The implementation of a competency-based nursing curriculum in a developing country: A qualitative descriptive study [version 1; peer review: awaiting peer review]

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Abstract
Background: Competency-based nursing curricula prepare nurse graduates with the required competencies to function effectively in a rapidly changing and increasingly complex healthcare environment. Implementation of a competency-based curriculum requires considerable investment in time and resources, and this process has not been described in Vietnam, a developing country. This research explores nurse educators' experiences from six Vietnamese nursing schools regarding implementing a competency-based nursing curriculum through the lens of McGrath's Input-Process-Output model.

Methods: A qualitative descriptive method was used. A total of 11 participants were nurse academics purposively chosen from six nursing schools where a competency-based nursing curriculum has been implemented, and 11 in-depth interviews were conducted.

Results: Participants identified various issues in implementing a competency-based nursing curriculum, including the need for curriculum redesign, required improvements in teaching and learning, and resistance from teaching staff. Adequate human resources and the availability of infrastructure facilitated the process. Simultaneously, barriers to implementation included nurse educators with poor preparation for a new curriculum, inadequate infrastructure, limited equipment, and no policies that support a competency-based curriculum.

Conclusions: The study findings describe the process of moving to a competency-based nursing curriculum implementation in a low to the middle-income country from the perspective of nurse educators and indicate critical success factors in facilitating the process in similar environments.
Keywords
competency, competency-based curriculum, change management, nurse education, Vietnam
Introduction
There is a critical shortage of adequately trained nurses in Vietnam. Nearly 126,000 nurses served a population of 96 million, highlighting how the nursing workforce supply did not meet the demand. As estimated, 230,000 nurses would be needed in 2025 to ensure a ratio of 25 nurses per 10,000 people. Therefore, governmental initiatives aimed to increase the number of professional nurses through enhancing the quality of nurse education and curriculum reform.

Vietnam is a member of the Association of Southeast Asian Nations (ASEAN). Several factors have shaped healthcare and nursing in Vietnam, including war, cultural influences, and gender relations. During the war, nursing care was mainly task-oriented, and this led to subsequent nursing models being similarly task-based, with nurses mostly reliant on following physician’s orders.

In partnership with an overseas university, the Vietnam Nurses Association (VNA) developed competency-based nursing curricula for four-year and three-year nursing programs, and the curricula subsequently were implemented in selected nursing schools. To date, there has been little critical evaluation of this initiative. This paper discusses progress toward implementing a competency-based curriculum in Vietnam.

Nurse education in Vietnam
Prior to the 1990s, nursing courses were provided by medical universities and colleges. In Vietnam, there are 36 universities, 41 colleges, and 81 secondary schools that train health professionals, including four levels of nurse education: secondary (two years), college (three years), bachelor (four years), and graduate degree. As of 2021, 72.5% of nurses in the country were secondary nurses, and less than 1% of nurses held graduate degrees. To upgrade nursing qualifications, recruitment and training for vocational nurses was ceased by 2021. A Bachelor of Nursing Sciences program was first offered in 1996. However, the program was criticized as being content-driven and medical-oriented, and the majority of faculty lecturers had a medical rather than a nursing background. As a result, the Ministry of Education and Training (MOET) issued the core curricula frameworks for the four-year baccalaureate and three-year diploma programs in 2012. These frameworks served as the core content of nursing programs.

Licensing for nurses in Vietnam is conducted through registration, with all nurse graduates required to take a nine-month pre-service training course in a clinical setting. In addition, nurses must fulfill 24 hours of training each year to maintain their license. However, new nurse graduates’ quality has varied and attributed to differences in curricula across nursing schools.

