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List of abbreviations

AFROL	African Online News
AIDS	Acquired immune deficiency syndrome
AKU	Aga Khan University
CNO	Chief nursing officer
HIV	Human immunodeficiency virus
ICN	International Council of Nurses
IMF	International monetary fund
MDG	Millennium development goal
MOH	Ministry of health
NHS	National health service
NPF	Nurse Prescribers Formulary
RCN	Royal College of Nursing
RPN	Registered psychiatric nurse
SPSS	Statistical package for social scientists
WB	World Bank
WHA	World health assembly
WHO	World health organisation
UK	United Kingdom
USA	United States of America

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CHAPTER ONE
OVERVIEW OF THE STUDY

"One of the penalties for refusing to participate in politics is that you end up being governed by your inferiors"
(Plato 427BC –347BC)

1.1   INTRODUCTION

The World Health Organization (WHO) in the 49th World Health Assembly (WHA 49:1) recognized the potential of nursing to make a major contribution regarding the quality and effectiveness of health services. It suggested that nurses and midwives must be involved at all levels of the health systems. In this regard it urged member states to involve nurses in health care policy and reform, and since then, the agenda of strengthening nursing and midwifery has remained in the WHO assemblies (WHO 1996).

In 2003, the World Health Assembly (WHA 56/19) recognized that in order to achieve the Millennium Development Goals (MDGs) (section 1.9.4), there is a need to provide support for countries to strengthen their nursing and midwifery services (WHO 2003). They (WHA) acknowledged that up to 90% of the health workforce comprises of nurses. Nurses and midwives make a substantial contribution to health-delivery systems in primary care, acute care and community care settings (WHO 2009). Despite their contribution to health care, they are seldom involved in policy development (WHO 2009:8). Still more worrying, though, is that according to WHO (2003), nurses' input into health policy development appears to be decreasing. It is suggested that in order to include nurses in the health policy debate, governments must develop legal frameworks to ensure clear nursing representation (WHO 2003).

Whilst nurse legends such as Florence Nightingale and Lilian Wald were prominent in influencing policy development, this tradition was neglected by nursing until the 1980s (Conn & Armer 1996:267). In 2000, the International Council of Nurses (ICN) adopted the position that nurses have an important contribution to make in health services planning and decision-making and in development of appropriate and effective health policy. Nurses can and should contribute to public policy pertaining to the determinants of health. The ICN's viewpoint on the urgency of nurses' involvement in health policy development was affirmed in 2005 when a document on "guidelines on shaping effective health policy" was issued (ICN 2005:19).   Hennessy (2000:1) contends that the shape of health care

provision and the health of the population are subject to nurses' input in health policy and hence the latter must participate in the policy development process.

Lima and Sampaio (2007:564) affirm that there was slight political movement in the 1940s, but it was not until the 1970s and 1980s that nurses began serious political activities to influence health policy in the developed countries. Although nurses from Western countries such as the USA and UK have made significant progress in influencing health policy development, they still face significant challenges. This is true for nurses even when they are part of the government system. For example, in a qualitative study conducted by Dollinger in the USA (2006:106,107) that examined nurses' advocacy in health policy, the findings revealed that nurses who work in the government have limited ability to influence policy due to the lack of status of the profession and the dominance of the medical profession in policy development.

In East Africa, nurse leaders appear to play a minimal role in health policy development. Additionally, literature searches do not reveal models that could potentially enhance nurse leaders' participation in this process, particularly from the context of the developing world, and especially East Africa. This study consequently aims to develop an empowerment model that may be used to enhance their participation in this respect.

1.2 BACKGROUND TO THE STUDY

A government's health care policies play a critical role in steering the health of the country. Their primary purpose is to promote the health status of the population by providing quality health care, improving access, facilitating choices and controlling costs in health services (Leatherman 1999). Health policies influence health indicators such as: infant mortality rates, life expectancy and the disease burden (Alubo 2001:313). *East Africa,* in the context of this study refers to the three countries, Kenya, Tanzania and Uganda, which are situated near or on the East coast of Africa (East African Community Portal 2010). In a case study of Uganda, Neema (2005:6) presented a paper to an expert group at a meeting where the impact of health policies was discussed and where reduction of maternal mortality was set as one of the priority health policy areas. An assessment of the key indicators after the policy was enacted revealed that the maternal mortality ratio in 1988/89 was 700 per 100,000 live births but decreased to 505 per 100,000 live births in 2000/01.

1.2.1   Impact of Health Policies

The usefulness of health policies is sometimes questioned and they are associated with negativity. Ambrose (2006) criticizes the policies imposed by the International Monetary Fund and World Bank in the 1980s, through the structural adjustment programme, on the Kenyan government. These focused primarily on reducing expenditure and led to downsizing the workforce in the government facilities, including health services. Consequently, nursing positions were frozen, resulting in large numbers of available nurses remaining unemployed and ironically creating a shortage of nurses in health services. This rendered health care providers incapable of offering preventive or promotive care and seriously compromised the quality of curative services in Kenya. When comparing the country's health indicators data after these policies were introduced, with the data for years before the introduction of these policies, the results revealed that health indicators had consistently worsened. Statistics show that the under-five mortality rate in 1990 was 97, but in 2000, it was 117 per 1000 live births. Also, the proportion of births attended by skilled health workers in 1990 was 44%, but in 2003, it was approximately 42% percent (WHO 2010b). This suggests that policies developed at national level could impinge on the nurse, nursing practice, health care and the population at large. In fact, in extreme instances like the one cited above, it would seem that some policies are moving development in Kenya towards a negative trend.

Health policies impact on patient outcomes and the nursing profession either positively or negatively (Cheek & Gibson 1997:669). For this profession, health policies directly or indirectly influence nursing practice, education, research and administration. Hennessey (2000:1) declares that "the shape of nursing is determined by health policy".

Nurses need to be involved in health policy development; otherwise, forces outside the profession will influence the direction of the profession. For example, in 1988 the American Medical Association proposed a new category of health care worker, "the Registered Care Technologist", to replace nurses in times of nursing shortage (Joel &Kelly 2003:302). When nurses are not involved in health policy development, negative outcomes for patients have been reported. In a qualitative study conducted in the USA by Aroskar, Moldow and Good (2004:267-273), with a group of 36 registered nurses working in the clinical setup, the findings indicated that policy changes made without nursing input

resulted in negative consequences in many areas which included patient safety, patient education, patients' ability to access services and nurses' ability to deliver quality care.

1.2.2   Need for nurses' involvement in health policy development

Nurses constitute the largest health care workforce in most countries. An estimated 35 million nurses make up the greater part of the global health workforce (WHO 2009:8). Nurses interact closely with patients and their families and often accompany patients around the clock in all sectors of health care. This gives nurses a broad appreciation of health needs, of how factors in the environment affect the health situation for clients and their families and of how people respond to different strategies and services. Nurses command expert knowledge based on their education and experience that could contribute positively towards improving all spheres of health care. ICN (2005:5) reiterates that nurses can make a major contribution in promoting and shaping effective health care policy because they closely interact with consumers, gaining an appreciation of the health needs of the population and factors that influence these health needs.

Nurses' involvement in health policy development ensures that health care is safe, of a high quality, accessible and affordable (Ferguson 2001:546). In a qualitative study conducted by DiGaudio (1993:72-94) analyzing the impact of nurses' contribution to health policy in the USA, revealed that nurses felt that when they participated in policy development they were able to positively influence areas related to access to health services, suicide prevention in adolescents, development of guidelines for the care of pregnant women and their children, and child abuse policy.

Unfortunately health policy development mainly includes policy-makers, doctors and lawyers but excludes nurses (Barclay 2010:15). A two-part survey that was conducted in Botswana by Phaladze (2003:27) examined the role of nurses in a HIV/AIDs policy development process. The sample included both policy makers and nurses. The findings revealed that nurses' participation in the given process was minimal and that policies were imposed on nurses, while at the same time, nurses were regarded as implementers of health policy. Important factors related to being excluded from the health policy development process include the negative image of the profession amongst policy makers and doctors monopolizing the policy development process. This study demonstrated policy makers' acknowledgement that exclusion of nurses from the policy development

process was a major mistake; whilst the impact of this omission is not discussed, the researcher alludes to the premise that this leads to problems in implementation and service provision.

Whilst there is scant literature from East Africa on nurses' participation in health policy development, in Kenya for example, the government made a public announcement that maternity services were going to be free. However, nurses were not consulted on this although nursing care and they themselves were directly affected by this policy directive. Any health policy has implications for nurse staffing, workload, quality and quantity of care delivered and patient outcomes.

Whilst not all health reforms have negative effects for nursing, nurses and patients, major difficulties are posed to nurses and nursing due to a lack of their input in health policy development. It is therefore important and desirable that nurses be included in this process to articulate issues and concerns on behalf of patients and themselves. As argued previously, nurses have more contact with the patient compared to all other health professionals and are knowledgeable and experienced in the issues pertaining to patients and health care.

The health policy implementation process may be more effective if nurses are involved and take part in the entire policy development process as they are major stakeholders in its implementation. This indicates that nurses can exert an influence on the government's ability to realize policy implementation goals. Specific MDGs related to targets such as the achievement of MDG 4 to decrease child mortality, MDG 5 to improve maternal health and MDG 6 to combat HIV/AIDS, malaria and other diseases can only be achieved through nurses' ability and willingness to implement health policy effectively (WHO 2010b, WHO 2010c, WHO 2010d). There are several reasons for this assertion, such as: if nurses do not understand the health policy, then they are unlikely to be committed to ensure its effective implementation. Exclusion of nurses from the policy development process, by policy makers, may result in health policies being developed that do not reflect the realities on the ground, thus making implementation complex so that achieving government objectives may be delayed or not realized.

1.2.3 The East African context

East Africa is on the eastern side of Africa (see figure 1.1). The official languages in Kenya, Uganda and Tanzania are Kiswahili and English (East African Community Portal 2010).

Figure 1.1 Map of Kenya, Uganda and Tanzania (East Africa) (The Friday Bulletin 2011).

Tanzania is the largest among the three countries where the study was conducted and has the largest population. Uganda appears to be most densely populated with the least land in square kilometers. All three countries have a large rural population, the main religion is Christianity, and the main economic sector is agriculture. Literacy rates are slightly varied with Kenya having the highest literacy rate (see table 1.1) (WHO 2010b, WHO 2010c, WHO 2010d).

TABLE 1.1 COUNTRY PROFILE			
Profile	Kenya	Tanzania	Uganda
Capital City	Nairobi	Dodoma	Kampala
Land area	580,367 square kilometers	945,203 square kilometers	236,040 square kilometers
Population	37,538,000 millions	39,459,000 millions	29,899,000 millions
	Majority rural population	Majority rural population	Majority rural population
Literacy rate	73.6%	69.4%	66.8%
Economic sector	Agriculture Tourism	Agriculture	Agriculture
Main religion	Christianity	Christianity	Christianity

(United Nations Development Programme [Sa], WHO 2010b, WHO 2010c, WHO 2010d)

Whilst Kenyans have a higher life expectancy and a healthy one, the other countries are not significantly different (WHO 2010b, WHO 2010c, WHO 2010d). The vital health statistics are recorded in table 1.2.

TABLE 1.2 VITAL HEALTH STATISTICS OF EAST AFRICA			
Health statistics	Kenya	Tanzania	Uganda
Life expectancy at birth in years	53	50	50
Healthy life expectancy in years	44	40	43

(United Nations Development Programme, WHO 2010b, WHO 2010c, WHO 2010d)

1.2.3.1 *Implication of the Millennium Development Goals (MDGS) for nursing in East Africa*

The United Nations Millennium Declaration, as agreed by UN member states in 2000, commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women. The MDGs are derived from this Declaration, and each has specific targets and indicators; member states have agreed to try to achieve them by the year 2015. The eight MDGs follow: goal 1 relates to eradication of extreme poverty and hunger; goal 2 refers to achieving universal primary education; goal 3, to promoting gender equality and empowering women; goal 4 deals with reducing child mortality; goal 5 relates to improving maternal health; goal 6 relates to combating HIV/AIDS, malaria and other diseases; goal 7, to ensuring environmental sustainability, while goal 8 concerns developing global partnerships for development. The MDGs are

inter-dependent: all have an influence on health, and, conversely, health affects all of them (WHO 2010b, WHO 2010c, WHO 2010d).

In 2003 the WHO (3,4), World Health Assembly (WHA A56.19) recognized that in order to achieve the MDGs, there is a need to provide support for countries to strengthen their nursing and midwifery services. The most significant MDGs in terms of nursing are goals 4, 5 and 6; these will not be attained without significant support from nurses. Nursing input into the development of health policies related to these MDGs will further their attainment. MDG 3 is particularly significant to this study in that it promotes gender equity and empowerment of women.

The MDGs imply that there is a great need for nurses' involvement in health policy to help realize these goals. Currently, there are very few women in parliament in the East African countries: the 2006 statistics indicate 7.3% in Kenya, 29.8% in Tanzania and 30% in Uganda (WHO 2010b, WHO 2010c, WHO 2010d). The ratios of human resources for health are well below the global average of 93 health professionals per 10,000 population (WHO 2010b, WHO 2010c, WHO 2010d). A low nurse/population ratio in a country means a smaller number of nurses to care for a higher number of patients. There is a correlation between the availability of human resources for health and health outcomes (WHO 2010b, WHO 2010c, WHO 2010d). There is evidence to suggest that as the availability of nurses and midwives increases, infant mortality and maternal mortality decrease. This is illustrated in table 1.3 where in Kenya, as the numbers of births attended by skilled health personnel have decreased along with antenatal coverage, under-five mortality has increased as has infant mortality. In Kenya the maternal and child health clinics are operated together, indicating a link. Nurse understaffing has been linked to negative outcomes, including increased mortality rates, patient falls, increased cross infection rates, medication errors, absenteeism and burnout among nurses, longer hospital stays and increased incidence of violence against staff (Pronovost, Lipsett, Jenckes & Bass 2001;WHO 2008:3-7). The significance of the MDGs to this study is that nursing input at all levels of health care governance and policy development process could influence the health outcomes positively.

TABLE 1.3 MILLENNIUM DEVELOPMENT GOALS' (MDGS) RELEVANCEIN EAST AFRICA				
Goals		Kenya	Tanzania	Uganda
MDGs 3 - Promote gender equity and empower women	Women in national parliament	2006 = 7.3%	2006 = 29.8%	2006 = 30.4%
MDG 4 - Reduce child mortality	Under 5 mortality rate per 1000 live births	1990 = 97 2000 = 117 2005 = 120	1990 = 161 2000 = 141 2005 = 122	1990 = 160 2000 = 145 2005 = 136
	Infant mortality rate per 1000 live births	1990 = 64 2000 = 77 2005 = 79	1990 = 102 2000 = 88 2005 = 76	1990 = 93 2000 = 85 2005 = 79
MDG 5 - Improve maternal health	Births attended by skilled health personnel 1990 – 1999 2000 – 2006	44% 42%	39% 42%	38% 42%
	Antenatal coverage 1990 – 1999 2000 – 2006	61% 52%	70% 62%	No statistics 47%
Health resources available (nurses and doctors)				
	Nurses and midwives	37,113	18,969	13,292
	Per 10,000 population	12	7	4
	Physicians	4,506	2,209	822
	Per 10,000 population	1	<1	<1

(United Nations Development Programme, WHO 2010b, WHO 2010c, WHO 2010d)

1.2.3.2 Nurse Leadership Structures in East Africa

Government structure for Nursing – Ministry of Health or equivalent

All three governments employ nurses in such a ministry, with a nurse leader termed the chief nurse. He/she reports to the director of medical services or equivalent. The chief nurse is given deputies to assist him/her. The chief nurse's role is generally advisory to the minister and permanent secretaries of health or medical services. Furthermore, they shoulder administrative and management responsibilities. They report to the permanent secretaries of health or equivalent. The leadership at the nursing council and professional associations, whilst not conducting a direct reporting relationship, do link up with the chief nurse (Mureithi, Mwenda & Yengo 2010).

Nursing Regulatory bodies

All three countries of East Africa have nursing regulatory bodies. These regulatory bodies are mandated to make provision for the training, registration, enrolment and licensing of nurses; to regulate their conduct and to ensure their maximum participation in the health

care of the community. They are all established under Acts of Parliament, within the laws of the country. The registrars are political appointments made by the ministers. The regulatory bodies also consist of a council that includes officials from the ministry of health and education such as the chief nurse, the director of medical services or equivalent who are members of the nursing council whilst the chairperson and other members are elected members (Mureithi, Mwenda & Yengo 2010).

Professional associations

Professional associations exist in all three countries while there are various specialized associations who are part of the national nursing association. The leadership is elected by its members. The chairperson represents nursing in the nursing regulatory bodies/council. His/her role is generally to advocate for the interest and welfare of the nurses. The role of the professional associations is to: advocate the interests of patients and nurses; create opportunities for nurses' professional development; and negotiate for salaries and benefits for nurses particularly in the public sector (Mureithi, Mwenda, & Yengo 2010).

The structure and the functions of nurse leaders in East Africa suggest restricted roles in health policy development, which are largely advisory. The structures appear to place nursing at a lower level compared to the directors of medical services, who are doctors to whom national nurses directly or indirectly report. The numbers of nurse leaders who can become involved in health policy development through links with the directors also appear to be small (Mureithi, Mwenda, & Yengo 2010).

Figure 1.2 illustrates the national nursing governance structures within the governments of the East African countries.

Minister of Health
(medical services)

Permanent Secretary

Director of Medical
Services

Professional
Associations

Ministry of Health
Chief Nursing Officer

Nursing Regulatory
bodies

* Deputy Chief
Nursing Officers

Provincial Nursing
Officer or equivalent
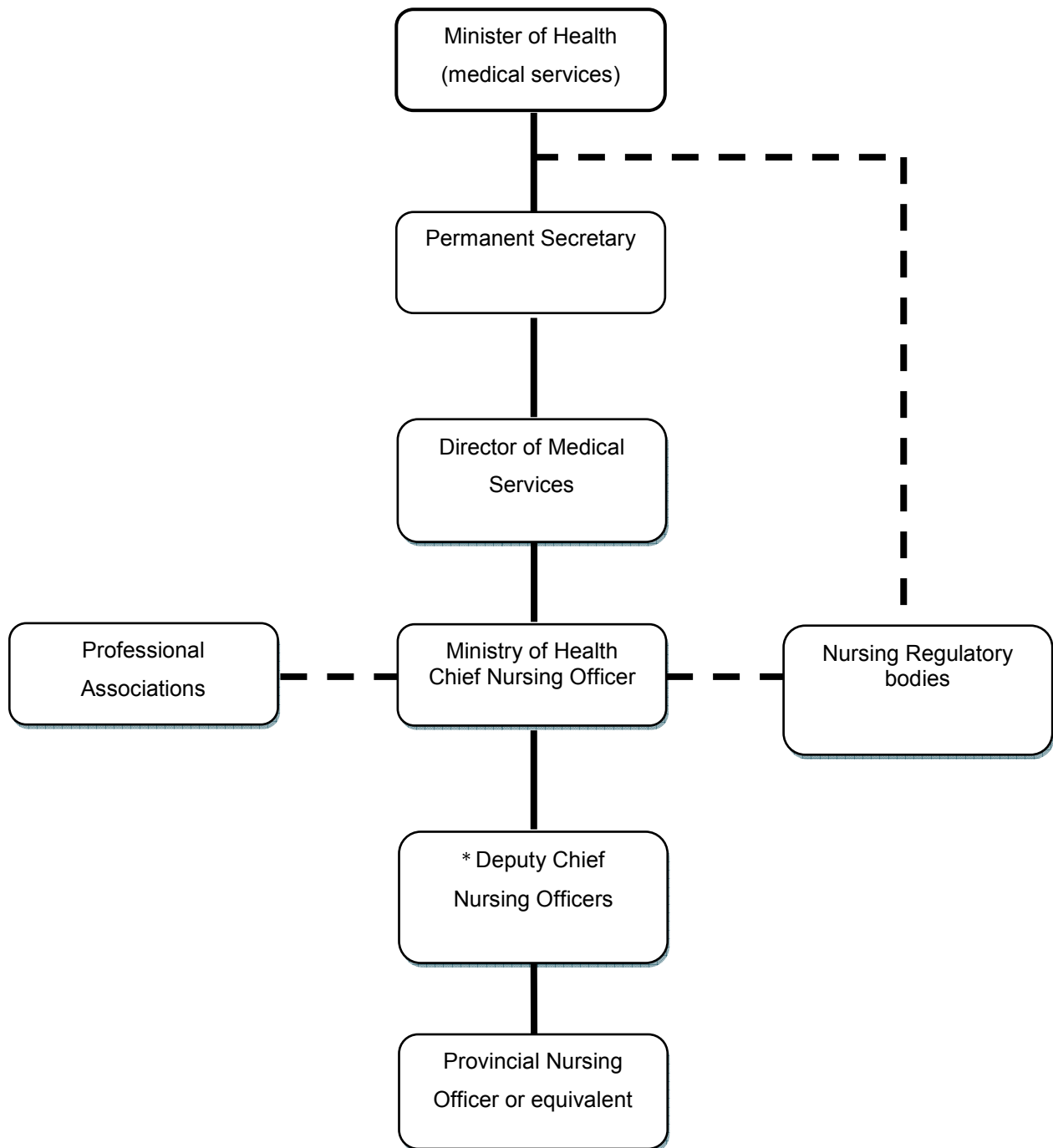
Figure 1.2 General Representation of the National Nursing Governance in East Africa (Registrar, Nursing Council of Kenya &Chief Nurse of Tanzania, 2010).

* Not evident in all three countries as a permanent and allocated position

1.3   PROBLEM STATEMENT

This study is based on the premise that there are serious challenges being faced in the developing world regarding: access to health care and health professionals, quality, equity and cost of delivering health care services. Positive changes in health care could be brought about through the participation of well educated, knowledgeable nurse leaders who appreciate that their influence is critical to health policy development (Ferguson & Drenkard 2003:183). ICN (2005:5) reiterates that nurses can make an important contribution in shaping health care policy because nurses closely interact with consumers, gaining appreciation of the health needs of the population and factors that influence these needs.

It is necessary to strengthen the role of nurses and their leaders in health care policy development globally, and particularly in East Africa. However, there is scant literature that explores the views of nurses in the health policy development arena so as to understand the nature of policy work and strategies that may facilitate increased participation (Wakefield & Kerfoot 2000:307). Furthermore, there is little published literature which aims to comprehend the phenomena of nurse leaders' participation in health policy development. This issue appears to be understudied in the African context and particularly in the East African one. Literature available on nurses' participation at health policy development stems mainly from the Western context, whose level of development is significantly different from that in East Africa in terms of social, political and economical development. Hence, application of knowledge from the West within the local context is often fraught with difficulties.

In other words, *nurses appear to play a limited role in the health policy development process in East Africa. There is a gap in knowledge about the extent of nurse leaders' participation in health policy development and the facilitators or barriers in this respect. Their participation can only be strengthened if this phenomenon is understood through evidence based knowledge and information.*

1.4   RESEARCH PURPOSE

The aim of this study is to develop an empowerment model that could be used to enhance nurse leaders' participation in health policy development. The study will, firstly, explore the extent of this in East Africa. Secondly, the study will seek to examine factors that influence such participation.

1.5   RESEARCH OBJECTIVES

The research objectives are to:

- o Explore the extent of nurse leaders participation in health policy development in East Africa
- o Build consensus on leadership attributes necessary for nurse leaders' participation in health policy development in East Africa
- o Build consensus on factors that act as facilitators to nurse leaders' participation in health policy development in East Africa
- o Build consensus on factors that act as barriers to nurse leaders' participation in health policy development in East Africa
- o Develop an empowerment model that can enhance nurse leaders' participation in health policy development

1.6   RESEARCH QUESTIONS

The research questions are:

- o To what extent do nurse leaders participate in health policy development in East Africa?
- o What are the leadership attributes that are required for their participation in this arena?
- o What are the factors that facilitate their participation?
- o What are the barriers to their participation?

1.7   SIGNIFICANCE OF THE STUDY

Nurses' role in health policy development needs to be strengthened; however, it can only be reinforced if the phenomenon is studied and understood. By conducting this study, the researcher aims to understand nurse leaders' role in health policy development. The

knowledge gained from the study will inform the development of an empowerment model that may enhance nurse leaders' participation in this field.

1.8   DEFINITIONS OF KEY TERMS

Policy– refers to the principles that govern a chosen course of action or inaction towards attainment of certain goals (Mason, Leavitt &Chaffee 2007:3). Merriam-Webster (2006-2007) defines policy as: a definite course or method of action selected from among alternatives and in the light of given conditions to guide and determine present and future decisions, which is a prudent or expedient conduct or action.

In the context of this study, policy refers to the principles that govern a chosen course of action or inaction towards attainment of goals which influence the interest of the public.

Health policy– these are guidelines that are laid down to promote the health of individual citizens, families, communities and the population at large (DiGaudio 1993:9).

In the context of this study health policies are guidelines, directives or principles pertaining to the health sector that govern the action or inaction that influence the health of the population.

Health policy makers– these are individuals who are mandated to develop policies related to health care issues (DiGaudio 1993:9).

For the purpose of this study, health policy makers are those who are mandated to develop health policies related to health care issues at national level.

Health policy development process –includes the stages of agenda setting, policy formulation, implementation and evaluation (Hanley &Falk 2007:80). The process is complex, dynamic and cyclical (DiGaudio 1993:9).

For the purpose of this study, the process includes problem identification and agenda setting, as well as policy formulation, policy implementation and policy evaluation.

Nurse – for the purpose of this study, this is a person educated at the basic level of a degree or diploma in nursing, registered and licensed by their respective Nursing Councils in East Africa.

Nurse leader–for the purpose of this study, a nurse leader is a registered nurse;the term further encompasses a nurse in a formally elected or nominated national leadership position at a university, national professional association, nursing council or ministry of health or equivalent.

Leadership - Tourangeau and McGIlton (2004:182) define leadership as a process of influencing followers to accomplish goals. Kouzes and Posner's ([Sa]) description includes four main concepts that are related to being challenging, inspiring, visionary and enabling.

For the purpose of this study, leadership is defined as the ability of a leader to influence followers towards a vision by inspiring, challenging, enabling and persevering.

Empowerment — is defined as support towards enabling individuals and groups to participate in actions and decision making related to health policy development (Mason, Backer &Georges 1991:72,73). Furthermore, empowerment is regarded on a continuum, as a process that evolves towards increased growth and advancement to participate (Manojlovich 2007). It refers to gaining control to be able to exercise one's power. It also relates to developing and building the skill base of people (Yoder-Wise 2007:174).

In the context of this study, empowerment refers to building, developing and supporting nurse leaders to participate and exercise influence in actions and decisions related to health policy development, along a continuum of advancing expertise.

Participation – is defined as a process through which influence is shared among individuals who are unequal hierarchically. There are many forms, which include short term, consultative or long term participation (West 2001:45).

In the context of this study, participation is considered to be part of, and exerting, permanent influence on, involvement in and contribution in the content of activities and the process pertaining to health policy development.

Empowerment and participation are strongly interlinked: empowering people requires promoting opportunities for their participation, while participation requires empowering people to enable them to exercise this human right. Both empowerment and participation can take place within the economic, social, or political context (Sidorenko 2006:2).

Model – this represents interrelated concepts that are assembled together in a rational scheme by virtue of their relevance to a common theme (Polit & Beck 2008:154-155).

For the purpose of this study, a model is that which contains interrelated concepts which are assembled together by their relevance to health policy development.

Health – is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 2010a).

Attribute – is a quality, characteristic that is inherent in and ascribed to someone or something. It is a term recognized as appropriate and serves to identify a characteristic quality (*Concise Oxford Dictionary of Current English* 1989:56).

Knowledge – refers to knowing, familiarity gained by experience, theoretical or practical understanding of a subject (*Concise Oxford Dictionary of Current English* 1989:556).

Process – course of action, series of operations, and series of changes (*Concise Oxford Dictionary of Current English*1989:820).

In the context of this study, process refers to courses of action and stages of operations.

1.9 RESEARCH DESIGN AND METHODS

The **Delphi survey** was chosen as an appropriate design to conduct the study as it is considered a useful method in exploring an area where there is an incomplete state of knowledge, uncertainty in knowledge and lack of empirical evidence (Amos & Pearse 2005:95;Powell 2003:376, 377). A Delphi survey includes the following criteria: expert panellists, iterative rounds, statistical analysis and consensus building.

The Delphi survey is a method that utilizes the expertise of a purposive sample of a panel of experts, to explore issues of concern through the use of iterative questionnaires and giving controlled group feedback. A non-random **purposive sample** of expert panellists who were nurse leaders was utilized because they were considered to have the opportunity to participate in national health policy development activities.   This sample was drawn from nurses who were registered nurses, working with the nursing councils, national nurses' professional associations, ministry of health or equivalent and universities. They came from the three countries of East Africa mentioned.

The study was conducted in three iterative rounds. Seventy eight expert panellists were invited to participate in the first round of the study; 37 (47%) took part in the first round, while 37 (all those who participated in the first round) were invited to the second round of whom24 (65%) responded; 24 were invited to the third round and all 24 (100%) responded.

The data collection tool was developed by the researcher for the questionnaire in the first round with reference to and informed by the literature reviewed; it mainly used open-ended questions which provided qualitative data. The questionnaire for the second round was informed by the data derived from the first round and was quantitative, containing closed ended questions, as was the third round questionnaire. All three questionnaires were pretested with a group of nurse leaders not included in the study. The validity and reliability of the data collection instruments as they pertain to the study are discussed in chapter three.

Ethical approvals were secured from the authoritative national research bodies in Kenya, Tanzania and Uganda after this was obtained from the University of South Africa, College of Human Sciences Research and Ethics Committee. Informed consent was secured from all participants. Ethical considerations pertaining to the study rights were upheld and are discussed further in chapter three.

Data analysis for the first round was performed by using the guidelines for qualitative data analysis. The most common reoccurring factors and attributes were identified. The round 2 questionnaire was formulated using the data generated from the round 1 questionnaire. The second and third rounds were analyzed with the aid of the Statistical Package for Social Scientists (SPSS): the descriptive statistics were examined, which included the percentage average, mean and standard deviation. A statistician assisted with data entry and analysis. The consensus accepted for the second round was >=90%; this was mainly to ensure that critical issues were retained in the study, while for the third round the consensus was set at >=70% so as to ensure that of the critical issues the most important ones were not eliminated. A detailed discussion of the research design and methodology is presented in chapter three.

1.10　SCOPE OF THE STUDY

This study was conducted in Kenya, Uganda and Tanzania with a panel of experts who were national nurse leaders who potentially participate in health policy development process. The findings of this study are relevant to these countries and the group of expert panellists but are not intended to be generalized to other countries.

1.11　ORGANIZATION OF THESIS

The thesis is structured in the following manner:

Chapter one: overview of the study

Chapter two: literature review

Chapter three: research design and methodology

Chapter four: findings and discussion

Chapter five: empowerment model for nurse leaders' participation in health policy development

Chapter six: summary of findings, conclusions, limitations and recommendations

CHAPTER TWO

LITERATURE REVIEW

"I not only use all the brains that I have, but all that I can borrow."
Woodrow Wilson - 28th president of the US (1856 - 1924)

2.1   INTRODUCTION

The aim of this study is to develop an empowerment model that could be used to enhance nurse leaders' participation in health policy development. This chapter discusses the literature reviewed which is related to nurse leaders' participation in health policy development. The purpose of a literature review is to locate, read, understand, interpret and form conclusions about published literature on the issue under study (Bless &Smith 2000:23). According to Polit and Beck (2008:65,106), there are two main purposes for a literature review: to understand the state of current knowledge and furthermore to develop an argument that supports the need to conduct the study. Both authors point out that a literature review is necessary to assess the gap in the current state of knowledge related to the issue of interest. The purpose of this literature review was to explore the state of knowledge related to nurse leaders participation in health policy development.

A traditional and methodological literature review was executed. Databases provided by the University of South Africa and Aga Khan University, which included but were not limited to Cumulative Index Of Nursing And Allied Health (CINAHL), Journal Storage (JSTOR), Pub med, Blackwell Synergy, EBSCO and Sage, were searched. Individual journals reviewed included: *Journal of Advanced Nursing*, *Journal of Policy, Practice and Nursing*, *Journal of Nursing Management*, *Journal of Nursing Administration Quarterly*, *Journal of Nursing Scholarship* and *Nurse Leader*. Predominantly, primary sources of literature were reviewed, namely research articles. Additionally, books and articles were surveyed as a way of snowballing to identify relevant primary sources of literature (Burns &Grove 2001:107).

This chapter presents the summary and the conclusion derived from the literature reviewed under the following sub-headings: policy development; involvement of nurse leaders in health policy development; barriers to nurse leaders' involvement in health policy development; facilitators of nurses' involvement in health policy development; nursing leadership and empowerment.

2.2 POLICY DEVELOPMENT

Policies exist at all levels of society. These include the professional, international, national, provincial, district, community and household levels (Cheek &Gibson 1997:668). There is agreement among authors on the basic meaning of the term policy. It is referred to as a set of specific plans for action, or the organizing of principles which guide and direct the development of goals that are designed to address perceived or actual problems (Toofany 2005:26; West &Scott 2000:817; WHO 2005:17). Policies are often expressed as a set of guidelines, rules or laws. Policies mainly encompass three aspects: the objective to be achieved, the methods for doing so, including the resource requirements and the plans of action to achieve the objectives.

Policy can be a method of restricting decision-making, for where there is no policy, there is freedom to make decisions, but where a policy exists, then one has to work within defined boundaries (Rozycki 2004). Cheek and Gibson (1997:669) challenge the controversy between autonomous practices on the one hand and control through legislation and policy on the other hand. However, the reality is that policy exists and is necessary to ensure equity, access, quality, cost effectiveness and availability of health professional resources. In countries where no policies exist, there is chaos and anarchy.

In this sense, "Health policies may be described as the strategies and courses of action adopted as being advantageous and expedient to provide within the resources available from a health system that at least maintains, and preferably improves, health" (Hennessy 2000:6). Health policies have major financial implications as they relate to allocation of resources; hence, health policies are strongly linked to economic policies (Collins 2006:16). Health care policies impinge on practice at every level, from national to individual, influencing all aspects of health service and practice (Chavasse 1998:173).

Policy and decision-making are often regarded as identical. However, they can be differentiated on the premise that policy is larger than decisions. Decisions can be viewed as a range of options from which one option is selected whereas policy can be perceived as a number of decisions and the strategy of putting them into practice (Walt 1994:40). This study is based on the second premise that policy making is more than decision-making; however, decisions exist within the context of particular health policies.

2.2.1 Types of policy

Policies are divided into four major categories: distributive, regulatory, self-regulatory and redistributive (WHO 2005:18). **Distributive** policies relate to the distribution of resources and services to groups within a population. The policy on the introduction of community health workers in Kenya can be considered a distributive one. **Regulatory** policies involve imposing a framework within which a group must function. Such a policy could, for instance, relate to the licensing of midwives to function within a clear framework. **Self-regulatory** policies are those where organizations seek to control their own interests, such as the scope of professional practice for registered nurses. Finally, **redistributive** policies are those that express an effort by the government to change the allocation of wealth. Redistributive policies may include higher taxation for high-income earners and higher taxes on luxury items like wine. These taxes are then used for purposes of enhancing the standard of living of the poor and less fortunate members of the population in a society, such as providing clean water or free access to health care (Walt 1994:43,44). All types of policies exert an influence on all levels of policy development.

2.2.2 Levels of policy development

Generally, three main levels of policy development are distinguished: micro, meso and macro. According to Mason, Leavitt and Chaffee (2007:8), there are several avenues for nurses to influence health policy and engage in policy development and political activism, which include the workplace, organizations, government and community.

Micro level policy development is concerned with policies at unit level. In the context of health care, these policies include those that are meant to facilitate successful health outcomes for individual patients and a specific group of them. Such a policy could concern wound management for surgical patients. To exert influence on workplace policy development nurses must ensure that they are part of the policy development forum at unit level. These experiences of micro level policy development provide valuable knowledge and exposure for macro level participation.

Meso level policy development is concerned with policies at organizational level. These policies are concerned with wider organizational issues which influence the care of the patient population that the organization serves. In this case, the organization may, for example, develop a programme to follow up all discharged patients or become a non-smoking zone for everyone. Meso level policy development also applies to the community.

Nurses can advocate for the community within which they live and vie for leadership positions at the local level.

The macro level is concerned with policy development at national level. These policies are concerned with broader issues that influence the health of the entire population. Such policies may include issues related to: access to health services, equitable distribution of health services, quality and availability of health services (RCN 2001:21). Nurses could compete for legislative positions to effect policy at macro level. Such a policy may be related to access to health care for the rural population where the majority of the population in developing regions like East Africa live in such areas. Macro level policy development is likely to influence micro and meso levels of practice and policy; however, the converse may not be true. Hence, it is important that nurses are knowledgeable about macro policy changes and how these affect them personally, their practice and the profession.

Nurses can influence health policy through their local branch (meso level) and national branch (macro level) of their professional nursing organizations. For nurses to be able to influence policy, they need to be members of nursing professional associations, be active participants and be united on issues of concern. Unison and numbers are an important bargaining point for these organizations. According to Holleran (1985:44,45), "Nurses could change and direct the whole health system if they would only get united and all work together". Additionally, nurses should be active in voting activities and selecting appropriate leaders as well as contending for office. They need to hold their leaders accountable for issues related to nursing practice, patient care and the nursing profession. As early as 1985, the ICN (International Council of Nurses), as cited by Holleran (1985:44), distributed draft guidelines to assist nurses' associations to increase their effectiveness in influencing health policy. However, more than 25 years later, nursing influence on health policy is sporadic and unheard.

The level of policy and that of politics are closely linked; this suggests that micro level policy development is less political and less likely to create conflict whereas macro level policy development is highly political and more likely to do so (Walt 1994:43). Policy development is a competitive process that includes the opposing interests of diverse groups that are involved in influencing and shaping the direction that a policy will finally adopt (WHO 2005:17).

Different types of policy influence nurses at a personal and/or a professional basis. This is interrelated with levels of policy development, which indicates that health policy affects nurses and nursing practice at unit, organizational and national levels. Whilst it is important for nurses to become involved in this process at all levels, this study is limited to health policy development from a macro level perspective and in the context of provincial, national, regional and global levels.

2.2.3 Theories and perspectives on policy development

For nurses to be involved as suggested above, they need to understand the process and the theories related to it. Whilst what the process encompasses may be considered simple, there are factors related to how policy is developed and who influences the process, that complicate it and make it hard to understand. At the macro level, there are major implications related to policy development and allocation of resources, which cause the process to be highly political.

2.2.3.1 Policy development process

According to (Mason, Leavitt & Chaffee 2007:79,82) the most common and simple model used to describe *what* this process is includes four main stages: problem identification and agenda setting, policy formulation, policy implementation and policy evaluation.

Problem identification and agenda setting is the stage at which problems and issues are identified and the policy agendas are set. However, public problems can only reach the policy agenda if they are converted into political issues (Walt 1994:44,45). There are many players and interest groups that try to ensure that their issues are included on the policy agenda while there are others like multinational businesses that try to keep issues off the said agenda. An issue of concern for health professionals was enacting a ban on smoking in public places, but the tobacco companies ensured that this issue remained off the agenda for many years. In the researcher's experience, nurses have been unable to get themselves included and use their expertise regarding health care to influence the policy development agenda. An issue of concern where nurses should have taken a lead role in putting it on the policy agenda was nurse migration and its effects on nursing practice and patient outcomes; conversely, physicians and others took a lead in addressing the issue (Ringa 2008).

The stage at which policies are created or changed is that of policy formulation. This is the technical stage of the process in which information is collected, analyzed, disseminated and legislative language is drafted (Hanley & Falk 2007:81). In this stage, various interest

groups and policy makers may draft alternative proposals and these may be evaluated in terms of costs and benefits. This is the phase during which interest groups need to ensure that they keep interested and exert pressure to ensure that the issue is formulated into policy, which is the product of the context within which it is created (WHO 2005:4). This stage involves negotiation and compromise, and as a consequence, weak policies may result (Perry 1991:551). Nurses' involvement in and contribution to this stage are critical to ensure that appropriate health care policies are developed.

Policy implementation is the stage wherein policies are adopted and what has only been on paper is put into action. At this stage, the content of the policy and its impact on those affected may be modified substantially or even invalidated. Nursing is usually involved at this stage but is unfortunately absent or unacknowledged at the agenda setting and policy formulation stages. Whilst nursing expertise would be most useful during the first two stages, nurses are absent from them. This often poses major difficulties for nurses and nursing, as they may encounter policies that are difficult to implement, with which they do not agree or which do not reflect the reality on the ground (Lange & Cheek 1997:7; Venturato, Kellett & Windsor 2007:10). Cameron (2000:1085), reporting on a study carried out in the UK, confirms that nurse executives are expected to implement government health policy, some of which they appear to question.

The stage which includes monitoring, analysis, criticism and assessment of existing policies is that of policy evaluation. This covers the appraisal of the content, the implementation and the effects (WHO 2005:4). This process is dynamic and cyclical and policy evaluation may aid in identifying either a functional program or problems, hence restarting the cycle (Mason, Leavitt & Chaffee 2007:80,81).

This study is grounded in the policy development process framework, which was utilized to identify the extent of nurse leaders' participation in health policy development during the various stages of the process. Furthermore, the framework was applied to identify factors that are facilitators and barriers to such participation.

Nurses are urged to be initiators of policy development and reform rather than passive recipients of policies (Cook 1999:309). Over 20 years ago, Holleran (1985:44) lamented that "if the profession is not leading the way then as always government will pick up the slack." This reiterates the need for nursing to take up a leadership role in health policy development. According to ICN (2000,2008), nurses must accept their responsibilities in

health services policy and decision-making, including their responsibility to attain relevant professional development.

2.2.3.2   Theories of policy development

There is little dispute about the various stages of the policy development process. However, there is debate as to whether these stages are linear, logical or part of a multifaceted phenomenon. It is clear that the said process is complex, with players influencing it from many differing perspectives. There are many theories of policy development: presented in the section below are four main ones as they relate to the health policy development process: rational (linear); incremental; mixed scanning; and Kingdon's multi streams (Hennessy 2000:8).

Rational theory

This theory views policy development as a problem solving process, where decisions are made during sequential phases. The theory consists of six elements: recognizing and defining the nature of the issue to be dealt with; identifying possible courses of action to deal with the issue; weighing up the advantages and disadvantages of each of these alternatives; choosing the option which offers the best solution; implementing the policy and possibly evaluating the outcome (Walt 1994:46,47). Ideally, this process includes consultation, consensus building, policy formulation, revision and production of documents, training, sensitization and communication (Mulligan, Mandike, Palmer, Williams, Abdulla, Bloland & Mills 2006:452). This perspective is more likely to bring about change and transform health care.

Such a theory can be considered idealistic. Critics argue that: firstly the policy maker rarely has clearly defined problems and information; secondly the policy maker must contend with his/her own values and those of the public; and thirdly problems rarely exist in a solo state: there are usually other policies (or older ones) that may be difficult to undo in order to start from the beginning (Sutton 1999:9).

Incremental theory

This holds that policy development rarely exists in isolation since any policy will influence others, and there are usually existing policies to contend with. The process encompasses goals, objectives and information that are intertwined and difficult to separate. Few alternatives are considered, and they will only differ marginally from existing policy (Sutton

1999:30). For each alternative, only a limited number of consequences are explored; the problem is continually redefined to try to make it more manageable as there is no single right answer. Finally, the resultant policy is usually an adjustment to current problems rather than being futuristically orientated. This theory is considered to be a reflection of how policy is developed in reality. Policy development from this perspective can be considered reform (Hennessy 2000:9). The major criticism of this theory is that it promotes the status quo and impedes change.

Mixed scanning theory

Developed in contrast to rationalist and incremental theories, the mixed scanning theory incorporates both the earlier theories, enables policy makers to choose the best approach for the situation and can be described as a compromise. The rational/linear model implies an exhaustive consideration of all possible options in detail, whereas the incremental approach suggests looking only at options and solutions that from previous experience are known to exist. In contrast, a mixed-scanning approach suggests taking a broad view of possible options and looking further into those that require a more in-depth examination (Sutton 1999:10). Criticisms of this theory are that it does not offer guidance on the conditions under which this theory is appropriately used, the degree to which taking a broad view is appropriate nor the depth of examination that is effective or necessary (Ijeoma 2007:827).

Kingdon's multi streams model

This model suggests that policy is made through three different streams: the problem stream, the solution stream and the political stream (Mason, Leavitt & Chaffee 2007:79,80). The first relates to placing issues on the agenda and is concerned with the competition and complexities of gaining the attention of policymakers concerning the priority of issues. The solution stream describes the policy goals; the ideas that float around are tested, discussed, reviewed, combined and packaged as solutions, for policy formulation (Khan 2006:11,12). The political stream describes the environment that influences the policy agenda, which includes the national mood, election results, change of administration, interest groups and/or other organized political forces (Stout & Stevens 2000:341,342; Tierman& Burke 2002:78,88).

The theory proposes that these streams are independent and wait for a "window of opportunity" to happen and an opportunity to open through couplings of any two streams,

especially the political, creating new opportunities for policy change. These opportunities are often time bound so that if policy change does not occur, then the streams continue floating, which may result in a missed opportunity (Walt 1994:56,57).

Critics of Kingdon's model argue firstly that it is a difficult model to conceptualize and secondly, that it is more relevant to agenda setting, not the full process of policy development. This criticism is partially unjustified as there is an indication that solutions are considered in the solution stream and are relevant to the policy formulation stage. Thirdly, Kingdon's study was undertaken in the developed world whereas the policy development process in the developing world differs significantly. In the developed world, the role of interest groups and stakeholders is pronounced while in the developing world, the role of stakeholders is weak and unclear (Khan 2006:11,12).

2.2.3.3　*Perspectives on policy development*

Policy development is a complex process, influenced by factors and individuals. Two main perspectives on *who* influences the health policy development relevant for health care identify elitists and pluralists.

Elitist perspective

Elites are a small number of politically dominant groups (Coxall, Robins & Leach 2003:8). The elitist perspective holds that policy choice and change is dominated by particular social classes and that the role of the state is to support this dominance (Walt 1994:37). This group includes people in government, industry, academia, media and in health care, doctors and the pharmaceutical industry. It is suggested that these elite groups are connected to each other in some way (Birkland 2001:105). This view maintains that the political elite is only open to members of the dominant social and economic class and that different parties hold differing levels of power through which they are able to promote their own interests. The ability to be included in the elite groups is more than the ability to present articulate arguments. It is related to power balances and imbalances as well as the attributes of the groups and their issues and interests (Birkland 2001:111). It is suggested that the elite group is generally stable in its membership; whilst politicians may come and go and governing bodies may change, the elite group are the constant that maintains influence on issues (Henrikson [Sa] internet). The stability of the elite members in itself can result in their exercising power over politicians in terms of access to information and (historical and policy related) knowledge that others lack.

Criticisms concerning the elitist perspective have held that all elites may not have a common agenda on a given issue. This model proposes a top-down method of policy development and governance that excludes the voice of the great masses. It implies that the general population cannot influence policy though there are methods through which policy can be influenced, which include civil society organizations as well as professional ones (Parry 2005:2).

Nursing has been slow in having itself included in the elite groups. The reasons for non-inclusion may be related to: nursing not being considered economically or educationally dominant by others and by its own members; the lack of a clear professional status as viewed by other professionals; and the lack of perceived power within and outside the profession. Additionally, structural relationships are organized in such a fashion that nurses remain dominated while others retain dominance (Daiski 2004:44; Fletcher 2006:56,57).

It appears that in developing countries like Kenya, Tanzania and Uganda, this is the perspective that holds true to a large extent. In Kenya during the 2007/8 political upheavals, negotiations were held to accommodate the coalition between the two principal political parties and, as a result, the ministry of health was split into two ministries. Whilst nursing structures and functions were affected by this split, the profession was not consulted, nor did the professional nursing organizations make any statement on their position.

Pluralistic perspective

"Pluralism involves the belief that power is widely dispersed through society, rather than heavily concentrated in the hand of an elite or ruling class." (Coxall, Robins & Leach 2003:8). The pluralistic view is therefore that no one group holds total power over others. It maintains that the state is neutral and does not support any particular view; there is freedom to vote, express opinion and exert influence; the right and ability of the people to participate allows for expression of opposition and whilst there are elites in society no one group dominates (Lewis 2006:2125; Olsson 2003:287).

The criticisms of this theory are that the state is not a neutral entity and is linked to powerful institutions that influence and promote policies that are in their own interest as perceived from the elitist perspective. According to Walt (1994:37), interest groups and coalitions form to represent the society and the interests of the constituents that they

represent. This theory is applicable to the developed world where different interest groups have access to policy makers, and structures and processes are in place to influence the latter, whereas in the developing world the political structures are in their infancy, unclear and weak (Khan 2006:11). This theory consequently appears idealistic in its principles. According to Archer (1983:72,73), nurses have been unable to influence policy in terms of this perspective, as nursing professional organizations and bodies are often frail and divided. Nurses' ability to form coalitions and partnerships within and outside nursing, to exert any formidable influence on policy development, despite their large numbers in health care, has been ineffectual. Indeed, nurses prefer to be seen as apolitical and rarely participate in political activism, hence being ineffective in influencing policy (Des Jardin 2001:614). Those who do get into policy development may tend to adopt the elitist perspective, joining policy makers and adopt their values and views, thereby isolating other nurses from the process and poorly representing the nursing perspectives (Daiski 2004: 44).

2.2.4 Political skills for participation in health policy development

Politics may be defined as striving to share power or striving to influence the distribution of power either among states or among groups within the state (Concise Oxford Dictionary 1982:793). Politics includes the policy development process, as well as its outputs and outcomes (Coxall, Robins & Leach 2003:4) and is defined as the process of influencing the allocation of scarce resources through policy decisions (Chan & Cheng 1999:167; Collins 2006:16; Mason, Leavitt & Chaffee 2007:4). This means that opportunities do exist for nurses to modify the outcomes of allocation of limited resources and policy. Policy development rarely takes place in isolation and is closely associated with political activity. Conversely, lack of political participation may lead to lack of influence in the policy development process. As indicated, nursing has been ineffective in influencing policy development, which may be attributed to its negligible political influence.

2.2.4.1 Political development

Cohen, Mason, Kovner, Leavitt, Pulcini and Sochalski (1996:259,260) have identified four stages of the political development of nurses. They progress through these stages at different paces, with the early stages typically prerequisites for the later ones.

Stage 1, the "buy-in" phase, encompasses activities that promote political awareness. This can be observed in Kenya where more nurses are willing to become members of the nursing professional organization, indicating "buy-in".

Stage 2, the "self-interest" phase, which includes activities related to enhancing nursing identity and self-interest in the political arena. A case demonstrating this stage was one where a local newspaper reported that, "Nursing staff in public hospitals have been pressing for a pay increase. They recently put on hold a strike after the Government promised dialogue." (Muiruri2008). This suggests that nurses in Kenya are additionally exhibiting the "self-interest" stage of political development which is reactive towards nursing issues.

