

**PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT: AN
ACTION RESEARCH APPROACH**

**A Thesis Submitted to the School of Nursing and Public Health: University of
KwaZulu-Natal, Durban, South Africa in Fulfilment of the
Requirements for the Degree: Doctor of Philosophy (Nursing)**

By

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Declaration

I Zanele Faith Dlamini declare that the thesis hereby submitted titled: **“Participation of Nurse Leaders in health policy development: An action research approach”** is my own independent work. All the resources and materials that have been used or quoted have been indicated and acknowledged by means of references.

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Abstract

Introduction

All aspects of nursing education, practice and research are influenced by health policy. Proactive participation in the policy arena is key to excellence in clinical practice and education for nursing. Nurses constitute the majority of healthcare personnel in most countries, playing a major role in providing quality care. South Africa has a nurse-based healthcare system with nurses comprising 80 per cent of health professionals. The nursing leadership is instrumental in influencing both policy and nursing practice. Therefore it is important that nurses understand and influence the public policy process. However, their participation in health policy development is limited, even though they play a critical role in providing care for individuals. This study contributes to the body of knowledge on the participation of nurse leaders in health policy development. It is hoped that the knowledge gained from this study may, at some point, be put into practice.

Purpose

To determine and analyse the extent of nurse leaders' participation in the health policy development process in selected regional and tertiary hospitals in the province of KwaZulu-Natal in South Africa.

Methodology

This study adopted an action research design using convergent mixed methods. Statistical data was also required to measure the effectiveness of research interventions. Both qualitative and quantitative data sources were given equal emphasis and equal weight. Eight face-to-face in-depth interviews of a minimum length of 20 minutes were conducted. Quantitative data was collected through self-administered questionnaires to 81 participants to allow for generalisation. Data were collected during 2015 to inform the diagnostic phase of the action research process. The second phase of the study consisted of a knowledge translation policy workshop and the development of a policy brief document.

Results

Findings from all data sources in the current study showed that the participation of nurse leaders in health policy development was limited, especially at provincial and national levels. Those who had participated did so at an institutional level. Nurse leaders participated only at the implementation stage. Their level of knowledge and confidence in health policy development was low, which has implications for the interpretation and implementation of the policies.

Conclusion

The findings of the study suggest that there is an increasing disconnection between policy and delivery. This serves as a barrier to involving the people who are in the frontline and responsible for delivering results, in policy development. Since nurse leaders are implementers of policy, their involvement in policy development would encourage greater ownership and result in better assessment of policy feasibility. The findings and recommendations of this study have implications for practice, education and policy-making in South Africa.

Key words: Nurse Leaders, Health Policy Development, Participation, Involvement, Action Research

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANM	Assistant Nurse Manager
AR	Action Research
CEO	Chief Executive Officer
COHSASA	Council for Health Service Accreditation of South Africa
CNA	Canadian Nurses Association
CNMO	Chief Nursing and Midwifery Officer
CPD	Continuous Professional Development
DENOSA	Democratic Nursing Organisation of South Africa
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
ICN	International Council of Nurses
JONA	Journal of Nursing Administration
KZN	KwaZulu-Natal
KZNDOH	KwaZulu-Natal Department of Health
MDG	Millennium Developmental Goals
MLIC	Middle and Low Income Countries
NDOH	National Department of Health
NHI	National Health Insurance
NM	Nurse Manager
OSD	Occupation Specific Dispensation
PHC	Primary Health Care
QAM	Quality Assurance Manager
RESON	Research on the State of Nursing
SANC	South African Nursing Council
SNO	Senior Nursing Officer
SDG	Sustainable Development Goals
SOP	Standard Operating Procedure
SSA	Sub-Saharan Africa
UKZN	University of KwaZulu-Natal
WHA	World Health Assembly
WHO	World Health Organization

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The 1994 advent of democracy in South Africa (SA) created a unique opportunity for passing new laws and policies. The legislation introduced affects the lives of individuals and society. The strain on healthcare services in South Africa is escalating, overloading nurses who are in the forefront and the largest group in the healthcare sector (Rispel, 2015). SA has a nurse-based healthcare system, with nurses comprising 80 percent of health professionals (NDOH, 2011). Nurses are closest to the patients and their families, with a responsibility of providing quality patient care. They have a better understanding of the healthcare needs of the community because they deal with demanding situations on a daily basis. They have expertise and capabilities for improving healthcare. Nursing is therefore in a unique position with the potential to achieve a high level of influence in healthcare priorities nationally. The large number of nurses and their numerous roles in various settings enable them to make decisions that could make a fundamental difference to the efficiency and success of the healthcare system (Etowa et al, 2016; Harper and Vlasich, 2016).

Nurses could play a vital role in the implementation and success of health sector reforms such as universal health coverage. They could help to accelerate interventions to meet national health targets (Ditlopo et al, 2014). Given the complexity of the SA healthcare system reform, nurses must be equipped to perform their leadership role to facilitate quality healthcare service delivery. It is important for nurse leaders to understand the rationale and the structure of healthcare changes, and the influence that nursing could have at all levels of healthcare provision. They need to direct the development of policies concerning the objectives and suitability of health restructuring during the planning stages. Their participation in the policy development process has the potential to improve health outcomes. Policy-makers and nurses should focus on the nursing responsibility in quality and cost effective healthcare approaches for achieving better health for all (ICN, 2015).

According to NDOH (2011) SA health policies are among the most progressive and comprehensive in the world. However, inconsistencies in the development and implementation of health policies and in service delivery have been observed. S.A failed to meet the Millennium Development Goals (MDGs) and had worse health outcomes than its peers. There have been calls from the health ministry to involve nurses in policies

related to health. The then SA Health Minister, Dr Manto Tshabalala-Msimang, in a speech at the Southern African Development Community AIDS Network of Nurses and Midwives Conference in 2007, mentioned that nurses and midwives must have influence in government and put forward their viewpoints to shape health policies. The decline in the HIV infections among mothers-to-be was acknowledged and nurses were urged to put more energy into the achievement of regional plans and programmes. The minister also asserted that nurses are key to ensuring the success of any healthcare policy. Furthermore, the importance of the involvement of nursing associations in policy-making and designing programmes to ensure equitable and accessible health services was highlighted. According to the minister, nurses could define the direction of health policy (Sap, 2007). The current SA Ministry of Health has also emphasised the critical role of nurses in the implementation and achievement of improvement plans in the health sector aiming at universal health coverage (Ditlopo et al, 2014).

The research on the state of nursing in South Africa (RESON 2008), identified inconsistencies in nursing organisation, leadership and policy development. There was also no relationship among the main stakeholders responsible for nursing policy development (Rispele, 2008). At the SA nurses' conference (2013), the theme was delivering quality care through nurses participating in health policies. The issue of participation of nurses in health policy decision-making was a recurring theme throughout the discussions. However, no strategies to enhance participation of nurses in health policy development were proposed. Maryland and Gonzalez (2012), agreed that nurses represent a critical force to ensure the effectiveness of any healthcare policy. Nurses are able to identify needs and fears related to health service provision because they have the advantage of being able to observe gaps and improvements in the current health system. Additionally, nursing is one of the 'highest ranking' professions and 'is consistently rated the most trusted profession' (Harper and Vlasich, 2016: 24). According to the ICN (2015), nursing has a role in contributing to health planning, policy, and the coordination and management of health services. The International Council of Nurses (ICN) encourages nurses to occupy leadership positions at all levels to enable them to participate in health policy locally, nationally and internationally, through support and advocacy by National Nursing Associations (NNAs). This would help improve the quality of the organisation of nursing and health systems.

According to Asuquo et al (2017), the IOM (2011) and Antrobus and Kitson (1999), nursing leadership is an essential driving force that could influence nursing practice and policy, and realise the vision of a transformed health care system. MacPhee et al. (2012), contend that effective nurse leaders are crucial in addressing complex issues associated with healthcare systems reforms. However, they stated that there is little information about the types of leadership development programmes that most effectively prepare nurse leaders for healthcare challenges. In South Africa, there are excellent doctoral programmes in nursing with a strong research component, but even the best of these may not offer training programmes for those who seek to specialise in health policy research and analysis (Forman et al, 2008).

Although nurses make a considerable contribution to healthcare delivery systems, their involvement in policy development is minimal. Globally nurses are not participating in policy formulation processes in the most desirable way (Harper and Vlasich, 2016; Rispel, 2015; Edwards et al, 2009). The ICN (2005) supported the contention that, in many countries, nurses have not played an active role or been given an opportunity to participate in the policy process. Traditionally, doctors and other health professionals have dictated the shaping of health policy. Nurses constituted 14 percent as opposed to doctors who formed 37 percent of policy structures (Barclay, 2010). A survey conducted by the American Hospital Association found that only 5 percent of hospital board members were nurses and 20 percent were physicians (Harper and Vlasich, 2016). Indeed, the need for nurses to be involved in policy development has been stressed, which should lead to improved quality of nursing care and better patient outcomes (Etowa et al, 2016; Arabi et al, 2014; Edwards et al, 2009). However, calls to increase nurses' involvement in policy development have not been very effective (Pan American Health Organization, 2004 in ICN, 2015).