Pathway to develop the competency-based nursing curriculum in Vietnam
Competency refers to the combination of required knowledge, skill, and judgment demonstrated by nurses in daily practice or job performance. In 2006, the Vietnamese government signed the ASEAN Mutual Recognition Arrangement (MRA) for nursing services to allow nurses greater mobility. In 2009, the ASEAN Joint Coordinating Committee on Nursing Service stipulated that nurses in ASEAN countries should have core competencies in the following areas: Ethics and Legal Practice; Professional Nursing Practice; Leadership and Management; Education and Research; and Professional, Personal, and Quality Development. In addition, this MRA requires that all member countries upgrade nurse education standards to meet the ASEAN core competency. In response, in 2012, the Vietnamese Ministry of Health (MOH) launched competency standards for professional nurses to develop a competency-based nursing curriculum (CBNC).

VNA played a leading role in empowering Vietnamese nurses through influencing policies and building capacity. VNA launched a cooperative project with the Queensland University of Technology (QUT), Australia, to initiate nursing competency standards. At the onset, a task force was established and included nurse educators, administrators, and clinical nurses. All materials and documents were translated from English to Vietnamese and vice versa. The team worked closely with QUT curriculum and process experts to draft the nursing competency standards based on the five ASEAN core domains of competency and the framework of competencies developed by the International Nursing Council. The draft was reviewed and revised several times through workshops with nursing, educational, and healthcare experts. The resulting Competency Standards for Vietnam Professional Nurses were approved in 2012, consisting of three domains, 25 competencies, and 108 indicators. VNA then collaborated with QUT again to integrate those competency standards into the nursing curriculum and develop CBNC based on criteria given by the MOET, resulting in the CBNC in pilot nursing schools. The biggest problem encountered in the CBNC development is the limited understanding of competencies among Vietnamese nurse educators. Thus, they had difficulties applying those competencies in the curriculum and changing curriculum outcomes into measurable competencies.
Methods

Research aim
This research aimed to explore the experiences of selected nurse educators in Vietnam regarding implementing a competency-based nursing curriculum through the lens of McGrath’s Input-Process-Output model.16

Design
A qualitative descriptive method was used based on Sandelowski’s methodology: the researchers work closely with and stay close to the data and present the findings in the everyday language,17 allowing us to foreground the words of participant nurse educators. The interview guide and questions can be found as Extended data.26

Conceptual model
Analysis of the educational system is contingent on the context in which the educational system is implemented.18 This study adopted McGrath’s Input-Process-Output model,16 as outlined in Figure 1, to provide a clear description of implementing a CBNC in Vietnam’s selected nursing schools. Specifically, *Input* typically refers to the elements that nursing institutions bring to the beginning stage of implementing the CBNC.19 *Process* can positively impact team coordination effectiveness, and *Output* often includes performance measures.20

Ethics
This research was part of a more extensive doctoral study involving a situational analysis of CBNC implementation across 10 ASEAN countries. It followed all requirements of an ethical research process and was then approved by the Institutional Review Board of Chiang Mai University (No. Ref.434/2019, given on the date October 3, 2019).

Settings and participants
The study participants were nurse educators who (1) were instrumental in developing and implementing nursing curricula and (2) willing to participate. Purposive sampling was used to target participants from the five nursing schools applying CBNC developed from QUT: Hanoi Medical University, Namdinh Nursing University, University of Medicine and Pharmacy in Ho Chi Minh City, Haiduong University of Medical Technology, and Hanoi Medical College. In addition, Hue University of Medicine and Pharmacy applied CBNC, which they termed an outcome-based curriculum, in collaboration with a Korean partner. Among six schools, four implemented four-year baccalaureate CBNC, and two schools applied for the three-year program. A total of 11 in-depth interviews were conducted with key respondents from the above six schools.

