curricular strengths and weaknesses can be mitigated by drawing from each to define what the nurse at each level will do. It will also help to define where each academic qualification fits in the practice structure.

The third reason identified is the fact that in spite of known variations in programmes, harmonisation had never been considered before:

“It has not been done. It has not been done!” (Int7:1)

Even though liberalization brought in a variety of nursing programmes, (more than ten years later) no form of harmonisation has been done justifying the need for it.

Differences in competencies of nurses with similar qualifications justify harmonization:

“...if you meet somebody in Cameroon with a bachelor’s degree in nursing, you can’t say that they have the same skills or same competence to do the same thing, so I begin to ask myself whether they are doing the right thing.” (Int9:2)

Not being able to ascertain if two nurses at same professional level from two different institutions can perform the same roles is worrisome. So there is need to harmonise education to avoid this confusion. These many reasons which were put together by comparing data from different interviews raised the focused code ‘*justifying harmonisation*’ to a subcategory.

Constant comparison of data revealed more characteristics of harmonisation including what participants saw as its process and content.

Process and content

The first code used was ‘*explaining harmonisation process*’ and was not a direct question posed to participants but emerged from their responses.

Process requires putting an agenda before actors involved in nurse education:

“so it is a question of recognising every actor and getting the various areas which are of contention and each person brings his own view on what should be done and then we put this together and come up with a common one which should be adopted by all” (Int1:8)

‘*Setting responsibilities*’ was another initial code that captured aspects of harmonisation:

“...if the exigencies are the certificates which must have the signature of the higher education sector, the important problem is that the higher education should write and tell them the exigencies, the requirements for training which should be applied by the ministry of public health as it carries out its training and then it will be there to endorse whatever thing is happening. I think that is the way I see that they can work together for the wellbeing of the people.” (Int12:3)

Responsibilities and expectations have to be set out. Each ministry should lay out its expectations of the other and also implement agreed responsibilities. Higher education holds the charter to award degrees and as such has to provide guidelines for diploma programmes to be affiliated to university programmes. When this code was compared to ‘*explaining harmonisation process*’ there was a certain level of similarity that suggested that the codes could be merged to a focused code.

Another initial code ‘*converting diplomas*’ was also seen as related to harmonisation process:

“Higher education has to have a rethink about the curriculum; they have to have a rethink about the conversion; how people will move from one level to another” (Int11:1)

Higher education has to provide curricular guidelines to facilitate the recognition of prior learning for nurses seeking to advance. This code was again merged to the expanding ‘*explaining harmonisation process*’.

In exploring the data further for more qualities related to harmonisation, the code ‘*defining harmonisation content*’ was used to capture data that cited a competency framework for different nursing qualifications. Closely related to the framework is the certification exam to test if the competencies have been acquired by the student.

“For us to be able to move this profession forward, we should come up with those competencies and of course come up with a certification exam for the nurses. So wherever you train and in whatever nurse training institution that you train, you should be able to pass a certificate exam that is meant to asses those competencies and to say this is good for practice, this is safe for practice, this person is good and safe for practice” (Int9:6)

Achieving competencies and success in the exams will serve as the basis for declaring a nurse qualified to practice safely. Quality care stands as an important goal for the harmonisation process.

‘*Reflecting on entry exams*’ captured data on entry examinations to screen candidates:

“These are some of the stakes that we have to take into consideration. Should everybody for nursing training come through a written – a national written competitive exam? Should it be so? Those are the things we should be accepting...” (Int12:7)

Entrance exams, its organisation and players will have to be agreed during harmonisation. The issue here is whether institutions conduct their own entrance exams or if the exams should be conducted at national level.

Another content of the harmonisation process was captured under the code ‘*labelling qualifications*’:

“The diploma nurses, we need to look for an appellation for all of them, it’s not HND, it’s not HPD, it’s not SRN. If someone is to do nursing in this country for three years and has to become a state registered nurse, then all of them wherever you do nursing if you pass your

qualification exam then you should qualify as a diploma nurse with a set of skills that you can perform, things like that". (Int9:7)

Existing appellations are different and breed confusion in role expectations. This is closely linked to the adoption of the competency framework which will mean diploma level studies will be guided by same competencies. A single appellation then will make it easy to identify their role.

‘*Setting national guidelines*’ another initial code described data addressing curricular issues, qualifications and teacher status:

“at each level they should be guidelines which should be put in place like rules which have to be obeyed concerning recruitment criteria...training criteria...the duration of training...people who have to train the nurse, different categories of personnel, their various qualifications...and all that.” (Int12:6) “...in order that we meet the exigencies of the society and then the holistic health care which we want to give the patients” (Int12:4)

National guidelines will provide a framework to monitor what every institution is doing. It will eliminate uncertainties created by unregulated diversity and provide a framework for regulation. It will also help nurse education remain accountable to the public that expects high quality healthcare services.

Comparing the above data from the codes ‘*setting national guidelines*’, ‘*reflecting on entry exams*’, ‘*labelling qualifications*’ were considered to be addressing the content of harmonisation and as such could be merged with the code ‘*defining harmonisation content*’

Further analysis showed that process and content were intricately woven together. The one adds value to the other and the inclusion of content gives more meaning to presentation of process. As such the researcher merged the two focused codes ‘*defining harmonisation content*’ and ‘*explaining harmonisation process*’ were merged to form the subcategory ‘process and content of harmonisation’.

Challenging debates

The initial code used here was ‘*challenging standardisation*’ then changed to “*challenging debates*” because the data showed difficult conversations that will characterise harmonisation process. The expansion of the focused code led to the subcategory ‘challenging debates’.

The concept of academic credit systems and grade point average (GPA) calculations has to be addressed:

“...if they want to move to higher education with any of the classes of nurses they have or midwives, then they must meet up with the criteria for semester training, covering up of the number of hours and so on per semester, so that at the end they can calculate on a GPA as its normally done in the university. Yes!” (Int10:3)

The university credit-based system is different from the hospital-based model. Ministry of health may have to adapt its programmes to university-type systems to facilitate upgrade. So dropping their modular system might pose a challenge to harmonisation.

Another challenge has to do with staff selection criteria:

“Maybe they will start complaining that in your training school you have to have this type of teachers, this grade of teachers and if they are not there then the certificate is not worthy.” (Int10:4)

Teacher selection criteria in both ministries are very different. Agreeing on guidelines regarding teacher criteria might present a challenge to the harmonisation process especially as higher education expects higher academic qualifications of its teachers.

Expectations and outcomes

The initial code “emerging outcomes” was used to code the data. A key expectation of such a process is that nursing programmes will have the same duration at similar levels

“It should be one, duration is one, if it is going as external then is four years, let all the universities be four years, not that some will be two, some will be three, yes!” (Int8:3)

Nurses will also expect that qualifications should be standardised such that a qualification can tell you immediately what its holder can do:

“They harmonise the qualification such that any person who has that qualification should be the same” (Int1:5)

So if you hold the same academic qualification from different schools, the same scope of practices and performance is expected of you. This is expected to eliminate role confusion in the job market as well as address doubts attached to diverse qualifications.

There should be no discrimination between private sector and state-owned institutions:

“...guidelines should be put in place which should be obeyed so that nobody – we should have no problem whether somebody leaves the private sector or somebody leaves the higher nursing education sector, some other person leaves the state registered nurse...” (Int12:8)

Another expectation is that the endorsement of certificates will be clear:

“The certificates must be signed even by the two ministers” (Int8:5)

For some nurses certificates should be endorsed by all the ministers involved once programmes have been harmonised. Nurses seem to see ministerial endorsements as the significant mark of credibility of certificates. The role of organised nursing in this is not mentioned.

Category Seven: Harmonisation of Nursing Programmes

This category has been gradually constructed through theoretically sampling and constant comparison of the data. In the process it could be established that harmonisation is a prospect that should be considered by education planners. The different components of the category included definition, process and content, justification, challenges and outcomes. Education planners have to rally key stakeholders to address the variations and diversity existing within nurse education. While curricular revision might be part of the process, the process will be more valuable if it produces a national competency framework for nurses at various professional levels as well as general

guidelines for nursing schools. The framework will define the role of a nurse at each level and eliminate confusion from variations in appellations and role expectation. Harmonisation will also have to address changes that institutions and ministries have to make, to foster collaboration. The key outcomes of harmonisation will be a competency framework that defines nurses' role, adoption of a single appellation of nurses of similar academic level, establishment of similar programme duration and diploma upgrade formula at the national level.

4.2.8 Constructing Category Eight

Deficiency in professionalism

Nurses show insufficient ability for autonomous practice:

“You cannot just sit there and wait for the doctor to come and order a nasogastric tube you should be able to assess and see that the patient needs a nasogastric tube yes! And when the doctor comes and ask you, you will stand your ground and say I needed to put this up immediately because of this, that, that” (Int10:1)

Nurses fail to manage patient care as expected of them and depend on physician's instructions. The ability to perform expected nursing roles provides a means of establishing the autonomy of their practice.

Nurses in leadership positions are seen to demonstrate unprofessional behaviours:

“I asked N, that why you are here just watching your profession being trampled upon and you are just watching quietly, what is your own role? She said when she goes on retirement that's when she will stand up and speak.” (Int8:8)

Some nurse leaders fear advocating for proper nurse education policies because they might lose their positions. Advocacy is reserved for retirement when there is nothing to lose in the process.

Some nurses are not ready to learn and don't get involved in scientific activities

“And they are not willing to learn, they are not willing to learn (Int8:2)...What do nurses do? Once you are through and are given a little job, when they close either they go to the

drinking joint, meeting houses or farms (Int8:3)...You cannot find them in academic forums to discuss something” (Int8:4)

Continuous learning, organising and participating in scientific/academic events is an aspect of professionalism that is not strongly emphasised by some nurses. Failing to organise and take part in such forums misses opportunities for continuing learning and capacity building.

Some nurses have linked shortcomings in professionalism to nurse education:

“If you ask a nurse who has passed through our nursing education process, can you detail the activities you will carry out on a vasectomy post-operation patient for the first three hours. Will she tell you?” (Int3:6)

The educational system doesn’t adequately prepare nurses to perform their roles in the different clinical scenarios they could find themselves in. Inability to meet those expectations diminishes professionalism.

Nurses should become more assertive of their role and change the way nurse education is implemented:

“I mean...in class we said we should go out of this “the doctor has said” and create our own abilities, our own technicalities, our own professionalism wherein you can proudly say that as a professional nurse I decided to put a nasogastric tube because for two days this patient has not eaten since I admitted the patient” (Int3:12)

Training has to move from emphasising carrying out orders to defining the autonomous role of the nurse in patient care. This also reflects defining the identity of the nurse as an autonomous practitioner.

Education is perceived as the key to addressing lack of professionalism in practice:

“If in nursing education we can succeed in getting nurses perceive [emphasis] their role in patient care, perceive their role in what they are doing and taking doctors instruction ooooh!

We would have gone miles and miles! But when shall that come? When shall that come?"

(Int3:2)

The belief then is that nurses have to be trained to master their role as autonomous professionals who can function independently of the physician. However, such a scenario seems a long way off implying the quality of training taking place now can't achieve this outcome.

Inferiority complex

Some nurses lack the confidence to operate as professionals and take decisions

"We are the ones to take our decisions and because people of – our level is too low, they are afraid to take decision and they are still hanging on doctors to be deciding for them."

(Int8:4)

The lack of confidence is due to low levels of education which cause the nurse to rely on the more educated physician for guidance and decision making.

Lack of confidence and deference to physician is directly linked to educational levels:

"because these nurses are having low qualifications, some of them are nursing assistants that will not be considered as nurses in this country, and then the ones who are nurses had diplomas and should I say they don't know their left from their right, they don't know their rights as professionals so they tend succumb to that subordination and think that okay the doctor is higher than them, they don't see them as colleagues or team members." (Int9:1)

Nurses with low levels of education are not academically prepared to apply critical thinking and make care decisions. This leads to an increase dependence on physician's instructions because they trust the physician's knowledge base better than their own.

Demonstrating knowledge and competence will earn nurses respect:

"If you talk intelligently, if you talk squarely on your profession they cannot do anything without calling you. And when they do it without calling you, you too will nullify it" (int8:1)

Education promotes confidence and makes the nurse more convincing in professional debates. These will cause policy makers to defer to the nurse when it comes to nurse education issues.

Disregard for the nursing profession

Nurses perceive that their profession is disregarded by other stakeholders. At the level of the political administration the profession is not given the respect it deserves.

“The last time we had a nursing society programme in Buea, we were there more than 500 or 700 nurses were there. I was very surprised that the minister did not bother to come and open or close the session.” (Int6:2)

The presence of public administrators during professional events is a key indicator of the importance of that profession to public life. Nurses see the absence of the minister during their own event as indication that they are not a valuable group within the health system.

Disregard of the profession is also perceived when doctors are given power over nursing:

“It was hard for them to understand that a nurse was somebody who had also gone through adequate academic training before going in into professional training they looked on them as though they were subordinates. And that is why even in the ministry we hear anything concerning nurses they were the doctors that were put in charge, even on the nursing training.” (Int12:1)

Physicians don't recognise the education that nurses undergo as sufficient to earn equality and respect. In addition to this policy makers assume that physicians can make decisions on nurse education and so place them in positions to do so.

The members of the public don't see nursing as an autonomous profession:

“I think that people in this country don't yet consider nurses [sic] as a profession (Int9:1)...A lot of people still think that we are a doctor's handmaid” (Int9:2)

Public perception of nursing is as a supporting profession to medicine and not an autonomous one as nurses will love to be seen. The situation some nurses say is again linked to education:

“one of the reasons that made nursing not to be regarded was that the entry qualification were not well defined as compared to medicine” (Int1:2)

Entry into medical schools is clearly defined and highly competitive as opposed to nursing programmes. People with little general education have access to nursing education thus reducing the status of the profession in the eyes of the public.

Conceptualising nursing

Nurses link deficiencies in professionalism to the lack of conceptualisation of nurse education:

“Conceptualising nursing is a way of nursing education that says that when you are giving that injection what does it mean for the patient?...When you were doing that dressing, you have done it so well but then what does it mean for the patient? What have you done for that patient? How has that patient conceptualised your practice during the dressing? This is where there is a big problem.” (Int3:5)

Conceptualisation goes beyond the psychomotor intervention in practice. It includes critical thinking, involving the patient actively in care decisions and transmitting the value of nursing care to the patient. The focus on technical skills is insufficient:

“...we need to develop a policy of conceptual practice. As observed the policy is technical practice and that is what the doctors know” (Int3:14)

The skill-focused model that characterises hospital-based training is what physicians recognise as it fits their perception of nursing as a supporting role. Introducing conceptual practice sets nursing apart and deviates from the handmaid-perception of the nurse.

Nursing education is seen as the tool to prepare nurses for this level of practice:

“Teach others that the patient is not just suffering from pain and then we are saying “ashia” “ashia yah” “E go cold yah” But then that pain is more than the ‘ashia’ we are saying. Whether it will be to study the psychoanalysis of that pain, tell me the emotional content of that pain then you can well appreciate the physical factor of it that is showing up. Just seeing like that is not only psycho-emotional...What is behind the pain, the causative factor of that pain? We know that it is emotional for that patient and the “ashia ashia very soon e go cold,” it will not be cold because the psycho emotional content has not moderated.” (Int3:11)

Nurse education should prepare nurses to be able to bring together knowledge, skills and affect into the assessment, care of, and interaction with the patient. Without this kind of model, care is substandard and the patient can't really be satisfied with nursing services and nurses don't get fulfilment.

“That is where we can lift, have an uplift in nursing practice. That is even where the nurse can obtain her own satisfaction” (Int3:12)

Conceptualisation will improve practice in a way that patients will be able to identify the autonomous nursing role and better appreciate the services of nurses. That recognition will bring fulfilment to the nurse.

Conceptualisation has not been fully achieved even at higher levels of education:

“...we begin to see a change in mentality, in conceptualising nursing, this is at the level of education, university, conceptualising nursing.” (Int3:1)

University level programmes are being seen to be gradually conceptualising nursing practice. This thus is making the case for nurse education to move to the university.

Professional independence

Data also revealed a desire by nurses for full professional autonomy. Nurses perceive that absence of autonomy will continue to slow down professional advancement

“That’s where we have had some problems in trying to advance the nursing profession when the nurses are not given the opportunity to speak on behalf of their own profession.”
(Int12:1)

Nurses think they have not had the opportunity to represent their own profession and so articulate forcefully the case of professional advancement.

The nurses want to be the main players in decision making when it comes to their profession:

“We need to be main actors; nurses need to be the main actors driving their profession. They are not! They are not in the driving seat! Somebody else is in the driving seat and somebody who does not have a listening ear, so the question is who is going to do it? That’s the big issue right now.” (Int7:1)

Non-nurses lead and make decisions on nurse education without listening to nurses’ views. Nurses seem to feel helpless as they seek their own nurse-led leadership. Thus the awareness of the need is felt, the solution is known and the nurses desire to get there.

The teaching role

Teaching nurses is one of the key facts that emerged from the data. The first issue is that there is significant presence of non-nurses among nurse teachers:

“...you get to a nurse training programme and find few nurses teaching. The greater part of the teachers are medical laboratory scientists and medical doctors who are not nurses and don’t understand the philosophy of nursing...it’s true that they need to come in for inter-professional learning because in medicine, we have to have all those people but what they do matters.” (Int9:3)

The significant involvement of non-nurses dilutes the transmission of the nursing philosophy to students. The role of non-nurses is acknowledged for inter-professional education but their influence should be limited to that role.

In other scenarios, nurses involved in teaching roles are not adequately qualified:

“The issue with teachers is that a good number of them are not qualified to teach nurses at the level where they teach” (Int9:1)

Some nurses teach at levels where their qualification is inadequate. This poses a risk to the quality of education the students receive. Qualified teachers should be academically prepared for their role:

“I think that a good teacher first, is that person who has a nursing background, who understands philosophy, the scope of nursing in this country, that person has a teaching certificate, who has been trained to be a teacher, it could be at whatever level, certificate level, but that person must have been trained, undertaken a teaching programme to become a teacher.” (Int9:7)

A good nurse is therefore not necessarily a good educator. Nurse educators must master the philosophy and scope of nursing practice and should have an academic qualification backing them.

Inter-professional collaboration

Nurses recognise the role of other professionals in nurse education as evident in the data.

“As nurses we have skills, there are certain skills that we need that cuts across other disciplines, for example as a nurse in this country you may be expected to collect specimen. Normally that specimen collection is the work of the laboratory scientist but in Cameroon given the limited resources, lack of nurses and all of that we have to do such things. So we need the laboratory person to come to the classroom and tell us how to do it better because they are better in doing it, but they cannot come and take over the profession.” (Int9:2)

Skills which are not primarily nursing but are being borrowed from other professions are best taught by such professionals to enhance their effective transmission to students. So when other health professionals are invited into nurse education it should not be to teach nursing or take over the profession but to teach nurses that particular content that is taken from his field.

Nurses expect key elements of training to remain in the hands of nurses:

“The nurses should play that role, they should teach, they should evaluate. They have the competence; they know any activity can be evaluated based on the primary objectives set by the nurses themselves not the doctors.” (Int7:1)

Teaching and evaluation of nursing and nursing programmes should primarily be the prerogative of nurses because they understand the goal of training and can best evaluate its outcome.

Professional recognition

There is a desire among nurses to see the recognition of their profession.

Participants believe that nurses are still to win the confidence of the patients:

“The perception of the patient about your practice: what language – can that patient also say “thank you nurse, I thank you nurse, I appreciate” as they say to the doctor... Have we seen a patient who has ever said that? That “that drug that you prescribed and given by the nurse” – meaning that it was given at the correct time and the correct dose and given to the correct patient, all those five things, can a patient say that?”

Patients can't see the input of nurses in their care. Their perception is that nurses only carry out the instructions of the doctor and so when they recover from their illness they give all credit to the doctor. Nurses should practice autonomously to earn recognition from patients.

Participants recount the value of proper nursing input to the health care service:

“We know that research has shown that where nursing care is very, very good, the rest of the public health indices improve automatically. For one thing their numbers matter, their skills matter, their intellectual know-how matters, then the care that they give matter. That is not considered, that is a big problem.” (Int7:1)

Nurses are vital to improving public health indicators if they are carrying out their duties as professionals. Improvement of such indices strengthens and improves the profession's status among all other stakeholders.

Category Eight: Professionalising Nursing

The category covers key issues related to professionalism in nursing as emerging from the data. Subcategories like: deficiencies in professionalism; inferiority complex; disregarding nursing; conceptualising nursing; professional independence; the teaching role; inter-professional collaboration; and professional recognition weave together the picture of how nurses grapple with professionalising their practice. The category reflects clearly the self-criticism, realisation of shortcomings, and a desire to gain patients' recognition among nurses. These indicate that professionalism is a tool to secure the profession's status by earning the respect and confidence of the public.

4.3 Linking the Categories

The categories above are not linear in their influence on nurse education development. These categories interact in a dynamic manner over time. The occurrence of some of them can be located at a particular point of the evolutionary pathway of nurse education:

- Multiple birth and formation
- Reactive growth and development
- Liberalisation and nurse education expansion
- Turf wars and intra-professional conflicts

Their occurrence can be situated at particular points in time yet their influence still permeates the profession as though they were constants. The other four categories represent the dynamic or fluid status reflecting current movements whose direction and final form are still to materialise:

- The change mode
- Moving nurse education to higher education

- Harmonisation of nursing programmes
- Professionalising nursing

These fluid categories represent current happenings and future desires. So as the wheel that is nurse education keeps turning and moving towards the desired outcomes of the fluid categories, the impact and influence of the constant categories remain and keep preying on the process. It can also be noted that the model constructed from the analysis of documents (Figure 1) is embedded within these categories and contributes to the more inclusive model shown on Figure 2.

4.4 Conclusion to Chapter Four

This chapter covered the constructivist grounded theory interpretation of the findings of this study. Data from both document analysis and participant interviews were analysed applying the key tenets of grounded theory and from this process eight categories emerged. The construction of these categories was presented so the reader can identify the steps in the analytical process. The next chapter presents a discussion and explication of the findings into a defensible theory grounded in the study's findings.

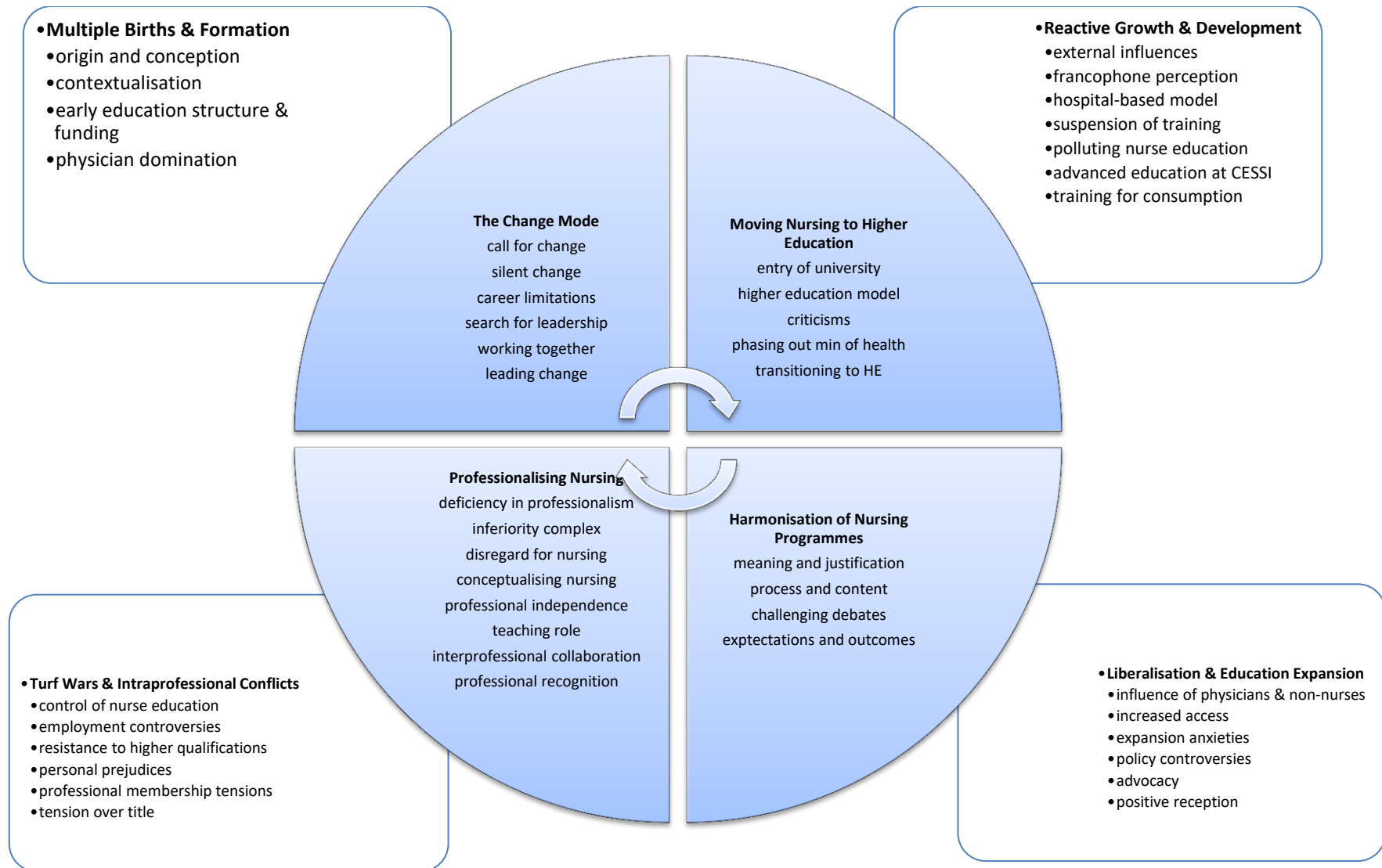


Figure 2: Relationship between factors that influence nurse education development

CHAPTER FIVE

NURSE EDUCATION IN CAMEROON: SEIZING THE OPPORTUNITY OF THE MOMENT

5.0 Introduction

This chapter makes the case for a theory on seizing the opportunity of the moment. The arguments are explicated from the constructivist grounded theory interpretation of the research findings presented in chapter four. The chapter begins with a presentation of the theoretical framework before moving into the grounded arguments for the case. The arguments also show evidence of rigorous review of literature on theories comparable to sections of the emerging grounded theory.

5.1 The Framework of the Theory of Seizing the Opportunity of the Moment

The results showed that multiple births and formation; reactive growth and development; liberalisation and education expansion; and turf wars and intra-professional conflict, demonstrate milestone occurrences in the evolution of nurse education in Cameroon. These events can be situated as starting or occurring at particular points in time. However, their effects are not bound by the periods of their occurrence. Their influence has remained in a sort of diffused manner over nurse education from the pre-independence through the immediate post-independence to the present era.

The other four categories: change mode; moving to higher education; harmonisation of nursing programmes; and professionalising nursing emerged as unanchored events. In other words they don't have a definite start date but have become part of the nurse education evolution. These categories are dynamic and represent intent, desires, hope, ideals or goals. There is therefore a complex interaction between these categories that influences nurse education. Building on Charmaz's (2006) constructivist approach to grounded theory, the researcher and the study participants can co-create reality. The participants contribute to this process by sharing their views and interpretation of events. The researcher explicates a theory grounded in these views by identifying the relationship and patterns emerging from categories in the data. Based on this constructivist model, the researcher's

task was to move from the descriptive model showing the different categories and their properties to a more complex analytical model that shows how these categories can be reconstructed to generate a theory applicable to the study setting. Figure 3 shows the framework of the emerging theory of seizing the opportunity of the moment.

