

Nursing Political Leadership and Governance Participation in the Arab Gulf: A Comparative Analysis of Bahrain, Kuwait, Oman, and Yemen

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Abstract

Nursing constitutes the largest healthcare workforce globally, yet nurses remain underrepresented in governance and policy leadership across the Arab Gulf region. Despite clinical excellence, a strategic gap persists between nursing's service contribution and its political authority. To examine the extent of nursing political leadership and governance participation across Bahrain, Kuwait, Oman, and Yemen, identifying structural barriers and enablers to professional advancement. Qualitative comparative analysis using survey responses, policy documents, and historical records. A multi-level maturity model was proposed to classify recognition systems, health system impact, and governance representation. Bahrain and Oman serve as the regional benchmarks, both achieving Level 4 (National/Structural Impact) maturity through parliamentary representation, regulatory inclusion, and the institutionalization of nursing within national strategic agendas like Vision 2040. While Kuwait demonstrated institutional leadership, it remains restricted by limited political pathways, and Yemen continues to exhibit foundational governance structures maintained despite ongoing conflict. No country has yet reached Level 5 maturity or achieved equivalent standards to Western nursing political leadership models. Key barriers to further advancement include physician-led hierarchies, expatriate workforce dominance, the absence of political competency curricula, and limited professional association infrastructure. Nursing political leadership in the region requires paradigm shifts from clinical service provision to strategic governance partnership. Establishing autonomous regulatory bodies, integrating political competency into nursing education, and creating leadership pipelines are essential for sustainable health system reform.

Publication History:

Received: September 13, 2026

Accepted: October 01, 2026

Published: October 03, 2026

Keywords:

Nursing leadership, political competency, Gulf Cooperation Council, health policy, professional governance, nursing advocacy, serves, legacy

Introduction

Nursing is the largest segment of the global health care workforce [1], but there is still a significant "strategic gap" present between clinical contributions and political authority [2]. Nursing has been numerically dominant, but the voices of nursing professionals are not heard at the highest levels of government or in the boardrooms of major corporations [3]. The WHO State of the World's Nursing Report (2020) highlights this gap, noting that nurses are critical to achieving universal health coverage; however, they are underrepresented in the development and implementation of health care policy [4, 5]. The IOM Future of Nursing (2010) established a worldwide call for change [6] and recommended that nurses practice to their full educational potential and serve as equal partners in the redesign of health care, workforce development, and policy formulation [7]. This report presented an important paradigm shift to view nursing professionals as more than just clinical providers of care, but as strategic governance partners in their own right.

The Arab Gulf undergoes healthcare transformation via infrastructure expansion and nationalization programs ("Omanization," "Saudization") reducing expatriate reliance [8, 9]. Globally, ~28 million nurses face a 4.5 million shortage; regionally, ~250,000–300,000 nurses operate within expatriate-dependent systems. Bahrain's nationalization reached 42% (1991) but declined to 36% (2023), while Kuwait's educated nationals remain a clinical minority [10]. Gender reforms, Kuwaiti women's 2005 enfranchisement, and Saudi Vision 2030 [11] reshaped leadership. change throughout pregnancy and the postpartum period. Therefore,

supporting women during this transition requires clinicians to understand each woman's situation as a whole and to integrate diverse sources of clinical informBahrain benchmarks regional progress, integrating nurses into the Parliament/Shura Council [12]. Yemen demonstrates resilience amid conflict, with nursing education since 1951 [13] and a nurse elected to Parliament in 1998 [14, 15].reflecting enduring professional leadership.

There is a significant "strategic gap" between nursing being the largest workforce in the health sector and a lack of meaningful participation in national governance [16, 17]. Although clinical excellence exists, there have been systematic barriers to nurses in Bahrain, Kuwait, Oman, and Yemen being part of independent regulatory bodies and legislative institutions. These barriers are due to physician hierarchies with no teaching of political competency and can only provide operational duties for nurses as opposed to having independent policy authority from episodic clinical awards. There has not been a level five maturity for any country; thus, nursing leadership is not sustainable, personalised and is not able to transition to long-term governance.

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Citation: Hasani F, Al-Maqbali MR, Alshammari M, Ali AL Shaabi YM, Alnomasy N (2026) Nursing Political Leadership and Governance Participation in the Arab Gulf: A Comparative Analysis of Bahrain, Kuwait, Oman, and Yemen. Int J Nurs Clin Pract 13: 447. doi: <https://doi.org/10.15344/2394-4978/2026/447>

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The primary aim of this study is to assess the current state of nursing political leadership and governance participation across Bahrain, Kuwait, Oman, and Yemen. Guided by this aim, the study addresses three research questions:

- RQ1: To what extent do Bahrain, Kuwait, Oman, and Yemen have formalized national honorific systems (equivalent to "Fellow" or "Living Legend" status) that recognize extraordinary nursing contributions, and how do these systems vary in maturity from ceremonial to national prestige recognition?
- RQ2: What evidence exists that nurse leaders in Bahrain, Kuwait, Oman, and Yemen have made lasting, structural impacts on national health systems (e.g., law or regulation change, permanent program creation, governance reform), and at what maturity level does each country's nursing leadership currently operate?
- RQ3: In what formal capacities (elected, appointed, or advisory) are nurses currently represented in national governance bodies, health policy committees, and legislative institutions across Bahrain, Kuwait, Oman, and Yemen, and what structural barriers prevent advancement to higher governance tiers?