Nurses have the ability to shape health policies. However, they will only be able to achieve this if they have the required understanding of the healthcare system as a whole. Nurses need to be aware of policy plans, policy-makers, and political conditions. Participating in health policy would assist them to achieve their professional targets and to accelerate the effectiveness of the healthcare system. They are promoters of excellence in health care improvement, but many of them lack adequate directional and individual power for advocating patients' rights (Arabi et al, 2014).

For nurses to be in a fit state to encourage patients, it is first essential for them to be inspired. They should know the levels of power, and the management of resources of health services in their organisations, as well as who is responsible. Walker and Gilson (2004) suggest that patient safety, accessing the needed resources without difficulty, and the promotion of quality health care could be safeguarded by the nurses' influence on health policy. They are possibly both a means for and likely stumbling blocks to, policy change. The limited involvement of nurses in policy participation could be the main hindrance to the effectiveness of nursing, the healthy functioning of the multidisciplinary team and the quality of care. Therefore there are many compelling motives to include nurses in policy development (Edwards et al, 2009).

1.1.1 Why nurse leaders should participate in health policy development

The literature (Asuquo et al, 2017; Ditlopo et al, 2014) suggests that nurses make up the majority of the health workforce globally and therefore the health system cannot function without nurses. Their participation will ensure that the nursing profession is not neglected in the decision-making process. Nurse leaders would bring nursing ideals to political debates and decisions. Nurses are able to recognise and define concerns, challenges and system gaps because they are in the frontline, which puts them in a good position clinically and administratively. Nurses' involvement in policy includes being a mouthpiece for patients, their families and community members in matters where the vulnerable have no chance to voice their opinions (ICN, 2015). Clinical experiences provide real-life examples showing the needs of patients and the outcomes of health policy on patient morbidity and mortality. They have knowledge of how policy decisions affect real lives. Nurses bring knowledge and skills gained in basic nursing education and in practice (Harper and Vlasich, 2016; Gebbie et al, 2000).

As researchers, nurse are uniquely placed 'to identify and pursue highly pertinent health services and policy research questions' through investigations (Edwards et al, 2009:145). The IOM (2011) suggested that nurses could potentially persuade policy-makers to shape health policy by identifying and developing evidence-improvements to care. These improvements could be tested and adopted through policy changes across the health care system. According to the ICN (2015), nurse researchers who can make policy relevant recommendations based on the findings of their studies are much needed. The future of nursing research is positive but a lot of improvements are still required to promote evidence-based nursing and policy. There are prospects of improving evidence-based

quality care considering what the combined expertise, commitment and knowledge of nurses globally could offer.

Nurse leaders have a wealth of experience in the fields of education, research, practice and management. Their expertise, if combined, would contribute greatly to the advancement of accessible, quality and cost effective health services. They have shown strong analytical thinking and problem solving abilities, good interpersonal skills, knowledge of health and disease conditions, the ability to partake in the multidisciplinary teams, negotiating among diverse groups and show remarkable creativity by doing more with less. Such skills that nurses possess are essential for political involvement. They fully understand both the fiscal and clinical implications of health policy pronouncements (Aarabi et al, 2014; Peters, 2002). According to Ditlopo et al. (2014), nurse leaders have concealed talents. They are required to manage challenging personalities, defuse unstable circumstances and handle conflicts on a daily basis.

According to the ICN (2005), nurse managers work under financial constraints in health care service delivery. They have a major role in the distribution of resources, although their role in budget decisions is limited. At the same time, they ensure the effective utilisation of supplies and equipment, and implement cost containment by preventing wasteful expenditure. They are able to motivate and advocate for the resources required for safe healthcare provision. Therefore, they are appropriately placed to advise on the implications of policies aimed at cost containment in healthcare. It is therefore important for nurses to be knowledgeable about health policy development process and its wider context, in order for them to influence decisions. If nurses do not have this understanding, they will be excluded from the process (ICN, 2005). The World Health Assembly (WHA), the highest decision-making body of the WHO, has repeatedly acknowledged that nurses are vital to the development of quality health policy and the implementation of successful health interventions (ICN, 2015).

1.1.2 Role of nurse leaders in research to inform policy

Research plays a significant part in shaping healthcare policy. However, 'research is often seen as an ivory tower activity and far removed from the daily work of nurses' (ICN, 2015:36). Research is part of the nurse's daily work and it must be recognised that every

nurse has a key role to play in it. As scientists and clinicians, nurses need to understand that policy, research and practice are inherently linked. They must engage in the policy process to help ensure that scientific evidence is used to inform and guide public policy. The healthcare system would be more effective, more responsive and more successful if nurses were forerunners in health science research. For nursing research to shape policy, it has to focus on major health issues affecting the community; the relevance of other disciplines; partnership with interdisciplinary teams of investigators; patient and family needs; and incorporation of the complexity of health issues (Grady, 2010). The mind-sets of policy-makers on the value of research could be changed by nurses through data, the sharing of their expertise, and by providing substantial evidence on behalf of different professional associations (Hall-Long, 2009).

1.2 PROBLEM STATEMENT

The study is based on the premise that nurses and nurse researchers in SA are undervalued in the decision-making circles that inform the nation's health policy. It is known that nurses are the core of the health system, yet nursing is relegated to the margins of health policy-making (Harper and Vlasich, 2016; Tarlov, 1999). "Nurses are at the core of healthcare delivery but marginalised from involvement in health policy development and decision-making" (ICN, 2015:40). The absence of nurses' involvement in policy development could be a major barrier to nursing effectiveness, health team functioning and quality of care.

Several studies (Arabi et al, 2014; Ditlopo et al, 2014; Juma, 2014; Shariff and Potgieter, 2012; Fyffe, 2009; Antrobus and Kitson, 1999) have examined the participation of nurses and nurse leaders in health policy development. Conclusions showed that nurses' role in health policy was limited. They often had little input into the development of health policy and participated only at the operational level of implementation. Nurse leaders were required to translate and interpret policies but were not involved in developing those policies. Thus the policy-making process was perceived as top-down in nature.

Studies conducted in Sub-Saharan Africa (SSA) and the Caribbean countries (Richter et al, 2012; Muller, 2010) mainly focused on the participation of registered nurses (at HIV clinics) in AIDS policy development. Results showed that although nurses played a leading role in HIV and AIDS prevention, their participation in the development of the

policy was limited. Moreover, they were not consulted on the ground. Their primary role was to implement policies, so they had no knowledge of the policy development process. However, the role of the nurse leaders and the level of their participation were not explored.

A study conducted in East Africa (Shariff and Potgieter, 2012) also found that the role of nurse leaders was limited and was not consistent across all the stages of health policy development. Furthermore, doctors occupied the majority of policy development positions, and other health professionals represented nursing matters at health policy development forums. The study also excluded nurse leaders (nursing practice experts) at healthcare facilities, so their views and role are not known.

Factors contributing to the lack of participation of nurses in health policy, from the perspective of Etowa et al (2016), Robinson (2013), Chase (2013), Kunaviktikul et al (2010) and McAskill (2009), include political factors, gender issues, financial issues, resource limitations, lack of skills training in policy development, lack of academic preparation, lack of leadership competency, the poor image and status of nursing and an inability by policy-makers to use research to influence policy-making. Moreover, nurses have limited skills in public relations, which influences their ability to justify and promote what they do, as well as lacking the knowledge and skills required in the policy process. There is also a lack of understanding regarding the reasons or benefits of their involvement, and they experience a lack of support from other sectors, such as the political sector, government officials and professional organisations. Their participation in the health policy development process has also been restricted by their having few opportunities to exchange ideas with policy-makers (Edwards et al, 2009).

It is necessary to strengthen the role of nurses and nurse leaders in healthcare policy development globally, particularly in South Africa (Rispel, 2015). However, there is scant literature in Southern Africa that analyses participation of nurse leaders in all the stages of the health policy development so as to understand the nature of policy processes and strategies that may facilitate increased participation. The nature of policy processes (how policies are made, and by whom) affects their relevance and often their execution. This often results in multiple interpretations or misinterpretation of policies in the absence of guidelines. For instance, Ditlopo et al. (2014) found that there were variations and inconsistencies in the application of the Occupation Specific Dispensation (OSD) policy in four selected provinces in South Africa namely Gauteng, Eastern Cape, Western Cape

and Free State. The various provinces and institutions interpreted the policy differently, which resulted in unintended negative consequences. Implementation of both the OSD and the nursing strategy policies were widely considered to be weak.

These findings were congruent with those of Motsosi and Rispel (2012), who indicated that the OSD was not correctly implemented because some clauses in the policy were misunderstood. The perceived undesirable aspects of the OSD related to policy design, but primarily to implementation (different interpretations of the policy, mistaken or unsettled payments), leading to unintended consequences such as unhappiness among nurses who did not benefit or whose posts were incorrectly translated. Khunou and Davhana-Maselesele (2016), observed that the draft OSD policy was not submitted to nurses for inputs. Furthermore, the NDOH did not conduct implementation workshops on the policy, which led to confusion.