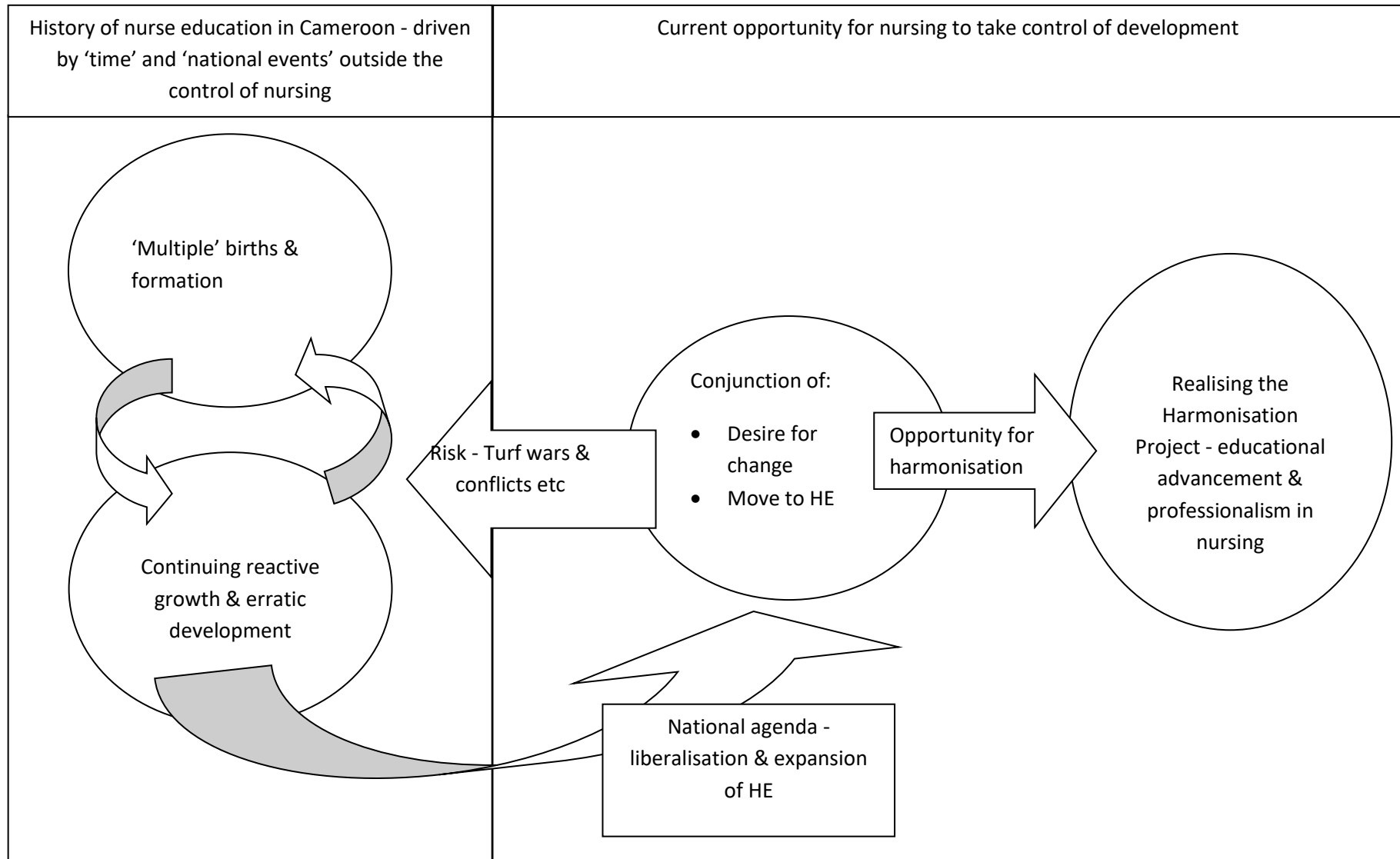


Figure 3: Theoretical framework for seizing the opportunity of the moment

The emerging framework shows that the present is a product of the past. In this context, multiple births and formation, and continuing reactive growth and erratic development have been moderated by time and events that are out of the control of nursing. Nurse education from the past right up to the immediate pre-liberalisation era has been moving, growing under the influence of its past and events generated by time. There is no organised or planned evolutionary process because every change is a reaction to some external event or just to needs generated by time.

The national liberalisation agenda, another event out of the control of nursing, brought nursing into higher education. This unplanned and uncoordinated move both fuels and coincides with a growing desire for change in nurse education. It also generates multiple educational systems that provoke turf wars and conflicts. These turf wars and intra-professional conflicts have the potential to take nurse education back into its past. However, harmonisation of nursing programmes offers the possibility of overcoming the risks and pushing nursing towards a planned and controlled future. It gives nursing the unique opportunity to take charge of its educational evolution.

The proceeding discussion provides more detail of the structure of this theory demonstrating evidence of its emergence from the research data. It also provides a critical comparison with extant theoretical models.

5.2 Time and National Events: Drivers of Nurse Education Outside the Control of Nursing

The results of this study show that the birth and growth of nurse education and nursing in general have been shaped by time and events that are out of the control of nursing. Nursing is seen to have had little leverage in the way it came into existence and how it was expanded after independence. As seen in figure 3 above, time and national events created a kind of back and forth movement that permanently linked the growth of nurse education to the nature of its birth. This back and forth interaction was out of the control of nursing and held back educational development.

5.2.1 ‘Multiple’ births and formation and continuing reactive growth and erratic development: the closed loop

Nurse education in Cameroon shares one major characteristic with other nations that experienced colonialization in that, it was imposed. In many developing countries, such as China (Xu et al., 2000) Taiwan (Shieh, 2004) and Lebanon (Huijer et al., 2005), formal nursing was introduced by Western missionaries. In Turkey formal nursing education started in 1920 with the Admiral Bristol Nursing School within the American Hospital in Istanbul as a school with private foreign school status (Bahçecik and Alpar, 2009). In Korea, formal nursing training was significantly influenced by a US army nurse (Lucka, 1946). In a 2007 article Khomeiran and Deans stated that nursing had started about one hundred years earlier with the arrival of western missionaries in Iran. The main difference is that while nursing in many countries started with women: In Turkey it was perceived as a women-job (Baser, 1997; Özeydin, 2006; Bahçecik and Alpar, 2009) and generally seen as a helping female vocation and a middle-class occupation (Callinicos, 1983; Erikson and Goldthorpe, 1992; Weston, 2011) in Cameroon the care assistants who later evolved to become nurses were predominantly male. The arguments about nursing as a predominantly female profession will not fit in the Cameroonian context. Statistics on the nursing workforce by NOHRC (2010) showed that there were more male than female nurses in Cameroon. The formal education of nurses developed from the needs of the colonial doctor for an assistant to the needs of the modern state for health workers to cover the territory immediately after independence.

The nature of the origins or births of professions have a strong influence in the manner of its growth trajectory especially when it comes to education. When a profession already exists before the formation of the state, the profession has the opportunity to shape its growth and define its educational structure. On the other hand when the modern state is created and then chooses to create a ‘profession’ according to its needs, it decides on the type and nature of education. In this context the state started training nurses determining everything from content to programme duration. So nursing had no significant role in the creation of its educational system. The complexity of a ‘multiple’ professional birth is exacerbated by the nature of the emergence of the modern state. In

this light, when the modern state is emerging from colonisation, it likely builds on the framework established by the colonial administration. That framework will influence the way the establishment of an educational system for a profession like nursing will be. So, ‘multiple’ births refers to the variety of stakeholders and/or conditions that determine the formation and setup of a profession and its educational structure. In the case of nursing as seen from this study, history and colonialism, birth of the state of Cameroon, physician control and government health policy all played key roles in the birth of the nurse education system. Conspicuously lacking is the role of organised nursing itself. However, these factors do not have exactly the same impact on the birth of the profession, some are more obvious while others are subtle but all are important. Colonialism brought the western system of healthcare to a setting that had been surviving on local traditional care models. Colonial doctors needed assistants to help them with their work and so we had dressers and local care assistants trained to play this role. In this context we don’t see a conscious effort to establish a particular profession but rather, to get physician assistants. This task-oriented philosophy influenced the government’s approach to setting up formal nurse education as it was tailored to meet its needs for the health care system being set up at independence. So though the appellation nursing was now being used, the philosophy was still based on the ‘care assistant’ concept. So aspects like colonialism and history will appear less obvious (though not necessarily less influential) than government health policy which is expressly stated in documents.

The modern state of Cameroon emerged from the framework of colonialism which implies that the modern state built on the state structures of the colonial era. In the works of Le Vine (1971) Cameroon emerged from a complex colonial era characterised by British and French control by League of Nations mandate (After WWI) and United Nations trusteeship (After WWII) plus the influence of Nigeria. The emerging state built on both its Anglo-Saxon and Francophone colonial legacy on the eve of independence and immediate post-independence era. West Cameroon state institutions were styled after the British state administration model while East Cameroon pursued the French system of government. As seen from this study there was a fundamental difference between the Anglophone and Francophone perceptions of nursing. The latter saw nursing as an auxiliary

occupation while the former saw it as a separate profession. These fundamentally different views had their impact on the birth of nursing. So there is a very clear link between the state emergence and evolution and the emergence of civil society groups. Mann (1993) refers to the process of emergence of the modern state as the ‘crystallization’ of the state. The crystallization process for Cameroon included independence of East Cameroon from France on the 1st of October 1960; independence of West Cameroon (administered as part of Nigeria) from the British by reunification with East Cameroon on 1st October 1961; and the creation of a federal state with a strong presidency (See Le Vine, 1971). Awung and Atanga (2011) observed that at the time this was the only bilingual federated state in Africa bringing together two systems whose colonial experience presented stark differences in language, administration, education and political style. The complexity of the state was really unique and reflected in its relationship with civil society groups. The argument here is that crystallization of the state determines its relations with civil society. In his theory of the modern state Mann (1993: 55) presents the state as a *“differentiated set of institutions and personnel embodying centrality in the sense that political relations radiate to and from a centre to cover a territorially demarcated area over which it exercises some degree of authoritative, binding rule-making, backed up by some degree of organized physical force”*. He goes on to add that the modern state penetrates territories with law and administration just as citizens and organizations also penetrate the state. The state therefore has a centre that projects control over its geographical border using law and administration. The civil society organisations can also penetrate the state and influence its policy just as the state penetrates it with its authority.

Professions are civil society groups and can project their influence on the state as well. If professions can penetrate the state on their own terms or from a position of strength they can easily advance their goals and interest with state backing. If on the other hand professions can’t succeed to influence the state policy then the professional project is likely to sputter. Professions have to establish a relationship with the state and the way that process goes will be influenced by the crystallization process. Building on Mann’s work Macdonald (1995) argued that understanding this relationship is essential to understanding the professional project. He goes on to use Mann’s (1993) model to

compare the process in England, USA, France and Germany. He concluded that the relatively widespread participation of different groups in political, administrative and judicial power accounted for the lack of serious challenge to the old regime where some of these groups had already established or negotiated their influence in the pre-modern British society. A case in point here was medicine which had already established its influence. This and the fact that the state did not systematically pursue the regulation of capitalism and its concomitant 'formally rational, abstract, utilitarian knowledge'; and that in some situations, because regulation of practitioners could not be avoided, and the state resorted to statutory methods of control (i.e. bestowing chartered powers on groups to regulate themselves with little supervision) all laid an enabling environment for the professional project. In other words, the crystallization of the modern British state saw a system where certain professional groups were already established. The state did not develop a project to systematically regulate the capitalist system meaning that regulatory processes might have been sporadic. Also, the state found that it was more convenient for it to grant professions a charter to regulate themselves with some level of state supervision rather than trying take upon itself the regulatory process. Conditions like this worked in favour of the professional project in the British society. Macdonald (1995) also noted that among other aspects of the crystallization of the modern British state is the fact that civil society and organisations had a better ability to penetrate the state. So, while the state might have gone on to give professional groups that had already established their presence legal power, their already strong position was a deterrent for the state to adopt certain totalitarian control measures. It is easy then to see why certain professional occupations in Britain were able to regulate their own education and training.

In the USA contrary to the common believe that it shares similar trends with Britain, Macdonald (1995) presents a very different argument on the state crystallization process and professional project between the US and Britain. He pointed out that the professional project in the US was less potent because of a number of factors not excluding the large size of the country, changing and growing metropolitan centres and a political/judicial structure that gave rise to professional associations for county, state and nation. He argued that American revolutionaries created a state that was weak and

decentralised such that the civil society groups were able to penetrate the state structure at all levels. The state emphasised the right of the individual to the extent that it will not interfere in capitalist activities and expected professional groups not to do so as well. Macdonald goes on that in such circumstances professions had to depend on the exclusivity of their knowledge base to establish their identity as colleges and universities controlled education. He continued that it was only in the later part of the 19th century that professional associations built on their knowledge base and their presence in universities to advance their projects. For France Macdonald (1995) concluded that the post-revolutionary state had a characteristic form of participation which though encouraged direct participation in political process, restricted at the same time the autonomy of institutions of civil society like professions with respect to the strongly articulated and centralised state structure. He emphasised the fact that older professions like law and medicine had previously established strong associations which were eventually subjected to the centralised monarchy. After the revolution professional bodies were seen as part of the elitist society but instead of eliminating these groups, they simplified them and increased centralised state control over the groups. So the post-revolutionary state retained the pluralism of French society but ensured that the state retained strong centralised power over the civil society. As Macdonald pointed out, the state took initiatives as part of its responsibility, in health and education which consolidated its influence and allowed academics a measure of control over training and entry qualifications. He adds that state sponsorship of higher education resulted in the 'grandes écoles' that gave the middle class affiliations that carried greater cachet and status than professional membership.

The case of Germany also demonstrates a different kind of state crystallization and impact on the professional project. Macdonald (1995) observed that by 1871 Prussia had led other German states to unification as the 'Kaiserreich' or 'German Empire'. The state was very powerful and penetrated every aspect of civil society and though professions saw their knowledge base recognised, they were subordinated to civil servants and academics. He went on that there was a higher social status accorded the highly educated middle class working with public service and academia than professional membership. The state he observed built its power by uniting the old regime, the

bourgeoisie and the military while at the same time limiting penetration of civil society in order to prevent strong working class groups and trade unions. He concluded that the professional project was less successful in Germany because a range of forces acted against the professions.

From Macdonald's (1995) analysis, states had unique contexts and situations that influenced their crystallization and relationship with professions. As already indicated Cameroon had its own unique colonisation experience that influenced its crystallization as a modern state. In the analysis of the results of this study, the nurse education system of the country was set up by the state which itself was influenced by its colonial past. Within such a multiple births/formation context, the nurse education system emerged. This context greatly determined how the profession grew or expanded. The state had created the profession to meet its healthcare needs. The state funded training for the number of nurses it needed at different levels every year. With expanding healthcare needs, the state again established further specialised cycles of training. The dominance of the state established when it created the profession and its education system ensured that the state became the main determinant of the future growth trajectory. The modern state of Cameroon crystallized as a federation between its French and English components but characterised by a strong and centralised presidency. According to Delancey (1987) the government of Ahmadu Ahidjo (first president of independent Cameroon) was built on a system of 'neo-patrimonialism' in which all power was centralised in the office and person of the president. In such circumstances, the penetration of civil society groups will probably be stifled or eliminated. Professions under such situations will struggle to establish their identity and define their role because that was already defined before the members were trained. It is like a piece of clay trying to stand up to the potter. With the eventual dismantling of the federal state of Cameroon, the politically dominant francophone system imposed its will on the Anglophone system. The concept of the centralised state as perceived by East Cameroon overcame that of the decentralised state as existed in West Cameroon. In this context the fledgling autonomy being enjoyed by the nursing body in West Cameroon was eliminated. Without any credible professional grouping, the nursing profession had no platform to contribute to change in its educational system and even status.

The centralised state mentality therefore gives little sympathy to professions to exercise any real form of control over their practice and education. Professionals might have the need for further education opportunities but can't get it because the centralised state that created the profession and controls it, does not need that level or category of personnel. So educational growth is not planned well ahead of time and is dependent on government's self-identified need. In such scenarios states make reactionary training policies driven by existing healthcare needs and not within a framework of long term growth and expansion of a particular profession. In other words they start training mental health professionals when they discover that mental health issues are becoming prevalent in the community. A good example from the data is the creation of CESSI as an advanced school for training nurse teachers for nursing schools and nurse supervisors for nursing functions in hospitals. This school and others being created in the country at the time clearly fit Macdonald's (1995) concept of the "grandes écoles" in the crystallization of the modern state of France. Educational policy in such a system is reactionary and growth is erratic because it is not previewed and planned. The dominance of the state which still retains its characteristic philosophy at independence all but ensures that professional education policy and control remain within its hands. The presence of a relevant professional body would have served to mediate between the state and the profession as participants indicated in this study. It would have been able to propose and advocate strongly for professionalization to improve healthcare as well as status of the nurse. So in situations where multiple births occur, in a context where the created profession already has its place defined and boundaries set, the profession can't control its growth trajectory. However, when individual professionals receive external educational exposure and return to the local context, they can play a role in proposing educational policy. But then there must be a professional structure that gives them that platform. Forward educational and planned growth is highly unlikely and professions in such situations will tend to move within a closed loop over time as events dictate.

While Macdonald's analysis of the role of the state on the development of profession is very similar to the findings of this study, there is a key difference. As he elaborated his discourse which he built on Weberian foundations, he cited the fact that the state-profession relationship evolves such that the

state grants professions monopoly of their practice to achieve regulation – the ‘regulative bargain’ (Cooper et al, 1988:8). The state thus recognises the profession and the boundaries of its education and practice. In return the profession helps the state to regulate that aspect of national life using delegated power. In this study the regulative bargain has not occurred and the state has remained in control and uses the profession for its own needs thereby creating sporadic growth opportunities. In another deviation, Mann’s (1993) analysis of the British situation identified the fact that strong professional groups already influential before state crystallization were more able to contribute to the professional project. However, in the context of this study, the already organised nursing professional body in West Cameroon could not stand the centralised power of the state and so disappeared. In East Cameroon which was politically dominant a commensurate structure did not exist thereby weakening organised nursing even further. This is indication that the power of the state and its philosophy of the role and place of civil society could not only slow down the professional project, they can also drastically reverse gains already made by professions.

The identity of professions emerging within a multiple birth context as in this study is defined and set by the state according to its needs. When the state is building on a pre-set foundation as in the case of countries emerging from colonialism, indigenisation of educational systems might fail to take place. For example, nurse education as revealed in the study was never contextualised. Local care models were not incorporated or integrated into nurse training. This is clearly attributable to its imposition by colonialists even though some countries like china were able to integrate their traditional care models into nurse education. According to Smith and Tang (2004) there is convergence between aspects of nursing practice and the Chinese cultural understanding of health. From this it is seen that the cultural belief among Chinese is that illness occurs when the patient and his environment are in disharmony and so treatment focuses on restoring the overall balance and not just treating the symptoms. In addition to an English-based programme, Smith and Tang (2004) described a strand of nurse education that specifically trains nurses in the principles of Chinese medicine. So there is an apparent integration of nursing into traditional care models which helps to indigenise the profession. Mackie and Bagallay (1954) acknowledged that African children had been educated in their traditional

systems on the causes and cure of diseases but the colonial education system focused on the need to help nursing students make the transition from their early African training to 'modern education'. The emphasis then was not about integrating but rather transitioning away from the local African training on the causes and management of diseases. It is on this framework that the modern state of Cameroon designed 'its' nursing profession.

Colonialism was a system built on expansionist tendencies of western European countries and justified by the argument of the 'necessity of civilizing the world' (McCann and Kim, 2013). Colonialism makes the case of superiority of certain civilizations over others. Nurse education was part of this system and as the study results indicated, the imposition of the colonial healthcare system and 'modern' nursing did not adopt any local healthcare models. Local care models were considered unscientific and therefore uncivilized. In implementing 'modern' nurse education in this manner, the identity crisis generated by multiple births is exacerbated. It is seen in these results that indigenous tribes had their health models that had been working for them and it can be argued that most of these models could have contributed in giving nursing a stronger cultural and contextual relevance. Nurse education at independence continued on this same trajectory ensuring that cultural models never had a place in nurse education. Such a policy advanced neo-colonial tendencies put in place not by colonialists but by the newly independent indigenous leaders. By so doing the marginalisation and rejection of traditional healthcare models also continued. It can be argued from this study that nursing in Cameroon has no distinctive identity. From documents studied the state's definition of nursing is differentiated from the more internationally accepted definitions of the role of the nurse. Nursing is seen by one group of people as an autonomous profession and another group as a strong support role to medicine. The advocacy by nurses with foreign education experience for an educational system that validates nursing as a profession did not yield any positive result as indicated in the study. Probably because the nursing definition of those advocates did not match with the state's perception of what nursing was. So what nursing in Cameroon is cannot be clearly articulated especially since the two dominant 'modern' philosophies are different and a traditional model has not been explored. Professions must be able to articulate their identity clearly in a way that emphasises their relevance

and value. Building on local traditional values can be essential towards enhancing that identity definition as well as expanding the knowledge base of the profession. For nursing building on some traditional models might help in the effort to set nursing apart from medicine. As indicated in the study primary healthcare and community health subjects became the primary way of acquainting students with traditional care practices. The principal goal here was to build trust with community members so that they could be further ‘modernised’ by a less confrontational approach. It was looking at indigenous practices and saying “yes this looks good, but it could be improved by adopting this or that western ‘scientific’ approach”.

In this section the argument has been made that the establishment and growth of professions within a context of a centralised state responding to its own needs has the potential to create a disruptive professional growth process. The power of the state over the profession determines its identity and nature of education when the profession is created by the state amidst other conditions completely out of the control of the profession. A significant aspect is the challenge of defining an identity that has no clear definition because of the historical context of the crystallization of the modern state. Identity crisis is also strengthened by dissonance between accepted foreign models that reject a more culturally recognisable identity. Other conditions include the nature of emergence of the modern state and the conception of profession by existing established stakeholders like other professions. In this context, professional education development is determined by myriad factors that are not recognised, anticipated or planned. Educational growth becomes erratic and sporadic and professionalism is threatened.

5.2.2 National agenda – liberalisation and expansion of higher education

The findings of this study exemplify the level of dominance of the state over professions. This dominance has been explored by a number of authors: Fielding and Portwood (1980); Gieson (1984); Cocks and Jarauch (1990); Macdonald (1995). The dominance of the state is fostered by the weakness of the organised profession and as such growth trajectories are dependent on the state policy. As already demonstrated in 5.1.1 above, state control set the pace for educational advancement which was based solely on sporadically identified needs of what role nurses should play

at each point in the healthcare system. Forty years after independence the government of Cameroon decided to liberalize the higher education sector and nurse education was swept into this new reforms. The political context at the time of liberalization has to be explained.

In an analysis of multi-party politics in Cameroon, Awung and Atanga (2011) describe the political evolution from the Ahidjo to the Biya government (current government). According to them, by 1972 Ahidjo had dissolved the federal state structure and the new constitution made him the sole repository of state authority. Therefore the professional project for nursing was further hampered because in such a context the state cannot allow the development of a strong autonomous professional group. They go on to report that the Biya government came to power in November 1982 with promises of liberalization, press freedom, opening of the political system and fighting corruption. After surviving a coup d'état in 1984 the new government asserted control over all state affairs thus perpetuating the authoritarian patrimonial state that was shaped by hegemonic alliances from various ethno-regional groups with the sole goal of maintaining the hold on power (Awung and Atanga, 2011). From the political stand point the change in government did not change the state's approach to power and civil society interaction. The centre of power remained with the authorities implying that professions in the country will have a difficult task to establish their autonomy and control their education. For nursing, the political system perpetuated the closed loop between multiple births and formation and continuing reactive growth. The political system did not favour any break from this closed loop and the profession had no role in determining future education trends. From the work of Konnings (2011) a combination of factors including the economic crisis, the reintroduction of multiparty politics, civil disobedience and the role of the Bretton Woods institutions will cause the government to introduce economic and political reforms in the decades of the 90s. As a condition for helping the government with funding the Bretton Woods institutions insisted on "reduction of public expenditure, removal of public subsidies, dismantling of the public sector, privatisation and promotion of private enterprise, trade liberalization, producer price reforms, currency devaluation, restructuring of state institutions and legal reforms aimed at supplying an enabling environment" (Konnings, 2011). Awung and Atanga (2011) argued that the government

failed to fully cooperate with the Bretton woods institutions on these reforms. However, Konnings (2011) observed that in spite of this quite some progress has been made even after initial government resistance including in the areas of liberalization. This was thus the socio-political context at the time when key government policy issues like the suspension of training of nurses and the liberalization of higher education respectively directly and indirectly affected nurse education.

Policies like liberalization are taken by the state based on its agenda at a particular time. As revealed in the study the nature of liberalization is the opening of the educational sector to civil society. Individuals and organisations have the opportunity to participate in the delivery of education under frameworks established by the state. Liberalization of higher education in Cameroon led to two significant impacts on nurse education: nurse education started in private higher institutes and a number of universities (both private and state-owned) and for the first time education programmes led to award of degrees; and the role of non-nurses (who now came in as entrepreneurs) in nurse education was strengthened. Critics of liberalization see it as commercialising nurse education because entrepreneurs have invested in the running of nurse education programmes. This commercialisation or marketisation is perceived to override the desire for high standards of teaching as economic concerns trump quality and professional values. Anxieties of professionals relate to apparent loss of control over student selection, educational structure and content, and proliferation of nurse education institutions. For a state controlled profession however, this education control had never been in the hands of the profession in the first place. Tight control by the state creates a sense of order that is lost in the liberalization environment which appears market-driven.

Marketisation has become a reality that academics have to live with it (Furedi, 2011). It often refers to the creation of “quasi-markets” in state funded and/or state provided services (Whitty and Power 2000) and is characterised by a separation of the provider from the purchaser with the introduction of choice between providers with state regulation especially in areas of investment, quality, entry of new providers, and price which is often free to the user (Levačić, 1995: 167). It creates a sense of education as a commodity which is being sold by the institution to the student customer. This perception is one of the main criticisms of marketization as Furedi (2011:3) sadly notes that many

universities have adopted the student as customer model. Drawing from the philosopher Socrates, Mills (1978) observed that in a context like marketization teachers do not necessarily strive to make students acquire knowledge but rather pander to their desires encouraging them to be even more pleased with vices and errors. Furedi (2011:4) adds that the present ‘worship’ of student satisfaction in universities has fostered an environment where institutions are so interested in pleasing student customers and avoiding complains for fear of litigation. Furedi (2010) seems to agree with Mill (1978) that intellectual development is compromised in students when they start perceiving themselves as customers. This is exacerbated by the fact that due to commercial pressures institutions might become more interested in securing more customers than focusing on the educational needs of the students (Furedi, 2011: 5; Mill, 1978). So while it might be argued that liberalization of education which usually goes with privatisation, will help to increase access to education and capacity building for the work force, Gregoruti et al (2016) studying the process in Latin America observed that institutions took advantage of loop holes in the law in the absence of strict regulations and that quality was a central concern and some of the mechanisms implemented to deal with it were effective. They added that even though enrolment had gone up, there were several mismatches that challenge the whole goal of the policy to increase human capacity for economic development.

The above paragraph presents strong views against marketization that emerge in a context of liberalization and match anxieties in the findings of the study. At the same time it can be forcefully argued that opening up higher education brings in qualitative improvements derived from competition. Training is no longer designed only to meet the needs of the Ministry of Health but is now directed at improved professional competencies that create better conditions for the redefinition of professional identity. In the liberalised setting professionals can now choose from the variety of academic institutions and programmes according to their needs and professional goals. Professionals who want to acquire education for international roles can make that decision. Those who want to specialise in a particular area can have access to that education even if it were not a prioritised area for government practice. Institutions have greater autonomy which makes them more responsive to the demands of students and stakeholders as well as changing international trends in education. The

state continues to play a role in regulating the creation and regulation of institutions and sets guidelines required for institutions to maintain their license. This helps to hold certain excesses in check and allow professions to take advantage of a freer system to influence education policies in their sector. These arguments echo the findings from the study reflecting the positive impact of liberalization. Brown (2011) proposes four characteristics of the marketised higher education system i.e. institutional autonomy, competition, price and information. He argued that aspects like regulated ease of market entry, genuine possibilities of student choice, linking of institutional funding to enrolment which encourages student recruitment and absence of externally imposed limits to student intake are conditions that when combined with price options create genuine competition among education institutions. The ability of the government to provide information on accredited institutions and for the institutions to provide information on what they offer increase diversity and choice for students and sponsors. Though it might sound like the buying and selling of education where the institution is selling and the student is buying, marketization according Furedi (2011) is more about having a highly controlled quasi-market that forces academic institutions to compete against each other for resources and funding.

As already observed liberalisation was not about nurse education but created a new dimension of national education that affected nursing. This shows how vulnerable professions could be to changes within their socio-cultural environment that did not necessarily target them. The impact of such changes could affect the professions positively or negatively. As discussed above liberalization has led to marketization of education including nurse education. At the same as the study results show, liberalization brought an expansion of nurse education and increased education access for practising nurses and for people seeking a career in nursing. Access is increased by the creation of many new institutions which come with a variety of programmes. In the research context, many nurses have already benefited from this expansion by obtaining higher qualifications which were hitherto unavailable. Higher qualifications are generally associated with higher salaries and better recognition in the work setting. This positive impact at the level of individuals creates a group that will be pro-consolidation of the gains of liberalization. Expansion of education also means more employment

opportunities for nurses who become teachers in new nursing schools on full time or part time basis. More income will likely translate to better living conditions and strengthen the social status of the profession. In a study of the implications of education on social mobility Lindley and Machin (2012) found that individuals with more education earned better wages and that even with increasing number of highly educated individuals, organisations demand for highly educated employees did not fall. However, they also argued that the trends inhibit social mobility because mostly the financially comfortable have benefitted from education expansion therefore increasing already existing income inequality. The subtle argument here is education is leading to greater upward social mobility but at the same consolidating class inequality. Nursing has been associated with gender and social class narratives.

Other authors have discussed nursing's evolution from the perspective of nursing as a 'helping female vocation and a middle-class occupation' (Callinicos, 1983; Erickson and Goldthorpe, 1992; Weston, 2011; Ayala et al, 2014). In this context social mobility in nursing was strongly related to women leaving their domestic roles to a respectable role out of the home. In a country like Chile, Ayala et al (2014) observed that the nursing profession began among the 'female elite' class with well educated women who moved into the nursing occupation from volunteering roles. The entry of Chilean nurse education therefore became a case of upward social mobility for women as it was of the profession. In other contexts, racism emerges as another factor in addition to class and gender influencing social mobility of nursing. D'Antonio (2004) highlighted the race issue by citing Burgess (1982) that the insatiable demand for nurses at the time led to training schools admitting just anybody with varying social and educational backgrounds. She advanced her argument by pointing out that general population numbers used to compare women in nursing to the general population ignored the fact that the numbers included "natives and immigrants, whites and blacks, reds and yellows of all kinds of social conditions". In analysing Burgess, D'Antonio (2004) argued that her position meant that women of other backgrounds were not a suitable benchmark for the widely held view at the time that nursing should be dominated by white middle-class women. So race and social background were

aspects that defined the profession and influenced social mobility. The entry of people of colour and poor social backgrounds into nursing was considered and upward mobility for these groups.