This research contributes to the global nursing evidence base by conducting a comparative analysis of political leadership and governance participation across Bahrain, Kuwait, Oman, and Yemen. By introducing a multi-level maturity model (0–5), the study provides a practical research and evaluation framework for tracking nursing's evolution from clinical service delivery to strategic policy engagement. Theoretically, it clarifies the "service versus legacy" paradox, demonstrating how episodic clinical recognition fails to

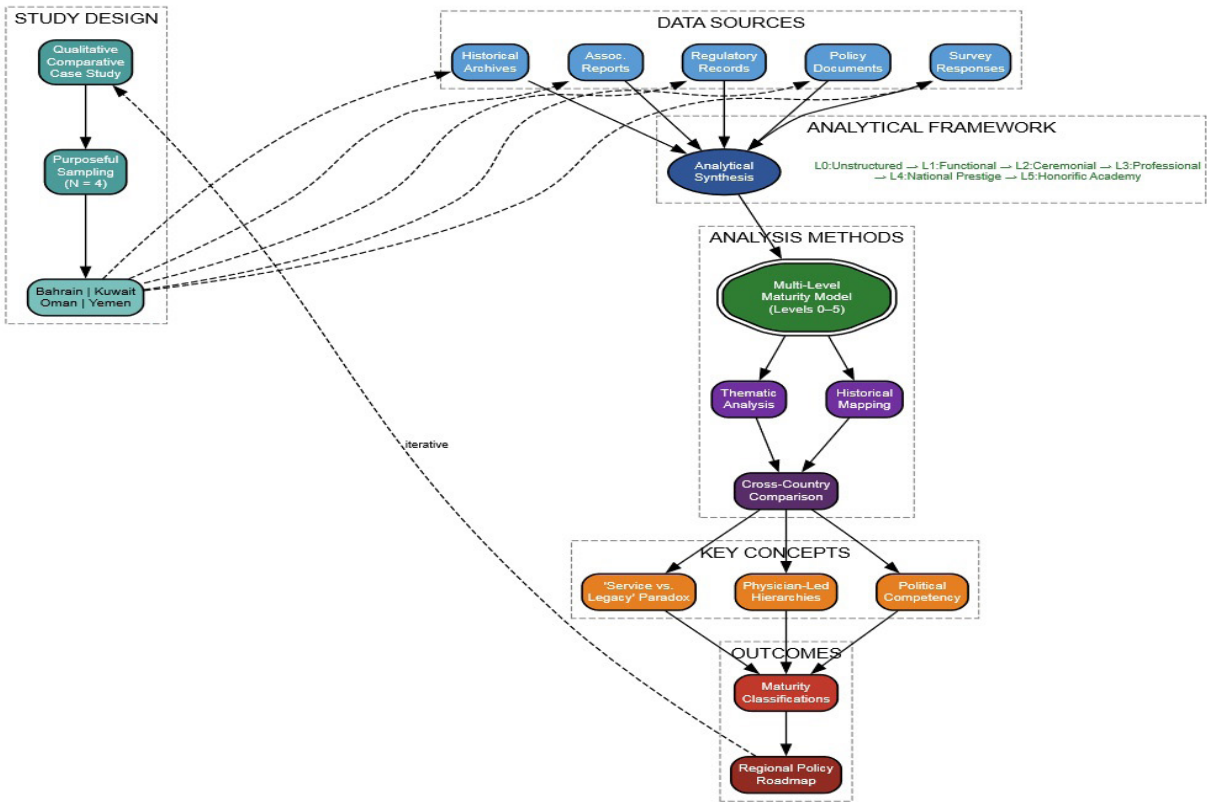
institutionalize professional authority within physician-dominated health systems. From an educational and practice perspective, the findings offer actionable insights for nursing training and curriculum development, emphasizing the critical need to embed political competency, health policy literacy, and leadership preparation into nursing education. Empirically, the study delivers evidence-based recommendations for strengthening nursing practice standards, establishing autonomous professional governance, and designing targeted leadership pipelines. Ultimately, this work advances nursing research and workforce development by offering a scalable analytical tool and policy roadmap that can inform nursing education reform, professional practice enhancement, and strategic leadership training across diverse healthcare systems worldwide.

Materials and Methods

Research design

The analytical core of this research is the application of a six level maturity model (Levels 0–5) developed inductively by the research team. The model was constructed through iterative analysis of regional policy documents, historical records, and survey data from nursing leaders across the four countries. Although conceptually informed by established maturity modelling traditions such as the Capability Maturity Model (CMM) and aligned with governance principles articulated by the ICN and the IOM Future of Nursing report, the framework itself is original and not derived from any existing ANA model. It was specifically designed to evaluate nursing's progression from clinical service roles to strategic governance authority within the Arab Gulf context.

Figure 1: Qualitative comparative case study design and multi-level analytical framework.



Sampling approach: selective purposeful sampling

The study utilizes selective purposeful sampling (also termed purposive sampling) to identify information-rich cases that offer depth and contextual relevance regarding nursing’s political trajectory. This methodology was chosen over statistical generalization to prioritize expert-level insights and a nuanced understanding of the historical and structural pathways to leadership in specific Arab contexts, and qualitative research questions are driven by the need for the study, as a result of the problem and purpose, which leads to exploratory questions focused on the actual phenomenon under study and were developed by one of the members of the research group.

Country selection criteria: The primary inclusion criteria required nations to be either members of the Gulf Cooperation Council (GCC) or, in the case of Yemen, a regional peer with a documented history of professional nursing development. Furthermore, final selection was contingent upon data availability, specifically the receipt of a sufficient number of completed survey responses from national nursing leaders and academics to achieve thematic saturation.

Exclusion criteria: Despite their strategic importance, Saudi Arabia, the United Arab Emirates (UAE), and Qatar were excluded from the final analytical dataset. Saudi Arabia was omitted because it yielded only a single survey response, failing the minimum threshold for reliable cross-country comparison. The UAE and Qatar were excluded due to a total lack of survey participation, which prevented a robust assessment of their political competency frameworks and leadership structures.

Table 1: Study sampling and participation summary

Country	Status	Rationale for Inclusion or Exclusion
Bahrain	Included	GCC member; strong data availability and advanced political engagement.
Kuwait	Included	GCC member; sufficient survey responses; established nursing history.
Oman	Included	GCC member; sufficient survey responses; unique regulatory model.
Yemen	Included	Regional peer; sufficient survey responses; unique post-conflict context.
Saudi Arabia	Excluded	Insufficient data; only one survey response received.
UAE	Excluded	No survey participation.
Qatar	Excluded	No survey participation.

Data sources

The study’s data architecture is built on a triangulated approach, integrating primary and secondary sources to capture the full spectrum of nursing’s political trajectory in the region. Primary data comprises survey responses from a purposive sample of national nursing leaders, academics, and policymakers (N=24 total across included nations). These surveys provide qualitative insights into perceived recognition systems, leadership maturity, and structural barriers. A total of 24 participants were recruited using selective purposeful sampling to ensure representation from senior nursing leaders, academics, and policymakers across the four included countries. The sample consisted of Bahrain (n=8), Kuwait (n=4), Oman (n=8), and Yemen (n=4). Participants were identified through professional networks, national nursing associations, and ministry-

level contacts. Recruitment occurred between January and March 2024, and all participants received an electronic invitation outlining the study purpose, confidentiality protections, and voluntary participation rights.