Stage 3, the "political sophistication" phase, is characterized by increasingly complex types of political activism and a growing recognition, on the part of policymakers, of the contributions that nurses can make to health policy. Nurses at this stage are more proactive about nursing and health care issues. This is rarely evident in the East African context. Observable instead is that nurses have left their concerns related to the shortage of nurses and its related effects on nurses and patient care to the medical profession to articulate (Amadala 2008). Ironically, nurses rarely articulate issues and concerns regarding patients and the population in relation to health care. Policy advocacy on behalf of the public is unusual.

Stage 4, the "leading the way" phase, which features nurses as initiators and innovations of health policy introducing ideas that reorder health policy debates and agendas. This is an area where nurses are struggling to make progress, even in the developed nations (Cohen, Mason, Kovner, Leavitt, Pulcini & Sochalski 1996:259,266; Cohen & Milone-Nuzzo 2001:29,30). Cohen et al. (1996:263) contend that the nursing profession, collectively, has reached the first three stages of political development while stage four, leading the way, is still a long-term political objective.

Cohen et al.'s (1996) theory was tested by Wilson (2002:32) in a study in Canada carried out to establish the level of political participation among nurses and non-nurses. She found no significant evidence of proactive political leadership but rather that the

participants' political involvement was more reactive to the issues at the time; though most non-nurses engaged in political action for self-interest purposes, nurses were oriented towards the public good.

Cohen et al.'s (1996) theory guides nurses regarding their personal and collective levels of political development but does not suggest *how and what* factors enhanced or impeded their progress through their political development. These authors' theory has its foundation in their historical review of political activism in America. The situation in the developing world is different and the stages may therefore vary; however, whilst there is no published literature that guides nurses' political development, this theory does provide insight (Cohen et al. 1996:259,266). It may offer a basic understanding of the level of political development among nurses in Kenya, Uganda and Tanzania. For nurses to participate in health policy development, they must be part of the political arena, be politically astute, be political activists and lobby effectively.

2.2.4.2   *Political arena*

The political arena encompasses the environment in which the policy development process takes place and includes the government institutions, interest groups, professional associations and media (ICN 2005:6). Since it is obviously a [sphere](#) [of](#) [intense](#) [political](#) [activity](#) (Wordnet 2006), nurses need to increase their political awareness to operate effectively within it (Antrobus 2003:42). There are avenues through which nurses can become involved in it. These include: active membership in nursing professional organizations, or within the community; lobbying through active involvement in nursing organizations; and lobbying through other voluntary sector organizations and charities (Barber 2007:424). Involvement in the said arena requires knowledge of issues of concern to the nursing profession, patients, or the public as well as of the political process, policy development process and leadership skills. Often the ease with which nurses function in health policy arenas is a reflection of their skill and political acumen, which involves more than theoretical knowledge. It encompasses experiential learning in health policy that enables nurses to progress along a continuum of expertise development similar to Benner's stages of 'Novice to Expert' in the clinical arena (Cohen & Milone-Nuzzo 2001:38). Nursing education needs to provide educational experiences for nurses to engender political awareness. Additionally, nurses who are already active in health policy arenas could support others as a means of opening up a health policy career route to more colleagues (Whitehead 2003:587,589).

To date, nurses in East Africa appear relatively apolitical, with others making decisions for nursing on health and nursing issues. Conversely, nurses have an in-depth knowledge of the issues related to health care and patients. However, due to their silence in the political arena, nurses exclude themselves and are not regarded as valuable partners by policy makers in influencing health care policy (Christensen & Hewitt-Taylor 2006:698; Phaladze 2003:22). The challenge then confronts nurses, to inform others about nursing and nursing knowledge and its potential and valuable contribution to health care and policy.

In 2005, ICN produced a document concerning guidelines for shaping effective health policy. The authors stress that nurses must understand the policy development process and promote the use of political skills. They suggest that nurses can influence health policy on an individual basis by keeping informed on issues affecting health, participate in research, publish to influence public opinion, work with special interest organizations, lobby influential people, as well as network with key nurses within and outside the profession. The guidelines state that nurses can influence policy through their nursing associations. These associations have the responsibility to participate in policy development by using such strategies as: being an expert resource, being visible, being unified, ensuring members are educated on policy issues, ensuring that nurses who are in key positions in the association are educated, and mentoring the younger generation of nurses for leadership in policy development and networking (ICN 2005:19,20).

2.2.4.3 *Political astuteness*

In a study examining the ideal attributes of Chief Nurses in Europe, it was revealed that political astuteness was one of the characteristics agreed on by the overall sample as the most valuable attributes (Hennessy & Hicks 2003:445). Political astuteness is the knowledge of the broader context of any given issue and involves tact, diplomacy and shrewdness. As early as 1980, Ford (1980:1478) suggested that without being politically astute and active, all knowledge and skills related to clinical practice would not impact on the broader and larger policy changes. Algase, Beel-Bates and Ziemba (2004:119) argue that, "the politically astute nurse recognizes, appreciates, and uses nursing expertise as a valued currency in the political process." This expertise stems from practical experience that includes the broader policy implications of clinical practice and the values and skills acquired during socialization into nursing (Algase, Beel-Bates & Ziemba 2004:119). Nurses need to be politically shrewd, directing their attention to understanding issues and policy arguments, contributing to policy discussions and negotiating with reasoned

arguments based on research evidence within all spheres of the political arena, which include the micro, meso and macro levels (Gerrish, McManus & Ashworth 2003:108).

2.2.4.4   Political activism

Political activism involves stimulating public debate; it entails grassroots participation and the use of media to involve the public in issues and decisions that affect their lives (Canadian Nurses Association 2000). Political participation includes activities such as: voting, contributing resources like time or money for a cause, serving as members of boards, attempting to influence voting, attending campaigns, holding public offices and standing for office (Archer 1983:70; Casey 2009:21). These activities allow nurses access to voice their opinions and concerns related to health care policy and health care. If nurses were apolitical, they would not be concerned with the issues related to nursing and health care (Wilson 2002:30). From nursing's historical foundation to its essential core, it is essentially political (Warner 2003:135). Legendary examples of political activists who successfully influenced policy include Florence Nightingale and Lillian Wald (Warner 2003:135).

In recent times, nurses have often appeared ineffectual politically and have considered political activity as undesirable and possessing negative connotations (Maslin-Prothero & Masterson 2002:110). Borthwick and Galbally (2001:75, 77) decry the Achilles heel in the self-concept of nurses and their leaders, which inhibits their political activism and influence on policy. They appeal to nurse leaders to develop skills in advocacy and political action to influence the direction that health policy takes. Politics is often associated with ill intending others, not with being personally political (Twarog 2007:6). Nursing's perception of being apolitical has led to concerns such as the fear that nurses will not have power to control their own future, the lack of values in the political process and a void in health care as a result of little or no involvement of nursing knowledge and expertise (Des Jardin 2001:468).

2.2.4.5   Lobbying

Lobbying is a specific form of policy engagement that constitutes an important strategy for making and changing laws. It is described as an attempt to influence specific legislation and as the ability to influence policy direction through fully understanding the policy development process (Holleran 1985:44). This is done through efforts to influence policy makers in support of or in opposition to any legislation that has been introduced, or any that may be (Minnesota Council on Foundations, Philanthropy and Public Trust [Sa]).

Lobbying includes activities such as communicating with policy makers by meeting with them, building relationships with key players, visiting and contacting them, building coalitions, phoning or writing to them and being willing to testify on issues of concern (CNA 2000; Ray & Roberts 2002:438-442).

Florence Nightingale was able to influence health policy by lobbying and using various mediums of communication that included: writing to influential people, influencing policy makers by speaking to them in management committees and influencing doctors by talking to them, often behind the scenes (Selanders 1998:227,228). For nurses to be active, effective lobbyists and to gain credibility, they need to be politically astute and knowledgeable about the issues they are taking up with policy makers. Additionally, it is important to identify politicians appropriately and know their preferences in relation to the matters of concern to nurses. Lobbying is often more effective when done collectively (Mason, Leavitt & Chaffee 2007:759).

The nursing literature indicates that lobbying is an important activity for nursing so that nurses must actively lobby on issues that affect nursing, health care and themselves (Antrobus 2003:43; Barber 2007:422). Whilst it can appear daunting to a novice, there is evidence to suggest that when applied, it does change the course of events in favour of nursing. Chan (2002:616) reports that in Hong Kong, nursing-degree education was established after successful lobbying by nurse leaders. The latter formed a coalition which consisted of the seven Hong Kong nursing associations. They undertook political activities which involved lobbying and organizing campaigns and petitions. These actions influenced the government's decision to introduce the degree-nursing programme. Literature therefore suggests that nurses have a role in policy development and that lobbying can help to further the nursing policy agenda (Jones 2004:266).

2.2.5   Existing health policies' impact on nursing and health

Aroskar, Moldow and Good (2004:267) conducted a study in the USA with the aim of examining clinical nurses' perspectives regarding the effects of health policy on patient care and nursing practice. These were mainly negative although there were some positive effects with regard to changes in health policy as well. These findings revealed a decreased quality of patient care, which raised ethical concerns for nurses. The effects included decreased satisfaction among the latter, leading to problems with recruitment and retention of nursing staff. However, as a result, some nurses became more assertive and demanded to be included in the policy development process (Aroskar, Moldow & Good

2004:266,276). Corey-Lisle, Tarzian, Cohen and Trinkoff (1999) reported on a study conducted in the USA which found that health reforms led to budget cuts, resulting in cuts in nurse staffing. As a result, nurses experienced job insecurity, increased workload and pace, increased utilization of unlicensed personnel, inappropriate assignments and decreased quality and quantity of patient care. Venturato, Kellett and Windsor (2007:10) explored the experiences of 14 registered nurses working in long term care in Australia with respect to policy reform: their findings concur with those above while in addition, they found that the nurses who participated in the study faced tensions between nursing values and practices and government policy and reforms.

McCloskey and Diers (2005:1140) reported on negative consequences related to health care reform in New Zealand, such as downsizing of nursing personnel and decreasing the length of hospital stay of patients. This meant that nursing workloads increased. As a result, these authors found that adverse clinical outcome rates increased substantially and that mortality decreased among medical patients although it remained stable among surgical ones. This indicates that nurses shifted their focus from preventing adverse events to life saving measures.

Joels (2008:35,40) contends that health policies can conflict with other policies, locally and internationally. This author reports on the impact of national policy on the health of people seeking political asylum, observing that refugees in the UK are only entitled to free access to primary care at the general practitioner's discretion and secondary care in case of emergency. This conflicts with the International Covenant on Economic, Social and Cultural Rights that enshrines the right to enjoyment of the highest attainable standards of physical and mental health. Additionally, it contradicts health professionals' ethical codes, of not discriminating against patients needing health care. Ironically, the National Health Service (NHS) in the United Kingdom (UK) was founded on the principles of providing health care for all, free at the point of need, underpinned by collective solidarity based on need, not on ability to pay. If refugees cannot access primary health care and can only be treated in emergency and life threatening cases, then the costs of care could increase substantially. This would increase the volume of patients to be attended to in the emergency departments. Policies may contravene nurses' ability to be patient advocates and question their ability to adhere to their professional and ethical codes of conduct. This could be a cause of ethical and professional role conflict for the nurse.

According to Ryan-Nicholls (2004:645), health reforms in Canada cut the budget, reduced the number of beds and deinstitutionalized mentally ill patients back to the community. Health reform created an increase in the level of independence for the Registered Psychiatric Nurses (RPN), altered their professional status by an increase in autonomy and accountability and changed the practice setting from acute hospitals to the community. However, this meant that there was a lack of uniform protocols, policy and procedures for practice.

Studies reviewed revealed that the health policy reforms were often related to budget cuts, which had an effect on downsizing nurse staffing, which in turn had ripple effects on nurses and patient care. These largely took the form of negative consequences for nurses and patients in terms of increased workload, decreased staffing, growth in numbers of unlicensed personnel, decreased job satisfaction, ethical dilemmas, job insecurity and decreased quality and quantity of patient care. Some positive effects, such as nurses becoming more assertive and gaining autonomy, resulted. Scruby (1999:217) puts this succinctly, stating that, "the impact of health care policy on nursing roles results in more work".

2.3   INVOLVEMENT OF NURSES IN HEALTH POLICY DEVELOPMENT

It is important and desirable that nurses be included in health policy development to articulate issues and concerns on behalf of patients and nurses. Nurses accompany patients around the clock; they have more contact with the patient compared to all other health professionals and are knowledgeable and experienced in the issues pertaining to patients and health care. The implementation of health policy may therefore be more effective if nurses are involved in and form part of the development process.

Nurses have made significant progress in political participation and their influence on health policy in some industrialized countries like the United States of America (USA) and the United Kingdom (UK). A literature review was undertaken by Latter and Courtenay (2004:26) in which they considered 18 research based studies conducted from 1993 to 2002 and related to nurses prescribing medication: the researchers found that these studies indicated that patients were generally satisfied with district nurses and health visitors prescribing medication, as were nurses themselves. Another study, by While and Biggs (2004:561,562), not included in the above review, confirms the above findings: that nurses found nurse prescribing helpful to their professional role. When the authors in this study explored this study further, their findings indicated that this allowed the nurses to use

their professional skills, enhanced their job satisfaction and provided quicker treatment to the patient. In research conducted by Bradley and Nolan (2007:123,125), the findings revealed that in addition to job satisfaction and faster patient treatment, nurse prescribing had an impact on enhancing nurses' self-esteem, their autonomy and the quality of nursing practice. These studies indicate that nurses' influence on policy can have a positive impact in this regard. Even then, nurses in the USA and UK face significant challenges in influencing health policy.

A study conducted in Canada by Scruby (1999) which examined community health nurses' role in health promotion policy found that nurses experienced frustration because of their lack of involvement in health policy development; they were alienated from the development process and were only marginally involved in policy implementation. The hierarchical structure within which nurses work contributes to a sense of powerlessness with respect to their involvement in policy development; the impact of health policy on nursing roles resulted in more work, and nurses had to redefine policy to be congruent within their practice context (Scruby 1999:217).

Seven years later, Dollinger (2006:106,107) examined nurses' advocacy regarding health policy in the USA and found that nurses who were employed by the government had limited ability to influence policy in the USA due to the lack of status of the nursing profession and the dominance of the medical profession in government. In circumstances when they are able to advocate, nurses function effectively to inform the debate and reinforce the values of patient-centered and holistic health care. However, nurses do not have significant influence and are not present in large enough numbers to make a substantive difference. According to Lewis (2006:2126-2128), who conducted a study in Australia, mapping the influence of medicine in health care policy development, the findings confirm that medicine, rather than nursing, remains influential in health policy development: this is attributed to its special body of knowledge, its structural organization within health services, legally granted professional autonomy and the public perception of the profession.

Chan and Cheng (1999:169,170,171) explored nurses' political participation in Hong Kong. The findings revealed that the majority of the participants disagreed that they could influence government policy. More than half agreed that they had no say in such policy. Moreover, the majority did not think that nurses possessed the power to influence it. These results indicate that nurses did not feel empowered to influence policy at national

level. The major flaw of this study was that the researchers used a convenience sample of student nurses pursuing a post registration degree programme. Nurses who are studying further may be significantly different from those who are not, since education exposes one to information and ideas that those not studying further may not have access to. Despite the weakness of the study, it does confirm the concerns regarding lack of nurses' participation in health policy development (Conn & Armer 1996:267; Ennen 2001:557).

Kunaviktikul, Nantsupawat, Sngounsiritham, Akkadechanunt, Chitpakdee, Wichaikhum, Wonglieukirati, Chontawan, Keitlertnapha, Thungaraenkul, Abhicharttibutra, Sanluang, Lirtmunlikaporn andChaowalaksakun(2010:225) explored the knowledge and involvement of nurses in health policy in Thailand, studying two groups of nurses which included hospital based clinical nurses and national nurse leaders. The findings indicated that the majority of the former were not involved in national health policy development. The nurse leaders were not involved in policy formulation or modification stages but were involved in the policy implementation stage.

In one of the very few African studies found in the literature, Phaladze (2003:22) investigated the role of nurses in the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) policy process in Botswana. The sample included policy makers and nurse leaders. The findings indicated that the majority of the nurses were aware of the national HIV/AIDS policy, but only a small minority was involved in the policy development process; this was mainly during the policy adoption, implementation and evaluation stages. It was found that the policy makers acknowledged that the omission of nurses from the policy development process was a mistake, though they blamed the nurses for not being proactive towards issues related to HIV/AIDs. Additionally, the policy makers did not feel nurses possessed the competence to participate in policy decisions. They blamed the Ministry of Health (MOH) for not including nurses in the process and acknowledged that doctors were dominant (Phaladze 2003:22,33). Of significance in this study is that the sample was purposive and included nurse leaders from regional and national offices and policy makers, as this methodology strengthened the findings and provided both perspectives.

The literature reviewed indicates that nurses' participation in health policy development is limited; they are largely excluded from the process at all levels. These challenges are present in the developed and as well as the developing worlds, though the extent may be different. Nurses consequently experience frustration and a feeling of disempowerment.

They have to redefine health policy to be congruent with the setting in practice. Implementation of policy may differ from government guidelines because it was incongruent with the realties, suggesting health policy implementation challenges for nurses and policy makers.

2.4   BARRIERS TO NURSES' INVOLVEMENT IN HEALTH POLICY DEVELOPMENT

Nurses are the largest group of health professionals and health care providers in most parts of the world (WHO 2009:8). Their influence in the policy development arena is far less than their large numbers merit, although they do face significant barriers to participation. In a study conducted by Oden, Price, Alteneder, Boardley and Ubokudom (2000:147) in USA, the majority of the public health nurses said that they encounter such barriers which include factors such as: lack of time, lack of resources, other priorities, lack of support, frustration with the process, lack of access to key individuals and negative attitudes of policymakers.   They indicated that they feel uncomfortable having confrontations with others; the process takes too long; the outcomes are uncertain and their contribution would probably not make a difference.   Deschaine and Schaffer (2003:270) contend that a lack of availability of resources poses obstacles in this respect. Their study revealed that such hurdles relate to political factors, lack of public understanding and gender.

According to Kunaviktikul et al.'s (2010:225) study in Thailand, barriers include a lack of opportunity to be involved in policy formulation; organizational structures which exclude nurses' involvement; lack of interpersonal communication skills; lack of the required knowledge and skills pertaining to the policy development process and lack of support from other sectors. The researchers did not explore the barriers that clinical nurses face in participation in health policy.

According to Evans and Ndirangu (2008:16), who conducted a study to examine the complexities of provider-initiated routine HIV testing and counselling in Kenya, the experiences of nurses revealed that policy making was a top-down process and their role was limited to implementation of policy.

2.4.1   Lack of political activity

There are contradictory views in the literature with regard to nurses' political activity. As mentioned, nursing often appears apolitical and is frequently draped in a cloak of silence. Some literature decries this, pointing to calls within and outside nursing for the necessity of

being politically active and of influencing the direction of policy (Antrobus 2003:40; Ballou 2000:172; DeClercq 1994:234). To add to the lack of clarity on this issue, there is a lack of consensus on whether political activism has increased or has declined in recent times. Warner (2003:135) for instance suggests that, "Nursing's collective political development in recent years indicates growth…", whilst Falk-Rafael (2005:212) considers that, "political activism/advocacy is rarely a salient feature and some have argued it is actually declining." Since nurses' participation in and articulation of issues and concerns related to health and health services can potentially effect an improvement on the national, regional, and global levels, they have a duty to investigate their role and enhance their level of participation in health policy development (DesJardin 2001:469). For nurses to influence health policy development, they must be politically active (Fyffe 2009:699). Yet, whilst nurses are encouraged to participate in health policy development, conversely they are not encouraged to be politically active (Chan & Cheng 1999:168; Hayes & Fritsch 1988:36). Without being politically active, nurses cannot effectively influence health policy development.

Although nurses demonstrate some degree of political participation, their level of political participation is restricted. In studies undertaken in the USA by Archer (1983:68), Hayes and Fritsch's (1988:36) and Gesse's (1991:187), findings demonstrated that most nurses do vote in elections. Chan and Cheng's (1999:170) study in Hong Kong found that whilst most nurses were registered voters, only about half actually voted in elections. Whereas this may be a reflection of the socio-political and cultural differences between the USA and Hong Kong, it lends support to Falk-Rafael's assertion that political activism is declining (2005:212). There appears to be some consensus in that nurses' political participation is limited to voting. This indicates that there is minimal political activism but that nurses are not a completely apolitical group (Casey 2009:1).

Gesse's (1991) study in the USA reports that nurses felt that people like them could influence government activities and that they would be listened to by government officials. Archer's (1983:68) earlier study revealed that almost half of the nurses investigated did lobby while more than three quarters did communicate to policy makers on specific issues. In contrast, most of the nurses in Chan and Cheng's study (1999) disagreed that they had the power to influence government policy or that nurses in Hong Kong were active in politics. Most nurses, in this study, did not lobby legislatures or express personal opinions on nursing or health to legislative bodies or through the media.

Various factors influence nurses' ability to be politically active in influencing health policy development, such as finding time for such activity and possessing knowledge about how political issues affect health care and the nursing profession. Archer's (1983:72) findings revealed that such aspects include: lack of preparation for political participation, socialization of nurses, lack of understanding of the importance of political participation, lack of understanding of their (nurses') political potential, job pressure, lack of unity in nursing, apathy, family and personal commitments. Chan and Cheng's (1999:171) study further revealed that: most nurses found politics too complicated; lack channels to express their opinions on health and nursing issues; lack time, energy and resources for political participation and fear that being politically active may affect their careers negatively. In a study conducted by Cramer (2002:105) which examined the factors that influence nurses' political participation, she found that free time was the single most significant predictor of organized political participation. Other factors found to be relevant were personal efficacy, political bias and political interest.

These findings suggest that whilst nurses generally are not apolitical, they do appear to be at various levels of political development in different countries. There is no clear consensus on nurses' political efficacy in relation to whether or not they feel they could influence government health policy.

2.4.2   Lack of skills in policy development

The term policy is often unclear to nurses and appears to mean different things to different people. Mason, Leavitt and Chaffee (2007:3), who are recognized for their work in the role of nurses in health care policy, emphasize that understanding the term is central to understanding its relevance to nursing. A reason that may influence nurses' apathy and inability to participate in health care policy development is the fact that the policy development process itself is poorly understood, as mentioned earlier (section 2.2.3.2). Whereas these definitions make the process appear linear and uncomplicated, the process is difficult and is influenced by many complex forces. Policies are often directed by dominant groups and reflect their values, beliefs and attitudes (Cheek & Gibson 1997:669; Kimenyi, Nyangito & Kulindwa 2004:1). Nurses do not generally feature in the dominant group; this deprives them of gaining an understanding and experience of the policy development process. The findings of Scruby's (1999:259) study in Canada indicate that nurses' lack of familiarity with policy/political process was a barrier to their participation in this regard.

In the African context, East African in particular, literature available on the policy development process is generally minimal, particularly that dealing with health care policy. This is complicated by the fact that access to the literature is limited to those who use libraries of Universities or Schools of Nursing. This engenders a general lack of interest in, and ignorance of, the activities of the government amongst the public, nurses included. Kithyoma (2005) states in this regard, with reference to the situation in Kenya, that, "Policy processes are not well documented by Government and the public is therefore not enlightened on how they can participate". Similarly Lau and Schlesinger (2005:78) point out, "Few people are aware of what the government is actually doing about most social problems, much less what politicians are suggesting as alternative solutions to those problems, nor what anyone is proposing to do in the future".

This complicates the understanding of the policy development process by nurses and thus renders their participation difficult. Hence, the said process is an important area for nurse researchers to explore and examine.

2.4.3   Lack of status of women in the African context

Participation of nurses in policy development is hampered by the low status accorded to women globally and in the African context. The status of nursing in all countries at all times is linked to the status of women. Gender has significant implications for the roles, responsibilities, and capabilities of the individual (Fletcher 2006:53). Nurses are inherently linked to the power dynamics that affect women.

Amnesty International (2002) decries this situation, asserting that "Despite worldwide progress in promoting women's rights, in no country are women free from discrimination". The African woman's life is replete with environmental, socioeconomic and psychological factors such as poverty, illiteracy, laborious domestic work, disease and abuse that are debilitating and unfair (Nelms & Gorski 2006:186). In most African cultures, it is acceptable for men to take other sexual partners while away from home. This often leads to women being infected with sexually transmitted diseases, including HIV/AIDS (Nelms & Gorski 2006:186). Confounding this is the traditional patriarchal system in which the decision-makers are men in the household; this is reflected in the overall health care system (Magadi [Sa]). This can be related to the overall health system where policy makers are men empowered to make decisions about resources, whereas women are the implementers of those decisions in a top-down fashion (Evans & Ndirangu 2008:16).

In Kenya, violence against women is widespread. Traditionally men are allowed to beat their wives, while the majority of illiterate persons are women. Women do not inherit land and are financially dependent on their male folk (AFROL [Sa]). Women's participation in the economy tends to be restricted to production, but decisions related to what they produce are made by men. Men often go to the urban areas to engage in employment and leave their wives behind to cultivate the fields. This restrains economic empowerment and influences decisions made in other areas of the women's life.

These factors and others contribute to the lowering of the status of women in East Africa. Governments have passed legislation to promote equality among the genders, but cultural and traditional values have made it hard for them to make tangible improvements. Health care is not gender neutral; it is patriarchal. Because gender is an essential part of the way we interact in organizations, it renders gender divisions normal, natural and unremarkable (Fletcher 2006:53).

2.4.4 Image of nursing

Historically, nursing has suffered from a poor public image that it has found difficult to cast off. As far back as during medieval times, nursing work was considered to be of low status and hence more appropriately carried out by people, particularly women, also perceived to be of low status (Evans 2004:322). From the Middle Ages to the 19th century nursing was mainly for "common women" who included women prisoners, prostitutes or alcoholics (Ellis &Hartley 2004:121). Florence Nightingale came across nurses who were alcoholics and who were considered dishonest and disreputable, resulting in their negative image and low standing in society (Holliday &Parker 1997:485).

Florence Nightingale is criticized in this respect, being perceived to have contributed towards nursing being regarded as unskilled and of low value compared to men's occupations, like medicine (Evans 2004:323). She advocated nursing as an occupation for women. She felt that every woman was a nurse, so that those who joined the nursing profession were doing what came naturally to them (Parker 2005:65). Notwithstanding this attitude, Florence Nightingale's vision completely changed society's approach to nursing, as she understood the contribution that nursing could make towards health care (Holliday &Parker 1997:486).

However, nursing has since not been able to sustain this influence at policy level, and the image of nursing has remained low compared to other professions such as medicine. Tzeng (1985) investigated attitudes towards nurses across 30 cultures, establishing that

the concept "nurse" was consistent with the concept "feminine": both were rated as good and active but also as weak and not powerful (Fletcher 2006:53).In the African, and particularly East African context, there appears to be scanty literature available on the status of nursing. A single study that was conducted in South Africa by Van Der Merwe (1999:1276) found that, "Nurses as women within the traditional African setting at home were considered to be different, separate and not equal to men".

Nurses are socialized into believing that their role is limited to "doing for patients what they might do for themselves if they were able" (Henderson, 1966 as cited by Ellis &Hartley 2004:153).Owing to medical technological advances and medical and curative dominance within health care, nurses have shifted their focus from preventive and promotive care to individual care and cure. This has resulted in the withdrawal of nursing from social and political activism and in the lessening of the reputation of nurses as a social change agent, resulting in a loss in nursing power as regards policy making (Conger &Johnson 2000:2).Nurses have focused on the physical and technical aspects of caring. Their role has been seen as that of performing procedures, rather than thinking, questioning and decision-making (RCN 1997:10). According to Bennett (2004:28),nurses are not politically orientated and are naive outside the patient care arena.

Nurses generally believe that they have a limited role in policy development and would rather leave policy development to policy makers. The nature of nursing profession is not understood by society because much of nursing work is private and often done behind screen and closed doors (Scruby 1999:314). The consequences for nursing are that nurses are left out of policy development process because: they themselves do not believe they can make a valuable input in policy development, and policy makers feel nurses cannot contribute positively to the process mainly due to their lack of understanding of what nursing profession encompasses and the contribution the profession could make to policy development.

2.4.5   Lack of education

Although the need for political action and policy influence has been recognized, nursing education has been slow to respond to this call (Conger &Johnson 2000:2). An important factor that has hindered nurses' participation in policy development is the preparation imparted by such education, which does not equip nurses with the knowledge and skills necessary for involvement in policy development (Bowell, Cannon &Miller 2005:6). In East Africa, at the university where the researcher is a lecturer, very little content of the

programme is devoted to the development of health policy (Aga Khan University 2007:56,57).

Although nursing education prepares nurses to advocate for patients at the bedside, it does not prepare nurses for advocacy at policy level. The skills of bedside advocacy do not appear to be transferable in representing patients' interests in the wider health care policy development level so as to secure better health care and outcomes for the population (Spenceley, Reutter &Allen 2006:180).

On the other hand, most nurses in Kenya, Uganda and Tanzania are educated at diploma level as an entry point into the profession: this level of education renders them less educated than other health care professionals (D'Antonio 2004:379). Access to higher education at tertiary level is limited and expensive. This level of educational preparation focuses mainly on clinical skills and theory related to patient care and management, not on leadership development or policy issues (Nursing Council of Kenya 1997). Nurses are prepared to run wards on a day-to-day basis and to avert crises, with training skewed towards a management model. Providing leadership and participating in organizational policy development and decision-making does not appear to be included.

In most cases, nurses who work within the government sector are those who had acquired a diploma level education and had moved into administration due to their number of years of service. Whilst the situation is slowly changing, these are the nurses from whom people for national offices are selected and who may be required to participate in health care policy development. Unfortunately, their background marginalizes them since it does not prepare them in this respect.

2.4.6   Lack of supportive structures

Of significance are the organizational structures within which the majority of nurses are positioned and have functioned, particularly in the East African context. Generally, health care organizations are bureaucratic. Policies, power and decisions are vested in the top level managers of the organization, whereas, as suggested earlier, the lower levels are mainly involved in implementation of those decisions (Chavasse 1998:173). There are few nurses, despite their being the largest workforce in health care, represented in senior management.

In the researcher's experience, within East Africa, the Ministries of Health or equivalent employ directors of medical services who are physicians; the chief nurses report to them.

The health care system generally accords more power, higher positions and remuneration to doctors. This has implications for nurses in relation to health policy where doctors and pharmaceutical companies are able to exert far greater influence on policy than nurses. This also extends to matters that pertain entirely to nursing. It is the researcher's experience that when nurses have tried to challenge these issues, they are ignored, alienated from powerful others and often give up or change their tactics.

The few nurses who do reach the top management adopt the ethos of senior management and represent management values rather than nursing issues or values. The rewards that they receive tend to make them reluctant to vote in favour of nurses or nursing. This is often referred to as the 'queen bee syndrome' whereby females who make it in traditionally male leadership positions exhibit a counter militancy which is rooted in their personal, professional and social success within the system (Amedy 1999:53). In other words, nurses who become executives owe their allegiance towards management rather than nursing. They will endeavour to maintain this position by eliminating any threat (Fedoruk 2000:14).

In this state of affairs, the majority of the nurses are excluded from policy development activities and hence lack exposure to these processes. They face challenges related to: political skills, health policy development skills, the status of women, the image of nursing, lack of education and lack of supportive structures. Workplace conditions may discourage participation in policy development. Heavy workloads, feelings of powerlessness to effect change, and understaffing may affect nurses' participation in such activities (Boswell, Cannon &Miller 2005:6). This leads nurses to view policy development activities as a burden rather than an opportunity. Consequently, this has effectively led to nursing being inadvertently controlled and regulated by powers external to it (Cheek &Gibson 1997:668).

2.5 FACILITATORS OF NURSES'INVOLVEMENT IN HEALTH POLICY DEVELOPMENT

The literature indicates various facilitators of nurses' involvement in health policy development. The participants in Gebbie et al.'s (2000) study suggested four main areas that could be utilized to enhance their participation: Individual activity, organizational activity, the role of the educational institution, and initiatives relevant to nurse researchers. Individual activity refers to increasing nurses' participation in policy development, which requires investing time and gaining expertise. Nurses should draw knowledge from

nursing practice and experience to support policy development activities. The participants suggested that nurses need to have interpersonal skills, communicate effectively, network with others in policy development, be members of professional organizations, be mentors and share information, link research to policy, acquire policy related knowledge and be visible participants in the process.

2.5.1   Experience

The literature survey revealed that studies had been done examining the effects of the implementation of certain health policies where nurses had participated in their development: these include a nurse prescribing policy and a continence care policy in the UK. Whilst they cannot be generalized to indicate that nurses' participation in health care policy always exerts a positive influence on the nursing profession, practice and patient outcomes, these studies indicate that nurses' influence on particular health policies had positive outcomes.

In the UK, nurse leaders influenced the policy authorising nurses to prescribe medication within the framework of the Nurse Prescribers Formulary (NPF). It took members of the Royal College of Nursing a quarter of a century to achieve this goal. Jones (2004:266) states that this policy involved, "inter- and intra-professional politicking, governmental lobbying, rule bending and general ducking and diving…", indicating that political skills are necessary for influencing health policy.

In another case in the UK nurse leaders influenced a policy for improving continence services. The political campaign took three years, from the time nurse leaders through the Royal College of Nursing (RCN) launched a campaign, up to when "Good Practice in Continence Services" was finally launched. These leaders launched a campaign to foster support and create awareness of the problem, and they also drew up a charter on the rights of people suffering from continence dysfunctions, which assisted in lobbying for support with influential government officials. Additionally, it helped in interesting the media in the issue and in building networks. Following this, the government set up a continence working group headed by a doctor, but including nurses; the end result was the "Good Practice in Continence Services" programme (Thomas, Billington & Getliffe 2004:252,257). Whilst it is clear here that the medical profession was held in high esteem by the government officials, this policy did positively influence health care. Political skills and media management skills were essential in persuading the government to become interested in the problem. This case demonstrates that nurses had learnt from their

previous experience in influencing health policy concerning nurse prescribers: influencing the continence policy took a much shorter period of time (three years).

2.5.2   Education and exposure

Gebbie, Wakefield and Kerfoot (2000:309-314) conducted a study in the USA with 27 nurse participants working in health policy development at micro, meso and macro levels. The findings indicated that personal experiences created interest in policy and politics, while family members, particularly fathers, served as role models. Their education which ranged from high school to graduate qualifications socialized the participants towards policy participation. Education exposed them to faculty role models who participated in influencing policy development. Courses related to policy development and politics increased their knowledge and skills in the policy arena. Employment influenced nurses' participation in the policy development activity. Some found clinical work stifling their talents and moved to health policy so as to make a broader impact on health care. Their influential contacts and positions gave access to relevant knowledge and skills related to policy development and political skills. Nurses indicated that being involved in political campaigns, like helping in elections, provided opportunities in policy development work (Gebbie, Wakefield & Kerfoot 2000:309-314).

Educational institutions must therefore offer health policy related courses and include policy development in the curriculum, encourage internships in policy development, encourage students to be members of professional organizations, emphasize interdisciplinary work as most policy makers are non-nurses and work towards enhancing policy makers' understanding of the contribution of nurses to health care.

Kerschner and Cohen (2002:120) adopt a different perspective. They explored the decision-making process of 4 state legislators in the USA through a phenomenological study. The findings revealed that legislators make policy decisions by: understanding the issue through listening and learning about it; taking a personal stand, which included critically evaluating the issue to form a personal opinion; assessing the situation for action by evaluating alternatives and choosing which strategies to consider and pursue. The policy makers further consider the influences that affect decisions in relation to priority, values, constituents, experience, sources of information, colleagues, time and political process. For nurses to influence health policy, they need to understand how policy makers make decisions. The approach used by the latter appears to incorporate components of

the rational theory of policy development discussed earlier (section 2.2.3.2).These authors' study broadens the comprehension of factors that can facilitate nurses' participation in health policy by investigating decision- making styles used by policy makers.

It was suggested that nurse researchers conduct policy relevant research, clarify policy relevance in published research, use data to inform policy, broaden the scope of nursing research to include broad health care issues, involve policy makers in research proposals and publish research beyond nursing journals. Whilst the study is dated, it used a qualitative approach which provides insight into the experiences of nurses active in policy development.

2.5.3   Professional nursing organizations

Gebbie et al. (2000:311) similarly proposed that nurses' professional organizations should: enhance the policy related ranks in the profession by creating fellowship programmes for nurses interested in policy development activity; groom nurses with potential in this regard at all levels; provide support for nurses to gain practical experience in policy development; encourage policy relevant research; offer policy related workshops; create policy forums; ensure visibility of nursing on public concerns related to health policy; build coalitions and networks; and develop media management skills.

The participants in Dollinger's study stated that greater numbers of nurses in the policy arena were important in influencing policy development. Dollinger (2006:1) contends that increased political involvement and the growth of professional associations have given nurses greater access to the legislative and executive health policy development process. This concurs with Gebbie, Wakefield and Kerfoot's assertions (2000).

2.5.4   Personal and professional development

Dollinger's (2006:115,116) study in the USA, on nurse advocacy in health policy, supports some of the findings of Gebbie et al., 2000. She also found that participation in health policy was facilitated by knowledge related to policy; political skills; education in policy or public health; higher education at graduate and doctoral levels; practice experience and knowledge of health system; ability to view health care issues from a broader perspective; communication; collaboration; negotiation; and coalition building. In contrast, Dollinger's study further included skills like analytic writing and public speaking.

Warner (2003:137-142) conducted a study in the USA with nurse activists who had extensive experience and held senior positions related to health policy development. She found that nursing expertise, networking skills, communication skills, when united, were

factors that enhanced their participation in policy development activity. Her research builds on the above studies and includes adopting a strategic perspective towards policy development by taking a broad view and assessing the political context. Her findings indicate that nurses believe in perseverance despite setbacks and barriers such as: losing elections, troubled relationships, racism, defeated legislation, and funding issues.

Kunaviktikul et al.'s (2010:225) study reported that nurse leader participants argued that political networks, political skills, bonding, unity, leadership, clarity in research direction, knowledge and experience were important for influencing health policy development .

The studies reviewed reveal that it is possible for contemporary nurses to influence health policy. Certain factors can enhance nurses' ability to participate in the policy development process. These include: gaining experience in policy development, having role models, being educated, being knowledgeable about health systems and policy development theories, conducting research to expand knowledge, being supported by professional organizations and developing leadership skills. When nurses are involved and successfully influence health policy development, there are clear benefits to the nurse, the profession and the patient. Thomas, Billington, and Getliffe (2004:256) challenge nurses by the following statement: "The potential for nurses to make an impact on the health agenda has never been as good as it is now."

2.6   NURSING LEADERSHIP

Kouzes and Posner ([Sa]) describe leadership as: challenging the process by looking for new ways of doing things; inspiring a shared vision by looking into the future and communicating the organization's goals to the rest of the group; enabling followers to act by listening and encouraging them to participate; showing them the way by first knowing the philosophy, goals and plan of the organization and encouraging followers to grow by acknowledging and rewarding their accomplishments. Their description includes four main concepts: challenging, inspiring, visionary and enabling.

Tourangeau and McGIlton (2004:182) approach leadership as a process of influencing followers to accomplish goals. This view appears to embrace a contemporary definition of management, of getting work done through others, which contributes towards the lack of consensus on whether leadership is part of management or vice versa (Klingborg, Moore &Varea-Hammond 2006:280). Kelly-Heidenthal (2004:910) and Tappen, Weiss and Whitehead (2004:5) describe leadership as an interaction in which the leader influences another towards achieving a goal. The leader sets direction, builds commitment and

confronts challenges. Lister (2008) describes leadership as a relationship between the leader and follower.

Nursing history reveals several legendary nurse leaders who have influenced the course of nursing and health care. Florence Nightingale, who started the first nursing training programme at St. Thomas Hospital in England in 1860, is credited with being the founder of modern day nursing – she changed the course and face of the profession. Lillian Wald and colleagues transformed public health nursing, Margaret Sanger led the struggle to offer women autonomy in childbearing, while Martha Franklin addressed issues related to discrimination(Camunas 2007:206;Kendig 2002:310;Lewenson 2007:25,26,29,30). These legendary nurses transformed different aspects of health care through effective leadership where they exhibited vision; the ability to communicate; network; influence change; showed courage; took risks; were innovative; possessed the ability to build and work in teams, exercised political skills such as lobbying and transformed situations (Dixon 1999:17; Hennessy &Hicks 2003:446,447). These nurses played extraordinary and significant roles in health care policy development by understanding it and deploying political astuteness and leadership (Ferguson 2002:546).

Currently, there are concerns regarding the availability of effective leaders physically, symbolically and functionally in the clinical, organizational and national levels. In a triangulated study conducted by McKenna, Keeney and Bradley (2004:74,75) in Northern Ireland, exploring the views of community nurses, doctors, policy makers and members of the public on nursing leadership within primary care, the findings revealed that whilst there was consensus that strong leadership was essential for the development of community nursing, there was no consensus on whether nurse leaders existed to lead community nursing into the future. The participants regarded the budget holders, who were doctors, as the leaders, and it is of concern that nurses agreed with that view. This suggests that nurses do not consider themselves as leaders and neither do significant other people. In the study conducted by Scruby (1999:220), referred to earlier (sections 2.2.5 and 2.3), community nurses expressed their frustration with the lack of leadership portrayed for health policy roles by nurse administrators. This suggests that nurse administrators are not aligned with the realities of community health nursing, which frustrates such nurses, and are not amenable to including clinical nurses in the health policy development process.

Campbell (1998:44,47), examined the role of first-line managers and the impact of restructuring in Canada. It was found that as a result the numbers of nursing administrative positions had been reduced. This resulted in a void in nursing leadership, which raised the question of who provides leadership to the large workforce of nurses. In the same study, nurse managers decried the lack of leadership and direction from senior administration. This suggests that nurse leaders in senior administrative positions were physically and symbolically absent from their leadership positions.

There is a dearth of research literature linking leadership skills and attributes required to participate in the health policy development process (Bennett 2004:28). In a speech by His Highness the Aga Khan (1999), he stated that, "Only recently has it become apparent that effective reform requires a significant investment in the personnel responsible for managing health services and providing care. While some programmes have been implemented to improve the capacities of those charged with managing the reformed health system, little systematic attention has been given to enhancing the clinical and managerial competence of nurses at all levels of the system". Leadership is considered a critical factor in the initiation and implementation of transformations in organizations and in a broader context is inextricably linked to influencing the policy development process at national level (Lievens, Geit & Coetsier 1997:416).

2.6.1   Leadership attributes

Strong leadership, as indicated, is important to contemporary nursing. A Delphi survey conducted by Hennessy and Hicks (2003:446,447) examined the ideal attributes of chief nurses in Europe: the expert panellists listed the 16 most important attributes, in ranking order: communication, promotion of nursing, strategic thinking, professional credibility, leadership, political astuteness, physical characteristics, personal qualities, team working, decency/integrity, innovation, good management, conflict resolution, information handling, research skills and decision-making/problem solving. These attributes appear to be the ideal ones for nurse leaders and can be considered to be applicable to nurse leaders who are in policy development positions. This study is considered important for the present one as there is a dearth of literature linking leadership attributes required to nurse leaders' participation in health policy development, except for studies by Gebbie et al. (2000) and Dollinger (2006) discussed under 2.5. Whilst the study does not link the two factors, it has explored essential attributes for national chief nurses, who would be expected to participate in the health policy development process.

It must be noted that leadership must be considered within the context of its being. In a study conducted by Casimir and Waldman (2007:47), examining, "A Cross Cultural Comparison of the Importance of Leadership Traits for Effective Low-level and High-level Leaders in Australia and China", the findings revealed that the perceived importance of specific leadership traits is determined partly by culturally endorsed interpersonal norms and partly by the requirements of the leadership role. Therefore, leadership must be examined within its context; yet, most leadership literature related to nursing is from the developed world.

In a case study reported by Dixon (1999:17) in the UK, she was able to effect cultural transformation through transformational leadership. She instituted transformational change by creating a shared vision, developing a strategy for implementing the vision, ensuring teamwork and developing a strategy of integrating physicians, and created a learning organization. Fradd (2004:245) describes a personal experience of political leadership exercised to influence policy in the UK. She maintains that the leadership competencies that helped in her role included: political astuteness, ability to work independently, being an effective collaborator, ability to develop relationships, self-confidence, humility and compassion, respect for the process and content of change, able to work across settings and ability to deliver results.

In studies conducted in the USA with nurse executives by Bieber (2003:55) and Carroll (2005:150),it was reported that: communication, political advocacy skills, being knowledgeable and competent in nursing, being a team player, and possessing management skills, interpersonal skills, negotiation skills, being creative, working collaboratively, being visionary and having courage were important leadership attributes. DiGaudio (1993:187) established that nurses viewed assertiveness and being proactive as positive traits for being involved in health policy activities.

Cook (1999:309),in a study in the UK, reports the following on nurse leaders' views of leadership. Its major aim was regarded as empowering others. Leadership requires having a vision and leading others towards it, achieving success with others, building trust and confidence, while it was felt that effective leadership in nursing should focusexternally on the outcomes of health care. These nurse leaders identified with transformational leadership traits and were able to differentiate transformational from transactional leadership. To develop health systems that are patient focused and population focused, nursing must develop leaders who have these attributes.

Leadership attributes can be acquired and learnt. A study by Hancock, Campbell, Bignell and Kilgour (2005:180) in the UK evaluated the impact of the "leading empowered organization programme", a leadership programme for senior nurses. The findings suggest that there was a sustained positive impact on competence, action plans, delegation, communication strategies, problem solving, risk taking, leadership and management.

If nursing envisions influencing the health policy and the health of the population, it will need to develop nurses with leadership attributes who are able to inspire change and influence the policy development process within the context where it exists. The challenge then is to explore the gap in nursing knowledge and examine the leadership attributes required for nurse leaders to participate in health policy development. This may assist in the project to develop effective nurse leaders who are able to effect transformation in health care by doing so.

2.6.2   Leadership theories

The dynamic nature of the health care system requires that the role of the nurse leader be redefined for the role to remain viable and to ensure that nursing concerns are still brought to the policy-making table (Fedoruk & Pincombe 2000:17). Leadership is complex: different qualities and behaviours are required in different situations and contexts. Leadership theories describe leaders' traits, styles of leadership and the characteristics of a leader. Historically, nurse leaders make good managers as they have been socialized to give and accept direction. However, the leadership theories utilized by nurses have marginalized them from the policy development process. This suggests that contemporary leaders need to explore recent leadership styles so as to enhance their ability to be involved in policy development activity.

In a systematic review conducted by Wong and Cummings (2007:508), utilizing English language research articles examining the relationship between nursing leadership and patient outcomes, they found evidence of significant associations between positive leadership behaviours, styles or practices, increased patient satisfaction, and reduced adverse events. Their findings reiterate the importance of an emphasis on developing effective nursing leadership as an important organizational strategy to improve patient outcomes. This finding can be related to the context of the national health policy development arena.

Autocratic leadership

In the autocratic leadership style, power is centered on the leader (Kelly 2010:6-8). He or she makes the decisions and the follower is expected to carry out the instructions. This is often the style used in nursing where the nurses follow doctors' instructions, institutional policies and professional standards. In the experience of the researcher, this scenario continues when nurses become national nurse leaders, which engenders dependency on rules and guidelines. Stordeur, Vandenberghe and D'hoore,(2000:37) conducted a study in Belgium, concluding that structure and culture are major determinants of leadership styles. Nurse leaders' socialization influences the leadership style they use when they become national leaders: this maybe autocratic. Evidence of this mental model is demonstrated in the research by Evans and Ndirangu (2008:16) in Kenya, where nurses revealed that policy development was a top-down process.

The criticisms of this style are that it can stifle innovation and independent thinking. This has been a primary style applied by nurses and to nurses and can be considered as a factor contributing to their inability to participate effectively in policy development.

Democratic leadership

In the democratic leadership style, power is shared and authority is delegated. The leader shares the decision-making power with his/her followers and participation is encouraged (Kelly 2010:6-8). This style is used by holders of more senior nursing positions who possess greater education and experience. It can be linked to the pluralistic perspective discussed earlier (section 2.2.3.3) which suggests that power is dispersed and that there is freedom to express opinion and exert influence: the right and ability of the people to participate allows for expression of opposition.

However, the role models and the mental models that are dominant within health care appear to be skewed towards autocratic leadership. In the researcher's experience, this style is often given lip service rather than practiced in reality. In a bid to appear participatory and meet policy development guidelines, policy makers may invite nurses to policy development forums but do not expect this to be a participatory process, having often already prepared proposals for discussion, which hinders nurses from participating; therefore, the latter accept the proposals.

Laissez-faire leadership

The laissez-faire leadership style is considered passive and permissive. The leader does not use his/her power; consequently, it is centered in the followers (Theofanidis &

Dikatpanidou 2006:2). This type of leader gives followers a high degree of independence and requires a self-directed team of high performers to attain results. When a nurse leader knows her/his team has reached an expert level of competence, then this style can be used effectively. It works well with mature and creative teams.

However, it may be criticized for lacking leadership, while the fact that the team may lack direction towards achieving the vision can lead to apathy and disillusionment (Kelly-Heidental 2004:13; RCN2001:63; Theofanidis & Dikatpanidou 2006:2). In the study by Ryan-Nicholls (2004:645), a concern was apparently voiced by nurses that they lacked rules to guide their community mental health practice, suggesting that they were used to being controlled by various forces and that they found independence daunting. This mental model is carried forward to the policy development forum where nurses expect to be recipients of policy for implementation rather than innovators of policy development and agenda setting. On the other hand, nurses in national offices may appear to be laissez-faire leaders because they are very busy with continuous meetings and out of town commitments, reducing their presence and visibility in the national office (Fedoruk & Pincombe 2000:13,14). Hence, their colleagues and subordinates, being accustomed to the autocratic style of leadership, may perceive this style to be lacking direction rather than being liberating and self-directing.

Transactional and transformational leadership theory
Transactional theory

Transactional leadership is aligned with management theories which comprise two major components: management-by-exception and contingent reward. Management-by-exception can be active, when the leader arranges to monitor and correct followers' performance, or passive, when the leader intervenes to take remedial action when something goes wrong. Contingent reward is a more constructive, positive transaction involving directed, consultative or negotiated agreements between leaders and followers about objectives and task requirements. The leader makes promises and provides suitable rewards and recognition if followers achieve the objectives or execute the tasks as required (Bass & Avolio 1996:10; Waldman, Ramirez, House & Puranam 2001:134,135). Transactional leadership is based on rewarding high performance and penalizing poor performance. This engenders conformity with expectations through external rewards and employee self-interest. It does not encourage internal rewards. Transactional leadership

has been criticized for lacking vision as regards the future and endorsing changes that focus on micro level policy and procedure rather than organizational or cultural change (Murphy 2005:131; Weston 2008:42).