The race, gender, or class perspective of upward social mobility for nurses differs from the trend emerging from the current study. The expansion of education opportunities is more linked with a higher social status of the profession when compared to others like medicine and an enhanced self-confidence in nurses themselves. Gender arguments cannot be made because there are an almost balanced number of female and male nurses in Cameroon. Racial discriminations have not been empirically found or reported in Cameroonian society. Rather expansion from liberalization brought nurses more respect from the society because nurses could now be educated at higher academic levels than what the system had been typically accustomed to since independence. The expression of appreciation and the attempts made by nurses to take credit for education expansion as revealed in the study findings indicate a generally positive reception of the current changes. Nurses are proud to associate their education with higher education even as liberalization breeds policy controversies in the nurse education process. However, there is little evidence from documents studied to support the arguments put forward by some nurses that expansion was a result of organised nursing's effort. Extant literature on the political situation in Cameroon at the time showed that government was responding to internal and external pressures (political and economic) that had nothing to do with nurse education. From this angle, the reactive and erratic growth paradigm is reinforced. It also implies that the liberalization process is completely out of the control of nursing and since its future direction cannot be determined the profession still cannot predict its continuous impact on nurse education.

In summary, the argument in this section then is that in a situation where there exists: multiple births and formation; domination by a strong centralised state; and absence of viable professional association, professional education is completely out of the hands of the profession. The profession is created by the state for its needs and makes any changes to the education system according to changing needs. There is no regulatory bargain between the state and the profession and the status of the occupational group as a profession is not recognised. In such a scenario growth is erratic and

reactive to government's whims. When national agenda in such countries suddenly tilt towards liberalization there opens another chapter of reactive growth as a result of increase access and opportunities for education. Liberalization policies when applied generally do not target a profession and its needs so educational changes are bound to raise anxieties and present real or apparent threats to long held standards and views of what education should look like. The tendency then to see liberalization effect on professional education is present but the advantages it provides once understood by members of the profession can serve as a unique opportunity for change. The opportunity emerges from the fact that government is letting go of its tight control and therefore definition of the identity of the profession. Liberalization especially of education therefore presents a unique opportunity for professions to seize the narrative of their education and redefine their identity and role within the country.

5.3 Current Opportunity for Nursing to take Control of Development

As discussed in 5.2 nurse education has been driven by time and events that are completely out of the control of the profession. The national agenda for liberalization of education was another significant event that showed more evidence of reactive growth. However, the findings of the study show that this national agenda presents a unique opportunity for nursing to take control of educational development.

5.3.1 The conjunction of the desire to change and move to higher education

The evidence from this study show that nurse education in Cameroon right up to liberalization was growing in a reactive and erratic manner. The addition of programmes was based on the identified need of the state which trained nurses to play particular roles in its health care policy. After about 15years into liberalization there is evidence that nurses are ready for change. The desire for change is supported by the realization that career limitations related to educational opportunities had prevented many nurses from achieving career goals. In situations where control of professional advancement has mostly been in the hands of an external player like the state, professionals are more likely to assess growth based on their own personal experiences. For example nurses who complained of the fact that in spite of a desire to acquire degrees in their profession they were hampered by the absence

of such programmes in the country. This again fits the narrative of the state creating, and then controlling a profession for its own use. When professionals take active steps to change their situation for many years, the desire for change can be assumed. Trying to obtain degrees even when they hold what used to be considered the highest qualification prior to liberalization confirms nurses' desire to maximise the opportunities suddenly coming up. Also, professionals can identify with regret aspects of failed leadership in the past and how it affected their further education directly. The results show that a number of external factors like: aspects of government policy that are seen to discourage nurse education advancement and disregard of nursing professional status are identified as situations that foster a desire for change. But in what can be seen as a critical self-analysis, professionals were able to identify their own actions and limitations that have contributed to stalling educational growth and advancement as well as recognition of the status of the profession. This evidence in the study of evolution of professions with respect to change is important. In a context where control has been out of the hands of the profession, it is important that external change is not imposed as it might perpetuate the sense of total dependence. So finding evidence for a desire to change coming from within the profession itself is more promising because professionals are the ones addressing their own issues.

The desire for change is also characterised by the definition of a destination as seen in the findings. In other words professionals know the kind of change they want and also know what is needed to achieve it. There is the recognition that change needs leadership at the level of people and at the level of institutions. At the people level is the need for an educated nurse leadership corps and at the institutional level, the university. The way to get change is by working together i.e. a joined effort from nurses and key players. Silent change (already taking place in the form of quiet recruitment and deployment of graduate nurses to ministry of health institutions, for example) that is already occurring within nurse education during this liberalization era is identified as evidence that change is possible and that it is already happening. The change characteristics here are similar to Lewin's (1951) theory of planned change in Swanson and Creed (2013). They present Lewin's theory as having three main phases: unfreezing; change; and refreeze. Though it appears linear and simplistic,

Swanson and Creed (2013) argue that it is a more complex and responsive model. Rousel (2006) indicated that unfreezing occurs when there is disequilibrium in the system which drawing from the current study could be caused by a national policy like liberalization. The change phase is characterised by the movements and strategies to implement change while the refreezing stage is characterised by stabilising the new situation to make it permanent (Swanson and Creed, 2013). The expansion of education and the silent change already taking place in the study findings mirror the change phase. The last phase of refreezing remains a destination as the findings of the study indicate that the change process still has the potential to go forward. This is not the only difference between the study's findings and Lewin's theory, as opposed to Lewin change in the study is unplanned. Liberalization might have been planned by the government but the effect on nurse education was not planned.

The move to higher education as seen from the findings is another consequence of the liberalisation agenda that offered undergraduate and postgraduate degree education to nurses. There is no evidence from the study that the move to higher education was a deliberate policy for nurse education. This 'academisation' Ayala, Fealy, Vanderstraeten, and Bracke (2014); Lahio (2010) is also referred to as the 'transfer/move' (Bahçecik and Alpar, 2009; Kenny, 2004; Traynor and Rafferty, 1999; Humphreys and Francis, 1999; Le Var, 1997; Caldwell, 1997), or the 'integration' (Zabalegui and Cabrera, 2009; Spitzer and Perrenoud, 2007; Burke, 2006; Glen, 1995). These authors mostly present academisation as a planned policy on nurse education and even other health professions (Friedrichs and Schaub, 2011) but the findings of this study show that academisation could and is occurring without a careful plan or policy to that effect. The Cameroon government's policy of liberalization of higher education did not close training occurring under different ministries like public health and vocational training. So, hospital-based programmes and higher-education based programmes are running parallel to each other. The unplanned nature of this policy on nurse education means that multiple dominant policies are concurrently in force on nurse education. In such a situation, nurses will tend to align with one policy or the other creating tensions. These tensions are increased by the parallel nature of policy implementation meaning nurse education gets caught up in the middle.

These conflicts and tensions could limit the ability of nurse leaders to take advantage of the unplanned academisation to move nurse education policy forward. The benefits of academisation are already accruing and can be recognised as nurses have already obtained undergraduate and postgraduate degrees. The implication is that there is success that could be used as motivation to move nurses to adopt the unplanned academisation and use it to professionalize nursing.

The desire for change which also include silent change, and the unplanned academisation taking place as a result of liberalization present a unique but temporal opportunity for nurse education in Cameroon. Traynor and Rafferty (1999) suggested that context, convergence and contingency were three sets of conditions needed for change to follow. Context refers to the creation of a positive climate of opinion or a case and pressure for change; convergence to the fortuitous fusion of professional and government agendas and contingency provides the unforeseen consequence or spark that ignites a policy change. They went on to demonstrate and compare how these three conditions have influenced changes in nurse education policy in the USA, Canada, Australia, Germany and the UK. To them lobbying power, unity and the rationality of professional arguments have not been sufficient to bring change. Traynor and Rafferty's (1999) proposition is similar to the present context in Cameroon as found in this study. However, there is one essential difference, that is in the countries they studied, there existed professional groups that were already key players in the education process and could maximise opportunities of convergence. But in this study, convergence is already occurring without an active input from the profession. In such a context there is a leadership void to bridge the gap between the dominant state policies incarnated by different government agencies all playing on nurse education. The desire to move forward and seize the opportunity is hampered by the conflicts that have been generated by the changes taking place. When professionals are able to critically analyse their educational system and their practice and identify need for change, they can easily come up with a strategy to accomplish that change. Recognising differences in education policy brought about by liberalization and academisation, harmonisation of education policy emerged as a necessary tool in seizing the opportunity to take control of nurse education. Harmonisation as

such a strategy should be able to overcome the forces that are pulling back change to pre-liberalization status quo.

5.3.2 Turf wars and intra-professional conflict against opportunity for harmonisation: a force field interaction

The conjunction of the desire for change and the move to higher education, present a unique opportunity for nursing to take control of its educational development. The forces that favour this conjunction emerged under the theme harmonisation of nursing programmes while opposing forces emerged as turf wars and intra-professional conflicts.

The long dependency of the nursing profession on the government to make all decisions about the educational policy of the profession had entrenched a concept of education embedded within the ministry of health. In this light, the influx of candidates and schools ushered in by liberalization as well as a completely different education philosophy was too great a disequilibrium for professionals to accommodate. The status quo had been built on a system where the state controlled and decided on type of programmes, number to be trained, selections of students, curriculum and examinations. The orientation to training was on clinical skill development. Training was aimed at producing nurses for the healthcare system. The move to higher education brought a new orientation to training that was perceived as lacking some of the underlying values of the older system. Institutions were given greater autonomy to manage education programmes and conduct student recruitment even though the state was responsible for licensing institutions and their programmes. At the individual level the sudden removal on the cap on academic qualification has threatened the gains of professionals who had become accustomed to holding the highest recognised qualifications in nurse education in the country. The perceived threat to personal gains coupled with the establishment of these professionals in key roles within the educational and administrative system, constitute major obstacles to the current change. Evidence of this is the rejection of higher education graduates by certain nursing associations. There is the concept of ‘us’ and ‘them’ with people trying to protect the training model in which they were trained. In some cases as seen in the findings, nurse leaders out rightly reject a

programme as substandard while acknowledging at the same time that they have not assessed the curriculum of the programme.

The nature of the conflicts also includes tension on who should control nurse education. The traditional adherents advocate that only ministry of health which understands health issues should train while the others think that higher education understands what education is and is better placed to train for health to consume. On the other hand there is also the desire to maximise the change happening. Professionals see the new educational opportunities as a tool to redefine their identity and professionalise their practice and education. There is the expressed desire for a highly educated leadership that can lead the educational project of the profession. Working together, moving training completely to higher education and harmonisation of nurse education programmes are proposed as the measures to take advantage of liberalization and advance the professional education project. Harmonisation is presented in the data as the major strategy to overcome the present challenges posed by turf wars and conflicts which together have the potential of derailing the educational project. If this were to happen the profession will go back to its history of erratic and reactive growth completely out of its control. The dynamics occurring in the study at this time demonstrates an interplay of factors that compares to force fields.

Intra-professional conflict and turf wars on one side and the opportunity for harmonisation thus appear as opposing forces on the education project. The interaction between these forces creates a situation similar to force field analysis developed from the work of Lewin (1951). According to Swanson and Creed (2014), Lewin's (1951) force field analysis provides a model of for change that defines the interaction between the forces driving change and constraining forces. They suggest that understanding how change supporters and opponents perceive those forces is imperative to 'planning, recognising, controlling and directing change'. Chambers, Wakely and Blenkinsopp (2006) assert that once these forces are identified, their relative strengths can be determined and they can be ranked accordingly. To manage the change then, Mitchell (2013) suggests that since restraining forces cannot be removed, they can be countered by increasing driving forces. Marquis and Houston (2008) support the identification of strategies to strengthen the driving forces but Toomey (2009) argues that

change agents must also find strategies to reduce the restraining forces. Force field analysis presents a comparable framework to address change as emerging from the study findings. However, the identification and weighting of driving and restraining forces is too simplistic to address the peculiarities of the study context. The forces that have actively and passively contributed to the present situation as well as the role of the state have to be understood and applied in the change strategy. So though the study identified two principal opposing forces, force field analysis does not capture the complexities involved in the evolution of nurse education in Cameroon. For example prior to liberalization, there was already a desire for degree level education among nurses (a driving force) and then when the opportunity finally came (strengthening the driving force) one would have expected an enthusiastic embrace of change. But instead, new restraining forces (turf wars, policy controversies, and intra-professional conflicts) erupted and seriously threaten the change. This is an indication that there are more complex factors that cannot be redressed by simply addressing the obvious driving and restraining forces.

Schein (1996:28) observed that the force field had to be manipulated under ‘complex psychological conditions’ for change to occur because usually, when a driving force is simply added it immediately generates a counterforce which comes up to maintain the equilibrium. Though force field analysis is a variant of Lewin’s theory (Burnes and Cooke, 2013) it doesn’t capture the complexity of the change process as the original theory. Lewin’s planned approach to change is made up of four elements i.e. field theory, group dynamics, action research and the 3-step model of change (Burnes, 2004; Burnes and Cooke, 2013; Swanson and Creed, 2014). Field theory proposes that understanding group behaviour requires mapping out the ‘totality and complexity of the field’ where the behaviour takes place (Burnes, 2004; Back, 1992). The field itself is comprised of all coexisting factors which are mutually interdependent (Lewin, 1946: 240). The basis for this theory is Lewin’s belief that all behaviour is a product of the psychological forces in a person’s ‘life space’ and as such changes to these forces elicit changes in behaviour (Cartwright, 1952). To understand and predict behaviour change will require constructing the person’s life space from the totality of his perceptual or psychological environment (Lewin, 1943; Burnes and Cooke, 2013). Lewin (1998) emphasises that

this life space includes only the aspects of the individual's environment that he consciously or unconsciously perceives. In other words the life space is the total psychological environment that is experienced subjectively though not necessarily consciously by the individual (Wheeler, 2008: 1640). The forces in the life space exist in some kind of dynamic equilibrium and are not static. According to Burnes and Cooke (2013) Lewin uses the term 'quasi equilibrium' to describe the state of interaction between the forces in the life space. They added that Lewin views behavioural change as being a slow endeavour but that under certain circumstances (personal or group crisis) the various forces in the life space can shift quickly and radically. In such situations the established status quo is broken and new patterns of behaviour emerge creating a new 'quasi-stationary equilibrium'. This recognition of the complexities of the individual's life space and potential for change might have influenced Lewin to consider the group as a better focus unit to plan change. He proposed that an individual in isolation could be forced by group pressure to conform so it is needless to concentrate change efforts on the individual (Lewin, 1947). His group dynamics according to Burnes (2004), Dent and Goldberg (1999) emphasises group behaviour over individual behaviour as the main focus for change.

The analysis of the current data shows an emergent change model very similar to Lewin's field theory than to the force field variant. The similarity lies in the recognition of the complexities of the context within which the change is occurring. Nurses' perception of the change taking place around them affects the way they are responding to it. As a result, some come out in support for the change while others appear to resist. With this consideration and contrary to Lewin's (1951) recommendation for change efforts to target groups rather individuals, the individual perspective must be factored in here. The nurses who are resisting change are primarily considering its impact on their personal lives and careers before the overall professional impact. For example the nurse teacher who lacks the appropriate qualification to teach at higher education is more worried about losing his job if training goes to higher education than the professional benefits of moving to higher education. Or consider the nurse administrator who resists the reclassification of nurses with degree qualifications because acknowledging higher qualification could mean losing his position to more

highly educated nurses. On the other hand the nurse who had wanted to acquire undergraduate and postgraduate degrees for over 20years but did not have the opportunity has just recently acquired those qualifications due to the present change and so advocates for it. It can be seen from here that most nurses are interpreting the current situation of nursing from a very subjective angle.

What comes up as an official position is being fuelled by subjective fears and anxieties. It is at this point where the change strategy in the study deviates from field theory. Firstly, the existence of organised nursing as a single and credible group working to advance nurse education and practice does not apply here. So focusing on the group behaviour only will not advance the change momentum. Evidence again is the fact that sweeping change brought in by national agenda has divided professionals rather than united. Secondly, there is evidence that the advancements in nurse education are perceived as personal threats to professionals who have benefitted from the status quo. So change planning must address these individual fears in a collective manner to significantly reduce resistance. Thirdly, the profession had never played a strong role in educational practice in the past and in the present such that there is no structural framework to harness group effort towards change. Consolidating and taking advantage of the current policy is by bringing key stakeholders to a 'harmonisation' discussion which must assess the impact of multiple births, state control, the lack of a collective identity, and fears of personal loss due to change. So harmonisation has to deal with the fears of the individual while taking into consideration the forces of history and dependence on government control. Government control is important because even government itself lacks an official unified strategy resulting in one agency moving fast towards academisation and the other holding fast to traditional hospital based training. For a profession highly dependent on government for order the present situation is very confusing.

Turf wars and conflicts are a threat to the drive for change because of the sense of loss change brings to certain professionals who are already in influential positions. The impact of the multiple births and a lack of professional independence are also constituents. Harmonisation of education policy is a strong vehicle to drive the change towards academisation and control of nurse education by nurses.

But the change strategy must provide reassurance against the perceptions of loss of influence and benefits that change provokes in established professionals.

5.3.3 Realising educational advancement and professionalization of nursing through harmonisation

The concept of harmonisation emerged as a strategy, a pathway and a destination. In this context it holds variable meanings ranging from unified policies on admission criteria, diploma appellations, curriculum, and competency framework to supervising authority. The justification for harmonisation is primarily the parallel policies and controversies they raise, of different government agencies in nurse education (which is fallout of liberalization).

a) The harmonization project

As a strategy, the harmonisation process from this study presents a unique framework that can bring nursing leaders together to address nurse education. The profession by reason of its birth and ownership by the state had not created mechanisms to facilitate intra-professional dialogue. As such it has been unable to gradually take over its own ownership. The ‘chaos’ created by liberalization including diversity and variations of nursing programmes has seen some professionals adhering to the traditional orientation of training and others to the new higher education approach. Recognising these differences is evident in the findings of this study. The findings also show recognition of the fact that nurses have to come together to discuss and lead the change in nurse education. The study shows that well-educated leaders (postgraduate qualifications) and universities should work together to produce a policy paper on nurse education. The nurse leaders should come together in some board or platform that will facilitate leadership and control of nurse education. There is no guarantee that getting such a coalition will move everybody in one direction, but it will create a working platform on which a national dialogue can be carried out. The platform for harmonisation will place nursing leadership in position to bridge the gap between government agencies operating parallel education policies. It will thus reverse the traditional expectation of government to solve the problems by placing nursing in the position to produce and propose a harmonised policy incorporating the best of

all the ministries. The process of harmonisation will also give nurses an opportunity to redefine the nurse and his/her role. The pre-liberalisation identity and role was set by the state while the liberalization identity and role is being defined by the state and private educational institutions. So the process will give a platform for the profession to redefine its identity and develop a plan on how it is going to be accountable to the public it serves. The successful execution of such a strategy will most likely set a precedence that will make nurse professionals more confident of their own abilities. It is going to establish trust between nurse leaders from different academic backgrounds that further strengthens the desire to work together to address other professional issues. They can build on this to get into a “regulative bargain” (Macdonald, 1995) with the state that will grant them their autonomy. As indicated in the findings, there is a desire for autonomy and control of the profession by nurses themselves. The profession desires to have the same status as in those countries that have managed to negotiate their autonomy from the government. The opportunity is ripe because of the ongoing liberalization agenda. Failing to maximise the present opportunity might see nursing waiting for another 40years for the ‘stars to align’ again. So the harmonisation project can be constructed as a strategy to achieve professional autonomy even beyond just control of nurse education.

The harmonisation project can be compared to the ‘Bologna Process’. It has been described by Davies (2008) as the single most important reform of higher education to take place in Western Europe in the last thirty years. She added that it started in 1998 when higher education ministers from France, Germany, Italy and the United Kingdom signed the ‘Sorbonne Declaration’ calling for the harmonisation of higher education qualification systems in Europe and the process started with 29 EU countries signing the ‘Bologna Declaration’ in 1999. Harmonisation from this study will be a process that will constitute a pathway to achieving the goals of nurse education. A very smooth functioning harmonisation project will lead to a state where the profession achieves all its goals, gains respect from all stakeholders and becomes a model for other professions and other countries. This is fairly utopian and as such a destination that might never be achieved in one lifetime because the profession exists and interacts with other components within a greater life space. As such the

susceptibility to change forces from this life space of the profession makes problem-free future a way to go rather than a destination.

The suggested process for harmonization in this study is built around a collaborative framework that brings key parties together. The dominant training philosophies as identified in the study are the hospital-based and the higher-education based approaches. Both approaches have their strengths and weaknesses and so harmonisation will seek to draw from the strengths of both models. So the designers and custodians of the two models will have to come together to work on a unified position. Recognising and proposing such a position is a healthy indication for the readiness to find a common approach to the conflicts. The actual process of doing so will set a trend or mechanism that will always bring nurse leaders together. So harmonization becomes a pathway for bringing nurses and stakeholders to address issues concerning education and practice. Such a model becomes the tool through which collective issues can be debated and addressed by nurses. The recognition of challenging debates as part of the process of harmonisation buttresses this proposition. Nurses cited the key controversial issues that have to be addressed in nurse education. The interpretation is that no issue is taboo or too controversial to be brought up from curricular changes to redefining the roles of the ministries (health for nurse employment and higher education for training). So the readiness to address all controversial issues holds potential for making harmonisation to become a pathway to address all critical issues that will affect the profession even in the future. In this context harmonisation is not just a word meaning coming together to achieve a common understanding but it goes beyond to become a way or method in which things can be done. In that sense it is a pathway for intra-professional debate and decision making. Its adoption in the educational project is based on the assumption that no one position holds all the merits. It also silently argues against uniformity as the desire to retain diversity while following harmonised guidelines is evident in the findings. This is a point of divergence from the Bologna concept of harmonisation.

The main aim of the Bologna process was to create a more coherent, compatible, comparable and competitive European Higher Education Area (EHEA) by October 2010 (Davies, 2008; Patricio & Harden, 2010; Hengen, 2010; Palese et al, 2014). This aim was to be achieved by: adoption of a

system of easily readable and comparable degrees; a system of two-cycle (undergraduate and graduate) degrees; a system of credits to promote widespread student mobility, such as the ECTS (European Credit Transfer and Accumulation System); promotion of mobility; promotion of European co-operation in quality assurance and lastly promotion of the European Dimension in Higher Education (Davies, 2008; Palese et al, 2014). By contrast, the current study showed that in as much as policies should be clarified and unified positions adopted, professionals still argue for diversity. They insist more on a guiding framework than a national curriculum (even though some still think a national curriculum should be imposed). It is thus a pathway because it will be the way to go when facing other professional issues in the future.

Harmonisation also emerges as a destination, a desired place where nurses wish to arrive. Coming together and working to address nurse education issues is not an end itself but a means to an end. In this context the expectations of the nurses are clearly spelled out in the findings of this study. The expectation is that all the present controversy and confusion brought about by liberalization will be resolved satisfactorily to allow nurses even easier access to higher education qualifications. These expected outcomes from the process are the key factors behind the consideration of harmonization as a strategy and way to go. The major expectations are that: a group of highly educated nurses form a board to deal with education policy; unified positions are adopted on the nature and designation of different levels of nurse education programmes; the establishment of a national competency framework for nursing and professionalization and independence of nursing. A separate expectation which is emphasised from the findings is the creation of clear and seamless pathway for the diploma nurse to obtain the bachelor degree. This option directly plays to some of the personal desires of nurses in that category and could offer a means of keeping their jobs and as such mitigate their resistance to change. Achieving these will mark success for the harmonization process. It will show that the process has arrived at its destination.

Just like liberalization in Cameroon, the Bologna declaration was about higher education and all disciplines and nurse education in Europe was swept by those overarching goals. According to Palese et al (2014) the Bologna process was a strategy to facilitate the movement of nursing transition from

vocational training to higher education (Spitzer & Perrenoud, 2006), to unify platforms of pre-registration programs across Europe (Davies, 2008) and to offer different exchange opportunities for undergraduate and postgraduate students and nurse educators (Jackson et al., 2009; Davies, 2008). So on nurse education the central piece of the Bologna process is the academisation of nursing with the actual transfer of education to higher education. This is another point at which the Bologna declaration framework deviates from the harmonisation project in this study. The harmonisation project while consolidating the role of higher education will also consider a complete transition to higher education in the future. However, the focus of the framework is to produce a working coordination that in the short to medium term retains training both in and out of higher education but with a clear policy of upgrading in higher education. The goal of a complete transition is desirable and has been proposed in the study but so also is what participants consider a more pressing issue – the elimination of policy controversies by the construction of national guidelines for nurse education. The realisation of educational advancement in its most visible form will be the adoption of a framework that allows diploma nurses to upgrade to degrees without having to start all over. This will facilitate the acquisition of postgraduate degrees and therefore a more educated profession and leadership.

b) Professionalizing nursing

The professionalization of nursing is another key expected outcome of the harmonization project. From the findings of the study professionalization is going to be achieved principally through education reforms. The study reveals that nurses desire to overcome inferiority complex, gain professional respect and also to achieve professional independence. Nurses propose a fundamental reform of nurse education at all levels to produce nurses who can make the profession more useful to and more appreciated by patients. From the study this emerged as conceptualising nurse education. The goal is to structure curricular to train nurses who can by their practice articulate the unique role of the nurse as a competent and autonomous practitioner who doesn't function only at the physician's order. The measurement of the outcome proposed is the sense of fulfilment in the nurse of importance and professionalism and the ability of patient to appreciate the distinct input of the nurse

in their care. Patients should be able to see by the nurse's action that nursing is different and autonomous from medicine. Curriculum revision is the main proposed tool in the harmonization project to achieve this goal. It is further intertwined with education reform in the sense that a competent set of nurses should lay out the framework for this revision, spell out teacher qualification and the role of non-professionals. This can also be seen as an effort to redefine the identity of the nurse. Up until this moment the identity of the nurse has been defined more by others than the professionals themselves. This has been linked in this study to the nature of the birth of the profession and the control of its growth by the government. The search for professionalization is seen as a strategy to redefine the profession for its members and to the public as well as obtain control over the profession and its educational system. This desire for control and independence can be seen in a Weberian context or the view of professions as seeking their own interests, protection of their economic domains, pursuit of upward collective mobility and consolidation of their class position (Berlant, 1975; Parry and Parry, 1976; Macdonald, 1999). However, in articulating this desire for autonomy and respect for nursing, the results indicate professionals perceive the recognition and respect of their clients as a key goal being sought through the harmonisation project. They desire to provide care that will be valued by patients and which can be distinguished as the nursing input by these same patients. In this light the desire for professionalism falls within the functionalist framework of professions (Car Saunders and Wilson, 1933; Parsons, 1954; Marshall, 1963; Huges, 1963).

Professionalization within the harmonisation project in the study seeks professional recognition by positively impacting clients through an improved educational system. Its achievement depends on the harmonisation project because of the emphasis on achieving professionalization through education. Curricular revision to provide the kind of conceptualised nurse training is considered part of the harmonisation agenda. Setting the interest of the patient as one of the success markers of the professionalization initiative helps to dispel any arguments that the profession suddenly wants to make a power grab to serve its interests.

The argument in this section therefore is that the harmonization project goes hand in hand with professionalization of nursing. The consolidation of educational advancement and professionalization depend on the success of the harmonization project. The project is demonstrated as a strategy to seize the present opportunities for nurse autonomy and professionalization on a framework of a unified educational system that retains diversity while setting common guidelines for competence. It is also demonstrated as a pathway that can always serve for future intra-professional projects. Lastly, harmonization serves as the destination where policy controversies that hamper nurse education are eliminated, professional leadership is established and professionalization ingrained in the training process.

5.4 The Harmonization Project to Achieve Control of Nurse Education: An Opportunistic Model

Professions created in postcolonial societies by new state governments building on the colonial civil service foundations retain subtle and obvious characteristics of their foreign nature. This subtle influence is stronger when the colonial establishment did not seek indigenisation by incorporating local models. These lay the foundations of an identity crisis that is strengthened by the states formal creation and definition of the role and status of the profession with complete control over its education. In such situations professional growth is reactive and erratic with the professionals having no control. With total dependency on state policy for existence and survival, the concept of professional autonomy may be desired but not fully understood as a practical possibility. The evidence of this is that when government agenda suddenly provides an opportunity where state control is released professions are ill placed to grab the opportunity. National agenda like the liberalization of higher education demonstrates the reactive nature of professions that have grown to depend on state control. When the new agenda exists concurrently with old traditions, controversies develop and are exacerbated by intra-professional conflicts born out of traditional and liberal ideological alignments i.e. camps of those who want to move with change and those who will prefer to remain with the familiar status quo.

In this kind of context, dependent professions have a unique opportunity to organise and take charge of the profession in a way that did not exist before. The change in national agenda and the conjunction of a strong desire for change and the advantages of moving to higher education emerges as key engines in the forward drive for control. However, a strategy for overcoming turf wars and conflicts that risk nullifying the gains of liberalization has to be designed by professionals to solve these issues. Harmonization emerges as a project that can achieve this goal. By its nature, process and agenda, the harmonization project brings professionals together within an unprecedented framework to address a national nurse education policy thus placing the profession at the centre of the discourse. Proper implementation of the harmonization project holds the promise of consolidating educational advancement and the professionalization of nursing through education. Significantly, it also lays the groundwork to both seize the current narrative and set up for future professional issues.

Therefore the harmonization project is the crucial piece of an educational driven framework that gives a dependent profession the ability to seize a unique opportunity where national agenda suddenly loosens state control in a manner that was not anticipated.

5.5 Conclusion to Chapter Five

This chapter presented the explication of the categories to generate the theory of seizing the opportunity of the moment. The theorizing process was demonstrated to have emerged from the data with the application of the constructivist grounded theory analysis. The theory captures the complex interpretation of the categories and their links to each other in proposing a harmonisation project as its key component. Chapter six the next chapter, explores the implications of the study findings. It also covers the limitations and evaluation of the theory of seizing the opportunity of the moment.