Shariff and Potgieter (2012) mentioned that nurse leaders were not aware of the policy formulation guidelines. Moreover, they did not clearly understand the policy implementation process. Policies were ambiguous to the nurse leaders who were expected to implement them. A better understanding of these processes could help policy-makers to propose more relevant and effective policies and support other policy actors involved with these processes (Green et al., 2011).

Shariff and Potgieter (2012), stated that much of the related literature so far derives largely from the Western context. Furthermore, participation of nurse leaders in health policy could be improved only if this phenomenon was investigated by gathering evidence-based knowledge and information. The World Health Organization (2012), found that research on health policy analysis is frequently merely descriptive and applies only to limited contexts, thus providing little insight into its main questions of how and why policies are formulated and successfully implemented as time goes on. In low and medium income countries (LMICs) there are very few national researchers dealing with health policy and systems studies, and appropriate training courses are lacking (WHO, 2012).

Despite the wealth of information in the studies on participation of nurses in health policy, the perceptions of policymakers are not well documented. Furthermore, in the majority of the published studies, practical strategies to enhance participation are missing. The strength of the current study lies in its action research approach to policy development,

which is under-represented in the literature. The WHO's objective of strengthening nursing and midwifery cannot be met if nurses are absent at the decision-making level, and their role is "as critical at the policy table as it is at the clinical level" (Pfeifer, 2012:17).

The ICN (2015), suggested that there is a need for nursing research that produces new knowledge on what works and what does not work in relation to involving nurses in shaping health policy, for example by identifying barriers and facilitating factors. It is important to establish whether these aspects are internal or external to the profession. This knowledge is essential for developing strategies to eliminate barriers and to facilitate the participation of nurses in health policy development (ICN, 2015). South Africa is undergoing a transition in the democratic process, with policies in all sectors undergoing reform, including the health sector, such as the National Health Insurance, Primary Health Care (PHC) Re-engineering and Sustainable Development Goals. It is therefore important to know to what extent nurses were involved in the development of these policies, and what barriers and facilitations were experienced during this process.

1.3 RESEARCH QUESTIONS

1.3.1 General question

To what extent do nurse leaders participate in health policy development?

1.3.2 Secondary questions

- How informed are nurse leaders about their role in health policy development?
- How have nurse leaders participated in the health policy development process?
- What factors facilitate the participation of nurse leaders in health policy development?
- What factors limit the participation of nurse leaders in health policy development?
- How do policy makers involve nurse leaders in the health policy development process?
- What gaps exist in the nurse leader's participation in health policy?
- What strategies could be adopted to enhance nurse leader participation in health policy development?
- What strategies could be implemented to enhance nurse leaders' participation in health policy development?

1.4 RESEARCH PURPOSE

To determine and analyse the extent of participation of nurse leaders in the health policy development process.

1.4.1 Objectives

- To establish the level of nurse leaders' knowledge of their role in health policy development
- To analyse the level of participation of nurse leaders in the health policy development process
- To determine factors that facilitate participation of nurse leaders in health policy development
- To determine factors that limit participation of nurse leaders in health policy development
- To establish how policy makers involve nurse leaders in policy development
- To analyse gaps in the participation of nurse leaders in health policy development
- To identify and strategies for enhancing nurse leaders' participation in health policy development
- To collaboratively implement strategies for enhancing nurse leaders' participation in health policy development

1.5 OPERATIONAL DEFINITION OF TERMS

The following definitions have been adopted in this study:

- **Nurse leaders:** For the purpose of this study, a nurse leader refers to nurses in leadership positions from the level of an assistant nurse manager (ANM), nurse manager (NM), Senior Nursing Officer and Chief Nursing and Midwifery Officer. The term further encompasses a nurse in a formally elected or nominated national leadership position at a university, national professional association, the South African Nursing Council (SANC) or Ministry of Health, or their equivalent.
- **Policy:** A policy refers to a proposed course of action of government, or guidelines to follow to reach goals and objectives, and is continuously subject to the effects of environmental change and influence (Hill and Varone, 2017; Buse et al, 2012).
- **Health policy:** Health policies are formal, written documents, rules and guidelines that state the policy makers' resolutions about reasonable actions that are thought to be required to strengthen the health system and improve health (WHO, 2012). In this study, "policy" and "health policy" are used interchangeably.

- **Policy development process:** This addresses matters such as issue emergence, policy agendas, the definition of policy problems, policy formulation, political practicality and policy implementation (Birkland, 2014). The study uses the same meaning.
- **Policy maker:** This is a member of a government department, legislature, or other organisation who is responsible for making new rules, laws, etc. (Cambridge English Dictionary and Thesaurus). The same meaning is adopted in the study. The national and provincial departments of health and the South African Nursing Council are the key policy-makers in South Africa.
- **Participation:** This means the processes and activities intended to inform, consult and involve nurse leaders to allow them to make inputs into the decisions that affect them.
- **Policy brief:** A policy brief is a document that provides a succinct explanation and analysis of a policy issue or problem, together with policy options and recommendations for addressing that issue or problem (Keepnews, 2016).
- **Policy environment:** This refers to the structural, social, economic, political and other factors that guide and are affected by policy-making (Birkland, 2014). The same meaning is used in this study.
- **Policy actors:** This refers to both individuals and organisations with power that are involved, or should be involved, in policy processes. These include nursing leadership, nurse managers and assistant nurse managers, nurse leaders at national and provincial level, nurse educators and organised labour.
- **Mobilising:** This is a process by which a people or groups are motivated to take action, such as lobbying, protesting, or any other form of expression in response to an issue or problem (Birkland, 2014).
- **Lobbying:** The term applies to the organised and constant process of pushing the legislative or executive branches to endorse policies that promote an individual's or group's interest (Birkland, 2014). This meaning is used in the study.

- **Policy domain/arena:** This refers to the place, space and substantive area of policy over which participants in policy-making debate and reach an agreement.
- **Stakeholders:** According to Mason et al. (2016) stakeholders are those directly impacted by specific policy decisions, who may be involved in the policy making process. This meaning is used in this study.

1.6 SIGNIFICANCE OF THE STUDY

The study outcomes will benefit at least four groups: current and future nurse leaders, human resource development professionals, nurse educators and future researchers. The study will be beneficial as it is of importance and relevance to nurses and nursing, especially in South Africa. From the health care, patient outcomes and the nursing profession angles, the researcher's position is that if health policies are geared towards producing the best outcomes, they should be formulated with input from nurses. The nurse leaders who participated in the study benefited by gaining information related to policy development issues through the capacity-building workshop. They also applied the knowledge gained in an informed way by developing a health policy brief. The participants' enthusiasm was enhanced by a sense of ownership of the policy, having participated in its development.

Montavlo and Veenema (2015), suggested that nurses must be engaged in ongoing professional development on health policy. Furthermore, nursing education programmes would have to include courses that empower nurses to assume an active role in the policy process. Priority content areas or approaches for inclusion in the nursing education curriculum and leadership development programmes were identified and recommendations made. The nurse educators and leaders could use the findings and recommendations of this study to design specific strategies to create an enabling environment that would facilitate nurses' participation in policy development.

The study contributes to the research base and theory of nursing science. The strength of this study is the action research approach, which is under-represented in the literature. Researchers doing similar work will also benefit, and there may be aspects of the method that would interest researchers in other areas. The findings of the study will identify strategies for enabling nurses to participate in health policy development.

1.7 OUTLINE OF CHAPTERS

This thesis is made up of chapters outlined below:

- Chapter One:** This is an overview of the study. This chapter presents the background to the study, the problem statement, the research questions and objectives and the significance of the study.
- Chapter Two:** This chapter summarises major findings in the literature pertinent to the study.
- Chapter Three:** This chapter explains the methodology. It describes the philosophical basis for the approach adopted by the study, the research design and procedures for sample selection, data collection and data analysis.
- Chapter Four:** This chapter presents results and analysis of data collected during the study. They are organised and presented in the form of descriptive summaries, tables and narratives.
- Chapter Five:** This chapter presents the policy workshop. The action part of the diagnostic phase was in the form of a capacity building workshop.
- Chapter Six:** Discussion of the major findings of the study, the quantitative and qualitative data.
- Chapter Seven:** Discussion and reflections on the policy workshop findings.
- Chapter Eight:** Conclusion, recommendations and limitations are presented.

CHAPTER 2 CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this chapter is to discuss literature reviewed in relation to the participation of nurse leaders in health policy development. Polit and Beck (2012), assert that there are two major purposes for a literature search: to understand the status of modern knowledge and also to develop a line of reasoning that supports the need to conduct a study. According to Burns and Grove (2005), the literature review forms the theoretical and analytical framework that serves as the foundation for a research study. Not only is the researcher assisted in identifying the methodological techniques used to research similar phenomena, but also in identifying contradictory findings. This chapter presents selected literature which gives a background to the study and gaps in current knowledge related to the issue of interest.

