Toward the indigenization of the nursing workforce in Saudi Arabia

Comparative study of three Gulf states: Saudi Arabia, Bahrain and Oman

Thesis submitted by

Kasem Al-Thowini

BSc, MSc

For the degree of

DOCTOR OF PHILOSOPHY

In the

Faculty of Health Services Research Unit

University of London

Department of Public Health and Policy

London School of Hygiene and Tropical Medicine

University of London

2009

Abstract

For the last three decades, the Gulf Cooperation Council (GCC) states, comprising Bahrain, Kuwait, Sultanate of Oman, Qatar, Saudi Arabia and the United Arab Emirates (UAE) have relied heavily on doctors, nurses and allied health professionals recruited from other countries. Globally, there is a persistent shortage of doctors and nurses and the GCC countries are no longer able to meet their human resource requirements through international recruitment. They have thus pursued policies that aim to increase the supply of qualified indigenous health-care professionals – indigenization.

This study aims to understand and examine why and how an indigenization policy has been formulated and implemented in a purposively selected sample of three Gulf States. Saudi Arabia, Bahrain and Oman have many commonalities and the structures of their health-care services, labour force and indigenization policies confront similar broad issues and challenges. However, they were selected to represent different social, cultural and policy environments in the region and different levels of success in creating an indigenous nursing workforce.

This study employs a qualitative research approach to generate an in-depth understanding of the factors that facilitate or inhibit the implementation of indigenization policies in nursing. This includes semi-structured interviews with 78 stakeholders comprising current and former policy-makers, human resource managers, religious leaders and nursing officials living and working in one of the three Gulf States. Document analysis provided the historical and technical background for understanding the mechanism of the indigenization policy process and practices. Findings reveal that cultural, economic and political issues play important roles, as do society's views on education, the role of women and the image of nursing. The recommendations to address these issues, particularly in respect of increasing women's participation in the workforce, may contribute to the development of nursing in the Gulf.

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Dedication

This dissertation is dedicated to my grandfather Abdullah, my father Mohammed and my mother Latifa who have shared with me their knowledge and experience and encouraged me to be always a student of knowledgeable and experienced people.

I also dedicate this dissertation to all the health-care professionals, especially those in the nursing profession in all three Gulf countries, who desired to provide meaningful information to help me complete this research.

Acknowledgements

I want to express my heartfelt thanks to all the participants – the indigenous nurses and students; national and local stakeholders; and those who assisted in organizing access to the research sites and willingly shared their thoughts, opinions and experiences. This research would not have been possible without them. I also want to express my great and deepest appreciation to my supervisors Anne-Marie Rafferty, Jill Maben and Elizabeth West for their support and encouragement.

I must express my special appreciation and gratitude to my day-to-day supervisor Jill Maben who also played the role of mentor, providing counsel and guidance throughout this research. She believed in and helped me, especially in those times when I really needed a friend and a supporter. I was so lucky to have someone like Jill as a friend and supervisor.

In addition, I want to thank my supervisory committee members, especially Professor Charles Tripp from the School of Oriental and African Studies. He was always very helpful and his input is very much appreciated. I also want to thank all the people and friends who supported me throughout this research especially Gill Walt, John Cairns, Karen Clark, Avril McAllister and all those who work in the health service and policy research units and computer department. My appreciation also goes to Professor Pam Smith (University of Surrey) and Dr. John Carrier (LSE) for their contribution and recommendations as examiners. Finally, I want to express my indebtedness to my wife Zubaida and my children Mohammed, Sara, Abdullah, Khalid and my newly born son Talal for their continuous support, encouragement and patience. Without them this research would not have been possible.

Chapter 1

Gulf states: introduction and historical background

1.1 Introduction

The major focus of this research is shortages in the Saudi Arabian nursing workforce Bahrain and Oman were selected as comparative countries because they have introduced successful indigenization policies to meet such shortages Comparison of the roles and functions of indigenization policies in the three Gulf states enables the researcher to analyse the contrasting experiences and assess their varying impacts on the nursing workforce Furthermore, comparative studies of a qualitative nature are required for systematic examination of attitudes to class, gender and religion within the local populations and their impact on attitudes to nursing The comparative study indicates that there is no single blueprint for the application of an indigenization policy; each country must adapt policy to local situations Debates located within the Gulf region and the broader international literature will help Saudi Arabia to develop an improved recruitment practice aimed at indigenous people

The Gulf region is where two continents (Asia, Africa) and three cultures (Arab African, Asian) meet and blend It traces its origins to the ancient culture of Dilmun a major trading link between Mesopotamia[1] and Arabia Felix a confederation of states in the southern Arabian Peninsula which formed a network of trade routes between India and Africa (Cordesman, 1997) Geographically, the Persian (or Arabian) Gulf lies between the Arabian Peninsula and south-west Asia It is connected to the Arabian Sea by the Strait of Hormuz. For several millennia, the Gulf and the Red Sea served as primary routes of interaction between the great civilizations of the east and the Mediterranean.

Located in the south-western region of Asia and covering about 3 million km² the Arabian Peninsula consists of Saudi Arabia, Kuwait, Bahrain, Qatar, the UAE, the Sultanate of Oman and the Republic of Yemen These countries (excluding the Republic of Yemen) constitute the Gulf Cooperation Council (GCC)

[1] Mesopotamia is the area between the Tigris and Euphrates rivers at the north-west end of the Arabian Gulf

26 May 1981, the collective aim is to promote coordination between member states in all fields in order to achieve unity (Christie, 1987). The three Gulf states which are the focus of this study are Saudi Arabia, Bahrain and Oman.

This chapter seeks to provide relevant comparative analysis of the three Gulf states and the context for comparative analysis of their human resources for health, with particular regard to nursing. Compiling profiles of these three states poses methodological problems as most Gulf states have relatively little information available on their development. In the absence of uniform data sources on most aspects of life (and human resources in particular) quantitative data on social, economic and health services are derived from a number of different sources, including the World Health Organization (WHO), the GCC and the World Bank.

The first section of this chapter examines the transformation of the Gulf region, its historical background, demographic features and the transformation of society. In addition, there is discussion of the pre- and post-oil eras – the importance of the discovery of oil and the major changes that ensued. The second section discusses the origin and formation of the GCC, its objectives and challenges. The third section examines religion and the role and impact of Islam in the Gulf health service. The fourth section examines the three Gulf states by focusing on key issues such as their social, political and economic characteristics, elucidating the main similarities and differences and examining public services and health in particular.

1.2 Transformation of the Gulf

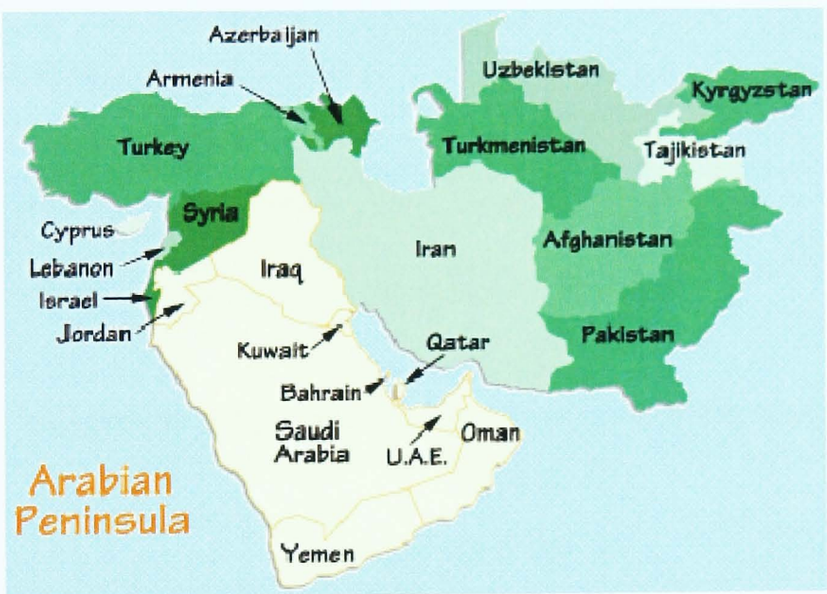
1.2.1 Background

Most of the people who live in the Middle East and North Africa are Arabs, but they have only recently controlled the region. Ottoman Turks controlled most of the territory until World War I; the colonial era began when the British, French and Italians succeeded them. Arab unity has been a dream for Arab nationalists for decades. It is difficult to determine the particular historical period that marked the rise of Arab nationalism, but Alnasrawi (1991) believes that awareness of a national identity among some Arab groups began to emerge during the eighteenth century and through the Ottoman occupation. Recent developments have made this more unlikely,

with increases in the Arab world's external dependence, internal fragmentation and disputes (Hudson, 1999). Arab intellectuals like Edward Said see the failure to mobilize and integrate human and material resources as proof of the powerlessness which is the fundamental problem facing Arab countries today (Hudson, 1999). Said (1996) argues that the inability to deal with and solve the Arab-Israeli conflict is the most fundamental problem facing Arab politics.

Despite the manifest failure to unify the Arab nations (more than twenty sovereign countries) there have been repeated sub-regional efforts to achieve a measure of integration or at least coordination (Hudson, 1999). The GCC is such an example and is discussed in section 1.3.

Map 1 **GCC states**



1.2.2 Demographic characteristics

The population of the GCC states has grown more than tenfold during the last five decades (4 million in 1950; 40 million in 2006). This is one of the highest population growth rates in the world (United Nations, 2006). Demographic growth in the region ranges from 3.32% in Oman to 1.51% in Bahrain. Total fertility rates remain high: from 2.63 children born per woman in Bahrain to 4.05 and 5.84 in Saudi Arabia and Oman, respectively (Table 1; Appendix 1). Further demographic and population data are presented in the relevant sections for each state. By 2004, life expectancy in the

GCC states had increased by almost 10 years to 72 years for males and 75 for females and about one third to one half of the population was under the age of 15 (International Monetary Fund, 2003). Also, more than 12 million foreigners lived in the GCC states – a significant proportion of the region's population. In the UAE, indigenous people comprised 63.5% of the population in 1965 and less than 20% in 2004 (Table 2) (GCC, 2006; Ministry of Planning, 1997; United Nations, 2006).

Table 1 **Demographic factors in Bahrain, Oman & Saudi Arabia (2005)**

Country	**Population size**	**Birth rate**	**Annual growth rate**	**Total fertility rate**
	(000)	Births/1000 population	%	Children born/woman
Bahrain	1038	18.1	1.51	2.4
Oman	3 100	36.73	3.32	4.5
Saudi Arabia	26 417	24.5	2.28	3.17

Source: Central Intelligence Agency (CIA), 2006a

Table 2 **Indigenous people and foreign workers in GCC states, 2004**

Country	**Nationals**	**%**	**Foreign workers**	**%**	**Total 2004**
Bahrain	438 209	62.0	268 951	38.0	707 160
Oman	2 325 812	80.1	577 293	19.9	2 903 105
Saudi Arabia	16 529	72.9	6 144 236	27.1	22 673 538
Qatar	223 209	30.0	520 820	70.0	744 029
Kuwait	943 000	35.6	1 707 000	64.4	2 650 000
UAE	722 000	19.0	3 278 000	81.0	4 000 000
GCC	21 184 323	62.9	12 486 349	37.1	33 677 832

Sources: Girgis, United Nations, 2006

1.2.3 Transformation of Gulf society

The discovery of oil has transformed Gulf society, new social groups have appeared and old ones have changed or disappeared – the Bedouin population has fallen dramatically in the last twenty years. However, this does not mean that traditional conservative values have been abandoned. Vassiliev (1998) argues that the powerful scale of economic modernization and the penetration of Western ideas and values has produced both partial erosion and, paradoxically, partial strengthening of tribal traditions. The Gulf middle class has grown in both numbers and wealth as a result of state financial aid for home and business loans (Vassiliev, 1998).

The GCC countries occupy about 90% of the Arabian Peninsula. About 1% is cultivated and the rest is mainly desert, although some areas are suitable for animal husbandry. Lackner (1978) described the interior of the Arabian Peninsula where Bedouins and peasant farmers in the oases persisted from pre-Islamic times into the 20th century. However, he argues that this was not a unified society as the tribal structure and (later) Islam divided the oasis, desert and urban communities. Isolation from each other and the modes of production quashed the possibility of a unified social, economic and political structure (Lackner, 1978).

Prior to the discovery of oil, the Gulf states had few raw materials or economic resources except the income generated from various locus-specific sources scattered around the region. For example, Saudi Arabia's main source of income stemmed from trading with and servicing Muslim pilgrims but this was not sufficient to provide even the most basic necessities of life. Other Gulf states combined various land and sea activities. Pre-oil Oman's two main economic enterprises were fishing and agriculture. For centuries, Oman was known for its exports of agricultural products such as dates, dried limes and frankincense.

The discovery of potentially vast reserves of oil in the 1920s and 1930s began a transformation which was eventually to produce the modern Gulf states. In 1932, an American geologist in Saudi Arabia found indications of oil (Vassiliev, 1998). In 1933, the Saudi Finance Minister signed an agreement with the American company Standard Oil of California (SoCal) to begin explorations in the eastern part of the country. This did not bring immediate wealth for Gulf state rulers but its discovery

made the internal politics of the Gulf important and of interest to the rest of the world, particularly Western countries. The oil extraction industry and the huge wealth generated from oil exports were controlled by a few people and increased pressure on traditional social structures. Thus, social revolution accompanied the discovery and exportation of oil and brought ideas, values and influences totally unknown in the previous history of the region (Vassiliev, 1998).

From 1945, and with increasing speed, most Gulf states transformed from a collection of small towns reliant on fishing, herding, oasis farming and trade to the world's leading oil producers and exporters with high per capita incomes, a wide range of welfare services and the beginnings of a modern petrochemical industry (Owen & Pamuk, 1998). The oil and gas sectors grew to dominate the Gulf states' economies. For example, many public works in Saudi Arabia in the 1950s and 1960s were carried out by the Arabian American Oil Company (ARAMCO). Al-Rasheed (2007) described how ARAMCO's involvement in building the infrastructure to facilitate oil production and shipment extended beyond the construction of roads, pipelines, ports and airports to the provision of schools, hospitals and a quasi-state administration. She argued that ARAMCO filled the gap left by underdeveloped or non-existent public services, education, water supplies and health facilities (Al-Rasheed, 2007).

Extensive political and economic changes in the Gulf in the early 1970s were followed by rapid changes in social conditions (especially in health and education) over two distinct phases in the post-oil era. The first (1973-1984) followed the first energy crisis; the second (1985-1997) followed the erosion of oil prices. Both are discussed in more detail below.

The first energy crisis began when oil producers in the Organization of the Petroleum Exporting Countries (OPEC)[2] stopped exports to Western nations during the 1973 war between Egypt, Syria, Jordon and Israel. During this embargo, the price of oil rose more than 400%, from US$ 2.59 per barrel in 1973 to US$ 11.65 in 1974 (Shwadran, 1977). When oil exports resumed the Gulf states obtained huge increases in revenues

[2] An oil cartel created in 1960. Consists of Iran, Kuwait, Saudi Arabia, Venezuela, Qatar, Indonesia, Libya, UAE, Algeria, Nigeria, Ecuador and Gabon

that continued into the early 1980s. These funded ambitious investment programmes to build up physical and social infrastructures. Initially, the emphasis was on construction and industrial development but rapidly increasing population and per capita income levels spurred the development of domestic household services (International Monetary Fund, 1997).

Social and economic changes followed this economic development. Largely rural or nomadic tribal societies became highly urbanized with huge changes in lifestyle (Kapiszewski, 2000). Gulf governments have changed from poor simple entities sufficient for governing mainly desert lands into rich regimes that face the complex challenges posed by international power politics and their people's newfound appreciation of the possibilities of modern life.

During 1974 and 1975, some economists predicted that the unprecedented transfer of wealth to oil exporting countries would make many of them rich beyond belief (Askari et al., 1997). Most of these predictions assumed that oil prices would not decline and government policies would effectively use and transform this wealth into productive projects or domestic assets. However, the majority of OPEC countries experienced severe financial difficulties following the collapse of oil prices in the mid 1980s. Economic conditions weakened and GCC governments could no longer afford lavish expenditure upon social services such as education, health and subsidies. Yamani (1998) argues that welfare and development had been central tenets of the ruling ideology and had protected the indigenous populations from the social and political problems endemic in other Arab and Middle Eastern countries. Gulf governments have tried to adjust to decreasing oil prices as they realize the danger of relying on an economy based on a single source commodity.

Oil and related materials (e.g. petrochemical products) now account for major budget revenues in most Gulf states. Saudi Arabia, the richest country in the Middle East, has the largest reserves of oil and is the world's largest producer and exporter. The oil sector in Saudi Arabia usually accounts for roughly 70%–80% of budget revenues, 40% of GDP and 90% of export earnings (Central Intelligence Agency, 2002). Oman and Bahrain are the only two GCC states in which oil reserves are small and

diminishing (Riphenburg, 1998). Oman was late to enjoy the benefits of oil wealth as it began oil production in 1967.

1.3 The GCC

Following many failed attempts at Arab unity, some analysts argue that a form of regional integration and cooperation might prove a tangible goal. The GCC is one of several sub-regional efforts to achieve a measure of integration, or at least coordination (Hudson, 1999). One of the least-studied regional organizations among scholars of international politics (Legrenzi, 2002), the GCC was established officially at a summit of Gulf State leaders in Abu Dhabi in May 1981. The six rulers proclaimed a new era of cooperation which had been thought impossible in such a tension-prone region (Abdulla, 1999).

The GCC comprises six Gulf states – Saudi Arabia, Kuwait, Bahrain, Qatar, the UAE and Oman. All are geographically close and share a common religion (Islam), language (Arabic), heritage and tribal background. Together, they control 45% of the world's proven oil reserves (Fasano & Iqbal, 2003). They also have common systems of government – all are either monarchies or ruled by a single family, centred on one tribe (Gause, 1994). Their economies share many characteristics – oil contributes about one third of their total gross domestic products (GDPs) and three quarters of their annual government revenues and exports. Their predominantly subsidized societies are thus highly dependent on oil. This form of government has created a relaxed way of life peculiar to the area (Al-Naqeep, 1990) which gives the region its own distinct identity.

Many political analysts predicted failure in the early years but the GCC has survived, despite continuing doubts, and found a receptive audience within and beyond the Gulf region (Nakhleh, 1986). Although relatively new, it is proving to be one of the few (perhaps the only) cases in the Arab world where genuine cooperation is not only working but also increasing, albeit intermittently (Christie, 1987). Some argue that the GCC represents possibly the most effective model of integration in the Arab world (Legrenzi, 2002).

It is important to note that the typically recalcitrant conservative Gulf states took less than three months to agree unanimously on the broad ideas and goals of the GCC, approve its final charter, sign many complex documents on policies and structures and hastily announce its formal birth (Christie, 1987). Some argue that such extraordinary and uncharacteristic speed only confirms the widely held belief that the GCC was more of a hasty reaction than a calculated initiative (Al-Alkim, 1994). However, the main objective of this regional organization is to effect coordination, integration and interconnection between members in all fields in order to achieve future unity (Abdulla, 1999). Economically, the GCC has created its own customs controls and imposed common external tariffs.

1.4 Summary

This section has covered the history and transformation of the Gulf region, focusing on its strategic location and describing the historical background, demographic characteristics and development of society. It has also reviewed the economic and social situation of the Gulf region before the discovery and exploitation of oil. In the pre-oil era, extreme poverty and a lack of adequate health and education services were common features. Changes and developments have taken place in the post-oil era, especially extensive economic development and developments in public services resulting from the huge oil revenues which have contributed to the development of the region's societies. This section has also highlighted the main reasons and factors behind the creation of the GCC, reviewed and discussed the council's objectives and the growing debates over its achievements.

1.5 Religion

1.5.1 Islam

Islam is a major determinant of the socio-cultural and political profile of the Arab world and the Gulf. It is a comprehensive system that regulates the spiritual as well as civic aspects of individual and communal life in accordance with human nature (Hasna, 2003). Islam is derived from the Arabic word for peace and means submission to the Will of God; a Muslim is one who submits to the Will of God.

Muslims do not believe that God assumed human form although they believe in the divine revelations of many prophets including Abraham, Moses, Jesus and Mohammad. Islam and Arab culture have played a major role in shaping the future of the Arab world and many other regions (Cordesman, 1997).

Most religious historians consider that Islam dates from 622 AD, as Mohammad lived from about 570 to 632 AD. The last of a succession of prophets, Mohammad founded Islam in Mecca, Saudi Arabia, following the angel Gabriel's recital of the first revelation. These revelations form what is now known as the Quran. Mohammad died after uniting the Arab tribes who had been torn by revenge, rivalry and internal fights. He produced a nation that extended from the Atlantic Ocean in the west to the borders of China in the east.

1.5.2 Impact on health workers

The sociological literature on the women's movement in Gulf countries is very limited. The traditional view that religion is all-pervasive has played an important part in forming feminist identities in the region. The teachings of the Quran state that both sexes are equal under the eyes of God and therefore both should be treated with justice and respect. However, traditional conservative Islam sees women as the weaker, irrational and irresponsible sex that needs to be subject to the control and protection of men. Some argue that Islam tries to minimize temptation, which may lead to sexual interaction, by taking an unequivocally negative attitude towards the interaction of the sexes (Mernissi, 1987).

Western culture tends to associate nursing with characteristics such as virtue and purity. Women comprise the majority of the nursing workforce in the three Gulf states but are challenged by the taint of immorality associated with gender interaction in the workplace (El-Sanabary, 1994). This is less true in Bahrain – although a Muslim country, it is more open to other cultures than any other society in the Gulf. This distinction is clear in the status of women in general and nurses in particular. In Bahrain, women can vote, drive, work in most fields of employment and dress as they like. These are precluded by religion in both Saudi Arabia and Oman.

Sometimes, local cultures are confused with religion or the two are spoken of as one and the same. Religion can also become conflated with cultural attitudes and it is rare for research to attempt to disentangle the two. Qualitative studies highlight considerable variation in individuals' views on the compatibility of a nursing career and their religious beliefs (Darr et al., 2008). Different Gulf states have different interpretations of whether it is permissible to nurse members of the opposite sex. Some see no conflict between Islam and nursing, citing examples from Islamic history where Muslim female nurses cared for injured soldiers on the battlefield (Rassool, 2000). However, as indicated in this research, some conservative individuals feel that providing nursing care to adult members of the opposite sex is unacceptable within an Islamic framework.

Issues with the style of nursing uniform (e.g. a fitted tunic) deter some parents and students, especially in Saudi Arabia. In addition, Saudi Arabia does not sanction co-education and so women do not meet male students during their initial nursing education. Quranic teaching supports the active search for knowledge for both sexes but the question is how best to do this within the cultural interpretation of the religious doctrine. Comparative studies of a qualitative nature that include young people and their parents in the three Gulf states are crucial, as is the need for similar studies that examine more systematically the impact of class, gender and religion upon attitudes towards the nursing profession. The Gulf states face the challenge of increasing the proportion of indigenous nurses who are able to deliver high-quality care, be aware of local cultures and speak the same language as their patients.

The next section reviews the development of the three Gulf states that are the main subject of this study – Bahrain, Oman and Saudi Arabia. This includes the historical background and social, political and economic characteristics.

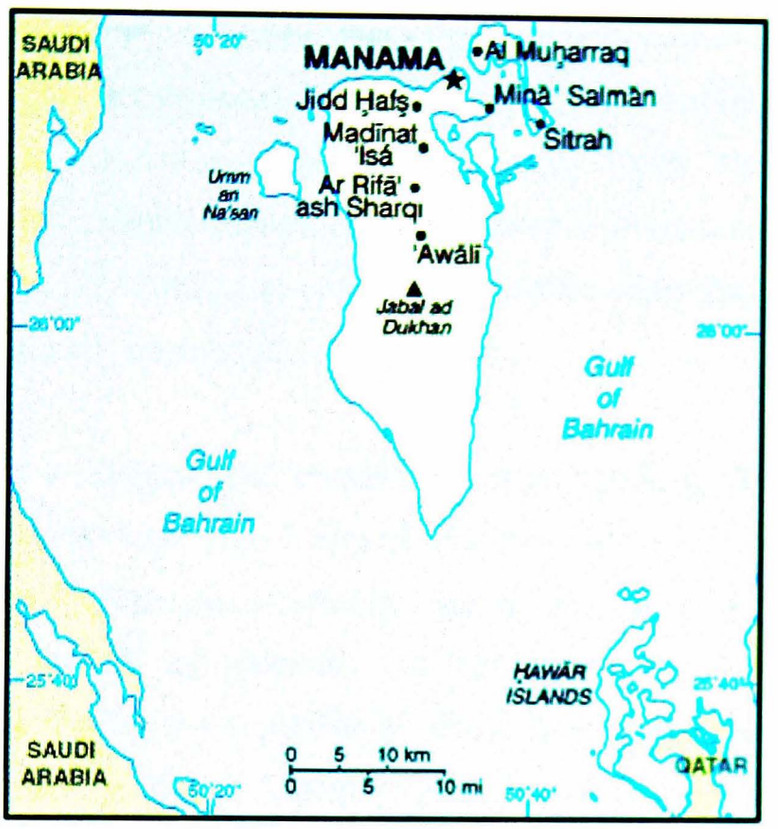
1.6 Bahrain

1.6.1 Geography

The Kingdom of Bahrain is a borderless nation comprising a group of 36 islands in the centre of the Persian/Arabian Gulf, 20 miles off the eastern industrial province of

Saudi Arabia. The three main islands are Bahrain (location of the capital – Manama), Sitra and Muharraq. Joined by causeways, they comprise about 95% of the 707 km^2 land area (Ministry of Information, 2000). Bahrain is one of the most densely populated of the Middle East countries with 89% of the population living in urban areas (United Nations Development Programme, 1997).

Map 2 **Bahrain**



Source: Ministry of Information, 2000

1.6.2 Demographic and social characteristics

Bahrain (two seas) refers to the islands' two sources of water – freshwater springs and salty seas (Ministry of Information, 2000). It has been populated by humans since prehistoric times and has been proposed as the site of the biblical Garden of Eden. Its strategic location in the Persian Gulf has brought rule and influences from the Assyrians, Babylonians, Greeks, Persians and, finally, Arabs (Ministry of Information, 2000). Under the Arabs, Bahrain was one of the first territories outside mainland Arabia to accept Islam, around 640 AD. Between the ninth and eleventh centuries, Persian influences made Bahrain a staunchly Shiite Muslim community. During this time it appears to have been well-governed and prosperous, becoming an important port on the trade routes between Iraq and India. This explains its

cosmopolitan ethnic structure of Arabs, Indians and Persians (Yarwood, 1988). The population was estimated to be 688 345 in July 2005 (Central Intelligence Agency, 2006a). This is overwhelmingly Shiite (70%) and Sunni (30%) but there are also small indigenous Jewish and Christian minorities. Most Bahrainis are of Arab origin although some trace their roots to Persia.

Bahrain became a protectorate of Great Britain in 1861. After World War II, increasing anti-British feeling spread throughout the Arab world and led to riots in Bahrain. In the 1960s, Britain requested that the United Nations General Secretary put Bahrain's future to international arbitration (Fuccaro, 2000). The majority of the population voted for independence. Bahrain remained a protectorate until 1968. The British withdrew in 1971 leaving an independent emirate under the rule of a sheik. In February 2002, the Emir proclaimed himself king.

Today Bahrain is a constitutional monarchy headed by King Hamad bin Isa al-Khalifa. His uncle is the head of government, the Prime Minister, who presides over a 15-member cabinet. Bahrain has a bicameral legislature – the lower house (Chamber of Deputies) is elected by universal suffrage; the upper house (*Majilis al-shura*/Consultative Council) is appointed by the King (Central Intelligence Agency, 2006a). Bahrain has a long established and clearly defined commercial legal framework, with somewhat looser civil and social legislation. A complex system of courts, based on a synthesis of Sunni and Shiite sharia, tribal law and British-based civil codes and regulations was set up in the early 20th century (United Nations Development Programme, 1997). These codes continue to be updated, particularly those regarding commercial legislation.

Women were granted the right to vote and stood in national elections for the first time in 2002. However, Shiite and Sunni Islamist males dominated the election, collectively winning a majority of seats. In response to the failure of the women candidates, the King appointed six women to the Shura Council. This also includes representatives of the Kingdom's indigenous Jewish and Christian communities (Central Intelligence Agency, 2006a). In 2006, Bahrain took an unprecedented step when the King appointed the first female judge in the Gulf region, highlighting the

progress of the women's movement and the rapid development of women's status in Bahrain.

Bahrain is expected to be the first Gulf country to run dry of oil (International Monetary Fund, 2003). This has proved to be an advantage as, without the resources for a boom, Bahrain has moved slowly but firmly into the technological age. Since 1967 a policy of economic diversification and liberalization has been adopted and vigorously pursued. State investment in large projects has been combined with the promotion of an enabling environment for both large and small private sector companies (United Nations Development Programme, 1997).

In Bahrain, oil production and processing account for about 60% of government revenues and 30% of GDP. Economic conditions have fluctuated with the changing fortunes of oil since 1985, such as during and following the Gulf crisis of 1990–1991 (International Monetary Fund, 2003). In the process of supporting economic growth, the Bahraini government has been successful in providing a modern infrastructure – a complex and well-developed transportation and communication system with regular traffic to a variety of destinations. In 1998 Bahrain had the highest per-capita GNP; percentage of population with access to safe drinking water; and number of adequate sanitation facilities, compared to Saudi Arabia and Oman.

1.6.3 Health service and the Ministry of Health

Bahrain has the oldest health service in the Gulf. The first hospital (Victoria Hospital) was built in 1900 and The American Mission Hospital (for male patients only) in 1902. In 1925 the Department of Health Services began as a clinic in a small shop in which a government-employed Indian doctor treated injured pearl divers (Al-Buraikhi, 1991). Following independence, the Department of Health of Bahrain was renamed the Ministry of Health.

Bahrain has universal health care, is considered one of the most developed Arab states and the 41st most developed state in the world (United Nations Development Programme, 2000). Child-mortality and life-expectancy levels compare well with those of mature developed nations. Statistics reveal a more than 60% reduction in the infant mortality rate (IMR) between 1978 and 1998. In 2006, infant mortality was 9

per 1000 live births (Appendix 1), the lowest mortality rate among the three Gulf states in this study. Health-care expenditure has continued to rise and accounts for 8.3% of GNP.

The health service faces a number of challenges including the increasing number of elderly people. Currently about 2.2% of the population, this figure is expected to triple in the next decade and extra resources will be required (Bahrain Brief, 2000). Bahrain's health service has progressed considerably since independence in 1971 and its health indicators are the best among the three Gulf states (see Table 3).

Table 3 **Health service indicators: Saudi Arabia, Bahrain & Oman (1970 & 2006)**

Category	Saudi Arabia		Bahrain		Oman	
Years	1970	2006	1970	2006	1970	2006
Hospitals	74	338	6	9	1	50
Hospital beds	9 039	28 522	929	1680	12	4 455
Physicians	1 172	34 261	92	1 980	13	4 290
Nurses	3 261	74 114	428	4 410	425*	9 516
Primary health-care centres	591	1 804	19	24	19	128

* Estimate

Sources: Data based on statistics from Ministries of Health in Saudi Arabia, Oman, Bahrain

1.6.4 Education

As in other Gulf states, the only form of education in Bahrain at the beginning of the 20th century was traditional (Quran) schools aimed at teaching young people religious duties and the reading of the Quran. However, following political and social changes, the first modern public school for boys was established in Muharraq in 1919. The Education Committee opened the second public school for boys in Manama in 1926. Two years later, the first public school for girls was opened in Muharraq (Ministry of Education, 2001). With a high level of government support, the Gulf Technical College (now Gulf Polytechnic) opened as the first institution of higher education in 1968.

Bahrain has been at the forefront of reducing gender distinction in education. The Ministry of Education acts on the constitutional policy of equal opportunity in education by extending educational opportunities to all Bahrainis in order to achieve justice and equality (Ministry of Education, 2001). The educational system comprises nine years of basic education (primary and intermediate) and three years of secondary education (Ministry of Education, 2001). Bahrain has one of the highest literacy rates in the Arab world and the highest female literacy rate in the Gulf.

1.7 Oman

1.7.1 Geography

The Sultanate of Oman is an independent country in the south-eastern corner of the Arabian Peninsula. An area of almost 309 000 km^2 borders the UAE to the north-west, Saudi Arabia to the west, Yemen to the south-west and the Arabian Sea to the east.

Map 3 **Oman**

Source: Ministry of Information, 2004

1.7.2 Demographic and social characteristics

Oman's history goes back to the very dawn of civilization. The coastal area fronting the Gulf of Oman is believed to have been known as Megan by the Sumerians who imported its copper from as early as 3000 BC (Ministry of Information, 2004). Arab history in the country began in the second century BC when tribal groups migrated from what is now Yemen. Oman was a British protectorate between 1891 and 1971 (Ministry of Information, 2004).

The Omani population was estimated at a little over 3 million in 2005 (Central Intelligence Agency, 2006a). Oman's long history of maritime trade, tribal migrations and contacts with the outside world has produced a heterogeneous population. Numerous ethnic and religious minorities include some who trace their origins to Iran, Pakistan, East Africa and India. Some are a legacy of the country's slave trade with its East African colonies; Omani of Indian descent result from historical trade ties between Oman and the Indian subcontinent (Al-Yousef, 1995).

Oman has always been unique within the GCC states (Al-Yousef, 1995). It is a large country with a diverse economy, settled agriculture, fisheries and a long maritime commercial tradition (Allen & Rigsbee, 2000). Situated outside the Persian Gulf, the Strait of Hormuz sits within its territorial waters. This narrow waterway passes between the Gulf of Oman in the south-east and the Persian Gulf in the south-west. Some 20% of global oil supply passes through it, making it one of the world's strategically most important chokepoints (Al Yousef, 1995).

The Sultanate of Oman has neither political parties nor legislature. In 1991, Sultan Qaboos bin Said established the Consultative Council (*Majilis al-shura*) in an effort to systematize and broaden public participation by providing a conduit of information between the people and government ministries. The selection process is unlike those in other Gulf states. Each provincial governor convokes the government-denoted notables (usually 100–200 people) in their area to recommend three potential council members. The Sultan selects one of these to be the member for that province. Former senior government officials comprise the largest group in the council but tribal leaders and businessmen are also heavily represented. As the government designates notables the representative nature of the electorate can be called into question. Nevertheless, it

is at least a means of bringing some of the citizenry into the process of nominating its representatives (Gause, 1994).

The council is empowered to review drafts of economic and social legislation prepared by service ministries, and provide recommendations to the Sultan. It also has the right to question service ministers (heads of ministries delivering public services e.g. housing, health, transport) who are also required to submit annual reports. This council has no authority on matters of foreign affairs, defence, security and finance.

Like Bahrain, Oman is one of the less rich states in the Gulf. Before the first exports of oil in 1967 it was a classically underdeveloped country depending on a traditional (largely agricultural) economy using old technology with low levels of productivity. As in all Gulf states, oil has been the basis of the Omani economy throughout the reign of the present ruler, contributing more than 80% of total revenue and 95% of foreign currency. This has enabled the government to pursue its programmes for economic diversification and social change (Riphenburg, 1998). Like other Gulf states, Oman is seeking to develop new sources of income to augment and reduce dependency on oil revenues and increase national investments in promising non-oil sectors, particularly manufacturing, mining, agriculture and fisheries (Riphenburg, 1998).

1.7.3 Health service and the Ministry of Health

Oman's performance in the health sector has been remarkable since 1970, when there were only twelve hospital beds (see Table 3 above). Annual growth rates for the period from 1971 to 1990 averaged 16% for hospital beds, 17.6% for doctors, 22.3% for nurses and 22.3% for inpatients (Al-Yousef, 1995). This enormous progress is demonstrated by the increase in life expectancy – from 57 years for both sexes in 1980 to 71 years for men and 75 for women in 2005. The estimated infant mortality rate dropped from 64 per 1000 live births in 1980 to 19.5 in 2005 (Al Riyami et al., 2004; Al Yousef, 1995; Central Intelligence Agency, 2006a). By the same year, the crude death rate had declined to 3.5 per 1000 population and the total fertility rate remained the highest among the GCC states at 4.5 births per woman (Appendix 1). In 2000, a WHO survey of 191 countries measured life expectancy against the amount of resources spent per head of population between 1993 and 1997. Oman came first,

ahead of several European countries such as Italy (third), France (fourth) and Spain (sixth). The survey results reflect Oman's effective and competent use of the financial resources available for health services.

The Ministry of Health is the main health-care provider in Oman. Allen and Rigsbee (2000) argue that the ministry's success in building a network of hospitals and clinics and training qualified medical personnel in such a short time could be attributed to the substantial base upon which they built. In 2005, the health service (Ministry of Health) comprised 48 hospitals, 128 primary health-care facilities, 3455 hospital beds, 2981 doctors, 7909 nurses and 5634 allied health personnel. Other governmental agencies (e.g. Armed Forces, Oman Police, Qaboos University) have their own hospitals.

1.7.4 Education

The UN 1994 International Conference on Population and Development found that education, particularly of women, is the single most important component in which a nation can invest to improve the welfare of its people. The conference stressed the importance of the links between education, women's empowerment and demographic indicators (United Nations, 1994). The Omani government also considers education to be a prime tool for developing the country's human resources. A universal education policy for both boys and girls was introduced in 1970. Until then, there were three primary schools (attended by approximately 900 boys personally selected by the late Sultan) and three private girls' schools – two for Indians and one for the children of American missionary staff (Riphenburg, 1998).

Between 1996 and 2000, 226 new schools were built and 11 new private schools were opened. The total number of students is now 528 357, nearly half of whom are female. Girls also comprise over 40% of the students in private education. Adult education operates in parallel with the regular education system, allowing those who have been unable to complete their education to obtain a qualification. In 2003, 80% of the 32 345 teachers were Omanis (Ministry of Education, 2004). Higher education is provided by a university, specialized institutes, technical vocational colleges and six teacher-training colleges.

1.8 Kingdom of Saudi Arabia

Saudi Arabia is unique. It does not fit any preconceived model of development as some of its characteristics far override any of the features it shares with other developing countries. Like many developing countries its borders have only recently been defined but, unlike others, it was never fully colonized. The main difference between Saudi Arabia and most other developing countries is its extreme wealth. Oil revenues are huge and therefore the country is not dependent on external economic aid. However, it does remain dependent on the West (particularly the USA) for its continuing existence as a monarchy.

Saudi Arabia is an Arab-Islamic country that contains the two leading holy Mosques of Islam. Social and economic development has taken place according to Islamic religious beliefs and its legal system (sharia) has been developed from the Quran and the prophetic traditions interpreted by the Prophet Mohammad (World Health Organization, 1998b).

1.8.1 Geography

Saudi Arabia occupies about 80% of the Arabian Peninsular, in an important strategic location between Africa and Asia. The Kingdom is bordered by Jordan, Iraq and Kuwait in the north; the Persian Gulf, Bahrain, Qatar and the UAE to the east; Oman and Yemen to the south; and the Red Sea to the west. The country is largely a land of deserts and no rivers with a harsh hot climate. Divided into thirteen regions, the most important are:

1. Riyadh – capital city
2. Eastern region – location of most oil fields
3. Mecca province – location of the holy mosque
4. Medina – location of the second most holy mosque
5. Qaseem region – central; mainly agricultural

Map 4 **Kingdom of Saudi Arabia**

Source: Ministry of Culture, 2002

1.8.2 Demographic and social characteristics

Saudi Arabia was established in 1932 by the father of the present King Abdullah bin Abdul Aziz Al Saud. King Abdul Aziz Al Saud's final conquests in the period after World War II united diverse tribes and territories that had been fragmented for a long period (Al-Rasheed, 2002). Today most of the Saudi population (80%) lives in the urban areas where most development projects and jobs are concentrated. This is a change from the traditional Saudi way of life in which most of the population lived in the desert or in agricultural villages. As outlined above, the discovery of oil and the large revenues from its export have dramatically transformed Saudi Arabian society.

In 2005, Saudi Arabia's population was estimated to be about 27 million, including more than 7 million resident foreigners. The population annual growth rate was estimated to be 2.31% and the total fertility rate was 4.05 (Table 1) (Central Intelligence Agency, 2006b). Saudi Arabia is known as the birthplace of Islam and the religion is evident in all aspects of life. The country has a highly conservative cultural environment and adheres to a strict interpretation of Islamic law (sharia).

Saudi Arabia has developed into an urbanized and modernized country over the past 50 years. The centralization of government has undercut tribal autonomy and undermined the social and economic benefits of its leaders but the system remains strong and deep-rooted. More than 50 tribes maintain a fragile unity but most political influence in the country rests with a few who derive their importance from a combination of factors such as size; military power; geographical location; character and orientation of their leaders; and religious outlook (El-Mallakh & El-Malkh, 1982). Tribal leaders (sheikhs) govern and acquire influence through their ability to mediate disputes and persuade their followers towards a given course of action. In the early years of the 20th century, some tribes proved politically decisive in the ongoing acceptance of the royal family's (Al Saud) rule.

The Kingdom of Saudi Arabia occupies an influential position because of its geographical location; role in influencing Arab affairs; leadership in the creation of the GCC; and special position in the Islamic world. It is a traditional and inegalitarian system that preserves inequalities and concentrates wealth and power in the hands of the few. Few such systems remain in the modern world (Walt, 1994).

The country's name is derived from that of its royal family. The house of Al Saud consists of several thousand princes and princesses, all interrelated. Yamani (1998) estimated that there are more than 8000 Al-Saud princes, making them the largest royal or ruling family in the world. Adopted in 1992, the Saudi constitution declared that Saudi Arabia is a monarchy ruled by the sons and grandsons of King Abdul-Aziz, the founder of the kingdom, and the Quran is the constitution of the country. Saudi Arabia has no separation of religion and state, no political parties and no national elections. The King is Prime Minister and head of the armed forces. The *ulema* (religious scholars), tribal leaders, wealthy merchants and educated technocrats constitute the four major groups that have varying influence on, and access to, the royal family.

In 1993, the King established the Consultative Council (*Majlis al-Shura*) to review government policy and make recommendations for his final decision. Its 150 members are appointed by the King and are male. Saudi Arabia is under severe pressure, internally and externally, to create a constitutional monarchy and reform its

political system. Women in Saudi Arabia cannot vote or participate in higher politics but, in February 2009, King Abdullah appointed the first woman as head of girl's education (Aleqtisadiya, 2009). This position has always belonged to the most conservative males in the country and therefore this appointment is considered to be a milestone for women in Saudi Arabia.

Saudi Arabia has changed from a poor, isolated and mainly desert land into a rich country in less than six decades. The sharp rise in oil revenues following the 1973 Arab oil embargo made Saudi Arabia one of the fastest growing economies in the world. Though constrained by falling oil prices in the mid 1980s, since 2004 the Saudi economy has seen a remarkable rise in its revenues due to sharp increases in the price of oil. In 2004, Saudi Arabia earned about US$ 116 billion in net oil export revenues, 35% more than 2003 levels. Net oil export revenues in 2005 and 2006 were forecast to increase to US$ 150 billion and US$ 154 billion, respectively (Energy Information Administration, 2006). Oil accounts for approximately 90% of the country's exports and nearly 75% of government revenues.

Since the early 1970s, eight Saudi Development Plans (SDPs) have been adopted, aimed at achieving the country's economic development goals (Al-Farsi, 1996). Each five-year plan has considered most aspects of the Kingdom's economy concerning infrastructures and commercial and agricultural needs. The Saudi economy is based on the free market philosophy and, despite its dependence on oil, the public sector is the largest employer and government expenditure is substantial.

1.8.3 Health service and the Ministry of Health

Before the introduction of modern medicine, Saudis depended upon traditional practitioners and religious healers. Organized preventive health services began in the early 1950s when the Ministry of Health, ARAMCO and WHO launched a successful campaign against malaria in the Eastern Province. This programme was extended to other provinces in the country (Al-Yousuf et al., 2002). In terms of disease and preventive health, Saudi Arabia is included in the WHO Eastern Mediterranean Region and is considered to be a low-to-middle economically developed country (Littlewood & Yousuf, 2000).

Between 1970 and 1980 health services became predominantly curative as most health personnel had been trained in patient-oriented, hospital-based medical institutes. Health care was delivered through a network of hospitals and clinics; preventive care was delivered by health offices and, to some extent, maternal and child health-care centres. The Kingdom provides free health services to all although foreigners are required to obtain health insurance and are generally treated in private health-care facilities. Health care is the responsibility of the health ministry but a number of other government health providers make considerable contributions to the health service. In 2003, they were responsible for 17% of all government hospitals and 25% of total beds (Ministry of Health, 2005).

As the main provider of health care, the Ministry of Health supplies comprehensive care for citizens via a range of preventive and curative health services, including health education programmes. In 1957, Saudi Arabia's health staff consisted of 62 doctors, 7 surgeons, 231 nurses, 71 technicians, 9 dentists and 64 midwives and nursing assistants (Lipsky, 1959). By the end of 2005, the ministry employed more than 100 000 doctors, nurses and allied medical staff. Primary health-care centres throughout the country provide a patient's first point of contact. They form a network closely linked to the general hospitals which, in turn, are linked to tertiary-care services by a referral and feedback system. These centres implement the various components of primary health care.

Currently, the principal health issues in Saudi Arabia are communicable diseases such as schistosomiasis and malaria; conditions resulting from the abundant mental and environmental stresses of modern societies; and injuries sustained from ever-increasing automobile accidents (Al-Mazrou, Al-Shehri & Rao, 1990). Injuries from road traffic accidents increased sharply from 504 in 1994 to 28 372 in 2002, 4161 of which were fatal (World Health Organization, 2005). Despite the emergence of these diseases and injuries, rapid socio-economic development in recent decades has had a visible impact on the health status of the population, changing mortality patterns and improving the quality of life (World Health Organization, 2005).

The government funds approximately 87% of total health expenditure. The Ministry of Health's allocation increased from 6.1% of the national budget in 2000 to 7.6% in 2005 (Ministry of Health, 2006). Other health service finance is derived from private

sources (e.g. personal out-of-pocket payments) and health insurance premiums (mainly from large private companies).

1.8.4 Education

When Saudi Arabia became a nation, education was largely limited to a few religious schools and has never separated from its religious roots. The Saudi education system conforms to Islamic law and the traditional gender separation of male and female students. Education is free, but not compulsory.

The Ministry of Education was created in 1953 and the first university opened in 1957. Girls' education started in 1960 despite violent opposition from the *ulama* in some parts of the country. Nevertheless, education in Saudi Arabia has developed remarkably since the 1970s. The urbanization and economic growth produced by oil wealth contributed towards a marked reduction in illiteracy rates – from 85% in 1970 to 38% in 1990 (Mohammed, 2003). In general education there was a total of 3.8 million students and 286 000 teachers in more than 22 000 schools in 1995. By 1999, there were about 4.4 million students and 357 000 teachers in more than 26 000 schools (Ministry of Planning, 2005). In 2004, there were 107 000 male and 159 000 female high-school graduates. In higher education, the total number of male and female students enrolling at universities increased from 165 000 in 1995 to more than 263 000 in 1999, a 12.4% average annual growth rate. This rapid development in modern education necessitated the employment of foreign teachers, especially in high schools and universities. Elementary and intermediate education is largely managed and taught by Saudis.

Since the 11 September 2001 attack on the USA, the Saudi education system has been under scrutiny and criticized by various countries and organizations. The USA, particularly, believes that the system has educated some of those now waging war against them. Some minority groups in the country, especially the Shiites, also want the government to reform its education system and to eliminate some false claims against them in some textbooks used in Saudi schools. The Saudi Government has responded to allegations that it teaches intolerance and promotes Wahhabism by embarking on a campaign of educational reforms – changing the content of most religious texts by replacing or omitting controversial and intolerant passages. The

Saudi government has requested American help to reform its education system and monitor the contents and standards of its textbooks.

1.9 Chapter summary

In summary, this chapter has described the transformation of the Gulf region from the pre-oil era to the present day. The demographic characteristics of the Gulf reflect the highest population growth rates in the world since the 1950s and their impacts on development. The chapter has examined the role of oil – the two phases of the post-oil era and the emergence of an oil economy in all Gulf states. Huge revenues have impacted on Gulf society by bringing new ideas and values and rapid changes in social conditions, especially in health and education.

The chapter has examined the origin and objectives of the GCC and the different viewpoints surrounding its creation. The GCC states depend mainly on oil for their survival. Their development depends almost entirely on oil prices which are subject to variation and make it difficult to plan long term. The process of economic diversification has been accelerated in an attempt to reduce dependence on oil and place greater reliance on other resources.

The context and emergence of the three Gulf states have been described and discussed in Sections 1.6 to 1.8 inclusive. Descriptions and analysis of each state's demographic and social characteristics, political context, economic development and development of urban infrastructure were provided. These were followed by explanations of how relatively recently established states have embarked on such developments (particularly of health and education) and made great progress. However, health services in these countries have faced the difficult task of ensuring that there are sufficient and competent human resources to provide a service to rapidly growing populations. Education has also witnessed remarkable development since the 1970s. The number of schools, colleges and students has grown substantially (especially for female education) and increased investment in education has produced marked declines in illiteracy rates.

Religion is a major component and determinant of the socio-cultural and political profile of the Gulf. Islam plays a major role in forming individual identity in general

and feminist identities in particular. Islamic scholars continue to debate women's role in public life in the Gulf with major implications for the development of a nursing workforce staffed mainly by women.

The Gulf states must confront and overcome a number of issues if they are to sustain present and future development. One important question is – will they be able to reform their economic, education and labour markets to meet current and future challenges? It is apparent from the evidence discussed in this chapter that the GCC has been a vehicle for coordination (and some integration) of similar political, social, security, economic and labour concerns.

The next chapter reviews and examines various literature related to the development of human resource and labour force characteristics, especially in the health service. In addition, it examines and reviews the development of the nursing profession, the shortage of indigenous nurses and its impact on the health service of the three Gulf states. Finally, I examine and explore policy-making processes and indigenization policies.

Chapter 2

Literature review

2.1 Introduction

As the effects of globalization are felt more widely, the survival of the economic and social infrastructures of the GCC states depends on a highly skilled workforce. This literature review consists of four main sections. The first elucidates nursing shortages and the challenges that nations face in meeting the growing demand for qualified nurses. The section highlights and reviews relevant literature related to nursing shortages in general and in the GCC states and Saudi Arabia in particular. It highlights and reviews literature related to the recruitment of indigenous and foreign nurses and factors that influence the shortage of nurses in the Gulf.

The second section reviews the literature on human resources in the health service in general and Saudi Arabia, Bahrain and Oman in particular. It examines the role of women and the social and cultural variables related to them in the Gulf. The third section examines and reviews the literature on the development and characteristics of human resources and labour market policy in the three Gulf states; and the role and size of foreign labour in the Gulf and its effect on the development and employment of indigenous people. The fourth and final section examines and reviews the literature on policy and the policy-making environment in the Gulf; implementation mechanisms of the indigenization policies in the three states; and the roles of culture, education and training in an indigenous workforce.

It is important to note four limitations in the literature on the indigenous nursing shortage in the Gulf states. First, few studies focus on this shortage. Second, most published works are basic and exploratory in nature and lack explication or rigour. Third, those that do exist do not adequately explain or clearly articulate the theoretical foundations of the indigenous nursing shortage in the Gulf. Fourth, the literature does not cover the consequences for the delivery of health care and the health system.

This literature review was not undertaken to generate or confirm hypotheses but rather to uncover and review works relevant to nursing shortages in general, and in the Gulf in particular. To this end, I have researched the period 1975 to 2007 in:

- databases
- published literature in Arabic and English
- grey literature in Arabic and English
- literature from the Arab and Gulf states and their sources
- national and international organizations' sources
- various web sites and search engines, e.g. Google, Science Direct, International Council of Nursing and Saudi Medical Journal (see Appendix 2).

2.2 Limitations

It is worthwhile noting other practical limitations to studying and analysing the Gulf's health-care and nursing workforces. These include a lack of standardized data and comparable databases and the quality and availability of basic data. For example, there are no comprehensive systematic national databases relevant to the nursing labour market. Also, employment statistics are not sufficient to provide a satisfactory description of nurses. Some countries do not have detailed statistical databases on their workforce and those data that are available are usually incomplete and often contradictory or inaccurate. Despite progress in recent years, there have been few efforts to use this information to improve the knowledge and management of health services. These limitations affect the measurement and analysis of nursing supply and demand across these three countries. Moreover, such limitations are not confined to developing countries. For example, data collected in individual states in the USA, UK and Europe also often have limited compatibility and comparability (Buchan, 1999).

In addition, the quality of the literature is inconsistent and there has been little research and analysis of nursing supply and demand in the international labour market (Baumann 2004). In the Gulf states, there are few review articles or data on human resources including nursing shortages, recruitment and retention (Kapiszewski, 2000). Data are fragmented, inconsistent, incomplete and difficult to compare. Models of

health-care delivery and nursing roles differ between the Gulf states and so it is difficult to interpret comparative statistics about nurses in a meaningful way, even where data exist. To the best of my knowledge, no study has focused specifically on the Gulf's indigenous nursing shortage and its consequences for the health service.

The next section highlights and reviews relevant literature on nursing shortages in general and the development of nursing in the Gulf; the chronic shortage of indigenous nurses; and factors that influence the shortage of nurses in the three Gulf states.