CHAPTER SIX

IMPLICATIONS, LIMITATIONS AND CONCLUSION TO SEIZING THE OPPORTUNITY OF THE MOMENT

6.0 Introduction

This study set out to conduct an analysis of nurse education in Cameroon taking into consideration its past, present and future. A grounded analysis of the results revealed categories and themes that illuminated the unique context of Cameroon and that influenced the pathway of nurse education evolution. A constructivist approach to grounded theory was used to weave an embedded model of these themes. The model linked the origins of the profession to its present state of evolution with a projection for the future that is dependent on maximising the opportunity of the present moment with respect to the national agenda. This opportunistic model holds promise for the profession to control its education and advance the professionalization of nursing in Cameroon. This chapter discusses the limitations of the study, the implications for education and practice, and a conclusion on the constructed model.

6.1 Implications of the Study Findings

The findings of this study have empirically revealed profound, complex interacting factors that affect nurse education in Cameroon. The factors revealed show a clear link between historical antecedents and present day policies on the continuing evolution of nurse education in Cameroon. On the strength of constructivist interpretation of these findings the researcher discusses in the proceeding paragraphs, the implications for organised nursing, government and other stakeholders. These implications are presented with authority and confidence generated not from a position of generalisability that characterises large scale quantitative studies, but from the conviction that based on the grounded analysis, the findings and the abstract interpretations drawn are true representation of the data obtained in this study. Typically, constructivist grounded theory as Charmaz (2006) argued, ‘leads to learning how, when, and to what extent the studied experience is embedded in larger and often hidden positions, networks and relationships’. The implications are discussed from

this framework because in the analysis the researcher has been able to demonstrate the links between previously unidentified factors at individual and collective levels and as such revealed where ‘distinctions and differences arise and are maintained’ (Charmaz, 2006). The researcher’s arguments and proposals are thus based on the fact that having dug down into the fundamentals of nurse education, and up to the abstractions drawn from data and probing into the experience of participants and contents of official texts, the proposed theory delves into the core of nurse education in Cameroon and poses new questions about it (presented in 6.3).

The opportunistic theory sounds a warning and proposes a way forward. The core of that way forward lies in the harmonization project, which in its presentation and execution will create a platform for debates, assessments and analysis to test and implement the recommendations of this study. On this basis the researcher presents the model as a working tool whose strength lies in the fact that it creates a platform for nurses and stakeholders to assess not only these findings and recommendations but also provides the abstract links between the factors to illuminate such debates. So while generalisability is not claimed, the researcher argues that the triangulation of sources within this study makes the case for a careful consideration of the implications of this study by those who might want to argue about the sample size for the study.

6.2 Implications for Nursing

The findings of this study have broad implications for nursing and nurse education within the country Cameroon. There are implications for government agencies involved in nurse education, for nurses and nurse leaders and for organised nursing. The participants of this study were all nurses with different educational backgrounds but what they shared in common was their experience of being in positions to contribute actively in the design and implementation of nurse education policy. This emphasis is being made to lend more credibility to the implications that are being made from the results and discussions. In other words the implications are based on the results of the critical analysis of the data from nurses themselves who in the process critiqued their own place and role in the nurse education process. A few implications will be outlined below which the researcher believes is essential in seizing the opportunity of the moment. However, the researcher believes that after

reading through this thesis, readers will be able to identify many different implications from the results, some of which might not be included here. In other words the selected implications discussed below are not exhaustive but prioritised in consideration of the opportunistic theory generated in this study.

6.2.1 Implications for government agencies

There should be the creation of an inter-ministerial platform for nurse education collaboration comprising the ministries of Higher Education; Public Health; and Employment and Vocational Training. Data reveals that all of these ministries are involved in the accreditation and supervision of nurse education programmes but are not collaborating with each other. All the agencies are working within the legal framework of government's overall policy: vocational training for rapid production of professionals, health for public health and safety and higher education for the advancement of knowledge, science and research. Nurse education fits in their individual agendas in different ways. The execution of their legal responsibility has been seen to be one of the key factors behind turf wars in the study. There are nurses who align with a particular ministry and antagonise the others generating even more conflict within nursing. Government agencies have to understand that the turf wars generated will only hinder the achievement of the goals of their agencies. The creation of the collaboration platform should coordinate their policies on nurse education and establish frameworks for the movement of nursing students across their programmes. In other words the platform should establish the academic relationship between the different programmes so that nursing students can easily move between the programmes of the different ministries. This is a vital component of the harmonization project because the present unilateral policies of these ministries pose a great threat to nurses' ability to seize the opportunity of the moment.

The ministry of health should set up and implement a plan to phase out all its nurse education programmes within a clearly defined timeframe. This study was not an evaluation of the ministry's performance over its 40-year period of monopolising nursing education. However, the data showed that the philosophy of training nurses for consumption created by the ministry of public health has been an obstacle to the establishment of a strong and autonomous profession. It only produced

40 years of reactive growth and erratic development of the nurse education project. Training for consumption meant that changes to nurse education were always related to clinical skills development. For example, when there is need for nurses to assist in the theatre we create a nurse anaesthesiologist diploma programme focused on that skill development. While this policy is reactive at best, it can be argued that these nurses met the public health needs they were being trained to meet. However, there is no empirical evidence that they actually met those goals or that their performance would not have benefitted from a higher education based model. Evidence from the data also showed how nurse leaders failed in many circumstances to advance the educational goals of the profession. The training philosophy and the limited access to higher education can be closely linked to the ability of nurse leaders over time to set and implement long term goals for nurse education. In other words, the nurse education model set up by this system did not equip leaders with the necessary knowledge and skills to execute their leadership roles. The immediate post-independence era may have validated the need for a training-for-consumption philosophy which no longer fits the current context. In this regard the ministry should let go of education so that nurses can be adequately trained to achieve both clinical and non-clinical skills that better prepare them for the challenges of contemporary practice. It can become a consultative partner that brings its needs and values to nurse education planners so that such will be incorporated into curriculum designs. Higher education gives nurses more self-confidence to take on their advancing clinical roles therefore being more useful to meeting the health needs of individuals and communities. As evidence from this research shows, countries with more advanced nurse education systems have better public health indicators. In giving up its interests in nurse education the ministry of health will actually achieve its goals of providing ever increasing high quality health services to Cameroonians.

The ministry of Higher Education should play a strong leadership role in the harmonization process of nurse education in the country. Part of this should include working with the ministry of health to phase out its training programmes and move all training to higher education. Based on evidence from this study the transition process should address the following:

1. *Establish a timeframe for transition:* students at different levels of their programmes should not be affected by the transition to higher education. All such programmes should either be allowed to go on to their natural completion or provisions be made for the students to continue within higher education. The latter option is more complex and will probably be disruptive to the students so the former is the more viable strategy. The transition period should also be used by higher education to prepare to accommodate a surge in number of students. The surge should be expected and planned for because all those who would have gone to study under the ministry of health will be coming to higher education. The preparation should include assessment of the capacity of current higher education institutions to accommodate increasing numbers without a reduction in teaching and learning quality. The necessary support systems for the process should also be identified and set up during this phase.
2. *Setting personnel redeployment scheme:* nurse teachers within the ministry of health will have to be redeployed as education moves to higher education. Those whose qualifications permit them to teach at university level should be given the option of transferring to the higher education sector. The surge in student numbers will also mean that the services of this group of nurses will be highly needed in higher education. For those that do not qualify, they should be redeployed to hospitals within the health system. Their teaching experience can also be maximised by assigning them to play clinical teaching roles for nursing students on placement. They can also be assigned responsibilities of mentors for newly recruited nurses. At the same time some of these may want to continue with primarily teaching responsibilities. In such a situation, higher education should make it possible for academic programmes to be designed to give them the educational experience and qualification needed to teach in higher education. These suggestions are made based on evidence from the study that emphasised that the needs of personnel to be affected in the event of a transition should be taken into consideration.
3. *Use of equipment and infrastructure:* the use equipment and infrastructure that the ministry of health has accumulated and set up over the years have to be reconsidered. Where possible

these could continue being used by higher education for nurse education purposes. As the research evidence suggests, it fosters collaboration and partnership because higher education will be using equipment and infrastructure owned by health. That way higher education can reduce the costs of buying new equipment or infrastructure with the expected student surge. Health will see that it still has a role in the education process as provider of clinical learning contexts and other infrastructure.

4. *Addressing training quality concerns:* research data shows that higher education programmes are perceived with scepticism by those who support hospital-based models. The main reasons are that there is insufficient focus on clinical skills and just minimal control from the authorities. Higher education planners must demonstrate that nurse education programmes under the ministry of higher education actually meet and exceed the standards expected by the ministry of health. Considering that the ministry of health is being asked to focus only on a consumer role, nurse education planners must ensure that the nurses among other expectations can meet the expectations of this employer.

The place of nurse education at the ministry of employment and vocational training should be assessed in the context of the transition to higher education. Evidence from the data showed nurses snubbing or ignoring its role. However considering that it is part of government policy to encourage rapid professional training nurse education at that level has to be aligned to higher education schemes to facilitate upgrade. The issue of the use of the title ‘nurse’ by auxiliaries came up as something nurses did not want. The programmes should be allowed to continue within this ministry, as training for care assistants but with curricular designs that allow for future upgrades into full professional roles. Adopting such an approach will facilitate the advancement of nurse education and professionalism. It will also show leadership by avoiding a collision course with government over a strong aspect of its economic growth policy.

Even in the event that all nurse education finally move to higher education, there will exist for a considerable time to come a pool of nurses with diplomas. The ministry of higher education should set up a framework that allows higher education institutions to create clear credit transfer schemes.

As evidenced by the data, the murky nature of transition from the SRN diploma to degree is perceived as an obstacle to progression for this group. It also fuels the conflicts and turf wars and poses a threat to the harmonization project proposed. With such clear stipulations institutions will be able to set up those schemes that recognise the prior learning and experience of these nurses and provide them a significantly shortened time frame to upgrade to bachelor's degrees. Institutions will also have the mandate to identify and customise such upgrade programmes to meet the needs of those nurses who most often might not want to leave work for school. The data also shows that some nurses resisting educational change do so because they fear that they will lose their positions to younger more qualified nurses. Creating such credit transfer schemes to innovative modes of studies like distance or online learning will reassure these nurses and as such eliminate their resistance to higher education.

All government ministries involved in nurse education should ensure that programmes are designed, validated and implemented by nurses. Study results show that organised nursing does not play a significant role in the development of nurse education policy and as such those policies could be lacking vital professional elements. The involvement of organised nursing will also eliminate the turf wars and conflict that have the potential to derail the harmonisation project. Such a policy will also ensure that nurse education programmes across the country and under different ministries are all coordinated in such a way that there is seamless transition from one level to the other. The challenges to professionalism linked to inadequacy in nursing programme designs is an indication that going without organised nursing involvement impedes those education policies from having their maximum positive impact. The involvement of professionals will help ensure quality assurance because most often ministries are not able to monitor closely and ensure the qualitative implementation of nurse education policy. Organised nursing will help the state in this regard and ensure that nurse education is actually leading to the production of competent nurses who are more competent to help the state in its health related agenda.

6.2.2 Implications for nurse leaders

Highly educated nurses must recognise their leadership role and actively take up the responsibilities therein. As the findings show, there are already a number of highly educated nurses (with postgraduate qualifications) in the country but there exists no national forum that brings these leaders together. The findings show an expressed desire for qualified nurses to come forward and take the lead especially in the domain of nurse education policy. So nurse leaders from academic through administrative to clinical services must create a united front to consider the harmonisation project. The present state of affairs in the country presents a unique opportunity for nurse leaders to implement this project and seize control of nurse education. Government policy of liberalization has been going on for more than 15 years now and there is no guarantee that this policy will remain a priority one in another five years. Government policy might change or the government itself might change and the window to maximise the benefits of liberalization might close for the current generation. As participants indicated once a credible crop of educated leaders emerge on a united platform the rest of the profession is going to follow their lead. This leadership will establish criteria and guidelines for nursing programmes and set quality benchmarks that every nursing programme should meet. It will be able to harmonise all nurse education programmes while still retaining diversity. Their academic qualifications and involvement with higher education will increase their credibility with colleagues and even with government agencies. Liberalisation policy of the state was not about nurse education but as has been argued through this thesis, it presents a unique and the first such opportunity for nurses to take control and determine the future growth patterns of the profession. The one most vital component for seizing this passing moment is a united board of highly educated nurse leaders.

There must be a national curriculum revision project as part of the harmonization agenda. This is not a call for a national curriculum but as the findings indicated there is need for the harmonization of nurse education programmes in a way that provides uniformity in education. Participants suggested reviewing curricular to identify strengths and weaknesses from the current variety of programmes and use that to build a national competency framework for nurse education. From their proposals this

framework will define expectations of nurses (clearly defined scope of practice) at diploma level, bachelor's level, master's and doctoral levels and even the place of auxiliary care assistants. If this is accomplished then curricular could be redesigned to ensure that even with their diversity they ensure that at each level of training the nurse is able to acquire the desired competency. This will eliminate the confusion in role expectations generated by a variety of names and qualifications even for programmes of similar durations. Curricular revision will also help nurse leaders address the key weaknesses identified in the conceptualisation of nursing practice. Participants countered that present nurse education philosophy emphasises 'technical' practice i.e. a skills-based focus that fosters the presentation of nurses as assistants to physicians. They expect curricular to be designed to isolate and transmit the autonomy of nursing care and practice that requires the nurse to carve out and implement care decisions that are not physician directed. In this way consumers of nursing services will start recognising the nurse in the nurse as the autonomous practitioner he/she is and as such lead to higher social status for the profession. In the implementation of this effort, nurse leaders must focus on higher education and move the profession in that direction. This is because even as criticisms were made against the higher education model, there was strong support for higher education qualifications by the study participants. Results show that there is a strong desire for more advanced education programmes and opportunities, and the recognition of the fact that the current opportunity had not been available prior to liberalization. This adds pressure on nurse leaders to seize the opportunity of the moment because no one can bet on what will happen when government moves away from its liberalization agenda.

Nursing leaders must define a new identity for the nurse in Cameroon and indigenise nursing programmes. The results of this study showed that: the present nurse education model was brought in by Europeans during the colonial era; local care models were rejected and never incorporated into the training curriculum; local care models have only been studied as part of community health practice without a focus on incorporation of what works. In pursuing a mostly foreign concept of nursing, nurse education designers have missed the opportunity to study and incorporate local healthcare models into nurse education. Such a strategy will increase the cultural significance of nursing with

added benefits to the health system. It will also allow Cameroon's nursing to make a unique and valuable contribution to the expanding knowledge base of nursing as a profession. These local models will help to establish a new identity for the nurse as an independent professional since the current model being implemented fosters a perception of nursing as a subordinate profession. The conflicts being generated by an Anglophone and francophone perspective to nursing which are all foreign could potentially be mediated by the incorporation of traditional models which will give nursing a 'Cameroonian flair'. Just as the study results showed that participants wanted nurses to come together and reflect on their identity and role in Cameroon, seriously considering the indigenisation of aspects of the nursing curricular could potentially move that process forward within the harmonisation project. Patients and nursing students must be made to see the link between nursing and cultural philosophies they identify with. This will require nurse educators to collaborate with the existing association of tradi-practitioners in the country. Being the custodians of traditional models of healthcare, their experience and practice will be essential to nurse leaders as they seize the current opportunity to not only move to higher education but also professionalize nursing by the inclusion of local health models that work.

6.2.3 Implications for professions

Professions in every country must study and document their history. That history must be taught to students of that profession with a focus on how it shapes and influences the evolution of the profession. In the course of this study it was difficult to find well documented sources that clearly reveal a study of the history and evolution of nursing in Cameroon. It was during this study that the researcher learned about aspects of that history and only during data analysis that the researcher was able to understand how much its history was influencing the evolution of nurse education in Cameroon. The study results also show that even nurse leaders have not reflected on this aspect of the profession. Multiple births could be an unidentified factor in the evolution of many professions in different countries. This lack of collective reflection on origins will complicate the profession's efforts to establish its own identity and to build and expand on aspects that reflect that identity. In the case where the profession is created by the state for its own needs, the perception of the profession

could be differentiated from more internationally accepted roles as seen in this study. By studying and teaching their history and evolution professions can easily establish their identity and build up historical facts to take control of their own education process. In systems with centralised state control mastery of these facts will be a great tool as professions make efforts to renegotiate with the creator state their identity and status.

Professions in state dominated systems must rise and take control of their education and practice. It will be rare for a state that runs a centralised system of government to grant autonomy to professions spontaneously. That can most likely happen only where the profession has positioned itself to take that power. A strategy that is very important to achieve this outcome is the creation of the powerful professional body that represents the profession with skilled leadership to address burning issues. In this study participants decried the absence of such an organisation and cited it as a key factor to the slow pace of growth and professionalization of nursing. It is usually only through similar structures that the profession can seize the opportunity of the moment and capitalise on state policy to take control of their own narrative. In the study the results show that even though the government policy of liberalization has been in place since the early years of the 21st century, nursing and its leaders have failed to capitalise on that policy and take control of nurse education. So the absence of such a structure to organise professionals towards a particular goal makes it almost entirely impossible to seize the opportunity of the moment. For nursing in Cameroon, it will be essential to create as a matter of urgency a Cameroon Nursing body that is ready to regulate the profession. They have to be ready to take power for nursing regulation and urgently apply the opportunistic theory while the present government agenda of liberalization is still ongoing.

6.3 Considerations for Further Studies

The findings of this study and the implications presented does not claim to present the master solution to the all the issues that might be influencing nurse education in Cameroon. Considering that this study is the first of its kind carried out in this context, every aspect of the findings can serve as indicators for deeper and more specific studies. Each of the eight categories that emerged from this study will benefit from studies that focus on exploring the depth and breadth of the influence that

each of these have on nursing and nurse education in Cameroon. For example it has been established that multiple births characterised the origin of formal nurse education in Cameroon but this study can benefit from a further in-depth study of the phenomenon and its implications. Another typical example will be to find out why the 'regulative bargain' did not take place and how leadership issues may have contributed to that situation. These facts which have been exposed in this study will need further exploration in subsequent studies to strengthen the implications arrived at in this study.

A key question which has been raised in this study is about the Cameroonian model of nursing. The study found that cultural models of care were not integrated into modern nursing education but did not explore what these models looked like. A careful study into cultural models of care will be instrumental in achieving the change proposed in this study. It will provide to nurse educators, researchers and practitioners insight into cultural aspects whose inclusion in nursing education might improve the identity and independence of nursing and demonstrate a unique contribution that Cameroon nursing can contribute to the global identity and knowledge base of global nursing. The study suggests a dialogue with traditional-practitioners in Cameroon as a starting point to explore this potential. A study on how to effectively and successfully conduct that interaction and collaboration will definitely lend strength to the currently proposed model.

Equally helpful will be a study on establishing the logistical timeframe during which the harmonization project can effectively be implemented. In this study, the project is presented as key to addressing nurse control of nurse education at the moment, and as way of addressing further nursing issues going forward. Researchers might be interested in critically analysing the project within the context of other possible influencing factors to establish an achievable timeframe for implementation of the harmonisation project. This might be combined with another research problem to identify the best methods to facilitate inter-ministerial collaboration on the harmonisation project. The findings of such a study will play a vital role in the implementation process because it will provide empirical strategies to harness ministerial support.

The above examples are only a few suggested studies whose execution will lend strength to the theory of seizing the opportunity of the moment. As other researchers read these findings they are likely to ask even more questions based on their backgrounds, experience and research interests. The findings of such studies will add value to the current study.

6.4 Limitations of the Study

Constructivist grounded theory was the method used in this study for reasons outlined in chapter three of this thesis. There was a desire to conduct an analysis that would be very helpful and accessible for researchers and professionals who have an interest in the study area. A simple descriptive phenomenological study on hind sight would have provided an understanding of the evolution of nurse education as perceived by the study participants. In other words just the lived experience of the study participants (Benoliel, 1996). However, using the constructivist grounded theory design made it possible to both achieve this and also construct an embedded model that will be more useful to policy planners in Cameroon. This method permitted the researcher to build a theory that fits the study setting and emerged from the data without a priori assumptions (Glaser, 1978). The model provides a framework for both understanding their context and how that understanding could be elevated to a working strategy for the future. The opportunistic model is constructed from data that also includes the fears and aspirations of those holding different ideologies and from those very same facts demonstrated how harmonization as a tool could be used to achieve a united diversity in advancing education and professionalizing nursing. In this regard professionals and policy makers will find these results more useful than just an in-depth understanding of the situation. An in-depth explanation of the context will provide a good understanding but then risk the question “so what?” The opportunistic model pre-empts that question because it argues for a strategy of transforming that understanding into action that can achieve professional desires. The design also has more intellectual value in that it gives researchers and critics a model to debate on, critique, contest, adopt, expand and consider transferability to other contexts. In this light the study outcome justified the design adopted for the study and will remain the design of choice if the study were to be

repeated. However, if the study were to be repeated there will be some adjustments that could be considered a limitation to the present study.

Firstly, in this study documents from nursing associations were not considered because none of them is a national representative/regulatory body. Also none of the associations have published any policy position document on national nurse education policy. But it might be valuable to get into their minutes and reports to find out how the issue of nurse education is debated or considered within the different associations. In that light reports from such associations will be added to the list of documents to consider for the study. The documents might provide more illumination of group contexts. It could provide some insight into how nurse education and professionalizing strategies are debated and dealt with by the different groups. However, the impact of the elimination of these other groups of documents on the study result is greatly limited. This is because the use of a variety of data sources in the study context still provides a natural theoretical fit (Husein, Hirst, Salyers and Osuji (2014). Collecting official texts including legislation, government decrees and communiques in conjunction with in-depth interviews from the study setting ensured that high quality data was still collected. This combination of data sources helped the researcher to focus on the social processes going on within the study setting and not just lived experience of participants (Benoliel, 1996).

Secondly, considering the limitations on the amount of time to complete this PhD project there was need for careful selection of participants to obtain rich data. Rich data gives a new perspective of the study setting as well as a 'dense and concrete fabric' for the researcher to build a critical analysis (Charmaz, 2006). Information rich professionals had to be selected to maximise time and avoid getting lost in substandard data from less suitable study participants. This may raise criticisms of purposeful sampling rather than theoretical sampling. To limit the impact of this, the researcher started out with purposeful sampling for the first interviews and then let the emerging data guide the next set of interviews (Charmaz, 1989; Glaser, 1978). The same approach was used in the document analysis where issues and references raised in a particular document led to the search of documents that may illuminate those issues. This study did not include nurses who are just clinical practitioners or nurse teachers. One of the reasons for this is that theoretical sampling kept leading to nurses who

were more knowledgeable about nurse education policy processes in Cameroon. In a more elastic timeframe a more nuanced interview tool could be designed to capture the thoughts of this group of nurses. However, that again will also depend on the direction that emerging data will indicate.

Thirdly, the dependence on interviews meant that the researcher had to count on the participants' memory of historical events that were not properly documented. This has been described as recall bias (Coughlin, 1990) and could have affected accuracy of dates and figures from participants. However, this has a less significant impact on the study since the evolution of education was revisited over broad time periods. The use of official texts as data source also limited the effect of recall bias on the overall outcomes of the study.

Fourthly, the delayed literature review could be perceived as a limitation to this current study. Strauss and Corbin (1998) argue that a good awareness of the current state of knowledge in the study area increases 'theoretical sensitivity' such that the researcher can approach the data without making preconceived judgements on it. It also reveals the extent to which other studies have explored the study area (Schreiber, 2001; Hussein et al, 2014). The literature review done prior to data collection in this study was aimed at getting a general awareness of the study area. The researcher combined this with a constant reflexive process to capture his thoughts and positions as well as his knowledge of study area to enhance theoretical sensitivity while at the same time avoiding the thorough early review traditionally expected. Charmaz (2006) whose interpretation of grounded theory guided this study did not take a strong pro-early literature review stance but acknowledged the importance of the literature review with respect to situating your own work with extant literature. So the rigorous literature review was conducted during the data analysis phase directed by the emerging concepts from the data. In this way the emerging theory was discussed and analysed with appropriate comparison with relevant extant literature. This approach adopted in this study both ensured that the researcher did not impose any theoretical framework on the data and that the researcher complied with the recommendations of Glaser (1978; 1998) for a delayed review to avoid contaminating the research findings. In addition considering that nursing education in Cameroon had not been previously studied in this manner (based on the absence of published data on this) adopting the early

general review and delayed robust review allowed originality based on the context which is one of attractions of the grounded theory method. In other words the theory generated shows some similarities with other extant theories but also reveals unique properties embedded in the study context.

The fifth limitation to consider here is the limited generalizability of grounded theory like other qualitative research findings. Hussein et al, (2014) recognised that generalization remains controversial in qualitative research because most often the goal of qualitative research is to generate a 'rich and contextualised understanding' of study participants' experience. The goal therefore is not to produce generalizable concepts. However, grounded theory researchers argue that the method has significant generalizability potential. This comes from the fact that the method can equally generate theories that are not limited to a particular context (Hussein et al, 2014). Stebbins (2001) concurred, adding that a key purpose of exploratory research is to produce generalizations (about a group, process, activity, or situation under study) inductively. Acknowledging the controversy around the issue of generalizability, this research did not consider generalizability to a global context as part of its goal. The results and theory generated from them is embedded in the Cameroonian experience and could be generalized over the Cameroon setting. However, the potential for the application of the opportunistic theory in contexts out of Cameroon depend on the characteristics of such settings. In this regard the research process has been clearly described every step of the way and an audit trail maintained so that researchers in other settings can assess the extent to which the theory applies to settings other than Cameroon.

The sixth limitation centres on the arguments on the meaning of 'theory' considering its more earlier association with positivism. Theories are statements that demonstrate the hypothetical relationships among variables thought to cause some phenomenon of interest (Buchanan, 1994). In the positivistic orientation the objectives of theory are 'explanation' and 'prediction' (Charmaz, 2006) thus researchers test hypotheses by predicting the changes in the dependent variable that will occur following manipulation of the independent variable(s) (Buchanan, 1994). In positivist research theory will therefore 'seek causes, favour deterministic explanations, generalisability and universality'

(Charmaz, 2007). Theory will have to clearly demonstrate the relationship between variables and explain the nature of the relationships. Predictions then should be possible and generalizations clear for ‘theory’ to be accepted. As Buchanan (1994) explained, the theory must be testable i.e. based on the verification principle that valid knowledge must be empirically testable; generalizable; and demonstrate high capacity to reveal underlying dynamics of the phenomenon under study i.e. power. In this study the application of a strictly positivist assessment of theory may raise arguments against the theory of seizing the opportunity of the moment. The reason for this lies in the fundamental difference between the positivist and interpretive approaches to theory.

In the interpretivist definition of theory, the emphasis is not on the explanatory power of theory but on the understanding of theory. According to Charmaz (2006) interpretive theory calls for the ‘imaginative understanding’ of the studied phenomenon with the fundamental assumption that theory is emergent; linked to multiple realities; indeterminate; that facts and values are inextricably linked; truth is provisional; and social life is processual. From this standpoint the current study fits effectively with the interpretivist definition. The findings of the study demonstrated the inextricably linked historical and current factors that interplay on nurse education in Cameroon building on the realities of nurses and individuals and collective realities from studied official texts. The dynamism revealed in the study over time reflects the changing nature of the ‘truth’ of nurse education in Cameroon over time. The construction of theory from this data thus demonstrate not only these characteristics but also processual nature of social life by articulating the relationship between nurses, organised nursing and stakeholders like the state and how negotiation can alter that process. In achieving these, the theory of seizing the opportunity of the moment has effectively conceptualized nurse education in Cameroon to facilitate understanding it in abstract terms (Charmaz, 2006). Rooting the theory in data and comparing its properties to extant theories of relevance and a rich contextual interpretation of the emerging patterns and relationships (Charmaz, 2006) have demonstrated that the theory meets the aim of interpretive theory.

Lastly, this was a first attempt at fully applying constructivist grounded theory in a research project which could be seen as a limitation. There was always the risk that the researcher could become

overwhelmed with coding especially during initial coding since the process is “time consuming, tiring and laborious” (Myers, 2009). Hussein et al (2014) also warned that coding could be so engrossing that the novice researcher fails to discover emerging themes from the data. To manage this limitation the researcher carefully applied Charmaz’s (2006) guide to carrying out constructivist grounded theory. In addition, a keen interest and passion for nurse education created an excitement with the emerging data that helped avoid the pitfall of getting lost in the initial coding process. There was a genuine interest in what the data will reveal and as observed in the reflexive account in chapter three, the study was a voyage of discovery for the researcher himself. Constant input from experienced supervisors also helped to overcome the challenges posed by the grounded theory method to first time users. If repeated this experience will help the researcher to be more intuitive, but won’t necessarily lead to significantly different results.

6.5 Evaluating the Model

In the methods chapter the measures to ensure trustworthiness of this study were discussed following the work of Lincoln and Guba (1985). However, considering that the constructivist grounded theory methodology has been applied to this research, it is important to evaluate the constructed model using Charmaz’s (2006) criteria. She proposes credibility, originality, resonance and usefulness.

6.5.1 Credibility

Credibility is achieved by ensuring that intimate familiarity is established with the setting and topic, data is sufficient to merit claims, categories have been systematically compared and cover a wide range of empirical observations, strong logical links between data and arguments and the provision of evidence to allow the reader to form an independent assessment and agree with the researcher’s claims.