The literature was reviewed utilising databases available through the UKZN library, which included EBCOHOST, Sabinet Science Direct, Academic Search Complete, and Google Scholar. E-Journals such as the Journal of Public Policy, the Journal of Nursing Administration (JONA), and the Nurse Leader. Theses, textbooks and e-books were also reviewed. The abstracts of all studies and publications were selected, based on their relevance to the subject under investigation. A rapid examination of the literature was undertaken to identify key questions that would clarify the theoretical and practical phases of the policy development process. In addition, a search was conducted on the issue of how to ensure that the voices of nurse leaders meaningfully influence policy priorities and directions.

2.2 THE LINK BETWEEN POLICY, RESEARCH AND PRACTICE

Policy and practice cannot be studied alone without also considering the impact of research. These areas are “intrinsically linked through dynamic interrelationships, which are characterised by synergies, resonance, and reciprocity” (Grady, 2010: 268). It must also be understood that research and practice do not exist in isolation. They are shaped by the same forces that operate at all levels of society, including political and socioeconomic factors. If researchers want to influence policy and practice, they must be able to identify and deal with external factors that might affect the uptake of their research (Uzochukwu et al, 2016; Grady, 2010).

Policy, research and practice are linked as stages in a process or a cycle. According to Walugembe et al. (2015), research can enhance policy decisions about resource allocation for services and programmes, as well as decisions about how to deliver and finance those services. It can facilitate innovative changes that lead to improved client outcomes and promote critical thinking and reflective practice. However, the authors see evidence as a remote resource which requires a vigorous approach to make it reachable, contextualised, utilisable and implementable. Evidence is used in the formulation of policy and practice guidelines. Once the research evidence is generated, it is synthesised and needs to be effectively communicated within a clear framework to guide policy, which in turn guides practice. Policy adoption and implementation is enhanced through the incorporation of evidence and in consultation with service managers (Hector et al, 2008).

According to Grady (2010), the links between policy, research and practice appear at various levels. For meeting health needs, policy needs to be integrated with scientific research and concrete interventions. The outputs of such research can be converted into action that will help tackle health problems more effectively. Walugembe et al. (2015) and Curran et al. (2011) also support that research findings could only have an impact on health outcomes if healthcare organisations, systems and professionals adopt them in practice. Research findings could enhance policy decisions about resource allocation for services and programmes and decisions about how to deliver and finance those services. It can facilitate innovative changes that lead to improved client outcomes and promote critical thinking and reflective practice. Grady (2010) calls for nurses to be proactive in all three areas to ensure that the highest standard of science provides the basis for public policies and that these policies are in line with the best interests of the public being served. In addressing today's challenges, policies and action are based on current scientific knowledge and experiences learned from the past. Research also enables practitioners to anticipate future challenges. Sustainable development and sound health policies require foresight and long term planning. Research and practice inform and help to shape public policy, which in turn influences research and practice (Grady, 2010).

In many discussions regarding the influence that research can have on policy and practice, there is an assumption that both policy and practice are shaped in the same way. However some disconnections have been noted by Jansen et al. (2010) between policy-makers, researchers and practitioners. The authors assert that policy-makers define a health

problem in terms of its relevance to their political ideology, practitioners define the same problem in terms of its relevance to perceived needs of individuals, while for researchers the problem must be relevant to theory, the existing body of knowledge and the interest of the investigator. Practitioners and researchers have no official power to decide over policy formulation and have limited influence on the political decision to approve or not approve a proposal. Each field is valued differently from the others in terms of status (Jansen et al, 2010).

2.2.1 Policy and research

Health policy emanates from various sources such as research studies, practice guidelines, expertise from practice-based backgrounds and community choices. However, what constitutes good evidence for health policy and whether evidence gathered by public health researchers is, in itself, adequate to guide policy, is still debatable (Humphreys and Piot, 2012). Decisions that policy-makers make are compelling as they are based on data results, which makes the credibility of research critical to its quality. Included in the data results are characteristics and levels of evidence that must be presented in language that policy-makers, who are not health professionals, can appreciate, since they make policy decisions. In supporting the decision to pursue a policy-based approach, evidence is critical. The effectiveness of evidence-informed decision-making is seen when research is integrated at all stages of policy and programme development. The relationship between policy and research is evident when those formulating or implementing policy cite the research evidence that informs their thinking and proposal (Grady, 2010).

2.2.2 Research policy models

The following models have been developed by Becker et al. (2012) to describe the link between policy and research and how the interaction between the two takes place.

- The **knowledge-driven model** assumes that research conducted by experts leads to policy.
- The **problem-solving model** assumes that policy is followed by research and that research priorities are shaped by policy. Thus, research supplies empirical evidence on which policy-makers can base their decisions and choices.
- The **interactive model** portrays policy and research as mutually influential.
- The **political/tactical model** suggests that the research agenda is politically driven and that policy is the outcome of a political process. Research can become political

ammunition or it can be ignored if it does not coincide with the answers that politicians want to hear. Sometimes, the very fact that research is taking place is important for political and tactical purposes, rather than the findings themselves. That is why research is sometimes seen as a political activity.

- The ***enlightenment model*** sees research as serving policy indirectly, addressing the context within which decisions are made and providing a broader frame for understanding and explaining policy (Becker et al, 2012).

According to Becker et al. (2012), research should provide directional inputs (to introduce and advance policy) as well as correctional inputs (to amend policy that is moving in the wrong direction) in order for the health policy and systems research to be most effective. While doing so, it must be understood that the role of research is that of an enabler (shaping policy) and not that of a decision-maker (making policy). In making decisions on matters such as speed, resources and diversions in the event of unexplored barriers, or new demands that may suddenly call for a change of course, the policy maker or implementer remains the driver.

2.2.3 Research and practice

Nurses are increasingly expected to implement evidence-based practice (EBP). Polit and Beck (2009) define EBP as the use of the best clinical evidence to make patient care decisions. Research needs to be incorporated so that clinical decision-makers are professionally accountable to their clients. As research is conducted over time, knowledge on the topic accumulates. In turn, knowledge is used in different degrees and at various rates. Evidence-based practice is defined as the combination of the best research information with clinical capabilities and patients' needs in the provision of quality, cost effective health care. The best research evidence is, therefore, the knowledge generated from high quality study findings to address a practical problem (Ellis, 2016; Burns and Grove, 2009).

Evidence-based practice assumes that it is practical and desirable to base practice on knowledge of what works. The extent to which research can inform professional practice is dependent on many factors. Research that does not come to the attention of professionals or policy-makers cannot inform their decision-making in any way. How it is disseminated and communicated and what people do with it is critical to whether that research will have influence on practice. For practitioners to take any notice and use

evidence as the basis for practice also requires them to be committed to the ideology of evidence-based practice (Becker et al, 2012).

Discussion on policy and practice assumes that there is a strong advantage for policy-making and professional intervention when research informs these activities. Burns and Grove (2009) contend that a team effort is required, and that the researchers, policy-makers and consumers synthesise the best research evidence for developing standardised guidelines for clinical practice. Knowledge generated through research is essential for describing, explaining, predicting and controlling nursing phenomena. Through research, nurses are able to describe current nursing practice issues, discover new knowledge and promote understanding of situations so that new knowledge can be used to improve practice. Research enables nurses to base their practice on planning nursing care, predicting possible outcomes and initiating activities to promote desired behaviour. The translation goal is to strengthen links between policy, research and practice (Ellis, 2016). According to this strategy, research findings should inform policy and practice. However, it has been noted that evidence is often unsuccessful in informing policy and practice, and that research is often not based on policy needs. The WHO aims to facilitate collaborative relationships between researchers and those who use research evidence, including policy-makers. Research translation is the process by which the evidence produced by research is turned into policy, practice and product development. In addition, the dissemination of health information and evidence to different target audiences requires improved communication methods (WHO, 2012).

2.2.4 Utilising research to inform policy

Research utilisation refers to that activity by which particular research-based knowledge (science) is implemented in practice (Squires et al, 2011). Literature suggests two main ways of applying research: first, to inform health policies, strategies and practices, particularly within health systems; and second, for producing new tools (drugs, immunisation devices and other products) to improve health. The population can be educated and public opinions and practices can be changed through the use of research. There is consensus with regard to the gap between what current health systems are achieving and the needs that health systems should be addressing. This is due to an inability to synthesise and apply available research data towards improving interventions and the functioning of health systems (IOM, 2017; Walugembe et al, 2015; Squires et al, 2011).

Research utilisation scholars often express concern about whether nurses use the best existing scientific evidence to guide policy and their clinical practice. This disparity between the availability of research evidence and its use in practice is known as the research-practice gap (Squires et al, 2011). According to Senkubuge and Mayosi (2012), South Africa is the emerging leader in Africa in the field of the synthesis and utilisation of research. However, that argument is based on other health professionals, as there is limited knowledge on the state of South African nurses where utilisation of research to inform policy is concerned. The authors further suggested that knowledge generated by health research is of benefit to the public internationally, as it contributes to the development of evidence-informed policies and an improvement in the performance of health systems (Senkubuge and Mayosi, 2012).