This leadership style endorses the status quo through conformity to expectations and lacks in engendering change. Policy development in itself is about change and transformation. Hence, there is the potential for a mismatch between the reality of policy development work and the use of this theoretical perspective on leadership. However, this approach may be employed if policy development is undertaken from the incremental perspective, which also reinforces the status quo. However, if such development is going to be congruent with the realities of society and meets the needs of the population, then the status quo will not be tolerated and an alternative leadership theory will need to be applied.

Transformational theory

Morrison, LaDon and Fuller (1997:32,34) describe transformational leadership as including four components: idealized influence regarded as charisma, inspiration, intellectual stimulation, and individualized consideration. These components are interrelated. Charismatic leaders are greatly esteemed and accrue idealized influence. Inspirational leaders provide meaning and optimism related to the mission, vision and its attainability. Intellectually stimulating leaders encourage followers to question assumptions and to reflect on problems from different perspectives. Individually considerate leaders work with followers, diagnosing their needs, and elevate them to greater heights (Bass & Avolio 1994:542; Bass, Avolio &Atwater 1997:10). Dixon (1999:17) describes transformational leadership as the ability to, "balance capable management with transformational skills that create shared vision, inspire others to embrace it, and empower them to lead implementation efforts."

Morrison, LaDon and Fuller (1997:32,34), examined the relation between leadership style and empowerment with respect to the job satisfaction of nurses in the USA. Transformational leadership appears to exert a powerful influence on job satisfaction both directly and indirectly through its effect on a person's intrinsic task motivation (empowerment). This is an important factor for nurse leaders to consider today, with the global nurse crisis and shortage of nurses. Durham-Taylor (2000:241) conducted a study in the USA which found that transformational qualities can be enhanced by further education, by achieving higher power stages and by being within more participative organizations.

Transformational leadership has been criticized for the amount of control centered within the leader, which may be exploitative. Additionally, this can be compounded by the charismatic component, which could engender manipulation. Another negative aspect of transformational leadership is that its members focus on the big picture and may neglect the important ongoing operations. And significantly, transformational leaders have been criticized for failing to develop competent successors. This often results in a leadership crisis when the leader departs. For example, nursing may have enjoyed transformation through the leadership of Florence Nightingale, but she has been criticized for not successfully building leadership capacity to continue after her (RCN 2001:68).

Despite the criticisms levelled at transformational leadership, as implied in the name, it has the capacity to transform and change. Change is the reality within health care, because the needs of the population are always altering and evolving. Evidence suggests that transformational leaders positively influence nurses' job satisfaction (attracting and retaining staff) and patient satisfaction, while decreasing adverse patient events. This can be translated on a broader base into the health of the population and health services, which will need transformational leaders to survive. This is possible, as may be observed from the transformational leadership of Florence Nightingale.

An example of both transactional and transformational leadership is evident in a study conducted by Upenieks (2003:465,466) in the USA, comparing the perceptions of nurse leaders from magnet and non-magnet hospitals. The former nurse leaders felt that "being supportive, honest, visible, accessible, collaborative, influential, positive, and good listener and communicator" were their most consistent attributes. However, the nurse leaders from non-magnet hospitals felt that, "being credible, direct, flexible, self-assured, fair, business oriented, knowledgeable, and possessive of the inner strength to implement their vision" were their most consistent attributes. It would appear that magnet hospitals have nurse leaders who are empowering and people orientated and who use transformational leaders theory, whilst non-magnet hospitals have nurse leaders who must remain focused on the organizational needs and goals and who appear to be skewed towards transactional leadership.

Today, change needs to be continuous and ongoing. Nurses need to abandon behaviours of compliance and conformity, encouraging creativity and innovation by using transformational behaviours to change organizations and health care. According to Leach

(2005:228), "Transformational leadership is a suitable approach in organizations requiring change, development, initiative, and creativity in turbulent and uncertain environments.".

2.7   EMPOWERMENT

The aim of this study was to develop an empowerment model; therefore, the concept is briefly explored. No discussion on empowerment is complete without a comprehension of the concept of power. One meaning of power is "to be able" (Hawks 1991:754). Power in the nursing context is often associated with negative connotations: organizational hierarchy; authoritative leadership; coercion and domination (Kuokkanen &Leino-Kilpi 2000:236). It is assumed to be extra personal, with the implication that for one's power to increase, another person has to lose some power.   Conversely, Hawks (1991:758), suggests that power can be viewed as the "actual or potential ability or capacity to achieve objectives through an interpersonal process in which the goals and means to achieve those goals are mutually established and worked toward".   In nursing, the concept of expert power is of particular importance, comprising the ability to influence others through the possession of knowledge and skills that are useful to them (Manojlovich 2007:2). Nurses possess expert power, above other health professionals, that would be useful in health policy development.

 Empowerment is defined as promoting self-actualization or influence and as giving authority or power, strength and confidence (Merriam-Webster 2006-2007). It has been described as the power to be able, and encompasses rights, strengths and authority. It can be defined as "moving decision making down the organizational hierarchy where competent decisions can be made" (Fullam, Lando, Johansen, Reyes & Szaloczy 1998:254). In this context, it can be thought of as according the authority and power to make or participate in decisions. Empowerment is generally regarded in a positive light, unlike power.   It can be viewed within the context of a continuum that starts with an awareness of an issue, usually a deficit, and proceeds to a point where one feels that the deficit has been corrected (Ryles 1999:602).   Jones, O'Toole, Hoa, Chau and Muc (2000:319) suggest that recognizing and understanding the barriers to a goal, and identifying appropriate resources to resolve it, lead to empowerment for health, growth and professional development. Ryles (1999:602) contends that true empowerment can only be achieved when there is a balance of power between the oppressors and oppressed.

2.7.1   Empowerment and nursing

Nursing is often perceived, and views itself, as the oppressed group in comparison to other health care professionals. This may be attributed to nursing's very foundation where Florence Nightingale rated nurses' obedience to the authority of doctors as a virtue and considered it appropriate for a respectable 'feminine' occupation (Daisk 2004:43). Ellefsen, Polit and Hamilton suggest that three organizational structures which can empower individuals are opportunity, power and relative numbers (2000:108). Unfortunately, in East Africa, nurses have not capitalized on the notion of relative numbers to empower the profession.   Suominen, Savikko, Puukka, Doran and Leino-Kilpi (2005:148) studied work empowerment, making a distinction between verbal, behavioural and outcome empowerment.   Participation in decision-making and policy development requires, and is an integral part of, verbal empowerment and communication ability. However, as Johns (1999:242) states, "at the level of silence, nurses have no voice; voice is muted in the presence of more powerful others, fashioned and reinforced through self perceived patterns of hierarchical communication and internalized threat of sanction". This makes a case for the development of an empowerment model for nurse leaders' at health policy development level, which will provide a framework for enhancement of their role in this respect.

2.8   SUMMARY

A review of the literature found that there are interrelated and complex factors that influence nurses' participation in health policy development, which was limited. However, research studies reveal that when nurses are involved and successfully influence health policy development, there are clear benefits to health care delivery. The factors which could facilitate nurses' participation in this regard include: effective leadership, political savvy and understanding the health policy development process. Nurses face challenges in being involved in health policy development at grassroots level, a situation which continues at government level. Nurses feel that they are excluded and are not part of the health policy development process and that they are not present in large enough numbers to make a difference. Other major factors acting as barriers to participation include lack of political and policy development skills, lack of status of nursing, lack of education and lack of supportive structures.

Whilst there is some literature from the developed world examining the role of nurses and their leaders in health policy development, there is very little literature from the developing world and particularly from Africa and Eastern Africa. Hence, the present study. The next chapter discusses the research design and methodology.

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

It takes two of us to create a truth, one to utter it and one to understand it.
Khalil Gibran (Mitroff &Turoff 2002:17)

3.1   INTRODUCTION

This chapter describes the research design and methodology undertaken to conduct this study.   The chapter includes a discussion of the Delphi survey, the philosophical orientation of the study, application of the Delphi process, data collection process, analysis and ethical considerations.

The aim of this study was to develop an empowerment model that can be used to enhance nurse leaders' participation in health policy development. The purpose was twofold, firstly to explore the extent of nurse leaders' participation in this regard in East Africa and secondly, to examine their views on factors that influence their participation. The Delphi survey, using a mixed-methods approach, was applied to gain consensus among nurse leaders (a panel of experts) on factors that either facilitate or constitute barriers to their participation. The data generated was utilized to construct an empowerment model.

The objectives were to:

· Explore the extent of nurse leaders participation in health policy development in East Africa

· Build consensus on leadership attributes necessary for nurse leaders' participation in health policy development in East Africa

· Build consensus on factors that act as facilitators to nurse leaders' participation in health policy development in East Africa

· Build consensus on factors that act as barriers to nurse leaders' participation in health policy development in East Africa

· Develop an empowerment model that can enhance nurse leaders' participation in health policy development

3.2   RESEARCH DESIGN

A research design is the overall plan for obtaining answers to the questions being investigated (Polit & Beck 2008:49). The research design maximizes the control over factors that could interfere with the validity of the study findings and assists one to overcome difficulties encountered during the research process (Burns & Grove 2005:223).

A Delphi survey design was chosen as appropriate to conduct the research as this technique aims to build consensus on the phenomenon of interest.

3.2.1   Delphi Survey

The Delphi survey is a method of collecting group opinion on a particular topic. It is based on the premise that 'pooled intelligence' enhances individual judgment and captures the collective opinion of experts (De Villiers, De Villiers& Kent 2005:639). It provides an opportunity for experts (panellists) to communicate their opinions and knowledge anonymously about a complex problem or a topic of interest, to see how their evaluation of the issue aligns with others, and to change their opinion, if desired, after reconsideration of the findings of the group's work (Kennedy 2004:505). Dalkey and Helmer (1963:458), suggest that it can gather "the most reliable consensus of opinion of a group of experts".

The key characteristics of a Delphi survey are: expert panel, iteration, controlled feedback, statistical summaries of group response and anonymity (Dalkey 1969:v; Rowe & Wright 1999:354; Vernon 2009:70). Such a survey is conducted by means of a series of questionnaires that are completed anonymously by individuals on the expert committee. It is a process of group communication without the group ever meeting face to face. The responses from each set of questionnaires are analyzed, summarized and then sent back to the participants until a large extent of consensus is reached on the area of interest (Hasson, Keeney & McKenna 2000:1009,1010). Both qualitative (round 1) and quantitative data (later rounds) can be generated through a Delphi survey (Bourgeois, Pugmire, Stevenson, Swanson and Swanson 2006:1). It is a flexible approach and can be modified to achieve the purpose of the research (Faucher, Everett & Lawson [Sa]:4802; Williams & Webb 1994:181).

Origin

The Delphi survey is named with respect to the legend of the Greek oracle at Delphi. The Greeks sought advice about the future from him (Thangaratinam &Redman 2005:120). He made use of a network of informers and was considered to be one of the most truthful. He accomplished this with the help of the data derived from his network (Cohen, Harle, Woll, Despa, & Munsell 2004:1011).

The Delphi survey has been used in modern history for over 50 years (Beech 1999a:283). Originally, the Delphi survey was intended to function as a forecasting tool in the military, but since then, it has been used for other applications in fields as diverse as health care,

business, education, and information technology (Skulmoski, Hartman & Krahn 2007:1). It has been employed for various purposes that include: long range forecasting, collecting historical data, communication improvement, policy development and analysis, educational planning, curriculum development and structuring models (Linstone &Turoff 2002:4). It has been applied in information systems research to develop concepts and frameworks (Okoli & Pawlowski 2004:17). With regard to health care, Austin-Lane, Girasek and Barbour (2004:54S) built a Conceptual Framework of Influences on State Tobacco Control using a modified Delphi survey.

Scientific merit

The scientific merit of the Delphi is a source of debate (Keeney 2006:211). Mitroff and Turoff (2002:34) defend it by suggesting that,

> We certainly no longer seem able to afford the faulty assumption that there is only one philosophical base upon which a technique can rest if it is to be "scientific." Indeed if our conception of inquiry is "fruitful" (notice, not "true" or "false" but "productive") then to be "scientific" would demand that we study something (model it, collect data on it, argue about it, etc.) from as many diverse points of view as possible.

Dalkey (1968:v) reports on the evaluation of the Delphi survey. The samples were graduate students and the studies included general knowledge as the subject matter, regarding issues where the answers were known and could be compared. Two basic issues were examined: a comparison of face-to-face discussions with the controlled feedback interaction of the Delphi survey and a thorough evaluation of controlled feedback as a technique for improving group estimates. The results indicated that face-to-face interactions made the group estimates less accurate, whereas anonymous controlled group interactions increased the accuracy.

According to Landetta (2006:470,471), there is a growing utilization of the Delphi survey method, which is evident from the numbers of articles published applying it. She explored the validity of such a survey and concluded that on the basis of the stable number of doctoral research studies utilizing it, the scientific community had accepted it as a research technique. Landetta (2006:479) also evaluated its application in social sciences and found evidence to suggest that it was a valuable method with potential in the areas of: input for quantitative models by means of expert opinion, diagnosis of complex social situations,

social forecasting, obtaining a consensus with respect to social needs and improvement in institutional participation and communication.

The Delphi survey is one such method that can be utilized to gain access to such knowledge. However, it is proposed that the researcher applies the method being cognizant of the advantages as well as disadvantages and seeks ways to minimize them, pays stringent attention to the key attributes of the method, applies it with rigour and provides a clear decision trail which may contribute towards improving the scientific merit of the study.

Utilization in nursing

Nursing embraced the Delphi survey in the 1970s, since then it has been widely applied within the health care field (Vernon 2009:69). It has been used for exploring various research problems. It has been applied in exploring the future occurrences in nursing education, clinical nursing research priorities and quality of care (McKenna 1994:1222,1223). Facione (1990) applied it to gain consensus on the definition of critical thinking (Rowles and Russo 2009:238), while Ganga-Limando (2003) used it to construct a conceptual framework for nursing education in francophone Africa. Kennedy (2004) applied the Delphi survey to devise a model of exemplary midwifery practice (Farle 2004:125).

Major Characteristics

In summary, the Delphi survey is a systematic process which aims to: gather information on a specific issue, reach consensus through iterative rounds, with the use of questionnaires, involves a group of experts, whose opinions are anonymous, expert panellists do not meet physically and who may be geographically dispersed.

Major advantages

This technique offers several advantages, which makes it an important research methodology for health and nursing research. It utilizes experts in the field and brings together the collective wisdom of expert panellists in a cost effective manner (Goodman 1987:730). According to Michigan State University Extension (1994), it facilitates group communication and sharing of information among participants, anonymously, which paradoxically also allows independent thinking. It allows the expert panellists to focus on key issues within the questionnaire, which in turn prevents them getting sidetracked. Content validity is assured by means of iterative rounds (Colton &Hatcher 2004: no page).

It provides *anonymity* and confidentiality to the expert panellists, which in turn prevents *dominance* by influential individuals and avoids *group pressure* (Sharkey & Sharples 2001:399). It can incorporate in the study *large numbers of participants* from geographically diverse locations and with the relevant expertise (Linstone &Turoff 2002:11). This study made use of expert panellists from geographically diverse locations that included the three East African countries of Kenya, Tanzania and Uganda. An important factor considered in this study was related to the positions that the panellists held (national nurse leaders); power differentials would have been an important issue, and the quality of the data may have been influenced if another method of data collection had been utilized, for example interviews or focus group meetings (Bowling 2005:363). There is a gap in knowledge with regards to the issue being studied, as discussed in chapter 2, this was an important rationale for selection of the study design because it is a useful method where there is an incomplete state of knowledge on the topic being studied.

Major disadvantages

The Delphi survey poses some important disadvantages as well. Such surveys can be time consuming due to their iterative nature, and the expert panellists may lose interest in the research study overtime (Keeney, Hasson & McKenna 2006:209). To overcome this disadvantage the researcher recruited participants who were likely to have a genuine interest in the topic (this is discussed in the panellist selection section) and who are part of, or should be part of, the health policy development process (Hasson et al 2000:1011). The danger of losing interest was overcome by keeping in touch with the participants via email and through telephone conversations.

Another disadvantage cited in the literature is related to a clear definition of consensus. The literature suggests that 51% to 70% agreement represents consensus (Polit &Beck 2008:238). This study considered 90% and above as consensus in the second round, a high cut off point to identify the most critical issues and to eliminate less critical issues, and then lowered it to 70% and above in the third round to ensure that amongst the critical issues identified, important issues were not eliminated.

Furthermore there are no clear guidelines suggesting definitions of experts, panel size and sampling techniques (Hung, Altschuld &Lee 2008:192; Sharkey & Sharples 2001:399). A purposive sample of nurse leaders (expert panellists) who would have gained knowledge about health policy development by virtue of their leadership positions was selected. A

clear sampling criterion for expert selection was developed on the basis of the model of the "closeness continuum" developed by Needham and de Loë (1990:138).

Another difficulty with the Delphi survey is that the attrition rates are high and increase with the number of rounds (Bailey 2009:28). Together with lack of clear guidance on panel size, this could be problematic. The study therefore included a larger panel size, well above the minimum recommended by the literature, to overcome attrition problems and increase the validity of the study.

Another disadvantage of the Delphi survey is that the expert panellists may change their minds during the course of the study about issues, which might hinder consensus building. The study itself may constitute an impetus for them to learn more about the topic; hence, gaining more knowledge may indeed change their opinions. Time may be a factor as that which may be a barrier in the present may cease to be a barrier two months later.

Linked to the selection of experts is the quality of their input (which is self-reported): this is critical to the outcome of the Delphi survey, as is true for many other survey research methodologies (McKenna 1994:1124). This was overcome by selecting only those individuals who by virtue of their positions are likely to be involved in policy development.

Finally, since it is a flexible method, there are areas, as mentioned earlier, that lack guidelines such as consensus, selection of the expert panellists and number of rounds. To overcome these issues the researcher explored the literature, which gives guidelines from the experiences of other researchers.

3.2.2 The rationale for the application of the Delphi survey

This study applied this survey because its *aim was to develop an empowerment model that can be used to enhance nurse leaders' participation in health policy development.* To achieve the aim of the study, it was important to explore the factors that act as barriers to or facilitators of this process. Skulmoski, Hartman and Krahn (2007:1) suggest that the Delphi survey is well suited for application when knowledge about a phenomenon is *incomplete*. A literature search revealed a limited amount of published literature investigating the extent of participation, or the barriers or facilitators experienced by national nurse leaders participating in health policy development and particularly so in the East African context. This led to the assumption that there was a need to explore this topic. Skulmoski, Hartman and Krahn (2007:1) further state that such a survey can be utilized well when the goal is to enhance understanding of *problems, opportunities and solutions*, as was the case in this study. Furthermore, the rationale for such a survey

stemmed from the following advantages: the sample was geographically dispersed (Kenya, Tanzania and Uganda), members did not need to meet face to face, dominance by certain high profile candidates might have had a confounding effect on the study had another method such as interviews or focus groups been utilized, anonymity may have encouraged openness to express honest opinions, multiple iterative rounds gave participants an opportunity to reevaluate their ideas (which may have increased the content validity of the tool) and finally, the questionnaire was self-reported and self-administered (giving the participants freedom to complete it at a convenient time and place and without pressure of work or from the researcher) (Bowling 2005:363).

The method was selected being cognizant of its disadvantages; the researcher aimed at ensuring that these were considered and minimized as far as possible, as discussed above see 3.2.1 (Amos & Pearse 2008:95; Powell 2003:376,377).

The study was conducted in three phases, using the Delphi survey. In the first phase, a questionnaire that included open ended questions and demographic questions. In the second phase, a closed ended questionnaire was developed from the unstructured information gained from the first round, and thereafter returned to the panellists. The third phase utilized a closed ended questionnaire, mainly for panellists to re-evaluate their ideas about factors that enhance or hinder their participation in the health policy development process.

Figure 3.1 illustrates the Delphi survey process utilized in this study.

Creation of a Database of Nurse Leader contact details

Formulation of Research proposal, study question, design & identification of study population (experts)

Literature Review informed the Research Questions & Methodology

Formulation of questionnaire 1

Approval of research study UNISA, AKU, Research Council Kenya, Uganda & Tanzania

Approval of research grant from AKU

Pre-tested 1st round questionnaire Modified questionnaire

Thesis

Sent out Round 1 questionnaire

Experts

Analysis of returned questionnaires Formulate 2nd questionnaire

Pre-tested 2nd round questionnaire Modified questionnaire

Antithesis

Sent out Round 2 questionnaire

Experts

Analysis of returned questionnaires Formulate 3rd questionnaire

Empowerment Model

Pre-tested 3rd round questionnaire Modified questionnaire

Synthesis

Sent out Round 3 questionnaires

Experts

Consensus

Analysis of returned questionnaires

Figure 3.1 - Delphi survey process flow chart utilized in this study

3.3 PHILOSOPHICAL ORIENTATION

Historically, nursing practice has been entrenched in a positivistic philosophy (Polit & Beck 2008:15,16,17). This tendency developed early in modern day nursing in the work of Florence Nightingale, who in turn was influenced by the work of Auguste Comte, a committed positivist of the time. By the effective use of data, she was able to influence policy and bring about attitudinal, organizational and social change (Porter 2001:20,21).

Modern day nursing has continued with this philosophical leaning although there appears to be a shift to encompass other philosophical paradigms. Indeed, the positivistic bias has influenced the work of nurse theorists like Orem and Roy. This philosophical perspective is visible in policy guidelines and nursing diagnosis (Clark 1998:1244). Current literature suggests three main philosophical orientations: positivism, constructivism (interpretivism, naturalism) and critical social theory (Burns &Grove 2005:26; LoBiondo-Wood & Haber 1998:128; Polit &Beck 2008:14). This indicates a shift from positivism to broader philosophical perspectives. The view taken here is that nursing may place restrictions on expanding its knowledge base if it restricts itself to a single philosophical paradigm (Mitroff & Turoff 2002:34). The important point is that the philosophical view must be appropriate for the study at hand while stringent methodological and ethical practices must be followed to generate sound knowledge (Polit &Beck 2008:284).

This study subscribes to the post-positivistic paradigm as it appeared to be most suited to the study's purpose. The selection of this philosophy was informed by the methodological literature review. Other paradigms such as critical social theory were evaluated for their strengths, weaknesses and application to this study but abandoned as the purpose of the study did not match their philosophical underpinnings.

3.3.1 Positivism versus post-positivism

Positivism

Positivism is a reflection of a broader cultural phenomenon that emphasizes the rational and scientific (Polit &Beck 2008:13,14). Scientific knowledge using the positivistic paradigm is generated through an application of logical principles and reasoning (Burns & Grove 2005:26). Positivists maintain that scientific knowledge is gained through objective means such as observation, measuring and quantifying with a view to making generalizations. Positivism is regarded as perhaps a necessity in all aspects of the health care environment, from haemodynamic values to incident trends. This paradigm is valued

by scientists and policy makers, who are in a position to influence the course of health policy development.

The major criticisms against positivism from a nursing perspective concern the fact that since it is a human science, some phenomena maybe hard to quantify, for example patients' lived experiences of grief. Moreover, it is questionable whether true objectivity can ever be achieved (Polit &Beck 2008:14).

Post-positivism

There appears to be some lack of clarity in the literature regarding the assumptions of positivism in relation to post-positivism. Crossan ([Sa]:46-47) equates positivism with quantitative methods and links post-positivism with qualitative methods. Polit and Beck (2008:15), on the other hand, acknowledge the difference between the two but concede that they are referring to post-positivism as positivism 'for the sake of simplicity'. Today, most positivistic research particularly in nursing cannot be classified as purely positivistic because reality cannot be completely known.

For the purpose of this study, post-positivism is understood as a modification of positivism and the Delphi survey is considered to fall within the post-positivistic paradigm, chiefly because it generates qualitative information (unstructured data) which is analyzed for most recurring themes and then utilized in a quantifiable method using statistical techniques to build consensus. This is different from qualitative research which endeavours to look at diverse themes and new concepts that emerge. Table 3.1 outlines the major differences between positivism, post-positivism, and post-positivism as applied to this study.

Paradigm	Positivism	Post-positivism	Post-positivism Applied to this study
TABLE 3.1 - MAJOR ASSUMPTIONS OF POSITIVISM, POST-POSITIVISM AND POST-POSITIVISM AS APPLIED TO THIS STUDY			
Methods	Quantitative	Primarily quantitative	Primarily quantitative; however, the initial round generated unstructured data
Logic	Deductive	Primarily deductive	Inductive in the first round and then deductive in the following rounds
Epistemology	Objective point of view.	Objectivity aspired to. Findings probably objectively "true"	Objectivity aspired to but findings do not aim for generalization
Axiology	Inquiry is value-free	Inquiry involves values, but they strive to be neutral as possible	Researcher endeavoured to be neutral
Ontology	Reality is objective exists independently of perception.	Belief in reality and desire to understand it but recognizing the impossibility of total objectivity	Belief in reality and desire to understand but recognizing the impossibility of total objectivity. This is so because the first round was unstructured.

Adapted from Polit & Beck 2008:14,15

Post-positivism as the philosophical foundation for this study

The philosophical underpinning guiding this study is post-positivism, mainly because of the intention and objectives of the study. Firstly, it aimed to generate ideas from nurse leaders' own knowledge and experience within their field of work, in health policy development. This generated unstructured data which was analyzed for the most *commonly* occurring concepts. The information generated was presented in a questionnaire format which generated quantitative data in the second and third rounds.

The advantage of this philosophical perspective as it pertains to this study is that it produced both structured and unstructured data. This facilitated both inductive and deductive enquiry, which eventually led to the construction of an empowerment model for nurse leaders' participation in health policy development.

3.3.2   Philosophical foundation of Delphi - Hegelian dialectic

Whilst the Delphi survey is consistent with the principles of post-positivism because of the use of numerical data and statistical features, its philosophical assumptions also have a base in Hegelian dialectic in relation to its consensus building ideology. Such a survey is based on the Hegelian dialectic of thesis, antithesis and synthesis (Steinhart 1998). In this regard, the thesis is an idea generation process (unstructured data); the antithesis takes place when there is a conflict of opinion (evaluation and re-evaluation of ideas) while synthesis occurs when consensus is gained (Inman &Elliott 2007:71,72,73). A "thesis" is opposed to an "anti-thesis," which the thesis generally provokes. They confront each other,

correct one another mutually or destroy each other but combine and finally engender a synthesis (Kojève 1934:8). This is a continuous process, so that synthesis does not necessarily mean an end but can give rise to another thesis. Turoff and Linstone (2002:31) suggest that whilst the Hegelian dialectic does not automatically lead to a new agreement, when this does happen, the resulting synthesis is likely to be strong (Vandenbosch, Fay & Saatçioglu 2001:115). This reinforces the rationale for the use of this paradigm in this study because knowledge on the issue is incomplete and needs, firstly, the generation of ideas, as well as the re-evaluation of those ideas, and secondly the agreement of the expert panellists to develop new knowledge, which is supported by strong synthesis. However, this does not signify that the model developed will be cast in stone; it may be an impetus for further research and development.

Figure 3.2 Hegelian Dialectic – Thesis – Antithesis - Synthesis (Adapted from Steinhart 1998).

In summary, the philosophical orientations related to this study are post-positivist and Hegelian: the former because of the use of numerical data and statistical analysis to understand statistical group responses and the latter owing to the use of generation of ideas, their reevaluation and consensus building ideology.

3.4   APPLICATION OF THE DELPHI SURVEY

3.4.1   Population and Sample (expert panel)

Population

Population refers to the entire group of people that share a common element in which the researcher is interested. The target population for this study comprised nurse leaders who occupy national or provincial leadership positions in East Africa. Hasson et al (2000:1010) suggest that, "Studies employing the Delphi survey make use of individuals who have knowledge of the topic being investigated". The following principles were utilized to ensure

that the correct population was being investigated: diversity, representativeness, accessibility and knowledge (Kombo &Tromp 2006:76, 77).

Diversity – whilst this population was homogenous because the expert panellists were all nurse leaders in national or provincial positions, these panellists were also diverse in that they stemmed from different work sectors and different countries of East Africa. *Representativeness* – the expert panellists were all nurses in senior national/ provincial positions, matching the objective of the study. *Accessibility* – this group of nurse leaders was accessible to the researcher. *Knowledge* – this was a critical factor for this study as in all Delphi surveys; therefore, careful selection of participants was carried out as explained below.

The eligible population for this study were nurses who held national leadership positions in the ministries of health (or equivalent), nursing regulatory bodies, national nurses' professional associations and nursing schools in tertiary institutions (offering degree education) of the three East African countries (Kenya, Uganda and Tanzania). The sample was derived from this population in order to ensure that only nurses who were most likely to have the knowledge and information relevant to the study purpose were included in the study. Those investigated in this study had to be competent in the use of the English language (Burns &Grove 2005:48).

Nurses who did not hold leadership positions or work permanently in these departments were excluded from the study (Polit &Beck 2008:290). Rwanda and Burundi (although new partners in the East African community) were also excluded from the study because they do not have clear national nursing leadership structures although they are in the process of establishing these. Another less important factor was that the language of operation in these two countries is still largely French, though with the East African union taking place, they are gradually moving towards adopting English and Kiswahili.

For the purpose of this study, this population was considered appropriate as it displayed the key characteristics which were of relevance to the study purpose. These are explained in the section below*.*

Sampling technique

Studies applying the Delphi survey usually use non-random, purposive samples. The sample selected when employing such a survey is referred to as the "panel of experts" (Keeney, Hasson & McKenna 2006:208). Purposive sampling refers to the sample being

selected purposely and depends on the researcher's judgment, in line with the aim of the study, regarding whom he/she judges to be typical of the population and is particularly knowledgeable about the issues being studied (Hasson, Keeney &McKenna 2000:1010; Polit &Beck 2008:294,295). Purposive sampling was used because the intention was to include participants who were knowledgeable about the subject being studied. The selection of the expert panellists was based on the researcher's judgement of the critical characteristics that the sample of nurse leaders possesses which were of value in terms of meeting the research objective. The selection of the right panel of experts is the most critical factor in the success of a Delphi survey as this depends on their collective expertise (Powell 2003:378).

Expert panel qualities and selection

The inclusion of a panel of experts was based on the rationale that a group is better than one expert when exact knowledge on a topic is not available (Donohoe & Needham 2008:3). Needham and de Loë (1990:138) suggest that expertise lies along a continuum which includes experts with subjective expertise for example patients, mandated expertise for example officials and objective expertise for example academics. The principles of this continuum were applied to this study, as stated in the sample criteria. Donohoe and Needham (2008:14) suggest that experts be identified considering their proximity to the issue under investigation. Some authors are liberal in their definitions of experts and suggest that these are people possessing the relevant knowledge and experience of a particular topic, within the context of a specific study (Thangaratinam &Redman 2005:120). In the present study, the expert panellists selected represented those most likely to be engaged in health policy development activities.

Sample criteria:

This study defined experts as individuals who fulfilled the following criteria:

- Registered Nurses
- Currently working in a senior leadership/management capacity in East Africa
- Working at national/provincial (regional) level or university
- Due to the nature of their position/work, had exposure to participating in health policy development at provincial, national, regional or global level.

The "closeness continuum" developed by Needham and de Loë (1990:138) was applied. As per the criteria proposed, nurse leaders with subjective expertise, mandated expertise and objective expertise were included in the study:

- Subjective expertise - Provincial Nurses/Public Health Nurses, leaders in National Nurses' Professional Associations who also work as registered nurses (possessing knowledge in terms of health policy implementation or mandated to implement policy or affected by health policy or who may participate in the health policy development process)

- Mandated expertise - Chief Nurses/ Registrars/ Chairpersons of Nursing Regulatory Bodies/ National Nurses' Professional Associations Leaders/Deputies (knowledge and experience in terms of the job requirement related to health policy development)

- Objective expertise - Academic nurse leaders/deans/academic head (knowledge gained due to academic position, education and research influence with regards to policy development).

To be noted was the fact that some nurse leaders held more than one position: for example one such leader in Kenya was (a) a provincial nursing officer, (b) deputy chair of the national nurses, professional association and (c) a deputy chair in the nursing regulatory body. Similar instances were noted in Uganda and Tanzania. Hence, the questionnaires were delivered to the higher office held. The other issue noted was that one of the expert panellists was a medical doctor who was leading a nursing programme. Whilst he did not meet all the sample criteria, he was willing to participate, he was in a position where he could influence policy, and he enriched the study by adding a diverse view, that of a non-nurse; hence, he was included.

A database with the current information pertaining to the nurse leaders was unavailable. Hence, one was created by calling the relevant offices and seeking the information related to the expert panellist. This was based on the sampling framework. This exercise took about 2 months to complete.

Panel size

Panel size refers to the number of expert panellists to be included in the study (Polit &Beck 2008:50). There are no clear guidelines for the number to be included in studies applying the Delphi survey because the sample is purposively selected and it depends on the

problem being investigated. Some studies have used 15 participants whilst others have used 60 (Hasson, Keeney &McKenna 2000:1010). Needham and de Loë (1990:139) suggest a sample size of a minimum of 10 (a smaller size does not generate enough ideas) and a maximum of 50 participants (a larger sample results in cost inefficiencies related to time, product and the iteration process). DeVilliers, De Villiers and Kent (2005:640) define sample size depending on whether it is homogenous or heterogeneous and suggest the following numbers: if they are from the same discipline (15 – 30) or from differing ones (5 – 10) per professional group. Delphi survey studies do not call for a representativeness of the sample in terms of statistical purposes; therefore, sample size differs from those in other surveys (Powell 2003:378).

The sampling framework below was constructed following the principles discussed in the sections above. The study provided an opportunity for 78 expert panellists from the three East African countries to be part of the research study. Four categories of leadership were covered: nurses holding leadership positions and deputies (due to the limited numbers of nurses at this level) in nursing regulatory bodies, ministry of health, professional nursing associations and nursing departments at university level (see table 3.2). A larger panel size was utilized than that suggested by most authors above. This is because attrition was anticipated to pose a problem. Donohoe and Needham (2008:13) reiterate that the qualifications of the experts, balance of expertise and panel size must be critically assessed. These principles were applied to the study by carefully appraising the sample characteristics and the panel size.

TABLE 3.2 – SAMPLING FRAMEWORK OF PANEL OF EXPERTS				
Organizations Represented	**Kenya**	**Uganda**	**Tanzania/Zanzibar**	
1. Nursing regulatory bodies	Registrar - 1 Deputy Registrar – 1 Council Chairperson – 1 Deputy Chairperson/ Deputy Chair Professional Association – 1	Acting Registrar - 1 Council Chairperson – 1 Deputy Chairperson –1	Registrar - 2 Deputy Registrar – 1 Council Chairperson – 1 Deputy Chairperson – 1	12
2. Ministry of Health/Ministry of Medical Services	Chief Nurse - 1 Deputy Chief Nurse - 1	Chief Nurse - 1 Deputy Chief Nurse - 1	Chief Nurse - 2 Deputy Chief Nurse - 2	8
	Provincial Matrons - 13	Provincial Matrons - 2	Provincial Matrons – 16	31
3. National Nurses Professional Associations	Chair - 1	Chair - 1 Deputy Chair - 1	Chair - 1 Deputy Chair - 1	5
4. Universities	Nursing department heads – 10	Nursing department heads – 5	Nursing department heads - 7	22
Subtotals	30	14	34	**78**
Total	Total Expert Panellists (sample) = 78			

In round 1, the number of expert panellists invited was 78 of whom 37 (47%) responded. In round 2, the number invited was 37; of these 24 (65%) responded, while in round 3, the number was 24 and all of them (100%) responded. This is unusual (see 3.2.1) and indicates that the high level interest and commitment of the expert panellists in the study.

3.5   DATA COLLECTIONPROCESS AND ANALYSIS

Data collection instruments

The data collection instruments utilized in the study consisted of questionnaires, in other words, instruments designed to solicit information about a topic of interest from a participant by the use of written questions (Bowling 2005:394). The data solicited is self-reported by the participants, meaning that it represents their knowledge, perception or experience and is self-administered: the participants complete the questionnaire themselves (Burns &Grove 2005:426). The questions can be closed ended or semi-structured (Bowling 2005:394).

Rounds

Delphi surveys are conducted over a series of iterative rounds, and expert panellists are expected to complete a series of questionnaires until consensus is reached (Polit & Beck 2008:238). Whilst there are no strict guidelines on the right number of rounds to be undertaken, generally the number of rounds in the literature is between two and four

(Sharkey & Sharples 2001:399). Brockhoff ([Sa] 305,306) investigated the performance of Delphi groups in relation to the number of rounds and concluded that it was not reasonable to extend the number of rounds beyond the third one (Linstone & Turoff 2002:305,306). The purpose of the rounds was: round 1 (thesis stage) to generate ideas; round 2 (antithesis stage) to review and evaluate ideas against the group summaries and round 3 (synthesis stage) to arrive at consensus. The number of rounds done in the study were **three rounds**, which literature suggests are usually enough to gain consensus (Keeney et al 2006:207). This decision was also influenced by the fact that there was a high degree of consensus on the majority of the issues explored (>90% round 1 and < 70% round 2); consequently, further rounds were not required.

Anonymity in Delphi surveys

A key feature of the Delphi survey is anonymity, which in this context serves four fundamental purposes: it assures the expert panellists' ethical rights, prevents group think, prevents dominance by influential or high profile individuals and encourages independent decision-making (Sharkey & Sharples 2001:499). The Delphi survey is a group communication process whereby the participants never meet each other with regard to the process (Rowe & Wright 1999:354). There is the guarantee of anonymity of the participants' individual responses and these are never known to one another (McKenna 1994:1222). The aggregate group views are communicated as group summaries for the individuals to review against their own opinions and ideas (Beech 1999b:40). Anonymity can be achieved at various levels. Participants may be completely unknown to each other, with there being no potential for other participants to ascribe a response to any individual. However, in highly specialized areas the participants may deduce who the other participants are; but since their judgments and opinions are anonymous, this has been termed quasi-anonymity (McKenna 1994:1224; Vernon 2009:71). The nature of the Delphi survey requires that the researcher follow up the expert panellist, which prevents total anonymity from that aspect as well, rendering it as quasi-anonymous (Keeney, Hasson & McKenna 2006:209). The study can be considered specialized and therefore the participants may know who the members of the sample were and or deduce this from the title of the study, but they would not know who participated and who did not nor what the individual participants' opinions and ideas were.

3.5.1 Round 1 (thesis generation)

3.5.1.1 Questionnaire 1 development

A literature review informed the development of the content and concepts of the questions for the round 1 questionnaire, in collaboration with the study supervisors (Polit & Beck 2008:238). The data from the participants' input and literature reviews were validated and informed the subsequent questionnaires. This questionnaire was partly structured and partly semi-structured, containing some close-ended questions though they were mainly open-ended (see annexure B) (Bowling 2005:394).

The questionnaire included two sections:

Section 1 covered demographic data on the panellists with reference to country represented, organization represented, number of years of experience in nursing, number of years in current position and contact detail (for round 2 and round 3 purposes). The demographic data helped to confirm that the expert panellists represented nurse leaders as proposed in the sampling framework and possessed the critical characteristics relevant to achieving the aim of the study.

Section 2 of the questionnaire aimed to answer the objectives of the study and inform its next phase. This section was composed mainly of open ended questions and a few close ended questions.

The first objective was to "explore the extent of nurse leaders' participation in health policy development"; consequently, the questions related to: stating the major components of their current job positions and membership of nursing professional organizations. Literature influenced the conceptualization of these questions. Hayes (1988:37) reports that membership of a professional organization was associated with political participation. The questions seeking to understand nurses' participation in policy development were influenced by the model developed by Cohen et al (1996:259, 260) representing the "Stages of Nursing's Political Development".

The questions related to the extent of participation in the stages of the policy development process and facilitators and barriers at different stages were influenced by the model of policy development which includes problem identification and agenda setting, policy formulation, policy implementation and policy evaluation (Walt et al 2008:310).

The second objective was to "build consensus on factors that act as barriers to nurse leaders' participation in health policy development". Questions related to the following: major barriers to nurse leaders' participation in this process at global, regional, national

and provincial levels; and major barriers to their participation in terms of problem identification and agenda setting, policy formulation, policy implementation, and policy evaluation. Research studies by Oden, Price, Alteneder, Boardley and Ubokudom (2000: 147) and Deschaine and Schaffer (2003:270) influenced these questions.

The third objective was to "build consensus on factors that act as facilitators to nurse leaders' participation in health policy development". Questions concerned with factors that would facilitate nurse leaders' participation in this activity at global, regional, national and provincial levels and factors that could facilitate their participation in terms of: problem identification and agenda setting, policy formulation, policy implementation and policy evaluation. Research studies by Gebbie, Wakefield and Kerfoot (2000:309,310-314) Dollinger (2006:115,116) influenced these questions.

The fourth objective, "build consensus on leadership attributes necessary for participation in health policy development", was represented by questions relating to leadership attributes essential to participation in health policy development and the leadership attributes the panellists felt that they possessed.

3.5.1.2   *Pretesting questionnaire 1*

Polit and Beck (2008:51) suggest that researchers who are concerned about their research process may undertake a pilot study which is a small-scale version of the major study. They add that if questionnaires are used, then they should be pretested for length, clarity and overall adequacy (Polit & Beck 2008:337). In Delphi surveys applied by Bayley, MacLean, Desy and McMahon (2004:14,15,16), McKenna, Keeney and Bradley (2004:71,72), McKenna and Keeney (2004:18,19) and Farley (2005:122,123), the researchers were silent about whether or not they had included pilot studies in their research studies. In Delphi surveys conducted by Roberts-Davis and Read (2001:37,38), Rayens and Hahn (2000:312), and Campbell, Shield, Rogers and Gask (2004:429),the researchers pre-tested the questionnaires. According to Powell (2003:378), pretesting is optional, but it will help to identify ambiguities and improve the feasibility of the administration of the process.

Pre-testing of the questionnaires was conducted during all three rounds of the study. The participants who were selected to pretest the tool comprised a purposive sample of nurse leaders (senior level) who worked in: a private regional hospital (1), district hospitals (2), a national military referral hospital (1) and a senior lecturer (1). The participants that were included in the pretesting of the questionnaires were excluded from the main study. The

criteria for pre-testing the questionnaires were length, clarity, language and overall adequacy. The participants were also asked to note the time taken to complete the questionnaire.

The feedback received from the participants as regards questionnaire 1 mainly concerned two aspects: they found the questionnaire lengthy and felt that there was repetition related to facilitators and actions. These critiques concerned questions dealing with actions regarding barriers (21), factors that would facilitate (23), actions that would facilitate (25), factors that would facilitate (26), and actions to be taken to facilitate (27) (see annexure B). However, after consultation with the supervisors as well as after evaluating the subtle differences in the questions, it was decided to leave them as they could potentially enrich the quality of data obtained. It was decided that if the data from the study should show repeated themes, then the questions would be merged when designing the round 2 questionnaire. The concern related to the length was linked to the issue of repetition. The pretest revealed that the regional aspect had been omitted from Question 21 (21.2); this was inserted.

The participants found the questions clear, the language acceptable, the topic relevant to nursing and the instrument user friendly. They indicated that it took around 40 minutes to complete the questionnaire. Feedback related to its content was minimal. One participant said, "the questionnaire made me interested in the topic and I went and read about it" (a disadvantage of the Delphi survey discussed in section 3.2.1). There appeared to be a lack of knowledge about the topic among the participants.

3.5.1.3   Data collection process

The data collection process began on 22nd September 2009 (Round 1) and ended on 23rd May 2010 (Round 3). After the first questionnaire was finalized it was printed and enclosed in envelopes together with the covering consent letter, questionnaire and self-addressed envelopes. The researcher secured the services of data collectors who were paid daily for their services and provided with money to use public transport or the university car (when available). All the expert panellists were telephonically informed that a questionnaire related to the study was on the way and that their participation would be appreciated. The data collectors in Kenya, Uganda and Tanzania hand delivered the package to all the nurse leaders included in the study who lived in the cities of Dar-es-Salaam, Kampala and Nairobi. The majority of the

expert panellists in these urban areas enjoyed access to email services, internet and computers and possessed both a personal and a work email address; hence, attachments of the copies of the questionnaire were also sent via email. The researcher emailed the questionnaire and covering consent letter to the 78 nurse leaders in the three cities and those living outside these cities. The questionnaires were delivered to the expert panellists outside the three cities by mail, fax or via email. Some of these participants possessed email addresses but lacked access to the internet. In such cases, questionnaires were faxed as per the expert panellists' request. There were challenges encountered due to the poor infrastructure, unreliable road transport services and lack of access to internet services; these resulted in delays.

All expert panellists made use of cell phones; therefore, they were called to follow up, as regards their response. A total of four emails were sent including the initial email with the questionnaire, the 1st reminder, the 2nd reminder and the final reminder. A weekly phone call was made to find out if the questionnaire was ready for collection; when it was available, the data collectors fetched it from participants who lived in the three cities. Once the completed questionnaire was received from a participant, he/she was not sent any further reminders. There was an interval of a week between each reminder (Kombo &Tromp 2006:104).

The process took six weeks, which was longer than anticipated. After the researcher was satisfied that no more questionnaires would be received, the return rate was 37 (47%) no further follow up was carried out. As this questionnaire contained open ended questions generating unstructured data, it was analyzed for the most frequently recurring concepts (refer to section 3.5.4.1). The data analysis process began with the receipt of the 1st questionnaire. There were 125 concepts identified in round 1.

3.5.2 Round 2 (antithesis stage)

3.5.2.1 Questionnaire 2 development

The aim of round 2 was to evaluate the level of consensus among the expert panellists on the barriers and facilitators identified from round 1. The concepts identified in the first questionnaire informed the formulation of the round 2 questionnaire. The second questionnaire was developed containing closed ended questions where participants were expected to evaluate the concepts presented to them in the light of their input to the first

questionnaire and to agree or disagree with these concepts (see annexure B). This gave them an opportunity to review their views in relation to their own input and that of others. The questionnaire contained 125 questions. The questions used a Likert scale that was aimed at gathering information about their level of agreement or disagreement (strongly agree; agree; undecided; disagree; strongly disagree). Such a scale is designed to determine the opinion of the participant on an issue under investigation. It encompasses a statement or word with a scale after each question (Burns & Grove 2005:431). There were questions that were linked or similar, in order to identify (in) congruence in the expert panellists' views.

3.5.2.2   Pretesting questionnaire 2

The round 2 questionnaire was pretested with the same group of participants that pretested the round 1 questionnaire. The participants found the questions to be generally clear, language acceptable and user friendly. They regarded the questionnaire as lengthy. There was a question in section 5 of the questionnaire that read "having more females at policy making forums". This was considered unclear; it was rephrased to "Having a gender balance (in terms of appointments) at policy making forums". They did not recommend any other changes. It took them about 20 minutes to complete the questionnaire; as a result, this was the figure inserted as the time commitment required to complete the questionnaire in the finalized questionnaire 2.

3.5.2.3   Data collection process

After round 2 questionnaire was approved by the supervisor, it was finalized. It was then printed and the covering letter and questionnaire were put in envelopes. Self-addressed envelopes were only inserted for those who lived outside of the three cities of Dar-es-Salaam, Kampala and Nairobi. It was noted in round 1 that most expert panellists did not use the self-addressed envelopes. The ones who lived in the three cities had their packages hand delivered and the responses were fetched by the data collectors. Some studies are known to include the entire sample (initial sample); even those that did not respond. In this study, only those who responded to the first round and completed questionnaire 1 were included in round 2; therefore, a total of 37 questionnaires were sent out (Skulmoski, Hartman & Krahn 2007:9). The rationale was that those who did not return questionnaire 1 may have not responded because they were not sufficiently interested or thought they could not contribute towards the study.

The same system of follow up as for round 1 was used: email reminders and phone calls. Round 2 yielded an acceptable return rate, 24 (65%), and when the researcher was satisfied that no more questionnaires would be returned, the follow up exercise was stopped.

The questionnaires were analyzed using the SPSS (version 15) software package. The data entry was carried out with the help of a statistician. Data was entered, summarized and analyzed for mean, standard deviation and percentage agreement (refer to section 3.5.4.2). Twelve questions that achieved a percentage average of <90% were omitted from the 3rd questionnaire, as these appeared relatively less critical issues for the expert panellists. It is noteworthy that areas of lack of consensus were mainly related to the barriers at various stages and levels.

The questions related to barriers, to nurse leaders participation, at various levels of policy development that were excluded: nurses' inability to actively participate when given the opportunity (63.6%); lack of relevant knowledge and skills necessary to participate (59.1%); their level of education is low (47.6%); lack of funds and resources to attend forums (68.4%); lack of confidence to air their views (65%); most of the nursing leadership representatives at health policy development level are as a result of political appointments (66.7%) and most policy development appointments are given to male leaders (66.7%).

The questions related to the barriers, to nurse leaders participation, at the stages of the policy development process that were also excluded: lack of knowledge and skills relevant to problem identification and agenda setting (62.5%); lack of a supportive environment in terms of mentorship and encouragement (87.5%); lack of forums to discuss policy problems and agenda items within nursing at national level (80%); lack of information about the policy development forums (81.8%) and poor planning by the nurse leaders on the process of problem identification and agenda setting (52.6%).

3.5.3   Round 3 (synthesis stage)

3.5.3.1   Questionnaire 3 development

The round 3 questionnaire was developed partly by excluding all questions that did not achieve >=90% consensus, because this indicated that those issues were less critical to the expert panellists. The remaining questions were included in the round 3 questionnaire. Furthermore, certain questions were elaborated and expanded on with the help of the

literature and the doctoral supervisor to create a greater understanding of the key concepts.

Related questions were condensed because there were recurring concepts (see annexure B): for example, three similar questions related to transformational leadership attributes were merged. This assisted the researcher to evaluate the consistency of the expert panellists' ideas and the critical issues. These concepts achieved a high level of consensus,>=90%, indicating a stability in the expert panellists' views.

The questions related to the attributes which nurse leaders possess and would like to develop were omitted from the final round as there was consensus and it was not the purpose of the study to build further consensus in these areas.

Questions from round 2 that were expanded and elaborated on with the help of literature were related to: political skills (Ray and Roberts 2003:438,439,440,441,442); communication skills (Sullivan 2004:54,55,56,57); information related to health policy development to be included in nursing education (Reutter and Williamson 2000: 24); experience and exposure to policy development (Byrd, Costello, Shelton, Thomas and Petrarca 2004:501); supportive mentorship, networks (Leavitt, Chaffee and Vance 2007:38); stages of policy development (Walt 1994:44,45); spheres of nurse leaders' influence in health policy (Camuňas 2007:206); active participation (Antrobus and Kitson1999:751; Upenieks 2003:146); media engagement (Kitson 2001:ii80; Mason, Dodd, Glickstein 2007:149,161); focusing the health agenda around health, not around medical and curative issues (Bradshaw 1997:352); research skills (Hennessy and Hicks 2003:446; WHO 2005:8); national nurses professional association's activities (Mason, Leavitt and Chaffee 2007:11); health policy process criteria (WHO 2005:7) and the policy evaluation process (Hall-Long 2004:275).