The results from this study were generated from a grounded analysis of data from interviews and official documents. Categories were developed from codes and focused codes generated from the data itself. Interpretations of these categories were substantiated with quotations from participants and documents alike. Some of the subcategories and categories that emerged and were woven

together to produce the final theory actually came from participants own words for example '*turf wars*', '*harmonisation*' and '*conceptualising nursing*'. In the interpretation of results, the reader can follow the researcher's trend of thought as categories were being created and their properties identified and fleshed out. A summary presentation of descriptive models generated from both the document analysis and from the interviews demonstrated the analytical process and the construction of categories. Moving from the framework built on the results to the opportunistic model continues to relate the categories to their source (which is the data) and to provide even more abstract explications of them. This clear demonstration of a process that was not necessarily linear as it appears allows the reader to form an independent assessment and to see how the theory emerges from the data.

6.5.2 Originality

Originality is verified by the freshness of the categories; evidence of new conceptual renderings of the data; social and theoretical significance of the study and evidence that the grounded theory challenges, extends, or refines current ideas, concepts and practices.

The opportunistic model constructed in this study offers new insights and conceptual renderings in the areas of the evolution of professions, change dynamics, professionalization, academisation and harmonization of nursing education. The creation and evolution of professions can be controlled by forces completely out of the profession itself. Nursing emerged as a task oriented role created by the state to achieve its health policy goals without evidence of any desire to create and advance a professional project. This is different from the view that profession are always organised and try to negotiate their regulation with the state. This brings a different dimension to how the origins of established professions within a particular setting could resemble the same common evolutionary pathways but yet retain distinct characteristics from the local setting.

Change dynamics as compared and contrasted with extant literature in this study shows that focus on group behaviour or characteristics in planned change is not sufficient. The impact of perceived personal loss was demonstrated here as a strong force against positive change from an entrenched elite. This personal loss which is not necessarily presented openly is a strong motivation behind

seemingly logical arguments against change efforts. So the argument is made strongly here that for change to occur, the fears over personal loss must be addressed in a forum for that purpose.

Academisation is one of the key categories to emerge from this study and is a very familiar concept in nurse education literature. However, in the context of this study it is emerging as an unplanned, unregulated concept. In other words though it retains the same meaning of moving nurse education to higher education, as opposed to the planned process common in literature, academisation is an accident of government agenda in the local setting. It is not a deliberately planned policy of the state or the professions. It does not reflect a shift to higher education but rather an entry of higher education which poses a set of controversies not seen in the usually planned process in different countries.

Harmonisation as demonstrated in extant literature is usually a process to standardise varied systems. This concept emerged as the cornerstone of the opportunistic model also as a process but again uniquely as a strategy, pathway and destination. It becomes a project that involves all these characteristics because by the participants' definitions, it will be the point at which controversies and conflicts on nurse education have been solved and not necessarily when all nurse education is at higher education level. It is also a medium to address policy debates within the profession on matters of education and beyond and a strategy to achieve professional control and influence over education policy and independence. So this is how a concept mostly linked to the standardisation of nurse education in higher education across countries in Europe (Bologna Process) emerges as a more complex concept in nurse education in Cameroon.

The professionalization of nursing emerges as closely dependent on the harmonisation project. Professionalization in this study has one other unique characteristic in that it is perceived as recognition of the nurse from the patient. This is linked to curriculum revision to create programmes that enable nurses to project the distinctiveness of nursing and earn the respect of patients. So while other aspects of professionalization, match with what is known, emphasising professional recognition

from the patient through an education project is built from the unique experience of nurses in the study context.

The theory therefore presents researchers, educators, and professionals with a new perception of the educational evolutionary process within different contexts. It demonstrates that familiar concepts might have global meanings which are different from contextual definitions as the concepts are constructed locally from the people's experiences and aspirations.

6.5.3 Resonance

This is about demonstrating that the theory portrays the fullness of the studied experience, reveals both liminal and unstable taken-for-granted meanings, shows links between larger institutions and individual lives and makes sense to participants/people who share their circumstances.

Prior to the study the researcher thought the study was going to revolve around education and curricular issues. But true to the emergent nature of grounded theory, the participants brought out more complex issues that were interpreted to be greatly influencing the educational trajectory. So the historical context and the evolution of the modern state of Cameroon became a component of those findings. The national government agenda of liberalization emerged as a defining unanticipated and unplanned era of the professional education project. This further demonstrated the extreme dependence and susceptibility of the nurse education process to government policy. So a project that was perceived from the beginning to be about just education has emerged as a more complex interaction between various factors beyond education including the political nature of the government. In a like manner, the fears and aspirations of individuals and how these relate to institutions they represent was exposed. So the perception of conflict is now couched within the broader context of multiple births and state control. Erratic education is a product of lack of autonomy and a state defined role and identity which is linked to both multiple births and the occurrence of complacency that wants to resist an unanticipated change. This complexity portrays the fullness of the studied experience and the interpretation is recognised by the participants and similar population as depicting their circumstances. This was confirmed when member-checking was done

with some study participants and nurses with similar characteristics as study participants but who did not take part in the study. All of them confirmed the findings and only added more evidence to support the categories.

6.5.4 Usefulness

This is about checking if the interpretations can be used by people in their daily lives, potential for further research, examination of any generic processes and contribution to knowledge.

First and foremost this study will be the first of its kind (no known publication of such) that examines nurse education in Cameroon especially using a grounded theory approach. The findings of the study contribute to the local and international nursing body of knowledge. The evolution of nurse education in Cameroon because of this study now exists in a form that can be empirically cited and challenged by nurses and other researchers. The uniqueness of the origin of the modern state of Cameroon and its impact on nurse education evolution creates another side to the professional project where the state creates and organises the profession for its own ends. The multiple birth and evolutionary process will be a new concept for Cameroonian nurses. Even as a well experienced nurse educator, the researcher only came to understand this historical context and its impact in the course of this study. Nursing programmes in the country don't explore the origins of the profession in Cameroon. International researchers can also have access to research literature on nurse education with the publication of these results.

Secondly, the theory can be used by nurses, change agents, professional advocates and researchers to advance policy goals and initiatives. The summary model showing the categories and their relationships as interpreted from the results provide a clear picture of the state of affairs and future potential of nurse education. The opportunistic model developed from there moves those results to an analytical level where they can be applied by professionals and policy makers. Nurse leaders will know where to start, how to go about and what to aim for in addressing the current challenges of nurse education in Cameroon. Out of Cameroon researchers can compare their situational context to the study context and see how the model fits or can be adapted to their context. Though this is a

model built around nurse education, the issues exposed and constructed could provide a new framework for looking at the evolution of the educational project for professions and occupational projects. Harmonization which is the central piece increases the potential for the theory to be applied in non-nursing situations.

Lastly, this theory will not be taken by researchers without question. Researchers will challenge it, explore it, build on it and in some extreme cases might even reject it. But for any of these outcomes to be considered they will have to be done through empirical processes thus provoking more research around the theory. The theory is very contextual, though the empirical process has been well documented to facilitate understanding and thus increase potential for transferability. Nurse leaders in Cameroon can use the theory and the recommendations of this study in an action research project to implement the harmonization project which will further strengthen the theory and demonstrate its application.

6.6 Conclusion

Nurse education in Cameroon has been critically analysed in the course of this study generating results demonstrating its nature and interacting factors. The lack of empirical literature on the subject in Cameroon was a challenge to the process of gathering facts and information to illustrate the study context. Nurse education was confirmed as originating from the colonial era as already commonly known but revealed the complex relationship that existed between unique factors influencing the start of nurse education in the country. The factors and the nature of their interactions generated ‘multiple births’ scenario that has been demonstrated to have held back the advancement of nurse education. At the start of the study, the researcher was expecting that the findings will be heavily based on curricular issues. The use of grounded theory methodology and the effective application of reflexivity helped the researcher focus on the emerging data and follow the emerging trends and patterns in the data. In this way the researcher had to follow emerging categories into issues regarding civil administration, the political philosophy of government, policy making processes, impact of government policies like liberalization, leadership capacity limitations, professional evolution, intra-professional conflicts and critical self-appraisal of nursing by nurses. All these concepts were not

anticipated at the start of the study just like harmonization and its nature. The findings it is believed have provided an imaginative interpretive understanding of nurse education in Cameroon generating a theory whose construction has been transparently documented to facilitate independent assessment.

The opportunistic theory to seize the opportunity of the moment is context-specific theory that demonstrates the relationships between the evolution of educational project of a profession and its origin. The theory demonstrates that national agenda can provoke growth and expansion of education as an unanticipated side effect. Consolidating and taking advantage of such opportunities greatly depends on the profession's ability to overcome conflicts and adopt a harmonization project. When combined with a desire for change and the higher education experience, harmonization becomes a vital tool to overcome conflicts and turf wars to achieve educational growth and professionalization. So, the opportunistic theory proposes the harmonization project as a professional tool to seize control of their education and advance professionalization (or other professional projects) when national agenda and a desire for change suddenly converge. The argument for the adoption of the harmonization project is made on the basis of the interpretation of the findings. These show that nurse education in Cameroon and the nursing profession run the risk of facing an aborted opening for advancement and professionalism through the opening provided by ongoing state policy of liberalization. In the event that that were to happen the profession will likely continue to experience reactive and stunted growths with the accompanying inability to conceptualize nursing practice and earn the respect of patients as well as individual and collective growth aspirations. Thus the study has illuminated the situation of nurse education in Cameroon, exposing its complex nature in a manner that the profession can rally and understand itself and adopt the recommendations herein to take control of its future. More than 50years of nurse education evolution has been covered in this study the findings and interpretation have revealed a dire situation as well as hope for the future. If the findings and recommendations of this study are not immediately adopted by organised nursing in Cameroon it is the researcher's empirical opinion that another generation of reactive and erratic development of nurse education will be unavoidable. So while a logistical timeframe for harmonization has not been proposed, there is a sense of urgency created by the fact that a key driver

of this process will be government's focus on implementing its liberalization agenda. Because nurse leaders and stakeholders have no way of knowing for how long this policy will remain a priority, the need to act now is very imperative.

REFERENCES

- Abbot P & Meerabeau L (1998) (eds) *The Sociology of the Caring Professions* (2nd Edition) London: UCA Press
- Abbott A (1988) *The System of Professions: An Essay on the Division of Expert Labour* Chicago: University of Chicago Press
- Adams L (2007) 'Nursing academic administration: Who will take the challenge?' *Journal of Professional Nursing* 23: 309-315 doi:10.1016/j.profnurs.2007.01.012
- Adebanjo F & Olubiyi K (2008) Reforms in Nursing Education: The National Open University of Nigeria Experience Online at http://www.nou.edu.ng/noun/acde2008/acde_en/papers.pdf/SUB-THEME%20II%20PDF/REFORMS%20IN%20NURSING%20EDUCATION%20THE%20NATIONAL%20OPEN%20UNIVERSITY%20OF%20NIGERIA%20EXPERIENCE_ADEBANJO-OLUBIYI.pdf [Accessed: 23 February 2013]
- Adelman C (2009) 'The Bologna process for US eyes: Re-learning higher education in the age of convergence'. In Collins S and Hewer I (2014) 'The impact of the Bologna process on nursing higher education in Europe: A review' *International Journal of Nursing Studies* 51(1): 150-156. DOI:1.1016/j.ijnurstu.2013.07.005
- Adelman D S (2002) *The transition from LPN to RN: Perceptions of LPNs considering the transition* Doctoral dissertation: University of Illinois at Urbana-Champaign
- Aiken L H, Clarke S P, Cheung R B, Sloane D M & Silber J H (2003) 'Educational levels of hospital nurses and surgical patient mortality' *Journal of the American Medical Association*, 290: 1617-1623
- Alexander B G (1995) *Nursing Colleges* Adler Museum In Horwitz S (2011) 'The nurse in the University: A history of university education for South African Nurses: A Case Study of the University of the Witwatersrand' *Nursing Research and Practice* 2011 doi:10.1155/2011/813270

Altmann T K (2011) 'Registered nurses returning to school for a bachelor's degree in nursing: Issues emerging from a meta-analysis of the research' *Contemporary Nurse* 39(2): 256-272

American Hospital Association (AHA) (2014) *Managing an Intergenerational Workforce: Strategies for Health Care Transformation*. In Dyess S M, Sherman R O, Pratt B A & Chiang-Hanisko L (2016) 'Growing nurse leaders: Their perspectives on nursing leadership and today's practice environment' *Online Journal of Issues in Nursing (ONLINE J ISSUES NURS)*, 21(1): 3-3. DOI: <http://0-dx.doi.org.serlib0.essex.ac.uk/10.3912/OJIN.Vol21No01PPT04>

American Organization of Nurse Executives (2014) *AONE position statement on the educational preparation for nurse leaders*. In Dyess S M, Sherman R O, Pratt B A & Chiang-Hanisko L (2016) 'Growing nurse leaders: Their perspectives on nursing leadership and today's practice environment' *Online Journal of Issues in Nursing (ONLINE J ISSUES NURS)*, 21(1): 3-3. DOI: <http://0-dx.doi.org.serlib0.essex.ac.uk/10.3912/OJIN.Vol21No01PPT04>

Andreski S (1974) *Social Sciences as Sorcery* Harmondsworth: Penguin

Andrukaitis S A (1995) 'Advocacy for bi-level differentiated nursing practice...second in a series of 3 articles' *Maine Nurse* 3-6

Antle May K (1986) 'Writing and Evaluating the Grounded theory Research Report'. In Chenitz W C & Swanson J M (eds) *From Practice to Grounded Theory* Mill Valley: Addison-Wesley, , California, pp. 146–154.

Associação Brasileira de Enfermagem (1980) Relatório Final do levantamento de recursos e necessidades de enfermagem no Brasil – 1956/1958. Brasília: ABEn

Awung W J & Atanga M (2011) 'Economic crisis and multi-party politics in Cameroon' *Cameroon Journal on Democracy and Human Rights* 5(1): 94-127

- Ayalaa A R, Fealy G M, Vanderstraetena R, & Brackea P (2014) 'Academisation of nursing: An ethnography of social transformations in Chile' *International Journal of Nursing Studies* 51 (4): 603–611 doi:10.1016/j.ijnurstu.2013.08.010
- Ayandiran E O, Irinoye O O, Faronbi O J & Mtshali N G (2013) 'Education reforms in Nigeria: How responsive is the nursing profession?' *International Journal of Nursing Education Scholarship*, 10(1): 1-8 doi 10.1515/ijnes-2012-0016
- Back KW (1992) 'This business of topology' *Journal of Social Issues* 48(2): 51–66
- Backman K & Kyngas A (1999) 'Challenges of the grounded theory approach to a novice researcher' *Nursing and Health Sciences* 1(3): 147–153
- Bahçecik N & Alpar S E (2009) 'Nursing education Turkey: from past to present' *Nurse Education Today* 29: 698–703
- Baird C T & Szczygiel B (2007) 'Sociology of professions: the evolution of landscape architecture in the United States' *Landscape Review* 12(1): 3-25
- Baser M (1997) 'Nursing during the Ottoman era and War of Independence' In: Köker A H (ed.) *History of Nursing and Its Development in Turkey*. Kayseri: Erciyes University press
- Baumann A & Blythe J (2008) 'Globalization of Higher Education in Nursing' *Online Journal of Issues in Nursing* 13(2) Manuscript 4
- Baumann A, Blythe J, Rheaume A & McKintosh K (2006) *Health Human Resource Series 3: Internationally educated nurses in Ontario: Maximizing the brain gain* (2nd edition.) Hamilton Ontario: Nursing Health Services Research Unit, McMaster University.
- Benoliel J Q (1996) 'Grounded theory and nursing knowledge' *Qualitative Health Research* 6: 406-428. Doi: [http://dx doi: 10.1177/104973239600600308](http://dx.doi.org/10.1177/104973239600600308)

- Berlant J L (1975) *Professions and monopoly: a study of medicine in the United States and Great Britain*. Berkeley, CA: University of California Press. In Macdonald K M (1995) *The Sociology of the Professions* London: Sage
- Blegen M, Goode C, Park S, Vaughn T & Spetz J (2013) 'Baccalaureate education in nursing and patient outcomes' *Journal of Nursing Administration* 43(2): 89-94 DOI: 10.1097/NNA.0b013e31827f2028
- Boschma G (2012) 'Community mental health nursing in Alberta Canada: an oral history' *Nursing History Review* 20: 103-135 DOI:10.1891/1062-8061.20.103
- Bowen G A (2009) 'Document Analysis as a Qualitative Research Method' *Qualitative Research Journal* 9 (2): 27-40
- Brady M (2010) 'Healthy nursing academic work environments' *Online Journal of Issues in Nursing* 15(1): Manuscript 6 doi:10.3912/OJIN.Vol15No01Man06
- Brown R (2011) 'The March on the market' In: Molesworth M, Scullion R & Nixon E (eds) *The marketization of higher education and the student as a consumer* London and New York: Routledge Taylor and Francis Group
- Brown R (2011) 'The March on the market'. In: Molesworth M, Scullion R & Nixon E (eds) *The marketization of higher education and the student as a consumer*. London and New York: Routledge Taylor and Francis Group
- Brown R, Falkingham E, Fischbach C, Nerud K & Schmidt H (2005) 'Meeting nursing shortage needs through educational partnerships LPN to RN under one roof' *Home Health Care Management & Practice* 18(1): 44-48
- Brush V L & Solchalski J (2007) 'International nurse migration: Lessons from the Philippines' *Policy, Politics and Nursing Practice* 8(1): 47-46
- Bryant A & Charmaz K (2007) *The Sage Handbook of Grounded Theory (Eds)* London: SAGE

- Buchanan D R (1994) 'Reflections on the relationship between theory and Practice' *Health Education Research, Theory & Practice*, 9(3): 273-283
- Burke L M (2006) 'The process of integration of schools of nursing into higher education' *Nurse Education Today* 26: 63–70
- Burnes B & Cooke B (2013) 'Kurt Lewin's field theory: a review and re-evaluation' *International Journal of Management Reviews* 15: 408–425 DOI: 10.1111/j.1468-2370.2012.00348.x
- Burnes B (2004) 'Kurt Lewin and complexity theories: back to the future?' *Journal of Change Management*, 4(4): 309-325, DOI: 10.1080/1469701042000303811
- Burrage M (1988) 'Revolution and the collective action of the French, American and English legal professions' *Law and Social Enquiry the Journal of the American Bar Foundation*, 13(2): 225-77. In Macdonald K M (1995) *The Sociology of the Professions* London: Sage
- Buttolph J J & Reynolds H T (2012) *Political Science Research Methods* (7th Edition) London: SAGE
- Callinicos A (1983) *Marxism and Philosophy* Oxford: Clarendon Press. In Ayala A R, Fealy G M, Vanderstraetena R, & Brackea P (2014) 'Academisation of nursing: An ethnography of social transformations in Chile' *International Journal of Nursing Studies* 51 (4): 603–611 doi:10.1016/j.ijnurstu.2013.08.010
- Cameroon Nursing Society (2011) *Book of Abstracts* 16th National Scientific Conference of Cameroon' Nurses Buea Cameroon
- Cantrell C H & Dickens M R (1982) 'Social Issues Influencing the Change Process' In Lancaster J & Lancaster W (eds) *Concepts for Advanced Nursing Practice: The Nurse as a Change Agent* St. Louis Missouri: The C.V. Mosby Company
- Carcary M (2009) 'The Research Audit Trial – Enhancing Trustworthiness in Qualitative Inquiry' *The Electronic Journal of Business Research Methods* 7(1): 11 - 24.

Carlos D J D, Padilha M I, Villarinho M V, Borenstein M S & Maia A R C R (2014) 'Nursing Schools in northeastern Brazil (1943-1975)' *Rev Rene* 15(2):326-33. DOI: 10.15253/2175-6783.2014000200018

Carr-Saunders A M & Wilson P M (1933) *The professions* London: Oxford University Press

Cartwright D (1952) 'Foreword' In Cartwright D (ed.) *Field Theory in Social Science: Selected Theoretical Papers by Kurt Lewin* London: Social Science Paperbacks

Carvalho A C (1965) 'Histórico da Escola de Enfermagem Job Lane' *Revista Brasileira de Enfermagem* 18 (2-3): 151-156.

Carvalho A C (1976) *Associação Brasileira de Enfermagem: 1926-1976 – Documentário* Folha Carioca Ed, Rio de Janeiro.

Chambers R Wakley G & Blenkinsopp A (2006) *Supporting Self-care in Primary Care* Abingdon: Raddiffe Publishing

Chan S & Wong F (1999) 'Development of basic nursing education in China and Hong Kong' *Journal of Advanced Nursing* 29: 1300-1307

Chang Y & Mark B (2009) 'Antecedents of severe and non-severe medication errors' *Journal of Nursing Scholarship* 41(1): 70-78 DOI:10.1111/j.1547-5069.2009.01253.x

Charmaz K (1989) 'Discovering chronic illness: Using grounded theory'. *Social Science and Medicine* 30: 1161-1172. Doi: [http://dx doi:10.1016/0277-9536\(90\)90256-R](http://dx.doi.org/10.1016/0277-9536(90)90256-R)

Charmaz K (2006a) *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis* London: Sage Publications Ltd.

Charmaz K (2006b) 'The Grounded Theory Method: An Explication and Interpretation' In: Emerson R M (Ed.) *Contemporary Field Research* Boston: Little Brown.

- Cocks G & Jarauch K H (eds) (1990) *German Professions 1800 – 1950* Oxford: Oxford University Press
- Collins S & Hewer I (2014) 'The impact of the Bologna process on nursing higher education in Europe: A review' *International Journal of Nursing Studies*, 51(1): 150-156. DOI:1.1016/j.ijnurstu.2013.07.005
- Cook L, Dover C, Dickson M, & Engh H (2010) 'Returning to school: The challenges of the licensed practical nurse-to-registered nurse transition student' *Teaching & Learning in Nursing* 5: 125-128
- Cooper D, Lowe A, Puxty A, Robson K & Wilmott H (1988) 'Regulating the UK accountancy profession: episodes on the relation between the profession and the state' Paper presented at Economic and Social Research Council Conference on Corporatism at the Policy Studies Institute, London
- Corbin J & Strauss A (2008) *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd edition) Thousand Oaks CA: Sage.
- Corbin J & Strauss A L (1990) Grounded theory research: Procedures, canons, and evaluative criteria *Qualitative Sociology* 13(1): 3-21
- Coughlin S (1990) Recall bias in epidemiological studies *Journal of Clinical Epidemiology* 43(1): 87-91
- Cronin P, Ryan F & Coughlan M (2008) 'Undertaking a literature review: a step-by-step approach' *British Journal of Nursing*, 17(1): 38-43
- Cutcliffe J (2000) 'Methodological issues in grounded theory' *Journal of Advanced Nursing* 31(6), 1476–1484
- D'Antonio P (2004) 'Women, Nursing, and Baccalaureate Education in 20th Century America' *Journal of Nursing Scholarship* 36: 379–384 doi: 10.1111/j.1547-5069.2004.04067.x

- Davies R (2008) 'The Bologna process: The quiet revolution in higher education' *Nurse Education Today* 28: 935–942
- Dean E (2009) 'Will nurses who do not have a degree be left behind on the career ladder?' *Nursing Standard* 24: 12-13
- DeLancey M W (1987) 'The construction of the Cameroon political system: The Ahidjo years, 1958–1982' *Journal of Contemporary African Studies* 6: 1-2
- Dent E B & Goldberg S G (1999) 'Challenging resistance to change' *Journal of Applied Behavioral Science* 35 (1): 25–41
- Department of Health (1989) *A Strategy for Nursing London* HMSO In Welford C (2002) 'Transformational Leadership in Nursing: Matching Theory to Practice' *Nursing Management* 9(4): 7-12
- Dey I (1999) *Grounding Grounded Theory: Guidelines for Qualitative Inquiry* San Diego CA: Academic Press
- Digby A (2006) *Diversity and Division in Medicine: Health-Care in South Africa from the 1800s* New York: Peter Land
- Dyess S M, Sherman R O, Pratt B A & Chiang-Hanisko L (2016) 'Growing nurse leaders: Their perspectives on nursing leadership and today's practice environment' *Online Journal of Issues in Nursing (ONLINE J ISSUES NURS)*, 21(1): 3-3. DOI: <http://dx.doi.org/10.3912/OJIN.Vol21No01PPT04>
- Dyson S (2005) 'Life History and Zimbabwean Nursing Student: "Global Boarder"' *Management in Education*, 19(1): 8-11
- Dyson S & Norrie P (2010) *Fundamental Aspects of Research for Nurses* London: Quay Books
- Economic and Social Research Council ESRC (2010) *Framework for Research Ethics (FRE)* Online at <http://www.esrc.ac.uk/about-esrc/information/research-ethics.aspx> [Accessed on: 28 May 2012]

- Edwards S D (1999) 'The idea of nursing science' *Journal of Advanced Nursing* 29(3): 563–569
- Ehlers V J (2002) 'Nursing education in the Republic of South Africa' *Nurse Educator* 27(50): 207–209
- Eide P & Allen C B (2005) 'Recruiting transcultural qualitative research participants: A conceptual model' *International Journal of Qualitative Methods* 4(2):44-56
- Eisner E W (1991) *The enlightened eye: Qualitative inquiry and the enhancement of educational practice* Toronto: Collier Macmillan Canada.
- Erikson R & Goldthorpe J H (1992) *The Constant Flux: a Study of Class Mobility in Industrial Societies* Oxford: Clarendon Press
- Estabrooks C A, Midodzi W K, Cummings G G, Ricker K L & Giovannetti P (2005) 'The impact of hospital nursing characteristics on 30-day mortality' *Nursing Research* 54: 74-84
- Federal Ministry of Education, Education Analysis Unit (2005) *Nigeria education sector diagnosis (a condensed version): A framework for re-engineering the education sector* In Ayandiran E O, Irinoye O O, Faronbi O J & Mtshali N G (2013) 'Education reforms in Nigeria: How responsive is the nursing profession?' *International Journal of Nursing Education Scholarship*, 10(1): 1-8 doi 10.1515/ijnes-2012-0016
- Fielding A & Portwood D (1980) 'Professions and the state – towards a typology of bureaucratic professions' *Sociological Review* 28(1): 23-54
- Fitzpatrick R & Boulton M (1994) 'Qualitative Methods for Assessing Health Care' *Qual Saf Health Care* 3: 107 -113.
- Freidson E (2001) *Professionalism: The Third Logic* London: Polity Press.
- Friedrichs A & Schaub H (2011) 'Academisation of the Health Professions – Achievements and Future Prospects' *GMS Z Med Ausbild* 28(4): Doc50 doi: 10.3205/zma000762 PMID: PMC3244734

Friese C R, Lake E T, Aiken L H, Silber J H, & Sochalski J (2008) 'Hospital nurse practice: Environments and outcomes for surgical oncology patients' *Health Services Research*, 43(4):1145-1163

Fröhlich R (2005) "Professionalisierung" In: Günther B G, Fröhlich R & Szyszka P (eds) *Handbuch der Public Relations, Wissenschaftliche Grundlagen und berufliches Handeln*. Mit Lexikon Wiesbaden: VS Verlag. In Balaban D C (2013) 'Development of communication science in Romania: Challenges and perspectives' *Professional Communication and Translation Studies* 6(1-2) Online: <http://www.cls.upt.ro/files/maria-nagy/SITE/Publicatii/01%20Balaban.pdf> [Accessed: 26 April 2016]

Furedi F (2011) 'Introduction of marketization of higher education' In: Molesworth M, Scullion R, & Nixon E (eds) *The marketization of higher education and the student as a consumer* London and New York: Routledge Taylor and Francis Group

Geison G W (eds) (1984) *French Professions and the State, 1700-1900* Philadelphia: Pennsylvania University Press

Glaser B (1978) *Theoretical Sensitivity* Mill Valley: The Sociology Press.

Glaser B (1992) *Emergence vs Forcing: Basics of Grounded Theory Analysis* Mill Valley: Sociological Press

Glaser B G & Strauss A L (1967) *The Discovery of Grounded Theory: Strategies for Qualitative Research* Chicago: Adeline

Glaser B G (2002) 'Constructivist Grounded Theory?' *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, 3(3): Art 12. In Bryant A & Charmaz K (2007) *The Sage Handbook of Grounded Theory (Eds)* London: SAGE

Glaser, B. (1998) *Doing grounded theory: Issues and discussions* Mill Valley CA: Sociology Press

Glen S (1995) 'Towards a new model of nursing education' *Nurse Education Today* 15: 90-95

Gomes T O, Silva B R, Baptista S S & Almeida Filho A J (2005) Enfermeiras católicas em busca de melhores posições no campo da educação e da prática em Enfermagem nos anos 40 e 50 no Brasil, século XX *Texto Contexto Enferm* 14(4):506-12.

Goulding C (1999) 'Grounded Theory: some reflections on paradigm, procedures and misconceptions' Working Paper Series: Management Research Centre University of Wolverhampton

Goulding C (2002) *Grounded Theory: A Practical Guide for Management, Business and Marketing Researchers* London: Sage.

Gregorutti G, Espinoza O & González L E (2016) 'Trans-Nationalization of Latin American Higher Education' In: Francois E J, Avoseh M B M & Griswold (eds) *Perspectives in Transnational Higher Education* SensePublishers

Gustavo G, Oscar E, Eduardo G L & Javier L (2016) 'What if privatising higher education becomes an issue? The case of Chile and Mexico' *Compare: A Journal of Comparative & International Education* 46 (1): 136-158,

Haddan S C & Lester M (1994) 'Grounded Theory Methodology as a Resource for Doing Ethnomethodology' In: Glaser B G (ed) *More Grounded Theory Methodology: A Reader* 159-180 Mill Valley CA: Sociology Press

Halstead J (ed) (2007) 'Nurse educator competencies: Creating an evidence-based practice for nurse educators' New York NY: National League for Nursing

Harvey L & Mason S & Ward R (1995) *The Role of Professional Bodies in Higher Education Quality Monitoring* Birmingham: Quality in Higher Education Project.