2.3 Nursing shortages

Both developed and developing countries face the major challenge of shortages in the health workforce, particularly nurses. There is consensus among stakeholders that the well-documented current and projected shortage of nurses exerts significant constraints upon health-care delivery in most nations (O'Neil, 2003). Nursing shortages relate not only to numbers but also to deficits in overall knowledge and skills in the workforce (Buchan & Edwards, 2000). Demand is soaring to unprecedented levels while a variety of factors limit the number of available nurses. For example, the UK has relied increasingly on international recruitment in recent years and annual admissions of foreign nurses have increased fivefold since the mid 1990s (Buchan, 2003). In 2001, 13% of nurses in the UK and 47% in London were born overseas (Larsen et al., 2005). In recent years, foreign nurses and midwives have been recruited largely from the Philippines, India, South Africa and Australia (Nursing & Midwifery Council, 2004). As in other developed countries, the current acute demand for trained nurses is expected to be exacerbated by the increasing demand for health care (Royal College of Nursing, 2002).

Similarly, nursing recruitment needs in the USA between 2002 and 2012 have been quantified to be in excess of 1 million nurses, including 623 000 to fill newly created jobs (Royal College of Nursing, 2004). The nursing shortage in some Latin American and Caribbean countries also threatens health care there. For example, Haiti has only 1.1 nurses for every 10 000 people, compared with 97.2 per 10 000 people in the USA (Pan American Health Organization, 2005). The shortage is most severe in the poorest countries, especially in sub-Saharan Africa (World Health Organization, 2006). For

example, in 2003 Malawi filled only 28% of nursing positions; South Africa had 32 000 vacant nursing posts; and a Zambian hospital had only one third of the 1500 nurses required to function well (World Health Organization, 2006).

It is particularly worrying that developed and developing countries are competing for a limited supply of health-care workers. Most developing countries face constraints (particularly financial) in developing their human resources. Gulf states have almost all the necessary resources but have not been able to take advantage of them. Over the past thirty years, they have not yielded the expected results in term of preparing and producing a well-qualified and skilled indigenous labour force.

2.3.1 Factors contributing to global shortage of nurses

Although little is known about their net effect on the demand for nurses (Simoens et al., 2005), the factors that contribute to shortages are well-documented. Increased demand has resulted from:

- advances in technology
- shifts from acute to primary care
- ageing populations.

Simultaneously, the supply of nurses has decreased through:

- reductions in student numbers
- wider career choices for women
- profession's poor image (International Council of Nurses, 2001).

Changes in the world economy and world order since the beginning of the 1990s have resulted in an increasingly global labour market (Agiomirgianakis & Zervoyianni, 2001). The international migration of nurses has increased in scale and scope but is not a new phenomenon (Larsen et al., 2005). Kingma (2006) and Bach (2003) argue that this has produced a highly competitive market in nurse recruitment, generating unregulated and sometimes unethical international recruitment practices. However, there has been increasing attention on the development of ethical guidelines for the recruitment of nurses in recent years (Ogilvie et al., 2007).

Norway introduced an annual restriction on the number of foreign nurses that may be recruited; an approach that has been adopted by others (World Health Organization, 2003). It is unlikely that the Gulf states would consider such an approach as foreign nurses are desperately needed to staff their health services. The global nursing crisis means that both developed and developing countries are seeking to solve domestic shortages in an increasingly competitive labour market. This leads to "fishing in the same pool" (Royal College of Nursing, 2002b) as health-care employers poach international nurse recruits. For example, the Gulf states recruit health professionals throughout the world, including Europe.

2.3.2 Consequences of nurse migration

A number of health and human rights organizations have focused on the controversial brain drain of health professionals from poor developing countries. The migration of doctors has received most attention; the movements of nurses and other health workers have been addressed only recently (Narasimhan et al., 2004; World Health Organization, 2006). A shortage of nurses does not only damage an organization's capacity to meet patient needs and provide quality care. Some health-care scholars have raised important questions about the impact of nurse turnover on the well-being of nurses and system costs (Hayes et al., 2006). The American Medical Association published a study about the impact of patient overloading. This found that the risk of patient death increased by 7% if a nurse's patient load increased from four to five during a single shift. Also, the risk of death increases proportionally to additional patient load (Pan American Health Organization, 2005).

Aiken et al. (2001) report that emotional exhaustion and problems of work design were common reasons for nurses leaving the profession in England, Scotland, Germany, Canada and the USA. Laschinger et al. (1999) argue that empowered nurses are more likely to initiate and sustain independent behaviours to achieve intended objectives in the face of difficulty. Moss (1995) links nurses' perceptions of themselves to quality of care and argues that dissatisfied and frustrated nurses can give only routine care.

2.4 Nursing shortages in the Gulf

2.4.1 Background

Nursing is a relatively new profession in the Gulf. Until the 1940s local practitioners, healers and *dayas* (unqualified but traditionally trained midwives) specialized in a variety of treatments (Zurayk et al., 1997). Today, *dayas* still perform a significant role in the provision of maternal and child health care in rural areas. Accounts of nursing shortages in the literature are compelling but research on nursing shortages in the Gulf is limited. One of the criteria for inclusion in this review requires published studies in which the nursing shortage is identified as either the purpose of the study or an incidental finding in studies involving indigenous nurses. However, this only served to highlight the paucity of research and data available. In 2006, the International Council of Nurses (ICN) stressed the importance of nurses in the provision of safe and effective care and as a vital resource for meeting the health-related targets of the United Nations Millennium Development Goals (MDGs).

Like many areas of the world, the Gulf region is challenged by a chronic shortage of indigenous nurses. Ball (2004) presents several reasons for this. Extensive economic development is recent and rapid and there has been a large lag between this rapid economic and social expansion and the growth of an indigenous labour force to sustain it. Also, a large infusion of capital resulted in the rapid growth of health facilities in the Gulf states in tandem with a politically motivated desire to exclude most indigenous people from the immorality of modern sector employment. Finally, the acute shortage of nurses can also be attributed to little enthusiasm for vocational training among young indigenous people. This combines with cultural and religious barriers that restrict female access to education and employment, especially in professions that require contact between men and women (Ball, 2004).

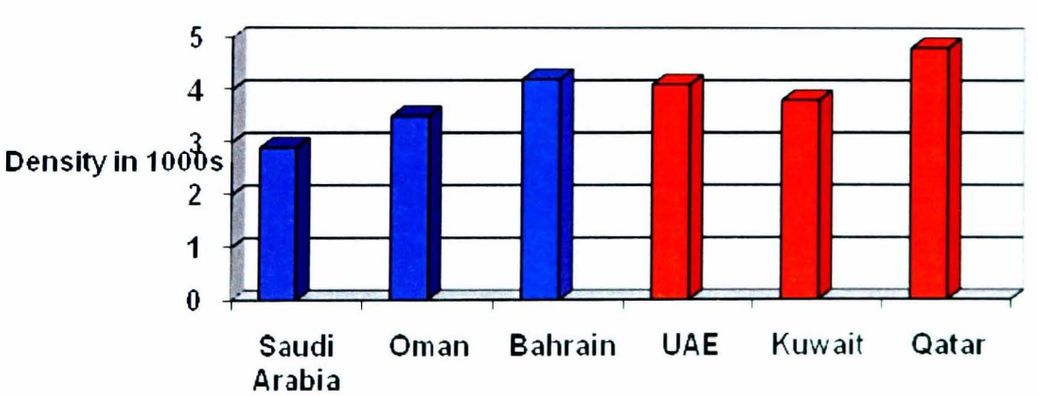
There is a low ratio of indigenous to foreign nurses as internationally qualified nurses are the majority in most Gulf states. In 2005, the ratio ranged from 36.5% in Bahrain to 91.75% in Qatar. Bahrain has the highest percentage of indigenous nurses among all Gulf states – 63.5% of the total number of nurses (Ministry of Health, 2006b). This might be attributable to the progress and speed of modernization in Bahrain and the resulting positive impact on education and health. Oman had only 5 indigenous nurses in 1972 but 59% of its 7909 nurses were indigenous in 2005 (Ministry of Health,

2006c). This remarkable change was achieved in a relatively short time through a commitment to the development of human resources over the past ten years. WHO has recognized these efforts to develop the nursing workforce. It has worked successfully with Oman to develop and increase the number of indigenous nurses and helped to establish regulations for nursing and midwifery practice to ensure that competent nurses deliver safe care (World Health Organization, 2003). Oman has invested heavily in nursing education, training and educational facilities. For example, enrolment in general nursing has grown almost sevenfold from 220 in 1990 to 1423 in 2000. This achievement has not been limited to nursing, a total of 435 physicians graduated between 1993 and 2000 (Ministry of Health, 2004).

Saudi Arabia has not been able to replicate Bahrain and Oman's success in developing and investing in their human resources. It is facing chronic shortages of indigenous health-care workers, especially nurses and doctors. The next section examines nursing development and shortages in Saudi Arabia.

The nursing shortage does not appear to be a short-term problem and is projected to worsen significantly over the next decade. The current nurse rate in the Ministry of Health is 28.2 per 10 000 population, one of the lowest in the Gulf states (see Fig. 1 below). It is estimated that Saudi Arabia needs 70 000 nurses to meet current nursing requirements (Ministry of Health, 2006a). One projection estimated a shortfall of about 200 000 nurses by 2025 (Al-Watan, 2004).

Fig 1. Density of nurses in the Gulf



Source: Based on data from World Health Organization, 2008

The statistical associations between human resources for health, intervention coverage and health outcomes have recently attracted attention. It is well-known that the status and levels of coverage are positively associated with health worker density (defined as the number of nurses per 10 000 population). For example, there is a statistically significant relationship between the aggregate density of health workers and coverage by both measles immunization and skilled midwives (World Health Organization, 2006). Nursing density varies, for example Qatar has a rate of 54.8 per 10 000; the European average is 66.3 nurses per 10 000 population (World Health Organization, 2005).

2.4.2 Recruitment and retention of indigenous nurses

Rapid population growth and worldwide nursing shortages have increased the demand for indigenous nurses in Saudi Arabia. The government has made numerous attempts to encourage educated indigenous women (particularly) to consider nursing as a career, but with only limited success. The reasons cited include salaries, shift schedules and the Saudi perception of nurses (Al-Ahmadi, 2002). In 2002, only 90 nurses graduated from the colleges of health in the 3 largest universities in the country. An additional 537 females graduated from 13 other health institutes but this number includes students from specialties other than nursing (Ministry of Health, 2004b).

In 2004, approximately 78% of the nurses working in the country's health service were foreigners (Abu-Zinadah, 2006). In 2005, Saudi nurses comprised only 40% of total nurses employed by the Ministry of Health (Ministry of Health, 2006a). WHO has projected that Saudi nurses will comprise only 44% of the nursing workforce by 2020 (see Table 4), double the 2004 rate. Presuming that 2000 nursing students will graduate annually, it will take more than 3 decades to fill the national shortage.

Table 4 **Health workforce planning in Saudi Arabia (2005–2020)**

Categories	8th plan (2005–2010)		9th plan (2010–2015)		10th plan (2015–2020)	
	Total	% Saudi	Total	% Saudi	Total	% Saudi
Physicians	38 104	23%	42 300	28%	46 846	33%
Nurses	76 573	31%	86 756	38%	96 131	44%
Pharmacists	10 830	33%	12 269	42%	13 315	49%
Allied medical staff	51 049	62%	57 837	72%	64 087	81%
Total	176 556	36%	199 162	42%	220 379	51%

Source: Adapted from World Health Organization, 2005

In 2006, the ICN stated that the present chronic shortage of indigenous nurses is a logical result of inadequate planning for human resources in the past 30 years. It could be said to indicate a lack of political will to address the problem and find suitable interventions to limit the negative impact on health systems. National strategic plans for human resource development are critical and essential to the realization of national health goals and to improve the population's health (International Council of Nurses, 2006).

2.4.3 Recruitment of foreign nurses

Globalization and trade agreements between countries have led to greater interdependency and increasing mobility of workers between nations. However, many international nurses prefer to migrate to Europe, the USA or Canada. Foreign nurses often see employment in the Gulf as a means to improve their practical and academic nursing skills and provide the financial capacity to sit the various exams and/or pay the recruitment fees necessary to obtain employment in North America or Europe. Ball (2004) argued that many Filipino nurses see their employment in Saudi Arabia as a transition or stepping stone to employment in other nations. Consequently, many are willing to endure difficult, often abusive and difficult working conditions in order to accumulate the necessary capital and experience (Ball, 2004).

Such attitudes make recruitment in the Gulf more challenging (Baumann, 2004). Saudi Arabia has attracted many foreign nurses with incentives such as tax-free salaries, free accommodation and generous travel packages. However, Saudi Arabia and other Gulf states recruit their foreign nurses according to a racialized division of labour. Nurses from America and European countries hold senior administrative and supervisory positions; Filipinos and Egyptians hold middle status positions; and nurses from the Indian subcontinent usually hold low ranking and janitorial positions (Ball, 2004). In addition, they receive different rates of pay for the same work.

All these factors combine with heightened terrorist activity; the international nursing shortage; aggressive competition for nurses; and Saudi restrictions on female movement to present severe challenges to continuing international recruitment to Saudi Arabia.

2.4.4 Factors influencing nurse shortages in the Gulf

As a profession, nursing lacks both appeal and prestige in the Gulf. Medicine and nursing are similar in that their educational and training infrastructures cannot produce enough graduates but the nursing profession has to confront additional barriers. Nursing does not have the same status as medicine and is widely perceived as "unclean".

In 2002–2003, a study to determine Saudi high school students' knowledge and perception of the nursing profession indicated minimal interest in nursing compared with medicine, computer science and teaching. It also showed that many were deterred by long and antisocial working hours; lack of respect for the nursing profession; and working with the opposite sex (Al-Omar, 2004). A survey of Saudi university students and their parents showed reluctance to enrol in nursing schools and poor knowledge and a negative image of nursing as a career. Interestingly, identical reasons (e.g. community image of nursing, long working hours, mixing with the opposite gender) were found in other Gulf states (Al-Omar, 2004). However, the study used a small sample of three female and three male schools in one city and used a questionnaire survey method. Such methods do not produce the rich inductive data necessary to understand and analyse students' attitudes toward nursing. In addition, the survey data usually contain much random variation as respondents give erratic

answers that reflect non-attitudes and produce a good deal of random noise at the individual level (Welzel et al., 2003).

A similar study in Qatar aimed to identify why female students were not interested in nursing. The findings were similar to those in Saudi Arabia as the majority of students cited society's negative image of nursing; mixing and working with males; and working conditions such as night shifts and long hours (Okasha & Ziady, 2001). However, this used methods similar to the Saudi study so the same shortcomings apply.

Under-investment, a poor career structure and low wages are three other reasons why large numbers of unemployed indigenous males and females spurn nursing. For example, the Bahrain Nursing Society cites low pay as one of the main reasons why Bahrain's nurses leave to work overseas (Gulf Daily News, 2007). The majority turn to careers with more pay, more prestige and easier working conditions. Other obstacles include the absence of national regulatory and nursing bodies to ensure quality and the professional representation of nurses; and poor coordination between nursing education institutions, stakeholders and various health service providers.

However, a quarter of a million young men and women enter the Gulf job market each year so there are insufficient "clean" jobs to go around (Aspden, 2006). The image of nursing is changing slowly in some Gulf states and more indigenous women are entering the profession. A study of nursing's image in a number of Arab counties (including Bahrain, Oman and Saudi Arabia) concluded that this has improved significantly only in Bahrain (Shukri, 2005). This study used a standard short questionnaire and included only policy-makers and nursing organizations such as nursing schools. Its findings are likely to be questionable as nurses and respondents from wider society were not included. Economic growth in the Gulf states entails an increase in employment opportunities and competition which gradually eliminates gender inequalities in education, finance, training and overall female discrimination (Morrisson & Jutting, 2005).

2.4.5 Importance of an indigenous nursing workforce

An indigenous nurse enhances patient care, the health service and the economy as a whole. A nurse who understands patients' language, culture and health needs can contribute enormously to the improvement of patient care and reduce costs to the health service (Hassan, 1971). Despite better training, a greater appreciation of patient care and broadening roles the effectiveness of foreign nurses in the GCC states may be hampered by a lack of cultural understanding and inadequate Arabic. Indigenous nurses can help to limit the effect of these differences between foreign nurses and their patients (Hamdi & Al-Haider, 1996).

Many problems and constraints limit indigenous women's participation in nursing but nursing managers and women's leaders are demanding more government intervention to effect change. However, others oppose government interventions and argue that nursing is an unsuitable career for Saudi woman as it subjects them to humiliation and degradation (Hamdi & Al-Haider, 1996). Conservative Muslim scholars argue that the breakdown of Saudi family values is directly related to women's employment outside the home, especially in occupations where men and women work together (El-Sanabary, 2003). Such a negative view, especially when voiced by respected groups in society, is another key reason for indigenous women's low participation in the nursing workforce.

2.4.6 Summary

This section began by noting the lack of available data, especially in the literature related to the Gulf region. There has been significant growth in nursing shortage literature in the last few years, driven by nursing shortages in both developing and developed countries and stimulated particularly by the need to meet the increased demand for more nurses. Despite the lack of comprehensive data (especially in the Gulf region) on the nature and extent of the nursing shortage, this is expected to become more serious as ageing populations in developed countries and growing populations in developing countries substantially increase the demand for nurses.

Retention of nurses is a significant problem for many countries. Numerous studies have reported that decreased levels of job satisfaction eventually lead nurses to leave the profession and pursue other occupations. Relatively low wages and few benefits are two of several factors that contribute to difficulties in both recruiting and retaining

nurses. This section has also focused on the nursing shortage in the Gulf and its consequences on the development of the nursing profession in the region, reviewing literature on the shortage of indigenous nurses and the various factors that influence this shortage in the three Gulf states. The main factors that influence the shortage of nurses in Saudi Arabia have been discussed in detail: a shortage of nursing colleges; nursing's negative image; low levels of interest among high school graduates; poor working conditions; night shifts; mixing with the opposite sex; and finally, and more importantly, restrictions on women's movement and religious and cultural factors. This section concludes with the importance of the role that indigenous nurses can play in the quality of patient care and the potential benefits to a health service that has a majority of indigenous nurses in its workforce.

The next section reviews the literature related to the development of human resources in the Gulf since the beginning of the 1970s. It traces the history of foreign workers and highlights the factors behind the current composition of the Gulf labour market.

2.5 Human resources for health in the Gulf

The performance of a country's health sector is only as good as the performance of those who provide the services – from admissions staff to the most specialized health personnel (Adams & Dussault, 2003). This fact has been systematically neglected by policy-makers and managers in most countries. Whether the explanation lies in their complexity; multisectoral nature; political content; or a lack of ready-made solutions, health workforce issues have been overlooked by many individual countries and the international community as a whole (Adams & Dussault, 2003). Advances in technology and longer lifespan have created an increasing demand for health care and spiralling costs (Buchan, 2002; World Health Organization, 1998a).

Rapid technological change and the increase in the specialization of labour have increased the demand for human resources in health services all over the world (World Health Organization, 2006). Therefore, the global phenomenon that is the lack of human health resources, particularly nurses, affects both developed and developing countries. A recent WHO report reveals an estimated worldwide shortage of almost 4.3 million doctors, nurses and support workers (World Health Organization, 2006).

In the Gulf states of Saudi Arabia, Oman and Bahrain the availability and skill levels of indigenous human resources (especially in the health service) make it difficult to sustain development. The shortage of doctors and nurses is chronic. Baumann et al. (2001) argue that health-care labour markets are affected by the interaction of long-term trends and labour market cycles. Also, they contend that the nature of health care and the services needed depend on the profile of the population to be served. As in many other parts of the world, demographic changes have affected the health-care labour market in the Gulf – the patient population and their growing needs for different types of care have, in turn, affected the numbers of health personnel in the labour force (Baumann et al., 2001). Demographic trends show that health services in the Gulf face a huge future challenge in providing health care to their growing populations. However, these trends also show that a young population can be an advantage if these future human resources are developed into qualified and trained personnel. Success in this could well meet future needs, especially for human resources such as doctors and nurses.

2.5.1 Shortage of indigenous human resources in the health service

As outlined in Chapter 1, health services in the GCC states have witnessed remarkable developments since the 1970s as a result of the huge revenues generated by sharp increases in oil prices. However, the health service is a labour intensive and highly technical sector that requires qualified and experienced personnel to function effectively (World Health Organization, 2002).

The three Gulf states lack the skilled indigenous personnel required to run their health services. For the last three decades they have relied heavily on doctors, nurses and allied health professionals recruited from other countries, particularly the Philippines; the Indian subcontinent; and other Arab countries such as Egypt, Sudan and Lebanon. More than twenty-five different nationalities may be found working in one hospital. Saudi Arabia is most dependent on immigrant labour – at the end of 2005 over 81% of physicians, 60% of nurses and 21% of allied health personnel were foreign born (see Table 5).

Table 5 **Human resource trends in health ministries in three Gulf states, 2003–2005**

Human resources	Saudi Arabia		Bahrain		Oman	
	2003	**2005**	**2003**	**2005**	**2003**	**2005**
Total number of doctors	15 973	20 219	816	1 026	2 635	2 981
Number of doctors who are nationals	3 040	3 773	673	848	624	813
% of doctors who are nationals	**19.1%**	**18.7%**	**82%**	**82.5%**	**24%**	**27%**
Total number of nurses	38 019	42 628	1 967	2 398	7 319	7 909
Number of nurses who are nationals	12 384	17 068	1 222	1 518	3 616	4 680
% of nurses who are nationals	**32.6%**	**40%**	**62%**	**63.5%**	**49%**	**59%**
Total number of allied health personnel	22 470	23 116	570	671	4 781	5 634
Number of allied health who are nationals	13 928	16 136	534	588	3 661	3 980
% of allied health personnel who are nationals	**62%**	**69.8%**	**93.6%**	**87.6%**	**76.5%**	**70.5%**

Sources: Saudi Arabia Ministry of Health 2006a; Bahrain Ministry of Health 2006b; Oman Ministry of Health 2006c

In Oman, 73% of physicians, 41% of the nursing workforce and 29.5% of allied health workers were recruited internationally. Bahrain has the lowest number of foreign health workers – 17.5% of physicians, 36.5% of nurses and 12.4% of allied health personnel (Table 5) – and therefore the largest numbers of indigenous health workers in all three categories.

Indigenous nurse shortages in Saudi Arabia and Oman seem to be the result of a set of economic, cultural and sociological factors. However, little is known about the causes of the severe shortage of indigenous physicians. For example, a yearly average of 90 physicians graduated in Oman between 2001 and 2005 (Ministry of Health, 2006c). This rate is not considered high enough to speed the Omanization process in this category. Medicine has a high status and is one of the most respected careers in the Gulf, therefore comparisons with other occupations (such as nursing) are not equally valid (El-Sanabary, 1993). In Saudi Arabia particularly, medicine has received more attention and resources than nursing because the shortage of indigenous doctors is more severe. However, indigenous women doctors in the Gulf share the same

constraints as indigenous nurses. In Saudi Arabia, for example, all women face the limitations on driving, travelling alone and working alongside males.

Competitive salaries and high-tech facilities have ensured a good supply of immigrant workers in the GCC states. However, the increasing international shortage of health-care workers means that this can no longer be guaranteed. In future, GCC states will be competing with countries such as the USA and the UK, both desperately short of health-care workers (especially nurses). They also offer relatively good pay and attractive working conditions (Buchan, 2002).

International recruitment can be a quick fix for workforce problems but it may be an obstacle to solving other social problems that are endemic in the region, such as youth unemployment and women's exclusion from public life. Millions of foreign workers are employed in the Gulf states, including many women, but large numbers of indigenous women are unemployed. The Gulf states spend billions of dollars on women's education and health yet do not utilize this important human resource in their workforces.

This thesis is concerned with the shortage of nurses in the Gulf and, because the nursing profession is dominated overwhelmingly by women (Davies, 1995), it is imperative to discuss the role and employment of women.

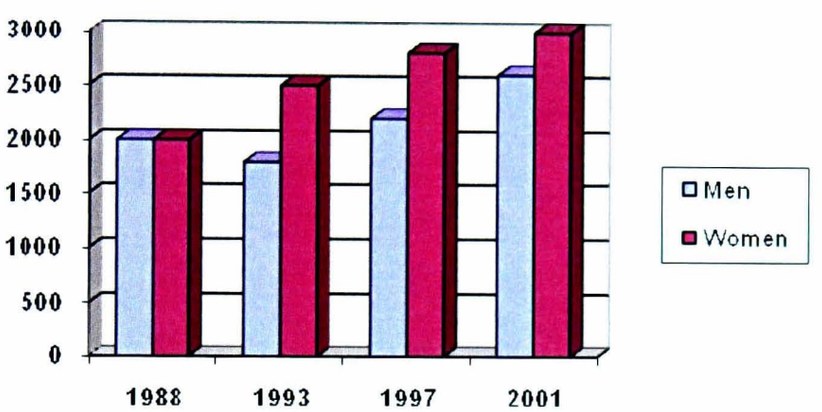
2.6 Women's participation in the Gulf workforce

Arab women have the lowest local labour market participation rate in the world (International Labour Organization, 2000). Since 2001, women's persisting exclusion from public life in the Gulf (and Saudi society in particular) has been the most hotly debated topic in the development process, amongst Muslims and internationally (Hamdan, 2005). The number of women in the labour force is rising modestly but remains relatively low throughout the Gulf region. Figures indicate that indigenous and foreign female workers constitute less than 20% of the total labour force in the three states (Appendix 1).

The GCC states spend billions of dollars on women's welfare (including education and health) and the educational profile of the female workforce is much higher than

that of male workers. In 1988, the graduating class from government secondary schools in Bahrain was evenly balanced between males and females (Fig. 2). Since 1993, Bahrain's female secondary school graduates have outnumbered male (United Nations, 2002; Fig. 2). Females now outnumber males in all but the earliest stages of the educational system. The percentage of women students enrolled at the University of Bahrain, the Arabian Gulf University and the College of Health Sciences is substantially higher than that of men (United Nations, 2003). Figures indicate that women are graduating at nearly twice the rate of men in some states (Girgis, 2002; United Nations, 2003).

Fig. 2 **Graduates of Bahrain secondary schools, by gender, 2001**



Source: Ministry of Education, 2002

These statistics could indicate that women in the Gulf are over-educated and consequently under-employed. The Gulf states have signed the United Nations convention that prohibits all forms of discrimination against women (United Nations, 2007). By accepting the convention, Gulf states commit themselves to undertake a series of measures to end discrimination against women in all forms. Ratification has strengthened the position of women in society but signing is not enough to guarantee the rights of women. There is still substantial discrimination in employment and women are often passed over in favour of men who may be less qualified and less skilled. Gulf governments need to operationalize the United Nations' convention through binding government legislation and regulations that support women's rights.

2.6.1 Women's participation in the three Gulf states

Indigenous women participate in the labour force at strikingly different rates across the GCC states. In Saudi Arabia, indigenous women constituted 7% of the total workforce in 1990, but only 4% in 2003 (Hamdan, 2005). Official data put the figures at 12.2% for 2003 and 15% for 2004 (Appendix 1) (Ministry of Economy and Planning, 2005a). Even these higher figures are lower than those in Bahrain and Oman. For example, the number of indigenous women working in Bahrain's public service has risen continuously from 7.1% in 1991 to 40% in 2005. The variety of occupations in which they participate is also increasing (International Labour Organization, 2005).

Restrictions on women's participation in the labour force cannot simply be attributed to traditional, social and cultural boundaries as they are very similar in these three states. Maben et al (2010) suggest that historical, cultural and religious forces create challenges to women's participation in the labour market in the Gulf states and impede local health workforce recruitment. However, the histories of Oman and Bahrain differ from Saudi Arabia in at least one important respect. As British Protectorates these two states were effectively within the UK's sphere of influence from the late eighteenth century until independence in 1971. This close contact may have had the effect of modelling different roles for women.

Women's rights in Bahrain and Oman have certainly advanced in the last ten years. For example, it has been reported that Bahrain's rapid modernization has eroded patriarchal authority in society to some extent. As a result, women have made significant progress in many fields, including the labour market (Seikaly, 1994). Social and cultural restrictions on women's education, skills and mobility still exist but Bahrain is more open than the rest of its GCC neighbours and much has been done to change these social circumstances. However, the prevailing social view stigmatizes women as emotional beings better suited to the home and family – and women have (in general) failed to complain publicly (United Nations, 2003).

2.6.2 Why is Saudi Arabia different?

Gender inequality keeps women at a disadvantage throughout their lives and negatively affects the development prospects of their societies (World Bank, 2005). Women in Saudi Arabia are subject to considerable discrimination and some authors

have suggested that a narrow and restricted interpretation of Islamic teachings has restricted gender equality (Hamdan, 2005). Religious lawyers (*ulema*) or clerics determine laws and conduct in Saudi society and reinforce practices such as the segregation of men and women, the ban on women driving and numerous other social restrictions. In fact, Saudi Arabia's adherence to sex segregation outside the home is practised to a degree unknown in most of the Arab and Muslim world. Doumato (2000) attributed this to two main reasons. First, Saudi Arabia's social fabric was not disturbed by a colonial experience so Western influence is very recent and has arrived to some degree selectively, by the Saudis own choosing. Second, social conventions and religious-based attitudes that support sex segregation, female domesticity and dependence on men have been incorporated into public policy. In combination, these factors might at least partly explain the persistent opposition to Saudi women working outside the home.

Generally, Saudi families also oppose the idea of women working outside the home, especially in occupations where men and women work together. These family and religious values have profound implications for policy-makers and planners in Saudi Arabia. Nevertheless, rising levels of education among women combined with local and international pressure on Gulf governments (especially Saudi Arabia) have contributed to positive changes in recent years. Ironically, the 11 September 2001 attack on the USA advanced the issue of women's rights throughout the Gulf (and Saudi Arabia particularly). Women are now in the spotlight and generating heated debate between those who support more rights and those who oppose them. Recently, several Saudi women have reported that the government is improving opportunities and equality for women but the culture and organizations they work for are slow to change (Vidyasagar & Rea, 2004).

Some authors suggest that Arabic society looks down on working women and views them as incapable of performing as well as men (Al-Nimr, 1996). Although most GCC governments have adopted public sector labour policies, including equal pay for equal work (Al-Nimr, 1996), women's participation in the workforce remains low in all except Bahrain. The Saudi Government stressed its commitment to enabling Saudi women to participate in the development of their country in the eighth SDP.

> We intend to provide more employment opportunities to Saudis, and in particular to women and to adopt appropriate policies that enhance women's participation in the

> labour market in the positions that best suit the skills of women and do not contradict with sharia (Islamic law) principles (Ministry of Economy and Planning, 2005b, Chapter 8:p10).

2.6.3 Summary

Sections 2.3 to 2.6 examined the general shortage of human resources in the Gulf and the particular shortage of indigenous human resources in the health service. Recruitment and retention of health workers in general and nurses in particular are major concerns for developing and developed countries alike. Moreover, countries are reporting that current nurse shortages can be attributed partly to patients' increasing care needs.

The literature review examined the development of human resources in the Gulf since the beginning of the 1970s. It traced the history of foreign workers in the Gulf and highlighted the factors behind the present composition of the Gulf labour market. One of the main features of this was the huge influx of foreign workers following the discovery and exportation of oil. It also examined labour force characteristics and reviews and various development plans in the three Gulf states of Saudi Arabia, Bahrain and Oman. A discussion of the shortage of indigenous human resources in general focused on the health service in particular. This emphasized that Gulf states suffer from a chronic and severe shortage of health-care workers in general and nurses in particular. It also emphasized the great concern over the shortage of skilled and unskilled indigenous human resources in most Gulf states.

Despite numerous attempts to reduce dependency on foreign labour, most of the Gulf governments have failed to alter the composition of their labour market in favour of indigenous workers. The employment of women in the Gulf and Saudi Arabia has been examined with a focus on the subordinate role of women in the labour market and the obstacles and restrictions on indigenous female employment. Finally, this section has examined some of the social and religious values that have profound implications for women's participation in the labour force in general and nursing in particular.

The next section reviews the characteristics of human resources in the Gulf and the labour markets in the three Gulf states.

2.7 Human resources in the Gulf

It is important to note that very little work has been undertaken on comparative human resource management in developing countries in general and the Gulf states in particular (Budhwar & Debrah, 2003). In addition, health workforce issues have become more prominent in many countries in recent years (Adams & Dussault, 2003; World Health Organization, 2006) but human resources for health in the Gulf is still in its infancy. However, in order to understand the nature of human resource management in any country, it is necessary to be aware of the various external contexts that affect their management.

Human resource management is shaped by external factors such as political, economic, social, and labour market considerations (Hendry & Pettigrew, 1990). It is known to be context-specific – that is, the degree and direction of influence of both culture-bound and culture-free factors vary from country to country (Budhwar & Debrah, 2003). Five contextual factors shape human resource management and practices in the Gulf states:

1. structure of the economy
2. political environment
3. structure of the labour market
4. national human resource development strategy
5. national culture.

The first two of these contextual factors were highlighted and explored in Chapter 1. The work relevant to the remaining three – the structure of the labour market; national human resource development strategy and national culture – is discussed below.

2.7.1 Characteristics of human resources in the Gulf

Human resource management in the Gulf has certain defining characteristics that include a highly segmented labour market with a clear distinction between privileged indigenous workers and foreign workers with insecure employment. The history of foreign workers in the Gulf began with the region's oil industry in the 1930s but the region only started to import large numbers of foreign workers following the sharp oil price increases in the 1970s. The young and growing private sector also recruits large

numbers of foreign workers to meet the enormous demand created by government expenditure. These factors have increased international recruitment markedly.

Historically, private sector firms traded ongoing investment and job creation for indigenous people in return for state patronage and a relatively free hand in the recruitment and employment of foreign workers (Grahl & Teague, 2000). This produced drastic changes in the population and labour force structures. The population in the GCC states has grown more than tenfold over a period of 50 years – from 4 million in 1950 to 40 million in 2006 (Kapiszewski, 2006). The growth rate averaged about 5% between 1970 and 1980 and 4.8% between 1980 and 1990. This compared with 2.4% and 2% respectively in developing countries and made it one of the highest rates of population growth in the world (Jaber, 2000). The demographic growth rate has now declined but fertility rates remain high at an average of about four children per woman in the three states. For example, the latest figures indicate that the Saudi population grew more than threefold during the last three decades, from 7.3 million in 1975 to 27 million in 2005. Population growth in the Gulf is attributed to rising improvement in living, health and social conditions during the last three decades. WHO data show that the majority of the Gulf's indigenous population is young – 40% of Saudis, 33.7% of Omani and 27.6% of Bahrainis are aged <15; 3.1%, 3.2% and 2.5%, respectively, are aged ≥65 (World Health Organization, 2004).

The increase in the Gulf states' population has been caused by a combination of the natural growth of the indigenous population and the extensive recruitment of foreign workers. The latter represent the majority of the total labour force in most Gulf states. In 1975, the proportion of foreign workers ranged from over 13% of the population in Saudi Arabia and Oman to over 22% in Bahrain. Two decades later (in 1995) the proportion of foreign workers ranged from over 27% in Oman to over 38% in Bahrain. Saudi Arabia had more than 6 million foreign workers, nearly half of its total indigenous population that year (Girgis, 2002) (see Table 6). In 2005, the proportion of foreign workers had decreased in both Saudi Arabia and Oman and increased slightly in Bahrain. The reduction is generally attributed to the high rate of indigenous population growth between 1995 and 2005.

Table 6 **Indigenous and foreign workers in the three Gulf states (1975-2005)**

	Saudi Arabia	Bahrain	Oman
1975	(1000s)		
Indigenous	6 089.3	201.6	666.0
Foreign	937.0	60	100.0
Total workers	7 026.3	261.6	766.0
% foreigners	13.3%	22.9%	13.1%
1980			
Indigenous	7 306	233.3	805
Foreign	2 382	103.4	179
Total workers	9 688	336.7	1 193
% foreigners	24.6%	30.7%	18.2%
1985			
Indigenous	8 764.2	276.1	973
Foreign	3 878.0	158.6	220
Total workers	12 642.2	434.7	1 193
% foreigners	30.7%	36.5%	18.4%
1995			
Indigenous	13 272	362.2	1 563
Foreign	6 262	223.9	586
Total workers	19 534	586.1	2 149
% foreigners	32.1%	38.2%	27.3
2005			
Indigenous	17 029 000	438 209	2 325 812
Foreign	6 644 236	268 951	577 293
Total workers	23 673	707 160	2 903 105
% foreigners	27.1	38.0	19.9

Sources: Girgis, United Nations, 2006

2.8 Labour markets in the three Gulf states

GCC states share distinguishing characteristics – significant proportions of foreign workers in their labour forces and segmented labour markets. Indigenous workers with better education and training work mainly in the public sector as it offers higher

salaries, more benefits and greater job security. The private sector is heavily dependent on foreign workers, recruited on fixed contracts and sponsored by indigenous firms. The labour market is so segmented that (in most GCC states) as much as 90% of the indigenous labour force is employed in the public sector and foreign workers comprise a comparably high ratio in the private sector (International Monetary Fund, 2004).

Sassanpour et al. (2004) argue that the labour markets in the GCC states are segmented between several dimensions: public and private sectors; indigenous and foreigner; and skilled and unskilled labour. They further point out that the most important factors in this are significant disparities in wage and non-wage benefits between the public and private sectors (even for comparable skills) and between indigenous and foreign workers employed in the same sector. Public sector pay and benefits is more generous to both indigenous and foreign workers. There are also marked dissimilarities in educational background, training and qualifications between indigenous and foreign workers (Sassanpour et al., 2004).

A lack of relevant data makes it difficult to compare public and private sector wages and benefits in most GCC states. Nevertheless, it is widely recognized that public sector workers receive a guaranteed annual salary. In addition, indigenous workers enter employment at higher levels; receive higher wages for similar work; are entitled to extra benefits (highly subsidized housing loans, transportation allowances and incentives for continued training and education opportunities locally and overseas); and are promoted faster than foreign workers. However, almost all GCC states are replacing traditional guaranteed employment policies for indigenous people in the public sector with a more selective recruitment policy to reduce overstaffing. Current labour market strategy stresses the importance of the private sector as the principle source of employment opportunities for indigenous workers in the future.

2.8.1 Labour market in Saudi Arabia

One of the most important issues in Saudi Arabia is the labour market policy and the severe shortage of qualified Saudi nationals in key professional areas such as the oil industry, high-tech sectors and the health service. Saudi Arabia has a high level of state intervention and a labour market clearly segmented into indigenous and foreign

workers (Mellahi & Wood, 2002). The sharp rise in oil revenues in the 1970s provided the government with the resources to devise a comprehensive development programme to improve development-planning mechanisms and the country's economic situation. The government drew up a series of five-year plans focused on improving infrastructures, most importantly those pertinent to human resources. Eight SDPs were devised between 1970 and 2005 (see Appendix 3).

The first SDP (1970-1975) focused on the infrastructures and basic services affecting education, health, electricity and water and initiated massive infrastructure projects. Shortages of indigenous skilled and unskilled workers necessitated the recruitment of foreign labour. By the end of the plan, foreign workers represented 43% of the total labour force and 13.3% of the total Saudi population (see Table 7). This marked the beginning of a massive recruitment of foreign workers and increasing dependency on them. The trend continued in the second SDP (1975-1980) which required even more foreign workers to develop the infrastructure and work in the expanding oil and gas industries. By the end of 1980, the number of foreign workers had almost doubled (24.6% of total population).

The third SDP (1980-1985) sought to continue the expansion of the country's infrastructure. It is important to note that there are no unified data on the number of foreign workers in Saudi Arabia; official figures show that there were 4.87 million foreign workers in 2006 (see Table 7). In May 2004 Saudi's Labour Minister disclosed that there were 8.8 million foreign workers in the country (Asia News, 2004), a figure significantly higher than the government had previously reported. The third SDP extended projects to other parts of the country and included the building of industrial cities. The number of foreign workers continued to rise and reached 72% of the total labour force and 30.7% of the total population by the end of the plan. Thus, foreign workers played a major role in implementing the massive Saudi infrastructure projects initiated during these three development plans.

The decade from 1985 to 1995 was a period of economic difficulty for Saudi Arabia – economic growth began to slow and revenues to decline as oil prices fell sharply. However, the problems associated with the legalization of foreign workers reflect wider regulatory weaknesses in the Saudi state. Many of these weaknesses stem from inadequacies in Saudi public administration. Those related to the labour market were

exacerbated by considerable deficits and slow or even negative economic growth during the 1990s. Many of the peculiarities of the Saudi case lie within the adopted legal framework and whether or not laws are enforced effectively.

Table 7 **Indigenous and foreign workers in Saudi Arabia**

(% of total workforce)

Date	**Indigenous workers**	**Foreign workers**
1975	57%	43%
1985	28%	72%
1997	36%	64%
2003	40%	60%
2005	44%	56%

Source: Al-Dosary, 2006

The sixth SDP (1995-2000) aimed to tackle unemployment at an early stage by developing Saudi human resources (Saudization). More resources were invested in education and training with an emphasis on ensuring that curricula could meet the needs of the labour market. However, the end of this plan was marked by an increase in unemployment among Saudis. With unemployment rates reaching 8.34% (Ministry of Planning, 2001), the seventh SDP (2000-2005) again stressed the importance of developing human resources and urged both public and private sectors to accelerate indigenization. The government also pledged to reduce the number of foreign workers to 20% of the total population in ten years (Looney, 2004).

It is important to note that (since the fourth SDP) most SDPs have included the same or similar objectives. All have stressed the importance of reducing dependency on foreign workers and increasing the number of indigenous workers. However, these ambitious objectives are proving difficult to achieve. Despite numerous attempts to reduce the number of foreign workers and encourage Saudi nationals to undertake productive work in all economic sectors the number of foreign workers has continued to increase, particularly in the private sector. Table 8 shows the composition of the labour force in the Saudi private sector.

Table 8 **Labour force in Saudi private sector by sex and nationality (millions)**

	2004		2005		
	Number of workers	Distribution %	Number of workers	Distribution %	Annual growth rate
Total labour force	**6.6**	**100**	**7.6**	**100**	**15.4**
Male	6.47	98.1	7.44	97.9	15.1
Female	0.13	1.9	0.16	2.1	28.1
Saudis	0.48	7.2	0.62	11.6	28.4
Male	0.46	6.9	0.59	11.0	27.9
Female	0.02	0.03	0.03	0.6	37.7
Non-Saudis	5.91	89.6	6.71	88.4	13.7
Male	5.21	88.2	5.83	86.9	13.7
Female	0.7	11.8	0.88	1.5	25.7

Source: Saudi Arabian Monetary Agency, 2006

In 2000, the Human Resources Development Fund (HRDF) was established to train the Saudi labour force in the skills required in the private sector and to develop a database for matching and placing Saudi workers in that sector. This independent agency generates most of its financial resources from government-collected fees and penalties imposed for the recruitment of foreign workers in the private sector. The HRDF and the private sector share the costs of training and wages during an employee's first two years (Appendix ٤). One of its most important aims is to establish programmes to replace foreign workers with Saudi nationals with minimal disruption. It also undertakes research and consultations on training and related issues and makes recommendations to both the government and the private sector (HRDF, 2003). Another important reform was the establishment of a ministry of labour in 2004 with responsibility for labour and Saudization issues. Also, existing labour policy was reformed and a new labour law was introduced in 2004.

2.8.2 Labour market in Oman

Oman also devised a series of five-year plans. These focused on diversifying the economy and improving the management of its human resources through vocational

and technical training programmes. From 1975 to 2005, six Omani five-year plans (FYPs) were devised. The first (1976–1980) aimed at establishing essential infrastructure such as government buildings, power stations and communication centres. The second FYP (1981–1985) aimed to complete the infrastructure needed to modernize the economy and raise living standards. The third FYP (1986-1991) was intended to augment the achievements of previous plans but the decline of oil prices in this period forced the government to reduce and cancel some development projects. The fourth FYP (1991–1995) concentrated on broadening and diversifying the economy and developing Oman's human resources.

By the end of 1995, Omani nationals represented 36% of the total labour force and foreign workers represented more than 27% of the population (Table 6). The fifth FYP (1996-2000) was regarded as the beginning of a new era of development planning in Oman. It called for wider public and private sector participation in improving the education, training and creation of job opportunities for Omanis. The sixth FYP (2001-2005) aimed at enhancing the drive for Omanization and providing incentives to encourage private sector participation. As in Saudi Arabia, all the FYPs stressed the importance of reducing dependency on foreign labour and increasing the indigenous population's participation in the labour force. The main objectives of Oman's human resource policies in the FYPs are listed below.

- Improve health and education services for the population in order to upgrade human resource quality and productivity.
- Improve employment opportunities for Omanis in order to avoid unemployment and provide training and qualifications that conform to labour markets needs.
- Replace foreign workers with highly qualified Omani workers. Furthermore, increase the participation of Omanis in the labour market in general, with a particular focus on increasing the participation of Omani women.
- Increase the efficiency of the Omani labour market by reducing the differentials in wages between the public and private sectors.
- Improve and encourage good work ethics in order to increase Omani human resources productivity (Ministry of Information, 2006).

However, the use of foreign labour has continued to rise despite all the efforts and measures proposed by the government. During the first four FYPs (1976-1995), the proportion of indigenous workers in the labour market decreased from 65% to 36% and foreign worker participation increased from 35.4% to 64.8% (Al-Alawi & Shiban, 1999). Since 1995, the situation has changed little and foreign-worker participation remains high. In the public sector, Omanization increased slightly from 68.5% to 74% between 1995 and 2000. However, the total Omanization ratio in the country's labour force remained unchanged during this period, at 34% (Ministry of Social Affairs and Labour, 2001).

In 2001, Oman established the Ministry of Manpower to be responsible for labour force issues in the country. In 2002, the government established the Self-Employment and National Autonomous Development (Sanad) programme aimed at increasing the participation of Omanis in the private sector by sharing the cost of their training and their first year's wage. This human resource development fund also provided financial and technical support to self-employment projects and the development of small businesses and aimed to establish a human resource database for better and effective planning of Oman's own human resources (Ministry of Manpower, 2003). A new labour law was introduced in May 2003 (Fasano & Iqbal, 2003).

Unemployment in Oman is estimated to be approximately 15% and considered one of the highest rates in the Gulf (Central Intelligence Agency, 2006a). In 2005, foreign workers in Oman represented more than 65% of the total labour force and 19.9% of the population (Kapiszewski, 2006). Similar to Saudi Arabia, Oman began reforming its education, training and labour force policies. The aim was to improve vocational and technical training programmes and to set a uniform minimum wage for Omanis.

2.8.3 Labour market in Bahrain

The Bahraini labour market is defined by three key characteristics:

1. high percentage of foreign workers
2. high percentage of public sector employment
3. strong segmentation between low-paid foreign workers in the private sector and well-paid Bahraini workers in the public sector (United Nations, 2002).

These are similar characteristics to those in Saudi Arabia and Oman. Therefore, one of the aims of Bahrain's strategy to meet labour market demands was to train and develop human resources, especially within the private sector (Ministry of Labour, 2006). Like most other Gulf states, Bahrain has more than 91% indigenous workers in its public sector and employs approximately 5% of the Bahraini population. However, 40% of Bahrain's public workforce is female (Ministry of Labour, 2006). Bahrain is considering measures (e.g. changing working hours, reducing wages) to make the public sector less attractive to indigenous workers.

The situation is strikingly different in the private sector where foreign workers comprised more than 57% of the total labour force in 2004 (International Labour Organization, 2005). Since 1975, Bahrain's foreign workers have constituted a higher percentage of the population than foreign workers in Saudi Arabia or Oman (see Table 6). In 2004, more than 64 000 jobs were created in the Bahraini labour market but 82% of these went to foreign workers. Similar to Saudi Arabia and Oman, 77% of Bahrainis who registered at the Ministry of Labour seeking jobs were high school graduates (Ministry of Labour, 2006).

Like those in Saudi Arabia and Oman, Bahrain's labour market is also segmented along gender lines – women are concentrated in a narrow range of occupations. The ILO (2005) reported that more than half of the Bahraini female labour force works in the public sector, mainly health and education. Women face additional constraints in labour market integration as indicated by their unemployment rates. These have been consistently double those of men since the 1980s. Unemployment among Bahraini nationals stood at 14% in 2004 (International Labour Organization, 2005). As in Saudi Arabia and Oman, high educational attainment does not necessarily translate into jobs. For example, female students represent about two-thirds of all enrolments at high school and post-secondary level but the 2001 census showed that women's share in the national workforce was only 25.78% (International Labour Organization, 2005). Therefore, high educational performance is not matched with job opportunities for the female population.

As in Saudi Arabia and Oman, the quality of education and training in Bahrain does not match labour market needs. According to the ILO (2005), graduates of all

education levels (including university) do not meet required standards. Bahrain developed a new National Employment Strategy that provided fiscal subsidies for training Bahrainis in the private sector and financial aid for the unemployed. It also introduced measures to improve educational standards and vocational and technical training programmes; increased the employment quotas for Bahrainis in small and medium enterprises; and abolished free visas for foreign workers (Fasano & Iqbal, 2003).

2.8.4 Foreign labour in the Gulf

In 2005, the Gulf states were home to 12.5 million foreign workers (United Nations, 2006). Their presence has enabled rapid development but created various difficulties in foreign affairs and brought about a number of negative cultural and socio-economic consequences (Kapiszewski, 2006). For example, Amnesty International reported that half of the 102 people executed in 2007 were foreigners, many of them Asian workers (Amnesty International, 2007). The Saudi government claims that these foreign workers committed major crimes against society.

Abdelkarim (1999) argues that huge imbalances between the indigenous population and foreign workers occur because most Gulf states have not formulated clear policies. They have failed to address issues such as population imbalances; unemployment among the indigenous populations; and the need to create job opportunities for their increasing numbers of young graduates. Abdelkarim further argues that politics and security factors (rather than economics) in some Gulf states largely determine attitudes to the presence and employment of expatriates (Abdelkarim, 1999). This means that some have developed a selective recruitment policy for foreign workers and more foreign workers will be recruited from friendly countries, regardless of their quality or local economic demand. For example, Saudi Arabia expelled the majority of around 1.5 million Yemeni workers during the 1991 Gulf War because Yemen sided with Iraq against Saudi-allied Kuwait.

Prior to the oil price boom in the early 1970s, the majority of skilled and unskilled foreign workers came from Arab countries, mainly Egypt, Yemen, Palestine and Sudan (Mohammed, 2003). By the early 1980s, an increasing number of foreign workers were being recruited from Asia – mainly Pakistan, India, the Philippines and

Thailand. Asian workers were preferred in both public and private sectors as they were cheaper, easier to manage (more organized, disciplined) and posed no threats to the fragile Gulf identity and security (Mohammed, 2003). Jureidini argues that the numbers of Arab workers were being reduced for both economic and political reasons as they were more expensive and their political activities in the Gulf were considered potentially threatening (Jureidini, 2001). Asian workers had all the advantages listed above but did not require the same level of social services (e.g. health and education) as, unlike the Arabs, they were not likely to settle and bring their families (McMurray, 1999).

Foreign workers are employed under a sponsorship system – an employer (the state, a company or an individual) invites them to the Gulf and provides the working contract that allows residency. This system has been criticized by various international human rights organizations as foreign workers are totally at the mercy of employers who can retain their passports, limit their freedom of movement and prevent them from changing jobs (Aspden, 2006). Assuredly, some are mistreated (International Federation of Human Rights, 2003). However, their home countries (especially in Asia) have pursued active policies for overseas employment and encouraged migration to Gulf states in order to alleviate domestic unemployment and generate foreign currency (Jureidini, 2001). In 2006, the World Bank estimated that remittances worldwide reached a new peak of US$ 268 billion (Chisti, 2007). India accounts for close to 10% of this global phenomenon and receives 24% of its foreign currency in remittances from Indian workers in the Gulf region (Chishti, 2007). For example, 6 million Indian workers working in the Gulf sent home around US$ 6 billion in 2006. In Saudi Arabia, foreign workers remitted more than US$ 15 billion in 2007 (Al-Riyadh, 2008).

At the beginning of 2004 oil prices began to rise and provide huge revenues for the GCC states. As in the 1970s, the huge increase in oil price necessitated the recruitment of more foreign workers in order to provide necessary services for the growing economies. Between 2004 and 2005 the number of workers in Saudi Arabia increased by 1 million (6.6–7.6 million). Foreign workers constituted more than 80% of this increase but only about 15% of foreign workers in the country are engaged in skilled labour (in oil, health care, communications), the majority are employed in low-

skilled industries (Pakkiasamy, 2004). The indigenous labour force exceeded its 4.7% target and increased by 5.1% during the seventh SDP but the number of foreign workers also increased by 2.4% (Ministry of Economy and Planning, 2005a). This was a small reduction on numbers during the previous plan but foreign workers still filled more than 53% of the 1.04 million new jobs created, mostly in the private sector.

Many countries face the challenge of creating new job opportunities for their people. Saudi Arabia has many job opportunities and often demand exceeds supply, especially in the private sector. But foreign workers occupy most of these jobs and their presence divides the country's labour market. One part is the public sector that provides reasonable wages, adequate working conditions, employment stability and clear work rules and regulations. This sector employed 142 341 Saudis in 1975 and 733 866 in 2006 (33% female), 91% of all public service employees (Saudi Arabian Monetary Agency, 2006). The other part comprises the free or private sector with generally low wages; poor benefits and working conditions; and workers subject to arbitrary rules and regulations. However, the exceptionally favourable situations enjoyed for decades by the Gulf's indigenous populations have started to change. Growing numbers are experiencing difficulties in finding suitable jobs (Kapiszewski, 2006).

There is a low level of female participation in the Saudi private sector (see Table 8). This is mainly attributed to the various cultural and religious restrictions imposed on women's freedom to move. In addition, many private sector organizations are reluctant to employ women as this requires them to meet certain measures and requirements imposed by (mainly) religious institutions. For example, women must be employed in a designated area, separate from the men's working area, and contact between the two sexes must be limited.