Data collection and data analysis
Study data were collected from October 2019 to April 2020 using semi-structured online interviews with 11 nurse educators. Interviews were chosen as a mode of collecting data in this research because its advantages in capturing the participants’ own words, reaching clarification, allowing interviewers the chance to probe and explore in depth, and having a flexible format.21 All the interviews were done on-line through an internet-based communication mode (Messenger, Zalo) because the coronavirus disease 2019 (COVID-19) pandemic happened at time of collecting data. Researchers talked to participants first about the research information, possible risks, and their right to withdraw, which was included in the consent form beforehand, and then the form was sent to participants online. Participants read it, agreed to join the interview and signed the form, then they scanned it and sent it back to the researcher before the interview.

![Figure 1. The Input-Process-Output framework of the implementation of a CBNC. CBNC, competency-based nursing curriculum.](image-url)
An interview guide consisting of 12 questions was developed based on the existing literature and the conceptual framework. Two nurse educators piloted the guide. The first author held interviews in Vietnamese and lasted between 45–60 minutes. Stimulus questions included “How did you implement CBNC regarding Input/Process/Output?” and “What were the facilitators to CBNC implementation, and the barriers?”. The researcher took field notes during the interview. After interviews, the researchers transcribed the recording immediately. Data collection was stopped when the data reached saturation. All the data, including audio files and transcripts, were kept and stored confidentially in a locked locker.

Qualitative content analysis was the analysis strategy of choice in this qualitative descriptive research because it focuses on description, allows researcher to work closely to data, and provides insights into participants’ thought and language use. Using a deductive approach, researchers first developed a categorization matrix based on conceptual framework, then applied manual coding into the analysis process. Researchers paid attention to the quality of the data collection and analysis process, peer debriefing, and member checking to obtain credibility. The two researchers who held the interviews transcribed verbatim as soon as the interviews ended. After the first author translated the interviews into English, the principal researchers analyzed the raw data. The qualitative expert in the team reviewed the data and checked the analysis independently. The results were discussed between them until a consensus was reached to ensure inter-rater reliability. The researchers maintained dependability by strictly following each step of the research process to ensure the accuracy of the data collection process, coding, and consistency of the inferences and transferability through the participants’ accurate description, data collection, and analysis findings were presented in rigorous detail.

The quantitative demographic data were analyzed using IBM SPSS Statistics (RRID:SCR_016479) software (version 22).

Results
The demographic characteristics of the participants are presented in Table 1. This group was predominated by female educators, accounting for 90%. Their ages ranged from 30 to 40 years old. Most of the educators were faculty members (73%), while 27% held management responsibility. The average year of working experience was 7 ± 2.63 years.

Six categories and 15 sub-categories were derived from the qualitative analysis process of participants’ experiences of CBNC, as listed in Table 2. These categories were examined a priori through the lens of McGrath’s Input-Process-Output model.

Curriculum redesign
Participants from the schools that implemented CBNC described the beginning of the process by reconstructing the curricula. All schools’ curricula were modeled after the competencies required by the MOH. The CBNC teaching objectives were integrated into the competency standards, and assessments followed those objectives and standards. But nurse educators found it challenging to work with the competency standards. These posed particular problems for clinical instructors who had to develop the course material for clinical instruction or evaluate students’ clinical performance. These problems led many to choose to ignore the standards:

“The competency standards are used to build lectures, but no hospital followed them.” (Interview 6).

<table>
<thead>
<tr>
<th>Demographic characteristics</th>
<th>Number (%)</th>
<th>Mean ± SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>34.25 ± 3.3</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (9.9%)</td>
<td></td>
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<tr>
<td>Female</td>
<td>10 (90.1%)</td>
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<tr>
<td>Working position</td>
<td></td>
<td></td>
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<tr>
<td>Faculty member</td>
<td>8 (72.7%)</td>
<td></td>
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<tr>
<td>Manager (Associate Dean)</td>
<td>3 (27.3%)</td>
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<tr>
<td>Years of working experience</td>
<td>7 ± 2.63</td>
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</table>
Participants discussed how nurse educators redesigned curricula in detail over a long period, based on the output standards from healthcare needs and employer criteria, the nursing program’s framework by MOET, and MOH competency standards. During this process, educators prepared the CBNC students’ guidebook providing directions for students’ independent learning:

“In the past, we did not have a student guidebook, but we did so with CBNC … [the guidebook] gives them [students] clarity on which days they need to prepare assignments at home, what to read, what to do for homework, and what to submit to teachers before going to class.” (Interview 2).