Hek G & Moule P (2006) '*Making Sense of Research: An Introduction for Health and Social Care Practitioner*' (3rd Edition), London: Sage Publications

Henderson V (1966) *The nature of nursing: A definition and its implications, practice, research and education* New York: Macmillan.

Hengen, P. (2010). 'The "Bologna Process" in European higher education: Impact of bachelor's and Master's degrees on German medical education'. *Teaching & Learning Medicine*, 22, 142–147.

Hickey G (1997) 'The use of literature in grounded theory' *NT Research* 2: 371–379.

Higher Education Better Regulation Group (HEBRG) (2011) *Professional, statutory and regulatory bodies: an exploration of their engagement with higher education* Online http://www.hebetterregulation.ac.uk/OurWork/Documents/HEBRG_PSRB%20report_FINAL.pdf [Accessed: 22 September 2012]

Holloway I (1997) *Basic Concepts for Qualitative Research* London: Blackwell Science

Hong Y S & Yatsushiro R (2003) 'Nursing education in China in transition' *Journal of Oita Nursing and Health Sciences* 4: 41–47

Hooper J, McEwen M & Mancini M (2013) A regulatory challenge: Creating a metric for quality RN-to-BSN programs *Journal of Nursing Regulation* 4:34–38

Horwitz S (2011) 'The nurse in the University: A history of university education for South African Nurses: A Case Study of the University of the Witwatersrand' *Nursing Research and Practice* 2011 doi:10.1155/2011/813270

Hughes E (1963) *Men and their work* New York: Free Press In Abbot P & Meerabeau L (1998) 'Professionals, professionalism and the caring professions' in: Abbot P & Meerabeau L (eds) *The Sociology of the Caring Professions* (2nd Edition) London: UCA Press

Huijjer H A S, Nouredine S & Dumit N (2005) 'Nursing in Lebanon' *Applied Nursing Research* 18: 63–64

Humphreys J & Francis B (1999) 'Rationalisation and professionalisation: a comparison of the transfer of registered nurse education to higher education in Australia and the UK' *Comparative Education Volume* 35(1): 81–96

- Hussein M E, Hirst S, Salyers V & Osuji J (2014) 'Using Grounded Theory as a Method of Inquiry: Advantages and Disadvantages' *The Qualitative Report* 19(27): 1-15 Online <http://nsuworks.nova.edu/tqr/vol19/iss27/3> [Accessed: 28 February 2016]
- Hutchinson L, Mitchell C & St John W (2011) 'The transition experience of enrolled nurses to a bachelor of nursing at an Australian university' *Contemporary Nurse* 38(1-2): 191-200 DOI: <http://0-dx.doi.org.serlib0.essex.ac.uk/10.5172/conu.2011.38.1-2.191>
- Hutchison S A (1993) Grounded theory: The Method In: Munhall P L & Boyd C A (eds) *Nursing Research: A Qualitative Perspective* New York: National League for Nursing Press
- Hylton J (2005) 'Relearning how to learn: Enrolled nurse transition to degree at a New Zealand rural satellite campus' *Nurse Education Today* 25(7): 519-526
- Illich I et al (1977) *Disabling Professions* London: Boyars
- Institute of Medicine (2010) *The Future of Nursing Leading Change Advancing Health: Focus on Education* Online <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx> [Accessed: 18 February 2012]
- International Monetary Fund (2008) *Globalization* In Baumann A & Blythe J (2008) 'Globalization of Higher Education in Nursing' *Online Journal of Issues in Nursing* 13(2) Manuscript 4
- Iphofen R (2009) *Ethical Decision-Making in Social Research: A Practical Guide* Hampshire: Palgrave Macmillan
- Jackson C, Bell L, Zabalegui A, Palese A, Sigurdardottir A K & Owen S (2009) 'A review of nurse educator career pathways: A European perspective' *Journal of Research in Nursing* 14: 111-122
- Johnson T (1972) *Professions and Power* London: Macmillan
- Joppke C (1992) 'Explaining cross-national variations of two anti-nuclear movements: a political process perspective' *Sociology* 26(2): 311-32

Junang J (1996) *Rapport d'Activités du Président du Conseil de L'Ordre (1991-1996)* Assemblée Générale de L'Ordre 2eme Session Ordinaire Yaoundé 26 Avril 1996.

Kamta C (1999) *Quel Passe pour la Profession Infirmière au Cameroun*. Paper presented at the 5th National Scientific Conference of Cameroon's Nurses Buea Cameroon

Karkos B, & Peters K (2006) 'A Magnet Community Hospital: Fewer Barriers to Nursing Research Utilization' *Journal of Nursing Administration* 36(7/8): 377–382.

Kenny G (2004) 'The origins of current nurse education policy and its implications for nurse educators' *Nurse Education Today* 24: 84–90

Khadria B (2007) 'International recruitment in India' *Health Services Research*, 42(Suppl.1): 1429-1436.

Khomeiran R T & Deans C (2007) 'Nursing education in Iran: Past, present, and future' *Nurse Education Today* 27: 708–714

King L (2006) 'Distance learning – meeting Africa's need for quality nursing care' [Guest editorial]. *International Nursing Review* In Baumann A & Blythe J (2008) 'Globalization of Higher Education in Nursing' *Online Journal of Issues in Nursing* 13(2) Manuscript 4

Knight J (2003) 'Updating the definition of internationalization' *International Higher Education* In Baumann A & Blythe J (2008) 'Globalization of Higher Education in Nursing' *Online Journal of Issues in Nursing* 13(2) Manuscript 4

Konings P (2011) *The Politics of Neoliberal Reforms in Africa: State and civil society in Cameroon* Bamenda: Langaa & African Studies Centre

Kumm S, Godfrey N, Martin D, Tucci M, Muenks M & Spaeth T (2014) 'Baccalaureate outcomes met by associate degree nursing programs' *Nurse Educator* 39(5): 216-220. doi:10.1097/NE.0000000000000060

- Lahtinen P, Kilpi H L & Salminen L (2014) 'Nursing education in the European higher education area: Variations in implementation' *Nurse Education Today* 34: 1040–1047
- Laiho A (2010) 'Academisation of nursing education in the Nordic Countries' *Higher Education* 60(6): 641-656 Online at <http://www.jstor.org/stable/40930316> [Accessed: 09 March 2015]
- Lancaster J & Lancaster W (1982) *Concepts for Advanced Nursing Practice: The Nurse as a Change Agent* (eds) St. Louis Missouri: The C.V. Mosby Company
- Larson M S (1977) *The Rise of Professionalism: A Sociological Analysis* London: University of California Press
- Le Vine V T (1971) *The Cameroons Federal Republic* Ithaca/London: Cornell University Press
- Lee Y K (2005) 'Nursing and the beginnings of specialised nursing in early Singapore' *Singapore Med Journal*, 46(11): 600
- Levačić R (1995) *Local management of schools: analysis and practice* Milton Keynes: Open University Press
- Lewin K (1943) Defining the 'Field at a given time' In Cartwright D (ed) (1952) *Field Theory in Social Science: Selected Theoretical Papers by Kurt Lewin* London: Social Science Paperbacks
- Lewin K (1946) 'Action research and minority problems' In: G.W. Lewin (ed) (1948) *Resolving Social conflict* London: Harper & Row
- Lewin K (1947b) 'Group decisions and social change' In: T.M. Newcomb and E.L. Hartley (eds) (1959) *Reading in Social Psychology* New York: Henry Holt
- Lewin M (1998) Kurt Lewin: his psychology and a daughter's recollections In: Kimble G A & Wertheimer M (eds) *Portraits of Pioneers in Psychology* 3: 105–120
- Lewindia N (1999) 'The Way Forward for the Nursing Profession in Cameroon' Paper presented at the 5th National Scientific Conference of Cameroon's Nurses Buea Cameroon

- Liese B & Dussault G (2004) *The state of the health workforce in Sub-Saharan Africa: evidence of crisis and analysis of contributing factors* Online at sitesources.worldbank.org/AFRICAEXT/Resources/No_75.pdf [Accessed: 24 December 2014]
- Lincoln Y S & Guba E G (1985) *Naturalistic Inquiry* Newbury Park CA: Sage.
- Lindley J & Machin S (2012) 'The quest for more and more education: Implications for social mobility' *Fiscal Studies The Journal of Applied Public Economics* 33(2): 265-286 DOI: 10.1111/j.1475-5890.2012.00161.x
- Lucka M V (1946) 'Korea: a challenge to western nursing' *The American Journal of Nursing*, 46(10), 668-670. Online at <http://www.jstor.org/stable/3457231> [Accessed: 24-05-2015]
- Lynn-McHale D & Deatrick J (2000) 'Trust between family and health care provider' *Journal of Family Nursing*, 6(3): 210-230.
- Maboh M N (2009) *Teaching in Practice: Assessing the Role of the Clinical Nurse as Teacher*. Master's Thesis University of Buea (Unpublished).
- Maccoby M & Scudder T (2011) 'Strategic intelligence: A conceptual system of leadership for change' *Performance Improvement*, 50(3): 1-12. Doi: 10.1002/pfi.20205
- Macdonald K M (1995) *The Sociology of the Professions* London: Sage
- Mackie J W & Bagallay O (1954) 'Nursing education in Africa, *The American Journal of Nursing* 54(8): 984-985 Online at <http://www.jstor.org/stable/3460742> [Accessed: 24 May 2015]
- Maingeh L C (1999) '*The History of Nursing across the World*' Paper presented at the 5th National Scientific Conference of Cameroon's Nurses Buea Cameroon
- Mann M (1993) *The sources of social power* Vol II Cambridge: Cambridge University Press
- Marks S (1994) *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* Johannesburg: Witwatersrand University Press

- Marquis B, & Huston C (2008) *Leadership roles and management functions in nursing: theory and application* (6th edition) Philadelphia PA: Lippincott Williams & Wilkins
- Marshall T H (1963) *Sociology at the crossroads*, London: Heinemann In Abbot P & Meerabeau L (1998) 'Professionals, professionalism and the caring professions' in: Abbot P & Meerabeau L (eds) *The Sociology of the Caring Professions* (2nd Edition) London: UCA Press
- May K (1994) 'Abstract knowing: the case for magic in method' In: Morse J (ed) *Critical issues in Qualitative Research Methods* London: Sage
- McCann C R & Kim S K (2003) *Feminist theory reader: Local and global perspectives*. New York NY: Routledge.
- McCleary L., & Brown G (2003) 'Association between Nurses' Education about Research and their Research Use' *Nurse Education Today* 23: 556–565.
- McGhee G, Marland G R & Atkinson J (2007) 'Grounded theory research: literature reviewing and reflexivity' *Journal of Advanced Nursing* 60(3): 334–342 doi: 10.1111/j.1365-2648.2007.04436.x
- Meerkerk E N (2010) 'Professionalization of Public Service: Civil Servants in Dordrecht, 1575-1795' *Journal of Urban History* XX(X): 1–23 DOI: 10.1177/0096144209359146
- Mekwa J (2000) *Transformation in Nursing Education* Book Chapter Online at http://www.healthlink.org.za/uploads/files/chapter13_00.pdf [Accessed: 23 February 2013]
- Melies A & Dracup K (2005) 'The case against the DNP: history, timing, substance, and marginalisation' *Online Journal of Issues in Nursing* 10(3). In Ponte R P & Nocholas P K (2015) 'Addressing the confusion related to DNS, DNSc, and DSN degrees, with lessons for the nursing profession' *Journal of Nursing Scholarship* 47(4): 347-353 doi:10.1111/jnu.12148
- Melrose S & Gordon K (2008) 'Online post LPN to BN students' views of transitioning to a new nursing role' *International Journal of Nursing Education Scholarship* 5(1): 1-18

- Merten K (1999) *Einführung in die Kommunikationswissenschaft*, Opladen: Westdeutscher Verlag
- Balaban D C (2013) 'Development of communication science in Romania: Challenges and perspectives' *Professional Communication and Translation Studies* 6(1-2) Online at: <http://www.cls.upt.ro/files/maria-nagy/SITE/Publicatii/01%20Balaban.pdf> [Accessed: 26 April 2016]
- Miles M B & Huberman A M (1994) *Qualitative Data Analysis* (2nd edition) Thousand Oaks CA: Sage Publications.
- Miller C L & Leadingham C (2010) 'A formalized mentoring programme for LPN-to-RN students' *Teaching & Learning in Nursing* 5: 149-153
- Miller-Rosser K Chapman Y & Francis K (2009) 'The use of oral testimony when reconstructing nursing history: a Saudi Arabian experience' *Singapore Nursing Journal* 36(1): 23-34
- Mills J S (1978) 'Grotes Plato' In: Robson J M (ed) *Collected works of John Stuart Mill*. Vol II Toronto: University of Toronto Press. In Furedi F (2011) 'Introduction of marketization of higher education' In: Molesworth M, Scullion R, & Nixon E (2011) (eds) *The marketization of higher education and the student as a consumer* London and New York: Routledge Taylor and Francis Group
- Minford P (1987) 'The role of the social services: A view from the right' In: Loney M, Bockock B, Clarke J, Cochrane A, Graham P & Wilson M (eds) *The state of the market* London: Sage
- Ministry of Higher Education Cameroon (2014) Portal of Private Higher Education Institutions Online at www.minesup.gov.cm/ipescam/en/about.php [Accessed: 28 December 2014]
- Minnick A, Norman L, Donaghey B, Fisher L & McKirgan I (2010) 'Leadership in doctoral nursing research program' *Journal of Nursing Education* 49: 504-510
- Mitchell G (2013) 'Selecting the best theory to implement planned change' *Nursing Management* 20 (1): 32-37

- Molesworth M, Scullion R, & Nixon E (2011) (eds) *The marketization of higher education and the student as a consumer* London and New York: Routledge Taylor and Francis Group
- Moreira A & Oguisso T (2005) *Profissionalização da Enfermagem Brasileira* Rio de Janeiro: Guanabara-Koogan
- Morrison C M (2014) *A heroic service? An oral history of district nursing in the Outer Hebrides from 1940-1974* Dissertation, University of Manchester Online <http://0-eds.a.ebscohost.com.serlib0.essex.ac.uk/eds/detail>
- Morse J A (2007) 'Sampling in Grounded Theory' In: Bryant A & Charmaz K (eds) *The Sage Handbook of Grounded Theory* London: SAGE
- Mruck K & Günter M (2007) 'Grounded Theory and Reflexivity' In: Bryant A & Charmaz K (eds) *The Sage Handbook of Grounded Theory* London: SAGE
- Mullen P D & Reynolds R (1978) 'The Potential of Grounded Theory for Health Education Research: Linking Theory and Practice' *Health Education Monographs* 6(3): 280-294
- Munhall P A (2012) *Nursing Research: A Qualitative Perspective* (5th Edition) Sudbury: Jones and Bartlett Learning.
- Myers M D (2009) *Qualitative research in business & management* Thousand Oak CA: Sage
- National Institute of Health (2009) *Belmont Report: Ethical Principles and Guidelines for Research Involving Human Subjects*. In Tappen R M (2011) *Advanced Nursing Research: From Theory to Practice* Sudbury: Jones and Bartlett Learning
- National League of Nursing (2006) *Excellence in nursing education model* New York NY: Author
- National Observatory for Human Resources for Health Cameroon NOHRHC (2010) *Cameroon: analysis of human resource situation for health* Ministry of Public Health Online at www.cm-minsante-drh.com/site/index.php/en/offre-de-formation/2013-03-25-13-49-11 [Accessed: 20th of December 2014]

- Ndatsu P N (2002) Nursing and midwifery council of Nigeria's role in maintaining standards in nursing education and practice In Ayandiran E O, Irinoye O O, Faronbi O J & Mtshali N G (2013) 'Education reforms in Nigeria: How responsive is the nursing profession?' *International Journal of Nursing Education Scholarship*, 10(1): 1-8 doi 10.1515/ijnes-2012-0016
- Neil S J (2006) 'Grounded Theory Sampling: The Contribution of Reflexivity' *Journal of Research in Nursing* 11(3): 253-260. In Bryant A & Charmaz K (eds) *The Sage Handbook of Grounded Theory* London: SAGE
- Neuman B & Fawcett J (Eds.) (2011) *The Neuman systems model* (5th edition) Upper Saddle River NJ: Pearson
- Neves E & Mauro M (2000) 'Nursing in Brazil: Trajectory, Conquests and Challenges' Online Journal of Issues in Nursing, 6 (1) Available www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume62001/No1Jan01/ArticlePreviousTopic/NursinginBrazil.aspx [Accessed 20th December 2014]
- Nikbakht N A, Emami A & Parsa Y Z (2003) 'Nursing experience in Iran' *International Journal of Nursing Practice* 9 (2): 78–86
- Nikbakht N A, Lipson J G & Emami A (2004) 'Professional nursing in Iran: an overview of its historical and sociocultural framework' *Journal of Professional Nursing* 20 (6): 396–402
- Oguisso T & De Freitas G F (2015) 'Brazilian nursing history on the shoulders of giants' *International Nursing Review* 62: 75–81
- Oguisso T (1996) 'Professional nursing in Brazil' *International Nursing Review* 43(3): 81– 84
- Oguisso T (2007) *Trajetória histórica e legal da Enfermagem* (2nd edition) São Paulo: Manole
- Oliver P (2003) *The Research Student's Guide to Research Ethics* Philadelphia: Open University Press

- Özaydın Z (2006) 'Upper social strata women in nursing in Turkey' *Nursing History Review* 14: 161–174
- Paixão W (1951) *Páginas da Historia da Enfermagem* Rio de Janeiro: Universidade do Brasil
- Palese A, Zabalegui A, Sigurdardottir A K, Bergin M, Dobrowolska B, Gasser C, Pajnikihar M & Jackson C (2014) 'Bologna process, more or less: nursing education in the European Economic Area: a discussion paper' *International Journal of Nursing Education Scholarship* 11(1): 1–11 doi 10.1515/ijnes-2013-0022
- Paniagua H (2002) 'Planning research: methods and ethics' *Practice Nursing* 13(1): 22–5
- Pang M C S, Arthur, D G & Wong T K S (2000) 'Drawing a qualitative distinction of caring practices in a professional context: The case of Chinese nursing' *Holistic Nursing Practice* 15: 22–31
- Parry N C A & Parry J (1976) *The rise of the medical profession: a study of collective social mobility* London: Croom Helm. In Macdonald K M (1995) *The Sociology of the Professions* London: Sage
- Parsons T (1954) *Essays in sociological theory* In Abbot P & Meerabeau L (1998) 'Professionals, professionalism and the caring professions' In: Abbot P & Meerabeau L (eds) *The Sociology of the Caring Professions* (2nd edition) London: UCA Press
- Patelarou E, Vardavas, C I, Ntzilepi P & Sourtzi P (2009) 'Nursing education and practice in a changing environment: the case of Greece' *Nurse Educ. Today* 29: 840–844
- Patricio M & Harden R M (2010) 'The Bologna process – A global vision for the future of medical education' *Medical Teacher*, 32:305–315
- Patterson B J & Krouse A M (2015) 'Competencies for leaders in nursing education' *Nursing Education Perspectives* 36(2): 76–82 doi:10.5480/13-1300
- Patton M Q (1990) *Qualitative evaluation and research methods* (2nd edition) Newbury Park CA: Sage

- Pellegrino E D (1968) 'Rationale for Nursing Education in the University' *The American Journal of Nursing* 68(5): 1006-1009 Online at <http://www.jstor.org/stable/3453625> [Accessed: 24 May 2015]
- Pera S A & Van Tonder S (2005) *Ethics in Health Care* (2nd edition) Cape Town: Juta
- Phillips K P A (2008) *Queensland health: Formulation of a best practice model for clinical education and training for nurses/midwives in Queensland*, Options Paper In: Hutchinson L, Mitchell C & St John W (2011) 'The transition experience of enrolled nurses to a bachelor of nursing at an Australian university' *Contemporary Nurse* 38(1-2): 191-200 DOI: <http://0-dx.doi.org.serlib0.essex.ac.uk/10.5172/conu.2011.38.1-2.191>
- Pittman P M, Kurtzman E T & Johnson J E (2014) 'Academic progression models in nursing: Design decisions faced by administrators in four case studies' *Journal of Nursing Education* 53: 329–335. doi:10.3928/01484834-20140520-03
- Polit D F & Beck C T (2004) *Nursing Research: Principles and Methods* (7th edition) Philadelphia: Lippincott William and Wilkins
- Ponte R P & Nocholas P K (2015) 'Addressing the confusion related to DNS, DNSc, and DSN degrees, with lessons for the nursing profession' *Journal of Nursing Scholarship* 47(4): 347-353 doi:10.1111/jnu.12148
- Porter-Wenzlaff L F & Froman R D (2008) 'Responding to increasing RN demand: Diversity and retention trends through an accelerated LVN-to-BSN curriculum' *Educational Innovations* 47(5): 231-235
- Prior L (2008) 'Repositioning Documents in Social Research' *Sociology* 42: 5821–36
- Prior L (2010) *Documents in Health Research* In: Bourgeault I, Dingwall R & De Vries R (eds) *The Sage Handbook Qualitative Methods Health Research* London: SAGE Publications Ltd at Essex University Library DOI: <http://dx.doi.org/10.4135/9781446268247.n22> [Accessed 26 February 2015]

- Rafferty A M, Traynor M, Thompson D R, Illot I & White E (2003) 'Research in nursing, midwifery and the allied health professions: Quantum leap required for quality research' *British Medical Journal* 326 (7394): 833–834.
- Ralph N, Birks M, Chapman Y, Muldoon N & McPherson C (2013) 'From EN to BN to RN: An exploration and analysis of the literature' *Contemporary Nurse* 43(2): 225-236
- Rapely T (2007) Exploring documents In: Rapely T (ed) *Doing Conversation, Discourse and Document Analysis* London: SAGE Publications Ltd at Essex University Library DOI <http://dx.doi.org/10.4135/9781849208901.n9> [Accessed: 28 January 2015]
- Rapley P, Nathan P, & Davidson L (2006) 'EN to RN: The transition experience pre- and post-graduation' *Rural and Remote Health* 6: 363
- Reilly L & Morrin K (2004) 'Faculty roles in supporting new deans and directors' *Journal of Nursing Education* 43:520-523
- Resnick D B (2007) *What is Ethics and why is it Important?* In Tappen R M (2011) *Advanced Nursing Research: From Theory to Practice* Sudbury: Jones and Bartlett Learning
- Rich K L R, & Nugent K E N (2010) 'A United States perspective on the challenges in nursing education' *Nurse Education Today* 30: 228–232 doi:10.1016/j.nedt.2009.10.015
- Roper N, Logan W W & Tierney A J (1996) *The elements of nursing: A model of living* Edinburgh: Churchill Livingstone
- Roussel L (2006) *Management and leadership for nurse administrators* (4th edition) London: Jones and Bartlett
- Salminen L, Stolt M, Saarikoski M , Suikkala A, Heli Vaartio, & Leino-Kilpi H (2010) 'Future challenges for nursing education – A European perspective' *Nurse Education Today* 30: 233–238 doi:10.1016/j.nedt.2009.11.004

- Schein E H (1996) 'Kurt Lewin's change theory in the field and in the classroom: notes towards a model of management learning' *Systems Practice* 9: 27–47
- Schreiber R (2001) 'New directions in grounded formal theory' In: Schreiber R & Stern P N (eds) *Using grounded theory in nursing* New York NY: Springer
- Schreyer P (2010) "Towards Measuring the Volume Output of Education and Health Services: A Handbook", *OECD Statistics Working Papers*, 2010/02, OECD Publishing. Doi: <http://dx.doi.org/10.1787/5kmd34g1zk9x-en>
- Scott E & Yoder-Wise P (2013) 'Increasing the intensity of nursing leadership: Graduate preparation for nurse leaders' *Journal of Nursing Administration* 43(1): 1-3 doi: 10.1097/NNA.0b013e318278607c
- Searle C (1965) *The History of the Development of Nursing in South Africa, 1652–1960* Cape Town: Struik
- Searle C (1982) 'The evolution of professions: Paper presented at the symposium is a professional association the answer?' *Curationis* 5(3): 4-7
- Shenton A K (2004) 'Strategies for ensuring trustworthiness in qualitative research projects' *Education for Information* 22: 63–75
- Sherman R & Pross E (2010) 'Growing our future nurse leaders to build and sustain healthy work environments at the unit level' *Online Journal of Issues in Nursing* 15(1) Manuscript 1 doi:10.3912/OJIN.Vol15No01Man01
- Sherman R O, Bishop M, Eggenberger T & Karden R (2007) 'Development of a leadership competency model from insights shared by nurse managers' *Journal of Nursing Administration* 37(2): 85-94
- Shieh C (2004) 'International exchange program: findings from Taiwanese graduate nursing students' *Journal of Professional Nursing* 20 (1): 33–39

- Shishu E & Junang J (2011) *Le Profil de la Formation de L'infirmier au Cameroun en 2011*. Paper presented at the 16th National Scientific Conference of Cameroon' Nurses Buea Cameroon
- Siddique M A, Aslam H D, Khan M & Fatima U (2011) 'Impact of academic leadership on faculty's motivation, and organizational effectiveness in higher education system' *International Journal of Business and Social Science* 2(28): 184-191
- Silva B R & Baptista S S O (2007) 'Movimento de expansão dos Cursos Superiores de Enfermagem na Região Norte do Brasil' *Rev Enferm UERJ*. 15(4):515-200
- Smeyers P & Burbules N C (2006) 'Education as Initiation into Practices' *Educational Theory* 56(4)
- Smith D R & Tang S (2004) 'Nursing in China: Historical development, current issues and future challenges' *Oita Care Research* 5(2): 16-20
- Smith M K & Smith M (2002) 'Globalization' The encyclopedia of informal education Online at www.infed.org/biblio/globalization.htm [Accessed: 28 April 2016]
- Spitzer A & Perrenoud B (2006) 'Reforms in nursing education across western Europe: from agenda to practice' *Journal of Professional Nursing* 22: 150–161.
- Spitzer A & Perrenoud B (2007) 'Reforming the Swiss nurse education system: A policy review' *International Journal of Nursing Studies* 44: 624 – 634
- Spradely J (1979) *The Ethnographic Interview* New York: Holt, Rinehart & Winston
- Stanley D (2006) *Congruent Leadership and Empowerment* EDU-COM International Conference Edith Cowan University: Research Online
- Stebbins R A (2001) *Exploratory research in the social sciences* Thousand Oaks CA: Sage.
- Strauss A & Corbin J (1990) *Basics of Qualitative Research: Grounded theory Procedures and Techniques* London: Sage Publications

- Strauss A & Corbin J (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd edition) Newbury Park Sage Publications
- Strauss A L (1987) *Qualitative Analysis for Social Scientists* New York: Cambridge University Press
- Suva G, Sager S, Santa Mina E, Sinclair N, Lloyd M, Bajnok I & Xiao S (2015) 'Systematic review: Bridging the gap in RPN-to-RN transitions' *Journal of Nursing Scholarship* 47(4): 363-370 doi:10.1111/jnu.12147
- Sverdlik B (2012) 'Who will be our nurse leaders in the future? The role of succession planning' *Journal of Nursing Administration* 42(7/8): 383-385 doi: 10.1097/NNA.0b013e318261938b
- Swanson D J & Creed A S (2014) 'Sharpening the focus of force field analysis' *Journal of Change Management* 9(1): 28-47, <http://dx.doi.org/10.1080/14697017.2013.788052>
- Sztembis B (2006) 'The past, present and future of nursing education in Poland: stages, conditions and activities' *Int. Nurs. Rev.* 53, 102-109
- Talbot S A (1995) *Principles and Practice of Nursing Research* St. Louis: Mosby
- Tappen R M (2011) *Advanced Nursing Research: From Theory to Practice* Sudbury: Jones and Bartlett Learning
- Thompson D R (2007) 'Strengthening nursing knowledge through international research networking' *Asian Journal of Nursing* 10 (1): 33-34
- Thompson D R (2009) 'Is nursing viable as an academic discipline?' *Nurse Education Today* 29 (2009): 694-697
- Thompson P A (2008) 'Key challenges facing American leaders' *Journal of Nursing Management* 16(8): 912-914
- Thorne S E (2006) 'Nursing education: Key issues for the 21st century' *Nurse Education Today* 26: 614-621

- Tomey A (2009) *Guide to Nursing Management and Leadership* (8th edition) St Louis MO: Mosby Elsevier
- Traynor M & Rafferty A M (1999) 'Nurse education in an international context the contribution of contingency' *International Journal of Nursing Studies* 36: 85-99
- Vroom V H & Jago A G (2007) 'The role of the situation in leadership' *American Psychologist* 62(1): 17-24
- Wall B M, Dhurmah K, Lamboni B & Phiri B E (2015) "'I am a nurse": oral histories of African Nurses' *American Journal of Nursing* 115(8): 22-42. PMID 26222467 NLM UID: 03272646, DOI: <http://Odx.doi.org.serlib0.essex.ac.uk/10.1097/01.NAJ.0000470397.61855.84>
- Watson R., McKenna H, & Thompson D R (2007) 'What does the Cooksey report hold for nursing research in the UK?' *Nurse Education in Practice* 7 (3): 121–122.
- Welford C (2002) 'Transformational Leadership in Nursing: Matching Theory to Practice' *Nursing Management* 9(4): 7-12
- Weston W (2011) 'The college class at work and home' *Society* 48 (3): 236–241
- Wheeler L (2008) 'Kurt Lewin' *Social and Personality Psychology Compass* 2: 638–1650.
- Whitty G & Power S (2000) 'Marketization and privatization in mass education systems' *International Journal of Educational Development* 20: 93-107
- Wilensky H L (1964) 'The Professionalization of Everyone?' *American Journal of Sociology* 70(2): 142-46
- Wiredu E (2014) *Introduction to NVivo 10*. Lancashire: Data Solutions Services
- Wong T K S & Pang M C S (2000) 'Holism and caring: Nursing in the Chinese health care culture' *Holistic Nursing Practice* 15: 12-21

Wong T K S, Pang S M, Wang C S & Zhang C J (2003) 'A Chinese definition of nursing' *Nursing Enquiry* 10: 79-80

World Health Organisation (2014) *World Health Statistics 2014* WHO Library Cataloguing-in-Publication Data

Xu Y, Xu Z, & Zhang J (2000) 'The nursing education system in the People's Republic of China: Evolution, structure and reform' *International Nursing Review* 47: 207-217

Yoakum C S (1931) 'The University and Nursing Education' *The American Journal of Nursing* 31(1): 53-56 Online at <http://www.jstor.org/stable/3410053> [Accessed: 24 May 2015]

Yordy K D (2006) 'The nursing faculty shortage: a crisis for health care' In Rick K L & Nugent K E (2010) 'A United States perspective on the challenges in nursing education' *Nurse Education Today* 30: 228-232 doi:10.1016/j.nedt.2009.10.015

Young P K, Pearsall C, Stiles K A, Nelson K & Horton-Deutsch S (2011) 'Becoming a nursing faculty leader' *Nursing Education Perspectives* 32(4): 222-228 doi:10.5480/1536-5026-32.4.222

Younger P (2004) 'Using the internet to conduct a literature search' *Nursing Standard* 19(6): 45-5

Zabalegui A & Cabrera E (2009) 'New nursing education structure in Spain' *Nurse Education Today* 29: 500-504

Zemke R, Raines C & Filipczak B (2000) *Generations at work* New York: Amacon

APPENDIX I: INTERVIEW SCHEDULE

The method chosen for this study is grounded theory with semi-structured interviews and document analysis as the principal tools for data collection. This means that to reach data saturation, there might be recurrent interviews and new sampling which will imply that interview schedules be developed more than once. Since we cannot predict at this point the direction that questions will lead to, this interview schedule is for the initial participants of the study. Subsequent interview schedules will be developed as necessary. The initial interview schedule shall consist of the following three sections.