The numbers of foreign workers have continued to grow in some Gulf states, primarily because of increasing demand from the private sector. The Gulf governments have begun to make serious efforts to reform their labour force and employment regulations to control the level of expatriate recruitment and increase the recruitment of indigenous workers. Saudi Arabia has begun to implement policy

reforms to create employment opportunities for the rapidly increasing indigenous labour force, while reducing dependency on oil.

The next and final section will describe the characteristics and elements of policy-making in the Gulf states. This leads to a discussion of the indigenization policies initiated to reduce dependency on foreign workers in general, foreign nurses in particular, and increase indigenous people's participation in the workforce.

2.9 Policy-making in the Gulf

2.9.1 Background

There is a huge gap in Western knowledge about the policy environment in the Gulf. One aim of this research is to fill some of this by exploring and examining the policy-making process in the three Gulf states. First, it is necessary to understand the environment in which policy is developed in order to understand the context of indigenization policies in the Gulf. This includes the process of policy-making (how issues join the policy agenda) and the actors' characteristics – position in power structures, values and expectations (Walt & Gilson, 1994). Social policy initiatives emerge because either a consensus of interest develops around a particular proposal for reform, or because it is functionally necessary in societies reaching certain stages in their growth (Hall et al., 1975).

In addition, this section aims to identify the policy drivers of indigenization and explore the implications of indigenization in the nursing workforce.

> Defining policy is rather like the elephant – you know it when you see it but you cannot easily define it (Cunningham & Sarayrah 1993, cited in Keeley & Scoones, 1999).

Public policy is concerned with how issues and problems come to be defined and constructed and how they are placed on the policy agenda (Parsons, 1995). Heidenheimer et al. (1990) point out that public policy is the study of: "how, why and to what effect governments pursue particular courses of action and inaction". Many policy-writers have claimed that policy is a purposive course of action followed by an actor or actors to deal with a specific problem and that it is different from decisions;

being more comprehensive and involving a series of more specific actions (Walt, 1994). Walt claims that public policies are those policies generated and developed by government agencies, or bodies, and officials and that therefore focus on purposive action by governments.

2.9.2 Public policy-making process in the three Gulf states

Government is depicted as a powerful force at each stage of policy-making, from the first stage of initiation of proposals to their final implementation (Hall et al., 1975). Bahrain and Oman have inherited characteristics of public policy-making from the period of British control (until the 1970s). Saudi Arabia has a number of characteristics which arose from Egyptian influence, especially at the beginning of the establishment of the Kingdom. In addition, the sharp increase in oil prices in the 1970s impacted hugely on public policy-making in the Gulf states due to the sharp increase in the number of public institutions established to provide the services necessary for these growing economies.

Hall et al (1975) argue that government is the locus of power when it comes to the planning of legislation. They further argue that the way in which government is organized and structured partly determines the nature and outcome of policy (Hall et al., 1975). Thomas and Grindle (1994) argue that the general context of the policy-making process in developing countries forms a backdrop for the conditions and circumstances that place particular issues on the agenda for government decision-making. They further argue that circumstances of crisis alter the dynamics of decision-making by raising or lowering political stakes for policy elites; altering the identity and hierarchical level of decision-makers; and influencing the timing of reform. They found that decision-makers adopt different decision criteria as a result of different agenda-setting processes. They conclude that political factors concerning religious and ethnic support and opposition; cultural and religious conflict's potential to destabilize the political system; and concerns about the political implications of projected unemployment appear to have been of central importance in shaping the decisions of policy elites (Thomas & Grindle, 1994). The assumption is that the Gulf region has similar policy-making characteristics as it is part of the developing world.

It is important to recognize that most of the Gulf governments are traditional inegalitarian systems. They preserve inequalities and oligarchical structures and concentrate power and wealth in the hands of a few (Walt, 1994). For example, the King takes all important decisions in Saudi Arabia. Lindblom (1980) differentiates between democratic and authoritarian systems when considering policy-making and policy outputs. He argues that authoritarian systems do not pursue policies designed to encourage and protect civil liberties (Lindblom, 1980). Hall et al (1975) differentiate between two approaches to the policy-making process: (i) pluralist model; and (ii) class model. The pluralist approach accepts that there are defects in democratic political systems but that these are largely inescapable and residual blemishes in a basically sound and just system based upon dispersed power. Also, inequalities in society are neither so great nor so cumulative that they result in domination by a single elite. The class or elite approach stresses the belief that social, political and economic power is distributed in a fundamentally unequal way within societies and power is centralized in the hands of a small and cohesive sector as is the case in the Gulf states.

Socio-economic factors (as well as beliefs, norms and values) are important dimensions of policy-making and its outcomes (Parsons, 1995). Walt and Gilson (1994) explain that actors are influenced by the context within which they live and work. They argue that context is affected by a number of factors such as instability in a political regime; war; ideology; historical experience; and culture (Walt & Gilson, 1994). This is even more relevant in a region like the Gulf where changes have occurred rapidly since the 11 September 2001 events and the war in Iraq. These rapid political and economic changes are crucial to an understanding of policy-making and the policy environment in the Gulf region.

In general, the Gulf states may be viewed as highly centralized states with high levels of administrative power and control vested in central governments. Therefore, central governments that are closely involved in most aspects of decision-making and planning take the important decisions. Administrative systems in the Gulf states consist of three levels:

1. Central government comprising the civil service, ministries and public agencies such as utilities, transport and trade.

2. Regional councils, which include regional municipalities (for example, Saudi Arabia has 13 regional councils).
3. Local municipalities.

2.9.3 Indigenization as a public policy

Public policies are those generated and developed by governmental agencies, bodies or officials and therefore focused on purposive action or decision (Walt, 1994). To understand a policy-making process in any setting requires understanding of the political process too. The political environment and processes which lead to changes in policies are often complicated and sometimes obscure (Hall et al., 1975). Indigenization policy-making is classically political: a competition among multiple stakeholders and interest groups each with differing goals, resources, tactics, information and power. Hall et al (1975) argue that different bodies and institutions within a political system frequently compete, jostle for advantage and engage in conflict to test their relative strengths. Further, like governments, interest groups (what they call pressure groups) have to examine the demands they champion in terms of the consequences for their own support and resources (Hall et al., 1975). Of all interest groups in the Gulf states, religious and business groups have perhaps the most pervasive and powerful influence on governments.

The three Gulf states have similar indigenization policies and one common denominator – a reflection of widely shared "public ideas" that indigenization is a regional issue and must be tackled as such. Cobb and Elder (1983) argue that the larger the audience for whom an issue has a wide appeal, the more likely that such an issue would move from a matter of popular concern to become a matter of government concern (Cobb & Elder, 1983). However, Hall et al (1975) argue that governments have substantial access to the public through mass communication and can use persuasion to gain support for their view of what is for the public good. The vast majority of planning and development legislations rest within governments and they determine the flow of legislation through parliaments (Hall et al., 1975). Nevertheless issue creation is a cultural and social process; something must be defined as a problem amenable to human solution before it can be considered a public issue (Burstein, 1991).

Indigenization's policy elements link it closely to other public policies (e.g. economic or labour) and thus it is influenced by, and influences, them. For example, sharia (Islamic) law in Saudi Arabia affects a wide range of public policy areas both theoretically and in practice. These include sectors that do not adhere to Islamic rules such as the non-Islamic financial sector, women's right to work and family law. The process in which public policy is decided through elections, debates and political processes does not exist in most Gulf states. This is because sharia law exerts great influence on much of everyday life and must be recognized and acknowledged in matters of public policy. However, indigenization policies reflect the Gulf governments' public commitment to increase job opportunities for the local population and reduce the number of foreign workers and dependency on their expertise.

The indigenization policies in the Gulf focus on the preparation and training of indigenous people to produce qualified workforces that, it is hoped, will fill the countries' labour market needs. A GCC report examined the link between higher education output and the demand for graduates to service economic development in the Gulf area. This warned of the mismatch between the outputs of the education systems and human resource planning, identifying those educational institutions that produce graduates who are not suitably qualified for the needs of the labour market. It further reported that despite the availability of huge job opportunities (especially in the private sector) foreign workers are still preferred – mainly because they are a lot cheaper and easier to manage (Gulf Cooperation Council, 1996).

In a study of the Kuwaiti labour force, Al-Dwailah (1997) reports that Gulf education systems tend to produce far more humanities students. She argues that unemployment is increasing because the labour market needs science and technical graduates. In addition, indigenous graduates shy away from manual jobs available in the private sector. This supports the argument of those who criticized the Gulf states' education systems for producing graduates that lack the skills and knowledge needed in the labour market. Al-Qahtani (1998) supports Al-Dwailah's (1997) argument and suggests that science and technical higher education institutions in the Gulf are more adaptable and more relevant to the labour market needs than humanity and art institutions. He further argues that one of the most important obstacles for indigenous

graduate employment in the private sector is their weakness in English and information technology. Al-Qahtani (1998) concludes that education systems in the Gulf suffer from structural weakness in preparing and enhancing indigenous graduates' skills that are essential in the private sector. However, few (if any) comprehensive studies in the Gulf examine and analyse the harmonization of education systems and labour market needs.

Mellahi (2000) argues that research into education and vocational training in the GCC states has been largely neglected. Despite its importance there has been no comprehensive study on these issues. Girgis (2002) points out that the level of education in both the indigenous population and the national workforce increased appreciably between 1965 and 2000. However, he argues that instead of fostering economic growth through productivity improvements educational efforts in these countries were dissipated by two major factors. Firstly, the choice of major studies was distorted by government employment and promotion policies that deviated sharply from the mix of skills and basic knowledge required by both public and private sectors. Secondly, indigenous people were hired in the public sector in order to distribute oil dividends. This produced overstaffing, underemployment and underuse of this important resource.

Girgis (2002) further argues that an inadequate and unresponsive education system combined with a lack of proper human resource planning to produce a massive inflow of foreign workers to meet increasing demand (particularly in the private sector). However, the private sector could not act as the swing employer by employing indigenous people regardless of their qualifications, experience and cost. In addition, he noted that indigenous workers were reluctant to join the private sector and employers were reluctant to hire them because they received higher wages for fewer skills than their foreign counterparts (Girgis, 2002).

Given public sector employment policies and government's pervasive economic role it is not surprising that the public sector is the largest employer of indigenous people in most Gulf states. Indigenous workers would not accept the low wages and benefits that foreign workers receive in the private sector. For example, Mellahi and Wood (2001) report that approximately 85% of the jobs in the private sector pay less than a

Saudi national would accept as a minimum wage. Saudi nationals would expect about six times the salary that a skilled foreign worker would accept.

2.9.4 Bahrainization

As in other Gulf states, unemployment is consistently the major government problem in Bahrain. Some analysts have linked high unemployment in the majority Shiite population with the continuing influx of foreigners (often Sunnis) from other Arab states (Melia, 2002). Rapid population growth, a young population and dependence on foreign labour increases the pressure for job creation, training and education. The Bahrain Centre for Studies and Research (BCSR) produced a report on behalf of the Ministry of Labour. This showed that as many as 20 199 (14%) Bahraini nationals were unemployed in 2004 and Bahraini nationals accounted for 43% of a total workforce of 336 400 (International Labour Organization, 2005). The study also showed that unemployment is mostly confined to Bahrainis. The Ministry of Labour claimed that the unemployment rate was only 4% in 2006 (Bahrain Tribune, 2006). However, Bahrain and other Gulf states conceal their true unemployment rates for various economic and political reasons.

More Bahrainis have found private sector jobs in recent years but studies show that there are obstacles to Bahrainization. These include inadequate workplace skills among Bahraini job seekers; their unwillingness to take up manual work; low wage levels; poor working conditions; and reluctance to hire Bahrainis among some employers (International Labour Organization, 2005). Recently Bahrain's Labour Minister blamed low wages and hard working conditions for the low Bahrainization levels in the private sector and cited reforms to education and training programmes (Bahrain Tribune, 2007). Similar to Saudi Arabia and Oman, the government has set a quota for most private sector businesses and stipulated that some professions are to be occupied only by Bahrainis. It has also established the Supreme Council for Employment and Human Resources with responsibility for setting the employment and labour force strategy for the country. Its main aim is to invest in human resources development through appropriate training programmes and tap the skills of indigenous workers to take up jobs in the labour market and make a positive contribution to the country's development.

As part of the government's endeavour to limit reliance on foreign workers, the work permit application process was tightened to exert control on licences and prevent possible abuse. A vocational training project was adopted to improve graduates' skills and enable their participation in the Bahrainization process. In addition, the Labour Market Regulatory Authority was established to set up strategies, schemes and programmes to upgrade labour market skills in Bahrain and reinforce cooperation with the private sector.

Bahrain is the only GCC state to have permitted the establishment of a trade union, the General Federation of Bahrain Trade Unions. Some analysts consider this a major breakthrough in the Gulf (International Labour Organization, 2003).

2.9.5 Omanization

Optimum utilization of the indigenous workforce is linked to the development of Oman's economy (Ministry of Development, 1996). In 1994, the government issued Ministerial Decree Number 127/94 to impose an Omanization quota on all private sector establishments. This ranged from 60% in the transport and communication sectors to 15% in the contracting sector, all to be achieved by the end of 1996 (Ministry of Social Affairs, 1999). However, indigenous workers comprised only 6.7% of the private sector by the end of 1996.

By the end of 1999, Omanis comprised 7.7% of the total labour force in the private sector (Al-Alawi & Shiban, 1999). Al-Rayan (1998) reported negative attitudes toward the indigenous labour force in the Omani private sector. Omani workers were criticized for their lack of appropriate skills and creativity. Al-Rayan (1998) suggests that the private sector prefers foreign workers because they accept low wages despite superior skills and have higher productivity and a willingness to accept poorer employment conditions. He further argues that indigenous workers are more passive and lack a proper work ethic.

Al-Alawi and Shiban (1999) argue that low productivity and a reluctance to accept manual jobs are two of the main characteristics inhibiting Omani private enterprise from hiring indigenous workers. They point out the wide gap between the products of the education system and labour market needs, concluding that the available

flexibility of foreign workers hinders the employment of indigenous workers (Al-Alawi & Shiban, 1999). However, Girgis (2002) points out that the Omani private sector employed 50 923 more Omanis in the period between 1996 and 2000 (only 10 846 between 1991 and 1995). This indicates a strong reversal of past trends. A 1999 study by the Oman Chamber of Commerce and Industry indicated that the private sector was too small to absorb the increasing number of graduates and the government would need to introduce more incentives to encourage the creation of more job opportunities for Omanis. It also confirmed previous findings that the education system is incapable of meeting labour market needs and Omanis prefer to work for the public sector (Oman Chamber of Commerce, 1999).

2.9.6 Saudization

During the three decades between 1975 and 2005, human resources were defined as a major challenge in Saudi Arabia, which has been described as "capital-rich, labour-poor" (Alsaeeri, 1993; Al-Shuaibi, 1991). In 1985, the Saudi government initiated a Saudization policy to tackle the severe shortage of indigenous human resources, reduce dependency on foreign workers and alleviate rising unemployment. The government estimated this to be 12.02% in 2006 (Ministry of Economy and Planning, 2007a). However, some human resource analysts argue that the Saudization policy was born in oil exploration and production agreements with American oil companies. These included a clause requiring Saudis to be employed wherever possible (Madhi & Barrientos, 2003).

The fourth SDP (1985-1990) led to the emergence of an indigenization policy aimed at reducing the country's dependency on foreign workers. All subsequent SDPs have emphasized the importance of this policy, encouraging both public and private sectors to provide more opportunities for Saudi participation in the workforce and introducing various laws and regulations to restrict the employment of foreign workers (Ministry of Economy and Planning, 2001). As in other Gulf states until the early 1990s, most Saudis were guaranteed a job in the public sector. However, the inflated public sector that resulted was populated by large numbers of indigenous employees without a real, productive job. The number of government employees without a real job and the number of graduates rose sharply between 1985 and 1995 (Abdelkarim, 1999). Since then, this unsustainable policy of a guaranteed job for life has ceased.

Since its emergence, Saudization has seen intensive debate about its definition and ultimate objectives. Some consider it to be a tool or means of replacing foreign workers and limiting their numbers. Others see it as a process of managing a trained and qualified local workforce, not simply to replace foreign workers but rather for systematic planning and management of an organization's human resource requirement (Al-Harbi & Al-Dosary, 2001). Howlett calls it "a way for employers to revitalize their business by placing Saudi nationals in positions where they will clearly add to company profits" (Howlett, 2002). Alzalabani asserts that foreign workers will be replaced with Saudis so that they can take a more active role in the economic and social development of their country (Alzalabani, 2003).

The fourth SDP defined Saudization as a long-term strategy approach that centres on: "...the intensification of efforts to develop national manpower through a quantitative expansion of education and training, especially in technical and vocational areas" (Ministry of Economy and Planning, 2000). Nevertheless, the majority of those who have written or advocated Saudization agree on two important aspects – increasing the participation of indigenous workers and limiting the number of foreign workers. Al-Nimer (1993) defines the aim of Saudization as a "process of replacing non-Saudi residents with Saudi citizens in particular areas, on the understanding that the latter possess sufficient qualifications and abilities to perform these jobs."

The eighth SDP (2005-2010) clearly states the objectives of Saudization.

- To optimize use of the national labour force and encourage Saudi nationals to engage in productive work in all economic sectors.
- To ensure harmony between the educational and training programmes of Saudis and labour market requirements.
- To provide more employment opportunities to Saudi nationals in the private sector.
- To rationalize the recruitment of foreign workers and limit it to actual requirements, to enforce decisions and regulations related to Saudization and to restrict employment in certain job categories to Saudi nationals.

- To provide more employment opportunities for Saudi women by adopting appropriate policies that enhance women's participation in the labour market in the positions that best suit their skills and do not contradict sharia principles.
- To reduce the unemployment levels of Saudis and recommend solutions that address unemployment.
- To encourage investment in productive and service activities that use high technology (Ministry of Economy and Planning, 2005a).

While most of these objectives have been stressed and repeated in all SDPs, the implementation mechanism(s) have not been clearly defined. Government agencies and the private sector were left with a set of aims to accelerate Saudization without proper guidelines on how to achieve these objectives.

Saudization has been the focus of Saudi policy-makers for various reasons: economic, social and, more importantly, national security. The Saudi government has made numerous attempts to alter the composition of the labour force through Saudization, especially in the private sector. Al-Sudani and Abdulkhair (2001) argue that progress is still slower than expected and the percentage of indigenous Saudi workers in the private sector is less than 10%.

They attribute this to a number of factors:

- inadequate supply of and demand for indigenous workers;
- gap between the education, skills and wages of indigenous and foreign workers;
- private sector preference for foreign workers rather than indigenous workers who lack adequate skills and are more expensive.

Al-Sudani and Abdulkhair (2001) suggest that the Saudization policy should focus on providing more training programmes and implementing existing labour and financial regulations aimed at reducing the number of recruited foreign workers more effectively. Al-Sultan (1998) argues that implementation of the Saudization policy would replace the majority of foreign workers and alleviate the existing burden on

public services caused by foreign workers and their dependents. Al-Humaid (2003) shares the view that large numbers of foreign workers have a negative impact on public services, especially health and education. He argues that reducing the number of foreign workers by implementing Saudization would give an accurate picture of demographic realities in Saudi society and could lead to an improved distribution of national resources and public services. The government often urges the private sector to restrict new employment to Saudis and gradually replace existing foreign workers to achieve an ideal indigenization of employment, with full optimal use of national human resources (Manpower Council, 2002).

Looney (2004) examined the compatibility of a Saudization policy and the present economic reform in Saudi Arabia, especially the implications of membership of the World Trade Organization (WTO). Looney found that Saudization is considered to be compatible with the economic reforms and does not conflict with economic diversity, competitiveness, free trade and mobility in the labour force. In his recent study, Al-Dosary (2004) points out that prolonged dependence on foreign workers has given Saudis an ever-increasing contempt for both the government and the private sector. He suggests a number of strategies that include: improving Saudis' competitiveness and professional standards so that they can compete with foreign workers; encouraging the commitment to employ, train and retain Saudis; and strengthening the role of media campaigns to increase public awareness of the importance of Saudization. In addition, he wishes to change public attitudes towards certain professions. He concludes that these policy options may well lead to the indigenization of the labour force by developing the skill of indigenous people and implementing the labour force importation policies (Al-Dosary, 2004).

Madhi and Barrientos (2003) argue that employment and career opportunities are clearly differentiated by nationality in the private sector, more than 80% of which comprised foreign workers. They recognize their contribution to the rapid economic development of the country and argue that the implementation of Saudization faces important constraints. This is especially true in the private sector where productivity and competitiveness are vital in the present global market. Foreign workers accept lower wages and possess the necessary qualifications and experience that indigenous workers lack. There is also the myth that indigenous workers lack a work ethic and

are unprepared for very demanding jobs. This is not limited to the Gulf states or developing countries. However, the Saudization policy continues to face certain constraints and challenges that include a continuous flow of foreign workers, particularly the unskilled and low-paid. Also, private-sector employers show continuing non-compliance with the resolutions and regulations of the Saudization policy and its relevant implementation mechanisms (Ministry of Economy and Planning, 2005b).

Foreign worker visas have been a source of easy money for some Saudis. Black market visas are sold to foreign recruitment agencies and then resold, mostly to poor foreign workers from countries such as India, Pakistan and Nepal. However, pressure from various Saudi groups and the soaring increase in unemployment among young Saudis has compelled the government to make drastic changes to employment structures.

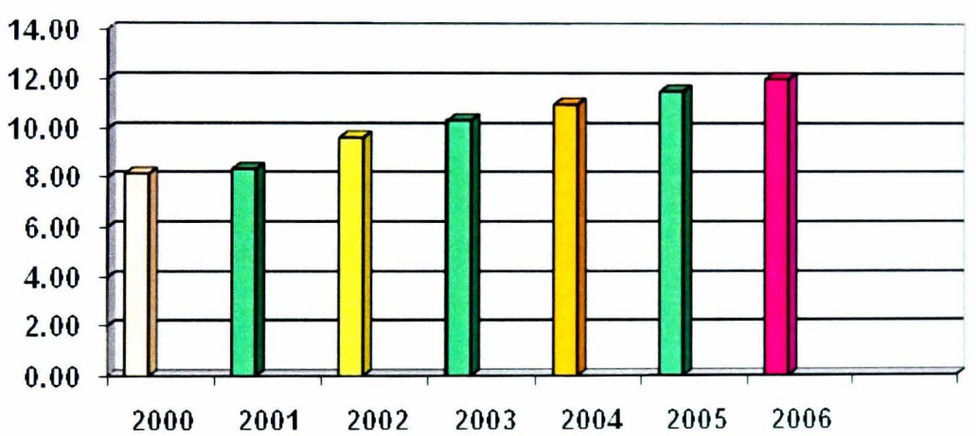
The government has indicated its commitment to enforce all Saudization legislation. For example, it has pledged to enforce the most prominent Saudization resolution (No. 50). Introduced in 1995, this requires private companies to employ Saudis and increase their number by 5% annually (Ministry of Labour and Social Affairs, 1999). In 2005, the Council of Ministers passed a decree to raise the private-sector Saudization rate to 75%. This was widely welcomed by Saudis who believed that the implementation of such a decision would significantly reduce unemployment in the country. The measures were received with cautious resentment by the private sector. It feared that they would compel the employment of untrained Saudis, which could jeopardise the future of private businesses (Arab News, 2005). In addition, the government has increased the cost of hiring foreign workers by introducing compulsory health-care insurance and increasing the cost of issuing and renewing work visas. Other measures include restrictions on transfers of sponsorship in order to curtail foreign labour movement and foreign workers' families entering the country. Also, a pool of professions (e.g. accounting, security, marketing) are to be filled only by Saudis (Ministry of Labour, 2005a).

Despite these measures to increase the cost of foreign workers, Saudis are still more expensive to employ. The private sector has voiced concerns over the implications of

Saudization (Mellahi, 2000) and has continued to raise concerns over measures such as tightening the restrictions on importing foreign workers. It has urged the government to examine carefully this policy's impact on the private sector. Some private sector owners are threatening to move their businesses outside the country if the government persists with these measures (Al-Watan, 2005).

Some authors (Abdelkarim, 1999; Girgis, 2002; Jaber; 2000) have indicated that the Saudi government has stopped its past open policy of hiring practically all indigenous people who wish to work in the public sector. However, it now faces potential negative consequences to national security from terrorism and increasing crime rates among higher numbers of unemployed nationals. The official unemployment rate was 12% in 2006 (Ministry of Economy and Planning, 2007b). It should be noted that the official unemployment rate among Saudi women was 26.27% in 2006 (Saudi Arabian Monetary Agency, 2007).

Fig. 3 **Official unemployment rates in Saudi Arabia (2000-2006)**



Source: Ministry of Economy and Planning, 2007a

Since the late 1990s, many human resource and economic analysts have warned the Saudi government about unemployment and its potentially dangerous consequences for the security and stability of the country (Financial Times, 2000). Concentrating on the social and security consequences of unemployment, Al-Thaqafi (2002) argues that dependence on foreign workers reduces job opportunities for Saudis and increases unemployment rates, which can be positively correlated with crime rates. He points out that unemployed Saudis committed more than 22% of the crimes in Saudi Arabia

between 1988 and 1997. The Crime Prevention Research Centre in the Ministry of Interior undertook a study of home burglaries in Saudi Arabia. This indicated that 75% of those who committed these crimes were either unemployed or single students under the age of thirty, of whom the majority were Saudis (Al-Riyadh Newspaper, 2008). Reducing and controlling the inflow of foreign workers will create more jobs for Saudis and reduce unemployment, especially among the young indigenous population (Al-Thaqafi, 2002).

In the past, Saudization was never a priority because there was no immediate necessity or urgency to implement it. The need for action became urgent only when unemployment worsened, especially since the mid-1990s when the government realized that the problem was no longer only economic. Unemployment in Saudi Arabia, the largest GCC country, had increased to about 13% among all males in 2004 and was as high as 35% among those aged 20–24 according to some estimates (Shah, 2005). Such a problem in the largest exporter of oil in the world has started to threaten the stability of the regime and now tops the government's agenda, perceived as an increasingly serious problem with a multitude of social and security dimensions.

Since 2004, Saudi Arabia has attained high rates of economic growth. These far exceed those achieved in the late 1990s – 2004 and 2005 may have been the best in the Kingdom's recorded economic history. GDP growth is estimated at 6% and there has been a significant expansion of foreign investment (Bank Audi Report, 2006). The private sector employment ratio is approximately 84%, which would in theory enable all Saudis to be employed (in the absence of foreign workers). Nevertheless, generating employment for the fast growing Saudi labour force and reducing their prevailing high level of unemployment remain as challenges for Saudi Arabia. This reinforces the need to take immediate and difficult decisions to accelerate structural reform in order to give renewed impulse to the expansion of non-oil economic activity.

2.9.7 Indigenization and the role of education and training

Education and vocational training in the Gulf states has not provided indigenous workers with the skills required in the public and private sectors. The vocational training curriculum geared towards relieving unemployment has met neither employer

nor student needs, nor expectations of their place in the labour market (Wiseman & Alromi, 2003). The GCC governments recognize the importance of skills and some have supported initiatives to reform their education and training systems. For example, Saudi Arabia recognized the importance of ensuring harmony between educational and training programmes for the Saudi workforce and labour market requirements (Ministry of Economy & Planning, 2004). Training and vocational education is emerging as the cornerstone of the national human resource strategy in Saudi Arabia, as in all other Gulf states. Since the late 1980s, human resource development in general and vocational education in particular has assumed high priority in Gulf development plans (Mellahi, 2000).

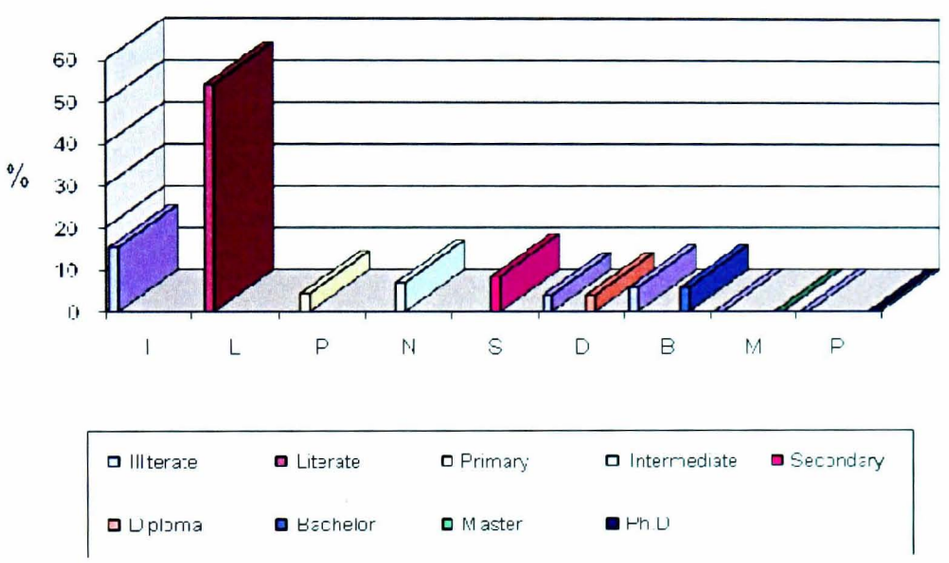
The fourth SDP indicated that structural changes, foreign investment and diversification of the Saudi economy would increase the demand for professional and skilled indigenous labour. It emphasized the necessity of orienting the complete educational system more explicitly with the labour market in all relevant activities (Ministry of Planning, 1985). Al-Dosary and Garba (1998) paint a bleak picture of Saudi education and training systems. They argue that growing unemployment and continued reliance on foreign workers indicates the ineffectiveness of education and training systems that lead to the failure of the human resource management and planning framework in the country.

The number of technical and vocational training institutes has increased since 2000 but education and training outcomes still do not align with labour market needs (Calvert & Al-Shetaiwi, 2002; Madhi & Barrientos, 2003). The latter argue that high school graduates prefer higher education over vocational and technical training. They attribute this to prevailing attitudes among young Saudis and their families who favour white-collar professions over manual and technical professions (Madhi & Barrientos, 2003).

There has been extensive debate concerning education and training issues and their relationship with the policy of Saudization. Some believe that inadequate and ineffective education and training is responsible for unemployment in Saudi Arabia. However, despite the validity of some of the criticisms discussed above, most critics have failed to demonstrate the link between education output and effective

Saudization. As previously described, 85% of foreign workers in the Gulf's private sector work in low-skill occupations and the majority have achieved high school standard or lower (see Fig. 4).

Fig. 4 **Educational levels of Saudi private sector workforce, 2005**



Source: Ministry of Economy and Planning, 2006

The training of Omanis has received special attention and support. The Omani development plans have taken tangible steps to expand technical and vocational training which has increased enrolment in these institutions. However, total enrolment in higher education remains low and did not exceed 20% in 2000 (Ministry of Planning, 2002).

WHO (2005) reports that the Gulf states' skills crisis can be solved if the public and private sectors invest more in adult skills training. Inadequate national competence; ineffectual plans for developing human resources in the health services; and poor coordination between the health and education ministries and other stakeholders are impeding progress.

2.9.8 Indigenization policies and culture in the Gulf

Societal culture refers to the main characteristics of a society that are shared via language, knowledge, skills, beliefs and customs. These combine to form a society's

way of life (Marcus & Ducklin, 1998) and help to explain much of the variance in work ethics, values, attitudes and behaviour (Dastmalchian et al., 2000; Hofstede, 1993). Gulf culture has its own traditions and values which are transmitted down the generations. One of the GCC's key objectives is to reduce cultural diversity and foster the homogeneity of the region's societal culture and all aspects of Gulf life. Gulf culture is also a key factor in shaping (and continuing to shape) human resource policies and practices in the region (Mellahi & Wood, 2001). For example, all the SDPs have been designed to emphasize the importance of religious and cultural values and reduce the influence of the different values and traditions of foreign labour.

In October 1998, the General Secretary of the GCC stated: "The problem of expatriate workers is starting to represent a danger for GCC states because they pose social and political problems that could grow more complicated in the future" (Kapiszewski, 2000). Many in the Gulf share this view. Al-Farsi (1996) disagrees, arguing that the presence of various cultural backgrounds, very different from the indigenous population, has not affected the homogeneity of Saudi Arabian culture and its society has been entirely unaffected. Al-Harbi (2003) argues that one of the most important advantages of an indigenization policy is that it minimizes the influence of external cultures brought in by foreign workers and maintains the purity of Gulf society and its cultural values and traditions. However, some cross-cultural writers like Hofstede (1993) consider that the commonality in religion and language accurately represents the Gulf or the Arab national culture and assumes that the GCC states are culturally identical.

The Gulf states do share more similarities than many other countries but the differences between and within them should not be overlooked. For example, indigenous people's low participation in the private sector is attributed partly to the fact that most prefer office and managerial work which is in short supply. Indigenous people in the Gulf shy away from manual work such as carpeting or plumbing and leave it to foreign workers. Graham (1991) argues that this attitude is not a result of the wealth and economic prosperity generated by oil revenues – manual work provoked social stigma long before oil was discovered. Graham points out that the Bedouin tribes shy away from what they consider shameful work and discourage their

people from accepting such jobs. Mellahi (2000) supports such views, arguing that Gulf society holds a negative perception of skilled and manual work and associates it with foreign workers. He agrees with Graham that families (especially Bedouin tribes) take pride in working in mostly managerial and clerical jobs in the public sector and not being involved in so-called "dirty work". It should be noted here that "dirty work" includes nursing.

Recent research indicates that 25% of indigenous employees in the private sector in Bahrain, Oman and Saudi Arabia failed to show up for work regularly and many others left their jobs after six months (Khalaf, 2007). However, indigenous workers in the Gulf are changing their attitudes towards jobs that traditionally have been looked down on. For example, young Saudis are looking beyond white-collar jobs and no longer focus mainly on clerical and managerial positions. This is encouraging to governments and the private sector. Limited job opportunities in public organizations; growing competition from foreign workers; high unemployment rates in most Gulf states; and high demand in the private sector have persuaded many indigenous people to consider manual work. For example, Saudis can now be seen working as waiters, electricians and drivers. This could also have a positive impact on the nursing profession in most of these countries and encourage more indigenous people to consider a valuable career.

2.10 Chapter summary

Well-publicized intentions to reduce foreign labour forces and create more opportunities for indigenous populations have not been realized. The numbers of foreign workers have increased in all Gulf states, primarily because of increasing demand, especially in the private sector. In response, the Gulf governments have designed employment regulations and intervention policies specifically to control the recruitment of foreign workers and increase the employment of indigenous people.

The first section in this chapter described the nursing shortages and the challenges of meeting the growing demand for qualified nurses. It highlighted and reviewed relevant literature related to nursing shortages in general and the GCC states and Saudi Arabia in particular. It also highlighted and reviewed literature related to the

recruitment of indigenous and foreign nurses and factors that influence the shortage of nurses in the Gulf.

The second section examined the literature related to human resources in the health service in general and in the three states of Saudi Arabia, Bahrain and Oman in particular. It examined the role of women and the social and cultural variables for women in the Gulf. Apparently, women in Saudi Arabia face more constraints and have more limited participation in the labour market than in any other Gulf state. Cultural and family-level factors affect women's presence in the labour market and their success in finding a job. Cultural proscriptions on female mobility are a significant constraint on women's employment in Saudi Arabia and also are important in explaining high unemployment rates among females.

The third section examined and reviewed literature related to human resources in the Gulf and examined the development and characteristics of the human resources and the labour market policy in the three states. It also examined the role and size of the foreign labour force in the Gulf and its effect on the development and employment of indigenous people. As increasing numbers of cheap foreign workers fulfilled the demand for unskilled workers the particular jobs available became racial in nature. Dirty, dangerous and difficult jobs have become associated with foreign Asian workers because indigenous people have refused to undertake them, despite high levels of unemployment. Although most scholars and labour specialists have cited many of these points as the main reasons for the general shortage of indigenous labour (in nursing particularly) they have seldom referred to the political dimension that most Gulf states take into consideration with labour market issues. Labour market policies are set in order to achieve a balance between indigenous people, foreign labour, ethnicity and religion.

The fourth and final section examined and reviewed works related to policy and the policy-making environment in the Gulf. It examined how social policy initiatives emerge and the important role of government at each stage of policy-making. It highlighted the main characteristics of the two (pluralist and elite) approaches to policy-making and how they relate to policy-making in the Gulf. In addition, section four examined how indigenization policy developed as a public policy in the three

states and how different agencies and bodies compete with each other for their own interests. The section drew attention to how governments access and control the flow of data and their techniques for gaining support from the public. The section concluded by examining the implementation mechanisms of the indigenization policies in the three states and the roles of culture, education and training in an indigenous workforce. Research suggests that the indigenous nursing shortage in the Gulf states is the result of a dynamic interplay between a number of complex factors including personal beliefs and values; gender relations; negative images; organizational structure; and religious and cultural constraints.

Scientific and rigorous research is needed to better understand the complexity of the indigenous nursing shortage in the Gulf in general and Saudi Arabia in particular. Therefore, the next chapter examines the methodology employed in this research. Qualitative methods continue to offer a valuable means of understanding and learning about nursing shortages and indigenization. Multiple methods of analysis are used to understand and explain this complex phenomenon. However, qualitative methods are especially appropriate for this research since its aim is to generate and provide an explanatory account of the subject under investigation.

Chapter 3

Research process and methodology

3.1 Introduction

Previous chapters have examined the broad context of three Gulf states – Saudi Arabia, Bahrain and Oman. In addition, they have reviewed the various literature relating to the shortage of indigenous nurses in the public health services; the development of an indigenization policy; and the prevailing approach to indigenization as a public policy. These policies are known as Saudization, Bahrainization and Omanization, respectively.

My research aim is to generate an in-depth understanding of the factors that encourage or inhibit indigenous women from considering nursing as a worthy career and the formulation and implementation of an indigenization policy in the nursing workforce in Saudi Arabia. To this end, I have tried to gain an understanding of the interests, strategies, perspectives and capacities of the various stakeholders in the three states. This has involved an in-depth investigation into how these policies have been formulated and implemented by stakeholders[3] and how they influence the nursing workforce.

Consistent with this aim, the research has been guided by several research objectives.

- To examine and analyse the policy of indigenization in the public health service and its impact on the nursing workforce in the three Gulf states, by:
  a) examining and analysing indigenization strategies and implementation;
  b) examining and analysing the principal differences and similarities in the strategies adopted by the three states toward indigenization of their nursing workforce.
- To explore the possible causes inhibiting or promoting the development of nursing as a career amongst indigenous people in the Gulf.
- To contribute to the body of knowledge on this topic.

[3] Stakeholders refers to those individuals and organizations who effect or are affected by a policy – for further explanation see the section on stakeholder analysis

These aims and objectives have emerged from my previous experience as a human resource manager in one of the largest hospitals in Saudi Arabia and from extensive review of related literature on human resources, specifically the indigenization policy in the nursing workforce in Saudi Arabia. I believe that my own positionality is important to this study as it has shaped the perspective of the researcher and of those being studied and thus become part of the research process (Flick, 2006). The researcher's reflections on his actions and observations in the field and his impressions, frustrations and experiences became data in their own right and are documented in this study. The next section provides more detail.

3.2 The researcher and the research

Even before my PhD candidacy I was interested in the discourse on human resources in Saudi Arabia, having worked in the human resource department of the Medical Service Department (MSD) of the Ministry of Defence and Aviation until 1997. During this time I developed relationships with a number of policy-makers and human resource managers, especially in the health service. At that time, I had not formed an opinion on the validity of the Saudi government's stated intention to implement a rigorous Saudization policy in the public and private sectors.

Like some of my colleagues, I was inclined to criticize rather than support government policies. Nevertheless, I did not undertake this research in order to find fault with, or dismiss as invalid, the government's understanding of what Saudization might mean. I soon realized that much more in-depth study was required for me to feel confident in my own knowledge. I began by collecting statements, documents and reports from supporters of various government policies. My understanding grew over time through reading, writing and interacting with those interested in the issue.

Myers has argued that:

> The more information we gather, the more we understand the organization as a whole and its constituent parts. This hermeneutic process continues until the apparent absurdities, contradictions and oppositions in the organization no longer appear strange, but make sense. (Myers, 1997)

It has been a major challenge to develop my own identity as a qualitative researcher. I have had to overcome prejudice and a number of misunderstandings. Qualitative studies require considerable skill on the part of the researcher. Some believe that they are easy to conduct and require no skills or training but I have found that the opposite is more likely to be true. However, my previous experience as a human resource manager (e.g. problem solving, engaging with many different people) has helped me to engage in qualitative research.

As a human resource manager, my responsibilities included designing and implementing recruitment strategies and making sure that suitable and sufficient health workers were recruited. Nurse recruitment was, and remains, one of the most difficult tasks in the Saudi health service. It was difficult to recruit and retain suitable candidates. Very few indigenous nurses are available so most are recruited from other countries. Foreign health workers tend to work for short periods (around two years) and my aim was to keep them for the longest possible time. During the few years I worked there, only a few Saudi nurses were working in the hospital. I worked in one hospital for seven or more years and cannot recall employing a Saudi nurse – not one applied.

This experience motivated me to examine the underlying issues of indigenization and the lack of interest in nursing as a career, especially as the recruitment situation has worsened with the global nursing shortage. I decided to look beyond the boundaries of Saudi Arabia and explore the situation in Gulf countries that share similar characteristics. I was not surprised to find similar problems in most Gulf states (with some variations in employment-related characteristics) and was inspired to research these crucial issues for the future benefit of the health service in Saudi Arabia. Few, if any, studies have explored the issue of indigenization in nursing and the critical shortage of indigenous nurses in the Gulf. In the absence of research into the complexity of these issues, we can only guess at their nature and depth.

I was fortunate that the Saudi Arabian government granted me a PhD scholarship to pursue my research aims. I became more immersed in the field as the research progressed and the original research questions were broadened and re-evaluated. Over time I have realized that it is true that one of the most difficult tasks for researchers is

to turn the experiences of their research into respectable academic writing (Takacs, 2003).

As a male Saudi national, I was able to function as an insider when interviewing Saudi respondents. The Saudis I interviewed probably knew something about me and may have expected me to be somewhat more sympathetic and patriotic than a non-Saudi. The clear aims of this study enabled me to understand and engage in debates with informants and gain their trust and respect. I was able to develop a relationship with informants and move from a stranger to a friend. Leininger (1991) holds that a researcher is seen as a stranger (and is not necessarily given accurate information) but becomes a friend when trust has grown. This enables the researcher to obtain reliable data.

In Bahrain and Oman, I was considered an outsider when I interviewed Bahraini and Omani informants. These dual roles of outsider and insider carried certain advantages and disadvantages. By crossing experientially and cognitively different standpoints they offered what Bartunek and Lewis (1996) call a kind of marginal lens through which to examine subject matter. I believed that it was important and necessary to take account of the political environment and the different sub-systems including the powerful interests groups such as religious and business elites when conducting research in the Gulf region. Hall et al (1975) argue that the policy process is not contained within, or limited to, a single centrally co-ordinated system. It embraces a number of sub-systems that all acts with varying degrees of autonomy e.g. pressure groups, political parties (if they exist) and other bodies (Hall et al., 1975). This meant learning to listen with an open mind and heart to all parties and respecting local customs and understanding the gender relations in these states. When we constantly engage to understand how our positionality impacts on our epistemology, we greet the world with respect and interact with others to explore and cherish their differences and understanding of the world (Takacs, 2003).

I felt that my gender affected my positionality, especially in a patriarchal, Islamic culture. All the indigenous women I interviewed possessed an understanding of the existing gender relationships and, as a result, we shared the gender-conscious rules of society. In the Gulf's conservative society I had to negotiate access through a number

of gatekeepers such as senior managers and colleagues, especially for females. Research interviewing was difficult, especially in Saudi Arabia where there are restrictions on talking to women in public. Language and local dialect caused further problems. Most interviewees spoke and understood English but some preferred, and felt more comfortable, speaking Arabic in order to express their feelings clearly. Interestingly, some used both languages.

My own overall reflections on this research highlighted the tensions, difficulties and interesting challenges embedded in conducting research in a context like the Gulf. Only limited data were available and there was an almost complete absence of any other research on nursing and indigenization in the Gulf.

3.3 Practical difficulties and implications of the lack of data

As a researcher, I was challenged by the practical difficulties of conducting fieldwork – not just gaining access to field sites. In general, it was difficult to find and access any reliable data and written documents related to human resources in any of the three states. For example, it was very difficult to obtain basic data from government agencies in Saudi Arabia, either because such information did not exist or because it was classified as confidential. This supported Hall et al's (1975)_assertion that governments enjoy advantages over other groups because they possess much information unavailable to others. Information on workforce trends, unemployment and other employment-related characteristics is not collected routinely in most Gulf states. In addition, little is known about certain categories of health workers like nurses. Government officials hesitate to make available written reports or statistics other than those already in the public domain.

Labour surveys and other reports related to labour forces offer the best comparability. Therefore, the researcher had no alternative but to rely on data provided by regional and international organizations (e.g. United Nations, GCC, WHO, ILO, World Bank, ICN and BBC) and independent local reports produced by financial institutions such as banks or recruitment agencies. The latter produce predictable data and analyses that may not always be based on reliable evidence, a common problem in developing countries. This lack of data in many developing countries reduces the comparability

of data sources and raises problems with consistent definitions of health workers (Pittman et al., 2007). On occasions, the lack of reliable, up-to-date data restricted and hampered research to assess the effects of policy implementation and workforce trends.

The search for data that proved not to exist was a disappointing and time-consuming process that prolonged the process and outcome of this research. It may also have limited the interpretation and comparability of some data related to Saudi Arabia. The limited availability of published data has caused greater reliance on the data from primary interviews with participants. However, rigorous data collection methods and techniques were applied to minimize the effects of such limitations, especially during the interview phase. The researcher used the interview sessions with stakeholders (especially those in senior positions as policy- and decision-makers) as opportunities to gain more information and data by persuasion, stressing the importance of such a study and offering assurances of anonymity and confidentiality.

Bahrainis, and to some extent Omanis, were more transparent and less secretive about data and relevant reports. The majority of data sought were obtained with reasonable effort. However, failure to remedy the shortage of available data and their reliability is likely to result in the Gulf falling further behind the rest of the world in both the provision of valuable and important research and the ability to design public policy based on reliable evidence.

3.4 Evolution of research questions

As stated, my research aim is to generate an in-depth understanding of the factors that facilitate or inhibit the implementation of indigenization policies in these three countries. One of the most important steps in this study was the definition of the research questions. Rein (1970) argues that social policy studies need good questions rather than good tools. Higgins (1981) argues that a researcher who can decide upon a series of good questions will avoid superfluous description and acquire deeper understanding more quickly._The research questions for this research evolved over a long period and were refined in response to reading the available literature in the field.

The following research questions guided this study.

1. What are the main causes inhibiting or promoting the development of nursing as a career among indigenous women of the Gulf?
2. What are the main factors facilitating or inhibiting the formulation and implementation of an indigenization policy in the nursing workforce in Saudi Arabia?

These questions were framed to explore what the stakeholders involved in the study understand by their respective indigenization policies in general and how they interpret their relevance to nursing in particular. The second question was particularly aimed at pinpointing potential explanations for Bahrain and Oman's greater success in increasing their indigenous nursing workforces. This could indicate what lessons can be learned from this success and their applicability to Saudi Arabia. A research approach was required to accommodate the diverse and complex views and perspectives of stakeholders' understanding.

3.5 Framework for understanding indigenization policies

The literature suggests that economic, social, cultural and human resource policies and practices, factors and variables are important determinants of indigenization policies and practices. Indigenization is presented as context-specific and it is argued that there is a strong need for more cross-national indigenization studies, given the growth of the national workforce; increased levels of competition; and the globalization of recruitment of health personnel, especially nurses.

The literature on the Gulf states shows the absence of an integrated framework that can help to highlight the different roles of context-specific facets of indigenization practices. The framework used in this thesis delineates the main distinctive facets associated with national factors, contingent variables and human resource strategies that may be used to analyse cross-national comparative indigenization policies and practices. This comparison of indigenization policies and practices at a national level helps to answer some typical questions, such as: How are indigenization programmes structured in each of the three Gulf states? What strategies are discussed? What is put

into practice? What are the similarities and differences? What influence is exerted by national factors such as religion, culture, government policy, education and training systems? The degree and direction of these factors is context-specific and varies from country to country.

Interestingly, most models of indigenization in the three Gulf states are recent, with principles developed from a restricted sample of human experience. The framework applied in this study utilizes a number of different approaches to understand the policy environment. This thesis draws on the Walt and Gilson (1994) policy framework to emphasize the context, actors and policy process of indigenization. Within context, the thesis highlights economic, social (including religious) and political factors. The main actors and their interests are identified by stakeholder analysis. A number of different approaches to process are used – for example, a grounded theory process of analysis which includes a number of distinct features (such as the use of constant comparisons and a coding paradigm) to ensure conceptual development and density.

Finally, the thesis utilizes approaches from the human resource literature to highlight why a shortage of health workers occurs and the influence of human resource policies and strategies on the indigenization policy. Each of the approaches and models identified in the thesis is a piece of a larger phenomenon. The thesis framework ties them together and presents the range of main national factors that create a metalogic for indigenization policies and their various components. Knowledge of the complex interactions and cause-and-effect relationships between these different sets of metalogic factors, contingent variables and policy environments is essential to understand the nature of indigenization policy in the three settings.

3.6 Research approach

This section examines the paradigm used in this research. Lincoln and Guba (1985) define a paradigm as a world view or a general perspective of breaking down the complexity of the real world. Qualitative inquiry has passed through a number of eras in which certain sets of principles and beliefs guided inquiry in different ways. They specified a number of features of qualitative research, including the following.

- Whenever possible, research should be carried out in the natural context because individuals cannot be understood in isolation from their contexts; relationships are complex rather than linear; and contextual value structures partly determine findings.
- Humans are the primary data-gathering instruments because it is impossible to create a priori a non-human instrument able to adjust to various realities and meaning.
- Tacit knowledge is legitimate because many nuances can be appreciated only tacitly.
- Meanings and interpretations are corroborated with participants because it is their constructions of reality that the investigator seeks to understand and explore.

Qualitative methods facilitate the study of issues in depth and detail to produce data that are freely defined by the subject rather than structured in advance by the investigator (Patton, 2002). Therefore, the decision was made to use the qualitative paradigm to achieve the aims and objectives of this research. Lincoln and Guba's (1985) comprehensive and rich naturalistic inquiry book became the researcher's main source for qualitative approaches and a constant companion throughout this research.

The researcher chose interviews and documentary analysis as the most appropriate methods for this research for the following reasons.

- It is well-known that the qualitative method is used usually when too little is known about a phenomenon for standardized instruments to have been developed or even be ready to be developed (Morse & Field, 1995; Patton, 2002). This was the case in this research.
- Indigenization issues, shortages of indigenous nurses and indigenous people's lack of interest in nursing as a profession clearly involve a number of factors and stakeholders. Thus, the researcher needed to choose research methods appropriate for uncovering and understanding the relationships between these various factors and stakeholders.

- From the indigenous participants' point of view, qualitative methods are particularly useful when describing issues such as a shortage of indigenous nurses and indigenization policies. Human resources management is in its infancy, especially on issues related to the nursing workforce in the Gulf. This study aims to extend our understanding of human resources in general, and nursing human resources in particular, in the three Gulf states. This goes beyond the descriptive approach and uses an exploratory qualitative methodological approach to examine indigenization of the nursing process in the three countries.

By determining the focus for the inquiry and comparing the characteristics of both the qualitative and quantitative paradigms with the goals of this research, the researcher was able to identify the most appropriate method for understanding the study phenomena within their context. Quantitative research seeks to count occurrences and establish statistical links among variables or to test hypothetical generalizations. In contrast, this study seeks to explore and understand the development and implementation of the policy of indigenization and its impact on an indigenous workforce in a specific setting. These aims cannot be achieved by means of statistical procedures or other quantitative methods. This study is concerned with newly developing phenomena which, as already stated, have not been fully explained by previous knowledge and understanding. In addition, qualitative approaches were considered more appropriate because of the sensitivity of the phenomena being studied and the scarcity of reliable published records. The flexibility of a qualitative approach allows appropriate pursuit of sensitive issues and reveals in-depth information that standardized and closed-ended questions might fail to reveal (Padgett, 1998).

A cross-sectional survey was considered but dismissed because of the lack of data to inform the survey questions. In addition, survey methods require the use of closed questions using defined categories. These were not known to the researcher during the data collection phase due to the lack of available evidence. A possible exception might be the use of open questions in a questionnaire but this was not considered appropriate as it might not produce the rich and valuable data required to understand

and analyse the phenomena. The researcher believed that face-to-face interviews and documentary analysis were the best methods to achieve the aims of this research.

3.7 Research design

Research design refers to the overall configuration of a piece of research to explain what kind of evidence is gathered and from where; and how such evidence is interpreted in order to provide robust answers to the basic research questions (Easter-Smith et al., 1991). Similarly, Yin (2003) defined research design as a way of collecting and analysing empirical evidence. He suggested three criteria for distinguishing between different research strategies: (i) the type of study questions; (ii) the researcher's control over actual events; and (iii) the degree of focus on contemporary, rather than historical, phenomena.

It is crucial to study the real-life context as the aim of this research is to understand and examine why and how indigenization policy has been formulated and implemented by stakeholders in the three Gulf states. A case study approach was deemed the appropriate strategy. The justification for this is presented below.