The survey instrument consisted of eight open ended questions designed to elicit expert perspectives on political competency, recognition systems, governance participation, and structural barriers. Questions were developed by the research team and piloted with two external nursing scholars to ensure clarity and relevance. Responses were collected electronically via secure forms and analyzed using thematic analysis.

Saturation was determined when no new conceptual categories emerged across successive responses within each country group. Saturation was achieved at n=8 for Bahrain and Oman, and at n=4 for Kuwait and Yemen, consistent with qualitative standards for expert level sampling. All data were anonymized prior to analysis.

Secondary data consists of a comprehensive review of national policy documents and regulatory records, such as the National Health Regulatory Authority (NHRA) frameworks in Bahrain and the Oman Nursing and Midwifery Council’s strategic plans. Professional association reports from the Kuwait Nursing Association (KNA) and the Bahrain Nursing and Midwifery (BNMS) Society were analyzed to evaluate the strength of independent advocacy. Finally, the analysis draws on historical archives and scholarly literature to map professional evolution, dating back to the establishment of the first nursing schools in Yemen (1951) and Bahrain (1959). This multi-source synthesis ensures a robust evidence base for evaluating the "strategic gap" between clinical contribution and governance authority.

Table 2: Summary of Data Sources and Participation.

Data Source Category	Specific Examples	Application in Study
Survey Responses (N=24)	Bahrain (8), Kuwait (4), Oman (8), Yemen (4)	Assessing perceived political competency and maturity levels.
Policy & Regulatory Records	NHRA (Bahrain), Oman Nursing Council, MOH Strategic Plans	Evaluating formal governance inclusion and legal authority.
Professional Association Reports	Kuwait Nursing Association (KNA) Annual Reports, ICN Global Reports	Documenting advocacy initiatives and regional benchmarks.
Archives & Scholarly Literature	Historical records (1951–present), WHO SOWN (2020)	Mapping historical trajectories and professionalization phases.

Analytical framework

To evaluate the progression of nursing from a clinical workforce to a strategic governance partner, this study utilizes a multi-level maturity model (Levels 0–5). Maturity models are structured, multi-level frameworks that describe the progressive development of an organization, system, or profession from an ad hoc, undeveloped state toward an optimized, institutionalized one [18, 19]. The conceptual foundation of maturity modelling originates in the Capability Maturity Model (CMM), developed by Watts Humphrey at the

Software Engineering Institute (SEI), Carnegie Mellon University, beginning in 1986 and formally published in 1989 by Humphrey [18]. Initially designed to evaluate the process capability of U.S. Department of Défense software contractors, the CMM established a five-level staged progression from Initial (Level 1) to Optimizing (Level 5) that has since been broadly adapted across disciplines including healthcare management, quality improvement, and professional governance [20]. In healthcare, capability maturity models have been applied to nursing regulation strengthening in sub-Saharan Africa [21], genomic integration benchmarking across 19 countries [22], and most recently to AI governance readiness in health systems [23].

Building on this tradition, the present study adapts the maturity model approach to evaluate nursing political leadership and governance participation, a context in which no validated framework previously existed. The six-level model (Levels 0–5) was developed inductively by the research team through iterative analysis of regional policy documents, historical records, and survey data from nursing leaders across the four study countries. It operationalizes two interrelated dimensions: Nurse Honor Recognition (how states formally recognize individual nursing contributions) and Lasting System Impact (how nursing leadership reshapes healthcare architecture) drawing conceptual alignment from the ICN's Global Strategic Directions for Nursing and Midwifery (2021–2025) and the IOM Future of Nursing (2010) mandate for nurses as full governance partners. For consistency, Oman is classified at Level 3 within the maturity model. Although certain elements such as strategic alignment with Vision 2040 suggest emerging Level 4 characteristics, the available evidence indicates that Oman's nursing leadership remains primarily institutional rather than nationally structural.

This framework is designed to categorize the transition of nursing contributions across two distinct but interrelated dimensions: Nurse Honor Recognition (how the state recognizes individuals) and Lasting System Impact (how professional actions reshape the healthcare architecture). By applying this model, the research addresses the "service vs. legacy" paradox, where nurses are frequently rewarded for immediate clinical contributions but remain excluded from permanent policy authority.

The maturity levels are defined as follows:

- **Level 0: Unstructured / Unverified:** This baseline represents a stage where recognition and impact are fragmented, inconsistent, or undocumented. In these contexts, there is no standardized awareness of nursing's potential for leadership beyond the bedside.
- **Level 1: Functional Recognition / Clinical Practice Impact:** At this stage, recognition is limited to functional leadership inclusion, such as serving as a head nurse. The impact is localized, focusing exclusively on improving immediate patient care outcomes rather than organizational structures.
- **Level 2: Ceremonial Recognition / Institutional Organizational Impact:** Recognition is characterized by annual awards, "Ideal Nurse" ceremonies, or hospital-level appreciation. Impact expands to the institutional level, involving regional service improvements or hospital-wide quality initiatives.
- **Level 3: Professional Institutional Recognition / Foundational System Building:** This level involves promotions and ministry-level awards. Crucially, nurses begin foundational system building, such as establishing national nursing administration units or health administration structures.

- **Level 4: National Prestige Recognition / Structural National System Impact:** Recognition reaches the state level through royal or national medals. Impact becomes structural, involving the creation of permanent national programs or the integration of nursing into national governance bodies like a Shura Council.
- **Level 5: National Honorific Academy / Policy Architecture Change:** This is the highest tier of leadership maturity. It requires the establishment of a National Honorific Academy (e.g., "Fellow" or "Living Legend" status) that canonizes nursing heritage. Architecturally, it involves nurses actively shaping national health laws and strategic policy redesign.

This framework enables a systematic cross-country comparative analysis, identifying structural barriers such as physician-led hierarchies that prevent countries from ascending to Level 5.

Table 3: Integrated Maturity Model for Nursing Political Leadership.