Thus, the questionnaire was condensed by merging similar concepts and omitting questions that did not achieve consensus but was also broadened by adding detail with the aim of enriching the development of the empowerment model. The questionnaire utilized the same Likert scale for the items where the researcher expected the expert panellists to indicate their agreement or disagreement with the issue.

3.5.3.2 *Pretesting questionnaire 3*

Round 3 questionnaire was pretested with the same group of participants that pretested round 1 and 2 questionnaires. They did not recommend any changes. They indicated that

it took 25 minutes to complete the questionnaire, which was therefore the time indicated in questionnaire 3's covering letter concerning the time required to do so.

3.5.3.3   Data collection process

The questionnaire was finalized after it was approved by the research supervisor. The questionnaires were printed and packages of covering letter and questionnaire put into envelops.   The packages were sent to the 24 participants that returned the 2nd questionnaire. Self-addressed envelopes were only inserted for those who lived outside of the three cities of Dar-es-Salaam, Kampala and Nairobi. Those who lived in the three cities had their packages hand delivered; the responses were picked up by the data collectors. Those in more rural areas were sent the questionnaire via email and mail.

The same system of follow up was used (email reminders and phone calls) as for rounds 1 and 2. It took a period of 4 weeks to receive all 24 (100%) of the questionnaires from the expert panellists.

The round 3 questionnaires were analyzed as per round 2 using the SPSS package; the same statistical analysis was carried out as in round 2. This round also yielded a high level of consensus on the majority of the issues. However, the consensus was reduced to >=70% to ensure that critical issues were not left out. There were 5 items that did not attract a>=70% consensus. This ended the data collection process.

In summary, the **round 1 questionnaire** consisted of open ended and closed ended questions; data from this round was summarized and a closed ended structured questionnaire (questionnaire 2) was designed based on the issues that emerged in round one. **The round 2 questionnaire** was returned to participants for them to evaluate their input, compare the views of others and either agree or disagree. This gave them an opportunity to reconsider their views. Subsequently, round two was summarized by means of descriptive statistics and returned to the expert panel, as the **round 3 questionnaire**, for them to re-evaluate their views considering the group mean, standard deviation and percentage agreement.

3.5.4   Data analysis

3.5.4.1   Qualitative data analysis

The unstructured data from the open ended questions in questionnaire 1 was transcribed into Word documents, verbatim; the documents were read for relationships and patterns. Similarities and differences were identified; words and phrases were grouped by cutting

and pasting the Word document into clusters of similar ideas and concepts and highlighting in different colours. This aided in grouping similar concepts together and identifying the most commonly occurring concepts. The analysis of this phase was undertaken independently by the researcher and an assistant; the notes were compared to validate the concepts that occurred. The concepts that most commonly occurred were then developed by the researcher into questions for the 2nd questionnaire.

3.5.4.2 *Quantitative data analysis*

The computer package SPSS (Statistical Package for Social Scientists) was used. Ascertaining the groups' collective opinion required the use of descriptive statistics, which was carried out in this study in consultation with a statistician (Hasson et al 2000:1012). Descriptive statistics were used mainly because the questionnaires were designed to collect nominal and ordinal data. The nominal data examined the percentages in terms of the percentage of agreement, while the ordinal data examined the measures of central tendency that included the means and level of dispersion such as the standard deviation (Polit & Beck 2008:238).

The statistical analyses were conducted to measure the level of agreement related to the concepts in the questionnaire. The statistical tests used were Percentage agreement (PA), mean (M) and standard deviation (SD). Higher levels of agreement indicated higher levels of consensus related to the concept and attribute. For the purpose of round 2 of this study,>=90% indicated convergence of opinion, was considered agreement and represented consensus, whereas <90% represented lack of agreement and lack of consensus, for the purpose of the study. For the purpose of round 3 of this study, >=70% indicated convergence of opinion, was considered agreement and represented consensus, whereas <70% represented lack of agreement and lack of consensus.

The mean value that was considered convergence in opinion (towards agreement) was considered to be <=2. Any mean value >2 was carefully analyzed together with the other parameters. The mean is a measure of central tendency calculated by adding all scores and dividing the sum by the number of subjects (Polit & Beck 2008:758).

The standard deviation indicates how much, on average, scores deviate from the mean. Standard deviation was linked to the mean and convergence (closer to the mean) or divergence (away from the mean value) (Polit & Beck 2008:565). A standard deviation closer to 0 meant convergence and represented stronger agreement; a standard deviation >2 signified divergence and represented lack of consensus. For the purpose of this study,

a standard deviation of 2 (because 70% of all opinion was expected to fall within a standard deviation of 2) was considered convergence of opinion; any standard deviation of >2 was carefully evaluated with other parameters.

To recapitulate, the parameters set in the study were percentage agreement >=90% for round 2, which was reduced to >=70% in round 3 to ensure that (as only very critical issues from the 2nd round were included in the third round), important issues were not omitted. The principles followed here were more ambitious than the suggestions in the literature, see the discussion of consensus in 3.2.1; however, this was to ensure that the results are dependable.

3.5.5 Validity and reliability of the data collection instruments

3.5.5.1 Validity

Validity is the extent to which a method measures what it is intended to measure (Delport 2002:166; Peat, Mellis, Williams & Xuan 2001:108). Validity encompasses face validity, content validity and construct validity.

Face validity refers to whether the instrument *looks* as though it is measuring the appropriate concepts (Polit &Beck 2008:423). It is a subjective judgment that the instrument measures what it intends to measure in terms of the relevance and presentation of the questionnaire (Babbie 2001:143). It includes the questionnaire being readable, exhibiting clarity of content and language and being unambiguous and clear (LoBiondo-Wood & Haber 1998:328,329). In this study, the literature guided the researcher concerning the development of the main concepts explored and the tool was pretested.

Content validity refers to the judgments of a panel of experts about the extent to which the content of the questionnaire appears logically to examine and comprehensively include the characteristics of the domain being explored. In the study, round 1 instrument questions were informed by the literature review presented in chapter 2 and by professional colleagues: the tool was pretested with nurse leaders and included input from doctoral supervisors. Round 2 instrument questions were developed from the data retrieved from the round 1 questionnaire which included content and concepts, being the input of the panel of experts, who were knowledgeable on the topic. Rounds 2 and 3 confirmed the content and concepts by giving the panel of experts an opportunity to review the concepts. This suggests that the final results are high in content validity (Bowling 2005:132,133).

Construct validity refers to the degree to which the instrument measures the theoretical concepts and constructs under investigation (Polit & Beck 2008:750). In the context of this study, the literature guided the researcher with respect to the development of the main and initial broad concepts. Secondly, the elements within the constructs were obtained from the panel of experts, in the first round of the study. Thirdly, the constructs were re-visited and validated by the panel of experts, during the iterative rounds. Finally the empowerment model was also validated by a sample of the panel of experts who participated in the study.

3.5.5.2 *Reliability*

This refers to the ability of the instrument to yield similar results when repeating the same study using similar conditions, producing the same or similar results consistently(Bowling 2005:132,133;Delport 2002:167; Sharkey & Sharples 2001:399). Keeney, Hasson and McKenna (2011) suggest that the Delphi survey enhances reliability in two ways: in the decision making process, as the members of the expert panel do not meet face to face, which eliminates group bias or group thinking, while an increase in panel size increases the reliability. This assertion applies to the study as the panellists did not meet face to face and group size remained stable in the second and third rounds (refer to panel size, section 3.4.1.2). However, the study would need to be repeated in future to confirm whether or not the questionnaires produce the same results with another panel.

3.6 ETHICAL CONSIDERATIONS

3.6.1 Approval and ethical clearance

To ensure that the study maintained high ethical standards, a copy of the proposal was submitted and ethical clearance sought from the Health Studies Research and Ethics Committee of the College of Human Sciences, University of South Africa. To ensure that ethical standards of the three countries where the study was conducted were upheld, approval was secured from the National Council for Science and Technology of Kenya, National Institute for Medical Research of Tanzania and Uganda National Council for Science and Technology. In addition, approval was secured from the Research Ethics Committee of the Aga Khan University (AKU) where the researcher works, as is required of faculty working at AKU (see annexure A).

Securing approvals from the national councils/institutes in the three East African countries was a long process: it took three months in Kenya, six in Uganda and eight in Tanzania.

Whilst the research councils in Kenya and Uganda approved the study with no queries, Tanzania's institute expressed minor concerns related to language (translating the questionnaire into Kiswahili) and compensation for participants. These concerns were addressed with the National Institute for Medical Research of Tanzania which was informed of the study's aims and resulting benefits to the participants and of the fact that there was no budget for compensation. The issue of compensation was analyzed and it was felt that if the Tanzania participations were compensated, then they would have felt obliged to participate in the study; furthermore, the information obtained may have been influenced by their perceptions related to compensation received. Additionally, if the Tanzanian participants were compensated, then all the participants would have to be compensated (in terms of the principle of fairness), yet no budget had been allocated for this purpose. Hence, the issue of compensation was dismissed. The Institute in Tanzania was satisfied with the researcher's response and rationale and granted the research clearance permit. After all approvals were secured, the round 1 questionnaire was pretested.

3.6.2   Ethical principles

The *right to autonomy* and informed consent was safeguarded by explaining the benefits, rights and risks involved in the research study in writing and securing consent by the return of the questionnaire. A covering letter that explained the purpose of the study at round 1 of the study was attached. Additionally, the researcher's details were made available to the participants so that they had the opportunity to contact the researcher if they had any questions. They were required to sign the cover page of the questionnaire and return it to the researcher, though returning the questionnaire was also accepted as agreement to partake in the study and implied consent. This was in keeping with the ethical principles of respect and the right of self-determination and of obtaining an informed consent (Burns &Grove 2005:196). The right of *self-determination* was respected at all times: participants could choose what information they would share with the researcher, and were at liberty to withdraw from the study at anytime without penalty. *Informed consent* - a covering letter explained the purpose of the study, the type of study and the data collection process as well as requested consent to participate from the expert panellist; it was the first page of the questionnaire (see annexure B). The participants were expected to return a signed consent, although, as indicated, the return of the questionnaire was accepted

as consent to participate in the study. Some participants did not return a signed consent but returned a completed questionnaire.

Anonymity refers to concealing the identity of the participants in all documents resulting from the research. This meant that the researcher would be unable to identify who returned the questionnaire and who did not; this is a key feature in any survey research. The main advantages were, as mentioned, that it encourages opinions that are true for the individual panellist, and opinions are not influenced by group thinking. Though this may potentially lead to lack of accountability for the response, this is a possibility not unique to a Delphi survey and is true for other self report surveys as well. In a Delphi survey, there is a need to know who has returned the questionnaires and who has not, and this could only be met if the researcher were to be aware of the identity of the individuals. For the purpose of this study, the following principles were applied: The participants expressed their opinions, anonymously. They were anonymous to the group, although the information collected was anonymously shared with the group, which resulted in the collective judgment of experts in the form of group means, standard deviation and percentage agreement (Madigan & Vanderboom 2005:3). This meant that the data was presented in aggregate form, representing the collective views of the expert panel members. Once the questionnaires were returned to the researcher, data entry was undertaken, where each questionnaire was coded; names were not used. The statistical summaries did not encompass the names of the participants or personal details that could link the data to the person. This process continued for 3 rounds. The study endeavoured to ensure anonymity; no panellist or their individual responses was known to anyone other than the researcher and statistician. The returned questionnaires were locked away; only the researcher had access.

Confidentiality was maintained at all times throughout the study's data collection phase and forms were coded numerically. After the data has been analyzed and the study completed to the satisfaction of the University of South Africa, the raw data forms will be destroyed after 3 years.

The principle of *beneficence* is applied to this study, as it is of importance and relevance to nurses and nursing especially in East Africa, where no similar study has been published. This laid the foundation for the ethical premise, as it would have been unethical to carry

out a study which would be unlikely to be useful to the profession. From the perspective of health care, patient outcomes and the nursing profession, the researcher's position is that if health policies are to be geared towards producing the best outcomes, they should be formulated with the aid of input from nurses. The study offers direct benefits to the population being studied. The nurse leaders who participated in the study, and those who did not, will benefit by gaining information related to the extent of nurse leaders participation in health policy development; they will also obtain information related to barriers and facilitators and essential leadership attributes. They may benefit from the recommendations made as a result of the study; if these are implemented, it could help them to influence health policy development. Finally, the empowerment model could provide a framework to enhance their practice in policy development. It is envisioned that the expert panellists will receive the final report of the study. This would be in line with the principle of giving back something to the participants for their time, effort and patience in participating in the study.

3.6.3   Model development

The aim of this study was to develop an empowerment model. A model is a graphic or symbolic representation of phenomena which objectify and present specific perspectives about the nature or function of a phenomenon (McEwen & Wills 2002:27). The empowerment model developed in this study is a theoretical model which was systematically constructed from the findings of scientific inquiry. The literature review lead to identification of the broad concepts related to nurse leaders participation in health policy development. This informed the development of the first questionnaire, which assisted with identifying categories that were linked to the broad concepts. The subsequent questionnaires were iterative and facilitated the gaining of agreement or disagreement on the main concepts and categories. The final questionnaire was further validated by the literature review. The findings lead to the conceptualization of an empowerment model for nurse leaders' participation in health policy development (discussed in chapter 5). The model was validated by a sample of the panel of experts, who indicated that it represented their ideas. A few minor changes were proposed which were integrated in the final model. The final model is a graphic representation of the knowledge generated from the study.

3.7 CONCLUSION

The aim of this study was to develop an empowerment model that could be used to enhance nurse leaders' participation in health policy development. The Delphi survey was applied to gain consensus from a panel of experts (nurse leaders) in East Africa. A purposive sample was drawn from nurse leaders working at national level in Kenya, Tanzania and Uganda. A reiterative questionnaire was utilized for gathering the views of the expert panel, and the study was conducted in three rounds. Statistical analyses were performed to measure the percentage agreement, central tendencies and dispersion. Ethical clearance was secured from various authoritative bodies in the 3 countries and the University through which this doctoral study was done.

The findings are discussed in chapter four.

CHAPTER FOUR
FINDINGS AND DISCUSSION

"If I have seen further, it is because I stand on the shoulders of giants."
Sir Isaac Newton

4.1   INTRODUCTION

This chapter discusses the findings. This study was conducted by applying the Delphi survey with a group of expert panellists in three iterative rounds, the aim being to develop an empowerment model that could be used to enhance nurse leaders' participation in health policy development. To achieve this aim, the objectives were to:

- o Explore the extent of nurse leaders participation in health policy development in East Africa
- o Build consensus on leadership attributes necessary for nurse leaders' participation in health policy development in East Africa
- o Build consensus on factors that act as facilitators to nurse leaders' participation in health policy development in East Africa
- o Build consensus on factors that act as barriers to nurse leaders' participation in health policy development in East Africa
- o Develop an empowerment model that can enhance nurse leaders' participation in health policy development

The chapter presents, firstly, a demographic profile of the expert panel members, secondly, reports on the extent of nurse leaders' participation in health policy development, thirdly, reports the leadership attributes for the said participation, fourthly, presents the facilitators to this participation and finally reports on the barriers in this regard.

As indicated, from a purposive sample of 78 expert panellists (nurse leaders) in East Africa who were invited to participate, 37 (47.4%) did so in the first round, while of the 37 expert panellists invited to participate in the second round, 24 (64.8%) participated: all 24(100%) participated in the third round. It would appear that by the second round, the expert panellists' interest in the study had been captured, as all who responded to round 2 continued with round 3. This may suggest that there is a growing interest in the topic among the expert panellists. Considering the iterative nature of the Delphi survey and the sample characteristics (national nurse leaders), the response rate for this study was considered acceptable. Studies utilizing a questionnaire as a data collection tool are known for low response rates (Keeney, Hasson & McKenna 2006:207). Gordon (2009:8)

indicates that in his experience, a response rate of 40% to 75% from participants can be expected. During a Delphi survey, the response rates usually decrease with the increasing number of rounds conducted (Van Teijlingen, Pitchforth, Bishop & Russell 2006:249-252). In this study, consensus was built over three rounds.   The first round generated unstructured data that is presented in data displays. The second and third rounds gave the expert panellists an opportunity to reevaluate their ideas (consensus building) in line with group summaries and descriptive statistics; these are presented in the tables.   The parameters set for round 2 were percentage agreement >=90%and for round 3 were >=70%, a mean value of <2 and standard deviation of <2; these were regarded as convergence of opinion towards agreement and consensus for the purpose of this study. Conversely, a percentage agreement of <90% (2nd round) or <70% (3rd round), mean of >2 and standard deviation of >2 was considered as divergence of opinion.   However, if the mean or standard deviation was above the set parameters and the percentage agreement was >=90% (2nd round) and >=70% (3rd round), then the concept was carefully evaluated (see 3.5.4.2). The numbers highlighted in grey indicate the area of lack of consensus. The highlighted areas without numbers (boxes in the table) indicate that the question was not included in that round.

4.2   DEMOGRAPHIC DATA

The demographic data was gathered to assist in interpreting the results and understanding the context of the sample (Polit & Beck 2007:325).   The information was linked to the inclusion criteria of expert panellists for the study (see 3.4.1) and encompassed organizations represented, country represented, position held, age and gender.

Countries Represented

The majority of the expert panellists came from Kenya (see table 4.1).   This may have been influenced by the fact that the researcher is based there. The majority of the expert panellists, 21 (57%) (n=37) for round 1, and 17 (71%) (n=24) for rounds 2 and 3 respectively, were from urban centers, while the rest were based in semi-urban centers. This was a limitation that possibly related to the lack of infrastructure in terms of roads and the lack of availability of the internet, because the expert panellists who were based in the semi-urban areas may have experienced difficulties in participating in the study. Jackman, Myrick and Yonge (2010:65) describe the Canadian situation where the majority of the population is urban and the rural population is marginalized due to its being in the minority.

Marginalization leads to resources being less available to the population. In the context of this study, this might be true for the semi-urban participants.

Organizations Represented

The majority of the expert panellists in the first round stemmed from the ministry of health 17 (45.9%) or academic organizations 10 (27%). This trend continued in rounds 2 and 3. This may be related to the higher numbers of expert panellists invited from the said ministry.

TABLE 4.1 COUNTRY AND ORGANIZATION OF EXPERT PANELLISTS		ROUND 1 (N =37)	ROUND 2 (N =24)	ROUND 3 (N =24)
COUNTRIES	Kenya	16 (43.2%)	14 (58.3%)	14 (58.3%)
	Uganda	6 (16.2%)	4 (16.6%)	4 (16.6%)
	Tanzania	15 (40.5%)	6 (25%)	6 (25%)
ORGANIZATIONS	Nursing Regulatory Bodies	6 (16.2%)	5 (20.8%)	5 (20.8%)
	Ministry of Health (or equivalent) (CNO/Deputy CNO, Provincial Matrons	17 (45.9%)	9 (37.5%)	9 (37.5%)
	National Nurses' Professional Associations	4 (10.8%)	3 (12.5%)	3 (12.5%)
	Universities	10 (27%)	7 (29.1%)	7 (29.1%)

Age

The majority of the expert panellists were above 40 years of age: 33 (89%) while24 (65%) were over 51 years old. This suggests that by the time nurse leaders acquire senior leadership positions, the majority of them are older and closer to retirement. This compares well with a study conducted by Carroll (2005:147) in the USA which found that 78% of nurse executives in her study were above 40 years of age. However, in a study conducted by Small (1989:128) in the USA, the findings indicated that there was no relationship between age and political participation.
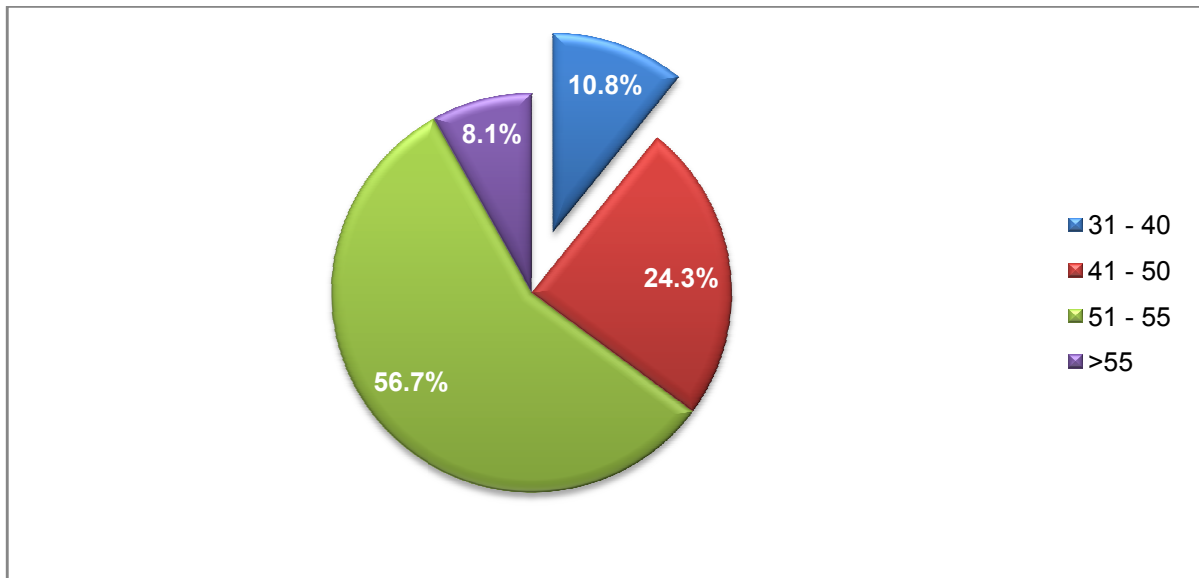
Figure 4.1 Age (Round 1) (n=37)
Gender

The majority 23 (62.2%) of the expert panellists were female. These percentages do not reflect the proportion of males/females in nursing in East Africa; for example, in Kenya, the percentage of males in nursing is about 28% (Riley, Vindigni, Arudo, Waudo, Kamenju, Ngoya, Oywer, Rakuom, Salmon, Kelley, Rogers, St. Louis, & Marum 2007:1398). These findings suggest that a higher proportion of men occupy leadership positions compared to that in nursing as such, though more men than women might have been interested in the study: hence, the higher numbers of male respondents. Literature from Canada suggests that male nurses progress faster in the leadership hierarchy than female nurses compared to their relative proportions in the nursing profession (Evans 2004:326).
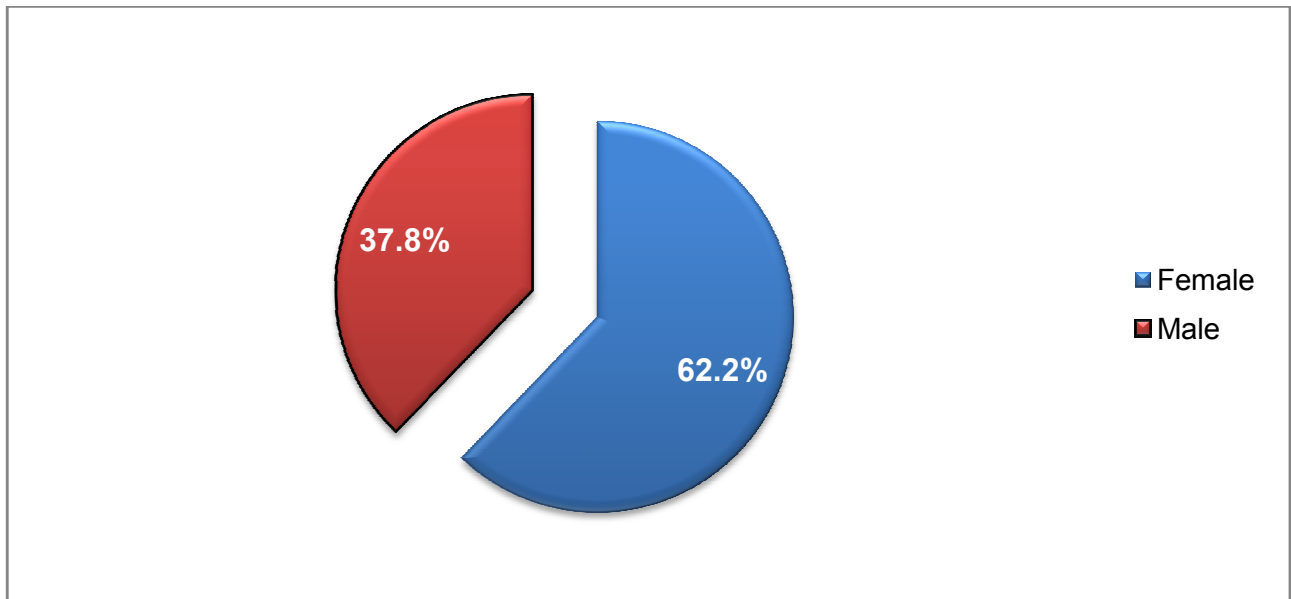
Figure 4.2 Gender (Round 1) (N=37)

Highest level of Education

The majority of the expert panellists 26 (70%) possessed a university degree. Whilst there is scant literature on the demographic attributes of national nurse leaders, Carroll's (2005:147) study revealed that all nurse executives had earned a minimum of a master's degree. However, the study was conducted in the USA, where nurses have enjoyed access to tertiary education for many years. More nurse leaders in this study had received tertiary education than the general population of nurses in East Africa. According to Riley et al (2007:1398) who developed a nursing database in Kenya, few nurses (0.8%) are registered with a BScN. Nurses in the East African region only began to gain access to university education from the early 1980s.
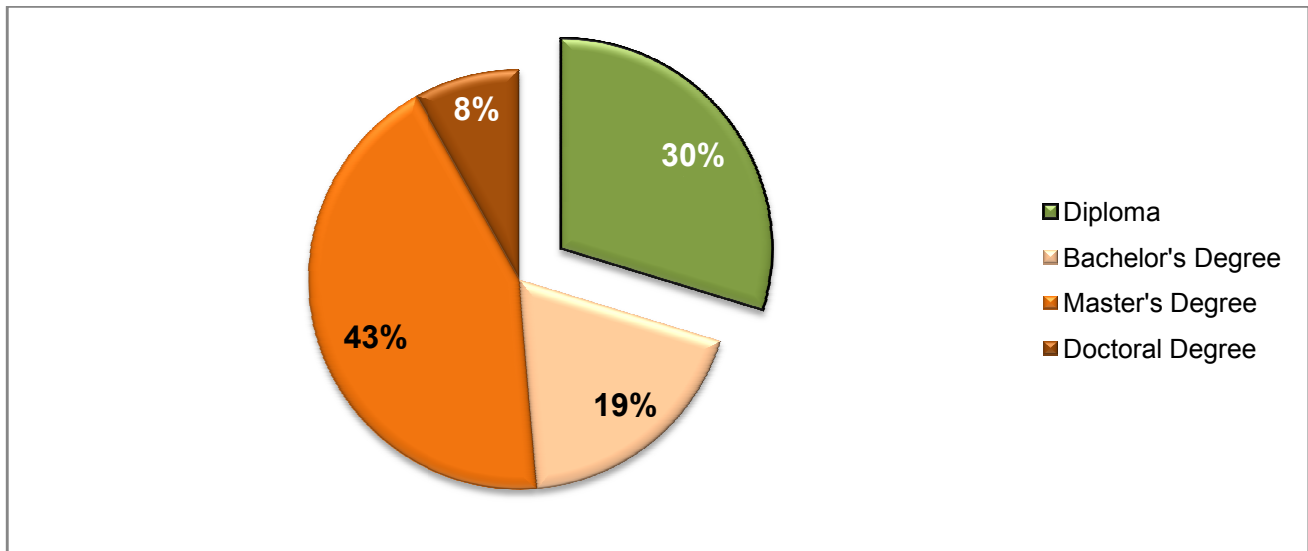
Figure 4.3 Highest level of Education (Round 1) (n=37)

Current job position

The majority of the expert panellists for all three rounds were provincial nursing officers and deans at universities (see figure 4.4). Larger or smaller numbers of participants from some groups are reflective of larger or smaller numbers of expert panellists included from that group and the numbers of nurses in the various national leadership positions and may not necessarily reflect any greater interest by a specific group of panellists.

This question helped to ascertain the representation of nursing leadership as per sampling framework and selection criteria. The expert panellists were representatives of the senior national nursing leadership, across organizations (see table 4.1) included in the sampling framework for all three rounds. It was critical to the validity of the study that there be adequate representation from expert panellists most likely to have participated in health policy development and therefore having gained knowledge and experience in this field, thereby aiding in achieving the study objectives.
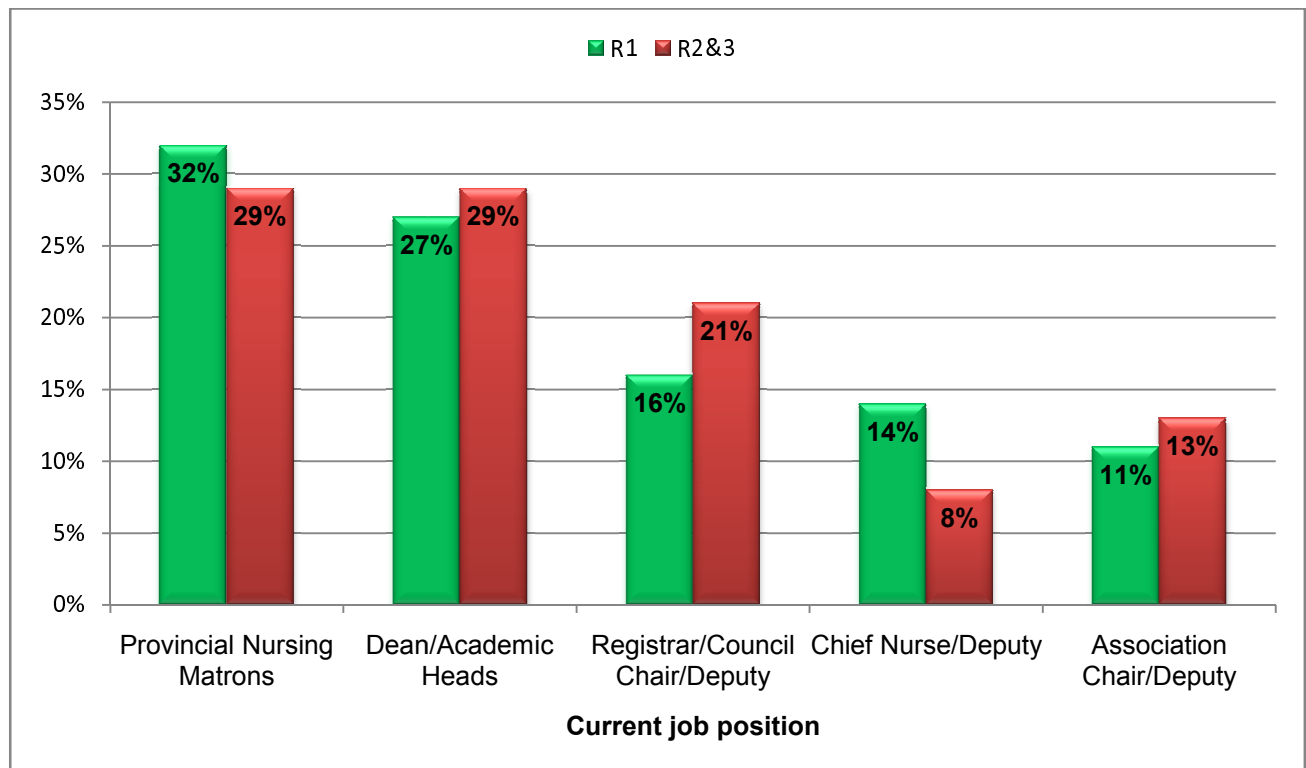
Figure 4.4 Current job position Round 1 (R1) (n = 37) and Rounds 2 and 3 (R2&3) (n = 24)

Years of Experience in Nursing

The majority of the expert panel members reported over 15 years of experience in nursing 31 (86%). Out of these, 54% recorded more than 25 years of experience. This indicates that the majority of the expert panellists had considerable experience and expertise in the nursing profession (Lamond & Farnell 1998:281).

Years of Experience in Current Position

Almost three quarters, 27 (73%), of the expert panellists reported up to 5 years of experience in their current position. Just over a quarter 10 (27%) indicated 6 to 15 years of such experience (see figure 4.5). Therefore, whilst the majority of the expert panellists (86%) reported over 15 years of experience in nursing, over a quarter had 6 to 15 years of experience in their current position. This indicates that the majority have occupied their current positions for shorter periods of time. This may suggest that by the time nurses acquire national leadership positions they are close to retirement age. This might influence their ability to participate in health policy development and to develop effective successors to lead in this arena.

The implications may be that whilst nurse leaders may have expertise in nursing, when they move to policy development, they possess less expertise in policy development and

are close to retirement. Since few others have been in the policy arena for over 10 years, they may lack mentors or role models to help them develop, and by the time they do acquire those skills, it might be time to retire. It is noteworthy that nursing might be losing nurse leaders who have gained policy skills to retirement.

It is suggested that it takes over 10 years to gain the experience necessary to become an expert. And the nature of the expert knowledge is specific to the domain within which the expert practices. Furthermore, if the expert is asked to perform outside his/her area of expertise, then his/her performance may be reduced to the level of that of a novice (Lamond & Farnell 1998:281).
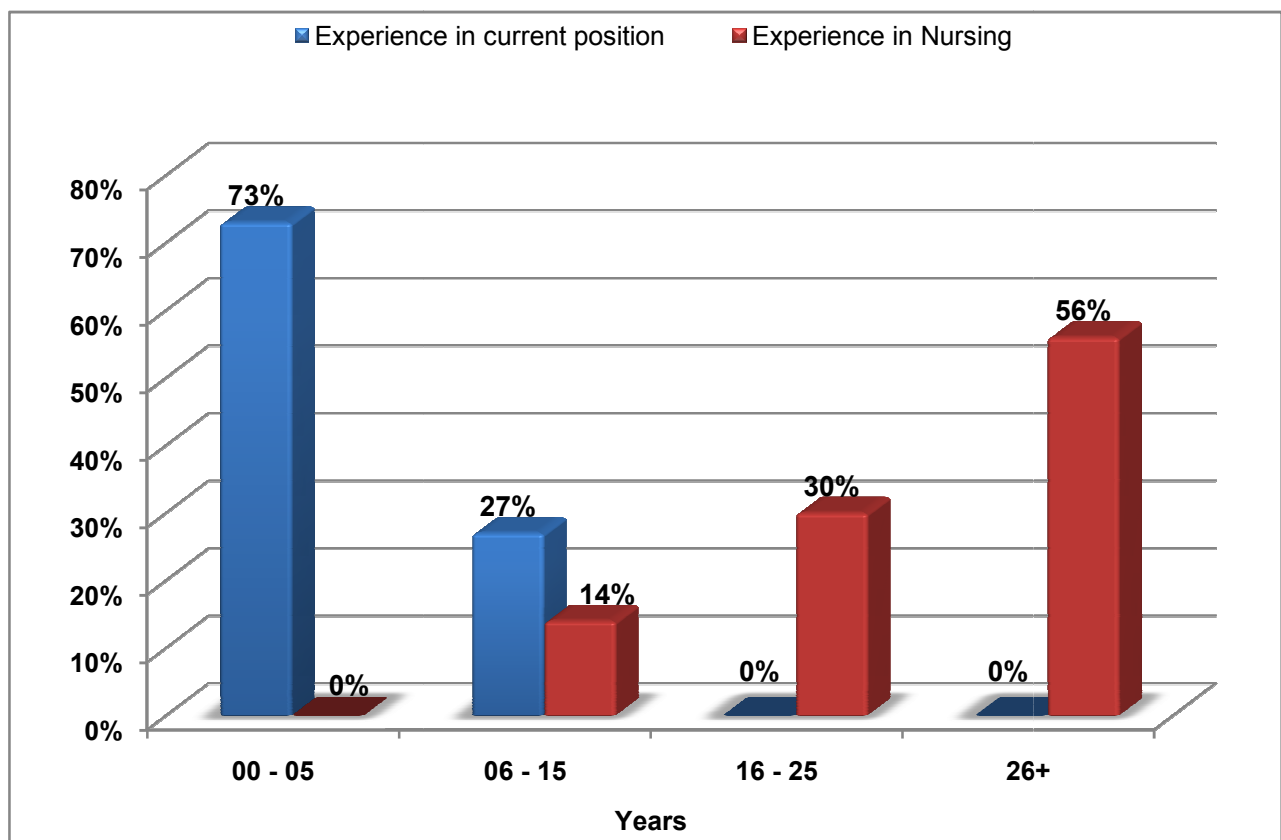

Figure 4.5 Years of Experience in Current Position (n =37) and Nursing - Round 1 (n = 36)

The demographic data indicates that expert panellists who represented the three East African countries were senior nurse leaders from the ministry of health (or equivalent), nursing councils, universities and national nurses' associations. The majority of them were

over 51 years of age and were females. They matched the expert panel criteria set for the study.

4.3 EXTENT OF NURSE LEADERS' PARTICIPATION IN HEALTH POLICY DEVELOPMENT (ROUND 1) (N = 37)

4.3.1 Major components of job position – in relation to policy development

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Data Display 4.1: Major components of job position
- Management – planning, supervision, monitoring, staffing, resource management
- Education – teaching and training
- Policy development – participation
  - policy formulation
  - policy implementation – implementation, interpretation and dissemination of policy

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The nurse leaders identified three major roles as illustrated in data display 4.1. Whilst they perceived their roles to be largely related to management and training, roles pertaining to policy development were identified by fewer expert panellists. These were related mainly to policy formulation and implementation, did not include the whole process. Deschaine and Schaffer (2003:269) report similar policy development responsibilities among public health nurse leaders in the USA. In contrast they did not play educational or policy dissemination roles as was seen in the current study.

4.3.2 Membership and role in professional organization

The majority of the expert panellists were part of a professional association: 35 (94.6%). Two (5.4%) left this question blank, perhaps indicating that they were not a member of any such organization.

The major role that was identified by the expert panellists in the professional organization was that of being members. A few identified themselves as playing leadership roles in the organization. Their role in terms of influencing health policy development or political activism through their professional organization was unclear. Membership in itself does give nurses an opportunity to be more politically active and to participate in health policy development. Two separate studies by Hayes and Fritch (1988:37) and Small (1989:128) in the USA among registered nurses, found a relationship between membership of a professional organization and political participation. The latter is linked to the ability to

influence the course of health policy development.   Professional organizations provide the opportunity for political participation.

4.3.3   Ways of involvement in health policy development

> **Data Display 4.2: Ways of involvement**
>
> ·   Nursing organizations
>   o   Nursing associations
>   o   Nursing regulatory bodies
> ·   Position held
> ·   Individual basis

The expert panellists indicated that they can become involved in health policy development through: nursing organizations, position(s) held and on an individual basis, as illustrated in data display 4.2. Camuňas (2007:206) and Gebbie, Wakefield and Kerfoot (2000:313) concur with data display 4.2; they further included community, government and educational institutions as spheres of nurses' influence on health policy.

4.3.4   Views on nurses' participation in health policy development

The majority of the expert panellists indicated that according to their experience:

- Individual nurses *do not* participate in *health policy development* 25 (68%)

- Nurses **do not** participate in *nursing related health policy* development 19 (51%),

- Nurses **do not** participate on *broader health policy development* issues 22 (59%)

- Nurses *do not lead* in *setting* the health policy development *agenda* 34 (92%).

The findings suggest that in the perception of the expert panellists, *nurses'* involvement in the policy arena is limited. In other words, the wider profession of nursing, beyond those in formal leadership positions, plays a small role in this respect. It is significant that the health policy agenda proposed at policy forums is largely dictated by others, not nurses themselves, despite their comprising the largest health workforce (see 1.2). To have nurses' concerns and issues recognized as health policy priorities, it is important that they be actively involved in influencing the health policy agenda (Cohen, Mason, Kovner, Leavitt, Pulcini & Sochalski 1996:260).

4.3.5 Nurse leaders' participation in policy development at global, regional, national and provincial levels

The majority of the expert panellists participate in health policy development at national level: 20 (54%). However, their participation decreases at regional, 16 (43%), global 11 (30%), and provincial, 11 (30%), levels of health policy development (see figure 4.6).

It is important to note that currently, the East African countries are establishing the East African Community; these findings suggest that whilst some of the nurse leaders are involved in regional health policy development processes, there is an opportunity for securing a higher degree of involvement.
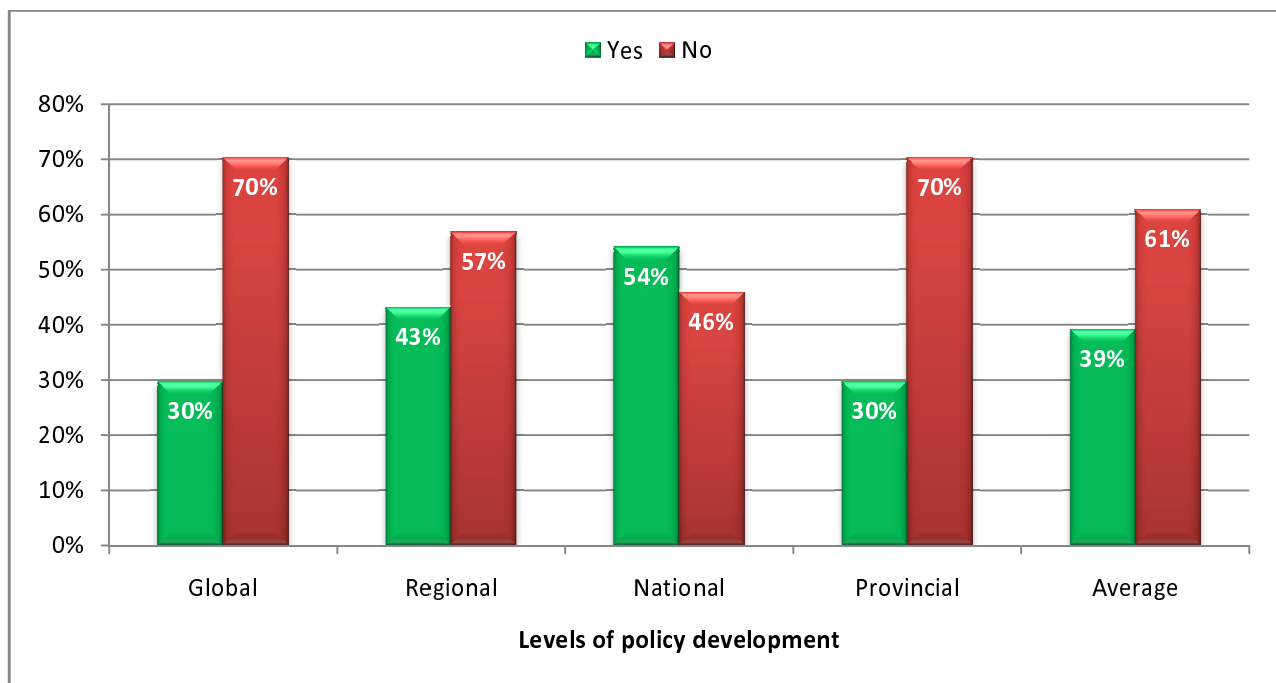
Figure 4.6 Participation in Policy Development at Global, Regional, National, Provincial Level - Round 1 (n =37)

4.3.6 Nurse leaders' participation in the stages of the policy development process

Over half 20 (51%) of the expert panellists do participate in health policy implementation. However, their participation decreases at other stages of the process, for instance in problem identification 17 (46%), policy formulation 18 (49%), and evaluation 17 (46%). This finding may indicate that there is some degree of presence of the expert panellists throughout the health policy development process though this also indicates that there is an opportunity for greater numbers of nurse leaders to be included in the process.

In terms of the data display 4.1, the expert panellists indicated that the major components of the requirements of their role were mainly policy formulation and implementation in

terms of the policy development process. This indicates some inconsistency in the data. What is clear is that the expert panellists do participate in this process, perhaps not throughout it and not consistently, but nursing is present to some degree in the process. This may also indicate that they may be part of the process on an ad hoc basis (see table 4.15 and data display 4.16).
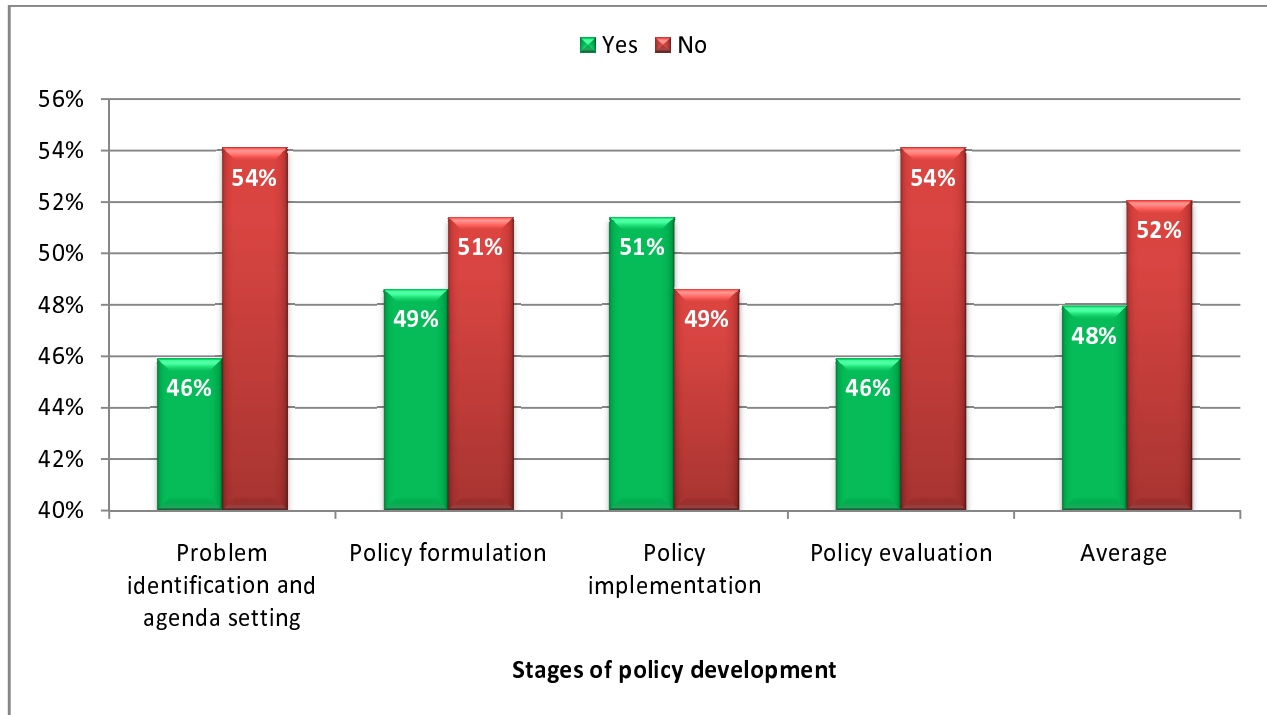
Figure 4.7 Participation in Stages of the Policy Development Process (Round 1) (n =37)

The data in this section suggests that some of the expert panellists do participate in health policy development at all stages of the process and at all levels of policy development. There is some indication that this is part of the nurse leaders' job but that it may be limited to policy formulation and implementation since their jobs are largely managerial in nature.

4.4   LEADERSHIP ATTRIBUTES FOR NURSE LEADERS' PARTICIPATION IN HEALTH POLICY DEVELOPMENT

The expert panel members were asked to describe essential leadership attributes, the leadership attributes that they have and those they would like to develop to enable them to participate in health policy development. Leadership attributes emerged in most questions analyzed, which may be related to the members of the sample being leaders so that they consider leadership integral to influencing health policy development within different structural levels and stages of the process.

4.4.1   Essential leadership attributes for participation in health policy development

Data display 4.3 illustrates the essential leadership attributes identified by the expert panellists. Additionally, this display illustrates the leadership attributes that they regard themselves as possessing and those they would like to develop. There were leadership attributes that the expert panellists considered essential but that did not appear in the attributes they possess or would like to develop, as indicated in the display. It is unclear why they were silent about them.

The findings revealed that out of the 15 essential leadership attributes, the expert panellists felt that they had developed 10. Critical thinking emerged as an attribute that they possess but was not identified as an essential leadership attribute. This finding is supported by the study conducted by McDaniels (1991:87) who found that there is a relationship between critical thinking and policy activities.

Three attributes emerged that the expert panellists felt they would like to develop as illustrated in data display 4.3. They perceive good communication and management skills as essential attributes, they have developed these attributes, and they would also like to develop them further. This indicates the importance of these attributes to the expert panellists.

DATA DISPLAY 4.3: LEADERSHIP ATTRIBUTES (ROUND 1 N=37)

- Political advocacy skills– lobbying

  (e.g. support of a cause and the act of influencing on behalf of others) ■ ★ ◎

- Good communication skills – listening, speaking, writing ■ ★ ◎

- Negotiation skills ■ (?)

- Interpersonal skills ■ (?)

- Assertiveness ■ ★

- Confidence ■ ★

- Courage ■ ★

- Visionary ■ ★

- Proactive ■ ★

- Creative ■ (?)

- A team player ■ ★

- Collaborative/cooperative ■ ★

- Respect for others ■ (?)

- Good management skills – planning, organizing, supervising and evaluation ■ ★ ◎

- Knowledgeable and competent in nursing ■ ★

- Critical thinker ★

- Being motivated to participate in health policy development ■

- Cultivating cordial working relationships with colleagues ■

- Having the ability to engage the media to change the image of nursing ■

Key: Leadership attributes			
■ - Essential	★ - Have developed	◎ - Would like to develop	(?) - Unexplored

Table 4.2 illustrates essential leadership attributes for participation in health policy development. Data related to leadership attributes emerged in other questions. This data was integrated into the questionnaire 2 in the sections, as it appeared from the qualitative data in round two. The replication of questions helped the researcher understand the consistency of the participants' views. In the third round, related questions were merged. The first column in the tables indicates the reference numbers of the questions in the questionnaires (R = round) while the second column contains the questions and that is followed by descriptive statistics related to rounds 2 and 3.

The findings indicate that there was consensus regarding the essential leadership attributes for participation in health policy development in both rounds two and three, as illustrated in table 4.2. The percentage agreement was 83% - 100%, while the mean was 1.00 – 1.61 and the standard deviation 0.00 – 0.97. This indicated convergence of opinion towards agreement for all the attributes in both the rounds: hence, consensus was achieved.

Whilst there is literature on leadership styles, skills and attributes, there is scanty literature linking leadership attributes for influencing health policy development (Bennett 2004:28). The information gathered in this study is unique in that national nurse leaders are suggesting essential leadership attributes for participating in health policy development. Mohlokoane (2004:1) asserts that, "Indeed the axiom behind all successful human endeavours, be it at family, business, political, spiritual or national level, can be summed up in one word - *leadership*." The findings of this study are supported by studies conducted by Hennessy and Hicks (2003:446), Carroll (2005:150) and Bieber (2003:55), which included samples of chief nurses and nurse executives respectively, that investigated the ideal attributes of chief nurses in Europe, and leadership skills and attributes of women and nurse executives, and leadership practices veteran nurse administrators. Their findings included attributes such as communication, interpersonal skills, visionary skills, negotiation skills, professional credibility, political astuteness, team working, innovation, good management, collaborating and courage. Furthermore, Carroll's (2005:147,148) included personal integrity which encompassed ethical standards, trustworthiness and credibility. Additionally, Cook's (1999:309) study indicated that the major aim of leadership was regarded as empowering others.