3.7.1 Case studies

This qualitative research examines stakeholders' perspectives of indigenization policies in three Gulf states and reveals factors that impede or promote their success in transforming nursing workforces. A case study strategy is useful and appropriate to gain a rich understanding of such a complex issue within its context, particularly when a holistic, in-depth investigation is needed. Hall et al (1975) report that the use of case studies has proved an attractive and useful method of illustrating and conveying the rich detail of various kinds of events. They argue that the case study approach is as effective as other approaches in suggesting general propositions about how policy develops. Also, that this approach is a valuable and useful means of conveying the immensity of the task confronting those who embark upon the journey from description stage to generalization stage. Case study overwhelmingly moves towards a conclusion and suits the exploration of the meanings actors attach to their behaviour in policy-making situations (Hall et al., 1975).

Chelimsky (1990) points out that case study is a method for learning about a complex issue, based on a comprehensive understanding obtained by extensive description and analysis of that issue taken as a whole in its context. Yin (1994) defines a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident". He gives several reasons for selecting this tool: "Case studies are the preferred strategy when how or why questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context" (Yin, 1994). However, Hall et al (1975) point out that the status of case study remains dubious, illustrating two main types of criticism of this approach:

(1) method has not been employed in a sufficiently scientific way to advance theory; and

(2) method does not lend itself to generalization and cannot form the basis of a theory.

Nevertheless, they conclude that the use of the case study method is justifiable and profitable if there is a conceptual framework from which to depart; a reasonably similar set of cases to provide good opportunity for careful comparison; and if policy-making is considered over time rather than by isolated decisions (Hall et al., 1975).

Taking all the advantages and disadvantages of the case study into consideration, this approach is appropriate for this research which seeks to delineate how stakeholders think about and interpret their country's indigenization policy. It captures the meaning of stakeholders' personal descriptions of their experiences and perspectives of indigenization policies and how they are implemented. Case study is also appropriate because the researcher has no control over actual behavioural events. The phenomenon is contemporary and the study questions fit the case study criteria. As a national and social policy, indigenization operates multidimensionally and involves many variables and factors over which the researcher has no control. Ghauri and Gronhaug (2002) argue that case study is particularly useful when the variables and concepts under study are difficult to quantify. In addition, the case study enables a holistic view of the phenomena and the issue of context. Its unique strength is its ability to deal with a full variety of evidence that includes documents, artefacts,

interviews and observations. Here, the case study strategy was used to identify the trends in indigenization policies in the three selected Gulf states and to establish the degree of success in implementing these policies in the nursing workforce.

This study involved multiple cases selected carefully to enable comparison. Based on the aims of this research, the single case strategy was not deemed appropriate to address the study questions. This study does not represent the critical case that seeks to test any hypothesis or theory. It does not represent an extreme or unique case but rather homogeneous cases that seek to understand and compare issues related to indigenization and nursing. Most importantly, multiple cases were necessary because one main objective of this research was to examine and analyse the principal differences and similarities in the strategies adopted to advance indigenization of nursing workforces. A single case study approach could not achieve this – it has been criticized for being weak in design as it does not allow meaningful comparisons (Ghauri & Gronhaug, 2002).

Multiple case studies were accepted as appropriate and essential for this research because indigenization of a nursing workforce involves a number of issues and stakeholders. This requires examination and comparison between and within the three cases. Multiple case strategies are more powerful and convincing as they provide more insight into the indigenization policy in three nursing workforces than would be possible in a single case strategy. Multiple case study research requires more extensive resources and time but provides more compelling evidence and enhances the overall impact of the study (Hakim, 2000).

3.8 Data collection process

Qualitative methods are being used increasingly in the public policy arena due to the increasing need to understand complex behaviours, needs, systems and cultures (Ritchie & Spencer, 1994). Jenkins-Smith (1990) suggests that the nature of the policy problem is such that a variety of approaches are required to deal with the complexity of the process. The questions and aims of the research are guided by the methods used. In this study, qualitative methods were considered most appropriate to describe

and explore the phenomena under study. Van Maanen (1983) defines qualitative methods as:

> an umbrella term covering any array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world.

As outlined above, natural settings obtained through semi-structured interviews and documentary analysis were used as the direct sources of data in this study. Before detailed explanation of the interviewing and documentary analysis stages it is important to highlight the selection of participants and means of access to the research's setting process and its sampling techniques.

3.8.1 Selection of case studies

The case studies selected for this study were the three Gulf states of Saudi Arabia, Bahrain and Oman. These have many commonalities in their societal norms and economic bases but differ in their management practices, policy development environment and implementation. Health-care services, labour forces and indigenization policies confront similar broad issues and challenges throughout the Gulf states. Saudi Arabia, Bahrain and Oman were selected to represent (to some extent) the different social, cultural and policy environments in the region. They were chosen for two main reasons: access and specific features pertinent to the research.

Bahrain and Oman were sampled because they had indigenization policies and interesting issues associated with nursing/indigenization. Bahrain was chosen to represent one of the smaller states in the Gulf in terms of area, population and labour force and for the size of its indigenous nursing workforce. It also has the highest percentage of indigenous nurses among the Gulf states (63% of the workforce are Bahrainis) and was therefore thought to be a useful case of indigenization best practice that could offer relevant insights.

Oman is a medium-sized country with several important population and labour-force features. There are sizeable numbers of foreign nationals among its population and it has a thriving indigenous nursing workforce (49%), second only to Bahrain. Given that Oman had only five indigenous nurses in 1975, this remarkable achievement makes it an essential case study for any investigator studying indigenization in the

nursing workforce in the Gulf. Oman is also unique among the Gulf Arab states for its ethnic diversity – many different Islamic and ethnic groups play important roles in its affairs.

Saudi Arabia is the largest state in the Gulf in terms of area, population, economy and labour force. It was chosen for the diversity of its health-care labour force and its huge reliance on foreign health workers, especially nurses. It was also one of the first Gulf states to initiate an indigenization policy. The high percentage of foreign workers in its health service enabled this study to emphasize the issues around indigenization policies and thereby analyse and anticipate their likely impact on the indigenous Saudi nursing workforce. In addition, it is the home country of the researcher and therefore best known to him.

Finally, some of these states were interested in facilitating a study of indigenization in the health service in order to improve current practice. This made access and the progress of research more likely.

3.8.2 Selection of participants

Having prepared the interview instrument, the researcher had to decide who to interview. This has been a major challenge, especially as the phenomena under investigation were new and never before researched in the Gulf countries. A total of 78 stakeholders were included and took part in semi-structured interviews (see stakeholder profiles Tables 9–13). The researcher sought to undertake individual interviews with stakeholders who had experience in the nursing workforce, education and/or training and those who had knowledge and experience of indigenization policies and human resource management.

Four parallel approaches were used to select stakeholders for this study. Firstly, the researcher's previous working experience in the Saudi health service enabled him to take advantage of personal relationships and connections with various individuals. Stakeholders who have worked in the Gulf states' health service for a number of years were contacted personally, by telephone and by e-mail. Secondly, the researcher contacted the Health Ministers' Council for the Gulf Cooperation Council (HMC). The HMC contacted a number of potential stakeholders in Bahrain and Oman,

described the study and invited those interested to contact the researcher by telephone or e-mail. Full information about the study was e-mailed to those who made contact (26) and interviews were arranged. The third overall sampling strategy involved case study visits to various health-care organizations, especially in the researcher's home country of Saudi Arabia.

The researcher spent three weeks approaching potential interviewees in their offices and workplaces to arrange flexible individual interviews (in order to avoid any effect on their work) with various stakeholders. Some interviewees knew about the study; others required explanations of the purpose and procedure. Convenient interview times were arranged for those interested in taking part (17), the majority of whom were from Saudi Arabia.

This section provides an overview of the participants in the three countries. Table 9 shows that stakeholders were drawn from a number of disciplines but a significant number were nurses, nursing students or from a nursing background. Nearly 60% were males but this is attributed to the fact that the Saudi Arabian case study provided more than half the stakeholders. In Saudi Arabia, males dominate most positions in nursing – especially at senior levels. The majority of stakeholders were Gulf nationals currently working in the three health services.

Table 9 **Disciplines and backgrounds of stakeholders**

Stakeholders	Saudi Arabia	Bahrain	Oman	Totals
Policy-makers	6	3	2	11
Human resource/indigenization managers	4	2	2	8
Hospital administrators	4	1	1	6
Nursing school administrators	5	1	4	10
Nurses	6	2	4	12
Nursing students	8	2	5	15
Religious leaders	3	1	1	5
WHO officer	-	-	1	1
Community/public	6	2	2	10
Total	42	14	22	78

Table 10 **Nationality of stakeholders**

Saudi Arabian	41	(53%)
Omani	23	(29%)
Bahraini	14	(18%)

Table 11 **Age of stakeholders (years)**

21-25	12	(15%)
26-35	14	(18%)
36-45	19	(24%)
46-55	25	(32%)
56-60	6	(8%)
61+	2	(3%)

Table 12 **Gender of stakeholders**

Male	46	(59%)
Female	32	(41%)

Table 13 **Ethnicity of stakeholders**

Gulf nationals	73	(94%)
Foreign nationals	5	(6%)

3.8.3 Sampling strategies

There are many qualitative and quantitative sampling strategies. The most dominant sampling strategy in quantitative research is probability sampling. This depends on the selection of a random sample from the larger population and aims to generalize a study's findings to the population (Hoepfl, 1997). By contrast, purposeful sampling is the most dominant strategy in qualitative inquiry. This seeks information-rich cases which can be studied in depth (Patton, 2002). This research starts with a purposive sampling technique and proceeds with another – snowballing. These sampling techniques were used in the present study, not for statistical reasons but simply as a

means of ensuring representation from the full spread of stakeholders in the three states, with as little bias as possible.

This qualitative research stresses in-depth investigation of new, rarely researched phenomena. Purposive sampling is used rather than random sampling because the emphasis is on the quality of stakeholders rather than their numbers. This is to gain the maximum knowledge about the subject of the inquiry. Patton (1990) identifies and describes sixteen types of purposeful sampling including: deviant case; typical case; maximum variation; snowball; and purposive. Purposive or theoretical sampling derives from the belief that the investigator's knowledge about the population and its elements can be used to handpick participants in the sample (Polit & Hungler, 1991).

The composition of a sample can be adjusted to meet a study's aims and coverage by adopting and designing a range of different approaches to purposive sampling (Ritchie & Lewis, 2004). Homogeneous samples were chosen in this study to give a detailed picture of the indigenization policies in the nursing workforces in three Gulf states which share similar subcultures and characteristics. This allows detailed investigation of social processes in a specific context. The stakeholders were chosen specifically to represent a range of views within the nursing industry; to represent the whole Gulf region; to unpack and examine issues on the policies and practice of indigenization; and because they shared common experiences and knowledge of indigenization policies and nursing issues in the Gulf. However, they also offered a diversity of views in their understanding, interests and perspectives of indigenization policy and nursing. This enabled the researcher to gain a more rounded and deeper understanding of the multi-dimensional aspects of indigenization.

The purposive sampling criteria employed in this study included participants with experience of indigenization policies; working in a nursing environment mainly staffed by foreign workers; and working in a nursing environment containing indigenous workers. Also, people living and working in one of the three Gulf states of Oman, Bahrain and Saudi Arabia and those employed by public health organizations such as hospitals, nursing schools and ministry of health agencies.

In spite of the apparent flexibility in purposeful sampling, Patton (1990) advises researchers to be aware of three types of sampling error that can arise in qualitative research: (i) distortion caused by insufficient breadth in sampling; (ii) distortion introduced by changes over time; and (iii) distortion caused by lack of depth in the data collection process.

The researcher handpicked stakeholders that he considered possessed the necessary knowledge and experience. In order to gain a true perspective of stakeholders' responses to the indigenization policy, interviews were conducted with those with experience of both an indigenization policy and working in a nursing environment staffed mainly by foreign workers but containing a considerable indigenous element. This was a relatively easy task in the researcher's home country (Saudi Arabia) because of his previous knowledge of the health sector and strong networking. The first interviews were held with existing contacts who met the specific criteria (purposive sampling): thirteen Saudi officials: nine male and four female. I asked a number of questions including the following:

1. What is the indigenization policy and what is this stakeholder's position on its implications for the nursing workforce?
2. Who does this stakeholder believe the researcher should talk to concerning indigenization and nursing and why?

The same steps were used in Bahrain and Oman but the researcher had to seek the help of the HMC in Riyadh, Saudi Arabia, to find the appropriate stakeholders.

Snowballing is a well-known technique used in network studies, particularly in situations where stakeholders are not easily identifiable (Goldenberg, 1992). It is a simple process of expanding the number of contacts by asking an initial group of stakeholders or participants to identify individuals they feel should be involved in the research (Goldenberg, 1992; Wasserman & Faust, 1994). This technique was extremely useful in helping to identify relevant individuals and organizations in the three Gulf states. Initially, pertinent stakeholder groups were identified by reviewing documents and conducting a series of brief and informal interviews to identify those with interest in, and knowledge of, the indigenization policy. This was used to establish a stakeholder database from e-mail and telephone lists and other databases.

A checklist for identifying stakeholders was drawn up to ensure that all were listed and that all potential supporters and opponents of indigenization policies had been selected. The key to the success of this process is to be as exhaustive as possible so respondents were asked to review this list to identify any potential stakeholders that they felt had been omitted. The majority named one or more potential participants. When the names of suggested new interviewees began to be repeated the researcher considered that he had reached the exhaustive stage at which no new participants can be suggested. The decision to stop sampling took consideration of the research goals and the need to achieve depth through triangulation of other data sources. Guba (1978) identifies strict guidelines to indicate when to stop the data collection process. These include: (i) exhaustion of resources; (ii) emergence of regularities; and (iii) overextension (researcher goes too far beyond the boundaries of the research goals).

3.8.4 Access to research setting

As a Gulf national the researcher required no special arrangements or visas to enter any of the countries. However, officials from ministries of health and other government agencies had to grant permission for visits to various organizations and health-care facilities in all three Gulf states. The researcher encountered many difficulties in gaining access to the required sites in most of these countries. Officials and people in Bahrain were the most helpful individuals in the three states.

Lofland and Lofland (1984) believe that successful access to situations is more likely if the researcher makes use of contacts who can help to remove barriers to access; avoids wasting participants' time by undertaking advance research for information that is already on public record; and treats participants with respect and courtesy. However, it was problematic to access some locations, especially in Saudi Arabia when women were present. Such situations required special arrangements in advance. Sensitivity to local practice suggested that I approach the management of the organization supervising a nursing college if I wished to make a visit.

3.9 Data collection methods

3.9.1 Interviews

Interviews were considered to be the most appropriate method for this study. In the absence of reliable data and information about indigenization, a guided conversation method is the most appropriate technique for eliciting rich, detailed materials that can be used in qualitative analysis (Lofland & Lofland, 1984). Qualitative interviews may be used either as the main strategy for data collection or in conjunction with observation, document analysis or other techniques (Hoepfl, 1997). Interviewing is one of the most widely employed methods in qualitative research and an important source of case study data (Fontana & Fry, 1994; Silverman, 1999; Yin, 1994).

I believed that face-to-face interviews would provide a richness of detail that would help to clarify and elicit stakeholders' beliefs and experiences of the study phenomena. Live interviews are particularly important and valuable as they supply immediate feedback on the enquiry and suggestions for its future (McNiff, 1997). In addition, stakeholders have greater freedom to talk about the issues that are relevant and important to them. This study employed the interview method because of its potential to provide in-depth penetration of the issues surrounding indigenization, especially those related to the perceptions, meanings and definitions of stakeholders. Interviewing enables the researcher to see the research topic from the perspective of the stakeholders. The potential to understand how and why a stakeholder holds a particular perspective enables the researcher to produce data of great depth.

Patton (1990) identified three types of qualitative interviews:

1. informal, conversational
2. semi-structured
3. standardized, open-ended.

Semi-structured interviews leave the researcher free to probe and explore within predetermined inquiry areas (Hoepfl, 1997). They also provide interviewees with full opportunity to express themselves freely and behave naturally. Semi-structured interviews were employed to encourage participants to relate to the story, that is – the

indigenization policy and the shortage of indigenous nurses. Data were sought to illuminate dynamics in two key dimensions.

1. In-depth examination and understanding of stakeholders' experiences with, and views on, indigenization policies and opportunities and barriers for indigenous nurses.
2. Contextual understanding of indigenous nurses' situations in local workplaces and how these might vary according to local policies and practices in the three Gulf states.

These two dimensions were operationalized through individual semi-structured interviews with stakeholders with different backgrounds and experiences in different circumstances across the three countries. A participant interview letter in both English and Arabic (see Appendices 4 and 5) was sent to potential participants. A series of semi-structured interviews was conducted with 78 stakeholders (see Tables 9–13) over an 8-month period from June 2005 to January 2006. Each interview lasted between 60 and 90 minutes; 19 were conducted in English and 59 in Arabic. The majority of interviews were audio recorded but 8 interviewees (6 Saudi Arabian; 2 Omani) asked to be interviewed without a tape-recorder. The majority of informants were interviewed in their own organization's offices. Those who did not belong to an organization were interviewed in public places such as hotel lobbies and libraries. Three were interviewed in their own homes.

Four group interviews were conducted. The first was held with a group of three female nursing students in Saudi Arabia who preferred to be interviewed together in the college dean's office. The second involved four Omani nursing education personnel who preferred to be interviewed together because of time constraints. The third and fourth group interviews involved three Saudi female nurses and three Omani nurses, respectively. They also wished to be interviewed together. Most (especially young) women preferred to be interviewed in groups because of the local culture, shyness and religious requirements that a woman should not be alone with a strange male. All these interviews used the same process and were arranged either by the individual whom I had intended to interview or by their organization. Group interviews have become popular in health research as they offset some of the disadvantages of one-to-one interviews (Green & Thorogood, 2004).

Semi-structured interviews allow the researcher to set the agenda and are also used as a way of encouraging participants to relate to the story or phenomena of the study. However, they are also time consuming, expensive and may miss important areas (Silverman, 1999). Despite the possible limitations associated with the use of interviews and the possible advantages of other approaches to data collection (such as questioner or focus groups), this approach to data collection was found to be the most effective means to gather and handle an adequate and appropriate range of data, given the context of limited resources within which this study was carried out.

The researcher prepared a semi-structured interview process (see Appendix 6) that incorporated an interview guide for use with stakeholders. In addition, the guidelines in Arabic and English (see Appendices 7 and 8) included general questions for all interviewees and specific questions designed for each case study. An interview guide is a list of questions or general topics that the researcher wants to explore during each interview (Hoepfl, 1997). The interview process is guided by this core of common questions but allows some flexibility in the questions posed by the researcher. This helps the researcher to draw out detailed data from stakeholders. Patton considers that the interview guide strategy offers more structure than a completely unstructured, informal conversational interview, but maintains a relatively high degree of flexibility (Patton, cited in Rubin & Babbie, 2001).

The interview guide presented two main groups of questions. The first set was designed to collect basic information about the stakeholders and their role in their organizations. The second was designed to elicit responses regarding a number of topics and sub-topics including: (i) human resources; (ii) the labour market; (iii) indigenization policy; and (iv) women's role in public life. Interviews were audiotaped and transcribed; field notes were typed into a word processing programme. The first two interviews in each country were used as pilots to test for ambiguous or missing questions that could be clarified or added for subsequent interviews.

In qualitative studies, the flow of information from participants sharpens the focus of the research question and other related questions of a more general nature (Strauss & Corbin, 1990). At the beginning of an interview, each stakeholder was asked several general questions (Appendices 7 and 8). Spradley (1979) calls these "grand tour

questions" as they ask stakeholders to give a verbal tour of something they know well. They are important for putting the respondent at ease and provide an opportunity for the researcher to show interest and build a rapport. At the conclusion of each interview, respondents were thanked for their participation and asked if there was anything that they wished to add or thought would be important for the researcher to know. Some interviewees provided additional information in the form of reports or referrals to related web sites or conference documents.

It should be noted here that the interview questions varied according to the interviewee's role and responsibilities. Specific questions were designed to reflect differences between stakeholders with different roles and responsibilities. In summary, these interviews aimed to identify the issues regarding the shortage of indigenous nurses and indigenization policies. The interview protocol provided a core of common questions but allowed some flexibility to adapt to different interviewees.

It can be problematic to carry out research when the researcher is not sufficiently familiar with the social mores or the language of his/her subjects (Hancock, 1999). As a GCC national whose native language is Arabic, my familiarity with the region's culture and norms helped me to navigate my way through these interviews and deal with some of the cultural challenges. Language is very important in qualitative research. Interviews were conducted in two languages (Arabic and English) so translation and clarification of questions was necessary to ensure validity and accuracy. Mainly, Arabic was used to obtain the data.

Some interviewees preferred and felt more comfortable in their Arabic mother tongue even though they could speak English. They felt that their own language enabled them to give a more accurate picture of what they wanted to say, especially those in important positions who felt that their words could reach a superior. Some interviewees were uncomfortable about expressing their feelings despite assurances of confidentiality. This may be due to the existing political culture and lack of transparency that characterizes the political systems in the region, particularly Saudi Arabia. Some respondents preferred to use English and others used English as their first language with occasional Arabic phrases or words to explain some cultural or social terms. Green and Thorogood (2004) suggest that: "Language functions largely

as the method of providing access to 'facts', as a window on the world, through which we can see the respondent's opinions, beliefs or behaviours". But they say that language is more central in most qualitative work: "It is seen as the route to understanding how the respondents see their world...or as the route to understanding the categories that shape the world."

All interviewers need at least to be aware of how interaction itself produces meaning. This entails sensitivity to the social context of the interview as experienced by both parties. It also assumes a cultural familiarity with the ways in which language is used in practice: how phrases, words and opinions are used other than for their intrinsic content. The researcher's bilingualism was very helpful for carrying out interviews and translating the transcripts into English although it was very time-consuming to translate and analyse the data at the same time. Yet translation is a vital part of the data analysis process. The comprehensibility of the English versions of the interview transcripts were checked with a native English speaker. No major problems were encountered in the interviews in Oman and Bahrain where they speak Arabic using similar dialogue or slang. The more social and cultural similarities there are between interviewer and interviewee, the better they will understand each other (Green & Thorogood, 2004).

Research in developing countries, such as those in the GCC, can face a number of problems concerning local cultural norms. The researcher's previous employment as a personnel manager with experience of many interviews with a range of people helped tremendously. It is not easy to interview women in these Gulf states (especially Saudi Arabia) and a number of steps are required to ensure good responses and cooperation. Most interviews with Saudi women had to be conducted either with the door of the room open or in the presence of a chaperone. For example, I had to interview three Saudi nursing school students in the presence of the director of the nursing school, a Jordanian woman. Two of these students wore a *nikab*, a type of veil which covers the whole head and face apart from the eyes. The third wore a scarf covering only her head. In Oman, some interviewees felt able to voice certain views and opinions on social and political issues that they might not have told to a fellow Omani. They felt that an outsider was unlikely to discuss these issues with other Omanis. Generally,

people in the Gulf states are hesitant to talk openly about sensitive issues such as politics and religion, fearing state reprisal.

As indicated earlier, all the Gulf states share common social and cultural characteristics. However, Saudi Arabia was the most difficult country among the three in this study in terms of access to research sites and to participants, especially women. Prior approval was required for visiting and interviewing female students. For example, in one college in Saudi Arabia the researcher had to pass through two guarded gates before arriving at the main gate. A Saudi female chaperone accompanied him inside the college and warned female students and staff to wear their veils (in Saudi Arabia these cover both head and face) by saying loudly that a male was on the premises. The researcher's cultural background and previous working experience enabled him to negotiate and navigate such customs during the fieldwork and interviews.

3.9.2 Documentary analysis

Analysis of documents was an invaluable source of information for this research. Multiple data collection methods provided not only rich and valuable information about the investigated phenomena but also enabled one source of information to be tested against another. Different forms of evidence from different management levels allowed scrutiny of alternative explanations (Mehmetoglu & Altinay, 2006). Documentary analysis provided the historical and technical background for understanding the mechanism of the indigenization policy process and practices.

Various government publications, reports, decrees, historical documents, policy statements, conference materials and newspaper articles related to the indigenization policies and nursing workforces in the three Gulf states were collected and analysed. Public records or official statistics produced by international organizations (e.g. WHO) and regional and national agencies (e.g. GCC) were rich sources of data for exploring the history of nursing in the GCC countries and the concerns of the nursing profession during the last 30 years or so. Special attention was paid to media and Internet reports and articles as in the Gulf they often contain ad hoc statements from

government officials who cite data that are not published. In addition, in a country like Saudi Arabia where there was a scarcity of information regarding indigenization and nursing, these materials were particular rich documents of social events and labour-market issues. Bryman and Burgess (1993) argue that documents tell us about the aspirations and intentions of the period to which they refer and describe places and social relationships at a time when we may not have been born, or were simply not present.

Several methodological issues were raised by the documentary analysis. First, the research was limited by what is available and accessible in the three countries. In most Gulf states, especially Saudi Arabia, not all organizations retain records or would allow a researcher access to them. Second, data collected or generated for one purpose can be difficult to use for another. Third, a researcher has no control over (or often much knowledge of) how data were collected. Finally, documents can be read in a number of ways and also can provide insight into the perspective of those who produced them. Official reports, policy statements and other documents (e.g. grey literature, unpublished reports) are sources of information that may enable the researcher to explore the political processes and world views of those who produce them (Green & Thorogood, 2004).

3.10 Data analysis of interviews and documents

This section describes the analysis and interpretation of the interview data and documents in the study. It should be noted here that all participants were stakeholders and policy stakeholder analysis was used to analyse the data from interviews and documents.

Bogdan and Biklen (1998) define qualitative analysis as: "working with data, organizing it, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others". It was daunting to organize data that included hundreds of pages of interview transcripts, field notes and documents (see Appendix 9). Transcribing and, in this case, translating was very time-consuming and exceeded time estimations

– one hour of Arabic audiotape took about seven hours to transcribe. Basic Microsoft Word software was used for storing transcribed audiotapes.

The analysis depended on locating the documents in the political process and competing institutional discourses within which they were produced. This required them to be read with prior knowledge of the topic; sensitivity to what had been omitted; and the relationships between the subjects of the report, the writers and the commissioners. However, the study is informed by policy analysis which is concerned with both prescription and description. It utilizes a framework proposed by Walt and Gilson (1994) who drew upon a number of theoretical disciplines. They suggest that policy analysis should focus on four dimensions: (i) content; (ii) context; (iii) process; and (iv) actors.

Content includes the substance of policy (such as the detail of the mechanisms of coordination among actors) and describes that surrounding policy-making and implementation. This study has two distinct contexts and their interface. The Gulf is: (i) represented by the political, economic and social context in the three states; and (ii) governed by the operation of the indigenization policy such as national and local policies in each state. The study also considered the influence of situational factors (e.g. transfer or death of actor who had acted as initiator or coordinator for implementation of the policy); structural factors (e.g. establishment of a new ministry of labour in Saudi Arabia; revision of labour laws in the three states); cultural factors (e.g. views on working women; psychological dependency on foreign workers); and external factors (e.g. 11 September 2001 attack on USA, Iraq war and their impact on various social issues in the Gulf, especially those related to women).

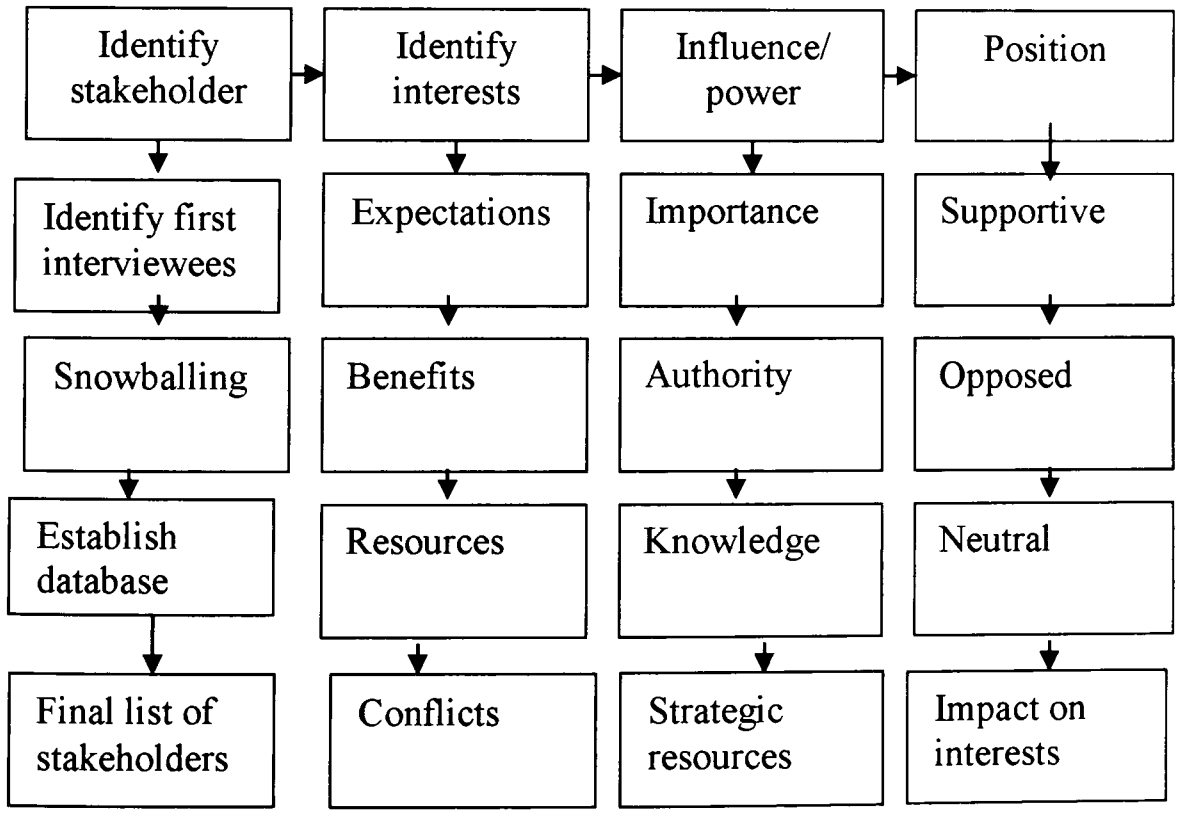
Process is concerned with agenda setting and decision-making in relation to the indigenization policies in the three states. This study focuses on the processes involved in indigenization management and coordination among various actors. Actors, the fourth dimension of the policy analysis, were of particular interest and therefore this study began with a stakeholder analysis. This is explained and described in the next section.

Codes and categories were generated directly from the data and not selected prior to data analysis. Often they were labelled with words found in the data. A stakeholder analysis approach centres attention on the actors or stakeholders, the active contributors to the policy environment. Semi-structured interviews were completed with stakeholders representing various national organizations, institutions, ministries and community members. The interviews were based on issues and themes derived from the study aims. The following topics and issues were covered:

- understanding of the indigenization policy;
- indigenization as a priority and the stakeholder's interest in the indigenization issue, especially in the health service;
- stakeholder's influence and importance in relation to the implementation of indigenization policy;
- stakeholder's position and input on the indigenization policy and relation with other stakeholders.

The matrix table used in the analysis of the indigenization policy in the three Gulf countries is shown in Fig. 5.

Fig. 5 **Matrix table for analysis of indigenization policy**



The stakeholder analysis and matrix used in the analysis are described and explained in detail in the following section.

3.10.1 What is stakeholder analysis?

Stakeholders can be defined as those actors who affect and are affected by a process through action or non-action (Freeman, 1984). Clarkson (1995) defines stakeholders as: "Persons or groups who have, or claim, ownership rights or interests in a corporation and its activities, past, present or future".

Stakeholders are any individuals or groups who are harmed or benefit by, and so have a legitimate interest in, the issue concerned. Clarkson identifies two types of stakeholders: (i) primary – those who are essential to the survival of the organization (shareholders, workforce, customers, those with authority and power over the organization); and (ii) secondary – those with whom the organization interacts but who are not essential to its survival (competitors, suppliers) (Clarkson, 1995; Freeman, 1984). Key stakeholders are those who can significantly influence, or are important to, the success of the policy (Overseas Development Administration, 1995). The stakeholder analysis approach has become an established framework in policy analysis.

Reich (1994) claims that stakeholder approach aims to identify the main policy actors; their understanding of the issue; and their position, interests and influence on the issue. Stakeholder analysis is an approach for gathering information about actors in order to understand their position on certain policies or decisions. Freeman (1984) originally investigated groups in terms of governments, political groups, shareholders, activist groups, consumers and employees. Several authors have proposed a variety of stakeholder types. For example, Henriques and Sadorsky (1999) introduce four groups: regulatory, community, organizational and media. Sirgy (2002) categorizes stakeholders into three groups: internal, external and distal. Lim et al. (2005) say that stakeholders are likely to require different degrees and types of attention and interest depending on their power, legitimacy and urgency and that the levels of these attributes can vary from time to time. Varuasouszky and Brugha (2000) argue that stakeholder analysis is a tool, or combination of tools, for generating knowledge about actors, groups and organizations in order to understand their behaviour, intentions,

interrelations and interests for assessing the influence and resources which they have, and can bring to bear, on decision-making or implementation processes.

A number of steps are used in stakeholder analysis. Dick (1997) suggests four: (i) identify the principle stakeholders; (ii) investigate their roles, interests, power and capacity to participate; (iii) identify the extent of cooperation or conflict between stakeholders; and (iv) interpret the findings of the analysis. Brugha and Varvasovszky (2000) argue that the collection and analysis of data on actors makes it possible to develop an understanding of – and possibly identify opportunities for influencing – how decisions are taken in a particular context. Gergen (1968) recognizes the importance of gathering information on actors and of their role as potential leverage points in the process of policy formulation.

Stakeholder theory addresses how the diverse and conflicting interests of stakeholders can be reconciled. However, it fails to address how to resolve conflicting interests within a category of stakeholders. Those within a stakeholder group may have different interests or interests that are ill-defined or even ill-conceived (Donaldson & Preston, 1995). The formulation, adoption and implementation of policy involve the interaction of stakeholders as they negotiate, accept and reject decisions and proposals. An indigenization policy discourse may involve many actors from various sectors pursuing various programmes of action, with varying interests and goals. Therefore, stakeholder analysis is a useful and effective approach for policy research. The four steps of the framework are described and explained in detail below.

The first step was to identify stakeholders; therefore all potential stakeholders were identified and listed (Table 9). This is a very important stage as it is critical to identify relevant stakeholders, especially where (as in this study) there is little understanding of the phenomena under investigation. The stakeholder literature provides few methods of identification; nor is it helpful when dealing with the self-selected groups that do not represent all those with interests in the issue. As explained earlier, purposive sampling was used in conjunction with snowballing techniques.

The second step was identification of stakeholders' interests in the policy. It was hoped that this would help to identify conflicts of interest. During interviews, each

stakeholder was asked about his/her interests in relation to the policy. The matrix table (Fig. 5) illustrates stakeholders' expectations and benefits, the resources that affect the policy and the conflicts between them. For example, there were major differences between the expectations and resources of the Ministry of Health in Saudi Arabia and other government agencies who control and supervise their own nursing schools. Donaldson and Preston (1995) argue that all stakeholders' interests have intrinsic value and recognition of these ultimate values and obligations gives stakeholder management its fundamental normative base. This stage was problematic because it was difficult to define some of the stakeholders' interests in the policy and thus establish any hidden interests. However, familiarity with the policy and the use of certain questions (concerning stakeholders' expectations, benefits, resources and interests that might conflict with the policy) helped to define these interests.

The third step was assessment of the influence and importance of stakeholders. The Overseas Development Administration (ODA, 1995) holds that influence refers to how powerful a stakeholder is and importance refers to those stakeholders whose problems, needs and interests are the priority of an indigenization policy. There was considerable discussion with a number of individuals who were familiar with various stakeholders of "significant importance" or influence on the policy. For example, the Ministry of Interior in Saudi Arabia exerts powerful influence (because of personal connections and its minister's power over other stakeholders) over the implementation of the Saudization policy. Also, it is highly significant that this ministry controls strategic resources for the policy, e.g. visas for foreign workers. In their typology of stakeholders, Mitchel et al. (1997) labelled those who have power and legitimacy as dominant stakeholders. Power can be defined as: "the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, or the ability of some actor A, to get another actor B to do something that B would otherwise not do" (Mitchel et al., 1997).

The position of stakeholders was assessed in the fourth step. Are they supportive, opposed, neutral or not interested in the policy and its outcomes? Brugha and Varvasovszky (2000) suggest that an analysis of stakeholders' interests helps to predict the positions that indigenization policy stakeholders have adopted. It is important to know each stakeholder's level of support for a comprehensive

indigenization policy as it defines the level of resources that he/she can bring and how much importance and priority is given to the policy.

The ODA guideline is a useful tool but has some limitations. As the analysis deals with a rapidly moving context, in which positions and power are subject to change, it may have to be updated if results are not used at once. In addition, there is a risk of overemphasizing actors' importance in the policy-making process (Varvasovszky, 1998).

The data were analysed inductively, a decision influenced by the grounded theory process of analysis. This theory-building research methodology includes a number of distinct features such as drawing constant comparisons and the use of a coding paradigm to ensure conceptual development and density (Glaser & Strauss, 1967). Within this study this element of constant comparisons was enhanced by the cross-national comparison method, therefore it is important to highlight the importance of comparative analysis in social policy. A description of the importance of comparative analysis in this study will be highlighted in the next section.

3.10.2 Cross-national comparison

The comparative approach has long been central to the study of social policy and is an important methodological tool for exploring key issues. Higgins (1981) argues that without some degree of comparison it will be very difficult to know whether problems of policy are peculiar to certain types of political and economic system or are inherent in the policies themselves. She further argues that comparative methods in social policy widen our understanding of the range of policy options. Higgins suggests that lesson-learning is another advantage of comparative studies but warns of the inherent dangers – a country could be lured into imitating the policies of another without sufficient regard for differences in national context. Higgins uses the examples of the UK and Germany to illustrate how different countries borrow ideas from each other. Initially the UK developed sickness and unemployment benefits while Germany concentrated upon pensions and sickness benefit. As both countries gained experience their systems came to resemble each other very closely (Higgins, 1981).

The example given above indicates that it is not practical to analyse indigenization policies in Bahrain, Oman and Saudi Arabia without some background knowledge and assessment of their social, political and economic performance. This comparative study of indigenization policies and practices at a national level shows that each country is pursuing indigenization policy through varying approaches. These differently affect the speed and outcome of the implementation process. The comparative approach helped to answer some typical questions, e.g. How are indigenization policies structured in each of the three Gulf states and what are the similarities and differences between them? In addition, the comparative method helped to investigate the degree of influence exerted (e.g. by differences in national culture, national institutions, human resource strategies) on indigenization policies and the possible reasons.

The original grounded theory was used in this research because it is so useful when applied to documents. It is also devoted to the development of concepts, categories and systems related to the research phenomenon. Glaser and Strauss (1967) originally described two levels of coding: (i) substantive or open coding; and (ii) theoretical coding. These are described and explained below.

3.10.3 Open coding

Each completed interview was transcribed into a Microsoft Word text format. Interviews in Arabic were translated into English and the documents were edited by adding headers to each interview. For example, an interview with the first stakeholder from Saudi Arabia was entered as (Z) 01S followed by the interview date, location and position. Open codes were applied by examining each interview text line by line and identifying labels or codes from the stakeholders' words. The data were coded manually twice. Each of these codes was compared with other codes within the same country and then with other codes in other countries. Codes were assigned to categories according to best fit, established by examining common concepts or similarities between themes. The goal was to conceptualize and create categories. Throughout this process, the data were subjected to various comparisons and questioning.

A pattern-coding system was used to categorize and correlate data across interviews. This resulted in the emergence of a number of abstracted categories. For example, several statements mentioned "people do not respect nursing as a career" and "as a nurse many people think of me as a maid". These were categorized as – negative image of nursing. This category was then compared with other categories across the three states to discover links, what Van Maanen (1983) calls umbrella terms. Another example generated from the data addresses the ill feeling caused by the lack of support and the rejection experienced by female nursing school students. This category (social influences) incorporates these specific concepts and their associated properties and dimensions. Each category generated from the data through open coding has been described with its properties and dimensions. Strauss and Corbin (1998) describe properties as: "characteristics of a category, the delineation of which defines and gives it meaning".

3.10.4 Theoretical coding

Theoretical coding was the final stage of data analysis, building upon the foundation of the open coding phase. At this stage the "negative image of nursing" category (also labelled by its inductive code of: "What's an indigenous woman like you doing working as a nurse?") was selected. In the other data from Saudi Arabia, this important finding was validated by comparison with other categories. No other properties or dimensions emerged during the rest of the analysis. The reliability of the data provided and the researcher's reliability in collecting and analysing these were verified by a number of participants in the three countries (Lincoln & Guba, 1985). The fieldwork memos written up throughout the data collection and analysis phases were a very helpful tool, enabling the researcher to identify and remedy any gaps in the approach. An example is given in Appendix 10.

3.11 Ethical considerations

Approval to conduct this research was obtained from the London School of Hygiene and Tropical Medicine Ethics Committee. Ethical issues in this research were addressed in keeping with the school's guidelines.

Before the fieldwork research began, each stakeholder was given written assurances in both English and Arabic concerning ethical considerations of informed consent and the right to anonymity and confidentiality (Appendices 11 and 12). Informed consent is a very important element of ethical consideration. In one case in Saudi Arabia, the director of a nursing college requested those female students who had agreed to participate in the research to provide written consent. This was an extra measure to protect herself, given the local culture that guides interactions between men and women.

Each participant received a brief description of the research and an assurance of confidentiality and their right to withdraw at any time without obligation. In the Gulf, as elsewhere, these are crucial and essential considerations for the development of trust and the proper conduct of research practice. The researcher was familiar with the culture and norms and recognized that this type of research requires a high degree of sensitivity to the feelings and position of stakeholders. It was important to gain trust during and after the data collection phase. As some people might feel uncomfortable with audiotaping, each participant was informed of its purpose and asked for permission to tape their interview.

3.12 Strategies for enhancing rigour of the research

Early in the research process the researcher became aware of the importance of providing checks and balances to conform to acceptable standards of scientific inquiry. Padget (1998) and Denzin and Lincoln (1994) identify and elaborate on a number of strategies for enhancing the rigour of research. These include:

1. prolonged engagement
2. triangulation
3. member checking
4. trustworthiness
5. credibility
6. transferability
7. dependability and conformability
8. negative case analysis

Strategies 4-8 inclusive were employed in this research and are now described in more detail.

Within a qualitative approach, trustworthiness refers to a conceptual soundness from which the value of the research can be judged (Marshal & Rossman, 1995). Denzin and Lincoln (1994) suggest that four important aspects should be considered to establish the trustworthiness of findings: credibility, transferability, dependability and conformability. Each of these important factors was addressed in this research.

In general, trustworthiness is bolstered by the amount of time the researcher can spend in the field and on the data, the triangulation of that data and the subsequent biases that the researcher brings to the study (Brown et al., 2002). The researcher spent more than five years collecting and analysing data and writing this research. Rigour was assured by making sure that the categories fitted the data; no data were forced or selected to fit preconceived or pre-existing categories; and no categories were discarded. Therefore, the researcher feels that this research is the result of good science and its findings are worthy of attention.

Credibility is produced primarily through prolonged engagement with stakeholders and triangulation of the data (Lincoln & Guba, 1985) therefore emerging concepts, categories and (later) findings were shared and checked with the stakeholders. Close relationships and regular contact with the stakeholders were maintained throughout the various phases of this research. Findings that emerged were e-mailed to the stakeholders for confirmation that they matched their expectations. They did.

Guba and Lincoln (1981) describe member checks as a continuous process which participants should not use to verify findings. Several methodologists have warned that the tendency to define verification in terms of whether stakeholders or potential users of the research judge the analysis to be correct may be considered a threat to validity (Morse et al., 2002). This may be true but does not apply to this study which is concerned with sensitive phenomena that have not been comprehensively researched and because of the scarcity of reliable published literature.

The credibility of this research also rests on the richness of the information gathered; the ability to analyse data triangulated with a comprehensive review of the literature on indigenization of the nursing workforce and related issues; and a documentary review of legislation and policy documents in the three Gulf states.

Lincoln and Guba (1985) argue that the researcher's goal is not to provide an index of transferability but rather an adequate database from which other researchers can draw a transferability judgment. Therefore, the findings of this study about shortages of indigenous nurses in the Gulf and indigenization policies may be transferable to other health-service groups and other public and private services. This will depend on the degree of similarity with the situation to which it is transferred. The researcher cannot specify the transferability of these research findings but can provide sufficient information and data for the reader to determine whether the findings may be applicable elsewhere (Lincoln & Guba, 1985). In addition, this research presents a body of literature and findings with detailed descriptions of the phenomena which may have value for future studies by researchers.

Denzin and Lincoln (1994) describe dependability as the stability of the research findings over time. Conformability is the internal coherence of the data in relation to the findings, recommendations and interpretations. An audit trail can be used to accomplish dependability and conformability simultaneously (Lincoln & Guba, 1985). For this study, a PhD colleague with demonstrable understanding of the research process and analysis acted as auditor. He followed all the steps of this research, starting with the transcriptions and ending with the findings, and was satisfied with the analysis. This reinforces my belief that the research demonstrates a sound and credible research process and findings.

Negative case analysis is an important concept in achieving credibility by examining carefully those stakeholders who appear to be exceptions (Brown et al., 2002; Lincoln & Guba, 1985). In this research, negative case analysis involved re-examination of all cases (after initial analysis) to discover whether the characteristics of the emergent themes were applicable and fitted all cases. The analysis was considered complete when the researcher had determined that there were no negative cases.

3.13 Chapter summary

This chapter provided a detailed discussion of the research process, beginning with an explanation of the background for the interest of such research and the topics that the researcher was interested to unpack and investigate. It also highlighted the positionality of the researcher; his reflections on this research; and the tensions, difficulties and challenges of conducting such research in a context like the Gulf. The practical difficulties and implications of the lack of reliable data on the phenomena under investigation have also been identified and elaborated upon.

The researcher has highlighted the difficulties and challenges encountered during his fieldwork, especially the difficulty in accessing data and information from various government bodies. The chapter highlighted the importance of developing good questions in order to acquire better and deeper understanding of phenomena. There is a detailed explanation of the research approach, paradigm used and reasons for choosing qualitative methods. A description and explanation of the research design process is followed by an examination of the case study and comparison between the case study employed in this study and other research approaches. The chapter also highlighted the advantages and disadvantages of applying the case study approach in policy-making studies and the main reasons for adopting it in this research.

The detailed steps used to select case studies, participants and the sampling strategies employed in this research have been described. A multi-case study strategy was selected to acquire an in-depth understanding of indigenization within its real-life context and to support meaningful comparisons between the three cases of indigenization in Bahrain, Oman and Saudi Arabia. The chapter also examined and explained the two data collection processes – interviews and documentary analysis. This included the interview structure guidelines and highlighted some of the difficulties the researcher encountered during the interviewing stage. The research analysis process included both interview and documentary analysis and highlighted some of the methodological issues raised by analysing documents in the three Gulf states.

The study was influenced by some elements of the grounded theory process of analysis which include a number of distinct features such as the drawing of constant comparisons and the use of a coding paradigm. The chapter highlighted the importance of the comparative approach in the study of social policy in general and in this research in particular. It examined the usefulness of using the approach to analyse the variables related to the social, political, economic and labour market performance in the three Gulf states. The chapter also described and explained in detail the stakeholder analysis and the framework and matrix table used to analyse the indigenization policy in the three Gulf states. The chapter concludes with an explanation of the main strategies used to enhance the rigour of the study: trustworthiness; credibility; transferability; dependability and conformability; and negative case analysis. The following chapters present the research findings.

Chapter 4

Indigenization – regional policy, multiple voices

4.1 Introduction

Indigenization remains an ambiguous and sensitive topic in the Gulf. A lack of detailed empirical research and reliable data on the labour market ensures that this remains an under-researched and under-evaluated policy. In addition, indigenization is a highly politicized and sensitive issue due to its association with virtually every aspect of life. For example, in Saudi Arabia, criticism of this government policy can be interpreted as a lack of commitment and therefore a lack of patriotism.

Queries about the policy aims, implementation process and employment practices had to be considered with political and cultural sensitivity. Some participants used vague concepts in order to conceal their real feelings or sensitive information. This made it a lengthy and challenging process to examine the interview transcripts for patterns, key words, key sentences or messages behind words and statements; and (finally) to interpret the data and produce findings. However, the resulting data revealed shortages of indigenous human resources in all three Gulf states' health services in general and a chronic nursing shortage in particular, in both Saudi Arabia and Oman. Direct quotations from the interviews have been used in the results chapters. Each interviewee was assigned a pseudonym that is used to identify their quotations.

It is important to note that the economic and social outlook of the GCC states, including their ability to meet major challenges, will be shaped most directly by factors that influence the demand for oil and related products. The GCC states must address a challenging set of problems to maintain economic, social and political stability in the region. Many indigenous and non-indigenous political, human resources and economic researchers have identified the indigenous human resource shortage in the Gulf as the greatest problem and one that exacerbates other troubled areas (Abdullah, 1999).

4.2 Policy development and structure

As outlined in Chapter 2, the rapidly growing populations in the GCC states are producing demographic changes with important implications for the labour market. Traditionally, the GCC's government sectors have absorbed large numbers of indigenous workers who have benefited from guaranteed employment with the higher wages and social benefits associated with government posts. However, this practice has been limited by budget constraints resulting from declining oil prices in the 1980s and 1990s. The GCC states have responded by initiating a policy to meet the dual objectives of creating high levels of employment for their own people while reducing their dependency on foreign workers – indigenization.

Agiomirgianakis and Zervoyianni (2001) define indigenous people as those who are linked by ties of culture, shared genealogy and history, religion, race or national origin. They point out that the operational definition of indigenization has varied among countries, although all have attempted to increase the number of natives in their workforce. The term is used in this study primarily to focus on activities or programmes to replace foreign workers with natives of the Gulf states.

The indigenization policies in the three Gulf states require broad definition and a dynamic perspective. Therefore, any analysis of them requires an understanding of the livelihood priorities of the indigenous workers; the relevant policy sectors; and whether these sectors have appropriate indigenization policies. Despite widespread rhetoric and increasing support for indigenization in the three Gulf states, their policy structures remain predominantly vertical and have not been operationalized realistically. The majority of administrators (especially in Saudi Arabia) have found it difficult to improve matters.

4.2.1 One concept, different perspectives

Indigenization in the three Gulf states has emerged from the pressure of growing unemployment among indigenous populations and other conditions prevailing in local labour markets, including the increasing presence of foreign labour and supply and demand conditions. Although some evidence points to the crucial role of foreign workers, there are limited data about the precise nature of the relationship between

foreign workers and high unemployment among indigenous people. A GCC official commented:

> We are certain that there is a strong relationship between the large presence of foreign labour and unemployment among Gulf indigenous people. When you have more than 12 million foreign workers in the Gulf states, there must be negative consequences on both the economy and the people. (Sami)

Others disagree with such an analysis and feel that foreign workers have been used to justify and explain high unemployment rates. One head of an indigenization department in Oman commented:

> We always hear policy-makers blaming foreign workers for their problems. After all these foreign workers came because we recruited them, they are not imposed on us or invaders. I think such remarks and justifications epitomises the ostrich syndrome. (Khaldoon)

Indigenization in the Gulf is often deemed to be a proper remedial measure for addressing the acute shortage of an indigenous workforce in vital sectors like the industrial and health-service sectors. Indigenization in the Gulf states is widely considered a national public programme that requires a policy response. One Saudi stakeholder indicated:

> The concept of indigenization is the same in all Gulf states, although its implementation differs from state to state. Indeed, policy-makers in the Gulf states discussing indigenization policy will not always tackle the same issues. (Waleed)

My interviews with many stakeholders, especially in Saudi Arabia, seem to indicate less than full understanding and limited knowledge of the indigenization policy and its procedures.

> There is a consistent failing on the part of large numbers of stakeholders in the country [Saudi Arabia] who cannot identify or understand fully the indigenization policy. If you ask people about it [indigenization policy] you will get different responses. Why is that? Because there is no agreement on what indigenization means and how it should be implemented. (Waleed)

4.2.2 Changing concept of indigenization policies

Until the early 1980s, the Gulf states guaranteed a job for every citizen graduate. This ceased when the governments were unable to fund higher salaries. The number of government employees without real, meaningful jobs and the number of graduates have risen sharply in the last 20 years. Although part of the Gulf governments' policy agendas, indigenization did not receive more substantial attention until the 1990s. It has never become a priority. Complexities in coordination and conflicts about responsibility have often led to ambiguities, fragmentation and neglect in government policy. For example, the fourth SDP (1985-1990) witnessed the official emergence of Saudization as a national policy aimed at reducing reliance on foreign workers by investing in the development of Saudis to replace them.

> The Fourth Development Plan was a turning point in labour force planning and employment in Saudi Arabia because it strongly focused on reducing the dependency on foreign workers and providing a practical dimension to the concept of Saudization. (Ministry of Economy and Planning, 2004)

However, stakeholders have come to no agreement about the definition and aims of Saudization. Some policy documents refer to it as a long-term human resources development strategy aimed at developing national human resources through education and training as originally introduced in the fourth SDP: "The issue of Saudization centres on the intensification of efforts to develop national manpower through a quantitative and qualitative expansion of education and training, especially in technical and vocational areas" (Ministry of Economy and Planning, 2000).