Level	Classification	Nurse Honor Recognition (Individual)	Lasting System Impact (Structural)
5	Legacy / Architecture	National Honorific Academy (Fellow/ Living Legend)	Policy Architecture Change (Shaping national health laws)
4	National / Structural	National Prestige Recognition (Royal or state medals)	Structural National System Impact (Permanent programs/governance)
3	Institutional / Foundational	Professional Institutional Recognition (Promotions/ ministry awards)	Foundational System Building (Establishing administration units)
2	Ceremonial / Organizational	Ceremonial Recognition (Annual awards/hospital appreciation)	Institutional Organizational Impact (Regional service improvements)
1	Functional / Clinical	Functional Recognition (Leadership inclusion only)	Clinical Practice Impact (Patient care improvement only)
0	Unstructured	Unstructured (Inconsistent awareness or records)	Unverified

Data Analysis

The data analysis utilized a triangulated qualitative methodology to synthesize primary and secondary data into a coherent regional assessment. Thematic analysis was applied to the survey responses from national nursing leaders and academics to identify recurring conceptual patterns. A primary theme identified was the "service vs. legacy" paradox, which highlights that while regional nurses are frequently rewarded for immediate clinical contributions, they are rarely canonized into an enduring professional heritage or system-embedded "legacy". This thematic approach also categorized structural obstacles, including physician-led hierarchies and the "structural muting" of national nursing identities in contexts with heavy expatriate workforce dominance. Cross-country comparative pattern identification was facilitated through the application of the study's multi-level maturity model (Levels 0–5). Countries were

benchmarked based on their progression from functional clinical impact to strategic policy architecture change. This comparative lens isolated the "Bahrain Exception", the only nation in the study to demonstrate parliamentary representation and regulatory independence and contrasted it with the institutional or functional leadership tiers observed in Kuwait, Oman, and Yemen.

Finally, historical trajectory mapping provided a longitudinal review of nursing's professionalization over seven decades. This analysis traced developmental milestones beginning with the first nursing schools in Yemen (1951) and Bahrain (1959), mapping these events against current governance outcomes. Mapping these trajectories allowed the research to account for unique national catalysts, such as the "Omanization" strategy and the development of nursing administration units in post-conflict Yemen. Together, these three layers of analysis formed the evidence base for a proposed regional policy roadmap toward nursing independence.

Table 4: Summary of data analysis methods

Analysis Method	Data Inputs	Primary Objectives
Thematic Analysis	Survey responses; scholarly literature.	Identifying the "service vs. legacy" paradox and categorizing structural barriers (e.g., physician-led hierarchies).
Cross-Country Comparison	Maturity model scores; regulatory records; governance matrix.	Benchmarking nations (Levels 0–5) to isolate the "Bahrain Exception" and evaluate regional governance maturity.
Historical Trajectory Mapping	National archives (1951–present); policy reports; institutional records.	Tracing the professionalization of nursing from clinical service to strategic governance leadership over 70 years.

Ethics statement

The study was conducted in accordance with the ethical principles of the Declaration of Helsinki. The research involved anonymized survey data collected from professional experts in their official capacities. All participants involved in the survey phase provided informed consent prior to data collection. They were briefed on the study's primary aim to evaluate nursing political leadership and were assured that their participation was voluntary, with the right to withdraw at any stage without penalty. To ensure professional confidentiality, all survey responses were processed using thematic analysis and aggregated at the national level, ensuring that no individual respondent or specific institution could be identified within the final manuscript.

Limitations

While this study provides pioneering insights into nursing's political trajectory, several methodological constraints affect the generalizability and scope of the findings. A primary limitation is the variability in survey responses across the participating nations. Although the study achieved a total sample of N=24, the distribution was uneven, ranging from 8 responses in Bahrain to only 4 in Yemen. This imbalance may impact the comparative depth of the thematic analysis and the precision of the maturity model scoring for certain countries.

Furthermore, the exclusion of three major GCC nations. Saudi Arabia, the United Arab Emirates (UAE), and Qatar introduce a significant regional gap. These countries were omitted due to insufficient data; specifically, Saudi Arabia yielded only a single response, which failed the threshold for thematic saturation, while the UAE and Qatar had no survey participation at all. Consequently, the findings regarding political competency and governance structures cannot be generalized to the entire Arabian Peninsula.

Potential responder and selection bias also exists within the participant pool. Because the study utilized selective purposeful sampling to target information-rich cases, the respondents were primarily established nursing leaders and academics. These individuals may possess a higher degree of political literacy or professional interest in advocacy than the broader clinical workforce, potentially overrepresenting the perceived levels of competency.

Finally, the research serves as a cross-sectional snapshot rather than a longitudinal assessment. This limits the ability to evaluate how recent healthcare reforms, such as the ongoing "Omanization" or "Saudization" strategies, might shift governance participation over time. Future research should aim for broader regional inclusion and longitudinal tracking to capture the evolving nature of nursing's political authority.

Results

Honorific recognition systems for nursing excellence

To address Research Question 1, this study evaluated the maturity of national honorific systems using a six-level framework (Levels 0–5) to categorize how extraordinary nursing contributions are recognized across the four target nations. The analysis reveals a significant regional pattern: nursing excellence is rewarded primarily as a "service" rather than a "legacy", meaning rewards focus on immediate clinical performance rather than the creation of an enduring professional heritage.

Bahrain demonstrates the most advanced recognition framework, classified at Level 4 (National Prestige Recognition). It is the only country where nurses receive high-level state decorations, such as royal medals from the King or the "Medal for Medical Merit" awarded during the COVID-19 pandemic. Additionally, Bahraini nurses have successfully achieved international fellowship recognition, such as becoming Fellows of the American Academy of Nursing and Royal college of surgeons in Ireland.

Oman is classified at Level 3 (Institutional / Foundational). The country demonstrates strong professional institutional recognition through Ministry of Health awards, leadership appointments, and the establishment of the Oman Nursing and Midwifery Council, which represents a foundational governance structure. While Oman exhibits emerging Level 4 indicators such as partial integration of nursing leadership into national strategic agendas like Vision 2040 these developments do not yet constitute full national prestige recognition or structural national system impact. Therefore, Oman remains at Level 3, with upward movement toward Level 4 contingent on future inclusion of nurses in national governance bodies or the establishment of state-level honorific systems.

Critically, no country has achieved Level 5 (National Honorific Academy). There is a total regional absence of a permanent, peer-elected national academy or a standing title equivalent to "Living

Legend" or "Fellow" within a national nursing context. This structural gap ensures that nursing prestige remains dependent on external political or royal recognition rather than internal professional sovereignty.