Section I: it consist of the following

- A checklist designed to check out logistics and equipment needed for the interviews.
- Objectives for in depth interviews
- The introduction which describes the opening statements, the rules guiding the interview etc.

Section II: consist of the interview questions.

Section III: contains the conclusion and dismissal note.

Formulation of the in depth Interview Schedule

This study has four research questions, three of which shall serve as the root questions for the interview. Follow up questions shall follow from the participant's response and questions will be rephrased as necessary to facilitate participant's understanding. The questions are formulated in different sections as shown:

Section A: Icebreaker and demographic questions

Section B: Basis of nurse education

Section C: Ideologies influencing the status quo

Section D: Possible model for nurse education in Cameroon.

Section A: Icebreaker and Demographic Questions

The icebreaker will be the welcome greeting and small talk. Typically in Cameroon people will comment on any popular social issue at the time before delving into business. Small talk could also include general comments about the work environment e.g.

“I noticed some new buildings or new coat of paint, it seems like things are changing around here” (This will be good for a place I have visited before)

These pleasantries are meant to defuse any tension prior to the interview and serve as ‘warm up’ for both the researcher and the participant. After these the following demographic questions will follow:

What is your present nursing qualification?

For how long have been in service?

What was your grade when you started working?

The above questions are intended to be general, unchallenging, get the participant engaged and yet get some information that could become relevant at some point during the rest of the interview or during the analysis of data. For example if the nurse has put in quite a number of years in service, and happens to still be at the same entry grade, it might be interesting to find out why there has not been an improvement. On the other hand if there has been an improvement it will become necessary to find out why and how it came about.

Section B: Basis of nurse education

The questions in this section are meant to discover the foundations of nurse education in Cameroon. Is this foundation linked to culture, is entirely foreign or does not even exist. It is about going back to the philosophical origins of nurse education. The root question here will be:

Nursing education has been going on for so many years in this country. What in your opinion is the foundation on which this education is built?

The expectation here is that the participant will share what they believe is the basis of nurse education in the country. Some participants might rush to provide answers, but it is likely that some participants might want to reflect on the question before providing a response. Follow-up questions (questions asking the respondent to throw more light on something they have mentioned) will be asked where necessary to elicit more information for the research questions.

Section C: Ideologies influencing the status quo

The questions in this section are aimed at examining participants' belief about nurse education in Cameroon. The root question here will be:

Nursing education is presently expanding in the country what do you think about the present education scenario?

It is expected here that the respondents will state their positions including criticisms, support, suggestions etc. on a variety of issues. These issues will likely include personal reflections and issues from public debates. It is likely there will be many follow up questions here as the researcher will try to establish the basis of the respondents' arguments. An example could be finding out what each participant thinks of the positions held by others.

Section D: Possible model for further professional education for nurses in Cameroon

The questions in this section will be aimed at getting participants' opinions of how the nursing educational system should look like from entry programmes right through advanced programmes to continuing education and professional development programmes. The root questions will be:

In your opinion, how should different views and opinions influence the designing or planning of nurse education in the country?

It is expected that the respondents will describe their aspirations of a problem-free education plan that will be acceptable to all stakeholders. Follow up questions will also include eliciting the respondents' position on how to overcome observed inconsistencies affecting nurse education.

Participants might be reminded of the positions of other stakeholders and asked to consider those positions in their plan.

NB:

Questions will also be greatly influenced by findings from document analysis. Participants may be asked in relevant follow up questions to comment on information emerging from document analysis

Pre-testing of the Interview Instrument

This interview schedule will have to be tested before the actual data collection. Piloting will begin with discussions on the schedule with the research supervisors. After making any necessary modifications, four participants meeting the study requirements will be selected and interviewed. Adjustments will then be made to the questions as necessary.

Structure of the Interview Schedule

Section I:

Checklist

- Advanced Notice
 - Contact each participant two weeks before date of data collection to give invitation and consent form as well as possible interview date.
 - Confirm date, time and place of interview with participants two days before interview.
 - Make sure participant understands interview will be audio taped.
- Questions
 - Begin with introductory or ‘warm up’ questions
 - Questions should be clear, concise and follow a logical sequence
 - Questions should be asked in language participant understands best.
 - Avoid ‘Why’ questions because they could come across as judgmental and put the respondent on defense.

- Effective use of prompts and follow up questions where necessary
- Logistics
 - Date, time and place should be at participant's convenience
 - Interview room should be spacious and comfortable with some degree of privacy to avoid interruption and noise.
 - Arrive in time and also respect the time allocated for the duration of the interview
 - Recording device should be well charged and ready
- Interviewing Skills
 - Avoid leading questions
 - Avoid interrupting participant during responses
 - Avoid bringing in my personal opinion into the interview
 - Stay alert and keep participant on the relevant issues during the interview and avoid other forms of diversion.
 - Constantly make participant show how his/her responses to different questions relate or contradict

Objectives

The objectives of this interview are:

- To get participant's views on the basis of nurse education in Cameroon.
- To find out the different ideologies that might be influencing participant's views or position.
- To get participant's views on how different viewpoints should be considered in nurse education design in Cameroon

Introduction

It will go like this:

My name is Maboh Michel Nkwati a nurse educator and student at the School of Health and Human Sciences, University of Essex UK. I wish to find out your opinion on issues regarding nurse education in Cameroon including how you think it should look like. The

interview is being recorded to ensure that we capture everything you say thus avoiding omissions or errors. Confidentiality will be maintained because your interview responses will not carry your name or any other information that may identify you.

Before we proceed I wish to remind you that this research is for purely academic reasons, so all your comments both negative and positive are needed. The interview may go up to one hour and you can indicate that the recorder be paused if necessary. You have also read, understood and signed the informed consent form which means you are ready to participate freely in the study.

Section II: Interview Root Questions

General Questions

1. What is your present qualification?
2. For how long have been in service?
3. What was your grade when you started working? If it has changed describe how you accomplished this

Basis of nurse education in Cameroon

Nursing education has been going on for so many years in this country. What in your opinion is the foundation on which this education is built?

Ideologies that influence the status quo

Nursing education is presently expanding in the country with what do you think about the present education scenario?

Possible model for nurse education

In your opinion, how should different views and opinions influence the designing or planning nurse of education in the country?

Section III: Conclusion

This will go somewhat like this:

We have discussed your opinions on a variety of issues regarding post-registration/postgraduate nursing education in Cameroon. You readily shared your views on these issues as well as on how you think the post-registration/postgraduate education model should look like. Thank you for your time and I hope you will be available until the end of the study if there is need to contact you again.

APPENDIX II: DOCUMENT ANALYSIS PLAN

Documents will be analysed for emerging themes which will be compared to those emerging from interviews. The analysis will also influence the choice of follow up questions posed to participants. This task will generally be structured as follows:

1. Author of document
2. Type of document e.g.
 - a. policy paper: addressing any policy issue that is relevant to nurse education or that has implications in nurse education
 - b. official reports: this will include reports from special committees set up to look into issues concerning nurse education
 - c. texts of application: texts providing instructions or directives on how particular policies should be implemented at different levels
3. Date of issue
4. Purpose and rationale of the document
5. Content

Documents will be approached from Charmaz's (2006a:39-40) position – establishing the context of the text (i.e. how it was produced, the authors, their purpose and assumptions they seem to be based on), categories within the text (including how they change in sequential texts over time and meanings they imply), any unintended information and meanings and who benefits or is the target of the text.

The content analysis will also be guided by the following inferences from the work of Rapley (2007):

- Looking for what is being said as well as what is not being addressed
- Looking at the kind of sources or evidence cited in the documents while keeping an eye on sources/evidence that were not considered
- Identifying the context
- Searching for any assumptions made in the texts
- Searching for recurrent themes in same and across different documents

We will be looking for the story that these documents can tell about the history of the present nurse education system.

APPENDIX III: INITIAL PhD RESEARCH PROJECT PLAN

Team

- Primary: Myself
- Supervisors
- Volunteers (2)

Stages and Activities

Activity	Duration	Period
Ethical Clearance: University of Essex and Cameroon	2weeks/4weeks respectively	Jan. to March 2015
Data collection and analysis (occurring simultaneously), review of literature	30weeks	6 th April to Oct. 30 th 2015
Review of data collection, analysis and literature review	4weeks	September 2015
Discussion of findings and continuation of lit. review	8weeks	1 st Oct. to 30 th Nov. 2015
Writing up thesis	4weeks	December 2015
completion and submission	4weeks	January 2016

Target

Submission and defence
of thesis

Award of PhD

Success Factors

Well researched study
design
Supportive supervisors

Competent research
skills
Familiar research
environment

Open communication
channels with supervisors

Multiple options for local
ethical clearance

Social support from family
and friends

Challenges

Delays in in obtaining local
ethical clearance
Bureaucratic delays in accessing
archives

Tracking old documents
Poor appointment habits
Irregular public transport
system

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<http://store.grove.com/Graphic-Gameplan>

APPENDIX IV: ETHICAL APPROVAL ESSEX



University of Essex

L. C. MCKEE

Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and fetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:

Nurse Education in Cameroon: Possibilities of a New Model

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
 Do you object to the title of your project being published? Yes ☐ / No ☒

3. This Project is: ☐ Staff Research Project ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Maboh Michel Nkwati	Health and Human Sciences
Peter J. Martin PhD (Supervisor)	Health and Human Sciences
Ms Susan Stallabrass (Co-Supervisor)	Health and Human Sciences

5. Proposed start date: April 2014
6. Probable duration: 15months

7. Will this project be externally funded? Yes ☐ / No ☒
 If Yes,
8. What is the source of the funding?

9. If external approval for this research has been given, then only this cover sheet needs to be submitted
 External ethics approval obtained (attach evidence of approval) Yes ☐/ No ☒

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s):Maboh Michel Nkwati

Name(s) in block capitals: ...Maboh Michel Nkwati.....

Date: 12th February 2015.....

Supervisor's recommendation (Student Projects only):

I have read and approved both the research proposal and this application.

Supervisor's signature: (signature) SPK all clear

Outcome:

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC ☒ *

This application is referred to the FEC because it does not fall under Annex B ☐

This application is referred to the FEC because it requires independent scrutiny ☐

Signature(s): (signature)

Name(s) in block capitals: WAYNE WILSON

Department: S. HHS

Date: 1/4/15 * REQUIRES UNH APPROVAL
 REMAINING FOR RESEARCH ABROAD

The application has been approved by the FEC ☐

The application has not been approved by the FEC ☐

The application is referred to the University Ethics Committee ☐

Signature(s):

Name(s) in block capitals:

Faculty:

Date:

APPENDIX V: ETHICAL APPROVAL UNIVERSITY OF BUEA

UNIVERSITY OF BUEA

P.O Box 63,
Buea, CAMEROON
Tel: (237) 23332 31 34/23332 28 13
Fax: (237) 23332 22 72



REPUBLIC OF CAMEROON
PEACE – WORK – FATHERLAND

FACULTY OF HEALTH SCIENCES-INSTITUTIONAL REVIEW BOARD

IRB00008917 – US Office for Human Research Protections (OHRP) IORG0007426

Chair : Prof. Simon Mbua Ngale Efange
Vice Chair : Dr. Emmanuel Vubo Yenshu
Secretary : Prof. Eric Akum Achidi

Your Ref: _____

Date: 15th August, 2015

Our Ref: 2015/346/UB/FHS/IRB

Notice of Ethical Approval

Application number: 2015-06-0464
Principal Investigator: Maboh Michel Nkwati
Study Title: Nurse education in Cameroon: Possibilities of a new model.
Application Type: Initial
Sponsor: Student
Review Type: Normal
Date of Approval: 15 August 2015
Expiration Date: 15 August 2016

Additional Comments:



Principal Investigators' Responsibilities:


1. The study must be conducted in strict accordance with the protocol approved by the Board
2. Changes to the protocol or its related consent documents must be approved by the Board before implementation
3. Adverse events or unanticipated problems must be reported promptly to the Board
4. Participants must receive a copy of the consent document, if appropriate.
5. The Principal Investigator is responsible for the on-going conduct of the study. The study must be implemented according to national and international guidelines for the ethical conduct of research on humans. (S)he must collaborate with the IRB's monitoring of the study's implementation.
6. Any future correspondence must include the application number, and the PI's name in the subject line.
7. A renewal application or project closure report must be submitted at least one month prior to the expiration date indicated above. These must be done using the FHSIRB's Form no. 8: Project Update and Closure Form. One hardcopy is to be submitted to the FHS IRB secretariat AND an electronic copy sent to fhsirb@gmail.com, making sure to reference the application number indicated above. This form is available at <http://www.healthresearchweb.org/en/cameroon/institution 2130>

Professor S. Mbua Ngale Efange
Chair,
FHS IRB



APPENDIX VI: AUTHORISATION TO COLLECT DATA REGIONAL DELEGATION OF HEALTH

<p>REPUBLIQUE DU CAMEROUN Paix - Travail - Patrie</p> <p>MINISTERE DE LA SANTE PUBLIQUE</p> <p>DELEGATION REGIONALE DU SUD OUEST</p> <p>Tel: 233 32 22 62 Regional Delegation 233 32 26 18 Regional Fund P.O.BOX:281 Buea</p> <p>Email: contact@swrdph.org</p> <p>Ref: <u>RII</u> /MINSANTE/SWR/RDPH/PS/ <u>567/374</u></p>	 MINSANTE	<p>REPUBLIC OF CAMEROON Peace - Work - Fatherland</p> <p>MINISTRY OF PUBLIC HEALTH</p> <p>REGIONAL DELEGATION</p> <p style="text-align: right;">Buea the: <u>02 OCT 2015</u></p> <p style="text-align: right;">THE REGIONAL DELEGATE</p> <p style="text-align: right;">TO: Mr. MABOH Michel NKWATI School of Health and Human Sciences, University of Essex, UK</p> <p style="text-align: center;">SUBJECT: Administrative Authorization to Collect Research Data</p> <p>After a careful review of this study proposal presented to us by Mr. MABOH Michel NKWATI, we are sure that the research ethics will be respected as the collection of data will be overseen by trained personnel after the consent of the participant has been obtained.</p> <p>With the clarity of his methodology and in view of the importance of this research in generating important information on Nurse Education in Cameroon, we have no objection to him carrying out his research on "<i>Nurse Education in Cameroon: the possibility of a New Model</i>".</p> <p>I therefore call on the health facilities concerned and the participants to give Mr. MABOH Michel NKWATI the necessary assistance needed to enable him carryout this study of scientific importance.</p> <div style="text-align: right;"> <p>The Regional Delegate of Public Health</p>  <p>Dr. MBOME NJIE Victor</p> </div>
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APPENDIX VII: INFORMED CONSENT STATEMENT

Informed Consent Form for Nurses and Stakeholders in Nursing Education

Invitation to Participate

Dear Respondent,

This informed consent form has two parts: the first part is the information sheet which is designed to provide you with information about the research and the second part is the attestation of consent to be signed by you if you agree to take part in this study.

Part I: Information Sheet

As seen above, I am Maboh M. Nkwati currently studying for a PhD in Nursing Studies at the University of Essex UK. I am doing research on postgraduate or post-registration nursing education in Cameroon and I'm inviting you to participate in this study after reading through this information sheet. You don't need to decide immediately whether to participate or not and you may talk to anybody you wish before deciding to participate in the study. You are also welcome to ask me any questions to clear any doubts you might have as you read through this document.

Purpose:

The purpose of this study is to explore issues related to nurse education in Cameroon. We want to learn about your views on the basis and evolution of nurse education including what you think it should look like.

Type of Intervention and Reason for Selection:

This research will involve your participation in interviews that may last up to 1 hour. You are being recruited because your experience as a nurse or a stakeholder in nursing education can help us to better understand issues relating to nurse education in Cameroon.

Your decision to take part in this study is entirely voluntary and I recommend that before giving your consent you should carefully read through this information sheet and ask me questions about any

doubts you might have. There will be no consequences on you if you choose not to take part in the study.

Procedure:

We want to understand the issues affecting nurse education in Cameroon and think that you can help us achieve this. If you choose to participate in this study you will be expected to take part in interviews with me that may take place more than once. This means that after transcribing your interview I might come back to you to confirm some ideas and get some clarification on others.

During the interviews we will sit in some quiet area at your place of work or any other quiet place of your choice and I will ask you some questions. If you do not want to answer any of the questions you may say so and I will move to the next question. No one else will be present during the interview except you may want somebody to sit in just for the company. With your consent the interview will be tape recorded (audio) but you won't be identified by name. Only the research team i.e. I and the two supervisors listed above will have access to this audio tape. During the study the tapes will be kept in a secure drawer that only I can access, and will be destroyed after completion of the research.

Duration

The research will last 10months and during this period I may interview you a number of times but each interview will not exceed 1hour and will always be at your convenience.

Risks and Benefits

We do not foresee any risks to you if you choose to take part in this study. However, it is possible that you might by chance share some personal information or be uncomfortable with some of the interview questions. This definitely is not our wish and you must not answer any question that you do not want to.

There will be no direct benefit to you but your answers will help us make proposals and recommendations that will improve nurse education in Cameroon. You will equally not receive any incentives or payments for participating in this study.

Confidentiality

We will not share information about you or from you with anyone outside the research team listed above. We will not ask your name during the interviews and information from you will be stored with a code or number that has nothing to do with your identity. The audio tape will at all times be kept in a locked drawer that only I will have access to. However, this confidentiality will be maintained within the ethical standards that guide patient care and safety.

Sharing the Results

The information from you will not be shared with anybody out of the research team. But the knowledge we gain from interviewing you will be shared with other researchers, policy makers and the general public through conferences, seminars, publications, reports etc.

Right to Refuse or Withdraw

After reading through this information sheet, you have the right to refuse to participate in this study or to withdraw from the study after informing the researchers. There shall be no consequences or retributions if you choose not to participate or if you later decide to withdraw from the study.

Contacts

You are free to ask me any questions now or if you have questions later you can get to us at the following addresses:

Maboh M. Nkwati

Faculty of Health Sciences, University of Buea P.O. Box 63 Buea Cameroon

Tel: +23769907212

Email: mnmabo@essex.ac.uk

Peter J. Martin and Ms. Susan Stallabrass

School of Health and Human Sciences

University of Essex, Wivenhoe Campus

CO4 3SQ

UK

This proposal has been reviewed by the IRB of the University of Essex UK and the University of Buea Cameroon.

Part II: Attestation of Consent

I have been invited to participate in this study on “Nurse Education in Cameroon: Possibilities of a New Model”. I have read through the consent form and

1. I agree to participate in this research of my own free will
2. I have had the opportunity to ask any questions about the study and received clear answers.
3. I understand that I may be interviewed a number of times
4. I am aware that the interviews will be audio taped
5. I realize that I may withdraw from the study at any time without any negative implications on myself.
6. I have been given full information on the purpose of the study, the researcher’s name and address in case I require more information.
7. All personal information I provide will remain confidential and no information that identifies me will be made publicly available.

Signed (Participant):

.....

Date:.....

Researcher's Statement

I have duly read the information sheet to the participant, and made it clear that

1. Participation is voluntary and comes with no rewards
2. Interviews will be scheduled with the participants at his convenience and that they will be audio taped.
3. All information from the participant will be kept confidential by the research team
4. Participant has the right to withdraw from the study.

I confirm that I have answered to the best of my ability all questions and doubts raised by the participant. I confirm that the participant has chosen to participate of their free will and have not been coerced into giving consent.

Signed (Researcher):.....

Date:.....

Name (Researcher).....

NB: One copy each to participant and researcher.

APPENDIX VIII: DOCUMENT ANALYSIS RESULTS

General Description of Selected Documents

Introduction

The Cameroon system of government is a centralised one with all authority resting in the hands of the president of the republic. Major decisions come from the top tiers of government (i.e. the central level) to the bottom or lower levels. As will be seen in the vast majority of official documents, policy decisions come from the presidency, prime ministry or ministerial levels and then are applied downward. In the overall description of these official texts, the following terms are used:

- **Order:** an order is usually issued by a minister of state and mostly defines or addresses issues within his/her ministerial jurisdiction. Such texts are also referred to as ‘decisions or ministerial decisions’ and will always constitute the reference document in the application of the issues addressed in it. It is worth noting that higher authorities like the president or prime minister could issue ‘orders’ as well depending on the issue being addressed.
- **Decree:** they can be issued only by the president of the republic or the prime minister and of usually wider scope and application. For example while an order will typically affect just one ministry, the decree could affect the entire government of multiple ministries. Since it comes from this height of decision making, it usually has more weight and remains the ultimate reference document for the issue being addressed. Ministers could issue orders spelling out the execution or implementation of decrees within their ministerial departments. However, such texts must not exceed the content of the decree from which they are being drawn.
- **Law:** a law can only be signed by the president of the republic. It is different from the decree in that only the president can sign it and he does so only after the content has been debated and adopted in parliament.

Thus to understand the position/policy of the state with respect to particular issues, the relevant orders, decrees and laws remain the key sources of information. This report is not the document analysis in itself but is meant to provide some context for the reader to understand exactly what was

consulted in the analytic process. The documents that were accessible to this researcher include the following:

1. Order No. 22 of 18 April 1970

Document: Order No. 22 of 18 April 1970 defining the aims of instruction, syllabus and terms and conditions of award of the diploma of state registered nurse, state certified midwife and state certified acoucheur

Signatory: Dr Jean Claude Happi, Commissioner General for Public Health and Population

Origin: Ministry of Public Health

Purpose: to define the structure of training and qualification for nurses and midwives in Cameroon

Date: 18th April 1970

Document Description:

This document spells out the programme requirements for the training of the mentioned group of professionals. The purpose of training, conduct of the trainees, role of the personnel in the healthcare setting, training methods, means of evaluation, modalities for the organisation of examinations, syllabus and conditions for diploma award

2. Circular Letter No. D36/LC/MSP/SG/DEC of 4th February 1994

A circular letter of 4th February 1994 addressed to directors of training schools for health personnel both public and private.

Signatory: Pr. Joseph A. Bede Minister of Public Health

Origin: Ministry of Public Health

Purpose: to revise the syllabus for health personnel training programmes

Date: 4th February 1994

Document Description:

This is a letter inviting directors of private and public schools for health personnel to a two day meeting to discuss the syllabus revision for training programmes. The meeting took place from the 14 – 25 of February 1994. This is not a policy document but it has relevance to the study in that it points to an event that contributes to understanding the context of the policy decisions being taken as well as some insight into the process.

3. Order No..../A/MSP/DEPS/SEAJ

Purpose: to fix the educational objectives and modalities for the award of state diplomas in nursing, medical laboratory technology and health technicians

Signatory:??

Origin: Ministry of Public Health

Date: not obvious

Document Description:

This is an elaborate document that builds on decree No. 80/198 of 9 June 1980 (on the statutes of training schools for health personnel) explaining the details of training including teaching methodology, assessments, promotion and certification examination modalities and content, etc. Analysis of the document content will reveal insight into the philosophy behind training, roles of stakeholders, and levels of training etc.

4. Fax Message No. (no. illegible)/MF/MSP/SG/DRH/SDF/SFI of 6 July 2005

Purpose: informing directors of training schools of the suspension of student recruitment

Signatory: Prof Angwafor III, Fru Secretary General at the Ministry of Public Health

Origin: Ministry of Public Health

Date: 6 July 2005

Document Description:

The document is a fax message from the ministry of public health addressed to the directors of public and private training schools for health personnel. The message informs the addressees that the recruitment of students into the state registered nurse programme, medical laboratory technology and specialised nursing programmes has been temporarily suspended. This document is important in that it is the only official document seen so far that confirms the suspension of training of nurses at some point in time. It also provides insight into the context and decisions taken at some point in the course of nurse education.

5. Decree No. 80/198 of 9 June 1980

Purpose: to establish the statutes of training schools for health personnel

Signatory: H.E Ahmadou Ahidjo President of the Republic of Cameroon

Origin: Presidency of the Republic

Date: 9 June 1980

Document Description:

This document is commonly referred to as “Decree 80” and has remained the reference document when it comes to the organisation of training for health personnel. The document has the following major sections: general dispositions; administrative organisation of schools (board of directors, management of schools, council of studies, disciplinary council); Academics (Cycle B, Cycles C and D, common dispositions to all three cycles); and Miscellaneous. Analysis of this document will contribute to understanding the basis and the present organisation of health personnel education within the Ministry of Public Health.

6. Decree No. 2000/697/PM of 13 September 2000

Purpose: to fix the modalities of training for civil servants or state employees

Signatory: Mr Peter Mafany Musonge, Prime Minister, Head of Government

Origin: Prime Ministry

Date: 13 September 2000

Document Description:

This document is not specific to nurses but includes all civil servants and dwells on training. Training or education here is within the context of further or continuing education for those already employed. It has the following major sections: general dispositions; modalities for selecting staff for further education; management of staff on further education; miscellaneous dispositions and conclusion. Considering the role of continuing education in nursing as well as the acquisition of higher certificates once employed, analysis of this document will show the position of the government vis-à-vis these issues. It may also provide insight as to how nurses can or can't take advantage of what it offers.

7. Order No.0041/A/MSP/DSP/SFPSSI of 1 November 1976

Purpose: to fix outcome objectives, programme and modalities for the award of the nursing aide certificate.

Signatory: Fokam Kamga Paul Minister of Public Health

Origin: Ministry of Public Health

Date: 1 November 1976

Document Description:

This document provides direction as to the training objectives, organisation of studies and examinations, structure and modalities of certificate examinations in the training programme for nursing aides. Analysis of the document will provide more information on the basis, philosophy, organisation and evolution of the nurse education in Cameroon.

8. The Training Curriculum for the Two-Year Post-Basic Nursing Education in the University Centre for Health Sciences

Purpose: to elaborate on the curriculum for training for advanced education in nursing

Signatory: N/A

Origin: Cycle for Advanced Studies in Nursing, University Centre for Health Sciences, University of Yaounde

Date: not indicated

This a curriculum document spelling out the modalities of training for nurses who upon completion are awarded a diploma called “Technicien superiure en soins infirmiers” i.e. advanced technician in nursing practice. The importance of this document in this activity is that its preamble provides information on the educational objectives and training philosophy. It also makes references to certain official texts/documents that provide more information on the educational context.

9. Decision No. 18060480/MINESUP/DDES/ESUP of 23 November 2006

Purpose: to fix guidelines for opening educational programmes leading to award of bachelor degrees in private higher education institutions

Signatory: Pr Jacques Fame Ndongo, Minister of Higher Education

Origin: Ministry of Higher Education

Date: 23 November 2006

Document Description

This document is not specific to nursing but spells out the conditions for private higher institutions to run bachelor degree programmes. Nursing is one of the programmes and analysis of this document will provide insight into the position of this ministry in the training of students at bachelor level.

10. Law No.005 of 16 April 2001

Purpose: to establish the orientation of higher education

Signatory: H.E. Paul Biya, President of the Republic of Cameroon

Origin: Presidency of the Republic

Date: 6 April 2001

Document Description:

This is an elaborate document that defines the vision and operation of higher education in the country. It is not programme specific and cuts across higher education in general. The document has the following major sections: general dispositions or introduction (Objectives of higher education, higher education policy, organisation and access to higher education); higher education institutions (composition of higher education institutions, common dispositions to higher education institutions); the university community (academic authorities, teaching personnel, support and administrative personnel, students, university solidarity); supervision, sanctions and penalties and conclusion.