	TABLE 4.2 LEADERSHIP ATTRIBUTES	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 1.1.) (R2 - 5.14, 1.8, 7.1.7)	Nurse leaders must have transformational leadership attributes - being able to influence, being visionary and inspiring a shared vision	100%	1.25	0.53,	100%	1.00	0.00
(R3 - 1.2.) (R2 - 5.15, 1.1)	Nurse leaders must be politically astute - able to lobby with policy makers and influence health policy of concern to nursing profession	100%	1.46	0.66	92%	1.5	0.78
(R3 - 1.3.)	Political skills include:						
	a) Being knowledgeable about the health issues of concern to nursing which are influenced by health policy				96%	1.17	0.48
	b) Identifying people and building relationships with individuals dealing with one's issue of interest at ministry of health level				83%	1.58	0.88
	c) Contacting policy makers dealing with one's issue of interest				96%	1.50	0.59
	d) Writing to policy makers dealing with the issue of interest – expressing one's opinion				87%	1.61	0.84
	e) Building coalitions – with groups that share similar interests to nursing, e.g. the Heart Association to influence reduction in smoking and cardiac diseases				92%	1.50	0.66
	f) Be willing to testify to policy makers on issues of concern to nursing profession				100%	1.25	0.44
(R3-1.4.) (R2 - 5.23, 1.2)	Nurse leaders must be effective communicators who are able to articulate and disseminate health policy related issues – listening, speaking, writing	100%	1.21	0.42	96%	1.21	0.66
(R3 - 1.5.) (R2 - 5.7)	Nurse leaders must have the ability to clearly articulate health issues of concern to nursing at policy development forums/arena	100%	1.21	0.42	100%	1.09	0.29
(R3 - 1.6.)	Some of the articulation skills nurse leaders must have include:						
	a) Being able to communicate effectively with colleagues in senior and junior positions				100%	1.17	0.38
	b) Being able to communicate in the right medium e.g. in person, on the phone, e-mail and media				100%	1.29	0.46
	c) Being able to craft and deliver clear messages – e.g. nursing position on proposed health policy				100%	1.21	0.42

	TABLE 4.2 LEADERSHIP ATTRIBUTES (continued)	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 1.7.) (R2 - 1.4)	Nurse leaders must have good (effective) interpersonal skills	100%	1.38	0.50	100%	1.27	0.46
(R3 - 1.8.) (R2 - 7.1.11)	Nurse leaders must be able to cultivate cordial working relationships with colleagues and others within and outside the profession, in junior and senior positions	100%	1.42	0.50	100%	1.21	0.42
(R3 - 1.9.) (R2 - 8.1, 1.12)	Nurse leaders must be effective in collaborating and cooperating within and outside the profession	100%	1.33	0.48	100%	1.29	0.46
(R3 - 1.10.) (R2 - 1.11)	Nurse leaders must be team players	100%	1.33	0.48	100%	1.09	0.29
(R3 - 1.11.) (R2 - 1.13)	Nurse leaders must have respect for others	100%	1.48	0.67	100%	1.04	0.21
(R3 - 1.12.) (R2 - 1.3)	Nurse leaders must have negotiation skills that generate win-win solutions	100%	1.21	0.42	100%	1.17	0.39
(R3 - 1.13.) (R2 - 7.1.9, 1.9)	Nurse leaders must be proactive and take initiative to formulate strategies of being involved at each stage of the policy development process	100%	1.33	0.48	100%	1.17	0.39
(R3 - 1.14.) (R2 - 5.19)	Nurse leaders must be motivated to participate in health policy development	100%	1.46	0.59	96%	1.33	0.87
(R3 - 1.15.) (R2 - 7.1.8, 1.6)	Nurse leaders must have personal confidence through encouragement and a feeling of empowerment	100%	1.29	0.46	100%	1.77	0.38
(R3 - 1.16.) (R2 - 1.7)	Nurse leaders must be courageous in articulating health issues of concern to nursing	100%	1.29	0.46	100%	1.13	0.34
(R3 - 1.17.) (R2 - 1.10)	Nurse leaders must be creative	100%	1.26	0.54	100%	1.22	0.42
(R3 - 1.18.) (R2 - 1.14)	Nurse leaders must have management skills – planning, organizing, supervising and evaluating	100%	1.25	0.53	100%	1.08	0.28
(R3 - 1.19.) (R2 - 1.15)	Nurse leaders must be knowledgeable and competent in nursing	96%	1.58	0.97	100%	1.13	0.34
(R3 - 1.20.) (R2 - 1.5, 5.8, 7.1.7)	Nurse leaders must be assertive in raising nursing concerns related to health care to policy makers	96%	1.38	0.77	100%	1.09	0.29
(R3 - 1.21.) (R2 - 2.3,7.2.1)	Nurse leaders must have critical thinking and problems solving skills through nurse leaders education	96%	1.33	0.70	100%	1.17	0.39

4.4.2 Leadership attributes for participation in health policy development – have developed and would like to develop

There was a high degree of consensus among the expert panellists on all the leadership attributes that expert panellists possess and would like to develop to enhance their participation in the policy development process. The percentage agreement ranged between 92% - 100%, the mean ranged between 1.17 – 1.63 and the standard deviation

ranged between 0.38 – 0.88. This indicated a convergence in opinion towards agreement for round 2. Since there was a high level of consensus in this respect, further consensus building was discontinued. Additionally, this did not further the primary goal of the study. This part was explored to investigate the gap between the essential leadership attributes and development needs. There does not appear to be a significant one.

4.5 FACILITATORS TO NURSE LEADERS' PARTICIPATION IN HEALTH POLICY DEVELOPMENT

The data analysis revealed little distinction between facilitators and actions proposed for the barriers and facilitators (see annexure B, questionnaire 1). A decision was made to merge these into two main sections of facilitators and barriers to nurse leaders' participation in the *health policy development process at its different stages.* Furthermore, there was little distinction in the four levels (provincial, national, regional and global) and a decision was made to merge these and present them together. Therefore, the findings are presented as a summary of:

- Facilitators to nurse leaders' participation in health policy development process
    - o at various levels
    - o at stages of the health policy development process (stages)
- Barriers to nurse leaders' participation in health policy development process
    - o at various levels
    - o at stages of the health policy development process (stages)

The expert panellists described the facilitators that they encounter whilst participating in health policy development at four levels: global, regional, provincial and national. These include: knowledge and skills, involvement, image of nursing, support, structures and resources.

4.5.1 Participation at various levels

4.5.1.1 Knowledge and skills

Knowledge and skills emerged as facilitators of nurse leaders' participation in health policy development, as indicated in data display 4.4. Knowledge and skills encompass being knowledgeable and skilled in health policy making, possessing a university education, content related to health policy being covered in the curriculum. Tertiary education to the level of at least a bachelor's degree facilitates being knowledgeable and enhances the possibility of participating in policy activities. It may also enhance the image of nursing and

situate it at a level equal to that of other professionals in policy development. The majority of expert panellists in this study (70%) held a basic degree (see 4.2).

DATA DISPLAY 4.4: KNOWLEDGE AND SKILLS (ROUND 1 N=37)

Facilitators
· Being knowledgeable and skilled in the health policy making activities at all levels
· Having at least a university level of education e.g. BScN
· Having content related to health policy development included in their basic nursing education

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There was consensus in rounds 2 and 3 that knowledge and skills were facilitators of nurse leaders' participation in the policy development process as indicated in table 4.3. The percentage agreement ranged between 79% - 100%, whereas the mean ranged between 1.17 – 1.65 and the standard deviation between 0.39 – 0.97. This indicates a convergence in opinion towards agreement; hence, consensus was achieved.

The findings indicate that the expert panellists agreed that education at degree level was necessary for nurse leaders' participation in health policy development activity. The necessary knowledge and skills can be acquired by nurse leaders through their education that must include content related to health policy in their curriculum.

Kunaviktikul et al's study in Thailand (2010:225) which included nurse leaders (26) from steering groups of national professional associations, reported that one of the barriers is that of knowledge and skills related to involvement in the policy development process and further suggest building knowledge and experience in the next generation of nurse leaders.

According to Dollinger (2006: 106, 107), there is evidence to suggest that well educated nurses who work in the government in the USA still find it a challenge to influence health policy. Rains and Carroll (2000: 39) contend that being educated on health policy has been shown to increase self-perceived competence in knowledge, skills, and understanding within the context of health policy activity. In the context of this study, knowledge and skills appear to be important precursors of participation in health policy development activities.

	TABLE 4. 3 KNOWLEDGE AND SKILLS	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 2.1.) (R2 - 5.1 7.1.4, 8.2)	Nurse leaders must be knowledgeable and skilled in the health policy development activities at all levels	96%	1.42	0.78	100%	1.17	0.39
(R3 - 2.2.) (R2 - 5.2)	Nurse leaders must have at least a university degree - level of education e.g. BScN	91%	1.63	0.97	91%	1.65	0.89
(R3 - 2.3.) (R2 - 5.3)	Content related to health policy development must be included in the basic nursing education	100%	1.54	0.66	91%	1.55	0.80
(R3 - 2.4.)	The content in the basic nursing programmes may include:						
	a) Types of policy: public policy, health policy, social policy				100%	1.29	0.46
	b) Theories and models of policy making				92%	1.50	0.66
	c) Policy development process				92%	1.42	0.65
	d) Policy making environment: social, political and economic influences				100%	1.33	0.48
	e) Legislative process: district, province, national				96%	1.50	0.72
	f) Influencing policy: roles and responsibilities of nurses, strategies to influence policy				96%	1.33	0.57
	g) Analyze health policy and political issues				79%	1.58	0.83

4.5.1.2   Involvement

The category of involvement was identified as a facilitator of nurse leaders' participation in health policy development.   Involvement includes being accorded opportunity, possessing experience and being active participants, as shown in data display 4.5. The opportunity to participate may engender experience, which would build confidence and enable active participation in health policy development when given the opportunity. Having opportunity may facilitate application of learnt theory to practice with regards to health policy development.

DATA DISPLAY 4.5: INVOLVEMENT (ROUND 1 N=37)
Facilitators ·   Having opportunities to participate in forums where policies are formulated by policy makers ·   Having experience in the health policy making process ·   Being active participants in health policy development process when given the opportunity

There was consensus in rounds 2 and 3 among the expert panellists on the facilitators related to involvement in the policy development process as listed in table 4.4.   The percentage agreement ranged between 91% - 100%, the mean ranged between 1.17 – 1.71 and the standard deviation ranged between 0.38 – 0.91.This indicates a convergence in opinion towards agreement; hence, consensus was achieved, indicating that involvement was a facilitator in this regard. In the study conducted by Kunaviktikul et al (2010:225), the strategies suggested by nurse leaders for increasing involvement in policy development included having experience in policy development activities.   Nurses' involvement in health policy has positive effects on access to, as well as the quality and affordability of, health care (DiGaudio 1993: 93,94).

	TABLE 4.4 INVOLVEMENT	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 2. 5.) (R2 - 5.5, 7.1.3)	Nurse leaders must have experience and exposure to health policy development process	96%	1.67	0.76	96%	1.21	0.51
(R3 - 2.6.)	Nurse leaders' experience and exposure to policy development may include:						
	a) Identifying policy makers and legislators who represent nursing in the community				92%	1.46	0.66
	b) Understanding policy makers' interests and commitment to health-related issues of concern to nurses				100%	1.33	0.48
	c) Analyzing nursing concerns or health issues that can be addressed through policy intervention/reform				100%	1.26	0.45
	d) Making presentations, that are evidence based, to policy makers and testifying at legislative hearings				100%	1.25	0.44
(R3 - 1.5.) (R2 - 5.4, 7.1.1 7.1.10)	Nurse leaders must have opportunities to participate in forums where policies are formulated by policy makers	100%	1.42	0.58	100%	1.14	0.35
(R3 - 2.13.) (R2 - 7.1.1)	Nurse leaders must have opportunities to be included by policy makers at every stage of the health policy development process	96%	1.29	0.86	100%	1.25	0.44
(R3 - 2.14.)	Stages of health policy development include:						
	a) Problem identification and agenda setting				100%	1.29	0.46
	b) Health policy formulation				100%	1.29	0.46
	c) Health policy implementation				100%	1.25	0.44
	d) Health policy evaluation				100%	1.29	0.46
(R3 - 2.15.)	Nurse leaders should be skilled at seeking an opportunity for influencing health policy development at:						
	a) Workplace e.g. hospitals				100%	1.21	0.42
	b) Community – e.g. the village/constituency they live in				96%	1.38	0.57
	c) Professional associations – national nurses' associations				100%	1.17	0.38
	d) Government – ministry of health				100%	1.17	0.38
(R3 - 2.16.) (R2 - 7.1.2, 5.6)	Nurse leaders must participate actively in the entire policy making process when given the opportunity to participate	100%	1.21	0.42	100%	1.23	0.43
(R3 - 2.17.)	Active participation includes:						
	a) Articulating issues of concern to nursing				100%	1.17	0.38
	b) Ensuring that nursing is positioned in the mainstream of health policy development to acquire power and influence				96%	1.21	0.51
	c) being visible				100%	1.21	0.41
	d) being accessible				100%	1.17	0.38

4.5.1.3   Image of nursing

Data display 4.6 illustrates the category related to the image of nursing. The findings suggest that nursing must be considered a valuable partner in policy development; nurses with potential must be appointed in policy making positions, while they must also engage policy makers and also the media, to change the image of nursing.

DATA DISPLAY 4.6: IMAGE OF NURSING (ROUND 1 N=37)

Facilitators
- Having nurse leaders' input respected by policy makers
- Having nurses with the ability to influence health policy when nominated to national leadership positions
- Nurse leaders must engage policy makers to ensure a bottom up and top down approach during the entire policy development process
- Having the ability to engage the media to change the image of nursing

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There was consensus among the expert panellists on the facilitators related to the image of nursing as listed in table 4.5 (in rounds 2 and 3). The percentage agreement ranged between 91 % - 100%, the mean ranged between 1.17 – 1.71 and the standard deviation ranged between 0.38 – 0.91. This indicates a convergence in opinion towards agreement; therefore, consensus was achieved.

The results indicate that nurses must take an active role in enhancing the image of nursing amongst policy makers. Dollinger (2006:106,107) examined nurses' advocacy in health policy in the USA and found that nurses exhibited little ability to influence policy due to the lack of status of the nursing profession and the dominance of the medical profession in government. Farsi, Dehghan-Nayeri, Negarandeh and Broomand (2010:14) recommend that to alter nurses' social position, they must be involved in policy-making and political affairs.

	TABLE 4.5 IMAGE OF NURSING	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 2.20. (R2 - 5.10)	Nurse leaders' input in policy development must be respected by policy makers	100%	1.38	0.50	100%	1.29	0.56
(R3 - 2.21. (R2 - 5.9)	Nurse leaders with the ability (right credentials) to influence health policy should be nominated to national leadership positions e.g. Director of Nursing Services	100%	1.25	0.53	100%	1.17	0.38
(R3 - 2.22. (R2 - 7.1.12)	Nurse leaders must engage policy makers to ensure a bottom up and top down approach during the entire policy development process	100%	1.54	0.72	100%	1.35	0.49
(R3 - 2.23.	Nurse leaders must be able to focus the health policy agenda around health, which includes health promotion and disease prevention				100%	1.29	0.46
(R3 - 2.24.	Nurse leaders must be able to ensure that the health policy agenda is not dominated by medical and curative issues				96%	1.38	0.58
(R3 - 2.18. (R2 - 5.24)	Nurse leaders must have the ability to engage the media to change the image of nursing	91%	1.71	0.91	100%	1.27	0.46
(R3 - 2.19.	Media management skills include:						
	Clearly articulating issues of concern to nursing				100%	1.25	0.44
	Being proactive in communicating with the media on health and nursing concerns				100%	1.25	0.44
	Responding to media releases related to health and nursing concerns				96%	1.33	0.70
	Using the media as a medium for nurses to inform policy makers of nurses' contribution to health care				96%	1.25	0.53

4.5.1.4   Support

The category of support was identified as a facilitator of nurse leaders' participation in health policy development.   Being supported includes benefiting from role models, supportive mentorship and networks for support and sharing experiences as illustrated in data display 4.7.

DATA DISPLAY 4.7 SUPPORT (ROUND 1 N=37)

Facilitators
·   Having *role model*s from whom nurse leaders can learn to participate in health policy development pr*ocess*
·   Supportive mentorship from nurse leaders who have been involved in and have actively participated in the development of health policy
·   Nurse leaders need to have networks for support and to share experiences on policy related issues (e.g. national nurses association – intensive care nurses chapter)

There was consensus among the expert panellists that support was necessary to facilitate nurse leaders' participation in the policy development activities in rounds 2 and 3 as indicated in table 4.6. The percentage agreement ranged between 92% - 100%, while the mean ranged between 1.17 – 1.58 and the standard deviation between 0.34 – 0.93. This indicates a convergence in opinion towards agreement; consequently, consensus was achieved.

Sundquist's (2009:84) study reveals that support, encouragement and inspiration were necessary for participation in health policy development. Kunaviktikul et al's study (2010:225) found that one of the barriers to participation in health policy was a lack of support.

	TABLE 4. 6 SUPPORT	**ROUND 2 (n =24)**			**ROUND 3 (n =24)**		
		PA	M	SD	PA	M	SD
(R3 - 2.7.) (R2 - 5.21)	Nurse leaders must have role models through whom they can learn to participate in the health policy development process,e.g. directors of medical services who are involved in health policy development	96%	1.42	0.72	100%	1.50	0.51
(R3 - 2.8.) (R2 - 7.1.6)	Nurse leaders must receive supportive mentorship from leaders who have been involved in and have actively participated in health policy development	100%	1.33	0.49	100%	1.25	0.44
(R3 - 2.9.)	Supportive mentorship for nurse leaders entails:						
	a) Accepting and seeking mentorship from nurses who have more experience in influencing health policy (expert – novice mentorship)				100%	1.25	0.44
	b) Having mentors who inspire, guide, advise and model behaviour while they participate in influencing health policy				100%	1.17	0.38
	c) Being mentors to nurses with less experience in influencing health policy (peer – peer mentorship)				96%	1.29	0.69
(R3 - 2.10.) (R2 - 5.18)	Nurse leaders need to have networks for support and to share experiences on policy related issues (e.g. national nurses' association – intensive care nurses' chapter)	100%	1.42	0.50	100%	1.33	0.34
(R3 - 2.11.)	Nurse leaders should develop networks for sharing information, and feedback with:						
	a) Colleagues who have less experience than themselves				92%	1.58	0.93
	b) Colleagues who have equal experience				96%	1.46	0.59
	c) Colleagues who have more experience				100%	1.29	0.46

4.5.1.5   *Structures*

The category of structures emerged as facilitators of nurse leaders' participation in health policy development, as illustrated in data display 4.8. These include: a legislature which ensures that national nurse leaders are included in policy development, a directorate of nursing services, enhancing the numbers of nurses at policy development level, nurses with ability in health policy activity and a gender balance. According to McDaniels (1991:76), males generally are more politically active and hence may participate to a greater extent in policy making. This view is supported by Deschaine (2003:270) and Evans (2004:326) who contend that female nurse leaders in the policy making arena may feel marginalized.

DATA DISPLAY 4.8: STRUCTURES (ROUND 1 N=37)

Facilitators
- Having legislature that ensures that national nurse leaders are included in the health policy development process
- A directorate of nursing services who is at par with the director of medical services at the ministry of health
- Enhancing representation (numbers) of nurse leaders' at national policy making level
- Nurses with the ability to influence health policy when nominated to national leadership positions
- A gender balance (in terms of appointments) at policy making forum

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There was consensus in rounds 2 and 3, among the expert panellists on the structures that facilitate nurse leaders' participation in the policy development process, as indicated in table 4.7. The percentage agreement ranged between 74% - 100%, the mean ranged between 1.17 – 2.13 and the standard deviation between 0.39 – 2.03. This indicates a convergence in opinion towards agreement, so that consensus was achieved.This indicates that there must be structures in place to facilitate nurse leaders' participation in health policy development.

In 2003, WHO suggested to member states that governments set up legal frameworks that will facilitate nursing and midwifery participation in health policy development (WHO 2003). Sundquist (2009:109) examined the role of formal Registered Nurse Leaders in policy development in the USA: her findings support those of this study, since the nurses in her study suggested increasing the number of Registered Nurses participating in policy. Additionally, Dollinger's (2006:106, 107) study indicates that nurses are not able to influence health policy development as they are not present in large enough numbers.

	TABLE 4.7 STRUCTURES	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 -1.1.) (R2 -5.13)	A legislature which ensures that national nurse leaders are included in the health policy development process	100%	1.38	0.65	100%	1.29	0.46
(R3 - 1.2.)	National nurse leaders to be included in health policy development include:						
	a) Nurse leaders from National Nurses' Association				100%	1.21	0.42
	b) Nurse leaders from Ministry of Health (national offices)				100%	1.21	0.42
	c) Nurse Leaders represented on Nursing Councils				100%	1.17	0.38
	d) Nurse leaders from academic institutions				100%	1.25	0.44
(R2 - 1.3.) (R2 -5.12)	Nursing must have a directorof nursing services who is on a par with the director of medical services (or equivalent) at the ministry of health or equivalent	100%	1.42	0.72	92%	1.38	0.65
(R3 - 1.4.) (R2 - 7.1.14)	Leadership positions must be allocated for nurse leaders at policy making levels (affirmative action)	100%	1.46	0.66	92%	1.29	0.62
(R3 - 1.6.) (R2 -5.11)	Policy makers must enhance the representation (numbers) of nurse leaders at national policy making level	96%	1.75	2.03	100%	1.26	0.45
(R3 - 1.7.) (R2 -5.20)	Policy makers must ensure that they have a gender balance (nurse leaders must be proportionate to the percentage of women and men in the nursing profession) at health policy development positions	90%	2.13	0.90	74%	1.83	1.03

4.5.1.6 *Resources*

Availability of resources emerged as a category that is a facilitator for nurse leaders participation in health policy development as indicated in data display 4.9. These include having resources and being able to mobilise them for policy making activity. Influencing policy development and the course of the health policy is largely about securing resources for health care; such work in itself requires resources.

DATA DISPLAY 4.9 : RESOURCES (ROUND 1 N=37)
Facilitators · Having the resources needed for participation in policy development activities e.g. financial, material and human · Being able to mobilise funds to finance policy making activities

There was consensus in (rounds 2 and 3) among the expert panellists that resources are required for participation in health policy development activities as listed in table 4.8. The percentage agreement was 91% - 100%, while the mean was 1.17 – 1.79 and the standard deviation 0.39 – 0.93 respectively. This indicated a convergence in opinion towards agreement: consensus was achieved, indicating that resources were important for participation in health policy development.

Historically, nursing is underfunded and lacks the ability to fund its political activities for influencing health policy while political activity requires funding to be successful (Deschaine 2003: 271; Jones, Baggott and Allsop 2004: 26, 27). Small's (1989: 129) and Casey's (2009:24) findings indicate that a correlation between income and political behaviour to influence policy: as income increases, so does political participation.

	TABLE 4.8 RESOURCES	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 -1.8.) (R2 -5.16 8.6)	Nurse leaders must have resources allocated for their participation in policy development activities e.g. financial, material and human	91%	1.58	0.93	100%	1.17	0.39
(R3 -2.27.)	Nurse leaders must possess business and financial skills to ensure that they are able to secure financial resources for the policy development process				92%	1.63	0.77
(R3 -2.28.) (R2 -5.17, 7.1.5)	Nurse leaders must be able to mobilise funds to finance policy making activities	96%	1.79	0.72	92%	1.63	0.65

4.5.2 Stages of Health policy development process

The expert panellists described facilitators that they encounter in participating in health policy development during the four stages: problem identification and agenda setting, policy formulation, implementation and evaluation. Facilitators in the stages of the process were similar to those identified in the facilitators at various levels. However, new categories did emerge as well.

4.5.2.1 Problem identification and agenda setting

Data display 4.13 indicates that possessing research, analytical, critical thinking and problem solving skills; the ability to disseminate research findings to relevant policy makers; and participating in strong nursing associations are regarded as facilitators in problem identification and agenda setting. The majority of the expert panellists (94.6%) in

this study were part of a professional nursing association although their exact role in it appears to be limited to membership (see 4.3.2).

In general, nurses' membership in professional organizations has been a challenge to encourage but trends appear to be changing and it has been increasing during recent years in East Africa. Literature emphasizes factors that have contributed towards nurses' relative powerlessness in setting public policy, which include: minimal membership in their professional associations as numbers could be a powerful advantage in terms of political action and policy influence (Hall-Long 2004:276). Membership in professional organizations has been found to be a precursor of political participation and influencing policy (Casey 2009: 24;Hayes & Fritch 1988:37; Small 1989:128). Furthermore, Snively and Rieger (2006:205–207) outline th e successes of the Oncology Nurses Organization in the USA in effecting policy through harnessing group action. These organizations may also constitute a source through which research can be conducted to inform policy. Nevertheless, nurse leaders need knowledge and skills in both research and health policy development to influence policy (Chen & Cohen 2003:194; Fitzpatrick 2004:71).

DATA DISPLAY 4.10: PROBLEM IDENTIFICATION AND AGENDA SETTING (ROUND 1 N=37)

Facilitators
- Having research skills and analytical skills to inform the agenda with evidence
- Critical thinking and problems solving skills through their education
- The ability to effectively communicate to and disseminate research findings to policy makers and stakeholders
- Being part of and actively participating in national nurses' associations
- Access to strong nurses' associations or unions

There was consensus among the expert panellists regarding the facilitators of nurse leaders' participation in the policy development process at the problem identification and agenda setting stage indicated in table 4.9 (in rounds 2 and 3). The percentage agreement was 91% - 100%, the mean ranged between 1.13 – 1.71 and the standard deviation ranged between 0.34 – 0.78. This indicates a convergence in opinion towards agreement; hence, consensus was achieved.

	TABLE 4.9 PROBLEM IDENTIFICATION AND AGENDA SETTING	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 -1.3.) (R2 -7.3.1)	Nurse leaders must be part of the agenda setting and problem identification process	100%	1.29	0.55	100%	1.17	0.38
(R3 -1.4.) (R2 -7.3.2)	Nurse leaders must understand the objectives of the policy makers and government, so that they can align nursing proposals within that context	100%	1.29	0.46	100%	1.21	0.42
(R2 -2.25.) (R2 -7.2.2)	Nurse leaders must have research skills and analytical skills to inform the health policy agenda with evidence	100%	1.33	0.57	100%	1.26	0.45
(R3 -2.26.)	Research skills include:						
	Ability to find appropriate evidence				96%	1.29	0.55
	Ability to analyze the usefulness of evidence				96%	1.25	0.53
(R2 -7.2.3)	Having the ability to effectively communicate to and disseminate research findings to policy makers and stakeholders	100%	1.21	0.42	96%	1.17	0.48
	Ability to use research evidence when advocating and influencing health policy development with regards to nursing concerns				100%	1.13	0.34
(R3 -2.29.) (R2 -7.2.5)	Nurse leaders must be part of and actively participate in national nurses associations	100%	1.71	0.75	91%	1.39	0.78
(R3 -2.30.)	Some activities of the national nursing organization may include:						
	Identifying issues of concern to nurses and health care				100%	1.21	0.41
	Drawing the attention of the public to issues of concern to nursing and health care				100%	1.21	0.41
	Taking a leadership role in the development of health policies that can improve the health of communities and ensure provision of quality health care				96%	1.33	0.70
	Gaining the collective participation and support of nurses				100%	1.13	0.34
(R2 -2.12.) (R2 -5.25)	Nurses leaders should be united as a profession and articulate issues of concern to nursing profession and health services through nurses professional organisation	96%	1.42	0.78	100%	1.21	0.41

4.5.2.2   Policy formulation

Facilitators during the policy formulation stage include: being part of the agenda setting and problem identification process, understanding the objectives of the government and being able to lobby (see data display 4.11). Noteworthy is the fact that nurse leaders want

to be involved across the stages of the process. The expert panellists seem to be suggesting that being part of the preceding phase makes it easier to participate in the next stage of the policy development process. They also appear to be implying that they are not involved in all stages of the process (see 4.6.1.2).They recognize the importance of lobbying with stakeholders to support suggestions, as indicated in table 4.2.

DATA DISPLAY 4.11 POLICY FORMULATION (ROUND 1 N=37)
Facilitators · Being part of the agenda setting and problem identification process · Being able to lobby with influential people (stakeholders) to support their suggestions in terms of the content of the proposed health policy · Understanding the objectives of the policy makers and government, so that they can align nursing proposals within that context

There was consensus (rounds 2 and 3) among the expert panellists on the facilitator of nurse leaders' participation in the policy development process at the policy formulation stage as listed in table 4.10. The percentage agreement was 96% and100%, with means of 1.42 and 1.50 and standard deviations of 0.58 and 0.72. This indicated a convergence in opinion towards agreement, so that consensus was achieved.

	TABLE 4.10 POLICY FORMULATION	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 1.5.) (R2 - 7.3.3 7.1.13)	Nurse leaders must be able to lobby with influential people (policy makers) to support nurse leaders' suggestions in terms of the content of the proposed health policy	100%	1.42	0.58	96%	1.50	0.72

4.5.2.3   *Policy implementation*

Facilitators during the policy implementation stage were related to being empowered to implement policies as illustrated in the data display 4.12. Other issues reemerged, such as being involved in the preceding stage (see 4.5.2.2),holding forums (see 4.5.1.2) and possessing resources (see 4.5.1.6).   This indicates that there are certain recurring facilitators.

DATA DISPLAY 4. 12 POLICY IMPLEMENTATION (ROUND 1 N=37)
Facilitators
· Being part of the policy formulation process so that they understand and are part of the health policies being implemented · Being empowered as regards health policy implementation · Holding forums to discuss health policy implementation issues · Having the health policies accessible to them · Being provided with resources like finances, to implement health policies

There was consensus (rounds 2 and 3) among the expert panellists on the facilitators to nurse leaders' participation in the policy development process at the policy implementation stage as listed in table 4.11. The percentage agreement was 96% - 100%, with means of 1.13 – 1.50 and standard deviations of 0.34 – 0.72. This indicates a convergence in opinion towards agreement; therefore, consensus was achieved.

	TABLE 4.11 POLICY IMPLEMENTATION	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 -1.6.) (R2 -7.4.1)	Nurse leaders must be part of the policy formulation process so that they understand and are part of the implementation process	100%	1.25	0.44	100%	1.25	0.44
(R3 -1.7.)	For nurse leaders to participate effectively:						
	a) Policy implementation process must be clear and transparent				100%	1.21	0.42
(R2 -7.4.2)	b) The health policies must be accessible to nurse leaders	100%	1.21	0.42	100%	1.13	0.34
(R2 - 7.4.5)	c) Nurse leaders must be empowered on health policy implementation	100%	1.21	0.42	100%	1.25	0.44
(R3 - 1.8.) (R2 -7.4.3)	Nurse leaders must be provided with resources like finances, to ensure implementation of health policies	100%	1.50	0.72	100%	1.13	0.44
(R3 - 1.9.) (R2 -7.4.4)	Nurse leaders must have access to forums to discuss health policy implementation issues	96%	1.42	0.72	100%	1.16	0.45

4.5.2.4   Policy evaluation

Facilitators of participation during the policy evaluation stage comprised possessing the tools and resources, as well as collaboration and cooperation within and outside the profession as illustrated in data display 4.13.   Most of the facilitators of policy evaluation are related to facilitators discussed earlier: commanding knowledge and skills (see

4.5.1.1), being involved (see 4.5.1.2), possessing resources (see 4.5.1.6) and collaboration and cooperation (see 4.4.1)

DATA DISPLAY 4.13 POLICY EVALUATION (ROUND 1 N=37)
Facilitators ·   Having knowledge and skills on policy monitoring and evaluation ·   Being involved in formulating the evaluation tools ·   Participating in setting measurable and achievable targets for health policy evaluation ·   The funds and resources available to evaluate policies ·   The necessary policy evaluation tools ·   Collaboration and cooperation within and outside the profession

There was consensus (rounds 2 and 3) among the expert panellists on the facilitators of nurse leaders' participation in the policy development process at the policy evaluation stage, as listed in table 4.12. The percentage agreement was 96% - 100%, with means of 1.21 – 1.50 and standard deviations of 0.42 – 0.93. This indicates a convergence in opinion towards agreement; hence, consensus was achieved.

	TABLE 4.12 POLICY EVALUATION	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 -1.10.) (R2 -8.3)	Nurse leaders must be involved in formulating policy evaluation tools	100%	1.46	0.51	100%	1.38	0.50
(R3 -1.11) (R2 - 8.5)	Nurse leaders must participate in setting measurable and achievable targets of health policy evaluation	100%	1.38	0.50	100%	1.29	0.46
(R2 -1.12)	For nurse leaders to participate effectively in the policy evaluation process, there must be:						
(R2 -8.4)	a) Clear policy evaluation process and tools developed by policy makers	100%	1.38	0.50	100%	1.21	0.42
	b) Clarity of the outcomes to be evaluated				100%	1.26	0.45
(R2 -8.6)	c) Funds and resources available to evaluate policy	96%	1.50	0.93	100%	1.26	0.45

4.5.2.5 *General*

Most of the concepts that emerged here have been discussed in earlier sections related to participation at various levels as indicated in data display 4.14. Some issues are new concepts but do reappear in the stages of policy development and have been addressed there: opportunity (see 4.5.1.2), being active participants (see 4.5.1.2), experience (see

4.5.1.2), being knowledgeable (see 4.5.1.1), resources (see 4.5.1.6), support (see 4.5.1.4), access to forums (see 4.5.1.2) and the allocation of leadership positions (see 4.5.1.5). This reiterates the importance of certain facilitators for nurse leaders' participation in health policy. It confirms the consistency in the ideas generated from the expert panellists.

DATA DISPLAY 4.14:GENERAL (ROUND 1 N=37)

Facilitators
- Having opportunities to be included at every stage of the health policy development process by policy makers
- Participating actively in the entire policy making process when given the opportunity to participate
- Experience and exposure to every stage of the health policy development process
- Being knowledgeable and skilled at every stage of the health policy development process
- Being able to mobilize resources for policy making activities e.g. financial, material and human
- Supportive mentorship from nurse leaders who have been involved in and have actively participated in the health policy development
- Access to forums for nurse leaders to be able to discuss health policy issues at all stages of the process
- Leadership positions allocated at policy making level

There was consensus (rounds 2 and 3) among the expert panellists on the general factors that facilitate nurse leaders' participation in the policy development process at the problem identification and agenda setting stage as listed in table 4.13. The percentage agreement ranged between 96% - 100%, the mean ranged between 1.25 – 1.35 and the standard deviation between 0.44 – 0.86. This indicates a convergence in opinion towards agreement, so that consensus was achieved.

	TABLE 4.13 GENERAL	**ROUND 2 (n =24)**			**ROUND 3 (N =24)**		
		PA	**M**	**SD**	**PA**	**M**	**SD**
(R3 -1.1.) (R2 -7.1.1)	Nurse leaders must have opportunities to be included at every stage of the health policy development process by policy makers	96%	1.29	0.86	100%	1.25	0.44
(R3 - 1.2.)	For nurse leaders to be able to participate effectively in the health policy development:						
	a) The processes must be clear to nurse leaders				96%	1.33	0.57
	b) The processes must be pluralistic and include nurse leaders				96%	1.35	0.57
	c) The information related to the operation of the processes must be available to nurse leaders				96%	1.33	0.57
	d) The processes must be open to information, ideas, research evidence and input from nurse leaders				96%	1.29	0.55

4.6 BARRIERS TO NURSE LEADERS' PARTICIPATION IN HEALTH POLICY DEVELOPMENT

4.6.1 Participation at various levels

4.6.1.1 Knowledge and skills

DATA DISPLAY 4. 15 KNOWLEDGE AND SKILLS (ROUND 1 N=37)

Barriers
- Their level of education is low; that is, they lack a university level of education (BScN)
- Lack of relevant knowledge and skills necessary to participate in the policy development process
- They lack knowledge and skills relevant to problem identification and agenda setting
- Lack of knowledge of the health policy formulation guidelines
- Lack of a clear understanding of the health policy implementation process
- Policies being unclear to the nurse leaders who are expected to implement them
- Lack of knowledge and skills concerning the policy evaluation process
- They lack a supportive environment in terms of mentorship and encouragement
- They lack information about the policy development forums
- Lack of confidence to air their views, related to policy issues, to the policy makers

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Knowledge and skills emerged as a category in the barriers to nurse leaders' participation in this respect as indicated in data display 4.15. Such barriers included: lack of tertiary education, of knowledge pertaining to health policy development process and throughout the stages of policy development, as well as of support and confidence. Lack of tertiary education potentially hinders participation in policy activities and influences all the barriers. The majority of expert panellists in this study (70%) held a basic degree (see 4.2).

In round 2, there was lack of consensus among the expert panellists on all barriers related to knowledge and skills for participation in the policy development process, as highlighted in table 4.14. The percentage agreement ranged between 48% - 88%, the mean ranged between 1.13 – 3.21 while the standard deviation ranged between 0.98 – 1.53. This indicated a divergence in opinions towards disagreement and lack of consensus. These barriers were therefore omitted from the next round.

The findings here indicate that the expert panellists feel that education and knowledge are necessary for participation (see 4.5.1.1) in health policy but are not a barrier to their participation. In contrast, Kunaviktikul et al's (2010: 225) study indicates that lack of knowledge and skills in this respect were a barrier for nurse leaders in that study.

	TABLE 4. 14 KNOWLEDGE AND SKILLS	ROUND 2 (n =24)			ROUND 3 (n = 24)		
		PA	M	SD	PA	M	SD
(R2 - 4.8)	Their level of education is low, that is, they lack a university level of education (BScN)	48%	3.21	1.38			
(R2 - 4.7)	Lack of relevant knowledge and skills necessary to participate in the policy development process	59%	2.71	1.49			
(R2 - 6.1.5)	They lack knowledge and skills relevant to problem identification and agenda setting	63%	2.63	1.53			
(R2 - 6.2.6)	Lack of knowledge of the health policy formulation guidelines	71%	2.50	1.25			
(R2 - 6.3.2)	Lack of a clear understanding of the health policy implementation process	74%	2.21	1.29			
(R2 - 6.3.3)	Policies being unclear to the nurse leaders who are expected to implement them	88%	1.92	1.06			
(R2 - 6.4.6)	Lack of knowledge and skills of the policy evaluation process	82%	1.13	1.36			
(R2 - 6.1.6)	They lack a supportive environment in terms of mentorship and encouragement	88%	1.79	0.98			
(R2 - 6.1.8)	They lack information about the policy development forums	82%	2.25	1.07			
(R2 - 4.10)	Lack of confidence to air their views, related to policy issues, to the policy makers	65%	2.63	1.28			

4.6.1.2   Involvement

Lack of opportunity to be involved in the health policy development process emerged as a barrier to nurse leaders' participation there, as illustrated in data display 4.16. Opportunity would engender experience; hence, lack of opportunity leads to a deficiency of experience. Gaining experience would also build confidence to participate actively when given opportunity. Nurse leaders' role appears to be skewed towards implementation of health policy. This finding is supported by the data presented earlier (see 4.3.6) where more expert panellists (51%) indicated participation in health policy implementation, a figure that was higher than in other stages of the health policy development process. It confirms that involvement is limited, not universal to all participants and does not take place during all stages (see 4.3.6).

The top-down approach toward policy development is not novel: for example, Bradshaw (2003:87), Evans and Ndirangu (2008), Kenya's Health Policy Framework (1994–2010:24) and Scott, Savage, Ashman and Read (2005:22) all cite top down management at government level, with the government setting the priorities and nurses being the

implementers. This robs nurses of opportunities to gain experience, exposure and confidence in policy development activity but also robs the health policy arena of nursing expertise (Winter & Lockhart 1996:248).

DATA DISPLAY 4.16 INVOLVEMENT (ROUND 1 N=37)

Barriers
- Lack of opportunity to be involved in the policy process by the policy makers
- Their input is called upon on an ad hoc basis and they are not part of the full policy process
- They lack forums to discuss policy problems and agenda items within nursing at national level
- Lack of experience necessary for active participation in the health policy development process
- Inability to actively participate in the policy process when given the opportunity
- Most health policies are developed at the national level; then forwarded to nurse leaders for implementation
- There is poor planning by the nurse leaders as regards the process of problem identification and agenda setting

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There was consensus (rounds 2 and 3) among the expert panellists on some of the barriers related to lack of opportunity to become involved in health policy development, as indicated in table 4.15. In the areas where there was consensus, the percentage agreement ranged between 79% - 100%, while the mean was between 1.54 – 1.92 and the standard deviation between 0.72 – 0.93. This indicated convergence of opinion among the expert panellists toward agreement, and consensus was achieved.

The barriers related to involvement were not unilaterally accepted as listed in table 4.15. The percentage agreement was lower than <90% at 53% - 87% (round 2) and 50% - 63% (round 3), with mean values of 1.88 and 2.83 (both rounds); the standard deviation was 1.17 and 1.46 (both rounds). When evaluated together they indicated divergence of opinion and lack of consensus. The barriers that did not achieve consensus in round 2 were omitted from round 3.

One might question the fact that there is agreement that respondents experience a, "Lack of opportunity to be involved in the policy process by the policy makers"while conversely, there is no agreement that there is a "Lack of experience necessary for active participation in the health policy development process" as indicated in table 4.15. It might be said that having opportunity would engender experience and vice versa. The lack of consensus in the barriers might be related to the different groups of expert panellists. Their views may differ, e.g. those of the provincial matrons versus the chief nurses. The expert panellists

were national nurse leaders and their divergence in opinion may have related to lack of opportunity beyond the government system. It could be assumed that nurse leaders are involved in health policy development at hospitals, in the community and through their professional associations. However, the sample consists of expert panellists who are at the national level; they may not be aware of the reality at grassroots level, or they may assume that nurse leaders in other set ups are involved in health policy development.

Kunaviktikul et al in Thailand (2010:225) found that one of the barriers to participation in health policy development was lack of opportunity to be involved directly in policy formulation. In addition, several authors have voiced their concerns that nurses are perceived as implementers of policy rather than being involved in the whole policy development process (Antrobus 1997:747; Aroskar, Moldow & Good 2004:274; Chibuye 1989:374; Winter & Lockhart 1996:248). Furthermore, Chan and Cheng's (1999:170) study established that two thirds of the participants disagreed that they could influence government policy, indicating feelings of disempowerment.

	TABLE 4. 15 INVOLVEMENT	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R 3 - 1.2.) (R 2 - 6.1.3)	Nurse leaders' input is called upon on an ad hoc basis and they are not part of the full policy process	100%	1.54	0.77	88%	1.71	0.91
(R3 = 1.3.) (R2 = 6.3.1)	Lack of opportunity for nurse leaders to be involved in the whole process of policy development	100%	1.58	0.72	91%	1.61	0.78
(R3 = 1.4.)	Nurse leaders lack opportunity to be involved in policy development at these levels:						
	a) Government – ministry of health				79%	1.92	0.93
	b) Workplace – e.g. hospitals				63%	2.33	1.17
	c) Community – e.g. the village they live in				50%	2.54	1.25
	d) Professional associations – national nurses associations				50%	2.71	1.46
(R 3 - 6.1.7) (R2 = 6.1.7)	They lack forums to discuss policy problems and agenda items within nursing at national level	80%	2.33	1.20			
(R 3 - 4.6) (R2 = 4.6)	Lack of experience necessary for active participation in the health policy development process	74%	2.33	1.40			
(R 3 - 4.2) (R2 - 4.2)	Inability to actively participate in the policy process when given the opportunity	64%	2.67	1.37			
(R 3 - 4.12) (R2 - 4.12)	Most health policies are developed at the national level, then forwarded to nurse leaders for implementation	87%	1.88	1.33			
(R 3 - 6.1.9) (R2 - 6.1.9)	There is poor planning by the nurse leaders on the process of problem identification and agenda setting	53%	2.83	1.37			

4.6.1.3   Image of nursing

Data display 4.17 illustrates barriers related to the negative image of nursing, which hinder nurse leaders' participation in health policy development. The findings suggest that nursing is not considered a valuable partner in policy development and that nurse leaders' potential contribution is not recognised as significant by policy makers. This also leads to lack of opportunity to be involved. This furthermore prevents nurses from gaining experience and confidence to make important contributions in health policy development activities.

DATA DISPLAY 4.17 IMAGE OF NURSING (ROUND 1 N=37)
Barriers ·   Their potential contribution to policy process is not recognized as significant by the policy makers ·   Lack of opportunity to be involved in the policy process by the policy makers

There was consensus (rounds 2 and 3) among the expert panellists on the barriers related to the image of nursing and its effect on nurse leaders' participation in the development of health policy, as listed in table 4.16. The percentage agreement was 70% -100%, the means were between 1.17 and 1.96 and the standard deviation ranged between 0.38 – 1.11 for both rounds. This indicates a convergence in opinion towards agreement, so that consensus was achieved.

This indicates that nurse leaders might lack opportunity to demonstrate their ability to make a contribution and to influence and change their perceived status in health policy forums. This is largely because much nursing is unseen, even hidden, which includes activities such as caring, system maintenance, safety, comforting, privacy and sacred work which are largely practised privately behind closed doors, curtains and screens (Wolf 1989:463-465). This means that the public and policy makers do not understand nursing and the unique body of nursing knowledge related to the profession (Wolf 1989:463-465). Phaladze (2003:27) examined the role of nurses in HIV/AIDs policy development in Botswana: her findings revealed that the reasons for nurses being excluded from the policy development process included the negative image of the profession amongst policy makers.

	TABLE 4. 16 IMAGE OF NURSING	**ROUND 2 (n =24)**			**ROUND 3 (n =24)**		
		PA	**M**	**SD**	**PA**	**M**	**SD**
(R3 - 1.1.) (R2 - 4.5, 6.1.4, 6.2.5)	Nurse leaders' potential contribution to the policy process is not recognized as significant by the policy makers (n =23)	96%	1.65	0.78	83%	1.88	0.90
(R3 - 1.9.) (R2 - 4.1, 6.2.2)	Nurse leaders' lack of opportunity to be involved in the policy development process by the policy makers	100%	1.17	0.38	70%	1.96	1.11

4.6.1.4 Structures

Data display 4.18 illustrates factors relating to structure which act as barriers to and facilitators of nurse leaders' participation in health policy development. The legislature does not support sufficient representation of nursing leaders at the policy development forums, and there is no director of nursing services at national level in the three East African countries included in this study. The nurses who attend such forums are very few in number, for example the chief nurse or deputy, or the registrar or deputy of the nursing council (see figure 1.2). In East Africa, nursing structures are largely dominated by the medical profession and the country's chief nurses report to the directors of medical services or equivalent (who are doctors) at the ministry; nursing councils are not autonomous because they fall under the authority of the ministry of health. In 2003, WHO suggested to member states that governments must set up legal frameworks that will facilitate the participation of nursing and midwifery in health policy development (WHO 2003).

In terms of the nursing associations, the majority of their leaders are also employed by the ministry of health or equivalent; as a result, a conflict of interest arises. Very few nurse leaders are actually involved in health policy development in East Africa.

DATA DISPLAY 4.18 STRUCTURES (ROUND 1 N=37)

Barriers
- Institutional structures and systems are such that they exclude them from being part of the policy process
- Most policy making positions are given to male leaders; thus female leaders cannot participate (gender imbalance)
- Most appointments to policy making positions are given to doctors
- Most of the nursing leadership representatives at health policy development level are placed there as a result of political appointments

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There was consensus (rounds 2 and 3) among the expert panellists on most of the structural barriers to nurse leaders' participation in the policy development process, as listed in table 4.17. The percentage agreement was between 75% - 100%, the mean was between 1.13 – 2.04 and the standard deviation ranged between 0.34 – 1.12. This indicates a convergence in opinion towards agreement; hence, consensus was achieved.

There were also areas of lack of consensus (round 2) as indicated in table 4.17. The percentage agreement was between 67% and 68%, the mean was between 2.46and 2.63 and standard deviations ranged between 1.14 and 1.38. This indicated a divergence in opinion and consequently lack of consensus. These barriers that did not achieve consensus in round 2 were omitted from round 3.

It must be noted that there was agreement that health policies were developed at national level, most policy making appointments were given to doctors, there was inadequate representation of nurse leaders at policy making forums and therefore, that other health professionals represented nursing issues at policy forums. Furthermore, institutional structures and unclear recruitment policies challenged nurse leaders' ability to be part of the policy development forum. This meant that there was significant exclusion of nurses from such activity, which might signify that nurse leaders are limited in their ability to gain the necessary experience and exposure required for active participation in health policy development. Thiscould constitute a significant challenge for nurse leaders who by their position are part of the process but are limited in their ability to include others in it as they are not the decision makers. Further, it could undermine their ability to move the policy development agenda towards nursing concerns since the majority of policy makers are non-nurses.

The findings also indicate that there is lack of consensus that nursing leadership representation at policy level is achieved by political appointment and that the positions are given to male leaders. Nevertheless, the findings (see figure 4.2) do suggest a higher percentage of males (37.8%) in this sample than is representative of nursing in East Africa (28% in Kenya). Male expert panellists' views will be different from those of female expert panellists. This is possibly the reason for lack of consensus on this concept. DiGaudio's (1993:212,213) study indicated that there are more males in policy making positions, while women did find that gender hinders their policy making activities; however, the males in the study did not regard gender as a hindrance. This view is supported by Deschaine (2003:270) and Evans (2004:326) who point out that female nurse leaders in the policy making arena may feel marginalized.

Dollinger's study contends that nurses are not able to influence health policy development as they are not present in large enough numbers and lack status, whereas the process is dominated by doctors and the medical model (2006:106,107). Sundquist (2009:109)

examined the role of formal registered nurse leaders in policy development in the USA, where participants suggested increasing the number of registered nurses participating in policy.