Participants noted that cooperation contributed to the success of CBNC implementation in Vietnam. The international partnership provided nursing schools with expertise and support in curricular reconstruction. Those overseas partners also funded training activities that played an indispensable role in the CBNC application:

“We got involved [in the QUT project], so … we completely redesigned our curriculum. We translated it into English and sent it to experts in Australia to be reviewed. Then, we applied the resulting curriculum.” (Interview 3).

The educators said they learned about CBNC, learned why the current curricula had to be adapted, and how to carry out those changes from training activities designed for faculty members and run by QUT. All educators teaching either theoretical or clinical nursing had to attend the training:

“First, we had to learn about CBNC; second, we had to learn new teaching methods; third, we learned about the application of information technology… We had to learn about adult learning principles, learn to ask questions and encourage interaction from students.” (Interview 5).

### Teaching and learning improvement

Most educators expressed that the quality of teaching and learning improved considerably under CBNC. The use of various teaching methods increased the quality of teaching and learning. One described the change to active teaching based on student needs:

“In traditional lectures, the teacher only preached and conveyed what was in the book. Students were very bored, and they would rather stay at home than go to class. When we applied the CBNC and the new teaching methods, the students were more interested in studying even though it required working harder.” (Interview 7).

### Table 2. Categories deriving from participant interviews.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-categories</th>
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<tbody>
<tr>
<td>Curriculum redesign</td>
<td>Competencies attached</td>
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<td></td>
<td>Arduous development process</td>
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<td></td>
<td>Cooperation</td>
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<td>Teaching and learning improvement</td>
<td>Switch to learner-centered</td>
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<td></td>
<td>Life-long learning</td>
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<td></td>
<td>Up-skilled students</td>
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<td></td>
<td>Improved evaluation</td>
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<tr>
<td>Resistance</td>
<td>Lack of readiness</td>
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<td></td>
<td>Low motivation</td>
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<tr>
<td>Human resources</td>
<td>Leaders and managers</td>
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<tr>
<td></td>
<td>Nurse educators</td>
</tr>
<tr>
<td></td>
<td>Students</td>
</tr>
<tr>
<td>Facilities (infrastructure, library, and equipment)</td>
<td>Availability/lack of facilities</td>
</tr>
<tr>
<td>Policy</td>
<td>Competency standards for Vietnamese nurses</td>
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<td></td>
<td>Lack of policies for CBNC</td>
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</table>

CBNC, competency-based nursing curriculum.
Educators described giving feedback to students as being very challenging since the use of contemporary research was a new requirement. Educators said they had to update their knowledge by reading, doing research, and attending conferences to improve the quality of lectures. They recognized the importance of lifelong learning:

“In the past, when students asked questions, lecturers just answered. Now, lecturers have to answer with evidence and show the references.” (Interview 3).

Educators noticed some remarkable changes in students under CBNC. They found the new teaching activities inspired students to learn and show their appreciation:

“Students would not accept the lecture if they [educators] followed the traditional didactic teaching method.” (Interview 4).

Educators also expressed their appreciation of students’ self-directed learning skills. They believed that those skills contributed to developing students’ competency, including critical thinking, problem-solving, and teamwork:

“They [employers] think those students [new graduates] are better workers because they can think and solve problems better than the past graduates.” (Interview 3).

However, they felt that the students studying under the CBNC model did not display good clinical skills. One issue highlighted was the change in the assessment. This change was a focal point for 8 of 10 participants, and examples of their responses included:

“In CBNC, we did not evaluate students only by the end-of-course examination grade ... We required a timely assessment grade, midterm assessment grade, and end-of-course examination grade, which weighed equally. It increases the quality so that the process is credible.” (Interview 2).