In order to meet national or global indicators such as the SDGs, a well-functioning health system must be able to produce access and use research-based information and the products of research. However, there is no nationally agreed-upon framework for research utilisation in South Africa. There is also a virtual absence of national planning, organisation and application of research into policy, health innovations, programmes and practice (Senkubuge and Mayosi, 2012).

2.2.5 Factors influencing uptake of research utilisation in policy

Determinations made based on research evidence may be costly, but could also be lifesaving. Effective interventions are often not translated into policy or implemented. For some health issues, clear evidence is not available regarding highly effective and appropriate interventions (Fernandes and Mariano, 2007). There are factors that influence the utilisation of research findings in any setting. A study on the uptake of research findings into policy was conducted in three countries, namely South Africa, Mozambique and Zimbabwe. The relationship between policy and research was found to be complex. Research utilisation to inform policy varied enormously among the countries, depending on whether or not the issue was viewed as a policy problem and placed on the policy-making agenda. Willingness to accept and make use of the research findings varied among policy-makers. This suggests that if there is buy-in from policy-makers and they are open to new ideas, then that evidence is bound to be utilised. The utilisation of research is also contextual; it depends on the applicability of research in that area. In some instances, policy is informed by local research and experience (Fernandes and Mariano, 2007).

Interest groups also play a part. For instance, Non-Governmental Organisations such as the Medical Research Council (MRC) have a positive influence on the profile and outcomes of the study. Funded studies are more likely to be acknowledged and policy-makers are more receptive to them than they are to recommendations from non-funded studies conducted by individuals. This may be due to political risks. Policy-makers are exposed to criticism for failures related or even unrelated to policy. The integrity of both evidence and researcher play a significant role in the use of research. Access to information resources such as the Internet also influence research utilisation (Hanney and González-Block, 2011).

2.2.6 Perceptions of nurses on research utilisation

Estabrooks et al (2011), revealed that research was not utilised in day-to-day practice, and that nurses were not active in conducting research. Many of the surveys conducted attempted to capture research application at the bedside by particular practitioners. However, it was not stated what it meant to those individuals to use research and what the result of this may be. Another study described nurses' use of research two years after graduating, as well as changes in their research use in relation to working conditions. Nurses' research utilisation was reported as being relatively low in both the first and second years after graduation (Forsman et al., 2012).

The researcher considers these findings as supporting previous claims by Jansen et al (2010) and Squires et al (2011) of an ongoing disjuncture between theory and practice, research and clinical application, and academic education and nursing practice. The actual reasons for this situation are, however, still unknown. A study conducted by Gathi (2012) presented different findings from Forsman et al (2011) and Estabrooks et al (2011) whereby the majority of nurses utilised research in their practice. In addition, it was found that a significant number of nurses had conducted research. However, barriers were identified, the most common ones being a lack of academic qualifications, experience, time and resources.

2.2.7 Perceptions of policy-makers and researchers on research

Studies have shown that neglect of the relevant evidence is mainly due to a lack of communication, discussion and support between policy-makers and researchers. There is limited knowledge about the system of working collaboratively among policy-makers and researchers, and also about barriers to facilitating policy discussions. Furthermore, little is

known about the views of researchers regarding factors that might enhance their participation in policy-relevant research and dialogue with policy-makers (Campbell et al, 2009).

A study conducted by Campbell et al (2009) in Australia and New Zealand explored the perceptions and practice of policy-makers and researchers concerning the use of evidence in policy. The use of research by policy-makers to inform policy agendas or to evaluate the effectiveness of policy was reported to be minimal. Generally, the policy content was informed by research. Most researchers reported that they used their evidence to inform local policies, mainly by increasing awareness around an issue. Policy-makers, on the other hand, had difficulty in accessing valuable research findings. Targeted strategies to inform policy-makers of the research findings were developed by only a third of the researchers. Both policy-makers and researchers were interested in further dialogue. This was seen as an important move towards improving the use of research evidence in policy. However, policy-makers were reported to have a high level of interest in research (Campbell et al., 2009). This suggests that some policy-makers and researchers are working in silos and that communication between the two parties is not adequate. There is a lack of reception for research among policy-makers and no reward is given to researchers for contributing to policy. The study did not further elicit what informed their policy agendas, how their priorities were set, or any consultation process that took place with the people that the policy was directed at.

Another study was conducted in six countries, namely Argentina, Egypt, Iran, Malawi, Oman and Singapore, to explore the perspectives of policy-makers on the use and implications of research. Informants demonstrated a substantial acknowledgement of research and its significance in policy formulation. They listed a string of limitations and enablers for the interpretation of research results into policy, such as inadequate or ineffective communication of research results, limited ability within countries to conduct research that was relevant research, and political constraints. There are no formal avenues for sharing research findings with policy-makers. The relationship between policy and politics also affects the extent to which policies can be (or are) based on research (Hyder et al, 2010). Communication seems to be a major problem in many countries. Uzochukwu et al (2016) found that in Nigeria, while researcher-practitioner linkage appeared to be good, communication with policymakers was poor. The communication gap between researchers, donors and policymakers may explain the poor

uptake of research outputs by policymakers. Furthermore, the research outputs and policy briefs were advertised but rarely used, one of the reasons being that they lacked operational guidelines for policy implementation in line with recommendations.

2.2.8 Barriers to research utilisation

There is growing concern that the findings from research studies are not being applied in clinical practice, which is not in line with evidence-based practice. The literature has shown that there is little harmony among different research initiatives. This makes it increasingly difficult for all stakeholders to know what research is being undertaken and to what extent current research efforts meet priority needs. Understanding of priority needs is not clear, as different constituencies define priorities from their own perspectives. The role of nurses in a research priority setting remains extremely limited. Furthermore, limited access to relevant research evidence continues to hinder effective utilisation of research results for disease control efforts in developing countries. Barriers to be overcome include the lack of standards in health informatics, problems of affordability and language, and copyright restrictions on the use of research data and materials (WHO, 2012).

Barriers to nurses' research use have been widely studied in different countries, such as Taiwan (Chen et al. 2013); Eastern Turkey (Tan et al, 2012); Saudi Arabia (Omer, 2012) and Korea (Oh, 2008). The barriers to research utilisation were found to be similar across countries. Factors that prevented nurses from implementing research findings included poor communication, lack of time, lack of institutional or financial support, insufficient support from colleagues, shortage of personnel and resources, misunderstanding of research reports, lack of appropriate capacity to disseminate knowledge, research that lacks validity and reliability, lack of generalisability of findings, lack of knowledge, personal scepticism, and the dependence of nurses on doctors and managers in making changes in clinical practice.

The more educated nurses were, the more they understood and conducted research. It is not stated how then their findings were communicated and the impact of their studies. The nurses with less clinical experience expressed barriers to research utilisation more frequently. Research utilisation has been shown to be related to nurses' personal factors such as their levels of education, their rank, and the department where they were working. However, research utilisation among Taiwanese nurses included other factors, such as their age and marital status. Marital status, in particular, was significantly associated with

nursing competencies. For instance, married nurses showed more competence in nursing than unmarried nurses, including research participation (Chen et al, 2013).

In Korea, a study was undertaken in a large tertiary university hospital where it was expected that research and education were valued. The results were no different. Research activities were relatively low. The main barriers to the use of research that were identified were a lack of direction for clinical application and insufficient time to implement new ideas in the clinical area (Oh, 2008). The Saudi Arabian nurses cited an important factor, namely, lack of EBP-related education. Despite the fact that the studies were conducted in various countries and at different time points, it appeared that the identified barriers seemed to be almost the same. However, the methodological challenges still remain. Barrier scales were used to measure the perceptions of nurses on what constituted barriers to research utilisation. How one expresses whether an issue is a high or low barrier is dependent on many factors, and especially cultural norms. Organisational factors such as lack of support are of concern because leaders should be the ones promoting EBP in their institutions. None of these studies looked at the challenges experienced by leadership and how they themselves utilise research. It would also be interesting to study how heavy workloads or a lack of time is linked to the ability to effect improvements (Omer, 2012).

2.2.9 Relationship between policy and research

Walugembe et al (2015) stated that policy and practice need to draw on the best research available, in addition to ensuring that the provision of safe and effective care practice is based on current, scientifically sound knowledge. Since the focus on research uptake is expanding, researchers, communication specialists and donors feel a moral and ethical imperative to try and ensure that research is utilised to inform policy and practice. The WHO's strategy on research for health that was accepted by the Sixty-third World Health Assembly in 2010, is based on the premise that in all countries, policies and practices in support of health care should be based on the best scientific knowledge. The findings of high quality research should not only be available to decision-makers. They need also to be communicated in ways that successfully inform policy, public health, and health care decision-making (WHO, 2012).