Other stakeholders consider Saudization to be a programme to replace foreign workers in order to solve the unemployment problem in the country. A government guideline document defines it as:

> ... a restriction of employment to Saudis and gradual replacement of existing expatriates with national labour according to a number of dimensions, reaching at the end of the day an ideal localization of employment with full usage of national manpower.(Manpower Council, 2002)

It is interesting that these two definitions are drawn from two different governmental documents. The government (policy-makers) that initiated and produced this policy

cannot agree on the definition and implementation of its own policy. So how can such a policy be adopted and implemented by its stakeholders? This must cause them huge confusion and foster a lack of commitment. A female Saudi administrator was very critical of the Saudization policy:

> There are few direct policy and actual legal policy statements on Saudization. What may be termed 'policy statements' are letters and directions from various policy-makers to indigenize by giving Saudi nationals preference over foreign workers. There is a lack of procedures and guidelines regarding how to implement Saudization. The Saudization policy is fragmented and there are many bits and pieces that need to be tied together. (Ahlam)

Asked about this ambiguity in the Saudization policy objective, a senior policy stakeholder replied:

> No. No ambiguity at all. Both definitions you [the researcher] referred to are right. First, we must upgrade their skills [the Saudis] by providing education and training then finding suitable jobs for them. It is not true that creating jobs for Saudis necessitates terminating expatriates. That is one way, but as our economy grows, new jobs will be created. (Waleed)

While the Saudi administrator denied the ambiguity and confusion created by the lack of clear objectives and structure of the indigenization policy, his counterpart in Oman admitted that indigenization policy was not well-developed:

> It is true that Omanization is a loose term. The only direction we have is to Omanize [indigenize] full stop. But how, where, and do we have the necessary resources to do so? Nobody gave us any answers. (Salmeen)

Salmeen was referring to a statement in a document from the Ministry of Manpower. This stated that Omnization is:

> To improve employment opportunities for Omanis to avoid unemployment and to provide them with training and qualifications in order to conform to labour market needs; and to replace foreign workers with highly qualified Omani workers. Furthermore, to increase the participation of Omanis in the labour market in general and with particular focus on increasing the participation of Omani women. (Ministry of Manpower, 2003)

The published indigenization policies are not accompanied by realistic assessments of how they are to be implemented within existing structures and constraints. Many administrators in all three states expressed concern about the lack of indications or guidelines as to how indigenization policies were to be implemented. On many occasions the researcher asked administrators for a copy of strategies and standards of implementation but not one could be produced. One head of an indigenization department in Oman commented:

> We do not have detailed written strategies and guidelines to explain what we should do and what are the main objectives of the policy [Omanization]. We find it difficult to delegate responsibility to others to implement the policy. This impedes any coherent coordination of the policy between administrators. (Khaldoon)

Another Saudi administrator in charge of Saudization pointed out:

> Administrators in various ministries have no links with indigenization policy-making because that's all done by others in the Ministries of Interior and Labour, and senior managers in this ministry [Ministry of Health]. This makes it very difficult for us because we see no links or coordination at the top level and many of us see no reason why they should link on our level. (Zaher)

Such confusion about the aims of the policies has created internal wrangling about where the responsibility for indigenization policies should lie and who should be responsible for overall maintenance. A substantial advance towards a coordinated indigenization policy could be achieved if any of these three Gulf states brought various actors into closer working relations with clear guidelines.

Most of the Saudi government's resolutions and initiatives on Saudization relate to quantitative aspects rather than qualitative dimensions. For example, the Council of Ministers decree (No. 50) in 1995 summarized the action required to meet the national objective of replacing foreign workers with Saudis, whenever possible. In addition, this decree urged further controls on the availability of foreign workers and introduced the first Saudization quota for private enterprises – requiring those with 20 workers or more to indigenize their workforce by at least 5% per annum (Shah, 2005).

These initiatives and measures indicate that the Saudization policy was used as a short-term tool to alleviate the unemployment problem in the country. Most government documents measure progress by the numbers of Saudis who have been employed and the foreign workers who have been replaced, without reference to the broader economic and development considerations. A head of department in the Saudi Ministry of Interior explained his understanding of the Saudization policy:

> Saudization is a national demand because one of the most important objectives of this policy is reducing the number of foreign workers. This will create more jobs for our people and at the same time reduce the level of unemployment, especially among Saudi youth. (Bandar)

These views focus on replacing foreign workers with indigenous workers and often represent policy-makers' stand on Saudization. However, the country's long-term development strategy spelled out in the eighth SDP (2005-2010) stresses the importance of meeting the requirements of diversifying the economy by providing qualified and skilled human resources:

> ...to develop human resources and continually ensure an increasing supply of manpower; upgrading its efficiency sufficiently to meet the requirements of national economy; and replacing non-Saudi manpower with qualified Saudis...and therefore diversifying the economic base and reducing dependence on the production and exploration of crude oil as the main support of the national economy. (Ministry of Economy and Planning, 2005b)

Although this clearly states that the ultimate aim of Saudization is to reduce dependency on foreign workers, it has been bound with certain guidelines and conditions. The country's planners see the strategic objective as not a purely replacement strategy but one that considers the requirements of national diversification of the economy, requiring qualified Saudis who can perform at the same (or higher) level as foreign workers. This strategic view and the mechanisms to achieve such aims have been spelled out:

> The ultimate source of a nation's wealth increasingly lies in its human resources and the productive skills of its labour force...recognizing this trend from the onset of development planning, the Kingdom's successive plans have given greater attention to human resources development through continuous support of primary, intermediate, secondary and higher education, as well as of technical education,

> vocational training, and pre-service and in-service training. (Ministry of Economy and Planning, 2006a)

The majority of stakeholders in Saudi Arabia expressed satisfaction with such statements that broadly outline the main objectives of the country's human resource policy and stress the importance of education and training. However, all stakeholders expressed their dissatisfaction and disappointment with the way the policy has been implemented on the ground. One senior Saudi administrator explained:

> People lost trust in these documents and statements. They are there for public consumption both internally and externally. Policy-makers wish to make people believe that they are doing something about unemployment and Saudization. These statements do not tackle cultural, political and economic issues affecting Saudization. (Ahlam)

4.3 Bahrainization and Omanization

Since gaining independence from Britain in the 1970s, Bahrain and Oman have developed two of the most progressive and advanced economies in the GCC states. Both have sought to diversify their economies in order to reduce dependence on declining oil reserves and encourage foreign investment. Bahrain and Oman are responding to shortages of indigenous workers by pursuing strategies similar to those in Saudi Arabia. The Bahrainization policy was established in 1988; Omanization started in 1994. Like Saudization, these terms mean the creation of employment for indigenous people by replacing foreign workers with nationals.

In 2001, Bahrain's Ministry of Labour and Social Affairs developed a strategy for employing and integrating the national workforce. This laid the basis for a range of policies aimed at expanding employment for Bahrainis, including reform of the labour market. Bahrain and Oman aim to tackle joblessness among the indigenous populations and reduce dependency on foreign workers. Their integrated and comprehensive approaches comprise the following components.

1. Adoption of a comprehensive human resource development and employment policy.

2. Removal of distortions and segmentation in labour markets through gradual but consistent structural reforms.
3. Investment in the quality of human capital by enhancing the productivity, skills and employability of youth.
4. Evaluation and institutionalization of labour market interventions and introduction of innovation-targeted programmes.

However, Bahrain differs from both Saudi Arabia and Oman in its human resource vision and willingness to seek professional assistance. Bahrain has asked the International Labour Organization (ILO) for help in developing a strategy to employ and integrate its national workforce in the labour market. This would include the main themes of creating more job opportunities for citizens; minimizing dependence on foreign workers; and supplying the labour market with a well-trained national workforce. One senior officer in the Bahraini Ministry of Labour pointed out:

> We have a clear vision and strategy for Bahrainization and as I have told you before we have asked for ILO assistance to help us achieve Bahrainization objectives. We need to join efforts by everybody in the country in order to implement Bahrainization policy. (Dawood)

However, it is obvious that combating unemployment is a dominant issue in both Bahrain and Oman. The Bahraini government adopted a number of proposals to Bahrainize jobs in order to solve this problem. For example, the National Employment Project (NEP) aimed at:

> Investing in human resources and developing them through appropriate training programmes and tapping the skills of local professionals so as to be accommodated in the labour market and have their positive contributions to the country's steady development. (Ministry of Labour, 2006)

Bahrain and Oman both adopted vocational training projects to upgrade graduate competencies and enable them to participate in the indigenization process. Bahrain has established a Labour Market Regulatory Authority to set up strategic schemes and programmes to upgrade the labour market in the country and reinforce cooperation with the private sector. Its aim is: "To put up mechanisms capable of ensuring more

stability in the labour environment and large-scale training and rehabilitation programmes for job seekers" (Ministry of Labour, 2004).

However, there is growing concern about unemployment among Bahrainis and Omanis, despite the sustained and targeted investments that have maintained economic growth and diversification and despite all measures and initiatives to limit dependency on foreign workers and create job opportunities for nationals. An ILO estimate predicted that nearly 100 000 Bahrainis (approximately $^1/_5$ of the total population) would enter the labour market in the period 2003–2013 (International Labour Organization, 2004).

A BCSR study showed that unemployment is confined mostly to Bahrainis (International Labour Organization, 2005). Unemployment rates for Bahraini males and females were 14% and 20.4%, respectively. Unemployment among Bahraini youth was among the highest in the world at 40% (International Labour Organization, 2005). The proportion of foreign workers in the total workforce remained unchanged between 1998 and 2004, at more than 57%. The ILO attributed this to inadequate workplace skills among Bahraini job seekers; their unwillingness to accept manual work; low wage levels; poor working conditions; and some employers' reluctance to hire Bahrainis (International Labour Organization, 2005).

4.4 Implementation of the indigenization policy

4.4.1 Implementation in the public sector

Indigenization began in the public sector. In the GCC states the public sector has seen continuing economic development since the 1970s, with significant expansion in the number of agencies, services and budgets during the 1970s and 1980s (Abdelkarim, 1999). Since a policy of indigenization in the Gulf was announced, the idea of employing indigenous workers in the public sector has gained considerable legitimacy and support. The Gulf governments have become the main employers of indigenous workers. For example, in 1977 the Saudi Civil Service Bureau that oversees employment in the public sector passed a resolution requiring only Saudis to be employed in that sector. The Saudi Civil Service Law explains the exception: "...an

exception may be allowed for non-Saudis to work temporarily in those positions that require special qualifications not available in Saudi nationals" (Ministry of the Civil Service, 1977).

This exception includes a large number of public institutions. The oil industry, health service, communication and many other highly technical and scientific institutions employ large numbers of foreign workers because of the shortage of qualified indigenous workers. Therefore, the main targets of the Saudization policy have been mostly clerical, managerial and low-skilled positions. Between 1975 and 2006, Saudi public-sector employees increased more than fivefold (see Appendix 9) – from 142 341 in 1975 to 733 866 in 2006. Of these, 243 757 (approximately 33%) were female workers. Together they represented 91% of all public service employees (Saudi Arabian Monetary Agency, 2006). The number of Saudis increased by 2.9% during 2005 but there was an insignificant reduction in foreign workers (less than 1%) in the same period. This is in clear contrast to one of the most important manpower developments goals highlighted in the last development plan:

> ...rationalizing the recruitment of labour from abroad and linking its employment and use with the actual need, activating Saudization decisions, and restricting employment in some occupations and economic activities to the national labour force. (Ministry of Economy and Planning, 2005a)

Analysis of foreign workers in the public sector shows a steady increase in numbers between 1975 and 1994, around 8.5% annually. In Saudi Arabia, the number of foreign workers in the public sector began to fall by around 9% annually from 1994 until 2004 when numbers began to rise by around 2.4% (Tables 14 and 15). It is interesting that the reductions in foreign workers started almost ten years after the official introduction of the Saudization policy. This suggests that the Saudi public sector is able to absorb only a small fraction of the growing number of Saudi job seekers and may indicate that the private sector will be the only significant source of new job creation.

In 2003, Manpower Council Resolution M48/2003 fixed a ceiling for foreign workers and their dependents – not to exceed 20% of the total Saudi population by the end of 2013. In the same year, the Minister of the Interior (also Chairman of the Manpower Council) pledged to establish a quota system for foreign workers in which no

nationality may exceed 10% of the total population (Manpower Council, 2003). It is difficult to imagine that the government can be serious about such a pledge when it issued 600 000 foreign worker visas in 2003 and more than 750 000 visas in 2004, an increase of 25% (Abou-Alsamh, 2004). It is also difficult to imagine that such an ambitious goal can be achieved when the number of foreign workers increased by 13.7% in 2005 (see Table 16), a trend that may well continue for the next few years.

Table 14 **Saudi public service employees, 1975–1996**

Year	Number of employees				Total
	Indigenous		Foreign		
	Male	Female	Male	Female	
1975	142 341		42 400		184 741
1976	140 807		47 055		187 862
1977	148 062		50 976		199 038
1978	154 789		57 252		212 041
1979	165 056		64 182		229 238
1980	183 501		69 397		252 898
1981	195 604		72 867		268 471
1982	247 978		86 243		334 221
1983	258 124		106 124		364 248
1984	274 459		121 331		395 790
1985	299 738		129 281		429 019
1986	316 629		140 494		457 123
1987	336 456		144 523		480 979
1988	356 307		147 552		503 859
1989	369 093		150 116		519 209
1990	386 760		147 938		534 698
1991	396 891		151 658		548 549
1992	420 653		159 612		580 265
1993	444 364		144 934		589 298
1994	460 845		133 014		593 859
1995	480 313		128 698		609 011
1996	506 577		109 714		616 291

Source: Ministry of the Civil Service, 2002

Table 15 **Saudi public sector workforces by sex and nationality, 1997–2005**

Saudis					Non-Saudis				Total	
Year	Male	Female	Total	Growth rate %	Male	Female	Total	Growth rate %	Saudis & non-Saudis	C r
1997	379 025	181 653	560 678	10.68	51 827	44 151	95 978	-12.52	656 656	
1998	383 996	195 419	579 415	3.34	49 736	39 272	89 008	-7.26	668 423	
1999	387 779	203 879	591 658	2.11	46 956	35 940	82 896	-6.87	674 554	
2000	408 640	204 682	613 322	3.66	45 776	35 672	81 448	-1.75	694 770	
2001	416 803	214 221	631 024	2.89	45 644	34 191	79 835	-1.98	710 859	
2002	438 023	214 912	652 935	3.47	43 400	31 653	75 053	-5.99	727 988	
2003	452 555	224 965	677 520	3.77	41 698	27 748	69 446	-7.47	746 966	
2004	463 487	231 007	694 494	2.51	41 342	27 429	68 771	-0.97	763 265	
2005	472 727	240 108	712 835	2.64	41 436	29 005	70 441	2.43	783 276	

Source: Ministry of the Civil Service, 2006

Table 16 **Saudi private sector workforces by sex and nationality, 2004–2005**

	2004		2005		
	Number of workers (mill.)	Distribution (%)	Number of workers (mill.)	Distribution (%)	Annual growth rate (%)
Total labour force	**6.6**	**100**	**7.6**	**100**	**15.4**
Male	6.47	98.1	7.44	97.9	15.1
Female	0.13	1.9	0.16	2.1	28.1
Saudis	0.48	7.2	0.62	11.6	28.4
Male	0.46	6.9	0.59	11.0	27.9
Female	0.02	0.03	0.03	0.6	37.7
Non-Saudis	5.91	89.6	6.71	88.4	13.7
Male	5.21	88.2	5.83	86.9	13.7
Female	0.7	11.8	0.88	1.5	25.7

Source: Saudi Arabian Monetary Agency, 2006

Since 2004, a sharp increase in oil prices has produced rapid growth in the Saudi economy. This has driven the recruitment of more foreign workers to meet increasing

demands, especially in the private sector. The Ministry of Economy and Planning attributed the increased demand and continuing dependency on foreign workers to:

> Inadequate numbers of Saudi graduates in scientific, technological and technical fields in general, and in various medical specializations in particular; and the difficulty for female graduates in taking up job opportunities in locations far from their families and homes. (Ministry of Economy and Planning, 2005b)

This might also be attributable to the accompanying growth in government spending and the creation of a huge number of projects in almost all sectors of the Saudi economy. Data show that gross domestic product (GDP) grew by 23.7% during 2005; the gross national product (GNP) grew by 6.6%. This was one of the highest growth rates in the world (United States Department of State, 2006). Accordingly, this increase in foreign workers is likely to continue as long as the Saudi economy continues to grow at the present rate, as more skilled and qualified foreign workers are required to sustain development. For example, the Saudi construction sector demanded that the Saudi government issue at least 1.2 million foreign worker visas to meet the requirements of contractors on government projects alone. The Chairman of the National Committee for Contractors pointed out that:

> ...to implement these projects we need at least 1.2 million additional visas to recruit engineers, skilled labour and ordinary workers. One thing everybody should know. There will not be any employment [for Saudis] without implementing development and service projects. (Arab News, 2007)

A Ministry of the Civil Service report issued in 2007 attributed the continuous presence and recent increase in the number of foreign workers in the public sector to:

> The absence of a comprehensive national Saudization policy in the country and the lack of coordination between government agencies. It also contributed to the shortage of qualified Saudis who could replace foreign workers. (Ministry of the Civil Service, 2007)

Saudi Arabia's labour force is characterized by a high percentage of public sector employment and strong divisions between low-paid foreign workers in the private sector and well-paid indigenous workers in the public sector. Bahrain and Oman are similar, with the number of indigenous workers in their public sectors exceeding 91%. Therefore, the labour markets of the three Gulf states share many structural features,

face similar constraints and are influenced broadly by the same set of trends. Differences in the resources available and economic diversification are likely to influence the speed and depth of the required policy efforts but there are enough similarities to discuss a broad common indigenization policy in all sectors of the economy.

As seen above, responses to the formulation and implementation of the indigenization policies have been confined to the bureaucratic arena. Strong commitment and leadership is necessary to ensure that these policies are implemented effectively. However, the most likely future scenario is that Gulf governments, decision-makers and human resource managers remain ambivalent. They will continue to rely on their own initiatives and understanding of how a policy should be implemented. In addition, indigenization might lose the direct attention and support of various non-governmental groups and those who have advocated these policies over the past two decades. Future training and monitoring evaluation efforts might also suffer as a result of serious implementation deficiencies, already recognized by stakeholders. One senior Saudi stakeholder explained:

> We know what the government should do to improve implementation of the policy but the problem is nobody is listening to us. On many occasions I myself have recommended certain measures to be taken to improve the policy from my experience working to implement the policy but no action has been taken. So what can I do? If I continue banging on about the issue they will consider me as a trouble-maker and you know what will happen to trouble-makers in our country. (Marzook)

There are fundamental deficiencies in the implementation of the indigenization policy, especially in Saudi Arabia. The public sector has insufficient capacity to set the overall direction; coordinate the strategy and work plans for the indigenization policy; and periodically monitor and evaluate achievements. Reforms could consider whether technical assistance from the ILO or other international organizations might enable the Saudi government to build its managerial capacity for indigenization. Also, stakeholders require more financial support to enable them to monitor and evaluate indigenization policy services.

4.4.2 Implementation in the private sector

The literature review described how GCC governments are keen for the private sector to become the main employer of their growing labour forces. This requires more detailed analysis of how indigenization is perceived and implemented in this sector. It is also important to note that the private sector health service is one of the fastest growing private sectors in all GCC states. All three Gulf states have youthful populations that produce an increasing number of job seekers who expect their governments to employ them. However, these governments have the finances and structures to absorb only a small fraction.

In almost all Gulf states, traditional open employment in the public sector is gradually being replaced by a more selective recruitment policy. This is intended to reduce overstaffing which has emerged as a major problem in most public sector organizations. Most GCC governments have formally announced that job opportunities in the public sector are likely to remain limited and that job seekers should consider the private sector. One Bahraini stakeholder commented on the government's role in employing Bahrainis:

> People have to realize that the golden years when the government guaranteed a job for every citizen are over. We cannot employ all Bahrainis in the public sector. We have more than we need, a lot more. Actually we need to reduce the size of our public sector employees. It is neither economical nor logical to be the main employer in the country. Private sector must take a responsibility in providing more jobs for our people. (Dawood)

As outlined in Chapter 2, a large segment of the indigenous workforce continues to prefer public sector employment because it offers higher wages, better merit increases, job security and training. However, as the public sector has reached saturation point the Gulf governments have turned their focus to the private sector. They have concentrated on improving the organizational and administrative environment of private sector establishments to make them more attractive to indigenous job seekers. The Gulf governments have realized that a rapidly growing private sector is essential for any progress in attacking their unemployment problems and job creation needs:

> It is a strange phenomenon we have in the Gulf, here we have millions of foreign workers who come to work and take advantage of our economic growth, and in the same time we have our own people unemployed. I think the private sector is getting greedy and taking advantage of the situation. What I mean is that we [the government] help the private sector to thrive in order to employ our people but it is not doing its job. (Dawood)

In recent years these governments have adopted a strategy of economic diversification in non-oil industrial activities and have started to pay more attention to small and medium-sized firms, which were often neglected in the past. In many countries, small and medium-sized firms have played a crucial role in creating jobs and providing economic stability (Looney, 2004). Although there have been several great successes in creating large numbers of jobs for the indigenous population, generally the private sector has shown reluctance to replace large number of foreign workers with indigenous workers.

The private sector in the three Gulf states is underpinned by a historic compromise which granted private firms access to state incentives and a free hand in sourcing and utilizing foreign workers in return for investment. The private sector employs 95% of the foreign workers in the three Gulf states, 85% of whom are unskilled (Al-Dosary, 2006). The private sector's lack of enthusiasm for indigenous workers and preference for foreign workers is based on a number of factors. Extensive surveys carried out by the Council of Saudi Chambers of Commerce and Industry documented the main issues.

- Foreign workers accept lower wages than indigenous workers.
- Foreign workers possess the necessary qualifications and experience to perform their duties; these are lacking in indigenous workers.
- Flexibility of movement – foreign workers will go anywhere in the country but indigenous workers prefer urban areas.
- Foreign workers are more stable; indigenous workers tend to move from job to job.
- It is easy to terminate the employment of foreign workers and repatriate them at any time.

- Foreign workers are easier to manage, more disciplined and more committed than indigenous workers.
- Indigenous workers are unwilling to adjust to working conditions in the private sector (working hours, shorter public holidays, six-day working week vs. five in the public sector).

(Council of Saudi Chambers of Commerce and Industry, 2002)

Over the years, the private sector has used many myths to portray indigenous workers as unstable, unqualified, unwilling or incapable of performing at the same level as foreign workers. There is also the myth that indigenous workers lack a work ethic and are unprepared for very demanding jobs. However, this is not limited to Gulf states or developing countries. A government study in the UK showed that immigrant workers have a better work ethic, are more reliable and work harder than British-born workers (London Paper, 2007). The Gulf governments have rejected such myths as bias. The private sector is simply justifying its reasons for not employing indigenous workers and continuing to employ foreign workers. For example, one Saudi senior manager in the Ministry of Labour commented:

> The government has done a lot for the private sector. As you know we have no taxation on Saudi businesses and have adopted a number of initiatives to help those [businessmen] to gradually phase out foreign workers. But unfortunately many are reluctant to employ Saudis and try to use a number of tactics to avoid Saudization. Previous experiences have proved that Saudi workers have been successful in many public and private organizations when they are given the opportunity to prove themselves. Unfortunately what the private sector is spreading about Saudis I consider a type of discrimination. (Waleed)

This strong verbal commitment to indigenization is not matched in practice. For example, an analysis of figures issued by the Ministry of Labour in Saudi Arabia showed that the number of private sector workers totalled 5.4 million at the end of 2005 (other independent figures estimate around 8 million), a 15.4% increase on 2004. Saudi workers comprised only 11.6% of the total labour force in the private sector (Table 16). In Bahrain, foreign workers comprised more than 57% of the total labour force in 2004 and the percentage increased in the following year (International Labour Organization, 2005). This illustrates that governmental institutions and the

private sectors have diverging interests and different perceptions of indigenization. The differences between the two parties are real.

It is interesting to note that the percentage of female workers in the private sector increased faster than that of male workers. For example, female worker numbers in Saudi Arabia increased by 37.7% to 0.03 million; male workers increased by 27.9%, to 0.59 million. The private sector is employing more female workers in line with the Gulf governments' drive to increase job opportunities for women while respecting religious and cultural attitudes. As indicated earlier in this chapter, foreign worker numbers in the three Gulf states have increased since 2004, suggesting that their indigenization policies face similar challenges in both public and private sectors. It also supports the contentions of some experts and critics that the indigenization policies written into the various development plans of the three Gulf states are barely being implemented (Cordesman, 2003).

Nevertheless, growing awareness of the existence of an indigenous people characterized by severe distress, chronic unemployment and hopelessness has reinforced the conviction that Gulf governments cannot remain indifferent and passive. The GCC Secretary General warned about the possible consequences: "The GCC countries need to look at the massive presence of expatriates basically as a national security issue and not merely as an economic matter" (Gulf News, 2005). Other experts, like the president of the Arab American Institute, believe that foreign workers are: "...a time bomb waiting to explode and unleash riots in the Gulf states" (Kapiszewski, 2006).

In Oman, business people have voiced their concerns over the mechanism adopted to force Omanization on the private sector. An Omani businessman commented:

> They [the government] always pressure us to employ Omani even if we do not need them or they cannot undertake the duties and responsibilities of the vacant position. If we say no, they accuse us of not been patriotic and preferring foreign workers instead. It is a huge problem for many of us. (Alshabibah, 2004)

However, such strong criticisms of the way that the indigenization policy is being implemented in the private sector are usually met by a government counter attack.

The private sector is accused of profiteering and not responding to major local challenges, especially growing unemployment among the indigenous populations. For example, the Saudi Minister of Labour and Social Affairs warned the private sector of more restrictions and measures to limit the recruitment of foreign workers:

> Saudi Arabia is not a recruitment agency for foreign workers coming from all directions. We have a responsibility toward our Saudi people to provide them with decent jobs. This is their right. We will do all we can to limit the number of foreign workers. (Al-Hayat, 2004)

Private-sector business people in the three Gulf states have argued that indigenization policies have produced fake jobs to fulfil government quotas. They assert that indigenous workers have been paid token sums to claim that they were working when they were not. The Ministry of Labour and some influential Saudi businessmen have clashed violently and there have been threats to move businesses outside the country if the government continues this forced Saudization. The policy has been described as a stumbling block to effective partnership with the government, demonstrating a lack of understanding of private-sector concerns, methods and principles.

There is a perception that the government is trying to shift liability and responsibility for the indigenization policy to the private sector. Forceful approaches to Saudization, such as the quota system, have encountered strong opposition from local businessmen who say it is potentially harmful and adversely affects productivity and profitability (Kapiszewski, 2006). One Saudi newspaper described an episode of Saudization in the private sector:

> One fine morning it was decided that the entire fruit and vegetable trade should be Saudized, and the next moment there were raids on fruit and vegetable stalls across the country. If any expatriate was found staffing the shop, he was arrested and the shop was closed down. This drastic measure led to complete confusion in the trade, which subsequently reported huge financial losses. (Arab News, 2004)

There is growing pressure on the new leadership in Saudi Arabia to push for Saudization although, as stated previously, this poses a challenge. The Minister of Labour and Social Affairs (who has the full support of the leadership in his endeavour for Saudization) said:

> They [Saudi businessmen] are attacking me every day and accuse me of slowing down their business by not granting them the [foreign worker] visas they demand; I am not going to succumb to such criticisms. Saudization will continue whether they agree with it or not and those who threatened to leave the country I tell them we have not closed the airport. (Al-Watan, 2006)

In 2005, the Bahraini Parliament introduced restrictions to limit some jobs to Bahrainis only. This is similar to what has been implemented in both Saudi Arabia and Oman (Table 17). However, some stakeholders in the three Gulf states have questioned the effectiveness of restricting some professions to indigenous workers and warned of adverse consequences on the quality of services and indigenization objectives. A senior official in the Ministry of Labour in Saudi Arabia commented:

> While restricting some sectors of the economy to create additional jobs for Saudis, people take this for granted. In some sectors, this has affected the quality of services. It has also deprived some of these sectors of foreign experience. Some businesses have complained that this measure has increased the price of their services and raised their labour costs. (Waleed)

A Bahraini administrator agreed with such an assessment and explained:

> Some business people have complained about this restriction because it has restricted them from employing foreign workers who are more experienced and cheaper than Bahrainis. It has also created a shortage of qualified personnel in some of these designated sectors. (Dawood)

The GCC labour market will experience an enormous influx of young indigenous workers in the next few years. These workers will need meaningful work and the projected job opportunities may not be enough to accommodate them. In addition, the GCC states employ large numbers of foreign workers at a fraction of the cost of employing an indigenous person with the same qualifications, or training them to the same level. Some private sector firms in the three Gulf states will not indigenize voluntarily and mandatory quotas might be considered as a last resort to force compliance with these policies. Already, these three states have introduced several strategies that include incentives for firms that comply and cooperate and penalties for those that do not.

Table 17 **Policy instruments to reduce supply of foreign workers and increase numbers of indigenous workers in the three Gulf states**

Supply of foreign workers	Demand for indigenous workers
Direct and indirect fees for foreign workers and their sponsors (work permits, health insurance)	Establishment of various human resource development funds to train indigenous workers
Centralized visa service with strict regulations for international recruitment	New vocational training institutions
Indigenization quotas for private firms	Incentives for employing indigenous workers
Restricted employment of foreign workers in certain occupations	Indigenization quotas in private firms
	Creating more job opportunities for indigenous population only

4.4.3 Incentives and penalties for implementing indigenization policies

Private firms in all three Gulf states may be asked to justify why foreign workers are necessary and prove that their skills and experience are unavailable among indigenous workers. The governments may force organizations to repatriate foreign workers and stop the transfer of foreign worker sponsorship from one organization to another. Moreover, private firms that tender for government contracts must meet the specified indigenization quotas and use money that would have been spent recruiting foreign labour on training programmes for nationals. The Oman Secretary General of the Tendering Board stated that: "For a private sector organization to win a government contract, it must meet Omanization quota requirements" (Al-Watan, 2004).

All three states have limited the number of foreign visas issued to private firms. This is aimed at minimizing the sale of visas to foreign workers, especially in Asia where many workers are desperate to enter Gulf states. Some private firms employ "ghost workers" – recruiting more foreign workers than they need and hiring them out to

other firms in order to collect a portion of the workers' wages. This practice is illegal and considered un-Islamic but is widely practised in most Gulf states. However, the measures introduced to limit and control such practices are usually open to abuse by well-connected people. As one Saudi Ministry of Interior administrator explained:

> The problem we are facing is when we introduce a policy like this [visa control] we find it difficult to implement it on those who are well-connected to decision-makers. In this case, these people get their own way by getting foreign worker visas that they do not need and which they sell as a commodity and make money out of it. They are creating a black market and depriving our people of job opportunities. (Bandar)

Not many private firms have fulfilled their requirements as it is proving difficult to enforce these regulations. Also, some labour-exporting countries have expressed concern over the effects of this recent acceleration of indigenization. For example, India estimates that the present Saudization policy could affect 1 million Indian workers working in Saudi Arabia, directly or indirectly (Arab News, 2007).

The Saudization policy in the early 1980s focused on top and middle management but this approach affected not only productivity but also the overall performance of the private sector. However, the government's aim of employing indigenous workers in meaningful organizational roles was at least partly achieved. The airline, banking and oil sectors have all achieved a 60%–90% indigenous workforce although the situation for health professionals is not so positive (see Chapter 2). This shows the effect of structured, rational decision-making. The banking sector achieved a 60% increase in Saudization in less than five years but the policy has barely begun in other sectors. This shows the selectivity within Saudization – it is dependent on the sector that the government chooses and who supervises or controls that sector. It also means that the government is concentrating on productive sectors rather than service and social sectors like the health service. However, successful Saudization indicates that indigenization aims can be attained by providing the right training and skills through well-planned programmes.

4.5 Indigenization in the health service

The health sector in the Gulf has witnessed major developments since the 1970s. The region has some of the most modern health-care facilities with the most advanced medical technologies in the world. However, Gulf health services face the difficult task of providing sufficiently competent labour forces to meet the increasingly complex health-care needs of rapidly growing populations. For the last three decades (as outlined in Chapter 2), the GCC states have relied heavily on doctors, nurses and allied health professionals recruited from other countries, particularly the Philippines; the Indian subcontinent; and other Arab countries such as Egypt, Sudan and Lebanon. For example, in Saudi Arabia, 80% of all physicians, 78% of nurses and 50% of allied health personnel come from abroad (World Health Organization, 2005). Moreover, a sizeable proportion of Saudis working in the health service are engaged in administrative duties. A Ministry of Health official reported during his interview:

> Many of our Saudi employees in almost all fields prefer to perform administrative duties rather than their own specialties. This is a serious problem especially among those we need most like doctors and nurses. It is a waste of resources. (Marzook)

The sustainability of a health-care system so dependent on foreign workers was called into question when oil prices fell dramatically in the mid 1980s. This gave further impetus to policies designed to increase the proportion of the workforce drawn from the indigenous population, including doctors, nurses and allied health professionals. Oil prices have soared and billions of dollars in revenues have enriched the GCC states since 2004 but international and domestic events provide continuing support for the policy of indigenization. Competitive salaries and high-tech facilities have always ensured a good supply of foreign health personnel but this is no longer guaranteed as international shortages increase. One Saudi senior Ministry of Health official commented:

> The golden days of the 80s and 90s are over. We used to hire any numbers we required and choose from a pool of candidates who were competing to get a job in Saudi Arabia, but not any more. We have now a difficult time to fill some positions especially those in critical areas such as oncology, intensive care and cardiac where there is a huge competition from other countries. (Aisha)

4.5.1 Global competition

The GCC states now compete with countries such as the USA, UK and others who have severe shortages of health-care workers. Although offering good pay and attractive working conditions, some of their competitors may be more attractive socially – particularly to female workers who are subject to various restrictions on their movement in the Gulf states. The UK also allows nurses and doctors to be accompanied by their families, something that is restricted or impossible in some parts of the Gulf. A senior member of the Saudi Commission for Health Specialties (SCHS) commented:

> Experience taught us not to be entirely dependent on foreign workers. During the second Gulf war when Iraq attacked Riyadh with Scud missiles many foreign workers fled the country. It was very difficult in the health service. We had to close wards and cut services. We were in a desperate situation; we had to offer very generous bonuses and other incentives to persuade people to remain in the country. This experience has made us realize that foreign workers are here temporarily and we need to depend on ourselves. (Salem)

Although international recruitment can be a quick fix for workforce shortages, it may also be an obstacle to solving some of the other social problems that are endemic in the region, such as youth unemployment and the exclusion of women from public life. Home-based solutions such as improving working conditions, improving staff retention and attracting returnees through part-time career opportunities may be more cost-effective than international recruitment (World Health Organization, 2003). The GCC governments have generally supported the migration of foreign workers from countries such as India, Pakistan, Bangladesh and the Philippines but are keen to reduce the outflow of revenue through remittances sent home by foreign health-care workers. They also want to ease the pressure on labour markets, reduce unemployment and accelerate development (United Nations, 2006).

4.5.2 Strategy for development of indigenous health-care workers

To meet the challenge imposed by shortages, the GCC governments have adopted strategies for the development of health-care workers in both public and private sectors. This comprises short- and long-term goals, including those listed below.

1. Setting specific priorities and mechanisms for indigenization in the health service according to their importance and the possibility of filling them by national manpower.
2. Rationalizing the recruitment of foreign workers and linking their employment and use with actual need.
3. Achieving greater harmonization between educational and training programmes and health service needs for a national workforce.
4. Increasing training programmes; building more medical, nursing and allied medical colleges in both the public and private sectors; and providing more incentives for students.
5. Enhancing coordination between various health providers for better utilization of available resources. (Fasano & Iqbal, 2003; Manpower Council, 2003; Ministry of Economy and Planning, 2006)

However, analysis of the 2004–2005 figures for selected health personnel in the Saudi Ministry of Health reveals that little was achieved. There was even a reduction in the number of Saudis in some health categories during the two years following the adoption of the strategy. First indications show the difficulty of achieving even the long-term aims if present trends continue. For example, data for physicians show a 5.6% increase in total numbers in 2005 but a negligible increase in the number of Saudis (<0.20%). Indeed, there was a 1.1% reduction in the number of Saudi physicians between 2004 and 2005 (see Table 18 below). It should be noted that Saudi Arabia has a fairly low ratio of physicians in comparison to other GCC states (15.3 per 10 000 population). In the UAE and Qatar, the ratio is 20.02 physicians per 10 000 population.

Table 18 **Ministry of Health selected personnel, Saudi and non-Saudi, 2004–2005**

Category	2004					2005				
	Total	Saudis	%	Non-Saudi	%	Total	Saudis	%	Non-Saudi	%
Physicians	18 621	3 541	19.0	15 087	80.0	20 219	3 773	18.7	16 446	81.3
Pharmacists	1 167	712	61.0	455	45.0	1 123	760	67.7	363	32.3
Nurses	41 356	14 524	35.1	26 832	64.9	42 628	17 068	40.0	25 560	60.0
Allied health personnel	21 802	13 342	61.2	8 460	38.8	23 116	16 136	69.8	6 980	30.2

Source: Adapted from Ministry of Health, 2006a

It is possible to assume that either there is a national shortage of medical graduates or there are medical graduates who prefer not to work for the Ministry of Health. The first assumption is more likely because the ministry is the main health provider in the country and medical personnel are paid the same in all public health providers. Data from King Saud University, the largest university in Saudi Arabia, show 217 medical graduates for 2004–2005: 155 male and 62 female; 193 pharmacists: 126 male and 67 female; and only 43 female nurses. No masters or PhD degrees were awarded for the four categories in the same period. A senior Ministry of Health explained:

> We have a severe shortage of Saudi doctors in the country. The main problem is the small number of medical colleges in the country; therefore, both the intakes and graduates are not sufficient to meet our needs. We must increase the capacity of our medical colleges and open new ones soon to alleviate the severe shortage. (Marzook)

Nevertheless, additional medical schools have been established during recent years and the number of medical students admitted has increased progressively. In 2004–2005, 1840 medical students enrolled at King Saud University Medical College, 37% of whom were female students. There are five other universities with medical colleges in the country but they have even fewer students and graduates. These universities produce a fraction of the country's needs for medical doctors. A senior SCHS official reported current needs for doctors, pharmacists and allied medical personnel: "We

need to train 20 000 medical doctors and about 50 000 nurses and allied medical staff to meet our current [2006] needs" (Al-Riyadh, 2007).

The situation in Oman is similar to that in Saudi Arabia although the various health categories show higher percentages of indigenous employees. For example, Omanization was 27% among physicians and 41% among dentists at the end of 2005. Moreover, Oman has achieved remarkable results in other health categories in comparison to Saudi Arabia. At the end of 2005, Oman achieved 73% indigenous worker rates among technicians and 86% among other paramedical personnel (Ministry of Health, 2007). A senior Ministry of Health official in Oman explained:

> We have sound and realistic plans to Omanize the majority of our health service personnel. I am sure if you look to our achievements in five years time (this was in 2004) you will know what I mean. However, we have one very serious problem, which is Omanizing our medical staff. We have a severe shortage in this area. As you know, it takes time and huge resources to educate and train medical staff. (Zubair)

This contrasts with the Saudi official's earlier picture of the bleak current situation but there are ambitious plans to increase the Saudization of the health service. Saudi Arabia has recently requested WHO support for particular priorities such as establishing more medical and nursing schools; developing more training programmes; producing more qualified teaching staff; and improving the quality of human resource management, leadership development and nursing administration (World Health Organization, 2005). The Saudi government is coordinating, supervising and promoting education and training in the health service by increasing support and enhancing the responsibility of the SCHS, founded by Royal Decree No. M/2 issued on 06/02/1413H. This national independent body was established to:

> Develop the professional practice, and promote technical skills, enrich scientific thought, and cater for sound practical applications in the field of various health specialists through designing, approving and supervising profession health speciality programmes and setting programmes for continuous medical education in health specialities within the framework of the general policy of education. (Saudi Commission for Health Specialties, 2006)

The SCHS is responsible for evaluating and supervising all health institutions and centres established for training and specialization purposes in both the public and private sectors in order to ensure the quality of provided services.

Bahrain provides a model for the indigenization of a health service. It has attained the highest percentage of indigenization in all health categories among all GCC states. For example, Bahraini nationals comprised 81% of physicians, 96% of dentists, 98% of pharmacists and technicians, 93% of radiographers, 81% of physiotherapists and 62% of nurses by the end of 2005. This was a result of the health strategy adopted by the Bahraini Ministry of Health. This framework for action was a result of a broad consultative process among health providers, the private sector and government departments. Manpower planning and development is a major focus of the Bahrain National Health Plan (BNHP):

> Recruitment, employment, deployment, continuous education and training strategies are key factors in the continued success and ability to sustain the health system. Over time these strategies should result in a Bahraini national workforce that will evolve by targeting educational opportunities, integrating training programmes and work experience, and improving incentives and contracted service obligations. (Ministry of Health, 2005b)

A Ministry of Health senior manager explained:

> We have one vision, many hands coming together which made all the difference. That is why we are different from our GCC partners. We have also a system of accountability and evidence-based management practice that many GCC states lack. (Lona)

This clear and well-defined strategy is a decisive move away from the short-term, limited approach to human resource planning in most Gulf states. It incorporates not only a health-system design but articulates the key strategies, tactics and resources necessary for reaching Bahrain's human resources goals. It also outlines a clear operational intent and investment strategy for providing resources to meet these goals. Also, it appears that coordination within government departments has produced a real difference in Bahrain.

4.6 Indigenization in nursing: where is the indigenous nurse?

For many decades, the nursing workforce in the Gulf states has relied on the recruitment of foreign nurses. In particular, nurses recruited from the Philippines, the Indian subcontinent and other Arab countries such as Egypt, Sudan and Lebanon. Saudi Arabia currently appears to be the most dependent on migrant nurses but the pattern is repeated throughout the Gulf.

The situation in the Saudi nursing workforce is unclear as different governmental organizations provide different official statistics on the number and percentage of indigenous nurses. The Ministry of Health reports that 40% of all its nurses in 2005 were Saudi (Ministry of Health, 2007a) (see Table 14) but the SCHS reports a figure of 32% Saudi nurses for the same period (Al-Riyadh, 2007). This contradiction is troubling when we know that these organizations are both governmental institutions. The Saudi private health sector figure is more alarming – only 2% of the estimated 14 000 nurses are Saudi (Ministry of Health, 2005a). This reflects the general indigenization trends in the public and private sectors elsewhere. The situation is serious – there are not enough indigenous nurses in the system to meet either current or future requirements.

The Saudi nursing workforce is projected to reach 31% by the end of the eighth SDP in 2010, a 9% increase on its predecessor. However, if history is a reliable indicator, even this modest projected increase might not materialize. For example, the percentage of Saudi nurses in the total nursing workforce increased by only 5% in the seven years between 1999 and 2006, from 17% to 22% (Marrone, 1999). It is difficult to imagine that the 9% target of the present SDP will be achieved without drastic and major measures. However, Ministry of Health analysis of the indigenous nursing workforce reveals an increase of around 48% between 2000 and 2005, averaging 8% annually. The biggest increase occurred between 2004 and 2005 (17%). In addition, foreign nurses increased by around 2% between 2000 and 2004 but decreased for the first time in many years in 2005 (by around 4.7%). Ministry of Health data and statistics are disputed by various stakeholders, many whom are part of government. Some argue that these data cannot be verified by an independent source and are

produced for public consumption. One female senior Saudi nursing official commented:

> I do not trust any information or data issued by any governmental organization. These bureaucratic administrators usually come up with data and statistics out of the blue and build a castle in the air to please their managers. I only trust it when it is verified by an independent source which is very difficult to have in Saudi Arabia. (Shahena)

When asked what made her so doubtful about Ministry of Health data, she replied:

> I believe it when I see it. When you go to any MoH hospital or facility who will you see there? I only see foreign nurses and more of them. I do not see many Saudi nurses. The question then should be asked where are these Saudi nurses the MoH talked about? I have two answers to this question. First either they do not exist in the first place or they work behind desks and have nothing to do with bedside nursing duties. In both cases, it means we have not increased the number of Saudi nurses on the ground, on paper maybe. (Shahena)

Other stakeholders indicated that even if the data are correct, the quality of the graduates is very low and does not meet the requirements for nurses. As one female Saudi nursing college explained:

> Let's be optimistic and give the MoH the benefit of the doubt because we honestly do not know whether the data is correct or no. But as a nursing education manager I say that what matters is quality not quantity. Most if not all of MoH nursing school graduates do not possess the right qualification to be a nurse. Why? Because they do not have a bachelor's degree in nursing, they have a diploma. Most not only cannot work with foreign nurses but also find it difficult to be trained by them because their English is so poor. So at the end of the day to me these graduates can be called nurse aids. (Rufaida)

Specialized education and training requirements will delay Saudization considerably for many years. The Dean of College of Nursing and Allied Medical Sciences (CNAMS) stated that: "It will take more than ten years before we can have a majority of indigenous nurses in our health service" (Al-Riyadh, 2007). Nursing shortages are projected to worsen with rapidly expanding populations and growing demand for nurses in the Gulf. Current projections estimate that the current Saudi population of 27 million will grow to 45 million by 2025, an increase of more than 53%. The

proportion of Saudi nurses is projected to increase by only 13% to reach 35% of the total nursing workforce in the same period (Al-Riyadh, 2007).

There are substantial differences between the data and projections from the Ministry of Health, other governmental departments and independent sources. There is also a lack of reliable data and information about the national nursing workforce and the accurate situation of the national indigenous nursing workforce. Increases in the percentage of indigenous nurses employed in the Ministry of Health between 2000 and 2005 have not been matched nationally. This makes it likely that the nursing shortage will worsen as the demand for nurses is expected to increase dramatically. However, Saudi Arabia is in the midst of a nursing reform that includes policies to change nursing education; increase the number of nursing institutions; and encourage masters- and doctorate-level education for Saudi nurses.

The Ministry of Health estimates that Saudi Arabia needs 100 000 nurses in the next five years to staff its 255 hospitals and 2000 health clinics presently under construction in various parts of the country (Al-Riyadh, 2008). On the basis that 2000 nursing students will graduate annually, it will take more than 40 years to fill the national shortage of indigenous nurses. However, the number of nurses required will rise considerably if the current nursing rate of 32.3 per 10 000 population is to match that of other Gulf states (e.g. 54.8 per 10 000 in Qatar). This will pose an even greater challenge for the Saudi Arabian nursing workforce.

4.6.1 Indigenization strategies in nursing

The issues associated with the nursing workforce in the Gulf are complex, dynamic and involve multiple stakeholders, including governments at all levels, community groups, professional bodies and educators. Not surprisingly, all three Gulf states have almost identical aims, with no significant differences in the interests and expectations of the majority of their different stakeholders. They share the same goal of achieving and maintaining an adequate supply of appropriately educated and trained indigenous nursing personnel to meet the needs of their populations. Five main strategies have been adopted to improve indigenization in the Gulf states.

1. Improved data, research and human-resource planning.
2. Appropriate education and training with further increases in nursing school places.

3. Support for nursing as a career choice for indigenous people.
4. Active promotion of recruitment and retention strategies.
5. Improved wages and working conditions.

Yet all three states lack suitable mechanisms and implementation procedures to put these strategies into operation. For example, limited national data on all three nursing workforces make it difficult to obtain an accurate assessment of the current situation on the supply and demand for nurses. Limited data and lack of research on the nursing workforce in the three states hamper the ability to understand present and future requirements. One senior GCC manager explained:

> One of the main and critical factors in the GCC nursing workforce is the lack of suitable data and information about the real situation of the nursing workforce in all Gulf states. We do not know exactly what is happening in regard to supply and demand. (Sami)

The majority of stakeholders in the three states have called for the establishment of an advisory committee to deal with human resource issues in the health service and more research to identify gaps in human resource planning in general, nursing in particular. A senior manager in the Saudi Ministry of Health pointed out:

> We simply do not know the full picture of the nursing situation in the country. There is no research that I am aware of that has identified and explained the profile of the nursing workforce in the country. It is frustrating when you have to make a decision while you do not have any reliable data to support your decision. (Marzook)

Bahrain has a relatively effective system for collecting and maintaining an adequate human resources database. This may be because the workforce is much smaller than those in Saudi Arabia and Oman. A Ministry of Health manager explained:

> We have a good human resources database. We collect on a regular and systematic basis vital human resources data that helps us to make crucial decisions regarding our human resources planning. (Fatena)

There is a lack of projections of nursing supply and demand requirements in the Gulf states. These are vital to ensure an adequate supply of skilled and knowledgeable nurses to meet evolving health-care needs. In addition, improved nursing practices

and workplace environments will encourage indigenous people to choose nursing as a career and help to retain existing indigenous nurses. Women in general, and nurses in particular, have many other employment options. Therefore, there is a clear need for a predictive strategy for health human resources that will help policy-makers to act proactively rather than reactively.

The strategy to develop appropriate nursing education and increase the number of indigenous applicants to nursing schools has been a focus in most Gulf states. In recent years, there have been strong calls to reform and upgrade educational opportunities in general, and in nursing in particular. There is a realization that quality education is a key factor in attracting and encouraging indigenous people to consider nursing as a career. As one senior Omani nursing educator explained:

> Those days when only intermediate or dropout students were the majority in the nursing schools are over. Now, because we have upgraded and improved our nursing education system we see more applicants who apply to nursing school. Demand for our nursing school is increasing and education plays a major part in such a change. (Rayan)

While it is true that demand for nursing education is increasing it is also true that the pool of applicants is generally insufficient throughout the three Gulf states, although the situation varies. Nearly all respondents stressed the importance of high-quality nursing education and considered it a tool to address the problems of low self-esteem among indigenous nurses by creating and strengthening nursing education programmes, continuing education and mentoring programmes.

4.6.2 Nursing education

As indicated earlier, multidimensional sociological and cultural factors in the Gulf act as barriers to education for women in general and potential nurses in particular. Nursing education is a significant component of human resources development in any health service. The production and retention of a competent nursing workforce requires nurses to be educated using a curriculum based on the knowledge, skills and competencies needed to practise (International Council of Nurses, 2006). Nursing education is considered part of the education system but most nursing education institutions do not fall under the jurisdiction or control of education ministries. For

example, nursing education in Saudi Arabia was traditionally part of the Ministry of Health's responsibility.

In recent years, a number of other government health providers (e.g. Ministry of Defence; National Guard) and the Ministry of Higher Education have opened their own nursing colleges that provide Bachelor of Science in Nursing degrees (BSN). The College of Nursing and Allied Medical Sciences (CNAMS) at the National Guard in Riyadh opened in 2001. In 2004, the first class of 12 women graduated with BSN degrees and was employed in National Guard hospitals. The college also offers bridging courses for nurses who hold a Diploma or Associate Degree in nursing. The aim is to develop and prepare a well-educated nursing workforce to meet increasing health service challenges and create satisfying professional career opportunities. Saudi nursing graduates are encouraged to enrol in higher degree courses (including masters and doctorates overseas) to prepare them for future positions of leadership. However, so many different nursing education providers (each with its own system and resources) results in duplication of efforts and programmes, creates confusion and wastes resources. A head of a nursing college stated:

> We have so many different nursing schools that belong to different organizations with no coordination which make things very difficult not only to us but also to those who are interested in nursing as a profession. We are making it difficult for everybody. It is a strange situation. After all it is one country and all are under one government. (Nawal)

Health services now find their work subjected to greater scrutiny and criticism than ever before and unsatisfactory practice often results in costly litigation (Clarke & Copeland, 2003). However, the Ministry of Health nursing schools continue to offer only diplomas or associate degrees in nursing. Some of the ministry's education managers have called for these institutes to be replaced. One nursing director in one of the government health providers commented on the quality of these nursing graduates:

> Even now I regret agreeing to take some of these graduates [MoH] into my nursing establishment. Their nursing knowledge was very low, they spoke very little English and could not cope with our work. I do not blame them, I blame the education system. They were basically difficult to train; they had to start all over again in order to come

> up to our nursing standards. No such calibre of nurses can work in today's health service environment. (Ahlam)

I asked if this participant knew about Ministry of Health graduate standards. Ahlam replied:

> [I am a Saudi nursing researcher] I had a good idea, but the reason I agreed to take them, first, because they were Saudis and I strongly wanted to give them a chance to train and second because I was under some pressure from hospital management who themselves were under pressure from the top and maybe the media. You cannot Saudize [indigenize] like that. You will do no good to both the individual and the organization. (Ahlam)

This highlights the pressure exerted on human resource and nursing managers to employ Saudi nurses regardless of their quality and the training they have received.

The increasing proportion of patients with more complex care needs increases the demand for health personnel trained in critical specialties such as intensive care. In addition, increased use of complex technology in health care has increased demand for nurses with a higher skill mix. Abu-Zinadah (2006) points out that the low educational standards in Saudi Arabia have impacted on the quality of nursing services and the ability of some graduates to meet changing health needs and respond to the complexities inherent in the care delivery system. Some indigenous nurses have voiced concerns that their qualifications and skills do not meet the same standards as foreign nurses, making them feel incompetent and unqualified.

The mismatch between national development goals and educational interest in the country is often greater than policy-makers and planners expect (Wiseman & Alromi, 2003). In 2000, more than 70% of the students in their survey of 524 senior high schools in Riyadh agreed that the general high school curriculum did not prepare them for work in the labour market. They said they wanted extra training before graduation to help them to succeed (Wiseman & Alromi, 2003). At a recent symposium held in Saudi Arabia to discuss the future of higher education, one participant said:

> The output of Saudi higher education does not cope with the labour market and graduates are weak in English language, computer applications and lack training in jobs that they would undertake. (Gulf News, 2007)

The current study's findings revealed widespread support and interest in specialized and continuing education among members of the nurse population in the Gulf states. Specialized education refers to educational and training opportunities that focus on a particular field of nursing practice (e.g. oncology, intensive care) with the purpose of providing specific skills and qualifications.