Educators said these changes improved the quality of student evaluation but added complexity to the CBNC implementation. For example, students were assessed for individual work and group work using presentations, discussion, case reports, computer-based exams, and traditional paper-based examinations. Notably, for the CBNC practicum section, students were graded as either “pass” (being competent) or “fail” (being not competent and needing to repeat the assessment until competence was reached) with no mark given. This troubled the educators at the course conclusion when grades were issued.

Resistance

Participants described a range of reactions to the implementation of CBNC. Not all educators accepted it. Most educators thought that more capacity building was needed to implement CBNC, requiring them to have updated knowledge and skills, including using internet-based classrooms, advanced simulation technology, new skills lab, and offices with the computer. For those who were ill-prepared, CBNC was challenging. As a result, they strongly opposed the curriculum:

“We have pressure from the clinical lecturers. Some of them oppose CBNC because they have to change a lot to update their knowledge and develop case studies/scenarios.” (Interview 3).

Some educators thought that resistance came from the increased workload resulting from the new curriculum, including a higher amount of time spent in teaching preparation:

“It was a total burden for lecturers. The first was the burden of composing PowerPoints for lectures; the second was preparing the lecture carefully; you have to spend more time preparing the lessons and preparing questions.” (Interview 4).

Educators also expressed resentment that they did not receive extra pay for their time adapting to the new curriculum. Staff nurses at hospitals, who act as clinical instructors, are not paid for their work.

Human resources

Most participants agreed that human resources were the crucial factor influencing the success of CBNC implementation. Human resources included educators, school leaders, and students. The capacity and motivation of educators to change people and institutions were the key to implementation. Support from school top managers or leaders was equally important. They stated that all stakeholders understood CBNC and its advantages, leading to a shared vision for applying the new curriculum. Without such support, CBNC could not be implemented in their schools:
“From the board of school leaders to department heads, they supported the CBNC. If this curriculum were implemented at the faculty level, not the school-wide level, the success would be completely minimal!” (Interview 5).

Nurse educators played a vital role in the implementation. When they were well-prepared for CBNC, they were crucial facilitators, though when educators had low readiness for CBNC, their lack of responsiveness to CBNC became barriers:

“The lecturers in your school, are they devoted to teaching? Do they want to follow CBNC? Do they want to improve the quality of students by using CBNC?” (Interview 3).

Facilities
Some educators felt that the availability of physical facilities was a critical factor in CBNC implementation. The facilities they mentioned included infrastructure, a library, and equipment. Most schools received partner support for their infrastructure (simulation centers, skill labs, classrooms), internet-based systems, and other equipment:

“We received investment for building a simulation center and then computers and printers for teachers’ work. Since then, the classrooms have been set up with new equipment.” (Interview 6).

Not having adequate facilities was a barrier. Most participants thought that there should be more investment in infrastructure and equipment in their schools. The libraries were not well-equipped and had an insufficient number of textbooks or journals and no online databases.

Policy
The nursing competency standards issued by MOH were thought to increase the difficulty of CBNC implementation. Some felt that the MOH standards were adequate and reflected the contemporary situation in Vietnam. However, many also felt the opposite was true.

“I found them [nursing competency standards] long and unrealistic.” (Interview 2).

The complexity of competency standards was viewed as creating dilemmas for nursing schools; on the one hand, they had to use them; on the other hand, they could not make the standards clear to stakeholders, including hospitals (users) and students.

“Why don’t people [educators] have access to that set of competencies? Because they read but do not understand what is being called a competency, they do not understand how to teach it.” (Interview 1).