2.3 THE POLICY DEVELOPMENT PROCESS

In South Africa, citizens' right to participate in policy and decisions that affect them is assured in the Constitution (Act 108 of 1996). Therefore, according to de Satgé (2009), participation in the policy and governance process is a cornerstone of South African democracy. The Ministry of Health is one of the largest ministries in South Africa and most of its departments are scattered around the country. Similarly, most of the divisions manage operations on their own. It is a common error to regard policy as being the domain for those working in parliament or senior officials. On the contrary, policy development takes place at various levels.

2.3.1 Levels of policy development

2.3.1.1 Macro-level (Directional)

This refers to high-level ideas. At this level, general abstract policy aims are set and this refers to the broad macro-level declaration of government aims and ambitions in a specific policy area. The long-term preferences of government in terms of the types of organisational strategies to be used in addressing policy aims are decided at this level (Arabi, 2014; Howlett, 2010). de Satgé (2009) confirms that the major targets and priorities of the department are indicated in their directional policies, which are small in number and wide in scope. It is important for nursing to be represented at this level, so that this field can have input regarding the feasibility of plans and thus guide the process based on the complex realities of day-to-day implementation.

2.3.1.2 Meso-level (Strategic)

The meso-level is where policy begins to take shape as a specific programme, rather than a high-level concept, and it is at this level that the policy is negotiated into a programme with specific scope and deliverables. The policy objectives are operationalised in order to achieve policy aims (Howlett, 2010). de Satgé (2009) refers to this level of policy-making as intermediate. The implementation of the major directions is detailed and clarified, and organisations are given guidance on the process.

Strategic policies provide a more detailed picture of how changes are made and account for progress. They emphasise specific targets, outputs and milestones. The transformative nature of the process has the greatest possibility for misunderstanding or misinterpretation of aims and objectives at this level (de Satgé, 2009). The participation of nurse leaders at

this level is important in order to specifically address the gap in translation. The same representatives as are at the macro-level would devise mechanisms to ensure a policy link at all levels.

2.3.1.3 Micro-level (Operational)

At the micro level, those working in this frame translate their understanding of how policy is conveyed as a programme (framework) into day-to-day work. This process is influenced by organisational structure. The specific setting of policy tools required to attain policy targets occurs at this level Howlett (2010). de Satgé (2009) describes operational policies as specific and narrow in scope. For the department to fulfil its day-to-day responsibilities, these policies must be followed. They are collected in manuals, handbooks and other resources. These include guidelines for decision-makers, as well as proposed procedures that should be followed for a programme of action for specific circumstances.

2.3.2 Stages of policy development

The policy process involves decisions made at a national or decentralised level, including funding decisions that impact on service delivery. Thus, consideration must be given to policies at various levels of the health system and over time to ensure sustainable scale-up (WHO, 2011). The literature presents various approaches used in the process of policy development, with the dominant view being the policy cycle. This is a sequence of interrelated stages in which policy issues and deliberations flow from “inputs” (problems) to “outputs” (policies). These include agenda-setting, policy formulation, decision-making/policy adoption, policy implementation and policy evaluation (Anderson, 2011).

2.3.2.1 Agenda-setting

The focus here is on how the problems that may become the targets of policies are identified and specified. Agenda-setting is viewed as comprising three mostly independent streams of activities, problems, proposals and politics, which occasionally link, opening a “policy window” and enabling some matters to reach the government agenda (Kingdon, in Anderson, 2011:93).

The problem stream consists of matters on which policy players inside or outside government would like to secure action. The proposal stream comprises possible solutions for problems. Proposals are ideas that are either taken seriously or discarded. The politics stream includes items such as changes in presidential administrations. At any given time,

many problems and issues will be competing for the attention of public officials, who will also have their own preferred ideas to promote. Agenda-building is thus a competitive process (Anderson, 2011). Nurses, who are at the coal-face, see the gaps in the healthcare system first-hand, and know where improvements are needed most, could have solutions for dealing with these challenges (ICN, 2015). Their participation at this stage is crucial for their contribution in advocating for health policy change (Harper and Vlasich, 2016).

2.3.2.2 Policy formulation

This refers to the stage of generation of options about what to do about a public problem. Once an issue has entered the government agenda, policy-makers are expected to decide on a course of action to follow in addressing it. At this stage, the options of resolving an issue are identified, refined, appraised and formalised. Dialogues are entered into to facilitate communication between policy actors with different perspectives on the issue and potential solutions. Presenters are given a forum to debate the proposed policy options. The dialogue is more structured, with experts being invited to speak for or against potential solutions. Proposals are drafted, which can take the form of draft legislation or regulations. These may also identify a framework for a subsequent round of public and private policy actors' deliberations, in order to negotiate a more specific plan of action (Anderson, 2011).

Different policy actors participate in separate aspects of policy formulation and policy design. It is imperative for nurse leaders to be engaged, so that they ensure that appropriate healthcare policies are developed. Their participation could also limit implementation difficulties, as they would have been part of the implementation plan. According to Huber (2015), the appropriate people need to be represented at policy-decision levels to facilitate planning, implementation and monitoring, as well as to build new partnerships in order to achieve the United Nations' new Sustainable Development Goals (SDGs) by 2030. A key component in the policy development process is an assessment of how a policy is likely to work in practice. According to the WHO (2005), policies are products of the political context within which they are developed. It is therefore useful for nurses to understand policy formulation as a social and political process. Nurse leaders are in a position to provide adequate, valuable and policy-relevant information for the policy formulation stage, as they perform their duties on a daily basis at grassroots level.

2.3.2.3 Adoption

This is the stage when the policy is endorsed or brought into force. New or changed public policies are often adopted by means of a ruling of the cabinet, or indeed of an individual minister, without any legislative change (World Health Organization 2005).

2.3.2.4 Policy implementation

Implementation is an iterative process in which ideas, communicated as policy, are transformed into behaviour, which is expressed as social action. The aim of the social action derived from the policy is public betterment. It is most frequently manifested as programmes, procedures, regulations or practices. Input, perceptions, and the voices of different stakeholders at different tiers are thus an important part of policy implementation (Mugwagwa et al, 2015). According to the WHO (2011), a health-related policy and its implementation is complex. The flow is from health-related policy formulation to health-related policy and programme implementation and health outcomes.

The conventional wisdom is that South Africa has good policies, but lacks delivery capability, due to a gap that is always evident between policy development and implementation (de Satgé, 2009). Clay and Shaffer (1984), in de Satgé (2009), observe that policy-makers sometimes avoid responsibility for the policies they make. The authors refer to this dichotomy between policy and implementation as an “escape hatch”. “Policy-makers who see implementation as a disconnected process to policy-making, may blame a poor policy outcome on inadequate political will or lack of sufficient resources in the implementation phase, rather than poor policy-making” (de Satgé, 2009:2).

The distinction between policy development and implementation could be ended by the development of a more interactive policy process. While implementation is largely perceived as an administrative function, policy makers often view policy-making as a political process. However, implementation always makes or changes policy to some extent (de Satgé, 2009). This suggests the importance of participation by implementers as part of the policy development process: “How a policy is to be implemented should be an integral part of the policy design” (Government of United Kingdom, 2001, in (de Satgé, 2009:9).

2.3.2.4.1 Theoretical frameworks for implementation

There are three major theoretical models of policy implementation, namely:

- **The top-down approach:** According to Buse et al (2012), this approach considers policy formation and policy implementation as divergent activities. Policies are developed at higher levels in a political process. They are then cascaded to lower levels, which are held responsible for the technical, managerial and administrative tasks of putting policy into practice. Since this approach adopts the perspective of those in higher levels of government only, the role of other actors is neglected in the process.
- **The bottom-up approach:** This approach recognises the active role that is likely to be played by individuals at operational levels. The way a policy is implemented could then be changed by using discretion to review the objectives. The bottom-up approach sees policy implementation as a cooperative process involving policy-makers, implementers from various levels of government and other actors. In evaluating the impact of a policy, it becomes difficult to separate the influence of individuals and different levels of government on policy decisions and consequences (Buse et al., 2012).
- **Principal-agent theory:** Another way of understanding policy implementation beyond the top-down and the bottom-up approaches is through the principal-agent theory, mainly developed by political scientists and sociologists. In this approach, a relationship exists between the principals (those who define policy) and agents (those who implement policy). This relationship may include contracts or agreements that enable the principal to stipulate what is provided and check that this has been accomplished. The complexity of the relationship is influenced by the context or circumstances surrounding the problem. For example, the political and economic climate or technological change (Buse et al, 2012).

2.3.2.4.2 Implementation guidelines

Preparation for implementation should occur throughout the policy development process. If the guidelines are based on evidence that is known to health professionals, linked with performance indicators and implementation strategies, they can lead to an improved quality of care and health outcomes. Guidelines can contribute to cost-containment, and when used in auditing at a local level, they can improve quality assurance. The guideline development process needs to be integrated at all levels of the health system, from national policy through to public health programmes. This process needs to include hospital and primary care implementation, financing, auditing and health professional

education, with all professional groups accepting and applying the principles and practice of the approach. The health outcomes of a country could be improved through evidence-informed policy and guideline development (Young and Quinn, 2014).