Unfortunately, few studies have provided theoretical frameworks or any empirical analysis to estimate the effects of education outcomes on the labour market in the Gulf. Much of the literature relevant to education in the Gulf has focused on either the status of women or the influence of Islamic principles (El-Sanabary, 1992). The performance of Saudi universities has also been attacked by a number of local media, especially after the release of a global rating of the world's universities. In 2009 two of the largest universities in Saudi Arabia – the King Saud University in Riyadh and the King Abdulaziz University in Jeddah – were ranked at 292 and 1203 respectively amongst 4000 universities worldwide (Ranking Web of World Universities, 2009).

Surprisingly there are no indigenous models for evaluating modern Saudi education or training despite concerted recent attempts to indigenize systems, curricula and personnel (Findlow, 2001). In addition, there is no effective coordination between nursing schools, nursing organizations, government agencies and hospitals to facilitate access to, or identify common outcomes for, all levels of nursing education. This observation does not apply to Bahrain. It has one College of Health Sciences that includes a nursing college among allied medical specialities and makes coordination and planning much easier and more effective than in either Saudi Arabia or Oman.

The three states offer a wider range of educational opportunities for those who wish to study nursing but there continues to be a severe shortage of nursing colleges and programmes that offer BSN degrees, outside a few major cities in the three states. The associate and diploma nursing programmes in Saudi Arabia and Oman are better distributed but are not attractive to the majority of today's high school leavers. The

expansion of nursing education into new geographical areas is therefore desirable and will require additional financial resources, clinical facilities and qualified faculties. As one Saudi nursing female manager explained:

> While workforce recruitment strategies are important to increase the number of national nurses, it is also as important to upgrade their quality to ensure that they are capable of working in today's highly technological health service that requires well-educated and trained national nurses. (Aisha)

Until recently, little attention has been paid to the shortage of nursing faculties that has resulted from retirement, resignations and fewer nurses entering academia (Peterson, 2001; Valiga, 2002). This shortage is one of the major critical issues facing most Gulf states as there are few indigenous professors and associate professors due to low enrolment in doctoral nursing programmes. These shortages combine with the part-time nature of teaching and low salaries to inhibit the ability to educate and train nursing students. Many nursing schools have been unable to increase their intake of indigenous applicants and have turned away many suitable applicants. An Omani Ministry of Health officer explained the difficulty in recruiting faculty personnel:

> We have plans to open more nursing schools in various areas in Oman but we have been hampered by the lack of buildings and suitably qualified teaching staff. I am talking about foreign faculty personnel because few indigenous personnel exist. We need to accelerate enrolments in masters and doctoral programmes to meet some of our needs. (Ali)

A nurse faculty is not created simply by erecting and equipping buildings and adding the role of educator to that of the nurse. It requires changes in attitudes, knowledge, skills, behaviour and experience to prepare for the new assimilated roles, settings and goals of the personnel involved (Infante, 1986). In addition, all three Gulf states lack coherent regulatory standards for education and clinical competence. The level of education and training of many indigenous nurses does not necessarily match the nature of their work and many are frustrated by their inability to compete or work closely with foreign nurses who have higher qualifications and skills. This creates tension and conflict.

The governments of these three Gulf states are largely aware of these problems and some have introduced a number of initiatives to improve and maintain educational standards. However, many senior policy-makers and education managers have hesitated and failed to introduce frameworks for training, education and practice for indigenous nurses. There has been little effort to reform nursing education. The HMC has focused on identifying the core commonalities across the Gulf states in areas such as: material resources; quality of nursing programmes; quality of faculties; criteria for student admissions and graduation; shared policies; standardization of curricula; and evaluation of outcomes. However, fundamental issues such as providing care standards and guidelines; defining professional roles; and providing in-service training and continuing career development have not yet been addressed systematically.

4.7 Recruitment and retention

Recruitment and retention of indigenous nurses is one of the most important factors in the development of nursing workforces in the Gulf. It is important to review the practices used to recruit indigenous people into nursing. In the absence of comprehensive national planning policies, the number of indigenous nurses has been determined by other factors, such as the number and capacity of the nursing schools. It is surprising to see the huge influx of high school graduates who major in (for example) the humanities, despite little prospect of finding a job after graduating, while nursing schools struggle to find students despite guaranteed jobs on graduation.

The supply of indigenous nurses relies heavily on nursing education programmes in nursing institutions and colleges. However, as previously stated, nursing education in the three Gulf states has not expanded rapidly enough to keep pace with the increasing demand for more indigenous nurses. The three states in general, and Saudi Arabia and Oman in particular, are in great need of indigenous nurses to overcome the shortages caused by increased international competition for foreign nurses. Some stakeholders have voiced their concern over the implications for patient care. One nursing director in a Saudi hospital suggested that limited staffing may affect the quality of patient care offered by her hospital and has suggested that international recruitment must not be looked at as the only solution:

> We are desperate for more nurses. It is quite a struggle and stressful when you are on a daily basis trying to respond to increasing demands from various departments for more nurses. It will be great if we can get Saudi nurses, but where can we find them? There are not many around. In addition, foreign nurses are hard to get these days. But we must not rely on international recruitment; it should be looked at as a quick short-term staffing solution. We must Saudize [indigenize] as fast as we can while keeping an eye on quality or we will face a crisis soon. (Jamila)

Demand for nurses, particularly indigenous nurses with advanced skills, is climbing steeply in all three Gulf states. International data suggest an increasing overall trend in international flows of nurses (Royal College of Nursing, 2004). Hospitals across the three states are finding too few nursing candidates to fill the large number of vacancies. Also, increasing demand for care is straining current nursing resources and raising concern of a significant negative effect on the quality of health care provided. This situation is likely to persist because the pipeline of undergraduate nurses cannot meet even present demand. The majority of stakeholders across the three Gulf states shared the anxiety that without active indigenization policies the health services might be brought to a crisis that produces complete dependence on foreign nurses. Similar concerns were voiced by a nursing director in an Omani hospital. She showed me her nursing establishment figures to illustrate the problem:

> As you can see I am about 20% less than my approved establishment. How can any nursing director work in these difficult circumstances? I worry every day about what is going to happen. I am almost begging any nurse who considers leaving to stay a little longer. In Oman, and I expect in your country too [Saudi Arabia], one of our major strategies for filling nursing shortages is importing nurses from other countries. However, recently we could not recruit enough to meet our needs. The future depends on how we can attract more Omanis to nursing. Omani nurses will be our last hope to survive as a health service. I am hoping that our Omanization [indigenization] strategy will deliver good results. (Layla)

Given the time it takes to train highly skilled nurses, significant relief of the current nursing shortage is unlikely in the foreseeable future. Both Oman and Saudi Arabia have continuously recruited foreign workers to fill crucial gaps. This has contributed to shortages in poor countries – for example, Bangladesh has sent many doctors and nurses to the Gulf for many years (Dussault & Franceschini, 2006). Spectacular

increases in the total number of nurses in the Gulf states is the result of a massive migration of foreign health workers, especially those from India, Pakistan, the Philippines and Korea (Ball, 2004). For example, Saudi Arabia is still the second most popular destination for nurses from South Africa and the Philippines (Buchan et al., 2005). However, a strict focus on increasing the number of indigenous nurses ignores the potential of the existing nursing workforces in the three Gulf states. At present these are not employed to maximum benefit in their health services. One Saudi nursing director explained:

> The problem is that our existing nurses are not utilized fully and many of them are not performing nursing duties. It is a waste of resources. Many of our nurses carry the title while working in other capacities such as clerks and similar administrative works. (Jamila)

There is no accurate estimate of overall retention of both indigenous and foreign nurses in the three states but there seem to be limited retention strategies such as peer support groups, opportunities for continuing education or incentives that address quality of work-life issues. In addition, a large number of respondents reported that decreased levels of job satisfaction among indigenous nurses lead them to pursue other careers. Retention of indigenous nurses is currently a significant problem in all three states and some hospitals report annual turnover rates approaching 25%. A Bahraini head of nursing in one major hospital explained:

> Many indigenous nurses are leaving and unfortunately most will stay home. They are not transferring to other hospitals so we as a country are losing their talents. I would say that between 20%-25% is our turnover rate. This is alarming when you combine it with turnover among foreign nurses. The situation is getting worse. Indigenous nurses are leaving for many reasons including religious, wages and mostly for difficult working conditions. (Bedoor)

4.7.1 Factors inhibiting recruitment and retention

Health service and nursing school stakeholders across the three Gulf states identified several social and organizational factors that directly affect indigenous nurses and nursing student turnover, including:

- low wages and benefits
- long working hours and shifts

- family commitments and social pressure
- religious reasons (working with opposite sex)
- inadequate training
- few opportunities for career development
- lack of respect from physicians and managers
- working conditions (lack of facilities)
- limited participation in decision-making.

The recruitment and retention of nurses and nursing students are major concerns for health-care providers as they may contribute to increased costs and problems with the quality of care. Numerous, mainly media, reports in recent years have described the inability of health-service providers to recruit and retain adequate numbers of indigenous nurses in all three Gulf states. One Saudization manager explained:

> There is going to be a crisis in this country if they do not act quickly. They are not proactive in their recruitment but rather reactive. There is no clear vision or strategy but rather hasty decisions based on hunches and reams of ideas. (Liz)

There has been little analytical research to assess the nature and overall magnitude of the current nursing shortage. Nevertheless, health service actors in all three Gulf states agree that the entire Gulf is facing a shortage of nurses that is exacerbated by the lack of recruitment and retention strategies. Initiatives to improve indigenous nurse recruitment and retention in the Gulf should include: (i) improved salaries and benefits; (ii) the development of nursing education, training opportunities and ongoing training; and (iii) additional employee support, including improved working conditions and organizational and social support. One Saudi nursing manager summarized what is needed:

> Improving the work environment is the key to retaining existing nurses and attracting new indigenous students to nursing. Nurses need reasonable working conditions, supportive management, flexible work schedules, fair promotion and training opportunities, respect and reasonable wages and benefits. (Aisha)

The Bahrain Nursing Society cites low pay as one of the main reasons for nurses leaving the country (Gulf Daily News, 2007). The head of the Bahrain Nursing Society warned policy-makers of the consequences of low wages:

> Our best nurses are quitting and leaving for other countries where they are offered more wages. I urge the King and the government to look into this matter because I would hate to see Bahrain suffering a severe shortage in the coming years. (Gulf Daily News, 2007)

In addition, most stakeholders in the three Gulf states view increasing job satisfaction for indigenous nurses as the key strategy for addressing the nursing shortage. However, little has been done. The vast majority of solutions fail to address the real problem and there is little evidence that nurses are experiencing improved working conditions. This might be attributable to a lack of cooperation between health-care professionals or a lack of human resource policies and accountability. Decision-makers may not have the evidence required for change.

4.8 Implementation of indigenization policy in nursing: what and where are the problems?

Given the imbalance of indigenous nurses and the greater demand for high-quality and motivated indigenous nurses, it is essential to identify the range of potential barriers that may deter indigenous people from considering this career. Changing lifestyles, new chronic diseases, greater longevity, the shortage of indigenous nurses and new treatment technologies have all prompted significant changes in health-care delivery. Health systems in the Gulf are facing increasingly complex challenges that require innovative solutions.

Rys (1964) cited in (Higgins, 1981) identifies a wide range of variables that have influences upon social policy, especially internal factors including the demographic, economic, social structure, political, pressure group, institutional evolution and social psychology factors. The body of evidence reported here indicates that a nursing shortage occurs when there is a unique, complex interrelationship of human resource policies and practices, social and cultural factors and image attributes. These factors include the contextual (politics, religion and culture; gender relations; discrimination against women; family influence; foreign nurses), organizational (working conditions; relationships with other health professionals) and situational factors that are impeding the indigenization policy for nursing in the Gulf states. These are examined in detail in the following sections.

4.8.1 Contextual factors

A policy's success is largely determined by political power and influence and the level of importance that political leaders attribute to it. Political decisions have a direct impact on the provision of health care and the development of the nursing profession in the Gulf. Higgins (1981) argues that the political factor represents the most important environmental element in the evolution of social policy; therefore the political dimension cannot be ignored and should not be underestimated when looking at the social policies of different countries. The success of the indigenization policies in nursing in the three states depends on collaboration between various government agencies, nursing associations and interest groups and requires indigenous nursing leaders to develop a greater awareness of politics and indigenization. Robinson suggests exploring the relationship between nursing and policy alongside the exploration of: "... the backdrop of the social and economic circumstances in which the activity of nursing is practised" (Robinson, 1997).

The current governments in the three states have generally demonstrated a greater commitment to indigenous nurses than their predecessors. The status of actors and their relationships with indigenization have been found to be distinctly different in the three states but many actors have expressed dissatisfaction at government inefficiency in implementing these policies. Increasing unemployment (especially among young people) and internal pressure in recent years has increased the Saudi leadership's interest in the indigenization policy and its potential for the country's economy and stability.

Saudi Arabia's political leaders have more importance and influence than their equivalents in Bahrain and Oman. Moreover, the various Saudi stakeholders have a loose coordination structure and do not seek common objectives – hence different government agencies clash over aspects of policy. Some actors within the government believe that the commitment to Saudization is not sincere or may be motivated by reasons other than the stated aims of indigenization. Other actors have questioned the intentions and motivation behind Saudization and argued that the government's main intentions are to regain legitimacy among Saudis, avoid conflict and maintain stability. A manager in the Saudi health service said:

> The only thing the government is interested in is its own internal security. Therefore, it is using Saudization as a tool to silence those critics who say that the government is not doing anything about foreign workers and unemployment. It also seeks to shift the blame of the high rate of unemployment among Saudis to other entities in either the public or the private sector. (Saif)

Reflecting on the usual reluctance to speak out in Saudi Arabia, I made the following memo after this interview: "I am surprised that someone who works for the government and sits in his office in the ministry is so brave and bold as to give me this analysis about the government's aim of its Saudization policy" (Memo 36).

Abdelkarim (1999) points out that politics and security factors (rather than economics) were and may remain the main determinants of attitudes to the presence and employment of Saudis and expatriates. He further points out that these political factors are also applied to the manipulation of the national population and decisions to increase the number and power of particular groups are responses to internal power struggles between different groups. Hall et al (1975) point out that social policy is partly a history of conflict between interests which have often concentrated in different social classes. They further point out that social policy is a history of conflicts being resolved, of accommodation, compromise and of agreements which cut across class boundaries. In this study a senior Ministry of Health manager explained:

> I have to be frank with you; there is a lack of commitment toward Saudization not only in the health service but in all sectors. There is a lack of vision and leadership. Nobody knows why we need to Saudize and more importantly how we are going to Saudize. (Marzook)

The Saudi case demonstrates that political leaders can exert significant influence to promote the achievement of policy objectives and it is very important to identify ways in which such power and influence can be strengthened. The whole process is complicated by clashes between government agencies over the objectives and implementation of the indigenization policy.

Bahrain and Oman seems to have stronger coordinating structures that allow various actors to work toward common objectives. A senior Bahraini in the Ministry of Labour explained:

> In Bahrain we share a common vision and aim of Bahranization in all sectors. Being a small country, coordination among various agencies is easier because we know each other. (Dawood)

There is an explicit policy commitment to indigenize and develop nursing practice in Bahrain and the high profile of indigenization produces a more sympathetic climate for the policy. In Saudi Arabia, there has been an expectation that indigenization will be implemented as planned without taking account of the factors that might affect this. The content of the indigenization policy has received more attention than understanding of the processes, which explains why desired and expected outcomes fail to emerge. Policy-makers may be reluctant to push through reforms that are often unpopular, especially in the private sector, as this can cause economic and social instability. Policy reform is a political process that affects the formulation and implementation of policy (Reich, 1994a). Indeed the challenges facing the three Gulf states may prove insurmountable without fundamental reform of political institutions.

Religious ideas and practice have had considerable influence on social policy, different religious ideas and beliefs have resulted in a wide variety of policy responses (Higgins, 1981). Higgins (1981) argues that the teaching of Catholicism has influenced social policy, especially in countries in which Catholicism is the dominant religion. She cites Ireland as an example of a Western country in which the influence of religious beliefs has had a profound and lasting impact upon the organization of the whole of contemporary society, not only in the field of social policy.

In the Gulf, religion plays a major role in society and exerts great influence upon social policy development and implementation. In Saudi Arabia, religion has greater influence and power over all aspects of life and its impact is felt more widely than in Bahrain and Oman. In some areas of policy the religious establishment has direct influence, especially those involving family and women's welfare. The influence of the religious establishment (especially in Saudi Arabia) has also been felt in education, where control of girls' education still rests with the religious establishment.

However, recently a series of factors have contributed to the decline of the influence of religion on social policy, especially in Saudi Arabia. Violence and violation of basic human rights by some religious authorities; terrorist attacks by extremists on Saudi soil; the considerable growth on expenditure on education, especially for women; and the new moderate leadership that took over in 2005 have all contributed to the decline of the religious establishment's influence on social policy.

Nursing is considered women's work as caring for and about others is historically associated with women and nursing (MacDougall, 1997). The majority of indigenous nurses in the three Gulf states are women and therefore religion and culture play an important part in shaping attitudes towards nurses' role in the public sphere. Gray (2005) argues that indigenization is essentially about culture. Therefore, indigenization in the Gulf was adopted in the context of the Gulf people and their culture.

Various passages in the Quran stress the spiritual equality of men and women and the duty of both sexes to meet the requirements of Islam. Different social roles are ascribed to men and women as a consequence of their different natures. However, some Muslim women believe that certain interpretations of Islamic doctrine degrade the conception of women. They argue that a belief in men's superiority over women is not congruent with the teachings of Islam but merely a reflection of culturally-bound opinions (Mernissi, 1991). A clear majority of indigenous nurses in the three Gulf states agree that the Quran accords women more specific rights and privileges than those granted by their societies. However, they find themselves caught between a rigid interpretation of Islamic law and the cultural norms of a society with a patriarchal understanding of gender roles.

The three Gulf states are characterized by extremely restrictive codes of behaviour for working women, rigid segregation and a powerful ideology that links family honour to female virtue. The principles of Islam apply to the conduct of everyday life for indigenous nurses. Islam guarantees a woman's right to seek education and employment but Gulf tradition dictates that her role should be limited to that of mother and wife. This study has revealed the many barriers to a woman's rights in all

three Gulf states. Saudi Arabia is the most strict and conservative concerning women's issues. One Saudi cleric commented:

> Women in this country are lucky because they are treated according to Islam rules. We did not invent these rules. They have been sent by God through Prophet Mohammad. What do you prefer? God's rules or human beings' rules? The problem is that some liberals and secular advocates have been trying to impose Western culture and ideas on our society. Praise to God they failed and women understand their role and will never change or trade their God's rules and directions for human rules and principles. (Abdullah)

The researcher reported that some women respondents believe that rigid interpretations of Islam limit their freedom and hamper their career. He smiled and replied:

> I hope that when you met these women a male relative was present in that meeting otherwise what they have done was wrong [referring to the Islamic rule that a male should not be alone with a non-related female]. Islam does not limit their freedom, women can go anywhere they wish but must be accompanied by a close male relative. This is Islam. Listen to me we cannot change Islam to suit people's circumstances. These rules are there to protect women and not like what is happening in the West where women have nobody to protect them as you know yourself. (Abdullah)

In another example, a Saudi Islamic scholar who represents the traditional view of conservative Islam said:

> We [meaning himself and those who hold the same views] are not against women going to work as nurses but with some conditions. Our interest is to see Saudi nurses working in our health service, but they must be segregated from males, both staff and patients. When we gave our approval to nursing schools, our expectations were that graduates will work according to Islam and the norms and customs of this country. (Ibraheem)

When asked to clarify what he meant by "when we gave our approval", he replied:

> This meant that whenever there is any proposal or policy initiated by the government, especially those related to women and their role in the public life like opening a nursing school for girls, our institutions [religious institutions] must be involved to ensure that such a proposal or policy is according to Islamic law and does not conflict

> with Saudi traditions and norms. Therefore, our approval is necessary for any policy of that kind to be implemented. (Ibraheem)

These quotations represent the reality in Saudi Arabia. Article 7 of the Constitution states: "Government in Saudi Arabia derives power from the Holy Quran and the Prophet's tradition" (Saudi Arabian Constitution, 1992). Under Article 45 Sunni scholars who form the body of scholars (*ulema*) are responsible for the interpretation of Quran and the Prophet's tradition:

> The sources of the deliverance of fatwa in the Kingdom of Saudi Arabia are God's Book and the Sunnah of His Messenger. The law will define the composition of the senior *ulema* body, the administration of scientific research, deliverance of fatwa and its [the body of senior *ulema*] functions. (Saudi Arabian Constitution, 1992)

The present *ulema* are the most conservative scholars in Saudi Arabia, a country in which conservative views are not uncommon. Studies routinely attribute Saudis with more conservative attitudes than people in other Gulf states (Zuhur, 2005). However, in recent years (especially after 11 September 2001 attack on the USA) the role and influence of fundamentalists and conservative groups have diminished considerably. A growing number of religious individuals with more liberal and pragmatic views on women's issues are emerging:

> We should be realistic. The world around us is changing and we cannot live in isolation. Our interest is to increase the number of Saudi nurses in our hospitals to take care of our people. No way can we continue relying on others to do the job for us. Nowadays, we cannot separate sexes especially in the health service. However, it is absolutely crucial to adhere to Islamic rules but not in a very rigid way. (Abdul-Aziz)

This liberal view on some social issues is gathering momentum in Saudi society but many liberal voices fear reprisal and stigmatization for standing against conservative groups. Nevertheless, the Saudi media are full of articles in which liberals attack conservative attitudes and challenge some of their Fatwa. This was unthinkable a few years ago. The following extract from an article by a Saudi journalist is one example:

> ...our education system does not stress tolerance of other faiths – let alone tolerance of followers of other Islamic schools of thought. It is one thing that needs to be re-evaluated from top to bottom. And the fact that from fourth grade we do not teach our

> children that there are other civilizations in the world and that we are part of the global community and only stress the Islamic empires over and over is also worth re-evaluating. (Arab News, 2004)

The majority of Saudis are disillusioned and shocked by what is happening on their streets. As one Saudi journalist said: "Terrorist incidents in Saudi Arabia are more or less becoming everyday news. Every time I hope and pray that it ends, it only seems to get worse" (Daily Arab News, 2004). However, segments of the population sympathize with the cause and doctrine of these extremist groups, for both religious and political reasons.

In Bahrain and Oman, religious scholars and institutions have less influence on policies. In Bahrain, the majority of the populations are Shiites while the rulers and the political elite are Sunni. There have been sectarian tensions and clashes with the Shiite population who feel that their grievances have not been addressed by the Sunni government. The majority of Shiite scholars tend to have more liberal views on women's issues than their Sunni counterparts. Their interests and expectations of the indigenization policy are similar to those of other stakeholders as their interpretation of the Quran is less rigid, with recognition and understanding of the role of women in public life. The researcher asked a Bahraini colleague to arrange an interview with a Shiite religious clerk to talk about the role of women and women's issues. He was reluctant because the researcher belongs to a rival sect (Sunni) and would be seen as a journalist who might twist what he said. It took five days to arrange such an interview and a copy of the audiotape was required. One Shiite Islamic scholar from Bahrain commented:

> As far as we are concerned, we fully support what the government is doing by indigenizing our nursing workforce. When it comes to education and work we do not differentiate between sexes. After all, this [indigenization] is a policy issue, we leave it to policy-makers who know and understand the issue better than us. Frankly speaking, my preference is to see Bahraini nurses working in our hospital rather than foreign nurses. Islam recognizes the contribution of working women regardless of their professions. (Hasan)

Sunni and Shiite doctrines have religious and cultural differences and doctrines despite their common Arab ethnicity. Hence, the minority Sunni scholars in Bahrain share views on social issues similar to their counterparts in Saudi Arabia, especially those related to women's issues.

Oman's constitution states that Islam is the country's religion and the main source of its law, but this Islamic state is more open and liberal. Women participate in public life, have more freedom and are subjected to fewer restrictions than women in Saudi Arabia. But religious and conservative groups still campaign against what they call the corruption of Muslim women. An Omani religious cleric explained:

> We [religious clerics] understand that times have changed and there is a need to accommodate various new ideas to develop our country. However, this does not mean that we forget about our customs and principles. Men and women must adhere to Islam's rules. (Jaber)

When asked where he stood on women's freedom and the right to work, he replied:

> Oh, I see. Now I understand. Recently there has been extensive and heated debate about the role of women in Oman. Let me tell, we do not oppose women working if they adhere to and follow Islam. We are not like other countries who are very strict and treat women unfairly like your country [Saudi Arabia] treats women. No. Here we respect women and tolerate them but we think sometimes some women go too far and this is not good for any of us. (Jaber)

When he was asked to elaborate, he continued:

> I think you know what I mean. However, what I meant was that some brain-washed Omani and others want us to open to everything coming from outside and tolerate certain non-Islamic customs such as relationships between men and women. There are those who are pushing for more freedom for women to do whatever they like. When it comes to religion, there are red lines that cannot be crossed by anybody. (Jaber)

Nevertheless, women in Oman have achieved many positive results and gained the respect of large segments of society. International organizations have also recognized the positive developments in women's conditions. A senior member of an international organization commented:

> I am so happy about the progress and development of women in Oman, not only in the health service but in all fields. They participate in all aspects of life. They are members of parliament and one has been appointed recently as a minister. So in comparison to some other Gulf states, they are among the top in terms of development and achievement. (Sharf)

A Shiite religious cleric who was asked about his view of the role of women, explained:

> The principles of Islam are the same. However, the interpretation is different. We [Shiite] respect women and feel that women have the same rights as men, but each has a different role to fill in life. However, women must behave as Islam orders them to behave. To wear modest clothes, wear the veil, but not the veil you have in your country [referring to Saudi Arabia where women are required to cover their faces], and follow the rules of Islam. (Hasan)

When asked about Shiite men's opinion of working women, he said:

> As I explained to you, women have so many rights in Islam. They can buy and sell, work and go to school and so on. We do not object to women working outside home. God created men and women to help each other, but each has his/her role to play. In this regard we are no different than Sunnis, but what you see in Saudi Arabia, I mean the restrictions and discriminations, this has nothing to do with Islam. Most are traditions and culture. So we need to separate culture from religion. (Hasan)

Most religious scholars in Saudi Arabia would certainly disagree with such an interpretation and comment. They argue strongly that Saudi Arabia follows the true version of Islam and is the custodian of Islamic teaching and principles. These fundamental differences between the two religious actors in the three states cannot simply be attributed to differences in terminology and concepts. These two views represent a battlefield on which two influential forces fight to influence and dominate Gulf society in all aspects of life.

Saudi Arabia is concerned with social issues and holds more conservative attitudes on most of these. In such countries, the stakeholders who belong to conservative religious groups will have more power and legitimacy and their claims will be viewed with greater urgency. However, there are constant debates and calls for modernization

and different interpretations of Islamic rules to meet people's aspirations and needs. Saudi Arabian society is gradually easing many barriers and restrictions due to the proliferation of satellite media, the influence of the West and information technology.

Within these contextual influences, conservatives have found the Anglo-American invasion and occupation of Iraq a great opportunity to legitimize their views and power and assume a more active role within Saudi society. Internally, the Saudi government faces a crisis of legitimacy from fundamentalists with whom it shares power. This is a dilemma for both modern Muslims and liberal forces in the country. The USA is a strong ally of the Saudi government and preaches freedom and liberalism but the Saudi government cannot break the powerful ties with fundamentalists for fear of catastrophic internal consequences.

Nursing is the most feminized of professions and has long been regarded as one of the most extreme examples of gender's influence on career choice (Ball, 2004). The dominant culture in Saudi Arabia has defined maleness and femaleness as points of opposition and difference with the male in a position of power and domination. While similar attitudes still exist in both Bahrain and Oman, their women's movements are more advanced and women have gained more rights and privileges than their Saudi counterparts. One female Bahraini nursing manger described her experience:

> Here in Bahrain the majority of people treat women with respect and dignity not like the way they are treated in your country [Saudi Arabia]. Women can move freely without any major restrictions. Yes, we have some conservative and less tolerant religious groups who do not accept such liberal views, but they are a minority who are entitled to their opinion but cannot impose it on others. [Laughing] I think that most of them are still influenced by your country, sorry to say that, but this is the truth. (Bedoor)

When asked if women could work alongside men without discrimination or harassment, she replied:

> You have seen it yourself. Women can work anywhere they wish. Certainly, there is some discrimination. Tell me anywhere in the world where women are not subject to one form or another of discrimination. Do not forget that Bahrain is an Arab and Muslim country. We have our culture and traditions but we have achieved so much. I cannot say we are perfect. I must also stress the fact that women have choices. This is

> much better than any other country in the Arab world with some few exceptions and I am proud of that. (Bedoor)

Bahrain's rapid modernization is said to have eroded the patriarchal aspects of society and women have made significant progress (Seikaly, 1994). The changing gender relations in Bahrain are reflected in the different environments in two nursing colleges in Saudi Arabia and Bahrain. In Bahrain, this is an open college like any other college found in the West or in other more tolerant Arab countries. Male and female nurses study side by side and share the same facilities; females can come and go as they wish, without mentors or restrictions. A Bahraini female nursing student explained how she was treated in her Bahraini school:

> We are all treated the same [males and females]. We share classes, labs and other facilities. We respect each other but we keep distant from each other. You know we are still a Muslim society. However, here you have choices. It is up to the individual to do what he/she wishes to do. My family trusts me and is proud of me. (Sana)

When asked how her family feels about her studying in a mixed environment, she replied:

> To be frank with you, they would prefer [her family] if it was a female only college. But they have accepted what is on offer and adapt to the situation. As I told you, they trust me. For me, I prefer it mixed because I want to know the other sex's point of view and learn from each other. (Sana)

In contrast, the Saudi nursing school is a restricted zone for males and very difficult to access. Female students are isolated and their movements restricted. One Saudi nursing student described her life in nursing school accommodation:

> Oh my God. You cannot imagine the kind of problems we are facing every day in our accommodation. We are like prisoners. We cannot leave our accommodation for any reason. Even in an emergency situation we must have a female minder with us all the time and we are not permitted to leave without written permission from our accommodation supervisor. (Torfah)

Another said:

> Even if I wanted to visit my relatives in the city, I had to go through so many bureaucratic regulations. One of them was that in order to get out of the compound

> one of my close relatives or guardian must come down here and sign a form that he will be responsible for my welfare and return me back after the visit. It is too much hassle and humiliation. We were treated like children, even worse. What is annoying is when you object to such treatment you will be accused of not following Islam's rules. (Mohaira)

A third student said:

> Because I am from another city, I cannot go anywhere because I do not have anybody who can come and collect me. I am married and have a child, but I was treated like a number not as a human being. I stay in my room cut off from the outside world until my husband or father come in some weekends to take me to the airport to travel and see my family. This is the regulations, what we can do? We need the education so we have to obey the rules. (Reem)

When asked why she did not travel to her family by herself, Reem replied: "Why are you asking me this question like you are from a different country? You are Saudi and you should know the rules." She was referring to both the school regulations, which prohibit students from leaving without a male relative, and the travel rules in the Kingdom that prohibit women from travelling alone. A close male relative or a guardian must accompany them.

In Oman, women have achieved remarkable progress in a short time. Since the 1970s, Oman has witnessed impressive transformations in health, education and equality. The government has initiated various programmes to educate and raise the status of women in society. A senior nurse elucidated:

> The position of women in Oman is progressing and there has been much progress, but still we have long way to go. Discrimination and disrespect for women is still widely common, especially in rural areas, as some people look at women as a social burden. That's why Omani families prefer to have boys than girls. (Hind)

Another Omani nurse described society's treatment of women and nurses:

> We [women] are scrutinized all the time by the society. On the top of that, we are nurses. This makes it more difficult for us. Whenever we do anything people will say is it Islamic or not, you can do this and you cannot do that. The problem in our culture is that as a woman you are not expected to ask questions just follow the rules.

> Most of these restrictions and rules stem from traditions not Islam but they tell us this is Islam. What can you do in a male dominated society? (Zaina)

Another Omani nurse said:

> When I started working in the hospital, some people in the community and some patients accused me of being immoral and corrupt because I work with men. I and some of my female colleagues have been subjected to many abuses especially from those conservative religious individuals who consider themselves as the custodians of Islam. (Asma)

Women in the Gulf are inevitably imbued with a notion of isolation and a suspicion of the public sphere. Modernization depends less on advances in technology and scientific knowledge and more on a sense of freeing women and providing them with similar powers and opportunities to their male counterparts. Gender is sometimes overlooked but in the Gulf states it is an important factor in explaining the relative underinvestment in the nursing profession and may be one of the major factors in the shortage of indigenous nurses in the Gulf.

Policy-makers' own values and ideologies affect policy-making and implementation (Walt & Gilson, 1994). Radebaugh (1975) recognizes cultural and societal attitudes as factors that influence a country's development of policy objectives, standards and practices. Religion could be considered as an ideology. Therefore, because the majority of the indigenization policy-makers in the three Gulf states adopt and follow Islam, actors can make the difference between effective and ineffective policy choices and implementation (Walt & Gilson, 1994).

Religion is intermingled with tribal traditions and customs in the Gulf states. The traditional disadvantage of women is part of an Arab tradition that limits their roles to mother and wife. Thus, women are visible in society but unable to influence decisions related to their affairs. Analysts of Gulf society blame the indigenous conservative forces such as Wahhabism, tribalism and patriarchal ideology for the slow pace of change in women's status (Meriwether & Tucker, 1999). Social attitudes to working women are conservative, especially for employment in mixed environment sectors such as the health service.

In Saudi Arabia, women are subject to discrimination and restrictions on their mobility in the name of Islam. Rigid interpretation of Islamic rules and doctrine has been used to restrict women's mobility and degrade their position. It is interesting that the religious clerics interviewed in the three Gulf states expressed similar views on most women's issues. For example, all talked about tolerance towards women and the many rights granted to them by Islam. However, they also talked about the importance of women adhering to Islamic rules and behaving accordingly. The Saudi and Omani clerics stress that internal and external forces are trying to corrupt Muslim women – what some Arab and Muslim scholars refer to as a conspiracy theory. One Saudi nurse said:

> Relationships with the opposite sex are very sensitive here; women have to be careful of existing gender codes. For example, just shaking hands with a man is forbidden according to Islam and many times I find myself in a situation where I have to shake a man's hand. Just a simple gesture could send the wrong message about you. (Buraida)

In Bahrain and Oman, religious institutions and cultural attitudes are more accepting of women who aspire to freedom. These countries have a more tolerant environment and thus Bahraini and Omani women have more obvious advantages than their counterparts in Saudi Arabia. This does not mean that religion plays a marginal role, it simply reflects the lessening of religious authority in Bahrain and Oman in recent years and more enlightened attitudes towards women among the clerics. It is true that the majority of the populations in both states follow sects of Islam that differ from those in Saudi Arabia. It has been suggested that gender roles and accompanying attitudes toward the division of labour between spouses might differ across religious groups depending on the groups' strictness (Heineck, 2004). However, gender inequalities are likely to decline as these Gulf states develop, the demand for qualified indigenous nurses increases and discriminatory practices become costly for the states and entrepreneurs (Morrisson & Jutting, 2005).

To a large extent, decisions pertaining to education, employment and marriage are made at family level. In the Gulf states, a father holds sole parental authority and his approval is necessary for a daughter to be accepted into an educational institution. Therefore, family traditions may prevent women from working in certain

environments or certain occupations, regardless of job opportunities and economic need. All nursing students who were interviewed indicated the importance of family in their choice of career. A Saudi nursing student said: "It will be very difficult for me to enter this [nursing] college if I did not have the support of my family" (Torfah). An Omani nursing student said: "It took me a long time to convince my family to be trained as a nurse. If my family and especially my father refused I would not be here now talking to you" (Amal).

Women's participation in the labour market has greatly increased in recent years. Three main factors explain this trend. Firstly, economic development and the ensuing shift of population from rural and agricultural sectors means that more women want to work. Secondly, women are more highly educated and want to capitalize on their educational status. Recent data show that more female graduates will be entering the workforce in Saudi Arabia and by 2015 there will be five women candidates for every civil bureau position vacated as a result of another woman's retirement or death (Al-Watan, 2006). Thirdly, the falling real incomes of households and rising poverty in certain countries seem to have persuaded women to participate in the labour force in greater numbers. Yet discrimination persists, health service employers in the Gulf countries perceive that women have high turnover and absenteeism rates as a result of family responsibilities. Some health service decision-makers are hesitant to promote women or provide training opportunities.

It is not hard to understand why the Gulf health-care system is reliant upon foreign-trained health workers. The three Gulf state governments regulate immigration policies but the proportion of foreign nurses in these states remains high. Oyowe (1996) claims that highly qualified professionals choose to leave their country of origin for political or economic reasons. This study argues that the most important factor that motivates qualified professionals to choose the Gulf is economic. The region is not politically stable and offers less peace and security than some other parts of the world. Other motivating forces could include improved learning opportunities and a higher standard of living.

Strong push factors drive nurses from developing countries to migrate to the Gulf, these include relatively low pay and poor employment conditions in source countries

(World Health Organization, 2003). All respondents felt that pull factors are influencing foreign nurses to leave their countries and most respondents felt that the large numbers of foreign nurses would be reduced only by dealing with one of the strongest of these – financial incentives.

Respondents described how foreign nurses are actively recruited in the source countries. One Saudi recruitment manager explained:

> We basically recruit nurses from all over the world. Whenever there is an experienced nurse, especially in critical areas and willing to come, we take her. Our recruitment agency is very active internationally and has offices and agents in many countries. (Mohammed)

Most of the health service managers in the three states emphasized that the international recruitment of nurses is positive and makes an important contribution to the development of the Gulf health services in general and nursing in particular. However, Smith and Mackintosh (2007) argue that migration of nurses in part acted to reinforce disadvantage based on gender, class, race and ethnicity. They identify the influence of changes in nursing structure and commercialization of care in these processes and demonstrate that employment conditions of foreign nurses have reinforced patterns of disadvantage. The majority of foreign nurses see their employment in the Gulf as a stepping stone to employment in other nations. Consequently, many are willing to endure difficult, often abusive, working conditions in order to accumulate the necessary capital and experience to facilitate this future employment (Ball, 2004). One Saudi recruitment manger commented:

> We have to be fair with foreign nurses. For years, they have been the backbone of our health service. We would not be able to provide health care for our people without their contribution. They also have played a major role in training our Saudi nurses. (Mohammed)

Kingma (2001) suggests that international recruitment campaigns often delay effective local measures to improve recruitment, retention and long-term human resource planning. Like other labour markets, the nursing labour markets respond to opportunities for employers to exploit patterns of employee vulnerability (Smith & Mackintosh, 2007). Some respondents raised the impact of international recruitment

on the development of indigenous nursing workforce in the Gulf as a crucial issue. A Saudi nurse commented:

> When you can have an easy way by recruiting an experienced and easy to manage foreign nurse why should you take the hard way by training and recruiting a Saudi nurse? It is also easy for them [managers in hospitals] to avoid clashes with the religious authorities who, some of them, oppose Saudi females to become nurses. (Hayat)

Numerous respondents stressed the dangers of continuing to rely on foreign nurses. One Omani, head of a nursing department, noted:

> For how long are we going to depend on foreign nurses? They are here as long as we can pay them. Sooner or later we will face a crisis when we either cannot afford paying them or when there are not enough of them around. (Layla)

The majority of respondents believe it is obvious that foreign nurses look after their own interests and may consider indigenization as a threat to their job security. Furthermore, they have been blamed for failing to support indigenous nurses or their training. One foreign senior nurse who is in charge of the Saudization department in a major health service provider commented:

> Foreign nurses have done a tremendous job in this country. However, I can understand some of the criticisms directed at foreign nurses by Saudi nurses. Yes, there are foreign nurses who hesitate and have no interest in training Saudi nurses because they fear that they will replace them. It depends on the system you have in place. It is in the job description that they have to train Saudis, however, if it is enforced or not, this is a management problem not the fault of the foreign nurse. (Liz)

However, some respondents believe that foreign nurses have been used as a scapegoat for government failure and a lack of proper planning in the labour market and human resource policies.

The majority of respondents believe that the current recruitment and retention efforts for indigenous nurses are inadequate for the needs of these three states. Many are dissatisfied with limited work and educational opportunities and the continued isolation from bedside and clinical activities. In addition, most feel that there are too

few opportunities to upgrade to nursing positions for which they are qualified and that foreign nurses reduce the number of senior positions available to indigenous nurses.

International migration can have positive effects on local training, knowledge and professional development but these must be weighed against some of the potential negative consequences for the indigenous nursing workforce. Smith and Mackintosh argue that in most countries, including the Gulf states, foreign nurses play a key role in the delivery of frontline care to patients. However, they conclude that professional foreign nurses have repeatedly acted both as a highly valued labour force on which patients and the service have relied and as involuntary contributors to the remaking of disadvantage – their own and that of others (Smith & Mackintosh, 2007).

Nevertheless, in the case of the Gulf states this requires a delicate balance between recognizing the benefits that foreign nurses bring to health-care delivery and a collective concern for the indigenous nursing workforce. The success of interventions to support the positive impact of international recruitment, while minimizing its negative consequences, depends on the level of socio-economic and technological development in each of the Gulf states and long-term strategy commitments from professional and political leaders (Kingma, 2001).

4.8.2 Organizational factors

Modern nursing has been a systematically disadvantaged and divided profession since its origin (Smith & Mackintosh, 2007). Management styles, incentives, salaries, working conditions and career structures are some of the organizational factors that can influence the recruitment and retention of indigenous nurses. However, remuneration and incentives seem to constitute the most basic influence on their retention in all three Gulf states. Nurses in both Oman and Bahrain have expressed dissatisfaction with low remuneration, inflexible working hours, shifts, heavy workloads, poor career development, poor working environments and workplace deficiencies such as the lack of childcare and family facilities. One Omani nurse explained:

> There is a shortage of facilities such as babysitting, children's playgrounds and family facilities. We used to have two months maternity leave but recently this has been reduced to only forty-five days. These things are important incentives for improving

> nursing's image with the public. There is also a need to increase a nurse's salary and benefits to encourage more people to join nursing especially in critical areas. (Zaina)

There are similar problems in Bahrain:

> We have a problem with night shifts and weekends especially for married female nurses. For example, our primary care is staffed with Bahraini nurses because it is only a day shift [7am to 3pm].That's why we have a higher demand for primary care from local [indigenous] nurses. (Fatena)

The high demand for work in primary care reflects the internal and external difficulties and constraints faced by indigenous nurses. Family commitments and the lack of proper facilities (such as childcare) put huge pressures on nurses who are trying to fulfil their responsibilities. Job satisfaction diminishes considerably when there is conflict between work and family commitments. Some studies have found that work-family conflict is negatively correlated with job satisfaction for both men and women (Allen et al., 2000). A Bahraini head of nursing pointed out: "In most of our health service institutions there is a shortage of facilities, such as childcare, breast-feeding and rest rooms" (Bedoor).

Some nurses have expressed their frustration with such working conditions and warned of the negative consequences. A Saudi nurse explained: "Frankly speaking, if the internal and external pressures, work conditions and destructive environment continue as they are, then many Saudi nurses would leave and some will change career" (Hayat). A lack of appropriate facilities can deter indigenous nurses from accepting positions in some health organizations. This was a primary problem raised by some nurses in Saudi Ministry of Health hospitals. Hussah explained: "I have been trying to transfer from this hospital for the last two years because they do not have childcare and breastfeeding facilities. It is very difficult for mothers with new-born babies and young children (Hussah).

Many indigenous nurses in the three Gulf states recognize that promotion and career development are influenced by personal connections and accompanied by a lack of transparency. The right connections can open numerous promotion and career

opportunities for an individual in Gulf society but this unfairness provokes anger and dissatisfaction. One Saudi nurse talked about her frustration:

> I have been trying to get a scholarship to go abroad for my Master's for more than a year but without luck. Some of my colleagues have their scholarships. Some finished and came back, and I am here suffering all this because of connections (*wasta*). It makes me angry but there is little I can do about it. (Buraida)

Wasta is a way of life and a force in most decisions in the Gulf. It serves as an affirmative action for the advantaged but excludes the less privileged and hinders conscientious officials trying to treat people equally. However, family obligations oblige people to help their own (Cunningham & Sarayrah, 1993).

Job satisfaction among indigenous nurses is determined largely by their interactions with other health-care workers, especially physicians. Most indigenous nurses in the three Gulf states reported ineffective and sometimes stressful relationships with physicians. Indeed, attitudes are influenced by the stereotyped roles of male authority and dominance in Gulf society. Bates (1970) noted that male physicians in most health settings limit the development of the nurse's role. Moreover, nurse training upholds the tradition that a nurse must always obey the physician. Interestingly, relationships between indigenous nurses and Arab physicians in the Gulf often do not follow tradition. The majority of respondents reported difficult relationships. One Saudi nurse commented:

> Oh, physicians. What can I say? It is a strange relationship especially with Saudi and Arab doctors. They do not support us or encourage us. They treat us like other women in the society. No respect for what we do. Western doctors are different. The majority treat us in decent way. Maybe because they understand our circumstances as women first and nurses second. It is really sad when you get negative treatment from your own people. (Hussah)

Some indigenous nurses felt that the more powerful medical profession had denied nurses the opportunity to advance. This was reinforced by organizational inequalities which inevitably affect nurses in general and indigenous nurses in particular. A Saudi nurse commented:

> We are treated here as servants by physicians. No respect for what we do and the problem is such an attitude is tolerated by the management. Doctors here can do whatever they like, especially Saudis. (Buraida)

A Bahraini head of nursing reinforced this opinion:

> I always receive complaints from our nurses about the way they are treated by doctors. Some doctors treat nurses very badly and in an inhumane way, degrading their service. It is a shame. I have suggested to the medical school in Bahrain to teach and inform doctors about nursing work. It should be part of their curriculum. (Bedoor)

Clearly, nurses need to be assertive and self-confident in order to protect their interests and gain respect. Writing in the UK, Davies (1995) called for nurses to regroup and take a stand on the feminine values of caring while rejecting the masculine doctrines of the medical profession. However, this might not be applicable for indigenous nurses in the Gulf environment where the male is in a position of power and domination supported by religious discourse. Nursing training in the Gulf is still governed by the traditional relationship between medical staff and nurses in which nurses are trained in the values of routine submission and deference to doctors.

4.8.3 Situational factors

This research shows that the nursing shortage is part of an overall shortage of qualified indigenous workers in the Gulf. However, nursing shortages occur in most countries, especially those that lack human resource planning. In addition, this research argues that female nursing shortages are exacerbated in countries with restrictive environments for female workforces. Shortages of indigenous women in the workforce would therefore appear more likely in countries that have limited freedoms for women, restrictions on gender relations and a lack of proper human resource planning. A Saudi female nursing manager commented on her role as a nursing manager:

> I obey and follow Islam's rules and instructions. As you see I wear the veil and cover my face and this has not prevented me from carrying out my responsibilities. I believe that our culture, not religion, is the main problem for women. As you know Saudi's culture is biased against women and always takes men's side. Look at me here, isolated just because I am a woman. Otherwise I should be down there [in the

> organization's headquarters]. When you ask them why I cannot be there, they say it is against Islam to work with men. (Aisha)

The researcher expected to interview this senior female manager at her organization's headquarters. However, her office is five miles from the main building – because she is a woman. It is even more puzzling that she shares her office with a male (her deputy). When asked why a man was sharing her office when she was not permitted to work at headquarters because she should not mix with the opposite sex, this female manager replied: "I know. It is a strange situation as you can see. However I cannot comment on this. You should ask this question to my manager in the main office. Maybe he has an answer for you" (Aisha).

Government regulations stipulate that a male and a female should not work in the same place – the main reason why this female manager was working five miles away from the main building. Managers and decision-makers try to find ways around certain rigid policies that are imposed (usually by an outside organization, in this case the religious authority) on organizations in Saudi Arabia.

Gulf governments frequently express and defend the sovereignty of their countries but in reality they, and some of their people, accept the proposition that they are subject to the overriding authority of other countries. A number of stakeholders across the three Gulf states believe that a psychology of dependence on foreign skills reflects a genuine and, in some cases, complete abandonment of belief in the capability and skills of indigenous people. This belief that indigenous people cannot survive and are incapable of sustaining development without the help of foreign workers is another significant barrier to achieving indigenization.

Gulf states dependence on foreign workers' expertise has existed for a long period but has become particularly extensive over the last three decades. For example, every new project (such as building a hospital) seems to require the importation of foreign workers to design, build and staff it, whether public or private sector. A Saudi Ministry of Health official explained:

> We still have the turn-key mentality. We like everything to be done for us. It is a culture that has haunted us for a long time. It is also the mentality that importing

> things is better and easier than trying to make them at home. It is the same mentality that applies to human resources. We trust foreigners more than our own people and we prefer to employ them at the expense of our people. This is the reality. (Zaher)

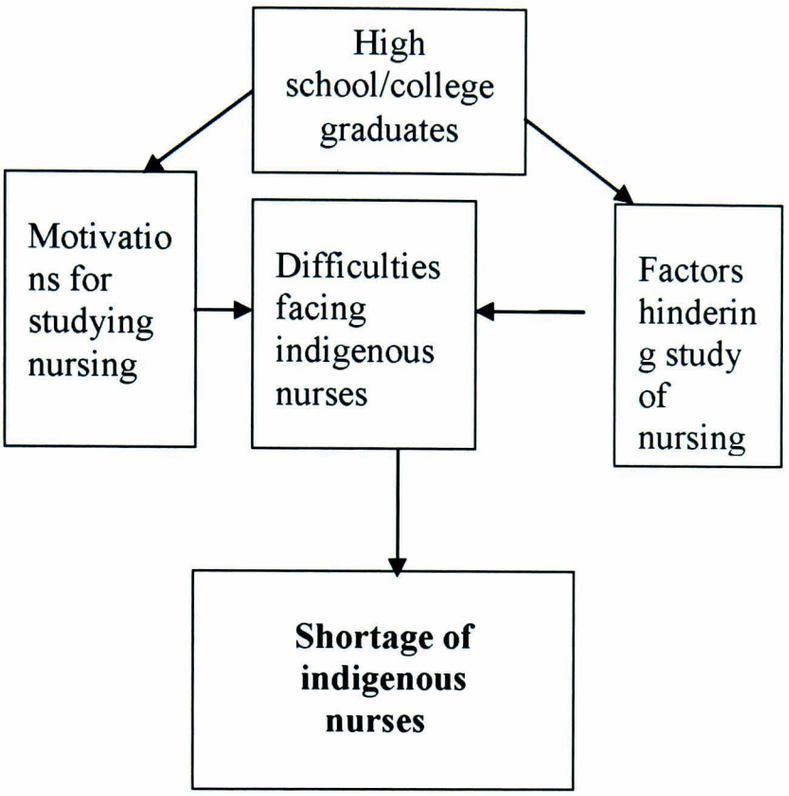
One Saudi nurse commented:

> I have been working in this hospital for the last six years. However, everybody still considers me as a trainee although I have trained many Saudis and foreign nurses. It is frustrating your own people do not trust you no matter what you do. What makes it hurt, is that all management, foreign nurses and patients alike treat you the same. Nobody trusts us or is willing to give us a chance. It is demoralizing. (Buraida)

On the individual level, those who require help in the house tend to import domestic helpers from abroad. This suggests that the policy of international recruitment is primarily a tool for promoting the weakness and dependency of indigenous people and ensuring their dependence on foreign workers and expertise. Walton and Abo El Nasr (1988) contend that indigenization is a transition from an importing stage to one of authentication, by which a domestic discourse of social work is built in the light of the social, cultural, political and economic characteristics of a particular country. It is almost 20 years since this dependency on foreign workers began but it continues to grow and pose more difficulties for indigenization.

Other difficulties, motivations and factors also hinder the promotion of the nursing profession in the Gulf. These are shown in Fig. 6 below. However, it should be noted that most of these difficulties are more relevant and specific to Saudi Arabia, especially those that relate to the image of nursing, respect for nurses, family influence and, more importantly, the freedom of women.

Fig. 6 **Causes and consequences of indigenous nursing shortage**



Motivations for studying nursing	Difficulties facing indigenous nurses	Factors hindering study of nursing
Guaranteed employment Attractive student allowances and benefits Good prospect of being accepted to continue higher education	Lack of: respect job satisfaction adequate training career development policy confidence Weak communication tools: English language Lack of essential facilities: day care, rest and breastfeeding rooms etc Unfair competition from foreign nurses Family pressure and commitments Night and weekend shifts Lack of freedom of movement: transportation	Negative image Low quality of nursing education Lack of: nursing instructors career development adequate support from decision-makers Weakness of English language Lack of: family support information about nursing prospects effective media campaign role models respect and encouragement

4.9 Chapter summary

This chapter has examined and analysed the origin and formulation of the indigenization policies and variations within and between various stakeholders in the three Gulf states, as well as the rhetoric and reality surrounding the content, context and implementation of indigenization policies. It has also analysed the factors that influence how the three states use indigenization policies to develop their national (particularly health) workforces and reduce their reliance on foreign workers. Although the three Gulf states share and use the same concept they have different perspectives and have adopted different implementation strategies. Most respondents agreed that indigenization remains an ambiguous concept in most of the Gulf states. The aim of indigenization policy in all these states is to reduce dependency on foreign workers but foreign worker numbers have increased in some of these countries. The three Gulf states differ in their vision and strategies regarding human resources. For example, Bahrain has sought international professional assistance to develop its labour force market.

The chapter examined and analysed the implementation of the indigenization policy in the public and private sectors; the bureaucratic response; and resources, incentives and penalties for implementation. Indigenization in the health service and the global competition has been analysed in detail for health-care workers in general and nursing in particular. Especially when countries can offer compatible or even better terms and conditions than the Gulf states, such competition makes it very difficult for the Gulf states to recruit foreign health-care personnel. Therefore, nursing shortages in these states are projected to worsen rapidly over the coming years. All three Gulf states strive to deal with this complex situation by designing and implementing various strategies to increase their indigenous nursing populations but various issues and factors hamper their success. Nursing education is key for achieving good outcomes from the indigenization strategies. However, vague nursing education strategies in some of these countries and the shortage of nursing faculties were identified as major problems that hinder the recruitment of more indigenous nurses. There is a lack of

research and studies that can provide the theoretical framework and empirical analysis required to shape education strategies and their outcomes.