11. Decree No.2001/832/PM of 19 September 2001

Purpose: to establish the regulations common to all private higher education institutions

Signatory: H.E. Peter Mafany Musonge, Prime Minister, Head of Government

Origin: Prime Ministry

Date: 19 September 2001

Document Description:

This document spells out the regulations that private higher educational institutions are expected to abide by. It contains the following main sections: general dispositions; mission and objectives of institutions; creation, opening and extension of institutions; guidelines for student admission; organisation and functioning; supervision, control and evaluation of institutions; funding of institutions; miscellaneous dispositions and conclusion. Analysis of this document may reveal the nature of education programmes in private higher institutions, their regulation and control. Again though not specific to any programme, this document applies to all programmes under higher education thus will apply to nursing programmes.

12. Decision No.01/0096/MINESUP of 21 December 2001

Purpose: to establish the conditions for creation and functioning of private higher education institutions

Signatory: Jean-Marie Atangana Mebara, Minister of Higher Education

Origin: Ministry of Higher Education

Date: 21 December 2001

Document Description:

This document builds on the prime ministerial decree no2001/832 of 19 September 2001 laying down regulations common to all private higher education institutions. It contains detail guidelines on creation, opening, approval, ratification, and extension of private higher education institutions. Analysis of this document may contribute to understanding the different nursing programmes accredited by this ministry.

13. Order No. 03/0093/MINESUP of 5 December 2003

Purpose: to set modalities for creation and opening in Cameroon of private higher education institutions delivering foreign diplomas.

Signatory: Prof Maurice Tchuenté, Minister of Higher Education

Origin: Ministry of Higher Education

Date: 5 December 2003

Document Description:

Building on previous orders and decrees on the same subject, this document spells out the modalities to open a private higher education institution that offers foreign certificates. Its analysis may provide information on how foreign nursing programmes being delivered to Cameroonians directly will be perceived by the state.

14. Order No. 02/0035/MINESUP of 16 April 2002

Purpose: to set conditions and modalities to obtain authorisation to teach, contracts and agreements for posts of responsibility in private higher education institutions

Signatory: Jean-Marie Atangana Mebara , Minister of Higher Education

Origin: Ministry of Higher Education

Date: 16 April 2002

Document Description:

This document provides information on conditions that teachers in private higher education institutions have to meet to qualify to teach. It also spells out the conditions for appointing the head of institution, the director of academic affairs and the accounting officer.

15. Order No. 06/0014/MINESUP/DDES of 2 February 2006

Purpose: to define the structure of studies and evaluation of professional bachelor degrees in state universities and private higher education institutions in Cameroon

Signatory: Prof Jacques Fame Ndongo, Minister of Higher Education

Document Description:

The document spells out the overall programme delivery structure for professional bachelor degrees. The degrees specified in this document are what can be described as ‘top-up’ degrees i.e. programmes to upgrade diploma holders to bachelor degrees. Analysis of this document may provide information on how nursing diploma upgrade programmes are expected to run.

16. Order No.18060480/MINESUP/DDES/ESUP of 23 November 2006

Purpose: to set conditions for setting up programmes leading to the award of professional bachelor degrees in private higher education institutions.

Signatory: Prof Jacques Fame Ndongo, Minister of Higher Education

Document Description:

This document spells out the conditions that any private higher education institution will have to follow to obtain authorisation to run professional bachelor degree programmes. An analysis of this may show how private sector institutions can contribute to nurse education programmes.

General Characteristics of Selected Documents

The content of decrees, laws and ministerial orders are usually different but they all have similar characteristics including:

- They all begin with a title, reference number and date as well as the office of the issuing authority.
- The first section provides the basis or assumptions behind the decision being considered e.g. they will typically begin with “mindful of ...” where ‘...’ could represent the constitution, reference to a law, reference to an earlier decree(s), or reference to an earlier order(s) etc. In many official documents all of these references are made. This section therefore provides a kind of justification or rationale for the decision that follows in the proceeding section
- The next section usually contains the decision being made and could be divided into chapters, sections, and articles depending on the issue being addressed. The amount of detail or volume or both usually is determined by the issue under review.
- They end with the date of signature as well as the name and office of the signatory.

4.0 Results

Major nurse education government policy decisions and rationales since independence

4.1 Classification of Documents

a. classification by source

Table 2: Classification of documents by source

Type Source	Laws	Decrees	Orders	Circular Letters	Total
Presidency of the republic	3	3	0	0	6
Prime Ministry	0	3	0	0	3
Ministry of Health	0	0	3	2	5
Ministry of Higher Education	0	0	6	0	6
Ministry of Vocational Training					
Total	3	6	9	2	20

c. classification by date of publication

Table 3: Classification of documents by date of publication

Type Date	Laws	Decrees	Orders	Circular Letters	Total
1960 – 1969	0	0	0	0	0
1970 – 1979	0	1	2	0	3
1980 – 1989	2	2	1	0	5
1990 – 1999	0	1	0	1	2
2000 – 2009	1	2	6	1	10
2010 – Present	0	0	0	0	0
Total	3	6	9	2	20

4.2 Policy Decisions

Emerging data reveals the following categories and sub-categories imported from NVivo 10

a. The role of non-nurses

Policy documents indicate that non-nurses had a significant role to play in formulating and implementing nurse education policy. It shows this through:

- The involvement of medical doctors in the training process
- The involvement of non-medical professionals in review of schools
- The inclusion of roles and language that set nursing as a subordinate profession to medicine

b. The role of the nurse

Policy makers indicate very clearly the role of the nurse which is a reflection of their vision of nursing. The following roles emerged from the data among others:

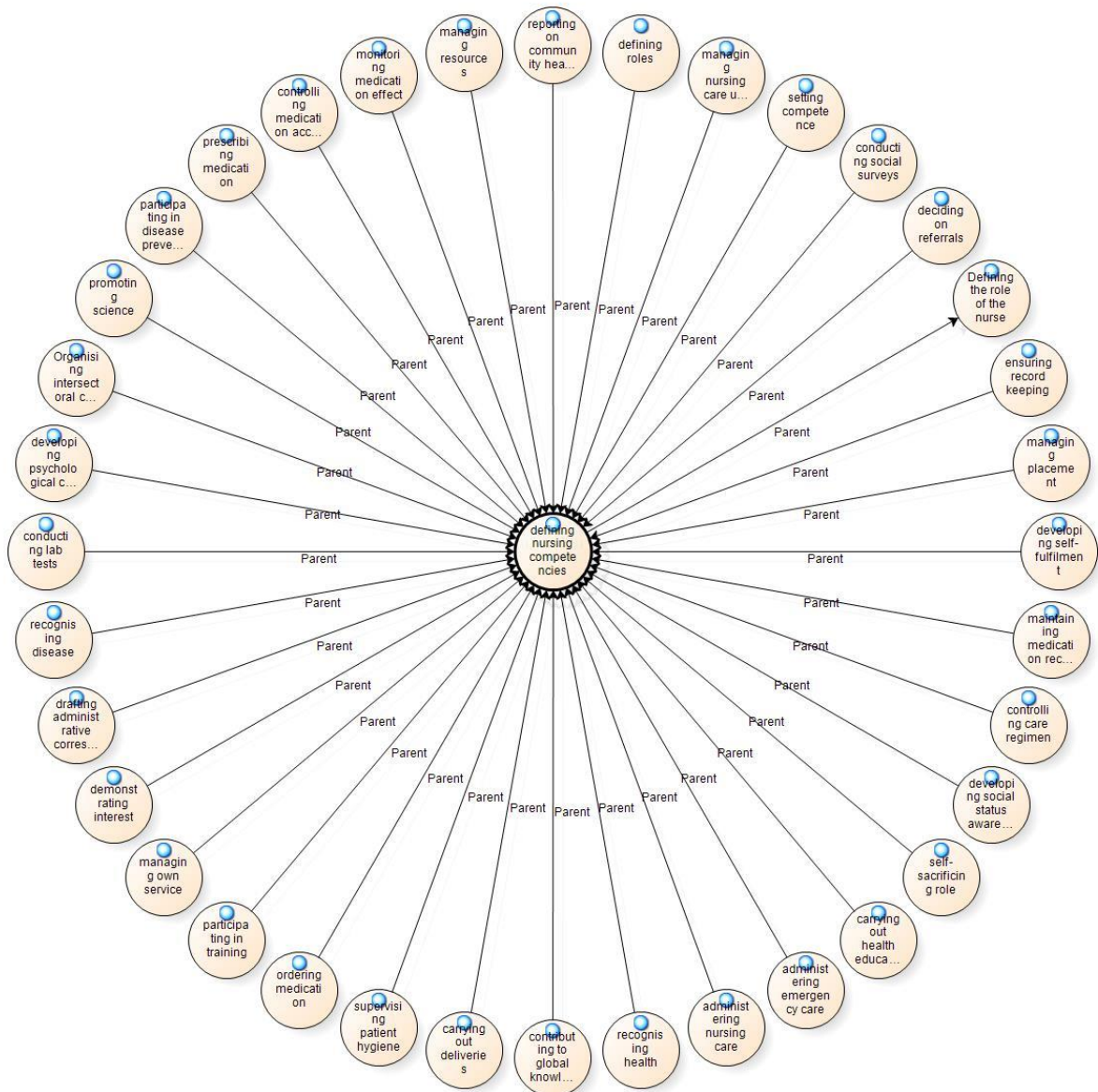


Figure 3: Nursing roles as indicated by policy makers

The roles described do not include advanced practice roles and presented nursing as a task oriented profession. It doesn't perceive nursing as a scientific profession built on certain theoretical models with nurses as professionals who have the ability to apply scientific principles and critical thinking in their care.

c. Defining the status of the nurse

The nurse's status is defined by the following policy items

- setting nursing actions within the limits of identified skills
- defining employment status of staff including those assigned to nursing schools

- linking training cycles to civil service categories
 - clearly defining sectors of activity
- d. Setting education structure

Policy extensively describes the structure of nurse education in the country. The figure below shows the main sub-categories that describe this structure

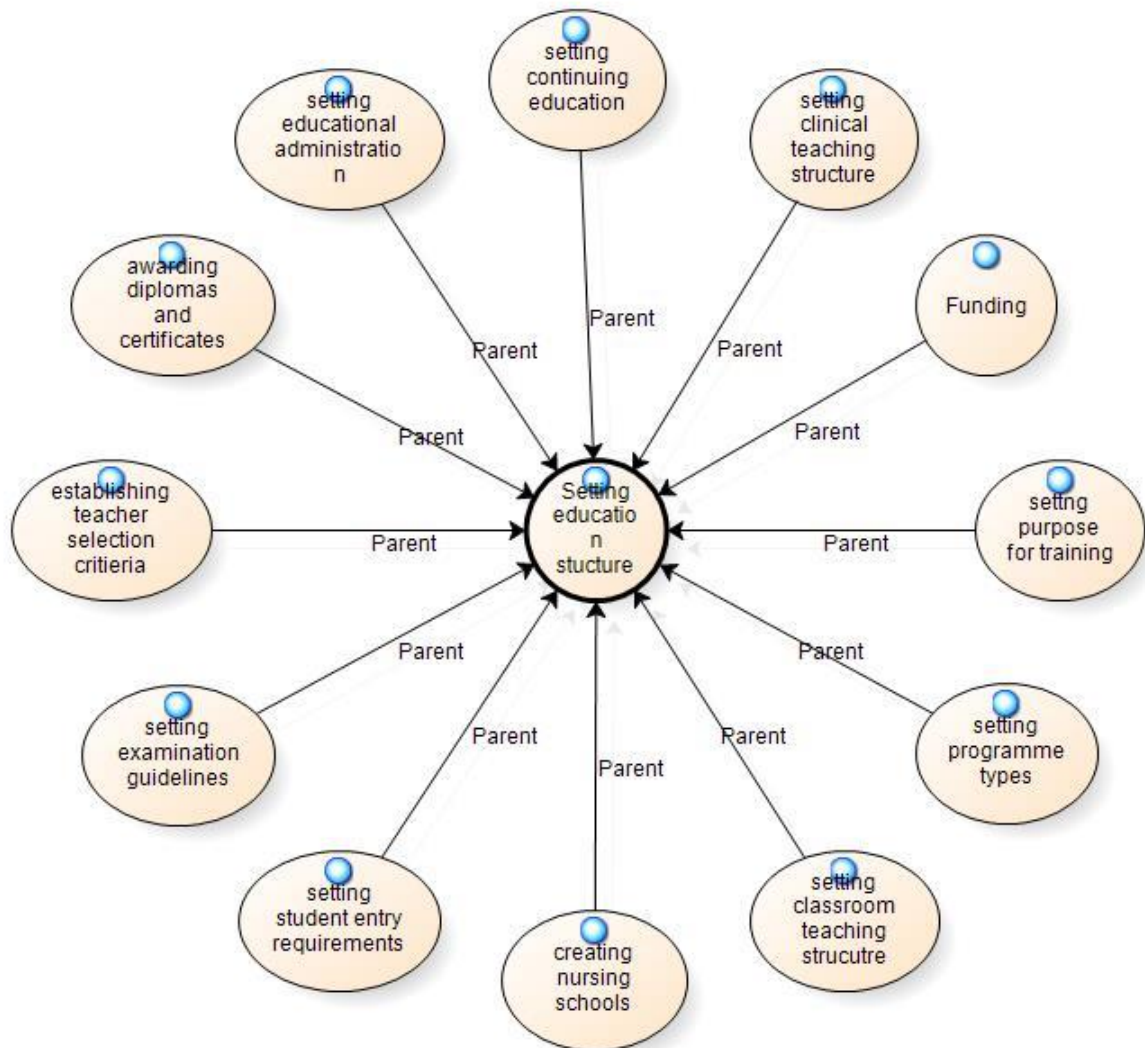


Figure 4: the education structure constructed from policy documents

e. State control of nurse education

Data shows that the government is the main controller of nurse education policy in Cameroon. Policy reveals this through:

- Affirming state control over education

- Defining the roles of the ministry of public service
- Establishing the role of the ministry of public health

f. The policy making process

Analysis of documents reveals certain characteristics in policy decision making process in Cameroon.

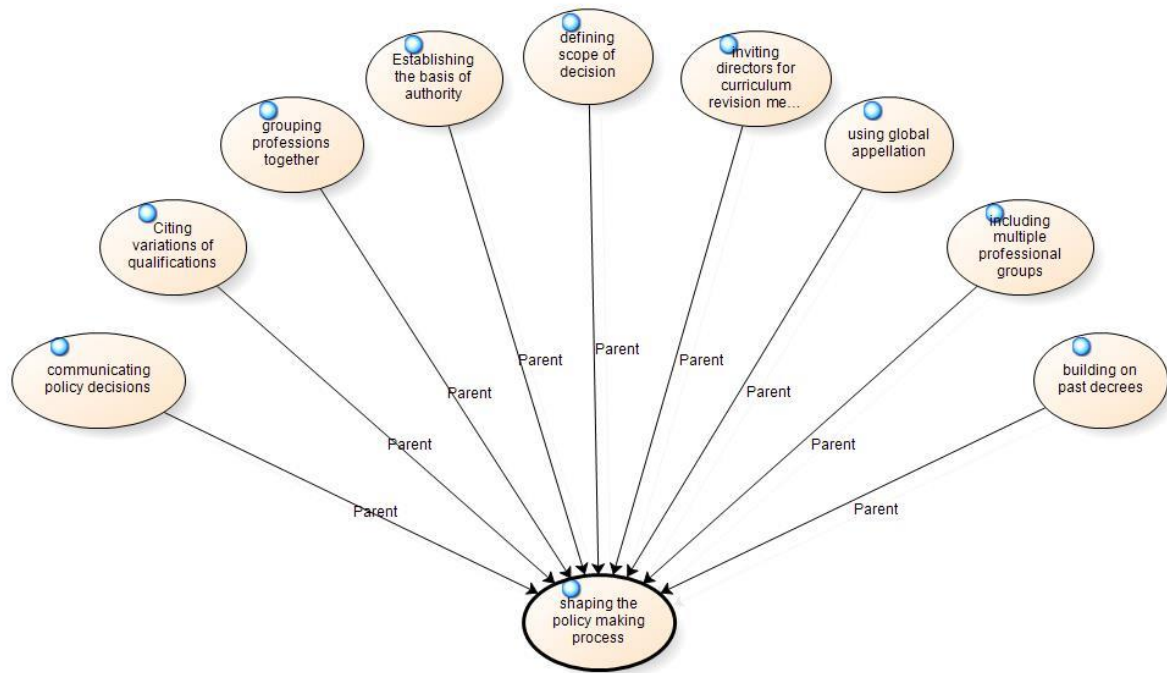


Figure 5: Shaping the policy making process

g. The role of private higher institutions

The documents reveal the role of private higher education institutions with the liberalisation of higher education in the country. Nursing became one of those programmes that were affected by this liberalisation.

h. Suspension of state registered nursing training

Policy documents mention the suspension of training for state registered nurses without providing clear reasons for the decision.

i. Other emerging categories

Initial policy analysis reveals that policy makers mention issues like team work and recognising the role of experts in nurse education process. However, it doesn't go beyond this.

Conclusion

The above discussion shows the facts emerging from the data but is not accompanied by detail analysis. The purpose here is to share these emerging trends so as to get input and suggestions from the supervision team.

APPENDIX IX: DESCRIPTION OF STUDY PARTICIPANTS

The study included 10 nurses who have been involved with the design and/or implementation of nurse education policy in Cameroon. The table below describes their characteristics:

Table 4: Characteristics of Study Participants

Characteristic	Quality	Frequency	% Frequency
Gender	Male	06	60
	Female	04	40
Education	SRN	02	20
	BSc	00	00
	National Advanced Diploma	02	20
	BSc/National Advanced Diploma	01	10
	Masters	04	40
	PhD	01	10
Longevity in Service (years)	0-9	01	10
	10-19	00	00
	20-29	01	10
	30-39	04	40
	40-49	04	40
	50+	00	00

APPENDIX X: SAMPLE NODE EXPORT FROM NVIVO

Name: a limiting francophone perception of nursing

Description: relating to issues showing the francophone limited perception of nursing

<Internals\\Interview Transcripts\\Interview 10 with Mrs Beatrice> - § 1 reference coded [1.16% Coverage]

Reference 1 - 1.16% Coverage

Actually is not only a problem of nursing nah, is it not a problem of the whole Cameroon? It's not only a problem of nursing but I know that having had a small experience in the francophone zone, I can only say that they maybe attaching importance to certain things that may not really be important.

<Internals\\Interview Transcripts\\Interview 12 with Mr Martin> - § 2 references coded [4.34% Coverage]

Reference 1 - 0.52% Coverage

in fact if I can tell you that uhm a nurse could not go beyond a first degree, I know in the francophone system

Reference 2 - 3.82% Coverage

the French people they used to have this appellation 'matron' and matron was just somebody who was in the hospital cleaning places taking care of cleanliness and then when they came here in Cameroon they saw that a midwife was also used to just taking care of patients in the hospital they said "no the matron is just a simple person, he is not supposed to rise up to any level" And that influenced the fact that midwives in particular could not excel to higher heights, they were just looked upon like ward servants and that has given the hegemony which doctors in the olden days who were trained in the French subsystem – they just looked at the nurses as being subservient. That they have no say, they didn't give them that opportunity to be able to. So in fact I can say the French policy influenced us in one way

<Internals\\Interview Transcripts\\Interview 6 with Mr Emmanuel> - § 1 reference coded [1.94% Coverage]

Reference 1 - 1.94% Coverage

you know francophone system all the country that have the background of French colonization are purely attached, politically attached to their colonial master and the colonial master policy they are tempted to [gesture meaning 'follow'], while in the Anglophone section there is some kind of patient freedom

<Internals\\Interview Transcripts\\Interview 7 with Mr Nelson> - § 10 references coded [4.59% Coverage]

Reference 1 - 0.58% Coverage

Again because I think and this is where the problem really comes in. The francophone, the key stakeholders in health in the Francophone – they do not understand the concept of the bachelor degree in nursing, they think it is unheard of

Reference 2 - 0.44% Coverage

Up till now there are many actors there that still don't understand the concept that nurses can at least have a bachelor's degree not to talk of a master's degree and now a PhD

Reference 3 - 0.36% Coverage

That is where the problem lies and that is why those programs ended at diploma level because they could not see nursing earning academic degrees.

Reference 4 - 0.51% Coverage

They have never understood it, until Buea broke the ice, some are beginning to understand but many are still not understanding, they being in the majority and that is where we lie, where the problem lies!

Reference 5 - 0.61% Coverage

There is still uhm one francophone driven ideology that does not see nursing beyond the diploma level. That is one, and that is very, very fundamental, and given that they are in the majority they are holding everybody back. It's a big problem.

Reference 6 - 0.37% Coverage

They don't see the nurse capable of doing research, they don't see the nurse even becoming a PhD, doing research and improving the quality of nursing.

Reference 7 - 0.50% Coverage

They don't see nursing influencing and setting the pace for the role of nursing in the overall health policy and in the overall policy of uhm providing health care services to the rest of the country.

Reference 8 - 0.64% Coverage

They don't see nursing as a fundamental service that is required to provide healthcare to the rest of the people. Issues of health promotion, prevention, all that kind of stuff, community nursing, they are not seeing the relevance of nursing in this sense.

Reference 9 - 0.25% Coverage

And when you have this particular, this type of ideology held by the majority, it becomes problematic.

Reference 10 - 0.33% Coverage

So as long as these positions continue to be held by significant majority of our compatriots we shall continue to have big problem.

<Internals\\Interview Transcripts\\Interview 8 with Mrs Christina> - § 7 references coded [3.63% Coverage]

Reference 1 - 0.18% Coverage

they are the ones who know, can Francophones do something good?

Reference 2 - 0.81% Coverage

It's a degree programme because you go to French speaking countries, Canada and so on it's a degree programme. So if I want to study I go to Canada I don't have problem yes I can continue because uhm all those African countries were French speaking African countries who were joined with us.

Reference 3 - 0.52% Coverage

So there is a lot of headache, it's just because of this fighting with Francophones like we would have worked together with the two ministries to readjust so that we get out of that mess.

Reference 4 - 0.48% Coverage

The mentality is poor we cannot advance, first of all the mentality, I don't know where it came from, whether it is because we joined with francophones. I don't just know.

Reference 5 - 0.47% Coverage

The way we look at our profession Francophones are not even looking at it, they are looking at the monetary part of it, so that is why we have difficulties in advancing.

Reference 6 - 0.78% Coverage

If we were only Anglophones we would have been like Britain and America. It is because we are joined to them and most of them in the ministry are those in policy making. So they are the ones who are tying us down, and to fight through them – we are in the minority – it's difficult.

Reference 7 - 0.39% Coverage

It's very difficult, very difficult! Even within this our council there is always tension because as you are going right, they are going left.

APPENDIX XI: EXAMPLE OF MEMO

Role of the nurse:

Policy documents detail the role expectations of nurses. They are expected to perform quite a list of activities related to patient care. This role definition is explicitly spelled out as the skills expected of nurses who will be trained at SRN level. The skill sets are defined clearly in the areas of clinical care, community and primary care settings, and health education. This document is signed by the Minister of Public Health and reflects what the government wants its nurses to do.

The roles itemised in this document paint the nurse as a skills expert. It is all about being able to carry out set of skills in different care settings. What seems to be conspicuously absent from the list is any focus on cognitive and analytical abilities. Does this mean they are more interested in a nurse who does, than who thinks? It is not also clear who was behind the content of this document. The minister's signature makes him the author and I think the fact that there is no mention of the content being the product of some committee or the other is also intriguing. However, this is a common characteristic of all the official documents.

The code '*conceptualising nursing*' has emerged from analysis of one of the first interviews. The participant raised the fact that there is a focus on technical practice as opposed to conceptual practice which combines skills and critical cognitive abilities. This shows that the curriculum is being implemented to produce just the kind of nurse the ministry of health wants for its services. I think that government wasn't really envisaging the nursing profession as it organised nurse education. The policy points out that they needed technical workers to carry out a list of tasks within the healthcare system. This will probably fit the stereotype of the nurse as there to execute clinical tasks that have been determined by the physician. It will be necessary to explore further how this role definition may have permeated and influenced other aspects of nurse education over time. Whether nurses have remained at this level expected of them or whether there is any tendency towards a more 'conceptual practice' and professional role.

APPENDIX XII: SUMMARY OF RESULTS FOR MEMBER CHECKING

Maboh M. Nkwati

5th January 2016

School of Health and Human Sciences

University of Essex, UK

Dear Sir/Madame,

Subject: Opinion on Nurse Education Evolution in Cameroon

I am a nursing research student in the above institution and recently collected data on nurse education in Cameroon. The research has ethical clearance both from the UK and Cameroon and the data was collected through interviews and document analysis of official texts.

Attached to this letter is a summary of nurse education in Cameroon. I would greatly appreciate it if you take about 10minutes of your time to read the summary and share your thoughts on the findings. Your identification is not going to be required or needed. I contact you because by virtue of your work and responsibilities you are well informed about the evolution of nurse education in Cameroon.

While looking forward to your feedback, accept my best wishes of health and happiness throughout 2016

Yours sincerely,

Maboh M. NKwati

Summary on Nurse Education in Cameroon

Nurse education in Cameroon began formerly in the colonial era and has evolved through major turns and twists to where it is today. From data collected in a recent study, the following summary was arrived at:

Birth and formation of nurse education

- Formal nurse education was a product of colonialism i.e. it came with the colonial era.
- The start of formal nursing started differently in both West and East Cameroon with the training of dressers or assistants using an apprenticeship model
- The training of assistants and dressers and the eventual start of formal training were significantly influenced by physicians
- The first training programmes were not contextualised to meet the needs of locals with local care models being despised as ‘unscientific’ or ‘magico-religious’.
- Contextualisation of the training curriculum evolved slowly over time through community health courses
- The early education structure showed the training of staff nurses in west Cameroon and nursing aides in East Cameroon. Both evolved to the training of SRNs, brevete nurses and nursing aides. Specialisation diplomas were available after the SRN programme and later higher training at CESSI
- From the early days, nursing students paid no fees and received bursaries while in school

Growth and development

- The growth of formal training was influenced by certain external factors including nurses trained from Nigeria and abroad, physicians and administrators
- There is difference in the Anglophone and Francophone perception of nursing in that the latter did not see nurse education progressing beyond the diploma levels
- Anglophones did not start with assistant nursing programmes and that these were introduced by the Francophones

- Nursing training was guided by a hospital-based system where schools were attached to hospitals and clinical skills were emphasised
- Training and programmes were mostly designed to meet needs identified by ministry of health
- Advanced training was opened at CESSI to train nurse teachers and administrators

Liberalisation and expansion

This period was marked by the liberalisation of higher education

- It increased the influence of physicians and non-nurses on nurse education through the authorisations to open nursing schools
- The period saw an increase in access to nurse education
- The expansion of nursing education brought about some worries for example variety of diploma programmes
- There were also policy controversies between the main ministries involved

Conflicts

- There is conflict on the control of nurse education i.e. who should be responsible for nurse education in Cameroon
- Employment controversies as graduates with HNDs for example are not readily employed by ministry of health
- There are signs of resistance by diploma nurses to colleagues with degree qualifications
- Personal fears influences some nurses acceptance of colleagues with higher qualifications
- Graduates from higher education based programmes are not registered by certain nursing organisations
- Some nurses want more restrictions on the use of the title ‘nurse’ especially by assistants and auxiliaries. Anglophone nurses think the term ‘infirmier’ used by the Francophones does not sufficiently capture role of the nurse professional

Desire for change

- Nurses desire change that will allow them get higher qualifications with ease
- There is quiet change occurring for example the deployment of degree holders to SRN and nursing assistant schools which is not an open policy
- There is a desire for educated nurses and higher institutions to lead change in nurse education policy
- There is desire for all stakeholders to work together for the advancement of nurse education

Move to higher education

- It started with the university (UB) and subsequently other state and lay private universities offering bachelor degree programmes in nursing
- The higher education model emphasises development of other skills like teaching, research etc as well as bedside skills. It also facilitates acquisition of higher qualifications
- The higher education model does not sufficiently focus on practicals and is too theoretical
- The ministry of health should consider allowing training to higher education and focus on consumption of the products from higher education
- A transition plan to take into consideration problems that might come in the even health has to stop training should be developed in line with international trends for example problems relating to personnel management if certain schools are closed

Harmonisation of nursing programmes

- It should be done to solve the multiplicity of programmes and diplomas
- It should be targeted at setting national admission standards, programme duration and a competencies for nurses
- It should involve calling together key stakeholders in nursing education to address issues related to entry requirements, curriculum, etc.
- It should include challenging debates like the use of credit systems in ministry of health schools and setting teacher qualification criteria

- It should lead to clarity on all nursing qualifications from all ministries and the production of a competency framework for nurses at different levels that should guide training

Professionalising nursing

- There are signs of deficiencies in professionalism among nurses
- Nurses demonstrate inferiority complex especially with physicians
- There are signs of disregard for the nursing profession by the government and the society
- There is need/desire to achieve professional independence
- There is a desire for recognition of the nurse
- There is a desire for the profession to set high standards for who can teach in nursing
- There is desire for training of nurses should be conceptualised from the present technical skills focus.

Kindly indicate by your comments your thoughts on the above findings on nurse education in Cameroon. You are welcome to also add some more ideas and opinions you deem necessary.