	TABLE 4.17 STRUCTURES	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 – 1.10.) (R2 - 4.4)	Institutional structures and systems are such that they exclude nurse leaders from being part of the policy process e.g. nurse leaders are in relatively junior positions	96%	1.58	0.83	75%	2.04	1.12
(R3 - 1.12., 1.13.) (R - 6.1.1, 6.2.1)	Health policies are developed at national level and then rolled down to other levels (district, provincial & national) for implementation	100%	1.46	0.72	91%	1.55	0.80
(R3 - 1.14.) (R2 - 6.1.2, 6.2.3)	Inadequate representation (numbers) of nurse leaders at the policy making forums	96%	1.54	0.83	92%	1.54	0.66
(R3 - 1.11)	Unclear policies regarding recruitment of nursing leaders at policy level				78%	1.87	1.14
(R3 - 1.15.) (R2 - 4.3)	Most appointments into policy making positions are given to doctors	100%	1.29	0.55	100%	1.13	0.34
(R3 - 1.16.) (R2 - 6.2.4)	Other health professionals including doctors represent nurses and nursing issues at health policy development forums as structures are not inclusive of nurse leaders	100%	1.58	0.78	88%	1.54	1.02
(R2 = 4.13)	Most policy making positions are given to male leaders; thus female leaders cannot participate (gender imbalance)	67%	2.63	1.14			
(R2 - 4.11)	Most of the nursing leadership representatives at health policy development level are as a result of political appointments	68%	2.46	1.38			

4.6.2 Health policy development process

4.6.2.1 Policy evaluation

Issues identified by the expert panellists as barriers to their participation in the policy evaluation process were as follows: consultants conducting the process, lack of clear evaluation process, policies attached to too many programmes, as well as a lack of directives and guidelines from ministries as illustrated in data display 4.19.

Given that the policy development process and particularly the policy implementation process is resource intensive, there may be a need for external audit and evaluation. For the purpose of transparency, there might be the need for external consultants; however, nurse leaders need to work with the latter.

DATA DISPLAY 4.19 HEALTH POLICY PROCESS – EVALUATION(ROUND 1 N=37)
Barriers · Lack of knowledge and skills concerning the policy evaluation process · The process being conducted by consultants attached to the relevant ministry (ministry of health) · Lack of clear monitoring and evaluation of the health policies implementation process · Lack of directives from the ministries about the guidelines for evaluation · The policies being attached to too many programmes, making monitoring and evaluation difficult for nurse leaders

There was consensus among the expert panellists on some of the factors that are barriers to nurse leaders' participation in the policy development process at the evaluation stage, as listed in table 4.18. In areas of agreement, the percentage agreement was 75% -100%, with means of 1.33 and 2.00 and standard deviations of 0.48 and 1.02 respectively. This indicates a convergence in opinion towards agreement in those areas; as a result, consensus was achieved.

In the area of lack of agreement, the percentage agreement was 68% - 86%, with means of 2.04 - 2.17 and standard deviations of 1.09- 1.20. This indicated a divergence in opinion and lack of consensus.

	TABLE 4.18EVALUATION PROCESS	ROUND 2 (n =24)			ROUND 3 (n =24)		
		PA	M	SD	PA	M	SD
(R3 - 1.8.) (R2 - 6.4.3)	Lack of opportunity for nurse leaders to be involved in the policy evaluation process	100%	1.33	0.48	75%	2.00	1.02
(R3 - 1.7.) (R2 - 6.4.3)	The policy evaluation process is conducted by consultants attached to the relevant ministry (ministry of health); hence nurse leaders are excluded at this stage of the process	96%	1.54	0.93	83%	1.79	0.72
(R3 - 1.6.) (R2 - 6.4.2)	Lack of clear monitoring and evaluation of the health policy implementation process by policy makers at the ministry of health	91%	1.88	0.99	68%	2.17	1.09
(R2 - 6.4.4)	Lack of directives from the ministries on the guidelines for evaluation	86%	2.08	1.18			
(R2 - 6.4.5)	The policies being attached to too many programmes, making monitoring and evaluation difficult for nurse leaders	86%	2.04	1.20			

4.6.2.2 Resources

Resources emerged as a category (illustrated in data display 4.20) as one of the barriers for nurse leaders towards participation in health policy development. These include not possessing resources and being able to mobilise these for policy making activity. Influencing policy development and the course of the health policy is largely about securing resources for health care, work which in itself requires resources.

DATA DISPLAY 4.20 RESOURCES(ROUND 1 N=37)
Barriers ·   Lack of resources (financial, material and human) to implement the health policy ·   Lack of funds and resources to attend the forums at which the policies are developed

There was not unilateral agreement related to the resources as indicated in table 4.19. There was consensus (rounds 2 and 3) among the expert panellists that they lack resources to implement health policies as indicated in table 4.19. The percentage agreement was 83% and 91%, with means of 1.75 and 1.83 and standard deviations of 1.07 and 0.92. This indicated a convergence in opinion towards agreement; hence, consensus was achieved.

There was a divergence in opinion among the expert panellists that they lack resources to attend the forums at which policies are developed as indicated in table 4.19. The percentage agreement was 68%, the mean was 2.63 and the standard deviation 1.31. This indicated lack of consensus. The finding might suggest that barriers as far as resources are concerned might not be common to all the expert panellists.

	TABLE 4.19RESOURCES	**ROUND 2 (n =24)**			**ROUND 3 (n =24)**		
		PA	**M**	**SD**	**PA**	**M**	**SD**
(R3 - 1.5.) (R2 - 6.3.4)	Lack of financial, material and human resources to implement health policy	91%	1.75	1.07	83%	1.83	0.92
(R2 - 4.9)	Lack of funds and resources to attend the forums at which the policies are developed	68%	2.63	1.31			

4.7   SUMMARY

The purpose of applying the Delphi technique was to build consensus among nurse leaders about factors that influence their particpation in health policy development. This was achieved through the utilisation of a panel of experts who were senior nurse leaders at national level in the three East African countries of Kenya, Uganda and Tanzania.

The findings of the study indicate that nurse leaders do participate in health policy development, though their participation is limited and not consistent across all the stages of policy development. The study revealed the essential leadership attributes required for participation in policy making as well as facilitators and barriers to participation. There was consensus among the expert panellists on the essential leadership attributes for, and facilitators to nurse leaders' participation in health policy making. The barriers did not attract unilateral consensus, and there were areas where consensus was not achieved.

The key concepts which emerged from the analysis relate to barriers and facilitators to nurse leader's participation in health policy development. These barriers and facilitators were linked and include; involvement, knowledge and skills, structures, image of nursing, resources and leadership attributes. There were many concepts related to barriers were there was lack of consensus compared to the facilitators where most concepts yielded consensus. Leadership attributes were identified at the various levels of social structures and within the process of policy development. Within the leadership attributes key concepts identified include; transformational attributes, political skills, communication skills, interpersonal skills, personal skills and technical skills. The findings of this study were utilized to develop the empowerment model that is discussed in chapter five.

Further discussions on conclusions, limitations and recommendations are presented in chapter six.

CHAPTER FIVE

EMPOWERMENT MODEL FOR NURSE LEADERS' PARTICIPATION IN HEALTH POLICY DEVELOPMENT

The spirit of the Knowledge Society is the spirit of Pluralism—a readiness to accept the other, indeed to learn from him, to see difference as an opportunity rather than a threat. His Highness the Aga Khan (2006).

5.1 INTRODUCTION

The aim of this study was to develop an empowerment model that could be used to enhance nurse leaders' participation in health policy development. To meet this aim, the study explored the extent of national nurse leaders' participation in the development of such policy in Kenya, Tanzania and Uganda and identified consensus on factors that influence their participation.

A Delphi survey using a panel of experts was applied to do so. The findings of the research have informed the development and content of the empowerment model described.

5.2 BACKGROUND TO THE MODEL

5.2.1 Aim of the model

The aim of the model is to empower nurse leaders to participate in health policy development. It is envisaged that when nurses do so, their influence on policies will impact positively on the health of the community and population.

5.2.2 Rationale for the model

Nurses comprise the largest health care workforce in most countries; they interact closely with patients and their families, working around the clock and within all sectors of health care. This gives them a broad appreciation of health needs, of how factors in the environment affect the health situation of clients and their families and of how people respond to different strategies and services (WHO 2009:8).

As early as the year 2000, the International Council of Nurses (ICN) adopted the position that nurses have an important contribution to make in health services planning and decision-making and in development of appropriate and effective health policy. Nurses can and should contribute to public policy pertaining to the determinants of health (ICN 2000). It has been recognized that in order to achieve the Millennium Development Goals, there is need for nurses' input in health policy development (WHO 2003).

In studies conducted in Botswana and Kenya, the findings revealed that nurses' role in the given process is limited to policy implementation (Evans & Ndirangu 2008; Phaladze

2003:27). Literature indicates that where nurses have been able to influence health policy development, there have been positive benefits for nurses and patients as indicated in chapter two (see 2.3). Nurse leaders' participation has the potential of influencing the reversal of the negative indicators towards positive improvement. It could influence access to health care and health professionals, quality, equity, and the cost of delivering health care services to patients and community (Ferguson 2001:546).

The results of the study indicate that nurse leaders participate to some extent in the health policy development process. However, this appears to be limited to certain nurse leaders (see 4.3.5 and 4.3.6). Their input in the process appears to be inconsistent and the opportunity of participation is not available to all nurse leaders. Their input is greater at the policy implementation stage. However, their participation decreases during other stages of the process.

The findings of the study indicate that certain essential leadership attributes enhance nurse leaders' participation in health policy development. These include: transformational attributes, political skills, communication skills, interpersonal skill, management skills and competence in nursing (see table 4.4).

The results of the study indicated that there are considerable facilitators of their involvement in this process. The impression gained from the results is that nurse leaders would like to be involved in it. These facilitators include: being knowledgeable and skilled in the health policy development activities, being involved and having experience and exposure to the process, and being accorded opportunities to be included at every stage of the said process by policy makers (see 4.5).

Significant barriers to nurse leaders' participation include: lack of opportunity for them to be involved in the whole process of policy development, where their input is called upon on an ad hoc basis and they are not part of the full policy process, while institutional structures and systems are such that they exclude nurse leaders from being part of the policy process so that health policies are developed at national level and then rolled down to other levels for implementation (see 4.6).

The findings of the study indicate that there is a significant gap in and barriers to participation in health policy development and that an opportunity exists for facilitating and enhancing nurse leaders' role and participation in this respect. Empowering nurse leaders to participate in health policy development would enhance their input in the process. A model for doing so was therefore devised.

5.2.3 Type of model

A model is a presentation of concepts that are assembled together in a rational interrelated scheme by virtue of their relevance to a common theme (Polit & Beck 2008:154,155). Models can be defined as intellectual inventions designed to describe, explain, predict, or prescribe a phenomenon (McEwen 2010:41). Prescriptive models are those that prescribe activities necessary to reach defined goals. They include propositions that call for change and predict consequences of the prescribed interventions towards achieving an outcome (McEwen 2010:41). This model is a prescriptive one as it proposes a structure that should foster change towards empowerment, with the resultant outcome of nurse leaders participating in health policy development activities.

5.3 ASSUMPTIONS OF THE MODEL

- Nurse leaders want to be part of the health policy development process and can make important contributions at the organizational, community, provincial and national levels
- They need to be empowered to enhance their contribution in this arena
- They can gain competencies to participate in health policy development and need to be supported to do so through: continuing education, experience, environment and participation
- Nurse leaders need to be proactive in seeking opportunities that will enhance their participation in this sphere
- Nursing education can empower nurses to be motivated and interested to participate. Nursing education plays a key and foundational role in equipping nurses with knowledge and skills in health policy, leadership and politics that are essential to participation in this process
- Experience can be gained in health policy development through professional nursing associations and work organisations which can enhance nurse leaders' participation
- The latter need to influence the environment so as to facilitate their participation in health policy development
- Nurse leaders need to participate in the health policy development process to generate expertise, be visible and play their rightful role as policy makers.
- Effective leadership can positively influence nurse leaders participation in health policy development

5.4 DESCRIPTION OF THE MODEL

The context of the model, its structure, key concepts and relationships between the concepts are described. The model is contextualized within nursing.

5.4.1 The context of the model

This model provides a framework to support nurse leaders enhance their participation in health policy development activities. It can be used by nurse leaders, nurses, policy makers and nurse educators for this purpose. It could be employed for the development of a career pathway regarding the role of a nurse policy maker. The model can be applied by national nurse leaders to mentor and support other nurses in their development in health policy activities. It can be utilised in its entirety or partially, depending on the self-assessment of the individual nurse or user.

5.4.2 Structure of the model

This model comprises seven major concepts (see figure 5.1). The blue block at the base, the large red and green arrows indicate basic nursing education, empowerment and leadership. The four circular shapes symbolise continuing education, experience, environment and participation.

The blue block at the base indicates that nurse leaders involved in health policy development require a basic degree as a foundation for such participation. Degree education enhances their ability to do so.

The ascending large green arrow indicates leadership development as it pertains to enhancing nurse leaders' participation in this arena. The left illustrates a novice leader, developing into an established leader on the right. The curved green arrows indicate movement from one stage to the next of the continuum. Each stage influences the level of empowerment in the following stage. Green indicates growth and hope (Kress & Leeuwen 2002:354).

The ascending large red arrow indicates a developmental empowerment process to participate in the devising of health policy: on the left there is little or no empowerment, moving towards full empowerment on the right, which is by no means a static point. The red reiterative arrows denote that both the concepts influence each other and build on each other in a reiterative and empowering relationship of "to be empowered" and "being empowering". Red is thought to be an energising colour (Kress & Leeuwen 2002:348).

The ascending arrangement of the circular shapes indicates growing empowerment.

These shapes are used to indicate infinite potential for the growth and expansion of the concepts. The overlapping of the circles indicates that the concepts are interrelated. The gradual darkening of the colour yellow indicates growing empowerment and leadership development within the person. Yellow is the colour of knowledge and competency in some cultures. The triangles within the circular shapes indicate the core category and its relationship with the sub categories as they relate to empowerment and development at a specific point.

5.5 VISUAL PRESENTATION OF THE EMPOWERMENT MODEL FOR NURSE LEADERS' PARTICIPATION IN HEALTH POLICY DEVELOPMENT
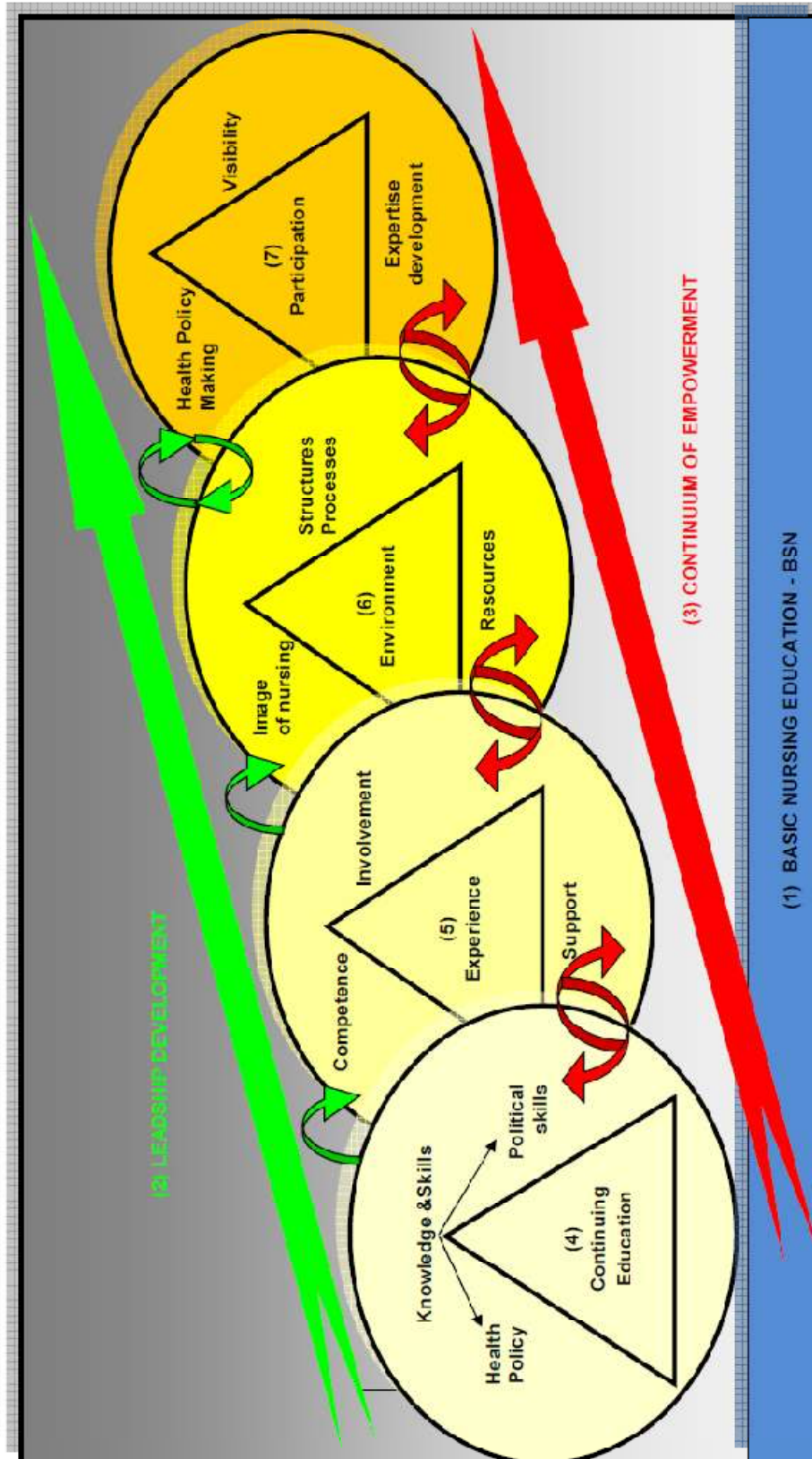
Figure 5.1 - Visual Presentation of the Empowerment Model for Nurse Leaders' Participation in Health Policy Development

5.5.1 Concepts and relationships inherent in the model

There are seven main concepts in the model. Three are fundamental to nurse leaders' participation in health policy development: basic nursing education, leadership development and continuum of empowerment. Additionally, there are four concepts in the model that exist as stages of empowerment; each builds on the previous stage. These are: continuing education, experience, environment and participation.

1. Basic nursing education

There was consensus in the study that nurse leaders must have attained at least a university degree level of education (see table 4.3). The findings of the study indicate that the majority of the expert panellists did possess a degree (see figure 4.3). Such an education might provide opportunities and access to health policy development positions. Degree education facilitates a level of knowledge and skills which contribute towards the intellectual processes necessary to participate in policy development in a meaningful way. A degree in nursing would place nurse leaders in policy development on a par with other professionals who are involved in health policy development, for example pharmacists and medical doctors. Nurses will then share the same educational status, which will accord credibility to their voice (Dollinger 2006:108).

2. Leadership development

Leadership is considered a key component in the ability of the nurse to participate in this arena. The model illustrates a continuum of leadership development which is vital for participation. Essential leadership attributes in the context of this model are those that enable nurse leaders to exert influence in the health policy development process with regards to health and nursing concerns. The findings of the study indicate that there was agreement among the expert panellists on the leadership attributes that are essential for participation in this arena. The key leadership attributes identified in the study include: transformational attributes, political astuteness, communication skills, interpersonal skills, being able to cultivate cordial working relationships, being effective in collaborating and cooperating, being team players, having respect for others, possessing negotiation skills, being proactive, being motivated, having confidence, having courage, being creative, possessing management skills, being knowledgeable and competent in nursing and having critical thinking and problem solving skills (see table 4.2). Leadership attributes can be acquired through tertiary educational institutions which play a key role in facilitating and

equipping nurse leaders with education that prepares them to be effective leaders. Furthermore, leadership development occurs through experience as well as a conducive environment and is demonstrated by means of participation.

3. Continuum of empowerment

The model illustrates a continuum of growth in terms of empowerment towards participation in health policy development, indicated by the red arrow at the base. Increasing empowerment occurs with progression through each stage of being empowered. 'To be empowered' and 'being empowering' refer to the two principles of empowerment that are interactive in the model. Nurse leaders should be supported "to be **empowered"** and should support by "**being empowering"**. These refer to a giving and receiving relationship with regards to growth in the health policy development field at every stage. Nursing influence in health policy can only be sustained if nurse leaders are supported "to be empowered" and if they support others by "being empowering". To be empowered and being empowering are in a reciprocal relationship and can be enabled through continuing education, experience, environment and participation as well as through supportive mentorship.

4. Continuing education

Continuing education is a key component and provides the basic foundation which supports nurse leaders towards empowerment in health policy development. Education can equip nurses with knowledge and skills which facilitate participation in the said process (see table 4.3).

Continuing education can be acquired through tertiary educational institutions. The education necessary for participation in health policy development can be offered by nursing education institutions during basic nursing degree programmes (BSN), post basic programmes, masters and doctoral programmes. These could be offered as stand-alone courses related to health policy and or as part of the degree programmes.

Continuing education supports other stages of empowerment which include: leadership development, experience, environment and participation. Education can facilitate acquisition of knowledge and skills in three main areas: health policy development, political skills and leadership (see leadership development (3) above).

- *Knowledge*

Health policy – the study findings indicated that there was consensus in the study that nurse leaders must be knowledgeable and skilled in the health policy development activities at all stages (see table 4.3). There was consensus on the basic content that will facilitate understanding of the field: types of policy; theories and models of policy development; policy development process; policy making environment; legislative process; influencing policy; nurses' roles and responsibilities in policy development and strategies for influencing policy and analysis of health policies (see table 4.3). Nurses' understanding of health policy would create motivation to become involved and should also clarify their roles with regard to participation of this kind.

Political skills – refers to being politically astute and being able to lobby with policy makers on issues of concern to the nursing profession. The findings indicated that there was consensus among the expert panellists that nurses must gain political skills. Those necessary for influencing health policy include: being knowledgeable about the health issues of concern to nursing which are influenced by health policy; testifying to policy makers on issues of concern to the nursing profession; being able to contact policy makers dealing with issues of interest; writing to them in this respect; expressing opinion; building coalitions; identifying people with similar concerns and building relationships with individuals dealing with issues of interest to nursing at the ministry of health level (see table 4.2).

- *Skills*

Practical placements – nurse leaders need to gain exposure in health policy activities to acquire practical skills and inculcate interest in the field. Educational institutions need to secure appropriate placements for nurses to gain relevant exposure in health policy activities. These placements include internships and observerships with the: chief nurse; registrar; national nurses' professional organisation chair; academic deans; permanent secretaries; directors of medical services as well as health ministers and assistant ministers. Nursing faculty play a role in facilitating these experiences and also being role models for nurses in the health policy arena. There was consensus in the current study that nurse leaders need stipulated experiences in health policy development activities to enhance their participation in this field (see table 4.4). It is proposed that these placements would create a larger pool of nurses who have benefited from exposure to health policy development and that more nurses may become interested in such activity.

5. Experience

This refers to the acquisition of specific experience related to health policy development. It is an opportunity to put learned knowledge and skills into practice. Nurses must be nurtured from the early stages of their careers to gain confidence in participation in health policy activities. Furthermore, these opportunities should be available at all stages of their career. The findings revealed factors that could facilitate gaining appropriate experience: competence, involvement and support.

- **Competence**

The term refers to nurse leaders acquiring proficiency in practical nursing either at organizational or community level. This might enable them to gain an understanding of issues of concern to nursing that are related to health policy. There was consensus in the study that nurses must be competent and skilled in nursing (see table 4.2). The majority of the nurse leaders in the current study reported over 15 years of experience in nursing (see figure 4.5). Practical nursing experience would inform and validate nurses' policy related input. Similarly, competence in nursing would accord credibility to nurse leaders' voices in health policy.

- **Involvement**

Nurse leaders must be involved in health policy development activities at the institutional level and in professional nursing organizations.

Institutional level – experience related to health policy development must be made available to nurse leaders through their work institutions, which must be inclusive, while these leaders must be proactive in seeking opportunity. Experience in the work institution must include involvement in health policy development activities and furthermore in leadership development and political skills. Health policy development experiences at institutional levels would contribute towards nurse leaders gaining interest, confidence and expertise in such a process on the macro level. There was consensus in the current study that nurse leaders must gain experience and exposure in this respect and be accorded the opportunity of involvement at every stage of the process (see table 4.4).

Professional organizations – nurse leaders must be members of the national nurses' association which is a platform for exposure to political activism, acquisition of leadership skills and gaining competence regarding participation in health policy development activities. Nurse leaders' membership must be accompanied by active participation in the association's activities, which must be open and inclusive of all nurses interested in

participation in health policy development. There was consensus in the current study that nurse leaders should be part of national nurses' associations to facilitate their participation in the policy development process (see table 4.9). The key activities related to being active participants in professional nursing organisations include: gaining the collective participation and support of nurses; identifying issues of concern to nurses and health care; drawing the attention of the public to issues of concern to nursing; being united as a profession and articulating issues of concern to the nursing profession and health services through nurses' professional organizations (see table 4.9).

Through inclusive work environments and strong professional associations, nurse leaders will gain access to and opportunity to access networks, where they can share experiences and concerns related to health policy.

- *Support*

The goals "to be empowered" and "being empowering" can be achieved by attracting mentorship and support. Nurse leaders are responsible for creating opportunities for other nurses to be involved in the policy development process and for mentoring nurses with less knowledge, skills and experience in health policy development; this is inherent in the model. Nursing influence in the health policy arena will only be sustained by offering proactive mentorship and support to the next generation of nurses.

There was consensus among the expert panellists that support was necessary to facilitate nurse leaders' participation in the policy development activities from leaders who have been involved in and have actively participated in these. Mentorship and support encompass having mentors (to inspire, guide, advice and model behaviour), accepting and seeking mentorship and being mentors (see table 4.6). It is understood that it is the nurse leaders' responsibility to seek these opportunities and the responsibility of the professional associations and work institutions to facilitate them.

Create networks for support – in the current study there was consensus that leaders need to have networks for support and to share experiences on policy related issues. Nurse leaders consequently need to create forums and avenues where they can be supported by international organizations (WHO and ICN) that are able to develop and strengthen the role of the nurses in health policy development. This can be accomplished through nurse professional organisations (see 4.6). Nurses need to be able to utilise their networks and mobilise them to support their concerns related to health policy.

6. Environment

Nurseleaders must seek to create an enabling environment for their participation and legitimate access to involvement in health policy development activities. The findings of the study indicate that there are significant challenges that nurse leaders encounter as they attempt to participate in policy development processes such as: lack of opportunity to participate, prohibitive structures and processes, the negative public image of nursing and lack of resources (see 4.6).

It is envisioned that by means of continuing education nurses would have gained the knowledge and skills pertaining to participation in health policy development. Furthermore, experience within institutions and professional organisations should have facilitated the application of such knowledge and skills as well as equipped nurses with the ability to influence the creation of an enabling environment. Influencing the environment could be facilitated through positions held, professional organizations, educational institutions, networking and unity of purpose within the nursing profession.

The concepts environment and participation are interdependent and each influences the other. An environment that is exclusive will make participation in the process difficult, while without participation, it may be difficult to create an enabling environment. The assumption is that unless nurse leaders are able to create an environment that is inclusive of nursing input in health policy development they will experience difficulties in gaining access to and being part of the policy development process. However, it is understood that there will always be barriers in the environment and therefore nurse leaders will have to continuously work towards creating an environment where they can participate in health policy development.

• Image of nursing

Nurses must be considered equal partners with other stakeholders in the policy development process. There was consensus in the current study that nurse leaders' potential contribution to the health policy process is not recognized as significant by policy makers and that the former's input in policy development must be respected by the latter (see table 4.16).

Nurse leaders must work towards renewing the public image of nursing in policy development to gain respect and achieve equal partnership (see table 4.5). This includes re-branding the nursing profession; role modelling and articulating the actual and potential

contribution that nursing makes to the country's health care and the role that nursing plays in health policy development at all stages and all levels.

Strategies were proposed by the expert panellists that may help enhance the image of nursing; these include: nurse leaders with ability and the right credentials being nominated to national leadership positions; and their engaging the media and policy makers to change the image of nursing and focus the health policy agenda on issues where nurses can make a contribution, such as health promotion and disease prevention (see table 4.5).

- *Structures and processes*

This refers to nurse leaders being proactive in influencing the policy development environment to become inclusive and supportive of their participation in this activity at government level. In the current study, the findings indicate that: nurse leaders lack the opportunity to be thus involved at this level, health policies are developed at national level and then rolled down to other levels for implementation, most policy making appointments are given to doctors while nurses were inadequately represented at policy development levels (see table 4.17). Structures that are supportive include: clear job descriptions (see data display 4.1), having legislature that includes nurses in health policy development, setting in place a directorate of nursing services, effecting greater nursing representation at policy development level, a gender balance at policy development forums and clear processes (see table 4.7).

Nurse leaders' job descriptions must include policy development responsibilities which will formalize their involvement. The current study indicates that nurse leaders' job requirements are related to policy formulation and implementation, though not for all participants (see data display 4.1).

The legislature must include nurses in the health policy development process. There was consensus in the current study that a legislature of this kind would facilitate nurse leaders' participation in this regard (see table 4.7). Nurses' national governance structures must include a directorate position for nursing at national level which is at par with the directorate of medical services and reports directly to the minister (see table 4.7).

Policy development positions must include larger numbers of nurses at all levels of policy development (see table 4.7). Nursing, being a profession largely dominated by women, must therefore be represented by women as per the proportion of women in the profession (see table 4.7).

Forums of national nurse leaders that include nursing regulatory bodies, ministries of health (or equivalent), academic institutions and national nurses association, should foster discussions of health policy related issues (e.g. national nursing leaders' policy action committee) (see table 4.7). This would ensure that there is a body of nurses who are members of policy think tanks that can stimulate policy discussions effectively.

Nurse leaders can only understand the processes when they participate at every stage of them. The results of the study indicate that nurse leaders must be able to clearly understand the health policy development processes (see table 4.3 and 4.13). Therefore, the process must be pluralistic and inclusive of nurses at all stages of policy development. Further, the processes must be open to information, ideas, research evidence and input from nurse leaders.

- ***Resources***

This denotes the ability of nurses to generate funds and resources that will assist the profession in activities related to influencing health policy. There was consensus in the current study that possessing resources facilitates nurse leaders' participation in health policy development and vice versa (see table 4.8 and 4.19). Gaining resources for health policy development activity could be facilitated by national nurses' associations in creating a branch of nurse leaders who are interested in health policy development. The national nurses' association could also advocate for funding to promote its policy related activities. Nurse leaders must acquire business skills to enable them to manage their budgets and make a case for funding their health policy activity. There was consensus among the expert panellists that financial skills are necessary to facilitate their participation in the policy development process.

7. Participation

Participation is considered as being part of and exerting permanent influence, involvement and making a contribution in the process and content of health policy development (see1.8). At this stage, nurse leaders will have gained competence in participation through continuing education and experience. Furthermore, nurse leaders will have acquired proficiency through creating an enabling environment by overcoming barriers and facilitating participation. At this stage, they will have to demonstrate the skills gained in the preceding stages. The key components related to participation include: the making of health policy, visibility, and development of expertise.

- *Health policy making*

This refers to the nurse leader participating in the policy development process, ensuring that nursing concerns are included in the agenda and taking a lead in developing health policy. Such leaders need to utilise their competence in health policy development, political skills and leadership attributes to achieve the goals of the nursing health policy agenda. The findings of the study revealed key factors which include: taking a leadership role in the development of health policies that can improve the health of communities and ensure provision of quality health care; nurse leaders must engage policy makers to ensure a bottom-up and top-down approach during the entire policy development process; they must be able to focus the health policy agenda around health, which includes health promotion and disease prevention, and they must be able to ensure that the health policy agenda is not dominated by medical and curative issues (see table 4.9). They should utilize the professional associations in taking a leadership role in the development of health policies that can improve the health of communities and ensure provision of quality health care (see table 4.2, 4.4 and 4.9).

Research skills –This refers to nurses being able to use a research and evidence base to support and inform their leaders' proposals related to health policy development (see table 4.9). There was consensus among the expert panellists that research, analytical skills and critical thinking skills are necessary to facilitate their participation in the given process, which would enhance nurses' image, visibility and credibility among policy makers and peers.

- *Visibility*

Refers to the power of the numbers that are required for influencing health policy development. Nurse leaders' participation in health policy could be enhanced if there were greater numbers of them involved at the policy development level: this must be more inclusive, and the process should be open to ideas and suggestions and inputs from nurse leaders who are and will be part of the process (see table 4.5). Having a critical mass of nurses involved in and familiar with policy development will result in influential, informed and united voting on policy matters (see table 4.7). In the current study, just over half of the expert panellists do participate in health policy implementation. Their participation decreases at other stages such as the problem identification and agenda setting stage (see figure 4.7). The example of the medical profession can be alluded to, where committees include all specialties of doctors such as surgeons, physicians and

radiologists.

Proactive management of the media – as well as utilizing the media to enhance the image of nursing, they can be made use of to highlight issues related to nursing and health care. In the current study, there was consensus among the expert panellists that it is necessary for nurse leaders to engage the media (see table 4.5). Media management skills include: clearly articulating issues of concern to nursing, being proactive in communicating with the media on health and nursing concerns, responding to media releases and using the media as a vehicle for nurses to inform policy makers of nurses' contribution to health care. The media can be utilized to engage policy makers. Nurses can make use of the media to facilitate creating enabling structures and processes that ensure their input in health policy is included. This will also contribute towards altering the image of nursing, enhancing its visibility and portraying nurses as astute policy makers.

Nurse leaders should take part in the training of nursing spokespersons to articulate the position of nursing on issues of concern to the profession. In addition, they could create a professional pathway in nursing for nurse journalists who would influence and work with television, newspapers and radio stations to change the negative image of nursing. It is important that the media be utilised for reaching the public in creating an understanding of the role of the nursing profession in health care and policy.

- ***Expertise development***

Nursing expertise in health policy development can be created if nurse leaders are involved in policy development on a regular basis over a period of time. This would constitute a career pathway for nurses who are potentially interested in furthering their careers in health policy development and being nurse policy makers. In the current study, the findings indicated that the majority of the expert panellists reported over 15 years experience in nursing practice; however, they possessed limited experience in the current position, since the majority had only up to 5 years of experience related to policy making in their current position (see figure 4.5). This might indicate a gap in nurse leaders' expertise in health policy development, contributing to their being excluded from the process. Furthermore, the apparent turnover of nurse leaders might be robbing nursing of expertise and of the fostering of future expert nurse policy makers.

Nurses with potential must be groomed by the nursing school to be policy developers right from the beginning of their careers. Therefore, nursing schools need to facilitate

placements for nurses while nurse policy makers should accommodate nurses in placements and also provide support and mentorship.

5.6   CONCLUSION

The empowerment model was developed from the findings of the study. It contains seven main concepts: basic nursing education, leadership development, continuum of empowerment, continuing education, experience, environment and participation. Basic nursing education for nurse leaders at policy development level needs to be at the degree level to facilitate their participation in the process. Nurse leaders' abilities, as effective leaders, will facilitate their participation in the said process. As nurse leaders acquire proficiency in health policy development activities through the various stages they will be empowered. Continuing education is the foundation for such empowerment. It is envisioned that if an education is received that prepares nurses with appropriate knowledge and skills and exposure in health policy, political activism and leadership may generate interest and motivation in nurses to be part of the process and understand their role in health policy development beyond clinical practice. If their basic education includes health policy related knowledge, it is likely that a greater number of them may be interested in devising such policy. Experience and involvement in health policy development at institutional level and through nursing professional associations will further consolidate the knowledge and skills needed. Nurses will need to be proactive in creating an enabling environment which will enhance their participation in health policy development. Such participation will engender expertise and nursing visibility in the health policy development process.

The model was validated with a sample of the expert panellists who participated in the study; the evaluation is presented in chapter six.

CHAPTER SIX
SUMMARY OF FINDINGS, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

"Never doubt that a small group of thoughtful committed citizens can change the world; indeed it is the only thing that ever has." Margaret Mead

6.1   INTRODUCTION

This chapter presents the summary of the major findings and conclusions, describes the evaluation of the model, makes recommendations and discusses the limitations of the study.

The findings are summarized and conclusions are presented according to the specific research objectives.   It will be recalled that the aim of this study was to develop an empowerment model that could be used to enhance nurse leaders' participation in health policy development. To achieve this aim, the research objectives were to:

- o Explore the extent of nurse leaders' participation in health policy development in East Africa

- o Build consensus on leadership attributes necessary for nurse leaders' participation in health policy development in East Africa

- o Build consensus on factors that act as facilitators to nurse leaders' participation in health policy development in East Africa

- o Build consensus on factors that act as barriers to nurse leaders' participation in health policy development in East Africa

- o Develop an empowerment model that can enhance nurse leaders' participation in health policy development

6.2   RESEARCH DESIGN

A Delphi survey was applied and it included the following criteria: expert panellists, iterative rounds, statistical analysis, and consensus building (see 3.2.1).

The expert panellists included in the study were national nurse leaders in leadership positions in the nursing professional associations, nursing regulatory bodies, as well as at the ministry of health and universities. They were drawn from the three countries of East Africa.

The data collection tool was developed by the researcher and was a questionnaire for the first round of the study with reference to research literature, posing open-ended questions.

The questionnaire for the second round was informed by the data obtained from the first round posing close ended questions, as was the third round questionnaire.

The study was conducted in three iterative rounds. Seventy-eight expert panellists were invited to participate for the first round of the study; 37 (47%) took part in the first round; of the 37 expert panellists invited to participate in the second round, 24 (65%) responded, while of the 24 expert panellists who were invited to the third round, all 24 (100%) responded.

Data analysis for the first round was performed by examining the data for the most commonly occurring concepts. The second questionnaire was formulated by using the data generated in the round one questionnaire. The second and third rounds were analyzed with the aid of the SPSS package; thereafter, the descriptive statistics were examined.

The consensus accepted for the second round was >=90%, in order to ensure that the most critical issues were retained in the study, whereas for the third round, consensus was set at >=70%,which was to ensure that of the critical issues identified, important issues were retained.

6.3   SUMMARY OF THE FINDINGS AND CONCLUSIONS
The findings and conclusions are presented according to the study's objectives.

6.3.1   Extent of nurse leaders participation in health policy development
National nurse leaders participate in the health policy development process to some extent (see 4.3). More nurse leaders (54%) participate at national levels of health policy development compared to the provincial, regional and global levels (see 4.3.5). Fewer nurse leaders (48%) participate throughout the health policy development process. Nurse leaders' input at the policy implementation stage (51%) was greater (see 4.3.6).

A significant proportion of nurse leaders are not part of the policy development process. This indicates that the process may not be sufficiently pluralist and inclusive for all nurse leaders to participate in health policy development. The health policy development process appears to be influenced largely by other role players such as medical doctors and pharmaceutical companies, not nurses.

Nurse leaders' jobs do require them to be part of the health policy development process at the level of policy formulation and policy implementation although their role is largely managerial and administrative (see data display 4.1).

The majority of the expert panellists (95%) belonged to their professional organization, but their role was limited to being members (see 4.3.2). There is significant support from nurse leaders for professional nursing organisations in terms of membership, although their participation appears to be limited to the buy-in stage of nurses' political development (see 2.2.4.1). Professional organizations appear to be underutilized as a vehicle for political activism to influence health policy development with regard to nurses' concerns. Their ability to be politically active might be restricted due to the nature of their job positions (see figure 4.4).

6.3.2 Leadership attributes necessary for participation in health policy development

The findings of the study indicate that certain leadership attributes are essential for nurse leaders' participation in this field. There was consensus among the expert panellists on the essential leadership attributes in this respect (83% - 100%) (see 4.4.1). These include possessing: transformational attributes, political skills, effective communication skills, good interpersonal skills, management skills, competence in nursing, and critical thinking and problem solving skills.

Effective participation in health policy development requires transformational nurse leaders who are able to exert influence and are visionary and inspiring. The health policy development arena is highly political with stakeholders exerting pressure towards achieving their own ambitions as regards health policy development. Political astuteness further enhances nurse leaders' ability to apply pressure on the health policy development process, by being knowledgeable about health issues of concern to nursing, contacting policy makers, lobbying, building relationships, and being willing to testify in policy forums.

Nurse leaders' ability to communicate effectively and articulate issues of concern to nursing is a key factor of their ability to participate in the health policy development process. They need to be able to clearly articulate health issues and deliver clear messages.

Nurse leaders have to develop good interpersonal skills to be able to cultivate cordial working relationships. They need to be effective in collaborating and cooperating, be good team players, have respect for others, exercise negotiation skills, be proactive, be motivated, possess confidence, display courage and be creative.

Nursing input can only be respected if nurse leaders are competent in nursing, command the necessary knowledge and skills in health care policy development, are effective managers and possess the research skills to inform their policy related input.

Nurse leaders need to be strategic in their approach towards having nursing placed in the policy arena. Nurses' participation in health policy development activities should be encouraged in the workplace, educational institutions and collectively in professional associations.

6.3.3 Facilitators of nurse leaders' participation in health policy development

The findings of the study indicate a number of facilitators in this respect (see 4.5). There was consensus regarding the said facilitators, which include: possessing knowledge and skills (79% - 100%), being involved (92% - 100%), enhancing the image of nursing (96% - 100%), support (92% - 100%), enabling structures (74% - 100%), having resources (92% - 100%) and health policy process related facilitators (96% - 100%).

Nurse leaders' participation in health policy development can be enhanced if they have attained a university degree, possess knowledge and skills in health policy development activities and if content related to health policy development is included in their basic nursing education. Knowledge and skills can be enhanced if nurse leaders enjoy access to supportive mentorship from leaders who have been actively involved in policy development activities, and benefit from role models from whom they can learn about participating in the health policy development process. Their participation can be positively influenced by their ability to reinforce their policy development activity with research evidence.

Nurse leaders' participation in such development can be enhanced if they: are accorded opportunities to be involved at every stage of the health policy development process, are experienced in and exposed to this process, seek opportunities for influencing this development and participate actively in the entire policy making process when given the opportunity.

To influence the public image of nursing, nurse leaders with ability (and the right credentials) should be nominated to national leadership positions, nurses' input in policy development must be respected by policy makers and nurse leaders must engage policy makers in both bottom-up and top-down approaches.

Institutional structures such as the governance of health services must be supportive towards facilitating nurse leaders' participation in the policy development process. The latter can be enhanced if policy makers make available opportunities for participation, enhance nursing representation at policy forums and ensure a gender balance in terms of equity in the proportion of women in nursing and those in leadership positions. There needs to be legislation such as a Nurses' Act that supports nurse leaders' participation and ensures that national nurse leaders are included in the health policy development process. Nurses can enhance their participation in health policy development by being active members of professional organizations and portraying unity in articulating issues of concern to nursing through these bodies. The legislature must accord autonomy to nurses' associations and allow an unrestricted voice.

National structures should incorporate a directorate of nursing services at the ministry of health and ensure that leadership positions at policy making levels (affirmative action) are allocated for nurse leaders, e.g. the post of permanent secretary.

Nurses must be able to mobilize resources and then manage these resources for policy development activities.

Nurse leaders must be afforded the opportunity to be included at every stage of the process by policy makers; it should be open to information, ideas, research evidence and input. The processes should be clear, transparent and pluralistic. In other words, the information related to the operation of the processes must be available and accessible to all nurses.

There is ample opportunity to enhance nurse leaders' participation in health policy development since there are more facilitators then barriers in this respect. Some of these facilitators appear to be available to a portion of the nurse leaders who are able to be part of the health policy development process (see figures 4.6 and 4.7), although there is a significant proportion that is excluded from the policy development process. Nurse leaders appear to want to be part of the said process. There is opportunity for their participation to be enhanced in terms of involving higher numbers of nurse leaders at policy development level; in terms of those who already occupy national positions the process must be more inclusive and open to ideas, suggestions and input from nurse leaders who are, and will be, part of the process. However, this can only occur if the barriers are overcome.

There appears to be a vacuum in the nursing education institutions, nurses' working institutions and professional organisations as regards their role and ability to facilitate other nurse leaders' involvement in policy development activity.

6.3.4   Barriers to nurse leaders' participation in health policy development

Lack of consensus

It was noted that not all of the barriers that were identified in the first round were retained by the expert panellists as the iterative rounds continued and as the expert panellists re-evaluated their ideas in relation to the group summaries and statistics (see4.6). The areas of lack of consensus regarding barriers included those of knowledge and skills, involvement, structures, evaluation process and resources.   This indicated that the objectives of building consensus were met and that the expert panellists did review and re-evaluate their ideas and discard some of them. Elimination of certain barriers may indicate that they are not altogether applicable to the group of expert panellists.

Areas of consensus

The findings of the study indicate that consensus existed among the expert panellists that there are barriers to nurse leaders' participation in health policy development (see 4.6). These include: involvement (79% - 91%), image of nursing (70% - 83%), structure (75% - 100%) and the policy development process (75% - 83%).

Nurse leaders are excluded from the health policy development process. They lack opportunity to be part of the whole process; instead, they are called upon on an ad hoc basis, which results in an inadequate representation of them at policy forums.

Certain structures exclude national nurse leaders from the policy development process. These structures relate to nurse leaders occupying relatively junior positions (see figure 1.2), health policies being developed at national level and the recruitment policy for national nurse leadership being unclear. The majority of policy development appointments are given to doctors and other health professionals who are then representing nursing issues at the health policy development forums.

Furthermore, the negative public image of nursing undermines nurse leaders' inclusion in the health policy development process. Their potential contribution to this process is not recognized as significant and they are not included in it by policy makers.

In addition, there are process related barriers that further hinder nurse leaders' participation in policy development.

These barriers, whilst fewer than the facilitators, appear to be formidable as they exclude a significant portion of these leaders from participation in the given process (see figures 4.6 and 4.7). These barriers deprive nurse leaders of the opportunity to gain experience, knowledge, exposure and expertise in the health policy development process.

A spiral effect is created whereby, nurses' lack of involvement in the said process results in their limited experience, resulting in minimal input if they are invited to participate. This further prevents their gaining experience and exposure and being involved in the process.

6.3.5 Empowerment model that could enhance nurse leaders' participation in health policy development

The findings of the study enabled the researcher to develop an empowerment model for these leaders' participation in this arena. After it was completed, it was presented to a sample of four expert panellists who had participated in the study, in order to validate the model for its applicability and usefulness as an empowerment model.

An evaluation tool was utilized for this validation. The tool was developed by the researcher with reference to literature (Chinn & Kramer 1999:109; Meleis 2007:258, 259;Parse 2005:136; Schwaninger & Groesser 2008:6). It included eight criteria which were drawn up to validate the model. They included: importance, precision and clarity, parsimony and simplicity, comprehensiveness, operationality, logical structure, validity and practicality. Definitions of the validation criteria were developed with reference to literature (Chinn & Kramer 1999:109; Meleis 2007:258, 259; Parse 2005:136; Schwaninger & Groesser 2008:6). A Likert scale, which included the measures for evaluating the expert panellists views, was drawn up: the points included accepted, accepted with minimum changes and not accepted.

6.3.5.1   Definitions of evaluation criteria

Importance: relates to the quality of having significance to the profession; acceptance by competent professionals may be indicative of importance (Chinn & Kramer 1999:109; Schwaninger & Groesser 2008:6).

Precision and clarity: are related to being clear and whether the areas discussed in the model are consistent; this further relates to whether the descriptions of the assumptions, concepts and principles are clearly formulated (Meleis 2007:259; Parse 2005:136; Schwaninger & Groesser 2008:6).

Parsimony and simplicity: signifies being simple and uncomplicated (Schwaninger & Groesser 2008:6).

Comprehensiveness: is related to covering the broad and substantive areas of Interest (Schwaninger & Groesser 2008:6).

Operationality: concerns being specific enough to be testable and measurable (Schwaninger & Groesser 2008:6).

Logical structure: relates to the degree with which the visual diagram represents and simplifies the understanding of the theory (Meleis 2007:259).

Validity: comprises being valid and offering an accurate representation of the study conducted (Schwaninger & Groesser 2008:6).

Practicality: relates to providing a conceptual framework for practice, education and research and being of use to the profession (Parse 2005:136, Schwaninger & Groesser 2008:6).

The model and the accompanying tool were dispatched to the expert panellists who agreed to validate them. Their feedback is indicated in table 6.1. They did not recommend major changes in the model.

All the participants indicated that the model was important and indeed significant for nursing. The majority found it clear and precise, one recommended minor modifications in terms of language and grammar. This was incorporated in it. Most of the panellists found the model simple to understand and uncomplicated. They indicated that it was broad and covered a wide area of interest with regards to nurses' participation in health policy. They regarded it as specific enough to be operationalized. Most of the expert panellists found the visual diagram clear and simple to understand. One indicated that instead of using a vertical orientation, the picture should be horizontal: this was incorporated in the final illustration. The expert panellists indicated that the model was valid and an accurate representation of the research study that they had participated in. They also indicated that it was practical. Overall, therefore, the model was accepted, in the two areas mentioned with minimal modification. These modifications were incorporated in the model, presented in chapter five.

6.3.5.2   Model Validation

TABLE 6.1 MODEL VALIDATION (N=4)				
Criteria	Accepted	Accepted with minimum modification	Not accepted	Comments
Importance	4 (100%)	0 (0%)	0 (0%)	Very relevant for nursing
Precision and clarity	3 (75%0	1 (25%)	0 (0%)	Grammar
Parsimony and simplicity	4 (100%)	0 (0%)	0 (0%)	
Comprehensiveness	4 (100%)	0 (0%)	0 (0%)	
Operationality	4 (100%)	0 (0%)	0 (0%)	
Logical structure	3 (75%)	1 (25%)	0 (0%)	Visual presentation needs to be horizontal rather than vertical
Validity	4 (100%)	0 (0%)	0 (0%)	
Practicality	4 (100%)	0 (0%)	0 (0%)	

Adapted from (Chinn & Kramer 1999:109; Meleis 2007:258, 259; Parse 2005:136; Schwaninger & Groesser 2008:6).

6.4   LIMITATIONS OF THE STUDY

A number of limitations were present in the study. These need to be noted and considered when interpreting the research findings.

The study was conducted in the three East African countries of Kenya, Tanzania and Uganda. Other countries in East Africa were omitted. Therefore, the findings are only applicable to the countries where the study was conducted.

Time – a disadvantage of the Delphi survey is that expert panellists may change their minds during the course of the study (see 3.2.1). This might have been the case in this study where a number of barriers were cited by the expert panellists in the first round; however during the iterative round several barriers were eliminated.

Purposive sample – the sample was selected as per the researcher's knowledge of the contribution that the expert panellists could make to the study. This may have resulted in some relevant nurse leaders being excluded. Polit and Beck (2007:295) caution that it is likely that a segment of the population will be systematically underrepresented; therefore, interpretation of the findings must be carried out with caution.

The response from Uganda was less than expected; this may have biased the study to some extent, owing to the greater participation of the expert panellists from Kenya and

mainland Tanzania. Infrastructure limitations meant that, Zanzibar was faced with a severe power shortage at the time of the round 2 Delphi survey, and the expert panellists did not return their questionnaires.

Consensus – the level of consensus set for this study was high, being at 90% for the second round while for the third round, it was70%. This was to ensure that only critical issues were retained in the study in the second round and also that in the third round, important issues were not lost. This might have led to elimination of some important issues.

Lack of consensus – several areas where there was lack of consensus emerged, and this might constitute a limitation of this study. It may be related to the proportion of the expert panellists from various sectors which might have affected the retention of certain issues such as gender related ones. Perceptions of different groups might be different from the perceptions of the group as a whole.

6.5   RECOMMENDATIONS

Recommendations are proposed with regard to nursing practice, education and research.