Discussion
Using McGrath’s Input-Process-Output model, this study explored the CBNC implementation experiences in selected nursing schools in Vietnam. A key success factor described was the critical importance of partnership and coaching in curriculum redesign, change management, staff development, and support from upper management. This led to perceived improvements in the quality of teaching and learning. However, barriers were difficulties in incorporating MOH competency standards and translating them into a clinical environment, nurse educators’ and clinical facilitators’ variable commitment, and inadequate library resources.

Partnership involvement in curriculum changes
The redesign process shifted from a traditional content-laden didactic curriculum to a new competency-based curriculum that centers on competency. The nurse educators had to revise the whole curriculum, beginning with incorporating the nursing competency standards, which were context-specific to the Vietnam situation, into the curriculum. The new competency-based curriculum was reconstructed in partnership with international partners. This process was similar to27 which highlighted the inclusion of competencies into the curriculum and assessment, and.28 Competencies are in line with international models, guidelines, and standards. The collaboration was vital in developing CBNC in Vietnam, given the limited in-country resources for nursing education reform. Other researchers have reported that curricula revision was enhanced by using external consultants to facilitate change.29,30

Quality of teaching and learning
The CNBC implementation brought about improvements in teaching and learning. The educational paradigm switched from teacher-focused to learner-focused, fostering a two-way relationship between teachers and students and causing a shift in nursing educator thinking. Students were motivated to learn using self-directed and experimental learning, while educators had to develop lectures using interactive and action-based teaching methods. Educators had to develop new skills and change their perspectives about ways of delivering knowledge. These changes were similar to those documented in31 and32 and reflect global trends in preparing the next generation of nurses.
Participants perceived that the students adapted well to the new curriculum; they demonstrated more skill and ability and readily took to self-directed learning with support from educators and a newly developed student guidebook. It has been argued that resistance to curriculum change might come from students who were not familiar with new learning methods; however, participants in our research reported that CNBC was well-received by the students. Although CNBC improves nursing students’ knowledge and skills, participants in this research thought students’ clinical performance under CNBC as lacking compared to those educated under the traditional didactic curriculum. CBNC students were less likely to perform in a clinical setting in a task-oriented way, resulting in nurses perceiving them as less “useful” on the ward. It is unclear whether the perception that students were not well prepared for clinical practice was due to curriculum change, a change in their approach to learning, or clinical educators’ misgivings about the new curriculum.

The quality of student evaluation under CBNC implementation improved. Students were assessed for individual work and group work using a variety of assessment formats in addition to the traditional style of paper-based examinations. This departed mainly from the traditional didactic curriculum, which focused solely on the end-of-course exam scores. Participants reported that CBNC allowed students to earn grades at multiple points during the course; timely grades, midterm grades, and end-of-course exam grades were weighed almost equally. In addition, the new grading structure increased the quality of the assessment by making the process more credited. Educators accepted the new forms of student assessment and found them effective. However, they said that more investment is needed to develop assessment instruments mentioned in the literature.

Barriers
The curriculum, teaching, and learning activities changes led to many difficulties and resistance during the implementation process. Whenever curriculum innovation occurs, impediments at the organizational and individual levels may be found. In our study, resistance came from those who had been working the longest using a traditional didactic teaching style. They were not ready for the change or were less motivated to embrace the changes also reported lecturers’ experience in a content-driven curriculum was not valuable in supporting their positions in the new program. Educators’ lack of knowledge and role identity was found in curriculum redesign, increasing resistance. Despite being trained in CBNC, some educators did not respond well to the new curriculum, resulting in low readiness to apply those required changes. This result is congruent with the literature indicating that some faculty members found their role as facilitators in CBNC challenging. CBNC is reported to increase the workload, possibly explaining why some educators and staff did not welcome the new curriculum. Other researchers have reported that technology in teaching was resisted by educators and students with limited experience with active learning methods and practice. More investment in faculty development is required to navigate the change to CBNC.

Another barrier was the nursing competency standards. Still, most study participants agreed that the standards were not well-constructed, and their language and explanations caused confusion among educators, students, and clinicians. The student’s competency measurement was possibly affected if educators misunderstood the competencies. A similar result was found in the work of. Further efforts must be made to ensure the consistency of language in the country’s nursing competencies.