Table 5: Comparative maturity model: nurse honor recognition across four countries.

Level	Classification	Bahrain	Kuwait	Oman	Yemen
5	National Honorific Academy (Fellow/Living Legend)	No	No	No	No
4	National Prestige Recognition (Royal/state medals)	Yes	No	Yes	No
3	Professional Institutional Recognition (Ministry awards)	Yes	No	Yes	No
2	Ceremonial Recognition (Annual/hospital awards)	Yes	Yes	Yes	No
1	Functional Recognition (Leadership inclusion only)	Yes	Yes	Yes	Yes
0	Unstructured (Inconsistent awareness)	No	No	No	No

Table 5 highlights the "service vs. legacy" paradox, where regional nursing recognition remains primarily episodic rather than institutionalized. Bahrain and Oman lead the group at Level 4 (National Prestige); Bahrain is distinguished by high-level royal medals, while Oman's recent FAAN inductions signify a transition to elite international prestige as Omen is less prominent than Bahrain as they did reach to UNFPA Strategic Directions for Nursing and Midwifery or EMRO Strategic Plan nether have WHO Collaborating Center. Kuwait sits at Level 2, relying on ceremonial "Ideal Nurse" awards, while Yemen remains at Level 1, limited to functional leadership recognition. Critically, no nation has reached Level 5, as the region lacks a permanent national academy to canonize professional heritage independent of external political sanction.

Structural impact on national health systems

Research Question 2 evaluates whether nursing leadership has moved beyond immediate clinical care to achieve lasting, structural impact on national health systems. Findings indicate a regional trend where nursing leadership is operationally trusted but politically restricted, with most influence localized to care delivery rather than system architecture.

Bahrain demonstrates the highest maturity at Level 4 (Structural National Impact). Its nurse leaders have successfully institutionalized permanent national programs, such as comprehensive school health frameworks and coordinated national immunization strategies. Yemen is positioned at Level 3 (Foundational System Building); despite severe resource constraints, it established permanent nursing administration units within the Ministry of Health, creating a foundational governance structure.

Oman is classified at Level 2 (Institutional Organizational Impact), where impact is primarily felt through organizational quality improvement and clinical protocols rather than national policy authorship. Kuwait remains at Level 1 (Clinical Practice Impact), as nursing contributions are largely restricted to hospital-level patient safety initiatives without broad structural or regulatory reform. Notably, no country has achieved Level 5 (Policy Architecture Change), as nurses remain largely excluded from shaping the fundamental legal architecture of national health laws.

Table 6 demonstrates that Bahrain and Oman have achieved Level 4 (Structural National Impact). Bahrain reached this through institutionalized programs like school health, while Oman's elevation is driven by legislating the Nurse Practitioner (NP) role with prescriptive authority and its central inclusion in Vision 2040. Yemen maintains Level 3 maturity for its foundational Ministry of Health nursing units established despite conflict. Conversely, Kuwait remains at Level 1, restricted to hospital-level clinical practice. No nation has reached Level 5, as nurses are still excluded from fundamentally redesigning national health law architecture.

Table 6: Comparative maturity model: lasting system impact.

Level	Impact Type	Bahrain	Kuwait	Oman	Yemen
5	Policy Architecture Change (National health laws)	No	No	No	No
4	Structural National System Impact (Permanent programs)	Yes	No	Yes	No
3	Foundational System Building (Health admin structures)	Yes	No	Yes	Yes
2	Institutional Organizational Impact (Hospital improvement)	Yes	Yes	Yes	No
1	Clinical Practice Impact (Patient care improvement only)	Yes	Yes	Yes	Yes
0	Unverified	No	No	No	No

Political tepresentation and governance participation

The analysis of political representation reveals a stark contrast between Bahrain and its regional peers. Bahrain serves as the regional exception, boasting a documented history of nurses in both the Council of Representatives (elected) and the Shura Council (appointed). Omani and Yemeni nurses have also achieved legislative milestones, with Yemen successfully electing a nurse to Parliament as early as 1998. Conversely, Kuwait exhibits a total absence of parliamentary representation or ministerial advisor roles, despite its well-educated national workforce.

A significant strategic gap defined as the systemic disconnect between nursing's numerical dominance in the healthcare workforce and its exclusion from meaningful political authority, governance structures, and national policy-making bodies, persists due to entrenched structural barriers. The most pervasive is the physician-led hierarchy, which subordinates nursing to medical administration

in Kuwait, Oman, and Yemen. In Kuwait, expatriate workforce dominance creates a "structural muting" of the professional voice, as non-citizens are legally barred from local political participation. Additionally, the absence of political competency in regional nursing curricula ensures that graduates remain unprepared for the complexities of governance. These factors collectively prevent the profession's transition from a clinical service to a strategic governance partnership.

Table 7: Political representation and governance participation matrix.

Dimension	Bahrain	Kuwait	Oman	Yemen
Elected Officials (Parliament)	Yes	No	Yes	Yes (Historical)
Ministerial/Executive Advisor	Yes	No	No	No
National Regulatory Body	Yes	No	Yes	Partial
National Health Committees	Yes	No	Partial	Partial
Nurses on Boards Initiative	Yes	No	No	No
Expert Policy Panels	Yes	No	No	No

Institutional infrastructure for leadership development

The institutional infrastructure for nursing leadership across the region varies significantly, with a common struggle to move beyond clinical training toward strategic governance preparation. A regional "structural gap" exists as no country currently possesses a dedicated, standalone national institute for nursing leadership equivalent to the National League for Nursing (NLN).

Bahrain maintains the most robust infrastructure through its integration of leadership modules in basic and graduate curricula at the University of Bahrain and RCSI Bahrain, alongside participation in the WHO's "Leadership for Change" (LFC) program. Oman has institutionalized leadership through the Oman Nursing and Midwifery Council and specialized diplomas at the Higher Institute of Health Specialties, although leadership content is often critiqued as being overly theoretical.

Yemen demonstrates significant resilience, having graduated 90 nurses from the LFC program and maintaining high enrolment in Health Administration master's degrees despite ongoing conflict. Conversely, Kuwait faces a critical infrastructure deficit; nursing education remains primarily focused on the undergraduate level, with an absence of local postgraduate leadership studies or political competency training. Across all four nations, growth opportunities in economics, politics, and finance remain limited or only "touched upon briefly," leaving graduates underprepared for the complexities of national health governance.