6.5.1   Nursing practice

- The findings indicated that there is only a small contribution from nurse leaders in health policy development. Their participation in health policy development consequently needs to be enhanced.

- The health policy development process needs to be pluralistic and inclusive of all nurse leaders practising in positions related to policy development, while the process must be open to their ideas and suggestions.

- Nurse leaders who are currently in health policy development positions need to create opportunities to enhance nurses' participation in terms of the low number of nurses who take part. The opportunity to participate needs to be made available at all stages of the health policy development process to all nurse leaders currently in leadership positions. Being included will enable nurses to gain experiential knowledge, exposure and confidence in the field of health policy development.

- Nurse leaders, through their professional organisations and their positions, need to lobby and create an enabling environment that will engender greater involvement of nurses in this arena.

- Nurse leaders need to be proactive in seeking opportunities for participation in health policy development through their positions and professional associations as regards themselves and other nurses. Nurses need to educate the public and policy makers about the contribution that they can make to health policy development.

- Nurse leaders need to partner with educational institutions and facilitate practice placements for nursing students to gain exposure in health policy arena. Nurse leaders definitely have a role in developing, mentoring and supporting nurses here. Internship and observerships can be created for nurses interested in policy development and as part of their continuing education placements and experiences.

6.5.2   Nursing education

- The findings of the study indicate that nurses need to be equipped with knowledge and skills pertaining to participation in health policy development, such as health policy, leadership and political skills (see 4.5). Nursing educational institutions need to facilitate nurses gaining knowledge and skills pertaining to such participation. Such institutions should offer courses and include health policy content in the curriculum of basic nursing, as well as continuing education programmes, and combine leadership development content with health policy content. This would create a larger pool of candidates who may be interested in participation in health policy activities.

- Nurse educators need to take an active role in health policy development activity and provide exposure for nurses as well as being role models in this area of practice. Nursing faculty therefore needs to be developed by receiving training in health policy related knowledge and skills.

- Nursing education as a whole needs to engender health policy development as a core area of nursing practice and relate clinical practice, education, research and leadership content to broader health policy implications.

6.5.3   Nursing research

- This is a formative study that is unique in the sense that it explores the gap in literature related to nurse leaders' participation in health policy, encompassing the extent of participation, essential leadership, as well as the barriers and facilitators from the East African perspective. A model was developed based on the findings of

the study. It is recommended that it be applied to different groups of nurse leaders and further tested and validated.

- The study should be replicated with other samples of nurses, utilising other research methodologies to build on the knowledge gained from the study.

- Future research could further the knowledge developed by this study by exploring the perceived status of nursing and factors that would enhance nurses' participation in health policy development from the *policy makers'* perspective.

6.6   CONCLUSION

The study is unique in the African context and particularly in the Kenyan, Ugandan and Tanzanian fields, where little is known about the extent of nurse leaders' participation in health policy development because the phenomenon appears to be under explored, as noted in current literature. This study affords an indication of the extent of their actual participation in this regard. The results indicate that nurse leaders do participate in health policy development however; this is limited to some nurse leaders only and is not uniform throughout the process. The findings of the study indicate that both facilitators and barriers exist. The former include: being involved in health policy development, having knowledge and skills, enhancing the image of nursing and enabling structures and processes. The latter include: lack of involvement, the poor image of nursing and structures and processes which exclude them. Nurse leaders have a key role in mentoring, supporting and developing future nurse policy makers. However, there are more facilitators than barriers; therefore, there is presently greater opportunity for enhancing their participation in health policy development. The findings identify essential leadership attributes for national nurse leaders' participation in health policy in the context of Kenya, Tanzania and Uganda. These include: transformational leadership skills, political skills, communication skills and interpersonal skills. The findings accrued from this study have aided in the development of an empowerment model for nurse leaders' participation in health policy development. It is hoped that it will be put to use in this important arena.

REFERENCES

AFROL, [Sa]. *Gender Profiles Kenya.* From: http://www.afrol.com/Categories/Women/profiles/kenya_women.htm (accessed 02 May 2007).

Aga Khan University (AKU), Advanced Nursing Studies Programme. 2007. *Post RN-BScN curriculum*.

Aggleton, P & Chalmers, H. 1986. Nursing research, nursing theory and the nursing process. *Journal of Advanced Nursing* I I:197-202

Algase, DL, Beel-Bates, C & Ziemba, R. 2004. Lead, link, and learn: a policy / research fellowship program in aging. *Policy Politics Nursing Practice* 5:116-124.

Alubo, O. 2001. The promise and limits of private medicine: health policy dilemmas in Nigeria. *Health Policy and Planning* 16:313-321.

Amadala, B. 2008. *Shortage of staff hurts health care in region*. *Daily Nation,* 2 October From: http://www.nation.co.ke/News/-/1056/473468/-/tkuho6/-/index.html (accessed 05 October 2008).

Ambrose, S. 2006. *Preserving Disorder: IMF Policies and Kenya's Health Care Crisis* From: *http://www.globalpolicy.org/socecon/bwi-wto/imf/2006/0601imfhealth.htm* (assessed 13 February 2007).

Amedy, LA. 1999. A Qualitative study of female superintendents: leadership behaviours in context. PhD (education) dissertation. Virginia Polytechnic Institute and State University, USA.

Amnesty International: Women in Kenya. 2002. [Online]. Available : Amnesty International Working to Protect Human Rights Worldwide Web site, http://web.amnesty.org/wire/March2002/Kenya (accessed 02 May 2007).

Amos, T & Pearse, N. 2008. Pragmatic Research Design: an Illustration of the Use of the Delphi Technique. *The Electronic Journal of Business Research Methods* 6(2):95–102. available online at www.ejbrm.com

Antrobus, S. 1997. An analysis of nursing in context: the effects of current health policy. *Journal of Advanced Nursing* 25:447-453.

Antrobus, S. 2003. What is political leadership? *Nursing Standard* 17(43):40-44.

Antrobus, S & Kitson, A. 1999. Nursing leadership: influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing 29*(3):746-753.

Archer, SE. 1983. A study of nurse administrators' political participation. *Western Journal of Nursing Research* 5(1):65-75.

Aroskar, MA, Moldow, DG & Good, CM. 2004. Nurses voices: policy, practice and ethics. *Nursing Ethics* 11(3):266-276.

Austin-Lane, J, Girasek, DC & Barbour, GL. 2004. A qualitative study of post-settlement influences on state tobacco control funding. *Health Promotion Practice* 5(3):46S-56S.

Babbie, E. 2001. Practice of Social Research. 8th edition. New York: Wadsworth Publishing Company.

Bailey, R. 2009. *A critical analysis of the Delphi technique. University of the West of England. 1-64.* http://www.pdfdocspace.com/docs/29380/report-8-a-critical-analysis-of-the-delphi-technique.html

Ballou, KA. 2000. Historical-philosophical analysis of the professional nurse obligation to participate in sociopolitical. *Policy, Politics, & Nursing Practice* 1(3):172-184.

Barber, C. 2007. Politics: why is it important to you? *British Journal of Healthcare Assistants* 1(9):421-424.

Barclay, L. 2010. Nurses should play greater role in health policy planning and management. *Nevada RNformation* 15.

Bass, BM & Avolio, BJ. 1994. Transformational leadership and organizational culture. *International Journal of Public Administration* 17(3&4):541-554.

Bass, BM, Avolio, BJ & Atwater, L. 1996. The transformational and transactional leadership of men and women. *Applied Psychology: An International Review* 45(1):5-34.

Bayley, EW, MacLean, SL, Desy, P & McMahon, M. 2004. ENA's Delphi study on national research priorities for emergency nurses in the United States. *Journal of emergency nursing* 30(1):12-21.

Beech, B. 1999a. Go the extra mile—use the Delphi Technique. *Journal of Nursing Management* 7:281–288.

Beech, B. 1999b. The Delphi approach: recent applications in health care. *Nurse Researcher* 8(4):38-48.

Bennett, H. 2004. Leadership in children's nursing: impact on policy. *Paediatric Nursing* 16(4):8-31.

Bieber, VH. 2003. Leadership practices of veterans' health administration nurse executives: an exploration of current practices and professional development needs. PhD (Educational Leadership) dissertation. East Tennessee State University, USA.

Birkland, TA. 2001. *An introduction to policy process: theories, concepts and models of public policy making.* New York: M.E. Sharpe.

Bless, C & Smith, CH. 2000. *Social research: an African perspective*. 3rd edition. Cape Town: Juta.

Borthwick, C & Galbally, R. 2001. Nursing leadership and health care reform. *Nursing Inquiry* 8(2):75-81.

Boswell, C, Cannon, S & Miller, J. 2005. Nurses political involvement: responsibility versus privilege. *Journal of Professional Nursing* 21(1):5-8.

Bourgeois, J, Pugmire, L, Stevenson, K, Swanson, N & Swanson, B. 2006. *The Delphi Method: A Qualitative Means to a Better Future.* From: http://www.freequality.org/sites/www_freequality_org/Documents/knowledge/Delphimethod.pdf#search=%22Laura%20Pugmire%20Delphi%22 (accessed 12 August 2008).

Bowling, A. 2005. *Techniques of questionnaire design,* in Handbook of health research methods : investigation, measurement and analysis, edited by A. Bowlings & S. Ebrahim. United Kingdom: Open University Press: 394-426.

Bradley, E & Nolan, P. 2007. Impact of nurse prescribing: a qualitative study. *Journal of Advanced Nursing* 59(2):120–128.

Bradshaw, A. 1997. Defining 'competency' in nursing (part 1): a policy review. *Journal of Clinical Nursing* 6:347–354.

Bradshaw, PL. 2003. Modernizing the British National Health Service – some ideological and policy considerations. *Journal of Nursing Management* 11:85–90.

Brockhoff, K. 2002. **IV.E. The Performance of Forecasting Groups in Computer Dialogue and Face-to-face Discussion.* In *The Delphi Method Techniques and Applications, Editors* Linstone, HA & Turoff, M. *The electronic version book.* From: http://www.is.njit.edu/-pubs/delphibook/ (accessed 20 August 2009).

Burns, N & Grove, SK. 2005. *The practice of nursing research: conduct, critique and utilization*. 5th edition. Philadelphia: W.B. Saunders.

Byrd, ME, Costello, J, Shelton, CR, Thomas, PA & Petrarca, D. 2004. An active learning experience in health policy for baccalaureate nursing students. *Public Health Nursing* 21(5):501–506.

Cameron, A & Masterson, A. 2000. Managing the unmanageable? Nurse Executive Directors and new role developments in nursing. *Journal of Advanced Nursing* 1(5):1081-1088.

Campbell, KA. 1998. Impact of Health Care Restructuring on the Role of the Nurse Manager. MN (Nursing) thesis. University of Alberta, Canada.

Campbell, SM, Shield, T, Rogers, A & Gask, L. 2004. How do stakeholder groups vary in a Delphi technique about primary mental health care and what factors influence their ratings? *British Medical Journal* 4(13):428-434.

Camunas, C. 2007. Power, Politics, and Policy, in *Nursing leadership and management theories processes and practice,* edited by RAP Jones. Philadelphia: FA Davis company: 201-220.

CNA, see, Canadian Nurses Association

Canadian Nurses Association. 2000. *Nursing Now: Issues And Trends in Canadian Nursing* (8) From: www.cna-nurses.ca (accessed 15 August 2008).

Carroll, TL. 2005. Leadership skills and attributes of women and nurse executives challenges for the 21st century. *Nursing Administration Quarterly* 29(2):146-153.

Casey, SS. 2009. State Political Participation of North Carolina Nurse Anesthetists. MSN (Nursing) thesis. Mountain State University, USA.

Casimir, G & Waldman, DA. 2007. A Cross Cultural Comparison of the Importance of Leadership Traits for Effective Low-level and High-level Leaders Australia and China *International Journal of Cross Cultural Management* 7(1):47–60.

Chan, S. 2002. Factors influencing nursing leadership effectiveness in Hong Kong. *Journal of Advanced Nursing* 38(6):615–623.

Chan, SW & Cheng, B. 1999. Political participation in Hong Kong: a study. *Journal of Nursing Management* 7:167-175.

Chavasse, J. 1998. Policy as an influence on public health nursing education in the Republic of Ireland. *Journal of Advanced Nursing* 28(1):172-177.

Cheek, J & Gibson, T. 1997. Policy matters: critical policy analysis and nursing. *Journal of Advanced Nursing* 25:668-672.

Chen, CC & Cohen, SS. 2003. Rooms without rules: shaping policies for assisted living facilities. *Policy, Politics, & Nursing Practice* 3(2):188-197.

Chibuye, PS. 1989. Nursing in action" nurses' influence in research and health policy development. *Journal of Professional Nursing* 5(6):326-329.

Chinn, PL & Kramer, MK. 1999. *Theory and nursing: integrated knowledge development* 5th edition. St. Louis: Mosby.

Christensen, M & Hewitt-Taylor, J. 2006. Empowerment in nursing: paternalism or maternalism? *British Journal of Nursing* 15(13):695-699.

Clark, AM. 1998. The qualitative – quantitative debate: moving from positivism and confrontation to post-positivism and reconciliation. *Journal of advanced nursing* 27:1242-1249.

Cohen, MZ. 1998. Introduction to qualitative research, in *Nursing research: methods, critical appraisal, and utilization,* edited by G LoBiondo-Wood & J Haber. St. Louis: Mosby: 127–131.

Cohen, MZ, Harle, M, Woll, AM, Despa, S & Munsell, MF. 2004. Delphi survey of nursing research priorities. *Oncology Nursing Forum* 31(5):1011-1018.

Cohen, SS, Mason, DJ, Kovner, C, Leavitt, JK, Pulcini, J & Sochalski, J. 1996. Stages of nursing's political development: where we've been and where we ought to go. *Nursing Outlook* 44:259-66.

Cohen, SS & Milone-Nuzzo, P. 2001. Advancing health policy in nursing Education through service learning. *Advanced Nursing Sciences* 23(3):28–40.

Collins, SE. 2006. Nursing and the public policy making process: a primer. *The Florida Nurse* 16.

Colton, S & Hatcher, T. 2004. *The Web-based Delphi Research Technique as a Method for Content Validation in HRD and Adult Education Research*. From: http://www.mpc.edu/FacultyStaff/SharonColton/Documents/Establishing%20the%20Delphi%20Technique.pdf (accessed 21 February 2009).

Concise Oxford Dictionary of Current English. 1989. Sv "attribute"; 7th Edition. Editor JB. Sykes. Britain: Oxford University Press.

Concise Oxford Dictionary of Current English. 1989. Sv "knowledge"; 7th Edition. Editor JB. Sykes. Britain: Oxford University Press

Concise Oxford Dictionary of Current English. 1989. Sv "politics"; 7th Edition. Editor JB. Sykes. Britain: Oxford University Press

Concise Oxford Dictionary of Current English. 1989. Sv "process"; 7th Edition. Editor JB. Sykes. Britain: Oxford University Press

Conger, CO & Johnson, P. 2000. Integrating political involvement and nursing education. *Nurse Educator* 25(2):99-103.

Conn, V & Armer, J. 1996. Meta-analysis and public policy: opportunity for nursing impact. ***Nursing Outlook*** 44(6):267-271.

Cook. 1994. *'Delphi Technique',* Michigan State University Extension: Issue Identification Information. From: *www.msue.msu.edu/msue/imp/modii/iii00006.html* (accessed 10 April 2009).

Cook, MJ. 1999. Improving care requires leadership in nursing. *Nurse Educator Today* 19:306-312.

Corey-Lisle, P, Tarzian, A, Cohen, M & Trinkoff, A. 1999. Healthcare reform: its effects on nurses. *Journal of Nursing Administration* 29(3):30-37.

Coxall, B, Robins L & Leach, R. 2003. *Politics, Democracy and Power, Contemporary British Politics.* 4th Edition. Palgrave MacMillan: UK, From: http://www.palgrave.com/PDFs/140390507X.Pdf (accessed 05 August 2008).

Cramer, ME. 2002. Factors influencing organized political participation in nursing. *Policy, Politics & Nursing Practice* 3(2):97-107.

Crossan, F. [Sa] Research philosophy: towards an understanding. *Nurse Researcher* 11(1):46-55.

D'Antonio, P. 2005. Editorial: nursing and history. *Nursing Inquiry* 12(4):241–242.

Daiski, I. 2004. Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing* 48(1):43–50.

Dalkey, N & Helmer, O. 1963. An experimental application of the delphi method to the use of experts. *Management Science* 9(3):458-467.

Dalkey, N. 1969. *The Delphi method: an experimental study of group opinion. Prepared for United States Air Force Project RAND.* From: http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPrefix=html&identifier=AD0690498 (accessed 20 July 2009).

DeClercq, E. 1994. A cross-national analysis of midwifery politics: six lessons for midwives. *Midwifery* 10:232-237.

Delport, CSL. 2002. Quantitative data collection methods, in *Research at grass roots: for the social sciences and human service professions,* edited by AS de Vos. 2nd edition. Pretoria: Van Schaik Publishers.

Deschaine, JE & Schaffer, MA. 2003. Strengthening the role of public health nurse leaders in policy development. *Policy, Politics & Nursing Practice* 4(4):266-274.

Des Jardin, K. 2001. Political Involvement in nursing – politics, ethics, and strategic action. *AORN Journal* 74(5):614-622.

De Villiers, MR, De Villiers, P & Kent, AP. 2005. The Delphi technique in health sciences education research. *Medical Teacher* 27(7):639–643.

DiGaudio, KM. 1993. Nurses' participation in policy making activities. PhD (Nursing) dissertation. State University of New York, USA.

Dixon, DL. 1999. Achieving results through transformational leadership. *Journal of Nursing Administration* 29(12):17-21.

Dollinger, ML. 2006. A grounded theory study of nurse advocacy in health policy. PhD (Nursing) thesis. State University of New York, USA.

Donohoe, HM & Needham, RD. 2008. Moving best practice forward: Delphi characteristics, advantages, potential problems, and solutions. *International Journal of Tourism Research* 11:1-23.

Durham-Taylor, J. 2000. Nurse executive transformational leadership found in participative organizations. *Journal of Nursing Administration* 30(5):241-250.

East African Community Portal. 2010. *Countries of East Africa.* From: http://www.eac.int/index.php?option=com_content&view=article&id=1:welcome-to-eac&catid=34:body-text-area&Itemid=53 (accessed 28 November 2010).

Ellenfsen, B, Polit & Hamilton, G. 2000. Empowered nurses? Nurses in Norway and the USA compared. *International nurse review* 47:106-120.

Ellis, JR & Hartley, CL. 2004. *Nursing in Today's World. Trends, Issues and Management* 8th edition. Philadelphia: Lippincott.

Ennen, KA. 2001. Shaping the future of practice through political activity: how nurses can influence health care policy. *AAOHN Journal* 49(12):557-570.

Evans, C & Ndirangu, E. 2008. Complexities of Provider-initiated routine HIV testing and counseling: The experiences of nurses in Nairobi, Kenya. Presentation at the

2nd Biannual Aga Khan University International Scientific Conference held in Tanzania (no dates).

Evans, J. 2004. Men nurses: a historical and feminist perspective. *Journal of Advanced Nursing* 47(3):321–328.

McEwen, M & Wills, EM. 2002. Theoretical basis for nursing. Philadelphia: Lippincott Williams & Wilkins.

The Friday Bulletin. (2011). The map of East Africa. From: http://fridaybulletin.com/?p=2091 (accessed 23 February 2011).

Falk-Rafael, A. 2005. Speaking truth to power: nursing's legacy and moral imperative. *Advances in Nursing Science* 28(3):212-223.

Farley, CL. 2005. Midwifery's research heritage: a Delphi survey of midwife scholars. *Journal of Midwifery & Women's Health* 50(2):122-128.

Farsi, Z, Dehghan-Nayeri, N, Negarandeh, R and Broom, S. 2010. Nursing profession in Iran: An overview of opportunities and challenges. *Japan Journal of Nursing Science* 7**:**9–18.

Faucher, J, Everett, A & Lawson, R. [Sa]. Applying a modified Delphi approach to determine the current state of the concept of knowledge No publisher 4801-4806.

Fedoruk, M & Pincombe, J. 2000. The nurse executive: challenges for the 21st century. *Journal of Nursing Management* 8:13-20.

Ferguson, SL. 2001. An activist looks at nursing's role in health policy development. *JOGNN* 30(5):546-551.

Ferguson, SL & Drenkard, KN. 2003. Nurse leaders in health policy: an education and practice partnership. *Policy, Politics, & Nursing Practice* 4(3):180-184.

Fitzpatrick, JJ. 2004. Translating clinical research into health policy. *Applied Nursing Research* 17(2):71.

Fletcher, K. 2006. Beyond dualism: leading out of oppression. *Nursing Forum* 41(2):50-59.

Ford, LC. 1980. Nursing at the cutting edge of health services reform. *The American Journal of Nursing* 80(8):1476-1479.

Fradd, L. 2004. Political leadership in action. *Journal of Nursing Management* 12:242–245

Fullam, C, Lando, AR, Johansen, ML, Reyes, A & Szaloczy, DM. 1998. The triad of empowerment: leadership, environment, and professional traits. *Nursing Economics* 16(5):254-258.

Fyffe, T. 2009. Nursing shaping and influencing health and social care policy. *Journal of Nursing Management* 17:698–706.

Ganga-Limando, RM. 2001. An analysis of the current basic nursing education systems of Francophone African countries of the World Health Organizations AFRO regions. PhD (Nursing) thesis. University of Natal, South Africa.

Gebbie, KM, Wakefield, M & Kerfoot, K. 2000. Nursing and Health Policy. *Journal of Nursing Scholarship 32*(3):307-315.

Gerrish, K, McManus, M & Ashworth, P. 2003. Creating what sort of professional? Master's level nurse education as a professionalising strategy. *Nursing Inquiry* 10(2):103-112.

Gesse, T. 1991. Political participation behaviors of nurse-midwives*. Journal of Nurse-Midwifery* 36:184-91.

Glouberman, S. 2001. *Towards a New Perspective on Health Policy. CPRN Study No. H/03. Canada.* From: http://www.renoufbooks.com (accessed 07 July 2009).

Goodman, CM. 1987. The Delphi Technique: a critique. *Journal of Advanced Nursing* 12:729-734.

Gordon, TJ. 2009. *The Delphi Method. The Millennium Project: Futures Research Methodology −V3.0, 1-29.* From: http://millennium-project.org/FRMv3_0/04-Delphi.pdf (accessed 06 June 2010).

Hall-Long, B. 2004. A voice for the people: a nurse's reflections on her role as an elected state representative. *Policy, Politics, & Nursing Practice* 5(4):274-283.

Hancock, H, Campbell, S, Bignell, P & Kilgour, J. 2005. The impact of leading empowered organisations (LEO) on leadership development in nursing. *International Journal of Health Care* 18(3):179-192.

Hanley, B & Falk, NL. 2007. Policy development and analysis: understanding the process, in *Policy and politics in nursing and health care*, edited by JD Mason, JK Leavitt and MW Chaffee. 5th edition. USA: Saunders Elsevier: 75-93.

Hasson, F, Keeney, S & McKenna, H. 2000. Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing* 32(4):1008–1015.

Hawks, JH. 1999. Power: a concept analysis. *Journal of Advanced Nursing* 16(6):754-762.

Hayes, E & Fritsch, R. 1988. An untapped resource: the political potential of nurses. *Nursing Administration Quarterly* 13(1):33-39.

Hennessy, D. (ed). 2000. The emerging themes, in *Health policy and nursing: influence, development and impact*, edited by D Hennessy & P Spurgeon. London: MacMillan Press Limited:1-36.

Hennessy, D & Hicks, C. 2003. The ideal attributes of Chief Nurses in Europe: a Delphi study. *Journal of Advanced Nursing* 43(5):441–448.

Henrikson, A. [Sa]. (Online). *Elitism*. http://www.americanforeignrelations.com/E-N/Elitism.html (accessed 05 August 2008).

His Highness the Aga Khan. 1999. *Speech by His Highness the Aga Khan at the World Bank InfoDev Conference (USA).* From: http://www.akdn.org/speech/578/The-World-Bank-InfoDev-Conference (accessed 02 May 2007).

Holleran, C. 1985. Nurses and health policy. *International Nursing Review* 32(2):43-45.

Holliday, ME & Parker, DL. 1997. Florence Nightingale, feminism and nursing. *Journal of Advanced Nursing* 26:483–488.

Hung, HL, Altschuld, JW & Lee, YF. 2008. Methodological and conceptual issues confronting a cross-country Delphi study of educational program evaluation. *Evaluation and Program Planning* 31:191-198.

ICN, See, International Council of Nurses

Ijeoma, EOC. 2007. Rationality, disjointed incrementalism and mix scanning theories for decision-making on globalization. *Journal of Public Administration* 42(8):816–829.

Inman, D & Elliott, G. 2007. Timely and Fair Assessment of Dissertations, South Bank University. In Proceedings of the 6th Annual ISOnEworld Conference, April 11-13, Las Vegas, NV From: www.isoneworld.org (accessed 21 June 2009).

International Council of Nurses (ICN). 2000, 2008. *Participation of Nurses in Health Services Decision Making and Policy Development.* From: http://www.orderofnurses.org.lb/ICN/NOVDECEN/D04_ParticipationDecisionMaking.pdf (accessed 15 July 2009).

International Council of Nurses (ICN). 2004. *ICN Salutes 150th Anniversary of Florence Nightingale's Work in the Crimea.* From: http://www.icn.ch/PR14_04.htm (accessed 12 August 2008).

International Council of Nurses (ICN). 2005. *Guidelines on shaping effective health policy.* From: http://www.icn.ch/Guideslines_shaping.pdf (accessed 01 October 2008).

Jackman, D, Myrick, F & Yonge, OJ. 2010. Rural nursing in Canada: a voice unheard *Online Journal Of Rural Nursing And Health Care* 10(1):60-69.

Joel, LA & Kelly, LY. 2003. *Kelly's Dimensions of professional nursing.* 9th edition. USA: McGraw-Hill Companies

Joels, C. 2008. Impact of national policy on the health of people seeking asylum. *Nursing Standard* 22(31):35-40.

Johns, C. 1999. Reflection as empowerment? *Nursing Inquiry* 6:241-249.

Jones, M. 2004. Nurse prescribing: a case study in policy influence. *Journal of Nursing Management* 12:266–272.

Jones, PS, O'toole, MT, Hoa, N, Chau, TT & Muc, PC. 2000. Empowerment of nursing as a socially significant profession in Vietnam. *Journal of Nursing Scholarship* 32(3):317-321.

Jones, K, Baggott, R. & Allsop, J. 2004. 'Influencing the national policy process: the role of health consumer groups'. ***Health Expectations*** 7(1):18-28.

Keeney, S, Hasson, F & McKenna, H. 2006. Consulting the oracle: ten lessons from using the Delphi technique in nursing research. *Journal of Advanced Nursing* 53(2):205-212.

Keeney, S, Hasson, F & McKenna, HP. 2011. Reliability and Validity in *The Delphi technique in nursing and health research*. UK: Wiley-Blackwell. http://books.google.co.za/books?id=MraZodytRF8C&lpg=PA (accessed 18 January 2011).

Kelly, P. 2010. *Essentials of nursing leadership and management*. New York: Delmar Cengage Learning. http://books.google.co.za/books?id=uXFkNpuJWJEC&lpg=PA7&ots=sErs3d4rvz&dq=auto cratic%2C%20democratic%2C%20and%20laissez-faire%20leadership%20%2B%20nurse&pg=PA8#v=onepage&q=autocratic,%20democrati c,%20and%20laissez-faire%20leadership%20+%20nurse&f=false (accessed 18 January 2011).

Kelly-Heidenthal, P. 2004. *Essentials of nursing leadership & management*. New York: Thomson/Delmar Learning.

Kendig, S. 2002. From practice to policy leveraging nursing knowledge in the legislative arena. *AWHONN Lifelines* 6(4):309–312.

Kennedy, HP. 2004. Enhancing Delphi research: methods and results. *Journal of Advanced Nursing* 45(5):504–511.

Kenya National Health Sector Strategic Plan (NHSSP II). 2005 – 2010. Introduction – Kenya's Health Policy Framework 1-78.

Kerschner, SW & Cohen, JA. 2002. Legislative decision making and health policy: a phenomenological study of state legislators and individual decision making. *Policy, Politics, & Nursing Practice* 3(2):118-128.

Khan, MM. 2006. Health Policy Analysis: The Case of Pakistan. PhD Thesis. University of Groningen, Netherlands.

Kimenyi, MS, Nyangito, H & Kulindwa. 2004. Mainstreaming Environment into Development Planning. Paper Presented to the United Nations Environment Program (UNEP). August 2004.

Kithyoma, W. 2004. *How can CSOs promote pro-poor policy & practice in the African Energy Secto*r? From: http://www.odi.org.uk/rapid/Events/CSOs_Kenya/Presentation1/_Afrepren.html (accessed 17 April 2007).

Kitson, A. 2001. Nursing leadership: bringing caring back to the future. *British Medical Journal* 10(Suppl II):ii79–ii84.

Klingborg, DJ, Moore, DA & Varea-Hammond, S. 2006. What is leadership? *JVME* 33(2):280-283.

Kojève, A. 1969. *Introduction to the Reading of Hegel*, Basic Books. From: http://www.marxists.org/reference/subject/philosophy/works/fr/kojeve.htm (accessed 12 July 2009).

Kombo, DK & Tromp, DL. 2006. *Proposals and thesis writing: an introduction*. Kenya: Paulines Publications Africa.

Kouzes, JM & Posner, BZ. [Sa]. *The Leadership Challenge: How to get extraordinary things done in organizations.*
From: http://hr.ubc.ca/files/pdf/otd/information_library/leadership/leadership_articles.pdf (accessed 16 September 2008).

Kress, G & Leeuwen, TV. 2002. Colour as a semiotic mode: notes for a grammar of colour. *Visual Communication* 1(3):343-368.

Kunaviktikul, W, Nantsupawat, R, Sngounsiritham, U, Akkadechanunt, T, Chitpakdee, B, Wichaikhum, O, Wonglieukirati, R, Chontawan, R, Keitlertnapha, P, Thungaraenkul, P, Abhicharttibutra, K, Sanluang, C, Lirtmunlikaporn, S & Chaowalaksakun, P. 2010. Knowledge and involvement of nurses regarding health policy development in Thailand. *Nursing and Health Sciences* 12:221–227.

Kuokkanen, L & Leino-Kilpi, H. 2000. The qualities of an empowered nurse and the factors involved*. Journal of Nursing Management* 9:273-280.

Lamond, D & Farnell, S. 1998. The treatment of pressure sores: a comparison of novice and expert nurses knowledge, information use and decision accuracy. *Journal of Advanced Nursing* 27:280-286.

Landeta, J. 2006. Current validity of the Delphi method in social sciences. *Technological Forecasting & Social Change* 73: 467–482.

Lange, A & Cheek, J. 1997. Health policy and the nursing profession: a deafening silence. *International Journal of Nursing Practice* 3(1):2-9.

Latter, S & Courtenay, M. 2004. Effectiveness of nurse prescribing: a review of the literature. *Journal of Clinical Nursing* 13:26–32.

Lau, R & Schlesinger, M. 2005. Policy frames, metaphorical reasoning, and support for public policies*. Political Psychology* 26(1):77-114.

Leach, LS. 2005. Nurse executive transformational leadership and organizational commitment . *JONA* 35(5):228-237.

Leatherman, S. 1999. *Health care policy issues and challenges. International Health Leadership Programs, Module 1.* From: http://www.darwin.cam.ac.uk/associates/leatherman/talk-issues.pdf (accessed 15 June 2008).

Leavitt, JK, (ed). Chaffee, MW (ed) & Vance, C. 2007. Learning the ropes of policy, politics and advocacy, in *Policy and politics in nursing and health care*, edited by JD Mason, JK Leavitt and MW Chaffee. 5th edition. USA: Saunders Elsevier: 34–60.

Lewenson, SB. 2007. Policy and politics: a framework for action, in *Policy and politics in nursing and health care*, edited by JD Mason, JK Leavitt and MW Chaffee. 5th edition. USA: Saunders Elsevier: 21–33.

Lewis, JM. 2006. **Being around and knowing the players: networks of influence in health policy.** *Social Science Medicine* **62**(9)**:**2125-2136.

Lievens, F, Geit, PV & Coetsier, P. 1997. Identification of transformational leadership qualities: an examination of potential biases European. *Journal of Work And Organizational Psychology* 6(4):415-430.

Lima, WC & Sampaio, SF. 2007. Political competence of nurses: literature findings. *Rev Gaucha Enferm* 28(4):564-569.

Linquist, P & Nordänger, UL. 2007. (Mis-?) using the E-Delphi method: an attempt to articulate the practical knowledge of teaching. *Research Methods and Methodology Issues* 1(1). [no page numbers].

Linstone, HA & Turoff, M, 2002. *The Delphi Method Techniques and Applications, The electronic version book,* From: http://www.is.njit.edu/-pubs/delphibook/ (accessed 20 August 2007).

LoBiondo-Wood, G & Haber, J. (eds). 1998. Nursing Research: Methods, Critical appraisal and Utilization. 4th Edition. St Louis: Mosby.

Madigan, EA & Vanderboom, C. 2005. Home health care nursing research priorities. *Applied Nursing Research* 28(4):221-225.

Magadi, MA. [Sa]. *Status of women and infant/child health in Kenya with particular reference to the high mortality zone in Nyanza province.* Population studies and Research

Institute University of Nairobi. From: http://www.uaps.org/recherche/status.htm (accessed 02 May 2007).

Manojlovich, M. 2007. **Power and empowerment in nursing: Looking backward to inform the future.** *Online Journal of Issues in Nursing* 12(1) http://www.medscape.com/viewarticle/553403_2 (accessed 24 November 2010).

Maslin-Prothero, S & Masterson, A. 2002. Power, Politics, and Nursing in the United Kingdom. *Policy, Politics, & Nursing Practice* 3(2):108-117.

Mason, DJ, Backer, BA & Georges, A. 1991. Towards a feminist model for the political empowerment of nurses. *Journal of Nursing Scholarship* 23(2):72-77.

Mason, DJ, (ed) Dodd, CJ & Glickstein B. 2007. Harnessing the power of the media to influence health policy and politics, in *Policy and politics in nursing and health care*, edited by JD Mason, JK Leavitt and MW Chaffee. 5th edition. USA: Saunders Elsevier: 149–168.

Mason, JD, Leavitt, JK & Chaffee, MW. (eds). 2007. Policy and politics: a framework for action, in *Policy and politics in nursing and health care*, edited by JD Mason, JK Leavitt and MW Chaffee. 5th edition. USA: Saunders Elsevier: 1–16.

Mason, JD, Leavitt, JK & Chaffee, MW. (eds). 2007. Policy and politics in nursing and health care, edited by JD Mason, JK Leavitt and MW Chaffee. 5th edition. USA: Saunders Elsevier: 759.

McCloskey, BA & Diers, DK. 2005. Effects of New Zealand's health reengineering on nursing and patient outcomes. *Medical Care* 43(11):1140-1146.

McDaniels, OB. 1991. Political participation of registered nurses: a correlational study. PhD (education) dissertation. University of San Diego, USA.

McEwen, M. (ed). 2010. Overview of Nursing Theory, in *Theoretical basis for nursing,* edited by M McEwen & EM Wills. 3rd edition. Philadelphia: Lippincott Williams & Wilkins:24-49.

McKenna, HP. 1994. The Delphi technique: a worthwhile research approach for nursing? *Journal of Advanced Nursing* 19:1221–1225.

McKenna, H & Keeney, S. 2004. Community nursing: health professional and public perceptions. *Journal of Advanced Nursing* 48(1):17–25.

McKenna, H & Keeney, S. 2008. Delphi Studies, in *Nursing research: designs and methods* edited by R Watson. Edinburgh: Churchill Livingstone/Elsevier: 251-260.

McKenna, H, Keeney, S & Bradley, M. 2004. Nurse leadership within primary care: the perceptions of community nurses, GPs, policy makers and members of the public. *Journal of Nursing Management* 12:69-76.

Meleis, AI. 2007. *Theoretical nursing: development and progress*. Philadelphia, Lippincott Williams & Wilkins

Merriam-Webster online dictionary. 2006-2007. Sv "policy" From: http://www.m-w.com/dictionary/policy (accessed 01 September 2007).

Minnesota Council on Foundations, Philanthropy & Public Trust [Sa]. *What Every Grant maker Should Know: Public Policy Engagement*. From: http://www.mcf.org/publictrust/wegsk_publicpolicy.htm (accessed 15 August 2008).

Mitroff, II & Turoff, M. (ed) 2002. Philosophical and Methodological Foundations of Delphi in *The Delphi Method Techniques and Applications, The electronic version book,* edited by HA Linstone & M Turoff From: http://www.is.njit.edu/-pubs/delphibook/ (accessed 20 August 2007).

Mohlokoane, MJS. 2004. Towards a leadership model for the effective management of further education and training colleges in the Gauteng Province. PhD (Education) thesis. University of South Africa, Pretoria.

Morrison, RS, LaDon, J & Fuller, B. 1997. The relation between leadership style and empowerment on job satisfaction of nurses. *Journal of Nursing Administration* 27(5):27-34.

Muiruri, B. 2008. *Shame of public service salaries. Daily Nation Online.* 19 July. From: http://www.nationmedia.com/dailynation/nmgcontententry.asp?premiumid=0&category_id=1&newsid=127659 (accessed 22 July 2008).

Mulligan, JA, Mandike, R, Palmer, N, Williams, H, Abdulla, S, Bloland, P & Mills, A. 2006. The costs of changing national policy: lessons from malaria treatment policy guidelines in Tanzania. *Tropical Medicine and International Health* 11(4):452–461.

Mureithi, C, Mwenda, J & Yengo, M. 2010. Correspondence. 05 January, Kenya.

Murphy, L. 2005. Transformational leadership: a cascading chain reaction. *Journal of Nursing Management* 13:128–136.

Needham, RD & de Loë, RC. 1990. The policy Delphi: purpose, structure and application. *The Canadian Geographer* 34(2):133-42.

Neema, S. 2005. *The impact of health policies and health sector reform on the readiness of health systems to respond to women's health needs, with special focus on reproductive health, reproductive rights and HIV/AIDS.* Paper presented at Expert Group Meeting, United Nations, Division for the Advancement of Women (DAW), Enhancing Participation of Women in Development through enabling Environment for Achieving Gender Equality and the Advancement of Women, Bangkok, Thailand, 8–11 November.   From http://www.un.org/womenwatch/daw/egm/enabling-enviroment2005/docs/EGM-WPD-EE-2005-EP.11%20%20S.pdf (accessed 28 July 2007).

Nelms, LW & Gorski, J. 2006. The role of the African traditional healer in women's health. *Journal of Transcultural Nursing* 17(2):184-189.

Nursing Council of Kenya (NCK). 2005. *Specialized areas Unit 4 Management*. *Module 5.* Kenya.

Oden, LS, Price, JH, Alteneder, R, Boardley, D & Ubokudom, SE. 2000. Public policy involvement by nurse practitioners. *Journal of Community Health* 25(2):139-155.

Okoli, C & Pawlowski, SD. 2004. The Delphi method as a research tool: an example, design considerations and applications*. Information & Management* 42:15–29.

Olsson, J. 2003. 'Democracy paradoxes in multi-level governance: theorizing on structural fund system research'. *Journal of European Public Policy* 10(2):283-300.

Painter, DR. 2010. The power of nursing. *Nephrology Nursing Journal* 37(2):114-116.

Parker, J. 2005. Nursing identity and difference. *Nursing Inquiry* 12(2):65.

Parry, G. 2005. *Political elites: new introduction by the author. European Consortium for Political Research* (United Kingdom)   From http://www.essex.ac.uk/ecpr/publications/chapter/Parry-sample-chapt.pdf   (accessed 05 August 2008).

Parse, RR. 2005. Parse's criteria for evaluation of theory with a comparison of fawcett's and parse's approaches. *Nursing Science Quarterly* 18(2):135-137.

Peat, J, Mellis, C, Williams, K & Xuan, W. 2001. *Health science research a handbook of quantitative methods.* Australia: Allen & Unwin

Perry, HL. 1991. Pluralist theory & national black politics in the United States. *Polity* 23(4):549-565.

Phaladze, NA. 2003. The role of nurses in the human immunodeficiency virus/acquired immune deficiency syndrome policy process in Botswana, *International Nursing Review* 50:22-33.

Polit, D & Beck, CT. 2008. *Nursing research: generating and assessing evidence for nursing practice*. 8th edition. Philadelphia: Lippincott Williams and Wilkins.

Porter, S. 2001. Nightingale's relist philosophy of science. *Nursing philosophy* 2:14-25.

Powell, C. 2003. The Delphi technique: myths and realities. *Journal of Advanced Nursing* 41(4):376-382.

Pronovost, PJ, Dang, E, Dorman, T, Lipsett, PA, Garrett, E, Jenckes, M & Bass, EB. 2001. *Intensive Care Unit Nurse Staffing and the Risk for Complications after Abdominal Aortic Surgery. Effective Clinical Practice.* From https://www.acponline.org/journals/ecp/sepoct01/pronovost.htm (accessed 12 January 2011).

Rains, JW & Carroll, KL. 2000. The effect of healthy policy education on self-perceived political competence of graduate nursing students. *Journal of Nursing Education* 39(1):37-40.

Ray, MM & Roberts, SC. 2002. Nurses as lobbyists: individual and collective strategies for influencing others. *AWHONN Lifelines* 6(5):438-442.

Rayens, M & Hahn, E. 2000. Building consensus using the policy Delphi method. *Policy, Politics, & Nursing Practice* 1(4):308-315.

RCN, See, Royal College of Nursing

Registrar, Nursing Council of Kenya & Registrar, Tanzania Nurses and Midwifery Council. 2010. Correspondence. 15 December, Kenya.

Reutter, L & Williamson, DL. 2000. Advocating healthy public policy: implications for baccalaureate nursing education. *Journal of Nursing Education* 39(1):21-26.

Riley, PL, Vindigni, SM, Arudo, J, Waudo, AN, Kamenju, A, Ngoya, J, Oywer, EO, Rakuom, CP, Salmon, ME, Kelley, M, Rogers, M, St. Louis, ME & Marum, LH. 2007. Developing a nursing database system in Kenya. *Health Services Research* 42(3):1389-1405.

Ringa, M. 2009. 1,600 nurses to be hired to ease shortage. Daily Nation, February 23. From: http://www.nation.co.ke/News/-/1056/481774/-/tlfpba/-/index.html (accessed 25 February 2009).

Roberts-Davis, M & Read, S. 2001. Clinical role clarification: using the Delphi method to establish similarities and differences between Nurse Practitioners and Clinical Nurse Specialists. *Journal of Clinical Nursing* 10:33-43.

Rowe, G & Wright, G. 1999. The Delphi technique as a forecasting tool: issues and analysis. *International Journal of Forecasting* 15:353–375.

Rowles, CJ & Russo, BL. 2009. Strategies to promote critical thinking and active learning in *Teaching in Nursing: A guide for Faculty*, edited by Billings DM & Halsted JA. 3rd edition USA: Saunders.

Royal College of Nursing (RCN). 2001. *Nursing Leadership, Study Guide* 1-76.

Rozycki, EG. 1987. Policy and social contradiction: the case of lifelong education. *Educational Theory* 37:433-443.

Ryan-Nicholls, KD. 2004. Impact of health reform on registered psychiatric nursing practice. *Journal of Psychiatric and Mental Health Nursing* 11:644–653.

Ryles, SM. 1999. A concept analysis of empowerment: its relationship to mental health nursing. *Journal of Advanced Nursing* 29(3):600-607.

Schwaninger, M & Grosser, S. 2008. System dynamics as model-based theory building. *Systems Research and Behavioral Science* 25:447-465.

Scott, C, Savage, J, Ashman, M & Read, S. 2005. Evaluating the role of modern matrons. *Nursing Management* 12(2):22-26.

Scruby, SL. 1999. The community health nurse's role in health promotion policy: an interdisciplinary feminist research paradigm. PhD (Nursing) thesis. University of Manitoba, Canada.

Selanders, LC. 1998. Florence Nightingale: the evolution and social impact of feminist values in nursing. *Journal of Holistic Nursing* 16(2):227-243.

Sharkey, S & Sharples, A. 2001. An approach to consensus building using the Delphi technique: developing a learning resource in mental health. **Nurse Education Today** 21(5):398-408

Sidorenko, A. 2006. *Empowerment & Participation in Policy Action on Ageing*. 1-9. From: http://web.uvic.ca/ocbr/assets/pdfs/CBR_Empowerment%20&Public_Policy.pdf (accessed November 15 2010)

Skulmoski, GJ, Hartman, FT & Krahn, J. 2007. The Delphi method for graduate research. *Journal of Information Technology Education* 6:1-21.

Small, EB. 1989. Factors associate with political participation of nurses. PhD (Education) thesis. North Carolina State University, USA

Snively, A & Rieger, PT. 2006. Lessons from our leaders: advancing oncology nursing through the power of the group. *Oncology Nursing Forum* 33(2):205-207.

Spenceley, SM, Reutter, L & Allen, MN. 2006. The road less traveled: nursing advocacy at the policy level. *Policy, Politics, & Nursing Practice* 7(3):180-194.

Statistical package for social scientists (SPSS) Version 15.

Steinhart, E. 1998. *Dialectic.* From: http://www.wpunj.edu/cohss/philosophy/courses/hegel/dialectx.htm. (accessed 01 June 2009.

Stordeur, S, D'hoore, W & Vandenberghe, C. 2001. Leadership, organizational stress, and emotional exhaustion among hospital nursing staff. *Journal of Advanced Nursing* 35(4):533-542.

Stout, KE & Stevens, B. 2000. The case of the failed diversity rule: a multiple streams analysis. *Educational Evaluation and Policy Analysis* 22(4):341-356.

Sullivan, EJ. 2004. *Becoming influential: a guide for nurses*. New Jersey: Pearson/Prentice Hall.

Sundquist, SA. 2009. Stories from Select Saskatchewan Formal Registered Nurse Leaders in Policy: A Content Analysis. MN (Nursing) thesis. College of Nursing Saskatoon, Canada.

Suominen, T, Savikko, N, Puukka, P, Doran, DI & Leino-Kilpi, H. 2005. Work empowerment as experienced by head nurses. *Journal of Nursing Management* 13:147–153.

Sutton, R. 1999. *The Policy Process: An Overview. Overseas Development Institute. Working Paper 118*. *1-35*. From: http://www.odi.org.uk/resources/download/1868.pdf (accessed 20 June 2009).

Tappen, RM, Weiss, SA & Whitehead, DK. 2004. *Essentials of nursing leadership and management.* Philadelphia: FA Davis.

Thangaratinam, S & Redman, C. 2005. The Delphi technique. Education. *The Obstetrician & Gynaecologist* 7:120-125.

Theofanidis, D & Dikatpanidou, S. 2006. Leadership in Nursing. *ICUS Nursing WEB Journal (NURSING.GR)* 25:1-8.

Thomas, S, Billington, A & Getliffe, K. 2004. Improving continence services – a case study in policy influence. *Journal of Nursing Management* 12:252-257.

Thupayagale-Tshweneagae, G & Dithole, K. 2007. Unity among nurses: an evasive concept. *Nursing Forum* 42(3):143-146.

Tiernan, A & Burke, T. 2002. A load of old garbage: applying garbage-can theory to contemporary housing policy. *Australian Journal of Public Administration* 61(3):86-97.

Toofany, S. 2005. Nurses and health policy. *Nursing Management* 12(5):26-30.

Tourangeau, AE & McGilton, K. 2004. Measuring leadership practices of nurses using the leadership practices inventory. *Nursing Research* 53 (3):182–189.

Twarog J. 2007. When it comes to union activity, politics matters! *Massachusetts Nurse (no volume or issue number):*6

United Nations Development Programme. [Sa]. *Millennium Development Goals, Tracking the MDGs: Targets & Indicators.* From: http://www.undp.org/mdg/tracking_targetlist.shtml (accessed 4 October 2008).

Upenieks, V. 2003a. What constitutes effective leadership? perceptions of maget and nonmagnet nurse leaders. *Journal of Nursing Administration* 33(9):456-467.

Upenieks, V. 2003b. Nurse leaders' perceptions of what compromises successful leadership in today's acute inpatient environment. *Nursing Administration Quarterly* 27(2):140–152.

Van Der Merwe, AS. 1999. The power of women as nurses in South Africa. *Journal of Advanced Nursing* 30(6):1272-1279.

Van Teijlingen, E, Pitchforth, E, Bishop, C & Russell, E. 2006. Delphi method and nominal group techniques in family planning and reproductive health research. *Journal of Family Planning and Reproductive Health Care* 32(4):249-252.

Vandenbosch, B, Fay, S & Saatçioglu, A. 2001. *"Where Ideas Come From: A Systematic View of Inquiry," Case Western Reserve University, USA . Sprouts: Working Papers on Information Systems.* 1(17). From: http://sprouts.aisnet.org/1-17 (accessed 12 January 2008).

Venturato, L, Kellett, U & Windsor, C. 2007. Nurses' experiences of practice and political reform in long-term aged care in Australia: implications for the retention of nursing personnel. *Journal of Nursing Management* 15:4–11.

Vernon, W. 2009. The Delphi technique: a review. *International Journal of Therapy and Rehabilitation* 16(2):69-76.

Waldman, DA, Ramírez, GG, House, RJ & Puranam, P. 2001. Does leadership matter? CEO leadership attributes and profitability under conditions of perceived environmental uncertainty. *The Academy of Management Journal* 44(1):134-143.

Walt, G. 1994. *Health Policy: An Introduction to Process and Power*. Great Britain: Oxford University Press.

Walt, G, Shiffman, J, Schneider, H, Murray, SF, Brugha, R & Gilson, L. 2008. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy Planning.* 23(5):308-317.

Warner, JR. 2003. A phenomenological approach to political competence: stories of nurse activists. *Policy, Politics, & Nursing Practice* 4(2):135-143.

West, E. 2001. Management matters: the link between hospital organization and quality of patient care. *Quality in Health Care* 10:40–48.

West, E & Scott, C. 2000. Nursing in the public sphere: breaching the boundary between research and policy. *Journal of Advanced Nursing* 32(4):817-824.

Weston, MJ. 2008. Transformational leadership at a national perspective. *Nurse Leader* 41-45.

Wong, CA & Cummings, GG. 2007. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management* 15:508–521.

While, AE & Biggs, KSM. 2004. Benefits and challenges of nurse prescribing. *Journal of Advanced Nursing* 45(6):559–567.

Whitehead, D. 2003. The health-promoting nurse as a health policy career expert and entrepreneur. *Nurse Education Today* 23:585–592.

WHO, See, World Health Organization
Williams, PL & Webb C. 1994. The Delphi technique: a methodological discussion. *Journal of Advanced Nursing* 19:180-186.

Wilson, DM. 2002. Testing a theory of political development by comparing the political action of nurses and non nurses. *Nursing Outlook* 50(1):30-34.