Implementing a competency-based curriculum in low- and middle-income countries like Vietnam is intricate. Having limited resources affects healthy CBNC implementation given the difficulty of acquiring laboratories, simulators, fully-equipped libraries, or IT systems. Clinical instructors provided essential clinical teaching but received no compensation for their work. Similarly, also mentioned that inadequate pay was a significant barrier to accepting and adopting competency-based shifts.

Limitations of the study
Our study has limitations. The data were mostly collected through internet-based interviews because of travel constraints during the COVID-19 pandemic, which may affect the depth of participants’ responses. CBNC is still new in Vietnam, thus educators’ experiences of CBNC were relatively brief, and further research into their perceptions of the long-term effects would be beneficial.

Conclusions
CBNC is still an unfamiliar approach in Vietnam. The importance of CBNC is well recognized at the institutional level, but its implementation includes both challenges and opportunities. The implementation required specific changes in curriculum design, teaching, and learning methods, which were met with resistance from educators because of the higher capacity required and increasing workload without extra pay. Human resources served the dual role of facilitator and barrier. It was a critical facilitator through the support of school leaders and facilities’ availability. However, human resources were also a barrier when nurse educators were not well-prepared for CBNC,
highlighting the need for greater awareness and capacity building. Other identified barriers included the current MOH competency standards, which were confusing, inadequate library resources, infrastructure, and equipment, and the absence of policies promoting CBNC. The implications for other schools that plan to apply CBNC include investment in human resources, raising awareness among school leaders, preparing nurse educators, and upgrading library and online resources.

**Reflexive statement**

I (Anh T.H. Nguyen) am 38 years old and have worked as a nurse educator for nine years. I see the nurse educators work with the curriculum daily in my routine work. However, whenever there is a requirement to change anything in the curriculum, I see them implement those changes with stress, anxiety, and unconfident responses. Honestly, I can say that many educators do not like educational changes or applying reforms. That made me curious to see what was happening in other selected education environments when they implemented new competency-based curricula.

Before entering my academic career, I spent five years working in the central office of the national nursing association. During this time, I had a chance to be involved in developing the nursing competency standards from the time the Ministry of Health promulgated them. This working experience allowed me to have a considerable understanding of the nursing competencies in Vietnam. Besides, my demographic characteristics are similar to the research participants, enabling me to understand their experiences and share deeply as an emic perspective. Thus, I could understand the ideas that the participants shared about making changes in the curriculum with integrated competencies.

**Data availability**

**Underlying data**

Qualitative Data Repository. Data for: The implementation of a competency-based nursing curriculum in a developing country. [https://doi.org/10.5064/F67ILPHZ](https://doi.org/10.5064/F67ILPHZ)

This project contains the following underlying data:

- Interview transcripts (from all participants)
- Spreadsheet data of participant demographic information

**Extended data**

Qualitative Data Repository. Data for: The implementation of a competency-based nursing curriculum in a developing country. [https://doi.org/10.5064/F67ILPHZ](https://doi.org/10.5064/F67ILPHZ)

This project contains the following extended data:

- Interview guide
- Additional questions in the interviews
- Interview schedule
- Blank consent forms

Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

**Author contributions**

Anh T. H Nguyen: Conceptualization, Data Curation, Formal Analysis, Funding Acquisition, Investigation, Methodology, Validation, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing; Wipada Kuviktitkul: Conceptualization, Supervision, Writing – Review & Editing; Teresa Elizabeth Stone: Conceptualization, Formal Analysis, Methodology, Supervision, Writing – Review & Editing; Acharaporn Sripusanapan: Conceptualization, Supervision; Petsune Thungjaroenkul: Conceptualization, Supervision; Dung T. T Pham: Formal Analysis, Investigation.
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