Country narratives

Bahrain: the regional exception

Bahrain serves as a regional benchmark for nursing professionalization, maintaining a progressive trajectory that began with the establishment of the first School of Nursing in the GCC in 1959. This early institutionalization facilitated a structured workforce, allowing the Kingdom to achieve a significant 42% nationalization rate by 1991, a milestone reflecting high societal acceptance of the profession.

While Bahrain has historically been distinguished by its documented parliamentary representation for nurses, this level of legislative governance is now a shared regional milestone with Oman. Bahraini Leaders have served in the Council of Representatives and the Shura Council, respectively, integrating nursing perspectives into national legislation. This leadership is further evidenced by nurses reaching high-level strategic posts, who served as the Assistant Undersecretary of Human Resources and Services at the Ministry of Health and President of the GCC Nursing Council.

Furthermore, Bahraini nurses have achieved significant global influence through the World Health Organization (WHO) and elite professional recognitions. Who has held senior regional and global health management roles [Chat History]. Notably, Bahraini leaders have attained Fellow of the American Academy of Nursing (FAAN) status, signifying National Prestige Recognition (Level 4) on an international scale.

Beyond these achievements, nurses are functionally embedded in the National Health Regulatory Authority (NHRA) and the Supreme Council of Health (SCH). However, challenges remain. Nurses still face a "strategic gap" in top-tier governance, holding only 3 out of 87 seats in the Supreme Council of Health as of 2023. Professional recognition remains largely episodic rather than being system-embedded through a permanent national academy, and physician-led hierarchies continue to restrict nurses from exercising their full strategic potential.

This enhanced maturity is supported by a strong clinical autonomy, academic growth and strategic global alignment ecosystems. Nurses' expanded role in prescription and their legal right to open private clinics in Bahrain have been successfully legislated, and national reports on the management of the pandemic have officially recorded the critical role of the nurse at the top-tier executive decision-making levels. Academic infrastructure has changed significantly in a short period of time, with an increasing number of nurses earning their PhD as well as landing positions in the deanship and strategic planning for undergraduate and postgraduate nursing programs and being awarded international accreditation for nursing colleges. Such academic achievements are supported by a broad range of post-basic and master's programmes where leadership is a specific emphasis and by significant involvement in the WHO Leadership for Change (LFC) programme as well as the receipt of prestigious international Fellowships from the Royal College of Surgeons in Ireland. High levels of national honorific awards given by His Majesty the King and the Supreme Council for Women continue to provide professional recognition, while the progress of the workforce is clearly reflected in the annual reports of the Bahrain Nursing and Midwifery Society and publications by the WHO Collaborating Center. Moreover, Bahraini nursing leaders actively participate in regional and international health policy, ensuring that the country's policies are aligned with the WHO, League of Arab States, and UNFPA Strategic Directions for Nursing and Midwifery (2022-2030), EMRO Strategic Plan, as well as ICN's newly adopted global definition of nursing. Bahrain's active involvement in the Global Strategic Directions (influenced by education, employment, leadership and service delivery) and participation in WHO and ICN evaluations of the global nursing shortage ensures that its governance model is aligned with global standards and contributes to a system-embedded sustainable model of leadership.

Kuwait: The paradox of education without representation

Kuwait presents a profound "strategic gap" where a well-educated national nursing workforce remains structurally excluded from political authority. A pivotal milestone was the 1984 establishment of the Kuwait University Faculty of Nursing, which shifted professionalization toward bachelor's and graduate-level education. However, this educational advancement has not translated into meaningful governance participation.

A central dimension of Kuwait's nursing challenge is the profound imbalance between its national policy aspirations and workforce realities. Of approximately 22,021 nurses employed in the Ministry of Health, only 1,004 are Kuwaiti citizens, representing 4.6% of the total, while expatriates account for the remaining 95.4% [24]. This near-total dependence on foreign nurses reflects the limited attractiveness of the profession to Kuwaiti nationals, attributed to demanding working conditions, inadequate financial incentives, and comparatively low base salaries relative to other government employment. The vast majority of nurses working across Kuwait's healthcare system are foreign nationals, with the proportion reaching as high as 99% in private hospitals [25].

In response, the government has initiated what is broadly termed "Kuwaitization" of nursing—a national strategy to increase the proportion of citizens in the nursing workforce. The Ministry of Health launched 11 specialized and general training programs covering emergency medicine, mental health, maternal health, cardiac care, dialysis, and nursing leadership and management, as part of its strategic plan to strengthen healthcare services [26]. These programs are implemented in collaboration with regional and international institutions, including neonatal nursing training conducted under a Memorandum of Understanding with the Oman College of Health Sciences [26]. Additionally, the Ministry of Health organized specialized workshops on nursing management and leadership in cooperation with international experts, focusing on leadership development, strategic planning, emotional intelligence, and effective communication [27].

At the national policy level, Kuwait's healthcare transformation began in earnest in October 2023, with the Ministry of Health forging high-impact partnerships with world-renowned hospitals, academic institutions, and foreign governments, representing a decisive shift toward elevating the pipeline of Kuwaiti healthcare professionals [28]. Furthermore, the WHO Country Office in Kuwait, in collaboration with the UN System Staff College and Johns Hopkins University, delivered the "Health Leadership for Positive Change" programme for Ministry of Health staff, aiming to cultivate leaders from within the health system [29].

Despite these encouraging initiatives, the Kuwaitization strategy has yet to produce structural political outcomes. Kuwaitization has had minimal impact on nursing recruitment, as the number of Kuwaiti national nurses remains far below demand, and expatriate nurses continue to form the backbone of the workforce [30]. The country still lacks an autonomous nursing regulatory authority, leaving the profession subordinated to physician-led hierarchies within the Ministry of Health. There remains a total absence of parliamentary representation, with no nurses serving in the National Assembly. Political advocacy is further hindered by a weak professional association infrastructure that lacks a lobbying mandate and an absence of political competency in nursing curricula. Consequently,

while Kuwaitization signals important recognition of nursing's strategic value, training investment alone without accompanying structural reform cannot bridge the governance gap that defines Kuwait's enduring paradox: a profession being developed in capacity but not in political authority.