Winter, KM & Lockhart, JS. 1996. From motivation to action: understanding nurses' political involvement. *Nursing and health care perspectives* 244-250.

Wolf, ZR. 1989. Uncovering the hidden work of nursing. *Nursing and Healthcare* 10:463-467.
Wood, MJ. (2000). Influencing health policy through research. *Clinical Nursing Research* 9(3):213-216.

World Health Organization (WHO). 1996. *Forty-ninth World Health Assembly: Resolution WHA 49.1, Strengthening nursing and midwifery*. From: http://www.wpro.who.int/NR/rdonlyres/2B17B927-98F9-478B-A447-AD3792DF1CBF/0/WHA491.pdf (accessed 15 October 2007).
World Health Organization (WHO). 2003. Fifty-*sixth world health assembly, Strengthening nursing and midwifery, Report by the Secretariat: A56/19: Provisional agenda item.* From: http://apps.who.int/gb/archive/pdf_files/WHA56/ea5619.pdf (accessed 15 October 2007).

World Health Organization (WHO). Regional Office for the Western Pacific, WPRO Nonserial Publication. 2005. *Health Service Planning and Policy-making: a Toolkit for Nurses and Midwives* (Module 1: Defining the problem). Western Pacific Region: WHO:1-45.

World Health Organization (WHO). Department of Human Resources for Health. 2007. *Global standards for the initial education of professional nurses and midwives. From*: http://www.who.int/hrh/nursing_midwifery/en/ (accessed 07 July 2008)

World Health Organization (WHO). Regional office for Eastern Region, regional committee for Eastern Region. 2008. *Technical paper: Promoting nursing and midwifery development in the Eastern Mediterranean Region.* From: http://www.emro.who.int/rc55/media/pdf/EMRC5505En.pdf (accessed 20 January 2009).

World Health Organization (WHO). 2009. *Nursing & Midwifery: Human Resources for Health Global standards for the initial education of professional nurses and midwives*. From: WHO/HRH/HPN/08.6 (accessed 20 January 2010).

World Health Organization (WHO). 2010a. *Frequently asked questions.* From: http://www.who.int/suggestions/faq/en/print.html (accessed 11 November 2010).

World Health Organization (WHO). 2010b. *Global Health Observatory (GHO) Kenya: Country Profiles, General: Health profile on regional site.* From: http://www.who.int/gho/countries/ken/country_profiles/en/print.html (accessed 15 November 2010).

World Health Organization (WHO). 2010c. *Global Health Observatory (GHO) Uganda: Country Profiles, General: Health profile on regional site.* From: http://www.who.int/gho/countries/uga/country_profiles/en/print.html (accessed 15 November 2010).

World Health Organization (WHO). 2010d. *Global Health Observatory (GHO) United Republic of Tanzania: country Profiles, General: General health statistical profile.* From: http://www.who.int/gho/countries/tza/country_profiles/en/print.html (accessed 15 November 2010).

Yoder-Wise, PS. 2007. *Leading and managing in nursing*. 4th edition. London: Mosby.

Annexure A

UNIVERSITY OF SOUTH AFRICA
Health Studies Research & Ethics Committee
(HSREC)
College of Human Sciences

CLEARANCE CERTIFICATE

Date of meeting: 6 May 2009   Project No:3273 404 2

Project Title: **An empowerment model for nurse leaders' participation in health policy development**

Researcher: **Ms NR Shariff**

Supervisor/Promoter: **Prof E Potgieter**

Joint Supervisor/Joint Promoter:

Department: **Health Studies**

Degree: **D Litt et Phil**

DECISION OF COMMITTEE
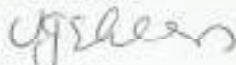
Approved   √   Conditionally Approved   ☐
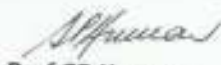
Date: 6 May 2009

Prof VJ Ehlers

RESEARCH COORDINATOR: DEPARTMENT OF HEALTH STUDIES

Prof SP Human
DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

THE AGA KHAN UNIVERSITY

19th May 2009

Nilufa Shariff
Aga Khan University
P.O. Box 39340-00623
Nairobi
Kenya

Dear Nilufa Shariff,

Re: Nurses' Participation in National Health Care Policy Formulation in East
Africa: Empowerment Model

It is my pleasure to inform you that your submitted research proposal has been approved by
the Aga Khan University Research Ethics Committee.

Please note that as the Principal Investigator, you have the full administrative, scientific and
ethical responsibility for the management of the research project in accordance with the
University policies and guidelines.

You will be required to present the final report of your study to the Aga Khan University
Research Office.

Best wishes,

Mr. John Arudo
Chair, AKU (EA) - Research Ethics Committee

3rd Parkland Avenue, Off Limuru Road P.O. Box 39340, Parklands - 00623, Nairobi, Kenya.
Telephone: 254 20 3747483, 3745808 Fax: 254 20 3747004 E-mail: aku-ea@aku.ac.ke
Website: www.aku.edu

An Empowerment Model for Nurse Leaders' Participation in Health Policy Development   Page 3

Name ..... MARTHA LOEFLER

Martha Loefler
Academic Head
Aga Khan **University**
ANS Programme, Kenya.

Signature ..... Chungi ..... Date ..... 18 - 05 - 09

20.   Ethical clearance (especially for health research involving human subjects).

This research proposal has been approved by the Aga Khan University Research

AGA KHAN UNIVERSITY
ADVANCED NURSING STUDIES PROGRAMME
743 PARKLANDS AVENUE
P. O. Box 39340, POST CODE 00623
NAIROBI - KENYA
TEL: 3747485 / 3745809   FAX: 3747004

John Amdo Bumbu Msc Inde

Chairman, Ethical Committee (Name, Signature & Stamp).

Date ..... 19 / 05 / 2009

SECTION E   **FOR OFFICIAL USE ONLY**

21.   Decision of the Uganda National Council for Science and Technology:-

21.1.   Research project reviewed:

i) Internally [   ]

ii) Externally by:

PAGE 2

THIS IS TO CERTIFY THAT:

Prof./Dr./Mr./Mrs./Miss...... NILUFA REYAZ
SHARIFF

of (Address)...... THE AGA KHAN UNIVERSITY
NAIROBI

has been permitted to conduct research in......

......XXXXXX
......Location,

...... NAIROBI ......District,

...... NAIROBI ......Province,

...... AN EMPOWERMENT MODEL
on the topic......
FOR NURSE LEADERS' PARTICIPATION

IN HEALTH POLICY DEVELOPMENT

......

......

...... 31ST DECEMBER 10
for a period ending ......, 20......

PAGE 3

Research Permit No. NCST/5/002/R/427
Date of issue ...... 29..5.2009
Fee received...... SHS.2000.00

Applicant's
Signature

Secretary
National Council for
Science and Technology

CONDITIONS

1. You must report to the District Commissioner and the District Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2)/four(4) bound copies of your final report for Kenyans and non-Kenyans respectively.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA
—————
RESEARCH CLEARANCE
PERMIT

GPK 6055—3m—10/2009

(CONDITIONS—see back page)

REPUBLIC OF KENYA

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegrams: "SCIENCETECH", Nairobi
Telephone: 254-020-241349, 2213102
254-020-310571, 2213123
Fax: 254-020-2213215, 318245, 318249
When replying please quote

Our Ref: **NCST/5/002/R/427/4**

P. O. Box 30623-00100
NAIROBI-KENYA
Website: www.ncst.go.ke

Date: **28ᵗʰ May 2009**

Ms. Nilufa Reyaz Shariff
The AgaKhan University
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on, *An Empowerment Model for Nurse Leaders' Participation in Health Policy Development'*

I am pleased to inform you that you have been authorized to carry out research in Nairobi for a period ending 31ˢᵗ December 2010.

You are advised to report to the Provincial Commissioner, the Provincial Director of Education and the Provincial Medical Officer of Health Nairobi before embarking on your research.

On completion of your research, you are expected to submit two copies of your research report to this office.

PROF. S. A. ABDULRAZAK Ph.D,MBS
SECRETARY

Copy to:

The Provincial Commissioner
Nairobi

The Provincial Director of Education
Nairobi

The Provincial Medical Officer of Health
Nairobi

THE UNITED REPUBLIC OF
TANZANIA

National Institute for Medical Research
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NIMR/HQ/R.8a/Vol. IX/904

Ministry of Health and Social Welfare
P.O. Box 9083
Dar es Salaam
Tel: 255 22 2120262-7
Fax: 255 22 2110986

10th December 2009

Nikila Shariff
Senior Lecturer, Aga Khan University
P O Box 30340-00623
NAIROBI

CLEARANCE CERTIFICATE FOR CONDUCTING
MEDICAL RESEARCH IN TANZANIA

This is to certify that the research entitled: An empowerment model for Nurse Leaders' Participation in Health Policy Development, (Shariff N et al), whose local Investigator is Elanor Shariff, The Aga Khan University, Tanzania Institute of Higher Education, has been granted ethics clearance to be conducted in Tanzania.

The Principal Investigator of the study must ensure that the following conditions are fulfilled:

1. Progress report is submitted to the Ministry of Health and the National Institute for Medical Research, Regional and District Medical Officers after every six months.
2. Permission to publish the results is obtained from National Institute for Medical Research.
3. Copies of final publications are made available to the Ministry of Health & Social Welfare and the National Institute for Medical Research.
4. Any researcher, who contravenes or fails to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine. NIMR Act No. 23 of 1979, PART III Section 10(2).
5. Approval is for one year: 10th December 2009 to 09th December 2010.

Name: Dr Mwelecele N Malecela

Signature

ACTING CHAIRPERSON
MEDICAL RESEARCH
COORDINATING COMMITTEE

Name: Dr Deo M Mtasiwa

Signature

CHIEF MEDICAL OFFICER
MINISTRY OF HEALTH, SOCIAL
WELFARE

CC: RMO
      DMO

Uganda National Council For Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

UNCST

Your Ref:............................

Our Ref:.............HS 590.

Date:....31/08/09........ ...

Ms. Shariff Nilufa Reyaz
Advanced Nursing Studies
Aga Khan University
Kampala

Dear Ms. Shariff,

RE: RESEARCH PROJECT, "AN EMPOWERMENT MODEL FOR NURSE LEADERS: PARTICIPATION IN HEALTH POLICY DEVELOPMENT"

This is to inform you that the Uganda National Council for Science and Technology (UNCST) approved the above research proposal on **June 08, 2009**. The approval will expire on **December 08, 2009**. If it is necessary to continue with the research beyond the expiry date, a request for continuation should be made in writing to the Executive Secretary, UNCST.

Any problems of a serious nature related to the execution of your research project should be brought to the attention of the UNCST, and any changes to the research protocol should not be implemented without UNCST's approval except when necessary to eliminate apparent immediate hazards to the research participant(s).

This letter also serves as proof of UNCST approval and as a reminder for you to submit to UNCST timely progress reports and a final report on completion of the research project.

Yours sincerely,

Innocent Akampurira
for: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

LOCATION/CORRESPONDENCE

Plot 3/5/7, Nasser Road
P.O. Box 6884
KAMPALA, UGANDA.

COMMUNICATION

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FAX: (256) 414-234579
EMAIL: uncst@starcom.co.ug
WEBSITE: http://www.uncst.go.ug

Your Ref:................HS-590

Our Ref:.............................

17/06/2010

Date:...............................

Ms. Shariff Nilufa Reyaz

C/o Agha Khan University

Kampala

Dear Ms. Shariff,

The Uganda National Council for Science and Technology (UNCST) has granted your request for approval to continue with the study entitled, **"An empowerment Model for Nurse Leader's participation in health policy"**. The approval will expire on **December 8, 2010**. If, however, it is necessary to continue with the research beyond this expiry date, a request for continuation should be made to the Executive Secretary, UNCST.

Yours sincerely,

Jane Nabbuto

for: Executive Secretary

UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

File No. HS 590

Name SHARIFF NILUFA REYAZ

Address AGA KHAN UNIVERSITY KAMPALA

Nationality KENYAN

Title of Research Project AN EMPOWERMENT MODEL FOR NURSE LEADERS

Date of issue 31 AUG 2009

Valid Until 08 DEC 2009

Holder's Signature..........

Certified Photograph

for Executive Secretary
Uganda National Council for
Science and Technology
P.O. Box 6884, Kampala

ANY ONE FINDING THIS CARD SHOULD HAND IT IN AT THE NEAREST POLICE STATION

THIS CARD IS A PROPERTY OF THE UGANDA GOVERNMENT

'ON. 698 /107/1

Renewed until..........
Executive Secretary

Renewed until..........
Executive Secretary

Renewed until..........
Executive Secretary

Renewed until..........
Executive Secretary

THE REPUBLIC OF UGANDA

UGANDA NATIONAL COUNCIL
FOR SCIENCE AND TECHNOLOGY

RESEARCH
IDENTITY CARD

Letter of Consent

Dear Sir/Madam,

Re: Request for participation to a study

I hereby request your participation in the study entitled: **"An empowerment model for nurse leaders' participation in Health Policy Development"**. The study is being undertaken in fulfilment of a doctorate degree in Nursing at the Department of Health Studies, University of South Africa. This research has been approved by the Research and Ethics Committee of the Department of Health Studies at the University of South Africa and the National Council for Science and Technology in Kenya, Uganda and Tanzania.

You are identified as an important stakeholder who is able to provide valuable information on the basis of your experience and expertise as a nurse leader on the issue of health policy development. Your participation in this study and input will be highly appreciated and valued towards developing an understanding of health care policy development in East Africa and possible ways in which nurse leaders' participation in health policy development can be enhanced in future.

Your input, as a part of an important contribution in the Delphi approach which I shall be using in this research, will be integrated with the contribution of other stakeholders. The integrated responses will be fed back to you in two follow up rounds in which you will be requested to provide further input on the issues under discussion.

Your participation in the study is voluntary. You may withdraw from the study at any point without any retribution. If you decide to participate, please complete the attached questionnaire and return it to me. Return of the completed questionnaire will be considered as consent to participate in the study. Completion of the questionnaire should take approximately **40** minutes. I would appreciate your response within the next two weeks and I undertake to give you a feedback in four weeks following that.

Throughout the process, your participation is voluntary and anonymous. It is therefore very important that you feel comfortable to share your opinion freely and honestly. The nature of Delphi requires that your address be known to the researcher. Your details will be known to the researcher alone and anonymity will be sustained throughout the study by using codes and symbols.

Thank you

Nilufar

Nilufa Shariff

Participant Signature _____

Date_____

First Round Delphi Questionnaire

Please answer all questions by either ticking the relevant boxes ☑ or writing your answers in the spaces provided.

Section 1

1. Please indicate your country

Kenya ☐

Uganda ☐

Tanzania Mainland ☐

Zanzibar ☐

2. Please indicate the organization that you represent

National Ministry of Health Offices ☐

Nursing Council ☐

Nursing Association ☐

Provincial/regional Matron ☐

Others specify _____

3. Your postal address

_____
_____
_____

Telephone Number _____

Fax number _____

Email address _____

4. Age

25 – 30 ☐

31 – 40 ☐

41 – 50 ☐

51 – 55 ☐

5. Gender

Male ☐

Female ☐

6. Please state your current job position?

_____

_____

_____

_____

7. Number of years of experience in nursing post basic training

0 – 5 ☐

6 – 15 ☐

16 – 25 ☐

26 - 35 ☐

> 36 years ☐

8. Number of years in the current position

0 – 5 ☐

6 – 15 ☐

16 – 25 ☐

26 - 35 ☐

> 36 years ☐

9. Highest level of education

Diploma ☐

Bachelor's degree ☐

Masters degree ☐

Doctoral degree ☐

Other ☐

Section 2

10. Briefly, describe the major components of your current job position

_____
_____
_____
_____

11. Are you a member of any nursing professional organization?

Yes ☐

No ☐

12. Briefly describe, your role in the professional organization?

_____
_____
_____
_____

13. In your experience you find that (please tick the one(s) that applies most closely):

Individual nurses participate in nursing related health policy issues in their individual capacity ☐

Nurses participate in nursing related health policy issues which affect the profession ☐

Nurses **represent nursing and participate in broader** health policy development ☐

Nurses **lead i**n setting the agenda for health care policy/reform ☐

14. In your experience, how do nurse leaders' get involved in health policy development?

_____
_____
_____
_____
_____
_____
_____

15. In your experience, what **leadership attributes are essential** to participate in health care policy development? Substantiate

_____
_____
_____
_____
_____

16. What are your leadership **attributes?**

_____
_____
_____
_____
_____

17. Please state the leadership attributes **you would like to develop** as a nurse leaders' to enhance your participation in health care policy development

_____
_____
_____
_____
_____

18. Have you ever been involved in policy development at (tick all relevant levels):

	YES	NO
Global level (e.g. WHO, ICN)	☐	☐
Regional level (e.g. EA region, WHO Afro region)	☐	☐
National level	☐	☐
Provincial level	☐	☐

19. If yes, what stage of policy making have you been involved in (tick all relevant stages):

	YES	NO
Problem identification and agenda setting	☐	☐
Policy formulation	☐	☐
Policy implementation	☐	☐
Policy evaluation	☐	☐

20. In your experience, what are the **major barriers** to nurse leaders' participation in health policy development at:

20.1.　　　Global level (e.g. WHO, ICN)

_____
_____
_____
_____

20.2.　　　Regional level (e.g. EA region, WHO Afro region)

_____
_____
_____
_____

20.3.　　　National level

_____
_____
_____
_____

20.4.　　　Provincial level

_____
_____
_____
_____

21. From your experience, what **actions** should be taken to overcome these barriers *at:*
    21.1.   Global level (e.g. WHO, ICN)

_____
_____
_____
_____

    21.2.   Regional level (e.g. EA region, WHO Afro region)

_____
_____
_____
_____

    21.3.   National level

_____
_____
_____
_____

    21.4.   Provincial level

_____
_____
_____
_____

22. In your experience, what are **the major barriers to** nurse leaders' participation in national health policy development in terms of:
    22.1.   Problem identification and agenda setting

_____
_____
_____
_____

    22.2.   Policy formulation

_____
_____
_____
_____

22.3. Policy implementation

_____
_____
_____
_____

22.4. Policy evaluation

_____
_____
_____
_____

23. From your experience, what **actions** can be taken to overcome these **barriers** in terms of:
   23.1. Problem identification and agenda setting

_____
_____
_____
_____

   23.2. Policy formulation

_____
_____
_____
_____

   23.3. Policy implementation

_____
_____
_____
_____

   23.4. Policy evaluation

_____
_____
_____
_____

24. In your view, what **factors would facilitate** nurse leaders' participation in health policy development at:
    24.1.   Global level (e.g. WHO, ICN)

_____
_____
_____
_____

    24.2.   Regional level (e.g. EA region, WHO Afro region)

_____
_____
_____
_____

    24.3.   National level

_____
_____
_____
_____

    24.4.   Provincial level

_____
_____
_____
_____

25. In your view, what **actions** should be taken to **facilitate** nurse leaders' participation in health policy development at:
    25.1.   Global level (e.g. WHO, ICN)

_____
_____
_____
_____

    25.2.   Regional level (e.g. EA region, WHO Afro region)

_____
_____
_____
_____

25.3.   National level

_____
_____
_____
_____

25.4.   Provincial level

_____
_____
_____
_____

26. In your view, what are **the factors that would facilitate** nurse leaders' participation in health policy development in terms of:
    26.1.   Problem identification and agenda setting

_____
_____
_____
_____

26.2.   Policy formulation

_____
_____
_____
_____

26.3.   Policy implementation

_____
_____
_____
_____

26.4.   Policy evaluation

_____
_____
_____
_____

27. In your view, what **actions should be taken to facilitate** nurse leaders' participation in health policy development in terms of:

27.1.   Problem identification and agenda setting

_____
_____
_____
_____

27.2.   Policy formulation

_____
_____
_____
_____

27.3.   Policy implementation

_____
_____
_____
_____

27.4.   Policy evaluation

_____
_____
_____
_____

Thank you for your time and participation

If you have any questions concerning the questionnaire or study you can get in touch with me at **0724808081 or** nilufar.shariff@aku.edu

Nilufar Shariff

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Kenya

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11th November 2009

Dear Expert Panelist,

Invitation to participate in the second round of the Delphi study: An Empowerment Model for Nurse Leaders' Participation in Health Policy Development

Thank you for your participation in the first round of the above mentioned study. Your input has been very useful.

You are invited to participate in the second round of this study by completing the attached questionnaire. This questionnaire was developed based on the integrated responses of all the expert panelists who participated in the first round of the study. The purpose of this questionnaire is to validate statements regarding the factors that influence Nurse Leaders' participation in health policy development in terms of the barriers and facilitators.

Your input is important as this questionnaire will be analyzed and the data will be used to develop the third and final questionnaire. Your participation entails completing the questionnaire which will take you approximately 20 minutes. You are requested to indicate your agreement or disagreement with the statements. If there are any additional comments that you would like to make, please do so in the space provided.

I would appreciate your responses in the next one week so that I can send you the final questionnaire within two weeks following that.

If you have any questions concerning the questionnaire you are welcome to get in touch with me on the email address and/or phone numbers above.

Thank you

Nilufar

Nilufa Shariff

Your Name _____

Email Address_____

Please answer all the questions. Mark the option that **most closely** matches your opinion with a cross [**X**]. Please note the options are as follows:

Strongly Agree = [**SA**]   Agree = [**A**]   Undecided = [**U**]   Disagree = [**D**]   Strongly Disagree = [**SD**]

SECTION A - LEADERSHIP ATTRIBUTES

1. Leadership attributes that are **essential** to influence health policy development are:

	SA	A	U	D	SD
Political advocacy skills– lobbying (e.g. support of a cause and the act of influencing on behalf of others)					
Good communication skills – listening, speaking, writing					
Negotiation skills					
Interpersonal skills					
Being assertive					
Being confident					
Being courageous					
Being visionary					
Being proactive					
Being creative					
Being a team player					
Being collaborative/cooperative					
Having respect for others					
Having management skills – planning, organizing, supervising and evaluating					
Being knowledgeable and competent in nursing					

2. Leadership attributes that **you have** are**:**

	SA	A	U	D	SD
Good communicator - listening, speaking, writing					
Being proactive					
Being a critical thinker					

	SA	A	U	D	SD
Being assertive					
Being confident					
Being courageous					
Being a team player					
Being collaborative and cooperative					
Being a visionary leader					
Being an effective manager - planning, organizing, supervising and evaluating					
Being knowledgable and competent in nursing					

3. The leadership attributes that you would like to **develop** to enhance your influence in health policy development are:

	SA	A	U	D	SD
Political advocacy skills - lobbying (e.g. support of a cause and the act of influencing on behalf of others)					
Communication skills - listening, speaking, writing					
Management skills - planning, organizing, supervising and evaluating					

SECTION B - LEVELS OF POLICY DEVELOPMENT

4. Barriers to nurse leaders' participation in health policy development at **Global, Regional, National and Provincial levels are:**

	SA	A	U	D	SD
Lack of opportunity to be involved in the policy process by the policy makers					
Inability to actively participate in the policy process when given the opportunity					
Most appointments into policy making positions are given to doctors					
Institutional structures and systems are such that they exclude them from being part of the policy process					

	SA	A	U	D	SD
Their potential contribution to policy process is not recognized as significant by the policy makers					
Lack of experience necessary for active participation in the health policy development process					
Lack of relevant knowledge and skills necessary to participate in the policy development process					
Their level of education is low, that is, they lack university level of education (BScN)					
Lack of funds and resources to attend the forums at which the policies are developed					
Lack of confidence to air their views related to policy issues to the policy makers					
Most of the nursing leadership representatives at health policy development level are as a result of political appointments					
Most health policies are developed at the national level then forwarded to nurse leaders for implementation					
Most policy making positions are given to male leaders thus female leaders cannot participate (gender imbalance)					

Factors that facilitate nurse leaders' participation in **health policy development at Global, Regional, National and Provincial levels:**

5. Nurse leaders' participation in health policy development at Global, Regional, National and Provincial levels is facilitated by:

	SA	A	U	D	SD
Being knowledgeable and skilled in the health policy making activities at all levels					
Having at least a university level of education e.g. BScN					
Having content related to health policy development included in their basic nursing education					
Having opportunities to participate in forums where policies are formulated by policy makers					
Having experience in the health policy making process					
Being active participants in health policy development process when given the opportunity					

	SA	A	U	D	SD
Having the ability to clearly articulate health issues of concern to nursing at policy development forums/arena					
Being assertive in raising nursing concerns related to health care to policy makers					
Having nurses with the ability to influence health policy nominated to national leadership positions					
Having nurse leaders' input respected by policy makers					
Enhancing representation (numbers) of nurse leaders' at national policy making level					
Having a directorate of nursing services who is at par with the director of medical services at the ministry of health					
Having legislature that ensures that national nurse leaders are included in the health policy development process					
Having transformational leadership attributes e.g. being able to influence and being visionary					
Being politically astute - e.g. able to lobby with policy makers and influence policy of concern to nursing profession					
Having the resources needed for participation in policy development activities e.g. financial, material and human					
Being able to mobilise funds to finance policy making activities					
Having networks for support and to share experiences on policy related issues (e.g. national nurses association – intensive care nurses chapter)					
Being motivated to participate in health policy development					
Having a gender balance (in terms of appointments) at policy making forums					
Having role models from whom nurse leaders' can learn to participate in health policy development process					
Being supported by international organizations like WHO and ICN that can help to develop and strengthen the role of the nurses in health policy development					
Being an effective communicator who is able to articulate and disseminate health policy related issues					
Having the ability to engage the media to change the image of nursing					

	SA	A	U	D	SD
Being united as a profession and speaking with one voice on issues of concern to nursing profession and health services					

SECTION C - POLICY DEVELOPMENT PROCESS

6. Barriers to nurse leaders participation in **health policy development process that include problem identification and agenda setting, policy formulation, policy implementation and policy evaluation:**

6.1. Barriers to nurse leaders' participation in **problem identification and agenda setting** are:

	SA	A	U	D	SD
Health policies being developed at national level and then rolled down to other levels for implementation					
Inadequate representation (numbers) of nurse leaders at the policy making forums					
Their input is called upon on ad hoc basis and they are not part of the full policy process					
They are not recognized by policy makers, for the important contribution nursing can make in problem identification and agenda setting					
They lack knowledge and skills relevant to problem identification and agenda setting					
They lack a supportive environment in terms of mentorship and encouragement					
They lack forums to discuss policy problems and agenda items within nursing at national level					
They lack information about the policy development forums					
There is poor planning by the nurse leaders on the process of problem identification and agenda setting					

6.2. Barriers to nurse leaders' participation in **health policy formulation** are:

	SA	A	U	D	SD
Policies being made at national level and rolled down to other levels for implementation					
Lack of opportunity to be involved, by the policy makers, at this stage of the policy making process					

	SA	A	U	D	SD
Lack of adequate numbers of nurse leaders being included at this stage of the process					
Other health professionals including doctors representing nurses and nursing issues at this stage of the process					
Lack of recognition of the positive contribution that nurse leaders can make to health policy formulation					
Lack of knowledge of the health policy formulation guidelines					

6.3. Barriers to nurse leaders' participation in **health policy implementation** are:

	SA	A	U	D	SD
Lack of opportunity to be involved in the whole process of policy development					
Lack of a clear understanding of the health policy implementation process					
Policies being unclear to the nurse leaders who are expected to implement the policies					
Lack of resources in terms of financial, material and human to implement the health policy					

6.4. Barriers to nurse leaders' participation in **health policy evaluation** are:

	SA	A	U	D	SD
Lack of opportunity to be involved in the policy evaluation process					
Lack of clear monitoring and evaluation of health policies implementation process					
The process being conducted by consultants attached to the relevant ministry (ministry of health)					
Lack of directives from the ministries on the guidelines for evaluation					
The policies being attached to too many programmes making monitoring and evaluation difficult for nurse leaders					
Lack of knowledge and skills of the policy evaluation process					

7. Factors that enhance nurse leaders' participation in **health policy development process that include problem identification and agenda setting, policy formulation, policy implementation and policy evaluation:**

    7.1.   Facilitators to nurse leaders' participation in **health policy development process** are:

	SA	A	U	D	SD
Having opportunities to be included at every stage of the health policy development process by policy makers					
Participating actively in the entire policy making process when given the opportunity to participate					
Having experience and exposure to every stage of the health policy development process					
Being knowledgeable and skilled at every stage of the health policy development process					
Being able to mobilize resources for policy making activities e.g. financial, material and human					
Having supportive mentorship from nurse leaders who have been involved in and have actively participated in the health policy development					
Having positive leadership attributes like having a vision, being courageous, assertive					
Having personal confidence through encouragement and a feeling of empowerment					
Taking initiative to formulate strategies of being involved at each stage of the policy development process					
Having access to forums for nurse leaders to be able to discuss health policy issues at all stages of the process					
Cultivating cordial working relationships with colleagues within and outside the profession					
Engaging the policy makers to ensure a bottom up and top bottom approach during the entire policy making process					
Being able to lobby influential stakeholders to support nursing concerns related to health policy at all stages of the health policy development process					
Having leadership positions allocated at policy making levels					

    7.2.   Facilitators to nurse leaders' participation in **problem identification** and agenda setting are:

	SA	A	U	D	SD
Having critical thinking and problems solving skills through their education					
Having research skills and analytical skills to inform the agenda with evidence					
Having the ability to effectively communicate to and disseminate research findings to policy makers and stakeholders					

	SA	A	U	D	SD
Having access to strong nurses associations (National Nurses Association or Union)					
Being part of and actively participating in national nurses associations					

7.3. Facilitators to nurse leaders' participation in **policy formulation** are:

	SA	A	U	D	SD
Being part of the agenda setting and problem identification process					
Understanding the objectives of the policy makers and government, so that they can align nursing proposals within that context					
Being able to lobby with influential people (stakeholders) to support their suggestions in terms of the content of the proposed health policy					

7.4. Facilitators to nurse leaders' participation in **health policy implementation** are:

	SA	A	U	D	SD
Being part of the policy formulation process so that they understand and are part of the health policies being implemented					
Having the health policies accessible to them					
Being provided with resources like finances, to implement health policies					
Having forums to discuss health policy implementation issues					
Being empowered on health policy implementation					

8. Facilitators to nurse leaders' participation in **health policy evaluation** are:

	SA	A	U	D	SD
Collaboration and cooperation within and outside the profession					
Having knowledge and skills on policy monitoring and evaluation					
Being involved in formulating the evaluation tools					

	SA	A	U	D	SD
Having the necessary policy evaluation tools					
Participating in setting measurable and achievable targets of health policy evaluation					
Having funds and resources available to evaluate policies					

Many thanks for your participation

Nilufar Shariff

If you have any questions concerning the questionnaire or study you can get in touch with me at **0724808081 or** nilufar.shariff@aku.edu

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May 04, 2010

Dear **Expert Panelist**,

Invitation to participate in the third round of the Delphi study: An Empowerment Model for Nurse Leaders'
Participation in Health Policy Development

Thank you for your participation in the first and second rounds of the above mentioned study. Your input has been
very useful and yielded valuable results.

You are invited to participate in the final round of this study by completing the attached/enclosed questionnaire. This
questionnaire has been developed based on the aggregate responses of all the expert panelists who participated in the
second round of the study. This questionnaire contains items on which agreement of 90% or higher was reached. The
purpose of this questionnaire is for you to **re-evaluate statements** regarding the factors that influence - Nurse
Leaders' participation in health policy development. This is an essential round as it serves to explore whether there is
any further convergence of opinion amongst the panelists.

Your input is important as this questionnaire will be analyzed and the information gained will be used to develop an
empowerment model for Nurse Leaders' participation in health policy development. Your participation entails
completing the questionnaire which should take you approximately 25 minutes to fill. You are requested to reevaluate
the statements and state your opinion. Please answer all the questions. If there are any additional comments that you
would like to make, please do so in the space provided or on the separate sheet attached at the end of the
questionnaire.

I would appreciate your responses in the next one week.

If you have any questions concerning the questionnaire you are welcome to get in touch with me on the email address
and/or phone numbers above.

Thank you

Nilufar

Nilufa Shariff, MSN, BSN, Dip. ICU, KRN
Assistant Professor,
Aga Khan University – Advanced Nursing Studies Programme - Kenya

Your Name _____

Email Address_____

Third Round - Questionnaire

Please answer all the questions. Mark the option that **most closely** matches your opinion with a cross **[X].** Please express your opinion by using the key below:

Strongly Agree = **[SA]**   Agree = **[A]**   Undecided = **[U]**   Disagree = **[D]**   Strongly Disagree = **[SD]**

SECTION - A

Nurse Leader Characteristics

1. Leadership attributes that are **essential** for influencing health policy development

Item *(with correlating item/s from the previous round in brackets)*	List of factors that influence nurse leaders participation in health policy development *(The mean (M), standard deviation (SD) and percentage agreement (PA) of the previous round have been indicated in the brackets)*	SA	A	U	D	SD	Comments
1.1. *(5.14, 1.8, 7.1.7)*	Nurse leaders must have transformational leadership attributes - being able to influence, being visionary and inspiring a shared vision *(M=1.25, SD=0.53, PA=100%)*						
1.2. *(5.15, 1.1)*	Nurse leaders must be politically astute - able to lobby with policy makers and influence health policy of concern to nursing profession *(M=1.46, SD=0.66, PA=100%)*						
1.3.	Political skills include:						
	a) Being knowledgeable about the health issues of concern to nursing which are influenced by health policy						
	b) Identify people and build relationships with individuals dealing with your issue of interest at ministry of health level						
	c) Contact policy makers dealing with your issue of interest						
	d) Write to policy makers dealing with your issue of interest – expressing your opinion						
	e) Build coalitions – with groups that have similar interests as nursing e.g. Heart Association to influence reduction in smoking and cardiac diseases						
	f) Be willing to testify to policy makers on issues of concern to nursing profession						
1.4. *(5.23 1.2)*	Nurse leaders must be effective communicators who is able to articulate and disseminate health policy related issues - listening, speaking, writing *(M=1.21, SD=0.42, PA=100%)*						
1.5. *(5.7)*	Nurse leaders must have the ability to clearly articulate health issues of concern to nursing at policy development forums/arena *(M=1.21, SD=0.42, PA=100%)*						
1.6.	Some of the articulation skills nurse leaders must have include:						
	a) Being able to communicate effectively with colleagues in senior and junior positions						
	b) Being able to communicate in the right medium e.g. in person, on the phone, e-mail and media						
	c) Being able to craft and deliver clear messages – e.g. nursing position on proposed health policy						

		SA	A	U	D	SD	Comments
1.7. (1.4)	Nurse leaders must have good (effective) interpersonal skills *(M=1.38, SD=0.50, PA=100%)*						
1.8. (7.1.11)	Nurse leaders must be able to cultivate cordial working relationships with colleagues and others within and outside the profession, in junior and senior positions *(M=1.42, SD=0.50, PA=100%)*						
1.9. (8.1, 1.12)	Nurse leaders must be effective in collaborating and cooperating within and outside the profession *(M=1.33, SD=0.48, PA=100%)*						
1.10. (1.11)	Nurse leaders must be team players *(M=1.33, D=0.48PA=100%)*						
1.11. (1.13)	Nurse leaders must have respect for others *(M= 1.48, SD=0.67, PA=100%)*						
1.12. (1.3)	Nurse leaders must have negotiation skills that generate win-win solutions *(M= 1.21, SD=0.42, PA=100%)*						
1.13. (7.1.9, 1.9)	Nurse leaders must be proactive and take initiative to formulate strategies of being involved at each stage of the policy development process *(M=1.33, SD=0.48, PA=100%)*						
1.17. (1.10)	Nurse leaders must be creative *(M= 1.26, SD=0.54, PA=100%)*						
1.14. (5.19)	Nurse leaders must be motivated to participate in health policy development *(M=1.46, SD=0.59, PA=100%)*						
1.15. (7.1.8, 1.6)	Nurse leaders must have personal confidence through encouragement and a feeling of empowerment *(M=1.29, SD=0.46, PA=100%)*						
1.16. (1.7)	Nurse leaders must be courageous in articulating health issues of concern to nursing *(M=1.29, SD=0.46, PA=100%)*						
1.18. (1.14)	Nurse leaders must have management skills – planning, organizing, supervising and evaluating *(M= 1.25, SD=0.53, PA=100%)*						
1.19. (1.15)	Nurse leaders must be knowledgeable and competent in nursing *(M=1.58, SD=0.97, PA=96%)*						
1.20. (5.8,1.5, 7.1.7)	Nurse leaders must be assertive in raising nursing concerns related to health care to policy makers *(M=1.38, SD=0.77, PA=96%)*						
1.21. (7.2.1)	Nurse leaders must have critical thinking and problems solving skills through nurse leaders education *(M=1.33, SD=0.70, PA=95.8%)*						

Nurse Leader Characteristics

2. **Knowledge and skills that are essential for nurse leaders to influence health policy development**

		SA	A	U	D	SD	Comments
2.1. (5.1 7.1.4, 8.2)	Nurse leaders must be knowledgeable and skilled in the health policy development activities at all levels *(M=1.42, SD=0.78, PA=95.7%)*						
2.2. (5.2)	Nurse leaders must have at least a university degree - level of education e.g. BScN *(M=1.63, SD=0.97, PA=90.9%)*						
2.3. (5.3)	Content related to health policy development must be included in the basic nursing education *(M=1.54, SD=0.66, PA=100%)*						

		SA	A	U	D	SD	Comments
2.4.	The content in the basic nursing programmes may include:						
	a) Types of policy: public policy, health policy, social policy						
	b) Theories and models of policy making						
	c) Policy development process						
	d) Policy making environment: social, political and economic influences						
	e) Legislative process: district, province, national						
	f) Influencing policy: roles and responsibilities of nurses, strategies to influence policy						
	g) Analyze health policy and political issues						
2. 5. *(5.5, 7.1.3)*	Nurse leaders must have experience and exposure to health policy development process *(M=1.67, SD=0.76, PA=95.7%)*						
2.6.	Nurse leaders experience and exposure to policy development may include:						
	a) Identifying policy makers and legislators who represent nursing in the community						
	b) Understanding policy makers interests and commitment to health-related issues of concern to nurses						
	c) Analyzing nursing concerns or health issues that can be addressed through policy intervention/reform						
	d) Making presentations, that are evidence based, to policy makers and testifying at legislative hearings						
2.7. *(5.21)*	Nurse leaders must have role models through whom they can learn to participate in the health policy development process e.g. directors of medical services who are involved in health policy development *(M=1.42, SD=0.72, PA=96%)*						
2.8. *(7.1.6)*	Nurse leaders must have supportive mentorship from leaders who have been involved in and have actively participated in health policy development *(M=1.33, SD=0.49, PA=100%)*						
2.9.	Supportive mentorship for nurse leaders entails:						
	a) Accepting and seeking mentorship from nurses who have more experience in influencing health policy (expert – novice mentorship)						
	a) Having mentors who inspire, guide, advise and model behavior while they participate in influencing health policy						
	b) Being mentors to nurses with less experience in influencing health policy (peer – peer mentorship)						
2.10. *(5.18)*	Nurse leaders need to have networks for support and to share experiences on policy related issues (e.g. national nurses association – intensive care nurses chapter) *(M=1.42, SD=0.50, PA=100%)*						
2.11.	Nurse leaders should develop networks for sharing information, and feedback with:						
	a) Colleagues who have less experience than you						
	b) Colleagues who have equal experience as you						
	c) Colleagues who have more experience than you						

		SA	A	U	D	SD	Comments
2.13. (7.1.1)	Nurse leaders must have opportunities to be included at every stage of the health policy development process by policy makers *(M=1.29, SD=0.86, PA=95.8%)*						
2.14.	Stages of health policy development include:						
	a) Problem identification and agenda setting						
	b) Health policy formulation						
	c) Health policy implementation						
	d) Health policy evaluation						
2.15.	Nurse leaders should be skilled at seeking opportunity for influencing health policy development at:						
	a) Workplace e.g. hospitals						
	b) Community – e.g. the village/constituency they live in						
	c) Professional associations – national nurses associations						
	d) Government – ministry of health						
2.16. (7.1.2, 5.6)	Nurse leaders must participate actively in the entire policy making process when given the opportunity to participate *(M=1.21, SD=0.42, PA=100%)*						
2.17.	Active participation includes:						
	a) Articulating issues of concern to nursing						
	b) Ensuring that nursing is positioned in the mainstream of health policy development to acquire power and influence						
	c) being visible						
	d) being accessible						
2.18. (5.24)	Nurse leaders must have the ability to engage the media to change the image of nursing *(M=1.71 , SD=0.91, PA=91%)*						
2.19.	Media management skills include:						
	a) Articulating clearly issues of concern to nursing						
	b) Be proactive in communicating with the media on health and nursing concerns						
	c) Responding to media releases related to health and nursing concerns						
	d) Using the media as a medium for nurses to inform policy makers of nurses' contribution to health care						
2.22. (7.1.12)	Nurse leaders must engage policy makers to ensure a bottom up and top down approach during the entire policy development process *(M=1.54, SD=0.72, PA=100%)*						
2.20. (5.10)	Nurse leaders input in policy development must be respected by policy makers *(M=1.38, SD=0.50, PA=100%)*						

		SA	A	U	D	SD	Comments
2.21. (5.9)	Nurse leaders with the ability (right credentials) to influence health policy should be nominated to national leadership positions e.g. Director of Nursing Services *(M=1.25, SD=0.53, PA=100%)*						
2.23.	Nurse leaders must be able to focus the health policy agenda around health which includes health promotion and disease prevention						
2.24.	Nurse leaders must be able to ensure that the health policy agenda is not dominated by medical and curative issues						
2.25. (7.2.2)	Nurse leaders must have research skills and analytical skills to inform the health policy agenda with evidence *(M=1.33, SD=0.57, PA=100%)*						
2.26.	Research skills include:						
	a) Ability to find appropriate evidence						
	b) Ability to analyze the usefulness of evidence						
(7.2.3)	c) Having the ability to effectively communicate to and disseminate research findings to policy makers and stakeholders *(M=1.21, SD=0.42, PA=100%)*						
	d) Ability to use research evidence when advocating and influencing health policy development with regards to nursing concerns						
2.27.	Nurse leaders must have business and financial skills to ensure that they are able to secure financial resources for policy development process						
2.28. (5.17, 7.1.5)	Nurse leaders must be able to mobilise funds to finance policy making activities *(M=1.79, SD=0.72, PA=95.7%)*						
2.29. (7.2.5)	Nurse leaders must be part of and actively participate in national nurses associations *(M= 1.71, SD=0.75, PA=100%)*						
2.30.	Some activities of the national nursing organization may include:						
	a) Identifying issues of concern to nurses and health care						
	b) Drawing the attention of the public to issues of concern to nursing and health care						
	c) Taking a leadership role in the development of health policies that can improve the health of communities and ensure provision of quality health care						
	d) Gaining the collective participation and support of nurses						
2.12. (5.25)	Nurses leaders should be united as a profession and articulate issues of concern to nursing profession and health services through nurses professional organisation *(M=1.42, SD=0.78, PA=96%)*						
2.31. (5.22)	Nurse leaders should be supported by international organizations e.g. WHO and ICN that can develop and strengthen the role of the nurses in health policy development *(M=1.54, SD=0.83, PA=95.5%)*						

SECTION - B
Structures
1. **Structures that facilitate Nurse Leaders participation in health policy development**

		SA	A	U	D	SD	Comments
1.1. *(5.13)*	Having legislature that ensures that national nurse leaders are included in the health policy development process *(M=1.38, SD=0.65, PA=100%)*						
1.2.	National nurse leaders to be included in health policy development include:						
	1. Nurse leaders from National Nurses Association						
	2. Nurse leaders from Ministry of Health (national offices)						
	3. Nurse Leaders represented on Nursing Councils						
	4. Nurse leaders from academic institutions						
1.3. *(5.12)*	Nursing must have a directorate of nursing services who is on par with the director of medical services (or equivalent) at the ministry of health or equivalent *(M=1.42, SD= 0.72, PA=100%)*						
1.4. *(7.1.14)*	Nurses must have leadership positions allocated for nurse leaders at policy making levels (affirmative action) *(M=1.46, SD= 0.66, PA=100%)* e.g. permanent secretaries, Director of nursing service						
1.5. *(5.4, 7.1.1 7.1.10)*	Nurse leaders must have opportunities to participate in forums where policies are formulated by policy makers *(M=1.42, SD=0.58, PA=100%)*						
1.6. *(5.11)*	Policy makers must enhance the representation (numbers) of nurse leaders at national policy making level *(M=1.75, SD=2.03, PA=95.7%)*						
1.7. *(5.20)*	Policy makers must ensure that they have a gender balance (nurse leaders must be proportionate to the percentage of women and men in the nursing profession) at health policy development positions *(M=2.13, SD=0.90, PA=90%)*						
1.8. *(5.16 8.6)*	Nurse leaders must have resources allocated for their participation in policy development activities e.g. financial, material and human *(M=1.58, SD=0.93, PA=91.3%)*						
1.9. *(7.2.4)*	Nurse leaders must have access to strong nurses associations (National Nurses Association or Union which are allowed an unrestricted voice by legislature) *(M=1.46, SD=0.59, PA=100%)*						

SECTION - C
Policy Development Process
1. **Processes that facilitate Nurse Leaders participation in health policy development**

Facilitators - General

		SA	A	U	D	SD	Comments
1.1. *(7.1.1)*	Nurse leaders must have opportunities to be included at every stage of the health policy development process by policy makers *(M=1.29, SD=0.86, PA=96%)*						

		SA	A	U	D	SD	Comments
1.2.	For nurse leaders to be able to participate effectively in the health policy development:						
	a) The processes must be clear to nurse leaders						
	b) The processes must be pluralistic and include nurse leaders						
	c) The information related to the operation of the processes must be available to nurse leaders						
	d) The processes must be open to information, ideas, research evidence and input from nurse leaders						

Facilitators – Problem identification/agenda setting

		SA	A	U	D	SD	Comments
1.3. (7.3.1)	Nurse leaders must be part of the agenda setting and problem identification process (M=1.29, SD=0.55, PA=100%)						
1.4. (7.3.2)	Nurse leaders must understand the objectives of the policy makers and government, so that they can align nursing proposals within that context (M=1.29, SD=0.46, PA=100%)						

Facilitators - Health policy formulation

		SA	A	U	D	SD	Comments
1.5. (7.3.3 7.1.13)	Nurse leaders must be able to lobby with influential people (policy makers) to support nurse leaders suggestions in terms of the content of the proposed health policy (M=1.42, SD=0.58, PA=100%)						

Facilitators - Health policy implementation

		SA	A	U	D	SD	Comments
1.6. (7.4.1)	Nurse leaders must be part of the policy formulation process so that they understand and are part of the health policy implementation process (M=1.25, SD=0.44, PA=100%)						
1.7.	For nurse leaders to participate effectively:						
	a) Policy implementation process must be clear and transparent						
(7.4.2)	b) Having the health policies accessible to nurse leaders (M=1.21, SD=0.42, PA=100%)						
(7.4.5)	c) Nurse leaders must be empowered on health policy implementation (M=1.21, SD=0.42, PA=100%						
1.8. (7.4.3)	Nurse leaders must be provided with resources like finances, to ensure implementation of health policies (M=1.50, SD=0.72, PA=100%)						
1.9. (7.4.4)	Nurse leaders must have access to forums to discuss health policy implementation issues e.g. reduction of teenage pregnancy (M=1.42, SD=0.72, PA=95.8%)						

		SA	A	U	D	SD	Comments
1.10. *(8.3)*	Nurse leaders must be involved in formulating policy evaluation tools *(M=1.46, SD=0.51, PA=100%)*						
1.11 *(8.5)*	Nurse leaders must participate in setting measurable and achievable targets of health policy evaluation *(M=1.38, SD=0.50, PA=100%)*						
1.12	For nurse leaders to participate effectively in the policy evaluation process there must be:						
8.4	a) Clear policy evaluation process and tools developed by policy makers *(M=1.38, SD=0.50, PA=100%)*						
	b) Clarity of the outcomes to be evaluated						
8.6	c) Funds and resources available to evaluate policy *(M=1.50, SD=0.93, PA=95.5%)*						

SECTION - D
Barriers
1. **Factors that hinder Nurse Leaders participation in health policy development**

		SA	A	U	D	SD	Comments
1.1. *(4.5, 6.1.4 6.2.5)*	Nurse leaders potential contribution to policy process is not recognized as significant by the policy makers *(M=1.65, SD=0.78, PA=95.5%)*						
1.2. *(6.1.3)*	Nurse leaders input is called upon on ad hoc basis and they are not part of the full policy process *(M=1.54, SD=0.77, PA=100%)*						
1.3. *(6.3.1)*	Lack of opportunity for Nurse leaders to be involved in the whole process of policy development *(M=1.58, SD=0.72, PA=100%)*						
1.4.	Nurse leaders lack opportunity to be involved in policy development at:						
	a) Workplace e.g. hospitals						
	b) Community – e.g. the village they live in						
	c) Professional associations – national nurses associations						
	d) Government – ministry of health						
1.5. *(6.3.4)*	Lack of financial, material and human resources to implement health policy *(M=1.75, SD=1.07, PA=91%)*						
1.6. *(6.4.2)*	Lack of clear monitoring and evaluation of health policy implementation process by policy makers at the ministry of health *(M=1.88, SD=0.99, PA=91%)*						
1.7. *(6.4.3)*	The policy evaluation process is conducted by consultants attached to the relevant ministry (ministry of health) hence nurse leaders are excluded at this stage of the process *(M=1.54, SD=0.93, PA=96%)*						
1.8. *(6.4.1)*	Lack of opportunity for nurse leaders to be involved in the policy evaluation process *(M=1.33, SD=0.48, PA=100%)*						

		SA	A	U	D	SD	Comments
1.9. *(4.1, 6.2.2)*	Nurse leaders lack of opportunity to be involved in the policy development process by the policy makers *(M=1.17, SD=0.38, PA=100%)*						
1.10. *(4.4)*	Institutional structures and systems are such that they exclude nurse leaders from being part of the policy process *(M=1.58, SD=0.83, PA=95.5%)* e.g. Nurse leaders are in relatively junior positions						
1.10.	Unclear policies of recruitment of nursing leaders at policy level						
1.12. *(6.1.1 6.2.1)*	Health policies are developed at national level and then rolled down to other levels for implementation (M=1.46, SD 0.72, PA=100%)						
1.13.	These levels of health policy implementation include:						
	a) District level						
	b) Provincial level						
	c) National level						
1.14. *(6.1.2, 6.2.3)*	Inadequate representation (numbers) of nurse leaders at the policy making forums *(M=1.54, SD=0.83, PA=95.5%)*						
1.15. *(4.3)*	Most appointments into policy making positions are given to doctors *(M=1.29, SD=0.55, PA=100%)*						
1.16. *(6.2.4)*	Other health professionals including doctors represent nurses and nursing issues at health policy development forums *(M=1.58, SD=0.78, PA=100%)* as structures are not inclusive of nurse leaders						

Thank you for your support

Nilufar

Any other comments

Thank you