The strategies for recruiting and retaining indigenous nurses and the factors that inhibit them were also highlighted and analysed. In addition, this chapter identified and analysed various factors (including contextual, organizational and situational) that are impeding or hampering the indigenization policy for nursing in the three Gulf states. By analysing in more detail religion's impact on nursing it has been shown that this is an important determinant of the development and implementation of social policies in the contexts of the three Gulf states. Although the religious establishment in each of these countries is only one interest group among many, religious groups have the most powerful and striking influence on the development of social policy. Despite important variations in religion's influence and impact on nursing in the three countries, it remains a very powerful factor in the development and implementation of certain social policies which include nursing. Finally, the chapter highlighted and analysed the main motivations and difficulties that promote or hinder nursing careers for indigenous women in the three countries, supported by a framework (Fig. 5) which examines and analyses these factors.

Chapter 5

Image of nursing in the Gulf: "What is an indigenous woman like you doing working as a nurse?"

5.1 Introduction

One key challenge facing the GCC states is how to create an informed, long-term strategy to ensure that there is an adequate supply of qualified, skilled and knowledgeable indigenous nurses to meet the growing health-care needs of their people. Several of the GCC states are facing severe shortages of health-care personnel, especially in nursing. Most Gulf states continue to recruit foreign health workers to fill critical gaps and as an interim strategy until sufficient numbers of indigenous people can be recruited over the long term.

Currently, there is international consensus that more nurses are needed in community and acute care settings. The shortage of indigenous nurses in the Gulf states is critical because few indigenous people take up nursing. Also, overseas recruitment is challenging as many international nurses may prefer to migrate to Europe, the USA and Canada (International Nursing Labour Market, 2004). However, it is difficult to identify the precise nature of supply problems. A lack of accurate, consistent, current and sensitive information in most Gulf states makes it impossible to describe or analyse the nature of the nursing shortage or make accurate projections for the future.

The poor image of nursing continues to be a major problem in most of these states. In countries such as Saudi Arabia the profession has low status and an unfavourable image as nursing involves domestic work and low levels of nursing education (Kearsey, 2002). Some countries have improved the professional status of nursing. For example, Bahrain has legally defined a baccalaureate degree as the minimum prerequisite for entry to practice and other Gulf states are considering similar options.

The purpose of this chapter is to present the findings on the image of nursing in the three Gulf states. It documents the trends of indigenous nurses and highlights the determinants of indigenous labour force participation. Attention is drawn to

systematic and cultural bias in understanding indigenous nurses' real contribution to the development of the health service and nursing profession in the three Gulf states. Various factors (e.g. religious prevalent social norms and discriminating practices) which limit the scope of indigenous nurses and underlie the gap between potential and actual performance are highlighted.

The chapter includes findings on the socio-economic development and religious and cultural values in the three Gulf states. The main theme drawn from these research findings is that Gulf women in general, and indigenous nurses in particular, are underutilized human resources who are capable of contributing towards the process of national growth and the development of the nursing profession. The gaps between the options available to men and women are unjustifiably large in most Gulf states. As a result, women have a limited range of choices and face many impediments to their full human development. This has profound implications for the social and economic development of the Gulf states. There is increasing consensus that gender is a key variable in the development equation and must be taken into account at all levels of programme formulation and policy-making (Moghadam, 1993).

Some authors attribute the low number of applicants to Gulf nursing schools to the negative image of nursing as a career (International Council of Nurses, 2001; Irwin, 2001). It is crucial to identify and understand the main causes for such a phenomenon. As stated in the literature review chapter, the shortage of indigenous nurses in the Gulf poses a threat to the future of the health service. An ideal workforce largely reflects the client groups served. The nursing shortage ratio ranges from 37% in Bahrain to 91.75% in Qatar (Shukri, 2005). Approximately 78% of nurses working in Saudi Arabia's health service are foreign (Abou-Zinadah, 2006).

The Gulf nursing profession is trying to improve capacity and encourage the indigenous population to participate but the situation is strongly influenced by social, cultural, religious, managerial and economic factors. However, one of the most important issues highlighted in this study has been how the image of nursing impacts on recruitment and retention. This chapter presents the findings of the perceptions of nursing as a profession among various Saudi Arabian, Bahraini and Omani stakeholders. It also aims to determine the extent of stakeholders' knowledge and

understanding of nursing in general and as a career and the nature of the factors that shape their thinking. A number of questions will be addressed – What image of nursing is held by key stakeholders within Gulf societies? How does the image of nursing vary between the three Gulf states? How do economic, social, religious, gender, media and role models constrict and constrain the image of nursing? Stakeholders spoke about these different factors that affect the image of nursing in their countries throughout their interviews. These are critical factors for both the positive and the negative image of nursing.

The Oxford dictionary defines image as a: "general impression of a person, firm or product as perceived by the public" (Pearsall, 1998). Several factors contribute to shaping an image and it is a long and arduous process to reshape an existing image (Kalisch & Kalisch, 1986). Generally, the available literature from the Gulf states suggests that the public holds a negative attitude towards the nursing profession (Meleis, 1980). However, the socio-cultural perspective of this image is crucial for understanding nursing in the region.

There is little doubt that nursing in the Gulf has undergone significant changes over the last decade but it is not easy to define if, and how, the public image of nursing has changed over this time. However, the findings of this study confirm that the image of nursing in most Gulf states continues to be a major concern for health policy-makers. Medicine, teaching and computing are the most preferred occupations among women in most Gulf states. In the 12 years between 1980 and 1991 only 63 nurses graduated from one Saudi Arabian nursing school attached to a large university. Only 24 nurses graduated from the nursing section of King Saud University (the largest university in the country) between 1975 and 1992 and not one nurse graduated from a nursing college in a university in the east of the country in the 5 years of its establishment (Hamdi & Al-Haider, 1996). It is very costly to sustain such programmes with very low intakes and few graduates. However, limited job opportunities have encouraged more women to consider nursing as a career.

Nurses in the Gulf face similar problems to their peers in other countries as well as specific difficulties and disadvantages. These include the economic and socio-cultural disadvantages related to their gender and social prejudices associated with their roles

providing health-care services to patients. Smith and Mackintosh (2007) argue that gender has always played a significant part in reproducing disadvantage among nurses who are generally poorly paid for their work, irrespective of specialty and position. The career has low status and an unfavourable image in countries such as Saudi Arabia, where nursing involves domestic work and low levels of education (Kearsey, 2002).

Inkson (2004) points out that sociologists emphasize the roles of social class, gender, and ethnic categories in defining the values and aspirations that children develop; the career modelling they experience; and the educational and financial opportunities they receive. Bedouin tribes constitute the majority of the Gulf populations. While major changes accompanied the growth of the oil industry in the 1950s and many nomadic Bedouin settled in villages and around cities, manual and domestic work is performed exclusively by social outcasts or immigrants. Nursing is considered to be such an occupation.

Although recruitment and the retention of nurses have been placed high on agendas in the Gulf states, the nursing profession has been subject to a plethora of influencing factors since health-care services were first established in this region over 50 years ago. In general, it has proved impossible to attract an adequate number of indigenous Gulf people, mainly because of low salaries, shift schedules and the social perception of nurses (Al-Ahmadi, 2002). Also, Gulf individuals are not accustomed to taking orders, especially from foreigners. This chapter explores the public image of indigenous nurses and presents the findings on the factors that have influenced the way in which the roles and responsibilities of the indigenous nurse are perceived.

5.2 Economic issues

The Gulf region is the largest exporter of oil in the world. Its countries have an oil-based economy and their governments exercise strong control over all raw materials. However, high rates of unemployment and limited job opportunities for indigenous populations, especially women, have continued to be major problems in most states. Ironically, all three Gulf states considered in this study have large numbers of foreign workers, primarily because of the shortage of qualified and skilled indigenous

personnel and the lack of interest in certain professions among indigenous populations.

Despite nursing's poor image, these limited employment opportunities have played an important factor in attracting indigenous people (particularly women) into the profession. A Saudi female head of a nursing unit pointed out that economic factors are among the most important pull factors: "Due to the fact that a graduate nurse will be guaranteed a job makes it very attractive to young people, especially females, who have limited job opportunities to join nursing schools" (Aisha).

In Saudi Arabia, economists have not reached consensus on the unemployment rate. Official figures estimate unemployment at around 7.4% among men and 21% among women (Ministry of Economy and Planning, 2005b). In Saudi Arabia such information is usually vague and at best unreliable and sceptics believe the true rates are much higher. A senior male official in the Ministry of Labour explained:

> ...but there are those who are not convinced of such figures produced by the government and predict that unemployment is higher than that, and some put it as high as 30%. I think unemployment is still high especially among women in the largest exporter of oil in the world. We are not trying to hide the fact that we have high unemployment among women and the rate of women's participation in the labour force is very low. (Waleed)

However, women in Saudi Arabia prefer certain careers and occupations which do not include nursing. The majority of those who consider nursing as a career have either not been accepted elsewhere (e.g. universities) or are attracted by the economic incentives offered by nursing education institutions. A female director of a nursing college explained:

> Unfortunately few choose nursing as a career. To be frank most or a large number of those who enrol in nursing are divided into three categories: those who could not be accepted somewhere else or couldn't find other opportunities; those who enrol for economic reasons to get a job; and those who are interested in the incentives that nursing colleges provide for their students. (Nawal)

The incentives include generous student allowances, free books, accommodation and transportation. One Saudi female nursing student agreed that these incentives and the prospect of finding a job after graduation are attracting more students, especially females, to nursing:

> I could not find any job in my home town [Riyadh] and my father refused for me to go and work outside Riyadh. I heard about this college and the prospect of being a nurse with a guaranteed job, I decided to apply to this college and have been fortunate to be accepted. (Torfah)

It should be noted that public nursing education programmes in the three Gulf states are usually attached to public hospitals. In addition, the graduates of these programmes are often employed as nurses in the public health service. Some stakeholders argue that it does not matter why indigenous high school graduates are attracted to nursing as long as there is an interest in this career. One female Saudi senior nursing college manager commented:

> It is acceptable at the present time that most people who wish to enrol in nursing schools have been refused places somewhere else, and some are attracted by economic incentives. I am confident that in the future more people will be interested in choosing nursing as a career. (Rufaida)

This comment indicates that most students had not considered nursing to be their first choice career and some had applied only because of the incentives provided. This supports the previous finding that most high school graduates do not consider nursing as one of their top choices. Similar stakeholders in Oman indicated that the rising demand for places in nursing schools among young people is also driven by economic incentives. As one non-Omani female senior Ministry of Health official explained: "Nursing is a guaranteed job in Oman and with the unemployment problem it is a safe haven for young people" (Hind).

Oman is facing similar unemployment problems that pose very difficult challenges for creating more jobs and developing new sources of income to augment and reduce dependency on oil revenues. Unemployment in Oman is relatively high – estimated at approximately 15% among males and 22% among females – and considered one of the highest unemployment rates in the Gulf (Central Intelligence Agency, 2006a).

Moreover, the government has limited capacity to employ new entrants to the labour force. However, nursing is one of the professions that attract young Omanis as it provides a promising opportunity to secure a job. An Omani male nursing school official pointed out that the economic factor is one of the most important reasons why young people join the nursing profession, although it might not be their first choice:

> I must stress the importance of the economic incentives which encourage more people to be interested in nursing. Securing a job after graduation is crucial for choosing a career and nursing has benefited from this trend. Recently we noticed high calibre students showing an interest in nursing. Certainly incentives play a major part in this trend. (Hamdan)

High school graduates comprise the majority of nursing school intakes in the three Gulf states and economic incentives are important elements in attracting this group, especially females, to nursing. One Omani female student emphasized the importance of such incentives: "If you are a nurse you have an international passport which allows you to work anywhere in the world. Many people know that nursing as a career will secure a person a job" (Arwa).

Similar comments were made by male and female nurses and nursing students across the three countries. Nevertheless, while it is true that nurses can secure jobs in many countries, cultural and religious restrictions (such as restricted freedom of movement for women) create obstacles that prevent them leaving their home countries or even moving and working within their own country. However, it is not clear how much this influences females who consider nursing as a career. Further research is required to understand what inspires indigenous nurses to consider this profession.

Bahrain has a very similar unemployment situation but lacks the economic capabilities of Saudi Arabia or Oman. Oil production is small and the economy depends more on sectors such as commerce, banking and tourism. Emphasizing the importance of economic factors for those choosing nursing as profession, especially women, one senior nursing manager commented: "The economic situation in the country is another factor that encourages people to consider nursing as a career. Nursing guarantees a job, especially for women" (Fahad).

This finding has been echoed by respondents across the different country contexts but Bahrain offers few economic incentives for nursing students. Allowances to nursing students have ceased in the last few years but this has not had a significant negative impact on the image of nursing in the country. Limited career opportunities and higher numbers of high school graduates have played a role in attracting more people to nursing. A senior female Ministry of Health official pointed out:

> In the past, students at the Bahrain Allied Medical College used to receive a student allowance but not any more. Some of the students, especially the poor ones, used to depend on this allowance to help them buy books and materials. Now it is free education without any allowance, I expect as a result of increasing demand for nursing school. This may change in the near future and students might have to pay for their education too. I also expect that interest in nursing will continue to grow with the increase in the numbers of high school graduates and limited job opportunities in the market, especially for women. (Lona)

Oman especially has a strong desire to advance the status of nursing and nurses' salaries have recently increased in both Bahrain and Oman. A female Bahraini nursing school director stated: "...recently, the government has raised the salaries for nurses to be comparable with other allied medical professions. This has helped the image of nursing and has encouraged more people to enrol in nursing schools" (Wardia).

In Bahrain, the long-awaited salary increase was received without much enthusiasm. Nursing salaries still lag behind those in Saudi Arabia and Oman and have had a negative impact on the retention of indigenous nurses in Bahrain, especially among male nurses working in the Ministry of Health.

> Our main problem is the nursing salary and benefits system. Our nurses' salaries are the lowest among the Gulf countries. As a result we noticed recently an increase in the turnover rate among local nurses, especially male nurses. They leave for the private sector which pays higher salaries than the Ministry of Health. (Wardia)

Salaries and benefits for health-care workers vary among the Gulf states. The richest states (e.g. Saudi Arabia, Kuwait, Qatar and the UAE) offer higher salaries and better incentives than the poorer states of Bahrain and Oman. However, these anomalies have not produced major reductions in nursing shortages in the richer countries.

Ironically, the less rich states (Bahrain, Oman) have the largest number of indigenous nurses in the Gulf. This indicates that financial incentives are very important but non-financial incentives, such as job satisfaction and career development, are important factors for improving nursing's image in the Gulf states, and in Saudi Arabia in particular.

5.3 Social attitudes

The image of nursing is strongly influenced by Islam and the role of women. The Gulf's culture is one of well-established tradition based on strong family, religious and social values. Most of these values influence the role of women, their ability to work and the type of career they choose but their level of influence varies. Saudi Arabian society is founded on strict conservative interpretation of and adherence to the Quran and male-female contact is strictly limited. Bahrain and Oman are less strict – women have more freedom of movement and opportunities for interaction with the opposite sex are tolerated. The gender interaction issues and strict cultural values that restrict the movement of women have deterred many Saudi women from considering careers in the allied medical professions, particularly nursing.

Gender has a huge impact on the choice of career in Saudi Arabia. Women have a traditional role which centres on home and family. They live in privacy from men, other than immediate family members. The official view of the ideal woman tends to elevate her public separation from men as the hallmark of Islamic society. It defines the particular Muslim society of Saudi Arabia as something distinct from, and morally superior to, the West and to other Muslim countries in which women are less rigidly separated (Doumato, 2000). This ideology emanates from religious scholars and conservative writers and is nurtured within state agencies and incorporated into public policy, sometimes with the explicit objective of correlating Saudi rule with the preservation of Islamic morality. Certain careers are barred for most women at present and gender segregation persists in most jobs. A male Saudi Ministry of Health official explained:

> There are those with very conservative views on the role of women who think women should not work at all and should stay home to take care of the family. On the other hand, others are more flexible and believe that women can work in jobs that suit

> them, such as teaching, medicine and others that do not require mixing of genders unless it is necessary, as is the case in the health service. (Marzook)

A senior Saudi manager in the Ministry of Labour commented: "Our culture values and certain interpretations of the Quran do not approve of women working alongside men. As a result women have limited career and job opportunities in the labour market" (Waleed).

A large section of Saudi society holds these restrictive views but similar views are found in Bahrain and Oman. The fundamental difference is that such views are backed and encouraged by government policy in Saudi Arabia, supported by the religious elite on whom the government depends for its legitimacy. Saudi Arabia signed the United Nations convention that gives women more economic, civil and social rights but religious clerics continue to determine laws and conduct and reinforce practices that limit the freedom of women in public life. Some authors suggest that a narrow and restricted interpretation of Islamic teachings has restricted gender equality in Saudi Arabia (Hamdan, 2005).

However, since 2001, external and internal pressures have encouraged the Saudi government to allow those with liberal views on social issues to question more conservative views. For example, women have been allowed to participate in the election and nomination of the Chamber of Commerce Councils and participate as consultants in the Saudi Consultative Council (Parliament) when women's issues are debated. Another very important step for Saudi women was the appointment of the first women as a deputy for the Minister of Education in February 2009. This is a major step in Saudi Arabia and will have very positive consequences on the status of women in the country.

In Saudi Arabia, almost all respondents raised the image of nursing as an important issue. Most stressed that nursing's negative image should be addressed as the starting point for any positive changes. The majority of Saudi people do not understand the role of a nurse in the health-care service There is a long history of portraying nurses as domestic helpers or, at best, assistants to physicians with the main duty of taking orders from medical staff. The media have played an important role in this negative

image, as explained later in the chapter. Nursing's negative image has fostered low social- and self-esteem among those who choose this career. One of the main factors in this is the absence of professional independent or governmental nursing bodies to inform the public about the profession, the real nature of nursing and the role of nurses in the health of the society.

Nurses in all Gulf states have low status and little access to power within the male and medically dominated health system (Littlewood & Yousuf, 2000). Historically, nursing care in most Arab countries was carried out by untrained women and servants and combined with the conservative religious interpretation of the role of women to diminish respect and recognition of nursing as a valid, worthy career. One female Saudi nursing student explained:

> The common image of a nurse in our culture is a maid or at best an aid to the doctor and most people do not show any respect toward nurses. In my case, even my family feels ashamed to tell others about what I am studying to be. They like to pretend that I am going to be a doctor and they spread such a lie to relatives and friends of the family. (Reem)

Such remarks and attitudes illustrate the social stigma that certainly affects the self-esteem of indigenous nurses. Doctors and nurses are afforded different status, rewards and prestige. Medicine is universally judged as an elite profession and doctors are well-respected and well-paid. Saudi families encourage both male and female children to study medicine (Vidyasagar & Rea, 2004) although the latter are subject to the discrimination and restricted mobility common to all women in Saudi Arabia. Nursing does not enjoy a similar status and families discourage their children (especially females) from considering this career. A Saudi nursing education officer in a hospital talked about her experience in nursing college:

> I did not really choose it [nursing], it was a coincidence. I joined the allied medical college. Not until later, I found out that I was studying nursing. At the beginning I did not like the idea that I was studying nursing, and tried to change to a different course. Fortunately, one of my teachers asked me if I liked what I was studying and I replied yes, she said then forget it is nursing and call it whatever you like and continue with it. I followed her advice and have never regretted it since. Now, I think I made the right decision. (Hussah)

Most of the stakeholders in all three countries mentioned nursing's poor image in Gulf society. The majority felt that the general public did not recognize and appreciate the professionalism of nurses. One female Omani nurse commented:

> From my own experience, I feel that there are some people who still cannot accept Omani women to work as nurses. Our culture and religious beliefs have traditionally been against working women. To work as a teacher, clerk or a social worker in an all-women working environment is acceptable but to work as a nurse where you must work with the opposite sex is a taboo. (Zina)

Nursing's image in most Arab countries is strongly influenced by social, cultural, economic and religious factors. A WHO representative in the Gulf pointed out: "What you see in the Gulf is no different than what you find in many other Arab countries. Nursing has not been recognized fully as an important profession by both policy-makers and the public" (Sharaf).

Both Bahrain and Oman have made very positive progress in improving nursing's image and more people have begun to recognize the important role of nurses in both the health service and the community. For example, the Bahraini Minister of Health worked as a nurse for a number of years before her appointment. Oman has also witnessed noticeable improvements over a short time. One Omani female nurse explained: "Nursing's image is changing, but not as fast as we wish it to be. People are beginning to accept the local [indigenous] nurses in the community and recognize their role better than before" (Samia).

Oman is learning from Bahrain's experience. For example, a number of Omani nurses have been appointed to senior nursing positions in the Ministry of Health and a number of senior nursing positions have been created solely for Omani nurses. Nursing's image has improved in the last few years, especially among young people. It is difficult to measure the changes but some useful indicators include higher demand for nursing school places and increases in the numbers of indigenous nurses in public and private health-care facilities. However, it must be acknowledged that economic factors play a major part. As indicated in Chapter 1, Oman (like the other two countries) has a young population with limited career opportunities. Young

graduates, especially women, tend to look for careers that offer the opportunity of employment and are needed in the labour market.

Traditionally, Bahrain has been known in the Gulf for its liberal views and tolerance. The different cultures in its cosmopolitan population have shaped its social structure and women enjoy far more freedom than those in Saudi Arabia and Oman. Women in Bahrain are allowed to drive and work in mixed environments, with very few restrictions. One Bahraini nurse's husband noted:

> Here things are different from other Gulf countries in the way they perceive and treat women. We respect women and the government has granted them more rights than any other Gulf states. As you know my wife is a nurse and some of my relatives are studying nursing, nursing to us is like any other occupation. (Hani)

Such liberal views are rare in Saudi Arabia. This might be attributed to the progress and speed of modernization in Bahrain which has impacted positively on all aspects of life in the country. It also might explain why Bahrain has the highest number of indigenous nurses in the Gulf.

Evidence suggests that nursing's image in Bahrain is far more advanced than in Saudi Arabia and Oman. A Bahraini nurse's husband commented:

> I understand that nursing is a noble job. Helping sick and weak people and providing health education to the community. People appreciate nurse's work. For example, my wife is dedicated to her work and loves her job as a nurse. (Hani)

Since the 1980s, Bahrain has developed a policy of investing in programmes aimed at communities, families and schools to promote nursing and strengthen the role of nurses in the community. A female Bahraini senior Ministry of Health official explained:

> I believe that society has recognized the role of a nurse as a result of hard work by both the Ministry of Health and nurses themselves. The Bahraini nurse has initiated such change by the services she offers to the community. A Bahraini nurse contributes to the community and does voluntary work and participates in immunization and health education programmes through visiting schools, poor and elderly people. Such work is rare or even unknown in other Gulf countries. (Fatena)

Like Oman, Bahrain has limited capacity in its nursing colleges. Despite the withdrawal of financial incentives (e.g. student allowances, free books) demand for nursing places remains high and many applicants are turned down. A senior female nursing manager explained:

> Although we have high interest, our capacity is very limited and this might create a severe shortage of indigenous nurses in the future if we do not act quickly. In 2004, 1000 applicants applied to our nursing college, we accepted only 120 of them. This was our maximum capacity; this constituted a very small number of our needs. (Lona)

Earlier in this thesis I presented evidence on the lack of coordination and cooperation between various institutions within the Gulf states. Effective coordination and cooperation could enable prospective nurses who are rejected because of a lack of nursing college places in one Gulf state to be redirected to other states that have spare capacity. After all, such coordination and cooperation is one of the main objectives of the GCC.

Bahrain has the highest percentage (63%) of indigenous nurses in the Gulf but officials recently warned of a rising nursing shortage. This is partly the result of a relaxed and complacent attitude towards nursing in the past few years. Also, Bahraini nurses are becoming increasingly dissatisfied with their pay and incentive packages. Bahraini officials admit this complacency and are aware of the increasing complaints about low salaries in comparison to other Gulf states. One senior nursing official explained:

> I know that some people have said that Bahrain's interest in Bahrainization has declined over the past few years. It is true that for the time being we are recruiting more foreign nurses to meet our needs. We have laid back for a while. We thought that we had done enough. This was a huge misjudgement on our part. However, the interest is still there and we can do it again, but I must admit it is going to be very difficult especially with the present nursing salary scale. We need to review our present salary and benefit scale if we want to maintain interest in nursing. (Fahad)

5.3.1 Role of the family

Within the Gulf States the concept of family is passing through a fast transition that affects its functions, roles, authority and structure (El-Haddad, 2003). Gender roles and the accompanying attitudes toward the division of labour between spouses might not differ much across the three countries. There is evidence to suggest that a woman's decision to seek employment is affected by her families' religious beliefs. In Saudi Arabia's conservative society the majority of people strongly believe that it is the man's responsibility to be the breadwinner while the woman takes care of the family. This attitude differs across and within countries according to family background, socio-economic status and the occupations of other family members.

Traditionally, people in the Gulf place a high value on time with their families. Working in shifts and/or late nights is unacceptable to either sex because it interferes with family time. This adds to families' reluctance to consider nursing as a job for their daughters. The requirement to provide physical care to members of the opposite sex is also considered to be in direct conflict with strongly held cultural and religious beliefs. Islam prohibits members of the opposite sex from touching one another unless it is a matter of life and death.

There are gender differences in nurse employment. Female nurses can work in both female and male wards but male nurses are restricted to male wards. The Saudi Ministry of Health reported that more than 3000 male nursing graduates were on waiting lists for jobs at the beginning of 2007(Arab News, 2007) and projected that the number of jobless Saudi male nurses would have increased to 7000 by the end of the same year. Conversely, there is a severe shortage of female nurses. The Deputy Minister for Planning and Development in the Saudi Ministry of Health said:

> I'm ready to employ within two weeks any Saudi female nurse, regardless of whether she has graduated from a government college or a private one but on condition that she cannot choose the location of her placement. (Arab News, 2007)

It should be noted that the majority of these unemployed male nurses hold nursing diplomas rather than BSN degrees and therefore find it difficult to find jobs in either government or private health facilities. The Ministry of Health has faced a lot of pressure to phase out existing nursing schools that offer only diplomas and replace

them with nursing colleges that offer degrees. Recently, Ministry of Health nursing schools were ordered to reallocate training places for male students to female students.

No clause in Saudi labour law prohibits women from working alongside males but local norms and religious tradition restrict work in mixed environments. The Saudi Labour Law states: "Work is the right of every citizen. All citizens are equal in the right to work. Women shall work in all fields suitable to their nature" (Ministry of Labour 2005b & 2005c). However, an ambiguous article states: "When implementing the provisions of this law, the employer and the worker shall adhere to the provisions of sharia (Islamic law)" (Ministry of Labour, 2005b). This clause is subject to various interpretations. Conservative Islamic scholars argue that it prohibits women from working in a mixed environment and therefore they should not be allowed to work alongside men. However, there is some flexibility to this rule in the health service where the nature of the work requires women to work alongside men.

Female health workers in general and nurses in particular, believe that their professions reduce their chances of marrying. Professional women who cannot or do not marry risk lonely lives as the extended family disappears (El-Haddad, 2003). Gulf society views unmarried and divorced women as a threat to moral and existing social codes. They are seen as predatory, come under more scrutiny and are subject to more restrictions than married women. Therefore, marriage is not only recommended but married women have more freedom and acceptance in society. A Saudi female doctor commented:

> I know many of my colleagues and friends who are in their thirties or forties and could not get married because of their occupations. However, you will find those men who only want to marry a doctor or a nurse to benefit financially from her salary. Most young people prefer to marry a woman who works but preferably a teacher or someone who is not required to work with men. (Malak)

In a study of Saudi women doctors, those who dropped out of medical college cited pressure from their husbands as important causative factors – the husbands objected to their wives spending time alongside men (Vidyasagar & Rea, 2004). Religious traditions and local norms prohibit any interaction between the two sexes if they are

not closely related by either marriage or blood. In the Gulf, the numbers of unemployed women include those who have chosen not to work after marriage. The necessity for working shifts and weekends requires a nurse to commute to and from work at times when her family expects her at home. In Saudi Arabia, married and unmarried women require written consent from either their fathers or their husbands in order to enrol at college or work. A senior manager in the Ministry of Labour explained: "A Saudi working woman, regardless of her occupation, will work until she gets married. Then it is up to her husband if he allows her to continue or not" (Waleed).

In Saudi Arabia, women have high levels of education and professional opportunities but Saudi law prevents gender equality by restricting their freedom to travel and requiring the agreement of a male relative before they can seek further education and work (Al-Fayez, 1978). A female Saudi nurse complained bitterly about this:

> This discriminatory law prevented me going for higher education in Australia. I am single and I do not have a free male relative to accompany me, which is a requirement for a government scholarship. This means two things. Either I find a husband quickly or drop my ambition to go abroad. I chose the latter. (Hayat)

Restrictions on women's movements in Saudi Arabia have had an adverse impact on their participation in the workforce. Women are not allowed to drive or to travel alone and most are forced to hire foreign drivers to take them to work. A Saudi senior manager in the Ministry of Labour explained:

> A Saudi woman cannot travel by herself to go and work in towns other than her own. In some parts of the Kingdom, we have many job vacancies for women, but because of such restrictions on Saudi women we have no choice but to employ foreign women instead. (Waleed)

It is more difficult for a Saudi female nurse who is required to work nights and weekends – a father, husband or driver is required to transport her back and forth to work. Some nurses, especially married women, find it hard to work in these conditions and are forced to quit. A director of one nursing college pointed out:

> The most common problems facing local [indigenous] nurses are those related to night shifts and weekends. Many nurses find it difficult to fulfil their job duties and

> requirements. A nurse's family member might refuse to drive her. This creates tensions within the family and disturbs the work flow in the health service. I have heard about many unfortunate incidents of abuse and divorce as a result of disputes over these issues. (Nawal)

A head of a nursing department in Saudi Arabia reported that 70% of Saudi nurses experience hostility from their families (Khaleej Times, 2006).

Oman and Saudi Arabia have similar approaches to women's issues in that women face greater discrimination in access to education and training. However, the important difference is that the Omani government has adopted a liberal view towards women's issues. Omani women occupy high positions as ministers and members of parliament. Unlike in Saudi Arabia, Omani women can work, drive and have more freedom of movement. However, culture and attitudes towards working women are slow to change as Omani society is religious and conservative. Nurses still have low social status and negative public perceptions predominate. As in Saudi Arabia, nurses and other women health-care workers find it difficult to balance careers and family responsibility as husbands or families fail to accept the changing responsibilities and duties of working women. An Omani female nurse explained:

> Some families would think twice before allowing their sons to marry a nurse because of the nature of our work, especially the late night shifts and working with the opposite sex. Working different shifts for me is still not a problem because I am single but married nurses find it difficult to carry their duties in such environment. (Amal)

About 40% of Omani female medical students and residents do not go on to practise. They effectively drop out after graduation, succumbing to societal pressures to marry and raise children at an early age (Mahmoud, 2004). Women in the Gulf generally choose work that has regular, predictable hours and a decent income to protect the health and well-being of the family. Women's economic choices are more likely to reflect their need to fulfil homemaking responsibilities than to enhance their professional aspirations (Sethuraman, 1998).

Bahraini society is more tolerant towards working women. Conservative segments of the population prohibit their daughters from becoming nurses but more people seem to accept nursing as a valuable and worthy profession. Among the three Gulf states, Bahrain shows the most respect for nurses. One female Bahraini nurse commented:

> I never felt I am subject to any form of discrimination. Actually, my family and I have the respect of our community. My children are proud of me and other children respect them because I am a nurse. This is because they recognize my contribution in the community. (Mona)

Nevertheless, Bahrain shares some characteristics with the other two states, especially men's growing preference for marrying working women in order to share domestic financial responsibilities. A head of a nursing department explained:

> In some Gulf states young people hesitate to marry a nurse, but in Bahrain we do not have a serious problem with such an issue. This is one of the positive changes of a persistent effort to educate people about the positive role of nursing. Nowadays, young people prefer to marry working women regardless of their occupations to share with them financial obligations. (Bedoor)

5.3.2 Knowledge

Some Gulf families find particular aspects of a nurse's job unappealing, for example – washing patients and working with the opposite sex. In addition, many students and parents are unaware of specific career and educational opportunities within the profession. Many stakeholders identified knowledge and information about the nursing profession as an important element in recruiting indigenous people. The majority of people in the Gulf believe that the health service is all about doctors, others (including nurses) are merely their subordinates. This attitude has marginalized the role of the nurse in the health-care process. One Saudi male nurse explained:

> The majority of people in Saudi Arabia lack a basic knowledge about what we do. What they know is that a nurse is there to assist the doctor and follow his instructions. That is why as you have seen many non-medical staff wear a white robe to gain respect from patients. (Moath)

A Saudi female nurse complained bitterly about society's view of nursing:

> Even the closest family members do not understand what I do. They say to me what all you nurses do is wipe bums and clean beds. Sometimes when our house-cleaner is

> on holiday, they make a remark that "We have another one to take her role", meaning me. I really have a hard time with such views but I am not going to give in. (Hayat)

People in Bahrain, particularly young graduates, are more knowledgeable about the role of a nurse. A Bahraini nursing college director explained: "Bahraini applicants apply to our college knowing what they are going to study and the career they are choosing" (Fahad).

Learning from the Bahraini experience, the Omani health authorities have recently started to advertise nursing in the public domain. However, some stakeholders believe that this process will take time and more resources. One Omani female nursing director noted:

> Being in contact with the public, I am aware that people lack the proper knowledge about nursing. People still do not trust our nurses because they do not understand their role. Certainly, things have improved compared to ten years ago. However, we have a long way to go. We need to invest more in our campaign to draw people's attention to what nursing is all about. (Layla)

5.4 Religion

Higgins (1981) points out the important role of religion and its influence upon social policy which, in her opinion, has received relatively little attention in the literature on comparative social policy. Many writers who have examined religion in its social context have shown it to be of great significance in the development of societies. It must be considered as one of a range of possible factors that shape the development of systems of social policy (Higgins, 1981).

Some critics argue that Islam is a patriarchal religion which subordinates women and does not tolerate women's liberation. However, Islam depends upon how specific verses in the Quran are interpreted and by whom. Some interpretations seem to devalue the role of women; others confer equality and dignity. Regardless of such views, however, religion is one of many institutions that influence people's lives in the Gulf.

The vast majority of people in all three Gulf states are Muslims. Some argue that Saudi Arabia uses religion incorrectly to suppress women, keep them indoors and restrict their movements. It is one of very few countries in the Muslim world where women cover their faces with veils. Some Saudi women believe that wearing the veil is an individual choice but this is contradicted by the fact that some state religious institutions require women to cover their faces. The government has initiated many positive steps to give women more rights in the last few years, although this modernization process has been slow.

Saudi Arabia aims to create a population of indigenous nurses who are qualified to provide care within the existing customs and religion. This is difficult and challenging in the face of strong religious opposition which advocates the segregation of the sexes. One Saudi Islamic scholar explained:

> According to Islam, women should not interact or work with the opposite sex unless it is very necessary. What I mean by necessary is only in emergency cases. Women must not mix with men in work or in public. A nurse can only work in female wards. A Moslem woman should cover her face in the presence of men. I am one of the people who think that the government should do more in segregating men and women. In the health service, I wish the government could do more in segregating health-care facilities and create a women-only health service. It can be done. An example is the education sector where complete segregation is implemented. I do not understand why they can't do it in the health service. (Abdullah)

Most stakeholders interviewed in Saudi Arabia disagreed with such interpretations despite such strict and narrowly defined Islamic rules. A senior officer in the SCHS commented:

> No way that the country can afford two health services one for male and another for female. It is neither economical nor practical to do so. In education the situation is completely different. Two different education systems started separately one for each sex and now are joined together, they are not separated any more. In addition, Islam and our customs do not forbid women from working as long as they follow certain customs such as covering their heads (*hejab*) and behaving morally. Unfortunately, some people believe women working in a mixed environment are disturbing the social order, and creating an environment for immoral behaviours. (Salem)

When the religious scholar was asked why most respondents disagreed with his comments and said they believed women should be allowed to work in mixed environments, he replied:

> I know that some disagree with what I have said, but the majority of Saudi people agree. I am aware that in the last few years many things have changed in this country. Those liberals and seculars who believe in women's liberty and freedom have raised their voices as a result of recent events both internally and externally. I think they have been brainwashed by the propaganda of the West. (Abdullah)

Some stakeholders believe that such a view is one of the most important barriers to the development of the Saudi nursing profession. Religious elites are highly respected individuals, people listen to them and they influence public attitudes and opinion. Some believe that Saudi society is the most homogeneous in the world (Al-Adaily, 1983) but Saudi society is not homogeneous. Islam is the only religion practised in Saudi Arabia and Saudis are predominantly Sunni. However, a considerable segment of the east and south of the country includes Shiite and Ismaili sects. Sunnis dominate the Gulf region but there are different degrees of adherence to its teaching. Certain religious practices and laws differ between the sects – cultural traditions such as gender segregation at work and school are fully upheld in the Sunni sect but Shiites are more relaxed. A Shiite female Saudi nurse explained:

> Shiite families are more open and tolerant towards women in general. Shiite women joined the oil company health service (ARAMCO) as doctors and nurses a long time ago. We have no problem working in a mixed environment but that does not mean we are not good Muslims. The main difference is in the interpretation of the Quran which distinguishes each sect. (Buraida)

However, Islam is the main source of legal, political and social authority in Saudi Arabia. It is considered a way of life and its role and influence touches all aspects of Saudi life, including nursing. One Saudi female doctor commented: "Unless those religious scholars who are respected in the society speak out in favour of working women, especially doctors and nurses, things will never improve" (Malak).

As in Saudi Arabia, issues such as veiling, working in a mixed environment and the role of women in society are matters of great debate in Oman. Each of the three states

has been influenced by religion but the influence appears stronger in Oman and Saudi Arabia. However, Oman's experience of colonialism and the influx of expatriates have produced a stronger liberal tradition and religious groups have less influence.

Fundamentalism and conservatism have strong rote and history in the Gulf. In the late 1970s a narrowly defined set of Islamic beliefs developed into a movement within the Gulf Islamic community. This movement has stood in opposition to modernism and espoused strict adherence to conservative Islam, especially since the Iranian revolution. Many criticisms of fundamentalist positions have centred on the irrationality of its doctrine – some of its claims cannot be proven and are contrary to scientific evidence. However, the main variation across these three states stems from Islamic beliefs and the extent to which each country upholds these beliefs in their respective social and legal systems. One Omani senior Ministry of Health manager explained that Omanis are not segregated by gender in workplaces:

> As you have seen yourself there is no segregation between men and women here in the Ministry. We work together and respect each other. Gender segregation is something of the past in Oman. Having said that, it doesn't mean that Oman doesn't have conservative religious groups who oppose any unnecessary contact between males and females, including working together. (Zubair)

However, one nursing manager in an Omani hospital contradicted this liberal view of mixing and working alongside men. She admitted that some female nurses find it difficult to work in a hospital environment: "It is a problem for us here [hospital], we cannot force a female nurse to work in a male ward. Working with the opposite sex is a dilemma, as you know, in the health service; it is very difficult to separate sexes" (Layla).

Bahrain is the only Gulf state with a Shiite majority population and is more tolerant and open toward women. The country has been exposed to Western traditions, values and business practices for a long time and to a much greater degree than Saudi Arabia and Oman. Bahraini women who wear mostly Western dress are worried that Saudi ideas might enter society and affect their rights. This tolerant environment is one of the important factors behind Bahrain's positive nursing image and, more importantly, the positive role of religious scholars who support working women. However,

Bahrain has conservative religious individuals similar to those in Saudi Arabia and Oman. They oppose certain women's rights including the right to work. In exit interviews some Bahraini nurses quoted religion as a strong reason for leaving nursing. A female assistant director of nursing in a major hospital pointed out:

> Religion is very important in our society; some nurses have resigned as a result of pressure from their families. We interviewed some of them about the reasons for leaving. Some indicated that they don't feel comfortable working in a mixed environment where men work alongside them. (Saida).

5.5 Gender relations in the Gulf

It should be noted that the limited and fragmented literature related to gender and women in the Arab world in general, and the Gulf in particular, has been one of the main limitations on the intended depth of this and related sections. Academic studies and researches on the subject of women and gender in the Arab world are scarce.

Gender is a concept that deals with issues related to all aspects of men's and women's lives – their different opportunities, needs and concerns in a specific culture. A United Nations' report defines gender roles as those that are socially assigned, interchangeable and may vary with class, race, ethnicity, religion, age and time (United Nations, 2001). The construction and reproduction of these roles take place at both individual and societal levels. Therefore, gender analysis explores relationships and inequalities in the private and public sectors of society (United Nations, 2001). Valverde, cited in Ceci (2004), argues that gender, gendering discourses and practices work to produce us as particular men or women, though they never do so completely, fully or all by themselves.

Some argue that the actions of people or individuals have to be understood within a wider societal setting in which structures, symbols and discourses – all imbued with gender – are taken into account (Davies, 2001). Davies stresses the importance of studying gender and that gender has become a useful and widespread concept in feminist theory and gender research. It suggests active performance and subjectivity – bringing our attention to the ways in which gender relations are constantly created, maintained and contested in interaction and daily life. By studying gender we are able to understand that gender and gender relations are not a static pre-given but are

moulded in ongoing actions that require at least two partners to be present (Davies, 2001).

The study of gender in the Gulf concerns the ways in which the dominant cultures in these societies have defined maleness and femaleness as points of opposition and difference in which males occupy positions of power, decision-making and domination. In recent years, many gender scholars have shown an interest in the study of gender relations in Islam. Meriwether and Tucker (1999) point out that historians and sociologists want to understand how the male-privileging "Islamic" discourse on male and female has evolved; to be able to recognize it when they see it; and, if they have feminist goals, to struggle against it. As historians they find an intriguing intersection between present Islamic discourse (on a monolithic and immutable Islam that dictates certain gender roles) and an Orientalist discourse that also stresses the unchanging and, in its version, oppressive gender system imposed by Islamic law and thought. Mernissi (1991) raised a call for feminist scholars to engage in serious study of the Islamic tradition and not to leave the representation and interpretation of this tradition entirely in the hands of those who would emphasize its more conservative and even antifeminist side.

The Quran assigns different social roles to men and women because of their different natures. Men are seen as the protectors or guardians of women because God has given them more power or strength and because they provide bread for the family. Prevailing Islamic practices and interpretations have made gender a subject of great debate in the Arab world in general and the Gulf in particular. During the early days of Islam women moved freely and held prominent positions in business and as Islamic scholars. Some scholars believe that the present practices of veiling and gender segregation in Gulf societies are influenced by cultural traditions. Most women do not cover their faces and some are unveiled in many Arab and Muslim countries. Moreover, there is no gender segregation in educational institutions and workplaces. In addition, some Arab and Islamic countries (including Gulf states such as the UAE and Kuwait) have a female prime minister and/or ministers.

Discrimination between male and female is more apparent in daily life in Saudi Arabia than in any other country in the Gulf. Amnesty International considers that the

abuse of women's rights in Saudi Arabia is not simply the unfortunate consequence of over-zealous religious police, but results from a state policy that gives women fewer rights than men and allows men to exercise authority without fear of being held to account for their actions (Amnesty International, 2006).

Women have become an important issue for planners in the Gulf states because they represent an untapped human resource. Some respondents suggested that public prejudices about the nursing profession have to be eliminated in order to build a Saudi nursing workforce. A male senior manager in the SCHS pointed out:

> We need to change the negative perceptions in the society about working women in general. There are many wrong perceptions about working women especially about those who work in mixed workplaces as is the case in health-service facilities. (Salem)

One Saudi female doctor explained: "We [women] need to struggle and work hard to change people's attitudes toward working women. It is very difficult for a woman in this society and it is more difficult if you are working women" (Malak). An expatriate head of the Saudization department in Riyadh explained how it is difficult for women to challenge the present culture: "Saudi nurses don't speak up for themselves. As you know in the Saudi culture a woman will never challenge a man" (Liz).

Gender relations also impact on the relationship between nurses and Arab male physicians. Regardless of nationality, Arab physicians are more likely to differentiate between Arab and Western nurses. The Associate Dean of a Saudi nursing college pointed out:

> The way local [indigenous and Arab] physicians treat foreign and local [indigenous] nurses is different. While they show more respect to Western nurses, they do not show any respect to us and other Arab and Far Eastern nurses. (Rufaida)

Other stakeholders believe that most medical personnel lack knowledge and understanding of the nurse's role in health care. A Saudi director of nursing in a large hospital in Riyadh commented:

> Medical staff do not understand the responsibility and contribution of the nursing staff in the patient care process. Some are ignorant in the way they treat my staff, and

> think they have the right to intervene in nursing management. When I was appointed as the first Saudi nursing director in this hospital, some considered this as an opportunity for them to control nursing. Because, I am a Saudi woman they thought that they could take advantage of me. (Ahlam)

This lack of understanding among medical staff and other health personnel is among the most important factors that contribute to the negative image of nursing (Hamdi & Al-Haider, 1996). This might be attributed to the fact that Saudi culture restricts any social interaction between the sexes and therefore there are only minimal and necessary interactions between the two sexes in the workplace. In addition, men in the Gulf are more likely than women to be exposed to Western traditions and values. Arab and Far Eastern nurses are more exposed to Western cultures and know their rights but many choose to avoid confrontation, fearing serious negative consequences such as termination of contracts or harassment. A Saudi female nurse explained: "Lebanese and Philippine nurses are scared of Saudi doctors. They will obey orders and listen to what they are told. They fear that by not doing so they will be terminated and deported" (Buraida).

This problem is not confined to Saudi Arabia, it is also found in Bahrain. One female Bahraini director of nursing commented:

> The existing relationship between medical personnel and nurses should be evaluated. We have received complaints from some of our nurses about the behaviour and the way some doctors treat them. I believe medical schools should think seriously about educating medical students about the role of a nurse and to show more respect for nurses and treat them as colleagues not as assistants. (Bedoor)

In both Bahrain and Oman, the concept of gender-differentiated lives is less prevalent and women have more freedom. However, in Oman the local traditional masculine culture is still dominant. Increased gender equality represents a threat to such masculine dominance and might result in conflicts of interest between men and women.

5.6 Media influence

The mass media comprise the print industry (magazines, newspapers) and electronic media (television, radio, Internet). They serve several vital functions as agents of socialization that instruct people in the values and customs of society; sources of information; and propaganda mechanisms that persuade the public to support particular issues (Walt, 1994). Most mass media in the Gulf are directly owned or controlled by governments and are very powerful tools (especially radio and television) in those societies with significant uneducated and illiterate populations. For example, in the Gulf states 33% of women and 16% of men aged 15 years and over are illiterate (Population Reference Bureau, 2008).

Traditionally, the media have been accused of portraying a negative image of nursing in the Gulf. For example, old Egyptian films often depict a nurse as a maid or, at best, a doctor's aid who is willing to obey orders. As the nursing profession is dominated by women, the media in Saudi Arabia find it difficult to communicate and interact with them. Until recently, Saudi television and newspapers were unable to show pictures of woman and few Saudi women are willing to talk or be interviewed on television. The cultural and religious restrictions reported above limit women's participation in the media. One male Saudi nurse pointed out:

> People do not know much about nursing. Information can make a huge difference in improving recruitment of locals [indigenous]. In my case I wasted four years of my life by entering an allied medical school instead of just going straight to a nursing college, and the reason was a lack of knowledge about nursing prospects and opportunities. (Moath)

Recently, however, there have been positive changes in the media's role in nursing in Saudi Arabia.

The majority of stakeholders in the three countries stressed the importance of promoting nursing. Some stakeholders feel that the media have not done enough to inform people of the positive prospects of a nursing career. One senior female hospital manager in Oman pointed out:

> I wish we could advertise more to encourage people to consider nursing as a profession and tell young people about the potential and the opportunities which are

> waiting for them in nursing. Many people in the country do not know a great deal about nursing and the role a nurse plays in patient care. (Layla)

A female Omani nurse explained:

> When something is vague, you will have a lot of doubts about it. But when you are provided with information about it, you feel comfortable. It is the same with nursing. In the past, nursing as a job was not common in Oman; most people do not know enough information about it. (Samia)

In Bahrain the media have more freedom to report on women's issues. Yet nursing issues have not received proper attention. One female Bahraini director of nursing remarked:

> The media has not done enough to help the nursing image. For example, there is a television health programme hosted by a doctor. It would be a good idea if a nurse was invited to talk about health in the community and the role of a nurse in both the health service and the community. (Bedoor)

5.7 Role models

Many stakeholders emphasized that positive role models could play a major role in improving the image of nursing. Although the three countries have different experiences of the potential impacts, most agree that positive role models could influence people's attitudes in conservative Gulf society. In Saudi Arabia, most stakeholders recognize the importance of role models but it is difficult to find nurses who could act as such. This is again attributed to the limited role of women in public life. One expatriate nurse who is also head of the Saudization nursing department explained:

> I think we [foreign nurses] need to act as role models. You have got to portray the goods of nursing. I think we should look at the image of nursing in Saudi Arabia and start to look for role models, get Saudi nurses to schools and the community to preach about nursing as profession and the important role a nurse plays in the health-care service. (Liz)

However, practising nurses with generally lower standards of education are considered negative role models. One Saudi nursing education officer said:

> We have few role models; unfortunately most of our nurses are either high school or college drop-outs or graduates of nursing institutions with nursing certificates. Few are those Saudi nurses who have bachelor or postgraduate degrees in nursing. (Hussa)

Shortages of qualified and experienced nurses who can act as positive role models make it difficult for policy-makers and nursing advocates to promote the image of nursing in a large country like Saudi Arabia. For example, a newly opened nursing college has only one Saudi nurse who teaches. She explained her role: "I am the only qualified Saudi clinical researcher in the country. They [nursing school] hired me here to teach and act as a role model for Saudi students" (Rufaida).

The Bahraini government and media do the most (among the three countries) to promote a positive nursing image. This is primarily because nursing is a more advanced profession and has a longer history in this country. Also, there are obvious variations in gender relations and the status of women between the three countries. Women in Bahrain run for, and are elected to, political and judicial offices. A woman was recently appointed as a judge – a huge step for women as only a very few Muslim countries have taken such a controversial decision. A director of a nursing college in Bahrain proudly explained:

> ...we have good role models who have contributed positively to the image of nursing in Bahrain. For example, when we interviewed some new applicants and asked them why do you want to be a nurse many indicated that they want to be like so and so [the minister] who was a nurse and now is a public figure. The Minister of Health was a nurse. Students recognize the important role of a nurse, and that nursing as a career could lead to better opportunities. (Wardia)

Donaldson & Carter (2005) found that groups of nursing students stressed the importance of access to good role models in order to observe and practise their skills and behaviour. Good role models were seen to have a major influence on the development of students' competence and confidence. Bandura (1977b) argues that role modelling is much more than imitative behaviour as it has a major influence on the observer's behaviour. However, the influence of the role model is related to the number of times that the student is exposed to the experience (Bandura, 1986). Gibson (2004) states that career theory proposes the importance and influence of role

models in helping to guide individual development. He points out that the traditional idea of a role model is that of an individual in an influential position, such as a parent, teacher or supervisor who provides an example for individuals to imitate.

Some regional and international organizations have recognized Bahraini nurses' contributions to the nursing profession and their positive role in improving nursing's image in both Bahrain and the Gulf. A female Bahraini Ministry of Health official explained:

> One of the most important turning points in promoting the image of nursing happened when the World Health Organization (WHO) chose a Bahraini nurse to be the (WHO) Chief Nurse Scientist. She was chosen out of 12 applicants from different countries. This caused people to talk about her as a role model. Another example was when the Eastern Mediterranean Regional Office (EMRO) appointed a Bahraini nurse as the director of this sub-organization of the WHO in Cairo (Egypt). Changing the nursing image from negative to positive is not an easy task. It is difficult and it takes time and effort. (Fatena)

Therefore, in Gulf culture, the mere physical presence of a smartly dressed indigenous nurse radiating enthusiasm and satisfaction in her work will prove a far better recruitment tool than any number of leaflets, pamphlets and radio or TV programmes.

5.8 Chapter summary

The findings in this chapter suggest that nursing has a poor image and offers a far from desirable career, especially among young graduates. Most of the stakeholders participating in this study mentioned the lowly status of nursing among Gulf people. There is a lack of knowledge and understanding of a nurse's role and its vital contribution to health-care.

Clearly, any strategy to promote nursing as a career must address its poor image. Targeted work will be necessary as there are limited channels through which indigenous students in the Gulf can access information about nursing and its role in the health-care process. Analysis of the three cases indicates that the public have prejudices and negative attitudes not only about nursing but also about working

women in general. Nursing is in a very awkward position – it remains predominantly female but women are still prohibited from engaging in any social activities that require close contact with men in some Gulf states. The three states have major variations especially in those factors related to society, gender, religion and role models. Gender and religious factors appear to be particularly important in the negative image of nursing in Saudi Arabia.

Governments will have important roles in raising the image of nursing and the development of the nursing workforce. Vigorous marketing of nursing's real and positive contribution to the health service is essential for informing the wider community. Higher education and health institutions need to establish marketing and recruitment strategies to encourage high school graduates to consider nursing as a career. This will require (and, in turn, produce) better-educated, well-qualified and self-confident nurses. Recruitment of high calibre indigenous graduates will reduce reliance on those who choose nursing by default.