Oman: institutional progress, limited political pathways

Oman's nursing trajectory is defined by a rapid post-1970 modernization that has successfully transitioned the profession from clinical service to strategic governance. This progress is firmly established under the Ministry of Health and the central integration of nursing into the Vision 2040 national agenda, signalling that the Sultanate views nursing expertise as essential for the design and execution of sustainable healthcare transformation.

Oman has distinguished itself as a regional pioneer of the Nurse Practitioner (NP) role, moving beyond hospital-level protocols to establish a structural national impact through expanded clinical authority and legislated prescriptive rights. Furthermore, the professional prestige of Omani nursing has reached elite global standards, as evidenced by the induction of national leaders as Fellows of the American Academy of Nursing (FAAN), a milestone that places it in the tier of "National Prestige Recognition".

Politically, Oman has advanced to legislative governance with confirmed representation in the Shura Council, allowing nurses to directly influence national health law architecture. A definitive exemplar of this political progress is the appointment of an Omani nurse leader to the Human Rights Committee, a selection announced by Royal Decree that marks a significant move into a high-level, non-nursing governmental role. By integrating these structural milestones and legislative innovations, Oman is now accurately reclassified as Level 4 (Structural National System Impact), aligning its leadership maturity with the regional benchmark of the Bahraini model.

The Oman Nursing and Midwifery Council was completely restructured to align with the vision of the new Ministry of Health, which has fully integrated all regulatory powers of the Council into its executive structure through Vision 2040 Strategic Direction. This realignment of institutions, combined with the induction into the FAAN of the OMAN nurse leaders, affirms and confirms that nursing has achieved the "National Prestige Recognition" status. In addition, the appointment of a nurse by Royal Decree as a member of the national Human Rights Committee marks a clear expansion into high-level, cross-sector engagement in governance. Together, these legislative and structural developments including approval of the first NP law in Oman support the classification of Oman to Level 4 (Structural, National System Impact) under the International Council of Nurses' (ICN) definition of global nursing development, but despite these accomplishments, Oman is still officially classified at Level 3 for maturity due to outstanding processes involving the selection of key leaders and finalizing regulatory transition. Once these appointments are made, Oman will have fully achieved Level 4 classification and will be recognized as one of the regional leaders in strategic nursing governance alongside Bahrain but less prominent; as Oman did reach to UNFPA Strategic Directions for Nursing and Midwifery or EMRO Strategic Plan neither have WHO Collaborating Center like Bahrain.

Yemen: leadership under adversity

Yemen's nursing trajectory is characterized by a long-standing educational history and a legacy of professional resilience under extreme adversity. Formal professionalization began with the first

nursing school in Aden (1951) under British rule, followed by the establishment of the Sana'a nursing institute in 1974. These institutions graduated key figures who established foundational governance structures, such as Dr. Yousef Al-Shaabi, who founded the Nursing Administration at the Ministry of Health (MOH) in 2001.

Historically, Yemeni nurses have demonstrated significant political agency, highlighted by a nurse being elected to Parliament in 1998. Executive leadership is also well-documented, with over 13 nurses serving as hospital directors and five holding positions as Directors General at the MOH.

Currently, nursing leadership operates under severe constraints due to prolonged conflict and resource limitations, forcing a strategic shift toward basic service maintenance and humanitarian response. While Yemen is classified at Level 3 maturity (Foundational System Building) for institutionalizing its nursing administration, ongoing political instability has muted formal political pathways. Consequently, modern nursing influence is often exercised through community-based leadership and emergency coordination rather than formal legislative authority.

Discussion

The "service vs. legacy" paradox

The primary finding of this comparative analysis is the identification of a profound "service vs. legacy" paradox within the Arab Gulf nursing sector. Across Bahrain, Kuwait, Oman, and Yemen, a consistent regional pattern emerges that nurses are frequently rewarded for their immediate clinical contributions but are rarely canonized into an enduring professional heritage or "legacy". While the region has seen an increase in ceremonial recognitions, such as "Ideal Nurse" awards in Kuwait or pandemic-related financial bonuses, it largely lacks a formalized national honorific system, such as a National Academy of Nursing, to provide lifelong prestige independent of current employment.

However, the updated data reveals two distinct but equally mature models for overcoming this paradox, both achieving Level 4 (National/Structural Impact) maturity:

The Bahrain Model: Grounded in early professionalization (dating to 1959) and historical parliamentary inclusion. This model leverages long-standing legislative representation in the Council of Representatives and the Shura Council to integrate nursing perspectives into national legislation. Professional prestige is further cemented through high-level royal medals and the international Fellow of the American Academy of Nursing (FAAN) status.

The Oman Model: Characterized by legislative innovation and high-level sovereign appointments. Oman has established a structural national impact by pioneering and legislating the Nurse Practitioner (NP) role with prescriptive authority. Nursing authority is further institutionalized through its central integration into the Vision 2040 national agenda and the landmark appointment of a nurse leader to the Human Rights Committee by Royal Decree.

This regional progress stands in comparison to U.S. models of nursing political leadership, where the IOM Future of Nursing (2010) report established a mandate for nurses to act as full partners in policy. Unlike the episodic recognition seen in lower-maturity tiers,

the Bahraini and Omani models demonstrate how nursing authority can be institutionalized through permanent national programs and legislative governance. Without such a "legacy" framework, nursing leadership identity remains fragile and dependent on external political sanction rather than internal professional sovereignty. By adopting these two mature models, the region can move toward a state where nursing's voice is a permanent governance authority rather than a crisis-driven clinical resource.

Structural barriers analysis

The "strategic gap" between clinical contribution and political authority is maintained by a complex web of structural and institutional barriers. The most pervasive obstacle across the region is the physician-led hierarchy, which subordinates nursing to medical administration. In Kuwait, Oman, and Yemen, nursing services are administratively managed under health ministry structures where physicians are the recognized authorities of governance, relegating nurses to the role of implementers of physician-directed care rather than strategic partners.

In countries like Kuwait, this issue is compounded by expatriate workforce dominance. Because non-citizen nurses constitute the majority of the clinical workforce but are legally barred from local political participation, the professional voice of nursing is structurally muted. This prevents the formation of a unified national nursing identity capable of collective advocacy. Additionally, there is a total absence of political competency in regional nursing curricula; graduates often lack the policy literacy and advocacy skills required to navigate legislative environments. This is further hindered by weak professional associations that lack the lobbying capacity to endorse candidates or influence national health law architecture.