The process of guideline development requires time, energy and resources. This process is crucial to ensuring universal ownership by health professionals who will provide support to effective implementation and improved quality of care. If a policy direction links guideline development to improved health outcomes, the process needs embedding in the system at all levels, from national policy through to public health programmes, hospital and primary care implementation (Garner et al, 2015).

2.3.2.5 Evaluation

This is the final stage in the policy-making process. It includes monitoring, analysis, reviews and consideration of existing or proposed policies. A policy should be evaluated independently for some time (months or years), depending on the magnitude of changes it brings about after it has been implemented, in order to measure the success of policy outputs and programme outcomes, identify surfacing issues and problems, provide feedback and aid improvement or corrective action. Reviews are decided upon at the time or during the policy development stage to accommodate progress and developments (Young and Quinn, 2014). At this stage, the policy has already been implemented. The nurse leaders are continuously faced with the ripple effects of implementation, as well as those of the policy itself. Therefore, their unique position not only enables them to identify limitations and constraints in policy, but also to initiate effective procedures to rectify them. The nurse leaders could use this window to enter and advocate for an evaluation of the outcomes of the policy.

2.3.3 Models of policy development

Researchers are often frustrated by their inability to influence policy (Ritter and Bammer, 2010). This section provides an overview of selected policy-making models and the ways in which research could be engaged with and influence policy decision-making. There can be variations in approaches to policy development.

- ***The rationalist approach***

This was the basis for the scientific method common in the 1960s and 1970s. Ritter and Bammer (2010) suggested that this model identifies key steps in policy-making and orders

them in a logical sequence. It starts from the point at which a problem or issue is identified. It then follows a series of steps that result in the following optimal solutions: articulate the problem, identify the causes, develop options, analyse options, select intervention, implement intervention and evaluate.

According to the ICN (2005), the rationalist approach tends to believe that one can start with objectives and work out, without bias, how best to realise these objectives. This approach applies when policy development is centralised. Individuals or organisations at different stages of the process have little opportunity to make an input on policies, because they are developed at the top and cascaded down for implementation. However, this could be applicable where societies do not have highly developed infrastructure in education, communication, public opinion groups, organised labour (unions), active political and professional groups (ICN, 2005).

According to de Satgé (2009:9), the “rationalist model of a linear policy development sequence”, which is characterised as “simplistic and reductionist”, is strongly criticised. The policy process has also been notably described, as “a chaos of purposes and accidents”. At the same time, the rationalist model tends to depoliticise the issues that are the focus of policy with neutral scientific language. “This masking of the politics under the cover of neutrality is a key element of modern power” (de Satgé, 2009:9). While some authors see this model as linear, Ritter and Bammer (2010) assert that it could be seen as a normative model for how one should make rational decisions, rather than as a descriptive model of actual policy-making. The advantage of the technical or rational model is that it easily encompasses the contribution that research could make at each step in the cycle.

- ***The incrementalist approach***

This approach to policy development emerged as societies became more multifaceted, with high levels of education and public expectation, and with an active means of expressing views and influencing decision-making (ICN, 2005). The incrementalism model sees typical policy-making as a process of small modifications to existing policies, based on successive limited comparisons between existing policies or very similar alternate policies. Policy-making is seen as involving ongoing small adjustments, with occasional sudden, rapid, major shifts in policy direction (Ritter and Bammer, 2010). This, according to ICN (2005), allows for an interactive process between key actors and interest groups,

with a common variation of responses. Consultation with key stakeholders, including the public and interest groups, is conducted regularly.

- ***Data-driven policy-making model***

According to Hinshaw and Grady (2010), this model was developed by the Agency for Health Care Research and Quality (AHRQ) to help analysts, decision-makers, policy-makers and planners in the policy-setting process. The key element underlying the model is who the stakeholders are. This refers to people who should be sitting at the table at different points throughout the process. It is important to include all stakeholders in all stages of the process. This facilitates a broader scope of alternatives, ideas and insights. The model includes four stage processes to ensure that research, if available, is utilised in policy formulation. These stages include the definition of priorities, data, assessment and action.

- *Definition of priorities:* During this stage, stakeholders need to develop a common definition, to understand other member's concerns and priorities, and to understand questions to be answered and key issues to be discussed.

- *Data:* Stakeholders need to assemble a data matrix that will serve as a reference tool, describing what data sources and resources are available to support the policy development process. They need to determine data measures to form a baseline. After policy implementation, the baseline data can be compared with outcomes, using the same measures to determine policy impact. Based on available data, policy decisions can be made at different levels. The need for a new data matrix has to be identified looking at previous initiatives and their impact in respect of that policy.

- *Assessment:* This stage involves analysis of the data and identification of the limitations of current knowledge. Stakeholders must be included at this stage. The findings of the process are then disseminated.

- *Action:* Assessment and selection of policy options is done at this stage. The impact is estimated and future challenges are projected to mitigate them. Recommendations should be presented with supporting evidence (data). Impact evaluation is also required (Hinshaw and Grady, 2010). This framework applies to nurse leaders, as they are the custodians of data in institutions. They have evidence, and must produce it in a compelling locally relevant story. They are held accountable for meeting targets based on the indicators set, such as the Sustainable Development Goals (SDGs), so the opportunity for influence exists as evidence which demonstrates the contribution of nursing to meeting the

government's vision and goals. However, this would only be possible if the health indicators chosen are sensitive to input from nursing.

- ***Policy networks framework***

Policy networks are clusters of actors with interests in a given policy segment, and the capacity to help determine a policy's success or failure. Marsh and Rhodes (1992), in Walt et al (2008), treat policy networks as a universal term, with policy communities at one end of a continuum and issue networks at the other. Policy communities are tight-knit networks with few members who share basic ideals and resources. There may be a strong influential main actor, surrounded by a number of other, more peripheral members, all of whom make up a policy community. An issue network, on the other hand, brings together many different groups and individuals for a common purpose or cause, and may have little continuity in standards or contribution. Network analysis reflects the phenomenon of shared decision-making and exchange of resources to achieve their goals (Walt et al, 2008).

- ***Kingdon's Multistream Theory***

According to Walt et al (2008), theories are more specific than frameworks, and suggest specific relationships among variables that can be confirmed or evaluated empirically. Kingdon's (1984) multistream theory is one of the most influential theories on the public policy process. According to Kingdon (1984), there are three independent streams that work in parallel: problems, policies and politics. The problems stream contains the general problems and conditions facing societies, some of which become recognised as issues that need public attention. The policy stream refers to the set of policy alternatives that researchers and others propose to deal with national problems. This stream contains ideas and technical proposals on how problems may be resolved. Political changes, national atmosphere and social pressure are among the fundamental elements of the politics stream (Winkel and Leipod, 2016; Arabi, 2014; Walt et al., 2008).

At particular stages the streams merge, and in their convergence, windows of opportunity occur and governments decide to act. Several health policy scholars have adapted ideas from Kingdon's theory to explain how particular health issues have emerged on policy agendas. Reich (1995), in Walt et al (2008), identified additional elements that are linked to the politics stream: organisational, symbolic, economic and scientific politics. All of these favoured child over adult health through the 1990s, explaining the higher position of the former on the international health agenda. Ogden and Walt (2003), also drew on Kingdon's ideas in their study on tuberculosis. They confirmed that the rise of the HIV and AIDS

epidemic provided the opening of global policy windows, facilitating advocacy networks to support the directly observed treatment, short-course (DOTS) as a treatment of choice for tuberculosis (Walt et al. 2008).

- ***The policy circle: moving from issue to policy***

This framework arose to support the Office of Nursing Policy (OPN) in Canada. It served as a guide to the OPN when advising the government on health issues. It was used to provide systematic, high-quality evidence-based health advice. This framework was adopted and is based on the previous work of Kingdon (1955), Milstead (1999) and Tarlov (1999). It is a modified model integrating some aspects of the previous models. The model consists of four distinct stages: (1) Setting the policy agenda; (2) Moving into action/legislation; (3) Policy implementation and (4) Policy evaluation. The framework deals mostly with stages 1 and 2, which are described as the policy cycle. These stages consist of four steps each, making eight steps which are: (1) values and cultural beliefs; (2) emergence of problems or issues; (3) knowledge and development of research; (4) public awareness; (5) political engagement; (6) interest group activation; (7) public policy deliberation; (8) regulation. The first four steps lead to setting the policy agenda. If citizens, communities, organisations and politicians do not value and believe in the issues that are highlighted in the policy arena, the issues will not be addressed. The policy development process will not proceed because of those issues.

The variety of models highlights the complexity of the policy development process. “There is no simple or single model that encompasses the entirety of policy-making” (Ritter and Bammer, 2010:356). Regardless of the approach used, nurse leaders should participate in the health policy development process. However, if nursing is to be an effective part of the process, nurses must understand all components of it and select suitable strategies for effective participation.