College of **Nursing**
& Allied Medical Sciences

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Founded in March 2002 AD
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Chapter 6

Discussion and conclusion: fate of the indigenous nursing workforce in the Gulf

6.1 Introduction

The indigenous nursing shortage sweeping through the Gulf states is at a critical level and could change from a health crisis to a national security concern. This thesis has utilized a number of different approaches (such as cross-national comparisons of human resources) to highlight why a shortage of health workers occurs and how human resource policies and strategies influence indigenization policies. It has also utilized policy framework to emphasize the context, actors and policy process while examining the policy of indigenization. The thesis has highlighted economic, social (including religious) and political factors.

A variety of approaches were used to provide a framework to explain diversification in indigenization and human resource practices in the three Gulf states. Stakeholder analysis was undertaken to identify the main actors and their interests. A grounded theory process of analysis included a number of distinct features (e.g. drawing constant comparisons, use of a coding paradigm) to ensure conceptual development and density. This research has outlined the different policies by which indigenous nurses and nursing students were recruited to work in the three Gulf states. These indigenization policies have been discussed particularly in relation to the image of nursing, cultural differences and the role of women. Also, the barriers to considering nursing as a career, career progression and career development have been examined. This research triggers questions and discusses issues that relate to the deeply rooted prejudice and discrimination towards women that prevails within the social and health systems. The realities and difficulties of unmasking such discrimination against women in general, and indigenous nurses in particular, are underlying factors.

The research has also raised further questions about the extent to which misperceptions and misunderstanding of the nursing profession can impact on nursing as a career choice, especially among women in the three Gulf states. It is important to

note that certain practices and difficulties are continuing in these states. Over the years, shortages of indigenous nurses in the health service have been addressed by recruiting overseas rather than training and enhancing the quality of indigenous nurses. This is supported by the fact that foreign nurses comprise more than 40% of the nursing workforce in two of the three Gulf states – Saudi Arabia and Oman (Table 5). One of the major problems for indigenous nurses is the requirement to fit into an established work environment that has been designed for foreign nurses. Many indigenous nurses devise ways to fit in and adjust to the existing environment, mostly to their detriment, but remain outsiders in the system with little hope of ever really fitting in.

The purpose of this research was twofold: (i) to elucidate further the reasons and consequences for the shortage of indigenous nurses in the three Gulf states; and (ii) to formulate a logical and systematic explanation of indigenization policies and their role in the indigenous nursing workforces in the three countries. The case study research method was chosen because it seeks to uncover all issues relating to the phenomena under investigation, taking consideration of relationships, context and meaning. However, major limitations in the existing literature on the indigenous nursing shortage and indigenization policies in the three countries should be noted. There are few studies about the phenomena under investigation and most published works on the subject are basic, exploratory in nature and lack an explication of rigour.

6.2 Empirical research literature

The literature review presented in Chapter 2 offers a general overview of the situation of shortages of indigenous nurses in the three countries and describes what is known about nursing shortages and indigenization policies within these Gulf states. This research posed two primary questions that are now discussed in more detail.

What are the main causes inhibiting or promoting the development of nursing as a career among indigenous women of the Gulf?

Implicit in this research question is the issue of whether or not the image of nursing; religion and culture; flexible work practices; nursing education and training; organizational factors; and other aspects of human resource development are valued

as critical elements of strategies to overcome the shortage of indigenous nurses in the three countries. The question sought to identify cultural and organizational enablers and barriers to decisions about effective practices to increase the number of indigenous nurses. I analysed the situation in the three case studies and found that the image of nursing; certain religious and cultural factors; and various human resource practices affect the overall policy strategy to increase the number of indigenous nurses.

What are the main factors facilitating or inhibiting the formulation and implementation of an indigenization policy in the nursing workforce in Saudi Arabia?
Responses to this question indicated a lack of understanding of the indigenization policy among most stakeholders (especially those in Saudi Arabia) and limited coordination and commitment to sharing information among the various stakeholders concerned with indigenization. These respondents reported that implementation (or encouragement) of indigenization policies and other human resource practices in their own organizations is hampered by a lack of leadership commitment and the absence of a national strategy. In contrast, respondents in both Bahrain and Oman reported that indigenization policies and other human resource practices are implemented in their own organizations as part of an overall national strategy. Strong leadership commitment and better coordination between indigenization stakeholders in the two countries were reported as the main factors that are increasing the number of indigenous nurses.

Clear vision and practices have enriched indigenous employees' productivity and commitment to their jobs and their employers. They described an alignment between their commitment to, and understanding of, an effective indigenization policy and human resource practices and the actual national indigenization policy. Bahraini and Omani nurses praised the value of their country's nursing education and training and other human resource practices. Their responses indicated that their professional training, combined with the strong role of women in public life and the positive image of nursing in these two countries, contributed to an understanding of the value of the indigenous nurse and therefore produced a positive impact on recruitment. Rather than feeling threatened by religious and cultural rhetoric (the case in Saudi Arabia), stakeholders in Bahrain and Oman understood the benefits that would accrue to their

countries and organizations by providing opportunities to expand nursing education and training and strengthen the role of women in public life. This attitude was enhanced by stakeholders' abilities to contribute to their country's health service and their own organizations.

The data from these two research questions allowed me to identify enablers and barriers to the indigenization of the nursing workforce in the three countries.

6.3 Key findings

Human resource professionals, scholars, economists and labour market specialists have studied and written little about the benefits of a sufficient indigenous nursing workforce or the consequences of a shortage of indigenous nurses. Studies by Budhwar and Debrah (2003) and Adams and Dussault (2003) and a WHO report (2006) were referenced in Chapter 2. These authors found that very little work has been undertaken on comparative human resource management in developing countries in general, the Gulf states in particular. In addition, health workforce issues have become more prominent in many countries in recent years but human resources for health is still in its infancy in the Gulf states. Researchers and scholars found the GCC states to be characterized by a significant proportion of foreign workers and segmented labour markets. Interestingly, Sassanpour et al. (2004) found that these segmentations occur in several dimensions – between indigenous and foreign workers in the public and private sectors; and between the public and private sectors.

This research has produced a number of important findings that the three Gulf states should consider in order to improve their nursing professions. These findings, and the implications for indigenous nurse recruitment and retention, are discussed below.

6.3.1 Image is a key to improving indigenization of the nursing workforce

The findings of this research suggest that economic incentives are very important motivators for encouraging indigenous people to consider nursing as a career but it is argued here that they are not the primary satisfier and motivator for advancement, recognition and job satisfaction. Accordingly, economic incentives should not be seen in isolation as the primary means by which to increase the number of indigenous

nurses. They can produce a good short-term response but should not be considered "the" solution to the shortage of nurses, as some suggest (Spetz & Given, 2003).

A striking finding of this study is the extent to which indigenous people in the Gulf continue to hold negative perceptions of the nursing profession. It is argued here that the Gulf nursing profession is attempting to improve capacity and encourage indigenous people to consider nursing as a worthy career in the face of the poor image and status of nursing in each of the three countries. Many Arabs, especially those from the middle classes, perceive nursing to be too close to domestic service to be a respectable career (Hijab, 1988). It will be a long and arduous process to reshape existing images in some of these countries, especially Saudi Arabia.

The findings of this research suggest that an improved image of nursing is one of the key factors for encouraging indigenous people to consider this career. This supports, for example, those many authors who attribute the low rates of admission to nursing schools to the negative image of nursing as a career (International Council of Nurses, 2001; Irwin, 2001). The majority of stakeholders reported that nursing is not the first choice of career and that (given the opportunity) many nursing students would have chosen a different path.

It should be noted here that analysis of the data suggests that the image of nursing is improving in both Bahrain and Oman, but remains poor in Saudi Arabia. Other evidence in this study suggests that practising indigenous nurses in most of the Gulf states considered this devalued image to be one factor that led many students to question their decision to consider nursing as a career. This resulted in a lack of good role models for new entrants and a lack of support for indigenous nurses.

Most stakeholders in the three Gulf states emphasized the importance of positive role models in improving the image of nursing. It is argued here that Gulf countries that work to promote a positive image of nursing recruit and retain more indigenous nurses than those who have weak and ineffective promotion strategies. Among the three Gulf states Bahrain does by far the most to promote a positive nursing image; Saudi Arabia does the least. Bahrain has the most indigenous nurses and Saudi Arabia the least (see Table 5).

Studies of mass media in the Gulf have analysed the representation of nursing and indigenization issues. Restrictions on all types of media, especially in Saudi Arabia, have minimized their role in pursuing issues of nursing and indigenization in the nursing workforce. The Gulf states retain a monopoly over all types of media and individuals are not allowed to publish their own newspapers or publications. Information ministries in all the GCC countries run the broadcast media and enforce press censorship through licensing of publications, obligatory submission of newspapers before distribution and registration of journalists (United Nations Development Programme, 2002).

Bahrain is the only Gulf state to have used the media intensively to promote the image of nursing, in conjunction with mechanisms such as community participation in health service delivery. The relatively free and active media have helped to broaden the debate on issues regarding the image of nursing and indigenous nurses. Furthermore, this has produced a well-established means of public engagement that Saudi Arabia and Oman lack. The openness in Bahrain has also enabled the media to take an effective and sensitive role in monitoring and reporting government performance in human resource issues, including the indigenous nursing workforce. In Saudi Arabia, the media continue to undermine or neglect any issues related to women, including nursing. Several labour market and human resource issues have attracted some attention in recent years (usually related to unemployment and the presence of foreign workers) but have not opened up any debates on indigenization policies in health human resources in general or nursing in particular.

The media can play a crucial role in encouraging the public to extend their vision of nursing as a career. The production of appropriate materials such as pamphlets, films and radio programmes could raise awareness of the role of nursing and indigenous nurses in the health care of the people. Gulf governments should encourage the media to provide prominent coverage of cases of mistreatment, sexual harassment and poor working conditions experienced by working women, and nurses in particular, in the workplace. This might discourage some women (especially indigenous women who are reluctant to expose mistreatment and harassment in the workplace) but could also work as a deterrent for those who consider women to be inferior to men.

There is a lack of workshops to train human resource managers, nursing managers and other nursing stakeholders on how to deal with the media or develop suitable campaigns to advance the nursing profession in the region. There is also no comprehensive archive of media material to promote nursing careers among the young indigenous population, especially women. Celebrities, well-known media personalities and professional media agencies could assist in this.

This research also found that nursing was rarely shown positively. Newspapers in all three countries, especially in Saudi Arabia, often commented on potential problems with the shortage of nurses and indigenization but rarely on the benefits of recruiting or training local nurses. Nurses have been portrayed as low class, unclean and sexually available and commonly associated with humorous and sexual story lines in fictional television programmes. However, over the period of this research there has been a slight improvement in the way in which nurses are portrayed.

6.3.2 Human resource practices inhibit career progression for indigenous nurses

Researchers have demonstrated that organizations achieve better outcomes when they encourage and promote practices that encourage workers' abilities, motivation and opportunities. This includes those in the health-care sectors (Gunnarsdottir & Rafferty, 2006; West et al., 2002). Inadequate human resource planning and management, poor working conditions, high attrition, inadequate compensation, low professional satisfaction and underinvestment in human resources are just some of the critical issues that drive indigenous nursing shortages and no one action will resolve the current crisis in the three Gulf states.

Furthermore, it is argued here that work conditions such as shift work, especially night shifts, and the mixing of genders in the hospital environment promote a negative image of nursing in most Gulf states (Al-Kandri & Lew 2005; Mansour, 1992). Promotion systems are not always transparent and can institutionalize disadvantage and create environments which facilitate discriminatory behaviours. It appears that promotion, particularly to nursing management positions, is not based on merit but involves systems of patronage (*wasta*) and satisfaction of subjective and culturally specific criteria – a process which facilitates various forms of discrimination. Henry's (2007) analysis of the experiences of career progression among a number of Ghanaian

nurses working in the UK's National Health Service (NHS) is an example of how patronage can jeopardize nurses' promotion and career progression. The process of promotion experienced by these nurses is based on interplay between the limited interview skills and discriminatory practices that hinder their progress and a process of institutionalization through employers' inadequate or inappropriate support mechanisms (Henry, 2007). Such processes and practices institutionalize disadvantages and have negative outcomes which could explain the under-representation of indigenous nurses in senior positions in the three Gulf states.

6.3.3 Local cultures and religion: impact on indigenization of nursing

The findings of this study lead me to contend that cultures and religion do impact on the indigenous nursing shortage in the Gulf region because the articulation and practice of a mixing environment where men and women work and blend together is culturally and religiously contingent. Thus, working women/female nurses, culture and religion are not mutually exclusive categories. Davies (1995) argues that traditional cultural constructions of gender have identified emotional and practical ability as feminine attributes and associated intellectual abstract abilities with masculinity. Such a construction is more highly visible in the Gulf which inhibits indigenous women's early participation in higher education in general, and nursing in particular.

Clearly, indigenous nurses in the Gulf face a set of difficulties and challenges similar to that experienced by many nurses in other countries. However, they also occupy a unique position within a highly conservative and restrictive culture that limits their freedom and participation in public life. Gender roles have been shaped by a rigid and conservative interpretation of Islam that affects women negatively and limits their education and labour opportunities. A workforce that is educated and trained appropriately, compensated fairly, respected and committed would appear to be an essential component for meeting the multiple challenges facing Gulf health care and to optimize performance.

The three Gulf states share many commonalities in the experiences of indigenous nurses but also significant differences. The most notable of these were seen in women's varying roles in public life, their freedom of movement, the image of

nursing and gender discrimination. Local culture and tolerance of the role of women played a crucial part in shaping experiences within the workplace and elsewhere. Saudi Arabia on the one hand and Bahrain and Oman on the other show striking contrasts in issues of social isolation, forms of discrimination, the role of the religious establishment and sources of support. The research also found significant differences in the quality of support, marginalization of indigenous nurses and image of nursing.

The research findings of this study indicate that the factors and conditions discussed above deter indigenous women from considering nursing as a career and have real consequences. The data in this research stress the importance of greater managerial attention and recognition of the vital roles of indigenous nurses in health-care outcomes. The organizational climate in health service organizations, specifically organizational support for indigenous nurses, has been an undervalued determinant of nurse recruitment and retention failure in most of the three Gulf states. In addition, this research argues that female nursing shortages are exacerbated in countries that inhibit female participation in the workforce. It is likely that those countries that restrict women's freedom and gender relations and lack proper human resource planning will experience shortages of indigenous women in the workforce more often than other settings.

During the last few years, governments have focused increasingly on women's issues and given some priority to the integration of women in social development policies. Women in the Gulf and elsewhere have questioned the conditions of women in Gulf societies and whether their interests, experiences and contributions are being considered. Women in the Gulf have been deliberately excluded from most social issues and considered only as mothers and housewives. They have also been excluded from the labour market and received disproportionately few development benefits. This lack of visibility in most social issues and limited participation in the workplace indicates a certain degree of social inequality, stemming from men's stereotyped expectations and encouraged by a lack of equal employment legislation.

6.3.4 Indigenous female nurses and multidimensional discrimination

Indigenous nurses are at greater risk of poor working conditions, little psychological support and limited job satisfaction, particularly those who work rotating and night

shifts. The study data show that discrimination in the workplace takes various forms, including direct gender discrimination and indirect discrimination embedded in organizational cultures, structures and practices.

Tensions and allegations of discrimination were evident amongst a range of indigenous nurses in the three Gulf states. Such discrimination not only has negative implications for indigenous' nurses welfare but also limits their feelings of loyalty to their countries, resulting in diminishing productivity and alienation. Middle Eastern nurses outlined hidden and clear discrimination as well as outright racism among foreign nurses, especially those from Western nations (Hawthorne, 2001). A Saudi nurse said: "I remained always as an outsider not accepted among foreign colleagues and administration" (Amal). Evidence from this study suggests that explicit policies regarding discrimination are rarely enforced in any of the three Gulf states.

In addition, indigenous nurses experience a lack of social connectedness in health organizations. This affects people's lives as the support of colleagues and superiors has an important impact on the quality of life at work (Gunnarsdottir & Rafferty, 2006). Inadequate support from colleagues and management is evident in this study – the evidence suggests a low degree of social cohesion in most of the health-care organizations in the three Gulf states. This has important impacts on work quality and leads to high turnover.

Dissatisfaction with wages and benefits was another important issue. There is evidence of widespread wage discrimination against indigenous nurses in health-care organizations across the three Gulf states. Indigenous female nurses respond to these difficulties by resisting and re-negotiating and overcoming discriminatory conditions but repeated failure to achieve career progression results in alienation from the workplace and deep demoralization. Evidence suggests that efforts to create better working conditions must include better staffing decisions, better communication and teamwork and safe working environments that facilitate healthy choices, supported by adequate resources (Baumann et al 2001).

6.4 Is there a GCC policy process?

This researcher has found no evidence of a Gulf-wide policy process. It is argued here that the policy processes in the three Gulf states have many similarities, one of the most important of which is the fragility of their regimes. This often brings state legitimacy into question and it is evident that many policies and regulations have the objective of enhancing government legitimacy. Also, large state structures grant governments far more importance than their people, particularly in Saudi Arabia and Oman.

All three states also share a weakness in policy capacity. For example, Saudi Arabia has national capacity but either non-existent or underutilized local capacity. This means that there is little technical capacity and too little analytical ability to conduct high-quality participatory policy processes. Often, large groups of people are excluded from participation in the policy process and decision-making in most of these countries is informed by, and strongly dependent on, foreign expertise and knowledge. Finally, the process of policy implementation in all three Gulf states is particularly problematic.

6.5 Implementation of indigenization policies: challenges and constraints

6.5.1 Slow policy response

Analysis of the indigenization policy actors has illuminated contrasting power relationships within each of the three Gulf states in this study. Delayed policy-making responses may have been responsible for past shortages of indigenous nurses but current and future nurse shortages may also be driven by a broader set of cultural, economic, image and sociological factors. These include fewer nursing schools; fewer young indigenous people entering the profession; a greater range of other professional opportunities for young indigenous people; the negative image of nursing; poor recruitment and retention strategies; and poor pay and working conditions for indigenous nurses.

In the Gulf states there are signs that nurse shortages will worsen in the near future if action is not taken. This will require policy responses that focus on the introduction of mixed policies to initiate innovative approaches to nurse education as well as career opportunities which offer strong incentives to recruit and retain indigenous nurses and improve their image, pay and working conditions.

This analysis has demonstrated the multifaceted scope of issues surrounding indigenization policies and human resources in the three Gulf countries. Weakness and imbalances between the indigenous and foreign nurse workforces may arise from multiple sources, impact on various aspects of the health service and affect multiple outcomes.

6.5.2 Recruitment and retention strategies

Effective recruitment and retention strategies are critical for increasing the number of indigenous nurses. Indigenous nurses are recruited to ease shortages of foreign nurses and fill growing nursing vacancies but are given very little (if any) career development, progression, promotion or social and organizational support. Gulf policy-makers, health managers and community leaders need to rethink their strategies for recruiting, training and retaining indigenous nurses in the present competitive market of global migration. These cannot and should not focus only on human resource strategies to manage the workforce. They will also need to consider those practices that form the norms of behaviour and attitudes toward women and their roles in public life in these countries. Indigenous nurses should not be seen as commodities, human resources or victims of the process but as human beings and partners in the development of their societies and countries.

Indigenous nurses should be respected as they offer the potential for the growth and development of the nursing profession in the Gulf. This requires a willingness to adopt, implement and continually evaluate how certain practices and policies impact on managing workplace differences between indigenous and foreign nurses. This research recognizes that neither government policy nor legislation can replace mutual respect, the sharing of ideas and acceptance between genders and professions.

Investment in strategies to improve basic amenities, infrastructure and working conditions could greatly improve the recruitment, retention and motivation of indigenous nurses. These include strategies that affect management styles; incentives and career structures; salary and benefit scales; and posting and training practices.

6.5.3 Indigenous workers lack skills and experience: myth or fact?

One of the most important findings of this study is the shortage of suitably qualified and skilled indigenous health workers. It is argued here that a number of factors contribute to this. First, few (if any) agencies or external institutions can train unskilled workers in a short enough time or to a level acceptable to (especially private sector) employer. Second, the private sector does not support in-service training although governments consider this the most helpful skill-development method. It is evident that much of the education and training that the workplace requires is general in nature and does not meet the requirements of private sector employers. Low levels of education, little exposure to technical expertise and lack of experience are among the main deficiencies of indigenous workers. Most employers in the three states are unwilling to incur training costs and would pay significantly lower salaries in order to recoup these expenses. One Saudi businessman explained: "Education and training are not our responsibility. They are the responsibility of the government. If we provide training to Saudis then they must accept low salary and benefits. We cannot offer both" (Arab News, 2004).

Without sufficient training and suitable wage and incentive scales indigenous workers are likely to become dissatisfied, reduce their work effort or simply seek employment elsewhere. In turn, employers question the loyalty of indigenous workers and find that they do not take long-term views of career opportunities and training prospects. Hence, private sector employers are unwilling to train indigenous workers and show a strong preference for recruiting and retaining foreign workers whenever the law permits. Given the labour market situation of a rapidly increasing demand for skilled labour and the potential loss of such labour to other employers, it is argued here that there is little incentive to provide training. This has resulted in a labour market that undervalues in-service training and over-emphasizes formal education and training. Indigenous workers are being asked to accept low salaries on the basis that their salary and benefits will rise as their skills and experience increase.

6.6 Gulf education and training systems cannot meet the needs of the labour market

The education system is an important factor in labour market supply. It is evident that the oil boom has financed huge investment – new schools, universities and vocational training centres have been built in the last three decades. This has resulted in a significant increase in the number of college graduates that has not been matched by better quality education or more provision of the specialties needed in the labour market. Students have viewed college certificates as passports to good jobs in the government sector, regardless of the quality or field of their degree. Public service is considered to be a safe haven and increasing numbers enter college as a way of guaranteeing such a job for life. Governments are no longer able to employ large numbers of new recruits and therefore there are surplus college graduates who cannot find jobs. This has produced high unemployment rates in some Gulf countries – reported to be as high as 20% in Saudi Arabia for example (Hardy, 2006).

It is evident from the findings of this study that the existing education systems in most of the Gulf states do not produce the graduates that the labour market requires. Unemployment is reaching alarming levels and has implications for stability and security in some countries. It is argued here that a number of significant developments in the labour market highlighted throughout this study underline the urgent need to transform the skills and roles of indigenous workers, especially health-care staff. Their education and training must keep pace with the changing requirements of the labour market and technological advances. The strategic actions required relate primarily to continuous realignment between education and training programmes, health service needs, evolving roles and work practices (Dubois et al., 2006).

Hiltrop (1996) suggests that a strategic approach requires organizations to take a long-term view of the skills, knowledge and levels of competence that staff will need and to treat their staff as an important resource that needs training and development. It is argued here that the three Gulf states, but especially Saudi Arabia, are facing strategic challenges which include the establishment of quality control systems to educate and train health-care personnel, especially nurses; development of a sustainable educational infrastructure that takes consideration of the lack of suitable teaching staff

and the shortage of nursing colleges; and the implementation of common GCC mechanisms to exchange expertise, training programmes and students.

6.7 International recruitment can be beneficial

The levels of indigenization among nurses and other health professionals are likely to remain variable as each country's social, political, economic and human resource practices will have different impacts in the three Gulf states. At the GCC level, the aggregate effect of foreign workers in general, health-care professionals in particular, is likely to become more prominent in the next few years as demographic, political, economic and labour market changes alter the overall balance. Gulf governments and private sector organizations have not been clear about their indigenization policies.

The positive effects of international migration (e.g. on training, knowledge, professional development) must be weighed against the potential negative consequences on the indigenous nursing workforce. This requires a delicate balance between recognition of the benefits of foreign nurses and collective concern for the indigenous nursing workforce. Successful interventions to support the positive impact of international recruitment and minimize its negative consequences will depend on the level of socio-economic and technological development in each of the Gulf states and long-term strategy commitments from professional and political leaders (Kingma, 2001).

International recruitment can play a positive role in GCC countries if it is utilized to raise the profile of the nursing profession's needs in the Gulf and influence indigenous students to select nursing as a career.

6.8 Availability, accessibility and transparency of data in human resources for health

Accurate and reliable data are critical for planning and for strategic decisions in human resources, both in general and in the health service. The Gulf states have very limited adequate and reliable data on demographic, macroeconomic, labour market

and human resource indicators. These are vital for any effective human resource planning and for strategic labour force decisions. As indicated in this research, no accurate data on health professionals and the health workforce are available in some of the Gulf states, especially Saudi Arabia.

Bahrain and Oman have acted to improve data collection. For example, the Bahraini health ministry has established a comprehensive data system for its health service workforce, covering their distribution, qualifications and training and other related information. The information is being used for staffing health organizations and in staff planning. In addition, accurate data are being used to assess available educational and training programmes and career planning. Such data are urgently required in Saudi Arabia.

6.9 Conclusions and recommendations

The evidence reviewed in this research confirms what many scholars and writers have noted about the Gulf region – severe shortages of indigenous health workers in general and in the nursing workforce in particular. Since the 1970s, the GCC states have relied heavily on foreign health-care personnel to sustain development in their health-care services. However, recent global shortages of health-care workers and severe competition from developed countries have made international recruitment very difficult and costly to sustain. Gulf states seeking other alternatives and solutions to fill these gaps have pursued policies and strategies (indigenization) aimed at increasing the supply of qualified indigenous health-care professionals. These indigenization policies have been discussed in this thesis, particularly in relation to the image of nursing; cultural and social differences; and the role of women. However, these measures have seen uneven development and variable success within these three Gulf countries. Bahrain and Oman, the comparative countries in this research, have introduced some successful indigenization policies to meet their shortages of health-care workers. The indigenization practices in Saudi Arabia suggest that little , if anything has been learned from over three decades' experience of indigenization policy especially in nursing.

Higgins (1981) points out one of the curious and fascinating questions that arises when comparing social policies in different countries – why should there be such an enormous variety of responses to what on the face of it appear to be similar states of need? Most of the Gulf states face the same problems of a shortage of health-care personnel (especially nurses) and how to educate their workforce, yet this research confirmed that no two countries have chosen the same solutions. The comparative study indicates that there is no single strategy or policy for the application of an indigenization policy; each state must adapt policy to local situations. This thesis confirms the importance of comparative studies. These are necessary and useful for systematic examination of attitudes to class, gender and religion and their impact on the development and implementation of certain social policies in the three Gulf states.

The evidence reviewed in this study confirms indigenous women's low participation in the labour market. Also, that the vast majority of those who are employed experience discrimination, lack of recognition and very poor working conditions. Discrimination reduces opportunities for education and training; career development; and full participation in the labour market and in part explains the severe shortage of indigenous nurses in the workforce in most Gulf states. Eliminating or reducing discrimination against women, particularly working women; recognizing their skills; and improving working conditions could increase their participation in the labour market. In turn, this is likely to encourage both public and private institutions to provide more incentives and employment opportunities for indigenous women. It is also evident that the significance and importance of these interventions will vary with the country context and type of organization or activity. For instance, it is unclear to what extent indigenous women in Saudi Arabia would benefit from the interventions mentioned above as no appropriate laws and regulations protect their rights and interests.

The evidence presented here provides new insights into the mechanisms by which the development of the indigenous nursing workforce is linked to inequality and discrimination against women in general and working women in particular. The evidence discussed here suggests that women's freedom of mobility and access to various resources are important factors in determining the extent of future shortages of health-care workers in general and indigenous nurses in particular. There are clear

indications (especially in Saudi Arabia) that restricted mobility and discrimination in both public life and the labour market contribute to limiting women's access to resources and their participation in the labour market.

Numbers of scholars identify a wide range of variables that influence social policy especially internal factors. These include demographic, economic, social structure, political, pressure group, institutional evolution and social psychology factors. These, especially the social and cultural constraints, are considered the major factors in limiting indigenous women's participation in public life and the labour market. Religion plays an important role in all aspects of life in most of these Gulf states, especially Saudi Arabia. It has received relatively little attention in the literature on comparative social policy in the Gulf, partly due to the sensitivity attached to this subject. However, religion and its influence and impact on the development and implementation of various social policies in the Gulf states has been analysed and examined in detail in many instances in this research.

This research confirmed that the considerable growth in expenditure on education (especially for women) and the new initiatives to reduce discrimination against women in recent years have contributed to the decline of the religious establishment's influence on social policy development, especially in Saudi Arabia. This research confirmed that social and cultural constraints in these Gulf states affect women more than men and contribute to their invisibility and vulnerability.

In addition, this research has highlighted the deficiencies and uneven quality of data, especially those related to human resources and labour markets. It confirms the lack of standardized data and comparable databases and the poor quality of available data. With no comprehensive systematic national database relevant to the health-care labour market and employment statistics in most of these states it is very difficult to make an adequate analysis of health-care supply and demand across these three countries.

This thesis has confirmed and stressed the importance of image as a key to improving indigenization in the nursing workforce. One important finding is that many

indigenous people in most Gulf states continue to hold negative perceptions of the profession of nursing.

Inadequate human resource planning, poor working conditions, inadequate compensation, lack of career opportunity, unequal promotion management and other human resource practices are critical issues that impact on indigenous nursing shortages in these three states. Nurses in different Gulf states undertake similar roles but show variations in their basic education, career structures, wages and titles. Many indigenous and foreign nurses experience problems caused by poor working conditions, discrimination and lack of recognition of their skills. These result in employment on lower grades, irrespective of speciality and experience. Improved access to education and training can help indigenous women to develop expertise and expand their knowledge and experience to enable them to compete with foreign workers. Efforts to raise women's participation in the labour market and improve the quality of their employment will succeed only if they go beyond the social and cultural constraints that bar women from full participation in public life.

Current strategies towards indigenization in the nursing workforce are neither friendly nor accessible to indigenous women in general and working women in particular. Clearest proof of this is seen in Saudi Arabia, where HRDF services and resources are directed towards men – women are either excluded or allowed very limited access. Other important issues such as gender-based discrimination in various sectors in the Gulf states and differential access to resources and opportunities have been raised in this research and also need to be addressed.

This research details how social and institutionalized discrimination in the Gulf health-care sector may be internalized by indigenous and foreign workers, affecting career progression and promotion opportunities. Currently, few interventions are concerned with issues such as discrimination and differential access to education, training, career development and employment opportunities in so-called male dominated areas and activities. However, such actions will require policy-makers to take difficult decisions and undertake measures with clear support from political leaders in these Gulf states.

Recruitment and retention strategies for both indigenous and foreign nurses are critical for increasing the number of nurses. Investment in strategies to improve working conditions and reduce discrimination against women could greatly improve the recruitment, retention and motivation for both indigenous and foreign nurses. This thesis confirmed that much of the existing education and training is general in nature and does not meet the requirements of the health service sector, especially in Saudi Arabia. Low levels of nursing education, a lack of faculties, limited exposure to technical expertise and lack of experience are among the main deficiencies for the indigenous nursing workforce. This research emphasized the important role played by foreign nurses in the three Gulf states. In addition, it confirmed that the employment conditions of foreign nurses have reinforced patterns of disadvantage based on gender, race and religion.

Evidence from this research suggests that both public and private sectors in most of these Gulf states (especially Saudi Arabia) were unprepared for the implementation of indigenization policies. Analysis of indigenization policies in their current formats suggests that they face many challenges and have produced negligible results to date, especially in the health service. Policy-makers and governments have been unable to handle some of their adverse effects. Also, in some countries the public were unprepared. They understood neither the content nor the objectives as the policies themselves were ambiguous. Some decision-makers are reluctant to undertake reform of human resources in the face of opposition from strong pressure groups such as religious and business groups. Also, some governments are failing to pursue aggressive indigenization reform programmes despite much favourable rhetoric. A series of delaying tactics has been followed by a deal with strong forces rather than reform programmes.

Slow policy responses in the past may have been responsible for the shortages of indigenous workers in general and in the health-care service in particular in most of the Gulf states. However, unemployment is reaching alarming levels and has implications for stability and security in most of the Gulf states, especially Saudi Arabia. It is argued here that a number of significant developments in the labour market highlighted throughout this study underline the urgent need to transform the skills and roles of indigenous workers, especially health-care staff. Their education

and training must keep pace with the changing requirements of the labour market and technological advances.

Finally, this research has raised a number of potential policy impacts which are summarized below.

1. The body of work and knowledge on human resources and nursing in Arab countries in general and the Gulf in particular is currently very small in comparison to that available for industrialized countries. This research aims to contribute to that body of work.
2. Human resource issues in these Gulf countries are very important, particularly in health care. Some of these issues (e.g. unemployment; shortages of qualified personnel, particularly nurses) continue to be major public problems. This research aims to contribute to understanding of the effects and effectiveness of some measures and interventions in order to contain and limit any negative impacts.
3. This research provides knowledge and information on the nursing profession and the barriers that prevent indigenous women from becoming nurses in these three countries.
4. This research provides insights and information for policy and decision-makers not only in the three countries concerned but for all GCC countries. Also, it informs future human resource studies.

Many important and unanswered questions regarding indigenization remain, including:

1. How realistic is the current policy on indigenization?
2. Should indigenization be implemented from grassroots level or from the top?
3. Is 100% indigenization in certain sectors practical and economical?
4. How can a balanced policy be achieved?
5. Will a mass departure of foreign workers have adverse effects on the economy and the expertise that these countries need?

6.10 Future research

If officials in Gulf states were asked to pick the one thing that might bring about major labour market change, what would they choose? Most stakeholders might opt for their favourite – an indigenization policy. However, there is a need for modern, flexible and well-developed human resource laws and regulations to keep pace with changing labour market conditions both internally and globally. Stakeholders should also think of changing the way that people and organizations across the Gulf states interact with each other and the decision-making processes. Increased levels of coordination and cooperation between Gulf states could solve common and similar problems related to the workforce, especially in the health service.

This research has concentrated primarily on the nursing work force and indigenization in three Gulf states but would be complemented and expanded by future research in four areas. Firstly, on the dynamic relations and collaboration between various public and private health organizations. Secondly, to acquire greater understanding of the policy and decision-making processes in the Gulf and the roles of various institutional players. Thirdly, on evaluations of indigenization policies in the Gulf states. The present research compared three cases of indigenization but a comprehensive evaluation of indigenization policies in all six Gulf states is required. The fourth and final area for further research is the need for greater focus on the roles of gender, religion and culture and how they affect Gulf women's full participation in the labour market.

This research has attempted to fill a gap between two distinct fields of literature – human resources for health in the Gulf states and the role of social and cultural factors in women's participation in public life and the labour market in the Gulf. There is a natural alliance and close relationship between these two fields that has only recently been recognized in the Gulf. Findings and analysis from this research hopefully will encourage scholars from both fields and from other disciplines to examine further this relationship. This would provide a broader foundation to enable indigenous people (both males and females) to participate equally in the development of human resources in general and the health service in particular.

I consider that the social and cultural barriers highlighted by this study are those that lie within the norms and spirit of the indigenous people of the Gulf. Human resource barriers are those that relate to work and the organizational environment that shapes and supports indigenous nurses. These barriers appear independent but do (at some level) occupy the same space and are interdependent with potential huge impacts on nursing development in the Gulf. I call the blending and interaction of these social, cultural and human resource barriers: the barrier of modernization.

This study has also highlighted the tensions and problems embedded in research undertaken in Gulf countries – limited available data, a lack of transparency and a dearth of previous nursing research. This thesis ends by reporting a great step forward – Saudi Arabia opened its first university for women in November 2008. Perhaps this will herald a new era in education for Saudi women.

Appendices

Appendix 1: Selected social and economic indicators in three Gulf states, 2006–2007)

Category	Saudi Arabia	Bahrain	Oman
GNP per capita (US$)	10 140	14 370	9 070
Population			
Total (millions)	26.417	1.038	3.1
Female (% of total)	46	64	43.4
Life expectancy at birth (years)			
Male	72	75	73
Female	74	76	76
Adult (15+) literacy rate			
Male (%)	87.1	88.6	86.8
Female (%)	69.3	83.6	73.5
Labour force participation			
Total labour force (millions)	8	0.420	1
Female (% of total labour force)	15	19	16
Ratio of female to male labour force participation	23	34	27
Unemployment			
Total (% of total labour force)	13-25	15	15
Educational access and attainment			
Net primary school enrolment rate			

Male	77	96	77
Female	79	97	79
Youth (15-24) literacy rate (%)			
Male	97	97	97.9
Female	95	97	96.7
Health			
Total fertility rate (births per women)	3.17	2.4	4.5
Maternal mortality ratio (per 100 000 live births)	33	28	87
Infant mortality rate (per 1000 live births)	17.4	9	10
Total number of hospitals	338	9	48

Sources: World Bank Group, 2006; Ministry of Health, 2006a; Ministry of Health, 2006b; Ministry of Health, 2006c.

Appendix 2: Main search methods

Key words and phrases

All key words and phrases were used to search for data for indigenization, nursing shortages, human resources for health, GCC health service, gender and women. Differing titles were found in the general search in both English and Arabic languages and were then used as search words. The list below gives examples and is not comprehensive.

Arab nursing labour market
Gulf states labour market
Nursing workforce
Foreign nurses in the Gulf
Shortage of nurses
Shortage of nurses in the Gulf
Globalization of nurse labour market
Human resources for health
International labour market
International nursing labour market
Labour market analysis
Nurse retention
Nurse job satisfaction
Nurse turnover
Workplace conditions
Culture and religion in the Arab world
Role of women in the Gulf states

Sources

Databases	Electronic databases Various educational institutions and libraries
Published literature	Science Direct Healthstar/Ovid Various health journals (Arabic/English)
Grey literature	Unpublished PhDs Unpublished reports (Arabic/English)
International and national centres and organizations	International Labour Organization (ILO) Health Ministries Council in Gulf Countries HMMC/GCC International research centres online library GCC Online International Council of Nurses International nursing organizations National Health Service (UK) Royal College of Nursing (UK) World Health Organization Bahrain Ministry of Health Oman Ministry of Health Saudi Arabian Ministry of Health Bahrain Ministry of Labour Oman Ministry of the Civil Service Saudi Arabian Ministry of Planning

Appendix 3: Indigenization (Saudization) legislation and development plans

Number and type of legislation	Subject and objectives
Labour Law(M/21) 1969	Terms and conditions of employment Gives preference to indigenous workers
50/1995 Decree of Council of Ministers	Sets national objective to replace foreign workers with Saudis when possible Sets 5% annual Saudization target for any company employing more than 20 people
7/B/4010/1996 Royal Decree	Stresses importance and necessity of implementing all terms and regulations of Decree Number 50 issued by Council of Ministers in 1995
M/8/1995 Royal Decree	Urges private sector to limit recruitment of foreign workers and increase numbers of Saudis Sets fees and tariffs for foreign workers e.g. for transfer of sponsorship and work visas; increased recruitment costs
107/2001 Decree of Council of Ministers	Establishment of Human Resources Development Fund (HRDF) stipulating responsibility for training, assisting and providing funds to employ Saudis in the private sector
Saudi Development Plans (SDPs)	**Objectives related to indigenization**
Third SDP (1980-1985)	Ensure adequate supply of labour Increase productivity Reduce dependency on foreign workers
Fourth SDP (1985-1990)	Introduce Saudization policy Targets to reduce number of foreign

	workers and increase number of Saudis
Fifth SDP (1990-1995)	Stress importance of employing Saudis Incentives to encourage private sector to employ more Saudis
Sixth SDP (1995-2000)	Prioritize important objectives in development of human resources Stress importance of quality in education and training Impose certain regulations on private sector to reduce recruitment of foreign workers
Seventh SDP (2000-2005)	Increase private sector's role in applying Saudization and incentivize by granting more projects to firms that encourage Saudization Increase role of, and support for, HRDF to absorb more Saudis and offer more training opportunities

Appendix 4: HRDF mechanism for funding qualified Saudi candidates in the private sector

Funding training course (HRDF)
Potential employer contribution (private sector) [share cost]
After successful completion of training
Employment by private sector that incurs half employee's salary
Government (HRDF) incurs other half of employee's salary for two years
After two years employer becomes fully responsible for employee

Appendix 5: Participant interview letter

Subject: Request for interview

From: Kasem Al Thowini

To: Stakeholders

I am contacting you about an interview I would like to conduct relative to my PhD at the London School of Hygiene & Tropical Medicine on the shortage of indigenous nurses and an indigenization policy in three Gulf states: Saudi Arabia, Bahrain and Oman. The tentative title of my dissertation is "Toward the indigenization of the nursing workforce in Saudi Arabia". My primary research question is "What are the main factors inhibiting or promoting indigenous women to consider nursing as a career in Saudi Arabia?" There are a number of other questions related to the issue that I would like to discuss with you if possible. The interview will take no longer than 60-75 minutes. Could you please let me know if you would be willing to take part in the study and if so when it would be convenient for me to contact you about conducting this interview?

I would like to conduct these interviews in the next several weeks. I look forward to hearing from you.

Yours sincerely,

Kasem Al Thowini

E-mail: Kasem Al-Thowini@lshtm.ac.uk

Contact numbers: London: 0044 208 740 1424. Mobile: 7947472058

Saudi Arabia: 00966 1 05546 5614

Appendix 6: Participant interview letter in Arabic

السيد\ السيدة

تحية طيبة

حيث اني ارغب في مقابلتكم بخصوص بحث الدكتوراه الذي اقوم به بجامعة لندن حول نقص الممرضات الوطنيات و سياسات التوطين في دول الخليج و خاصة المملكة العربية السعودية والبحرين و عمان وان السؤال الرئيسي و الذي يحاول البحث الإجابة هو : ما هي ابرز المصاعب و المحفزات التي تمنع او تشجع انخراط المراة الخليجية في هذه البلدان في مهنة التمريض ؟ هناك أيضا عدة أسئلة أخرى تتعلق بنفس الموضوع الذي آمل مناقشته معكم.

سوف لن تستغرق هذه المقابلة أكثرمن ساعة. آمل منكم في حال الموافقة ابلاغي بالموعد المناسب لكم لاجراء المقابلة.

وشكرا لكم

الباحث : قاسم الثويني

Kalthowini@hotmail.com

Appendix 7: Interview process

At the start of the interview, the researcher went through the research information sheet, explaining the research purpose and guaranteeing anonymity. Each interviewee read and completed a consent form and the researcher asked permission to audiotape the interview. The structure and key themes of the interview guide were presented to each interviewee before starting the interview. The interview guide had three sections: (i) personal details; (ii) work life and experience, (iii) experiences working with indigenous nurses and indigenization policy. Finally the interviewees were asked if they had anything to add in respect of indigenization of the nursing workforce and nursing profession in the three Gulf states.

In accordance with the qualitative interview technique and semi-structured approach there was some flexibility in the way that the interview guide was followed. The researcher was keen to explore stakeholders' own stated concerns and encouraged a natural flow in the conversation. The researcher engaged in dialogue with the interviewee to explore individual themes and viewpoints. Jackson (2005) suggests that dialogue requires one to find something in one's own experience that is similar, or approximate, to the experience of the other and therefore may bridge the gap between the two.

Each interview generally lasted around one hour. In some cases the interviewer had to compress questions when there was less time to explore detailed individual experiences. Some interviews had no particular time constraints and some lasted more than two hours, enabling the interviewee to describe and elaborate on particular events. The only exceptions to these one-to-one semi-structured interviews were four group interviews: (i) a group of three nursing female students in Saudi Arabia preferred to be interviewed together in the college dean's office; (ii) four Omani nursing education personnel preferred to be interviewed together because of time constraints; (iii) three other Saudi female nurses preferred to be interviewed together; and (iv) three Omani nurses wished to be interviewed together. The same interview process was used. Most women, especially the young, preferred to be interviewed in groups because of the local culture, shyness and religious requirements that a woman should not be alone with a strange male.

Appendix 8: Interview guide

A- General questions

1- What is the nature of your job?

2- How long have you worked in this position?

3- What do you like about your job?

4- What do you not like about your job?

B- Specific questions

1- Do you have a shortage of staff? If yes:

2- What are the areas most affected by such a shortage?

3- Do you have a shortage of indigenous qualified personnel? If yes:

4- What are the areas or specialty most affected by the shortage?

5- How critical is the shortage and what effect does it have on health-care delivery?

6- What is the percentage of indigenous nurses in your nursing workforce?

7- Do you have an indigenization policy or programme? If yes:

8- How do you define indigenization precisely and how was it started?

9- What are the main objectives of this policy?

10-Who are the stakeholders interested in this policy in your organization and why?

11-How do managers view the indigenization policy results?

12-Are there assessment or evaluation criteria in place for this policy or programme?

13-What types of human resource practice are used?

14-What tactics or policies are used?

15-As a departmental manager what are your three greatest problems with the indigenization policy?

16-Which processes do you think need review and change?

17-What role do human resource managers play in indigenization activities?

18-What are the future plans of indigenization and what role will it play in increasing the number of indigenous nurses?

19-Who has the overall responsibility for implementing indigenization?

20-Should indigenization programmes operate at the national or regional level?

21-What considerations influence the choice of indigenization programmes?

22-What are the guidelines that policy-makers follow in designing indigenization programmes?

23-What are the different models of human resource management related to indigenization systems in the health sector in your country?

24-How are indigenization performances indicators applied and used?

25-What are the methods used to assess the effect of indigenization in your country?

26-What are the principal lessons to be learned from current applications of indigenization policy?

27-What are the differences and similarities between the current indigenization programmes in the health service and other sectors?

Appendix 9: Sample of translated interview questions (Arabic)

عينه من أسئلة المقابلات الشخصية

أ- أسئلة عامة

١.ما هي طبيعة العمل الذي تمارسه؟

٢. منذ متى وأنت على رأس عملك الحالي؟

٣. ما هي ألأشياء التي تحبها في عملك؟

٤. ما هي ألأشياء التي لا تحبها في عملك؟

ب- أسئلة في طبيعة العمل

١. هل يوجد لديك نقص في الموظفين؟ إذا كانت ألأجابه بنعم
٢. ما هي ألأقسام التي تعاني من هذا النقص؟
٣. هل تعاني نقص في أعداد الموظفين المواطنين؟ إذا كانت ألأجابه بنعم
٤. ما هي ألأقسام أو التخصصات التي تأثرت بهذا النقص؟
٥. ما هو تأثير هذا النقص على الخدمات الصحية؟
٦. كم نسبة الممرضات الوطنيات؟
٧. هل يوجد لديكم نظام معمول به لتوطين الوظائف؟ إذا كانت ألأجابه بنعم
٨. ما هو تعريفك لمفهوم التوطين وكيف بدأ؟
٩. ما هي أهداف سياسة التوطين؟
١٠. من هم المهتمين الرئيسيين بسياسة التوطين ولماذا؟
١١. كيف يقيم المديرين نتائج هذه السياسات ؟
١٢. هل يوجد نظام لتحليل مدى نجاح سياسات التوطين؟
١٣. ما هي الطرق والأساليب ألمتبعه في إدارة الموارد البشرية؟
١٤. كمدير أداره ما هي المشاكل والمصاعب التي تواجه سياسات التوطين؟
١٥. ما هي ألأساليب أو ألإجراءات التي تعتقد أنها تحتاج إلى تغيير أو إعادة نظر؟
١٦. ما هو الدور الذي يقوم به مدراء الموارد البشرية في تطبيق سياسات التوطين؟
١٧. ما هي الخطط ألمستقبليه لسياسات التوطين وما هو دور هذه الخطط لزيادة نسب التوطين؟
١٨. من المسئول ألأول عن تطبيق خطط وسياسات التوطين؟
١٩. هل تعتقد أن سياسات التوطين يجب أن تكون على المستوى المحلي والوطني؟
٢٠. ما هي العوامل التي تؤثر على نوع اختيارات برامج التوطين؟
٢١. ما هي الطرق والموجهات التي يسلكها واضعي السياسات عند وضع برامج التوطين؟
٢٢. ما هي النماذج المختلفة والمتبعة في إدارة الموارد البشرية واتي يستعان بها عند إعداد خطط التوطين في المجال الصحي في بلدك؟
٢٣. ما هي المعايير ألمستخدمه لقياس مدى نجاعة ونجاح سياسات وخطط التوطين؟
٢٤. ما هي الطرق والأساليب ألمتبعه لقياس مدى جدوى خطط وسياسات التوطين في بلدك؟
٢٥. ما هي الدروس التي من الممكن تعلمها من التطبيق الحالي لبرامج التوطين؟
٢٦. ما هي ألاختلافات والتشابهات ما بين خطط وسياسات التوطين في القطاع الصحي وغيره من القطاعات ألأخرى؟
٢٧. هل يمكن ألأستفاده من الخطط والسياسات ألأخرى المطبقة في القطاعات ألأخرى وكذلك المطبقة في دول أخرى؟

Appendix 10: Data management and analysis

Shortly after each interview the researcher described the setting in a note and detailed key themes emerging from the interview in order to capture immediate insights. The audiotapes were transcribed verbatim and then coded as the researcher listened to the audiotape and corrected the transcription where necessary. While coding manually, the researcher made case-specific notes to capture the in-depth themes emerging from the data. The purpose and content of each code were defined and noted in a logbook to provide an audit trail of evidence. Each interview was given attributes detailing key variables to allow grouping of cross-case data retrieval. The researcher held regular meetings with his supervisors over the period of the study to discuss the coding strategy and empirical and theoretical insights as the research progressed. Discussions with supervisors and others stimulated a valuable richness and multi-dimensionality in the analytical process. The ongoing analysis of data was supported by regular meetings with supervisors who included people with knowledge of policy, nursing workforce and career development issues relevant to the study.

Appendix 11: Fieldwork memo

Title:	Memo 49
Issue:	Differences in social life/role of women
Date:	Tuesday, 8 March 2005
Location:	Bahrain

When I visited the college of Allied Medical Science and Nursing, I was struck by the differences of atmosphere between this college and … one of the colleges of nursing in Saudi Arabia I visited earlier. Although Bahrain is only half an hour drive from the Saudi border, differences between the two countries (especially in social life), are huge. Female students here have the freedom to come and go as they wish, interact with other male students, use public transportation and are taught by male teachers. In the Saudi nursing college, female students complained of the restrictions imposed on their freedom. They are not able to leave their college accommodation unless accompanied by one of their male relatives. Women in general in Bahrain have more freedom and can drive and feel independent. Is there any correlation between freedom for women and choosing a profession? Would Saudi nursing schools be more attractive if female students enjoyed the same freedom as their counterparts in Bahrain? In your next interview with … raise the issue of role of women and freedom of women on nursing.

Appendix 12: Consent participation form

Consent to participation in research

Title: Human resources practices in the Gulf: the recruitment of indigenous nurses

Researcher: Kasem Al-Thowini

Address: London School of Hygiene & Tropical Medicine

32 Keppel Street, London, United Kingdom WC1E 7HT

E-mail: Kasem.Al-Thowini@lshtm.ac.uk

Supervisors: Professor Anne-Marie Rafferty

Dr Jill Maben

Aim: you are being asked to participate in this research that seeks to study and examine the shortage of indigenous nurses and the indigenization policy in three Gulf states: Saudi Arabia, Bahrain and Oman.

Risks and benefits: there are no known dangers or risks from participating in this research, nor will there be any direct benefit in terms of financial compensation. Hopefully, however, there will be some benefits for the nursing development in the Gulf after the research is completed.

Right to withdraw: you have the right to withdraw from this study at any time.

A summary of findings will be provided to you on request free of charge.

Voluntary consent: I, ..., have read and understood what is being required from me to participate in this study. I understand that I can withdraw from this study any time I wish and I also understand that there will be no compensation or direct benefits for me. I certify that I am agreeing to participate in this study.

Participant's signature: Country: Date:

Appendix 13

Arabic consent participation form

اسم البحث: توطين مهنة التمريض في دول مجلس التعاون الخليجي: دراسة مقارنه لثلاث دول السعودية-البحرين-عمان.

اسم الباحث: قاسم محمد عبدالله الثويني

المشرفين ألأكاديميين: البروفسوره آن ميري رفرتي

الدكتوره جيل مابن

الهدف: المشاركة في بحث دراسي يهدف إلى معرفة وضع ومشاكل مهنة التمريض في دول مجلس التعاون الخليجي وخاصة في المملكة العربية السعودية ومملكة البحرين وسلطنة عمان. كما يهدف البحث إلى معرفة النقص الحاد في أعداد القوى العاملة الوطنية في مهنة التمريض والأسباب التي تؤدي إلى عزوف المواطنين عن ألانخراط في مهنة التمريض.

ألأخطار والفوائد: لا يوجد أخطار متوقعه أو فوائد مباشره من ألاشتراك في هذا البحث. إلا أن فوائد ألبحث بعد ألانتهاء منه ستكون ممكنه بالاستفادة من استنتاجاته وتوصياته.

ألتعويضات: لن يكون هناك أي تعويضات أو مزايا أو تكاليف ماليه مقابل ألاشتراك في هذا ألبحث.

سرية المعلومات: لن يظهر اسم أي من المشتركين في هذا البحث أو أي معلومات شخصيه عنهم. كل الموافقات والمراسلات والمقابلات مع المشتركين سوف تكون في أمان وسريه عند الباحث ولن يطلع عليها أحد. بعد ألانتهاء من البحث و سوف يتم إتلاف كل هذه المعلومات من قبل الباحث.

حق ألانسحاب: للمشارك في هذا البحث حق ألانسحاب في أي وقت يشاء وبدون أي أدنى مسئوليه عليه.

ألنتائج والتوصيات: سوف يقدم لكل مشارك في هذا البحث موجز عن نتائج هذا البحث وتوصياته حسب الطلب من قبل المشارك كتابيا للباحث لتزويده بهذه المعلومات.

موافقة المشترك: نعم أنا المشارك-المشاركة في هذا البحث قد اطلعت على أهداف ومتطلبات وشروط هذا البحث وأوافق على ألاشتراك فيه وعلى هذا أوقع

اسم المشارك:

التوقيع :

التاريخ :

توقيع الباحث :

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