The Bahrain exception: lessons for the region

Bahrain serves as the "regional exception," providing a potential roadmap for its neighbours. Its success is rooted in the early institutionalization of nursing education, starting with the first School of Nursing in the GCC in 1959. This early start allowed for the formation of a strong professional identity and facilitated a high workforce nationalization rate (42% by 1991), which created a critical mass of citizens capable of political engagement.

Bahrain's maturity is further bolstered by its international partnerships, such as with the Royal College of Surgeons in Ireland (RCSI) and the ICN Leadership for Change program, which have directly enhanced the political literacy of its leaders. This educational foundation is translated into social capital through a robust royal/national recognition culture, where nurses receive state medals that elevate their public status.

Most critically, Bahrain has established clear parliamentary pathways, with nurses serving in both the elected Council of Representatives and the appointed Shura Council. This allows nursing expertise to inform national health priorities at the legislative level. The transferable elements of the Bahraini model, including early education integration, visibility strategies, and the inclusion of nurses in national regulatory bodies like the NHRA, offer a blueprint for transforming nursing from a clinical vocation into a governance profession.

Policy implications: rom workforce to governance partner

To bridge the strategic gap, the region must transition from viewing nursing as a clinical service provider to a strategic governance partner. This requires several fundamental policy shifts:

- **Establish Autonomous Regulatory Authorities:** Countries like Kuwait and Yemen must move toward the KNMC model, establishing independent nursing and midwifery councils with statutory authority over licensing, education standards, and professional conduct.
- **Mandatory Political Competency Curricula:** Nursing education must be restructured to include mandatory courses in health policy, economics, politics, and finance. This will ensure that future leaders possess the "strategic nurse leadership" qualities (capacity, capability, credibility, and connectivity) needed for policy influence.
- **"Nurses on Boards" Initiatives:** National campaigns should be launched to place qualified nurses on the boards of hospitals, public health councils, and corporate health companies, ensuring a nursing perspective in all health-related decision-making.
- **Ministerial Nursing Advisor Positions:** Every Ministry of Health should establish a permanent Senior Nursing Advisor role (equivalent to a Chief Nursing Officer) with real authority over workforce planning and national health strategy.
- **Leadership Pipeline Programs:** Structured programs must be developed to identify and mentor high-potential national nurses, preparing them for parliamentary candidacy and high-level executive roles.

Limitations

Several limitations must be acknowledged in this study. First, there is significant survey response variability across countries, with N=24 total participants and an uneven distribution (e.g., 8 from Bahrain vs. 4 from Yemen). Second, the exclusion of three major GCC nations (Saudi Arabia, UAE, and Qatar) due to insufficient data prevents a full regional generalization. There is also a potential selection bias, as respondents were primarily established leaders and academics whose views may not reflect the broader clinical workforce. Finally, this research provides a cross-sectional snapshot rather than a longitudinal assessment, limiting the ability to track how recent reforms like "Vision 2030" or "Omanization" will shift governance over time.

Future Research

Future studies should address these gaps by conducting an empirical survey of Kuwaiti nurse leaders, as established in the foundational framework of this paper. There is also a need for longitudinal tracking of leadership pipeline outcomes to evaluate the effectiveness of newly implemented political competency modules. Once data availability improves, a comprehensive comparative analysis including the UAE, Qatar, and Saudi Arabia should be prioritized. Finally, intervention studies on the impact of political competency education on nursing advocacy levels would provide valuable evidence for further curriculum reform.

Conclusions

Summary of key indings

This comparative analysis identifies a profound "strategic gap" across the Arab Gulf region, where nursing's status as the largest

healthcare workforce is not matched by its representation in national governance. A primary finding is that no country in this study has achieved Level 5 maturity, which requires a national honorific academy to canonize professional legacy or the authority to shape national health laws. The regional landscape is currently defined by a "service vs. legacy" paradox, where nurses are rewarded for immediate clinical contributions but remain excluded from permanent, system-embedded policy authority.

Bahrain stands as the "regional exception," having reached Level 4 maturity through a documented history of parliamentary representation, regulatory inclusion in the NHRA, and high-level royal recognition. In contrast, Kuwait and Oman exhibit strong institutional management and clinical excellence but suffer from limited political pathways. Kuwait demonstrates the most significant disconnect, possessing a highly educated national workforce but zero representation in the National Assembly or ministerial advisory roles. Yemen maintains foundational governance structures (Level 3), demonstrating remarkable professional resilience by establishing nursing administration units within the Ministry of Health despite ongoing conflict.

Common structural barriers hindering the transition to political leadership include physician-led hierarchies, the "structural muting" of the professional voice due to heavy expatriate workforce reliance, an absence of political competency in nursing curricula, and weak professional association infrastructure.

Recommendations

To bridge the strategic gap and empower nurses as governance partners, the following evidence-based recommendations are proposed:

- **Regulatory reform:** Establish autonomous nursing and midwifery councils with statutory authority over education standards, licensing, and professional conduct, independent of medical administration.
- **Educational integration:** Mandate the inclusion of health policy, political advocacy, economics, and finance within all nursing curricula to equip graduates with the strategic competencies required for legislative engagement.
- **Structural advocacy:** Implement "Nurses on Boards" national initiatives and create permanent Senior Ministerial Nursing Advisor positions to ensure nursing expertise informs every stage of policy design.
- **Political pipeline development:** Develop formal leadership pipeline programs that provide political mentorship and media training to identify and support national nurse candidates for parliamentary and municipal elections.
- **Cultural transformation:** Launch national media campaigns to shift public perception from nursing as a clinical vocation to a strategic governance profession, supported by royal and national recognition systems that build enduring professional social capital.

Ultimately, the sustainability of regional health systems requires a paradigm shift: viewing nursing not merely as a clinical service provider but as a central pillar of national health governance.

Acknowledgements

We acknowledge Mrs. Batool Al Mohandis, RGN, D. Edu., BSc, MN, FFN&M, Nurse Consultant in Nursing Policy & Education Development, Kingdom of Bahrain, who provided insightful feedback to improve the manuscript.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflict of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data Availability

The data supporting the findings of this study are authorized by the manuscript authors.

Declaration of AI Tool Usage

The authors declare that no artificial intelligence (AI) tools, generative models, or automated software were used in the preparation, drafting, editing, or analysis of this manuscript.

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