2.3.4 Making “good policy”

Good policy is often associated with “modernised”, “professionalised” policy development competencies, where policy includes different actors in its formulation and is designed around agreed-upon outcomes. It is marked by an inclusive policy-making processes in which citizens and interest groups are important actors, and policy processes, which are administratively driven, give priority to improved co-ordination within and between government departments (de Satgé, 2009). Characterisation of “good policy” is commonly

acknowledged, although the emphasis varies between different frameworks, as illustrated in Table 2.1.

Table 2.1: Good Policy

FORWARD LOOKING	OUTWARD LOOKING	INNOVATIVE, FLEXIBLE AND CREATIVE
The policy-making process clearly defines outcomes that the policy is designed to achieve. Where appropriate it takes a long-term view based on statistical trends and informed predictions of social, political, economic and cultural trends to assess the likely effects and impacts of the policy.	The policy-making process takes account of influencing factors in the provincial, national, regional and international situation. It draws on experience in other countries. It actively considers how policy will be effectively communicated with the public.	The policy-making process is flexible and innovative. It questions established ways of seeing and understanding, encourages new and creative ideas; and where appropriate, reviews established ways of doing things to make them work better.
EVIDENCE-BASED	INCLUSIVE	JOINED UP
The advice and decisions of policy makers are based upon the best available evidence from a wide range of sources. All relevant evidence, including that from specialists, is available in an accessible and meaningful form to policy makers.	The policy-making process takes account of the impact on and/or meets the needs of all people directly or indirectly affected by the policy. It involves key stakeholders directly.	The process takes a holistic view; looking beyond the institutional boundaries of the department to government's strategic objectives. It considers appropriate management and organisational structures needed to deliver crosscutting objectives and their cost and capacity implications. It defines joint working arrangements with other departments clearly and develops strategies to overcome barriers to effective joined up programmes. Implementation is considered as an integral part of the policy making process.
REVIEW	EVALUATION	LEARNS LESSONS
Existing/established policy is constantly reviewed to ensure it is really dealing with problems it was designed to solve. There is an active ongoing assessment of unintended consequences.	Systematic evaluation of the effectiveness of policy is built into the policy making process.	There is an active learning process approach to identify and communicate the lessons of what works and what does not.

Adapted from (Bullock et al., 2001 in de Satgé, 2009)

2.3.5 The policy brief

In recognising that finding opportunities to incorporate research results into policy and developing mutual support and respect between researchers and policy-makers takes time, strategies have been put in place to improve the use of evidence in policy. These include giving policy briefs or other short summaries of research directly to policy-makers. A policy brief is a concise communication tool or document providing policy options for a particular audience. The purpose of the policy brief is to justify the need or urgency of an issue and the reason for choosing a particular policy option or course of action outlined, and therefore serves as a motivation for action (Young and Quinn, n.d).

The policy brief is defined by de Satgé (2009) as a short, neutral summary of what is known about a specific issue or problem. The purpose of designing policy briefs in the form of a report is to facilitate policy-making. The decision-makers are the most common audience for a policy brief. However, it is also common to use the document to support broader advocacy initiatives targeting a wide, but well-informed, audience (e.g. decision-makers, journalists, diplomats, administrators, researchers). Two types of policy briefs are described in the literature:

The **advocacy brief**, which argues in favour of a particular course of action; and the **objective brief**, which gives reasonable information to enable the policy-maker to make up his or her mind (Young and Quinn, n.d).

2.3.5.1 Characteristics of the policy brief

According to Young and Quinn (2009), in constructing a policy brief that can effectively serve its intended purpose, the following characteristics must be considered.

Evidence-based: The policy brief provides evidence and actionable recommendations for the policy makers to make practical decisions within a short time. Potential audiences would only be convinced by arguments supported by evidence that the problem exists and the significance of adopting particular options.

Focused and succinct: Aspects should be directed at convincing the target audience. It has to be restricted to a particular problem.

Comprehensive: The issue brief provides a large amount of complex detail. This allows the reader to easily understand the core of the issue, its background, the stakeholders and any recommendations about the future of the issue. It may include tables and graphs. The

reader is informed about the sources on which it is based, and where to obtain more information from a short list of references.

Practical and feasible: The brief should be realistic and provide insight into the current situation, as well as practical solutions or recommendations that will be acceptable to the target audience.

Legible: The layout or writing technique may be varied to catch the reader's attention (Young and Quinn, n.d).

2.3.6 Nursing, policy and politics

The practice of nursing and healthcare delivery is directly shaped by political decisions and health policy initiatives, at both “macro” and “micro” levels. It is, therefore, imperative for nurses to have political awareness. However, Hannigan and Burnard (2000) asserted that the study of politics is still probably seen by most practising nurses as irrelevant, in that policy and politics are thought to have no direct effect on everyday clinical care. The authors therefore believed that was another compelling reason why nurses should be aware of politics and policy. Nursing is an independent and autonomous profession. Nurses also possess a considerable level of autonomy in their day-to-day work. Such nurses exercise their independent professional judgement without needing close supervision of their practice. By exercising their professional autonomy, nurses are, therefore, whether they are aware of this or not, makers of health policy at the level of everyday practice (Mason et al, 2016; Hannigan and Burnard, 2000).

Nurses are educated for the political journey. The communication, advocacy, listening, problem-solving and reflection skills that nurses possess could be essential in intense times of political compromise. Since nurses do not communicate with their elected officials, the officials listen to non-nursing individuals. The key to shaping health policy and a strategy for merit in nursing is for nurses to be part of the political arena. “In the absence of nurses in the policy development process, others make decisions for them” (Hall-Long, 2009:780).

2.3.6.1 The political development of the nursing profession

Cohen, Mason (2006), developed a framework that conceptualises the political development of the nursing profession. Four stages of development were identified.

Stage 1, the “buy-in” phase, where the nursing profession recognises the importance of being politically active. This is evident in South Africa through the presence of nursing unions that even affiliate with certain political parties. Some nurses may also choose to join non-nursing unions. That is an indication that the profession is now politically aware (Ehlers, 2000).

Stage 2, the “self-interest” phase, which includes activities related to enhancing nursing identity and self-interest in the political arena. This stage is characterised by nurses working together as a united front. Although nurses are involved in unions, they do not seem to have a political base. Their diversity hinders them from exhibiting “self-interest” and pushing the agenda of nursing issues (Mason et al, 2016; Ehlers, 2000).

Stage 3, the “political sophistication” phase, is depicted by increasingly complex types of political activism and a growing recognition, on the part of policy-makers, of the contributions that nurses can make to health policy. Thus far, nurses have not been seen tackling issues and concerns regarding patients and the population in relation to health care that could culminate in policy. Policy advocacy on behalf of the public is still limited (Ehlers, 2000).

Stage 4, the “leading the way” phase, which attributes nurses as initiators and innovations of health policy ideas, instigators, leaders and formulators of health policy. This is an area where nurses are struggling to make progress. Studies have shown that they are still not proactive in policy issues (Ditlopo, 2014; Ehlers, 2000).

2.4 PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT

Health systems are rapidly developing and changing. Nurse leaders, as part of this system, should move forward along with these changes. All aspects of nursing education, practice and research are influenced by policies. Thus, they need to be proactive in the health policy arena to be better able to control and excel in education for nursing and practice, and improve health outcomes. Taking the initiative to participate in policy development is central to excellence in clinical practice, research and education for nursing. The necessity for nurses to participate in health policy development has been widely emphasised. This could lead to improved quality of nursing care and the broader health system. However, calls to increase nurses’ involvement in policy development have not thus far been very successful (Edwards et al, 2009).

The terms nurse manager, nurse administrator and nurse leader are used interchangeably in the nursing textbooks, which only recognise participation of nurse leaders at the organisational level. According to Marquis and Huston (2009), policies are formulated by top management (usually by policy committees). Nurse managers have the responsibility of communicating a policy that has been formulated to all those who may be affected by it. The relative value of the policy is often perceived in relation to how it was communicated. The manager also has the role of reviewing and revising policies and procedures to ensure their currency and applicability.

Marquis and Huston (2009) further assert that managers who are uninformed about the legal, political, economic and social factors impacting on health care may make strategic planning errors that have disastrous implications for their professional development and the financial viability of the organisation. Therefore, nurse managers need to develop political alliances and coalitions. Nurses can increase their power and influence by forming alliances with other groups. More power and political weight result from people working together than from people acting alone. It is imperative that leaders develop political skills and use political strategies if they are to survive in their role (Marquis and Huston, 2009).

Stevens (1985) stated that the nurse executives need to participate in strategic policy-setting in the institution. They also need to convey the institutional perspective to their subordinates. The nurse executives may become scapegoats for circumstances beyond their control if they are unable to explain policy changes with credibility. They have to be intimately involved with policy determination. Institutional strategic policy requires the input of nursing for it to be successful. Stevens (1985) also supports Marquis and Huston (2009) about the importance of nurses being politically informed. Lack of experience in politics is evident in the collective action or inaction of nurses. "Nurses' naiveté in politics" leads to a lack of involvement until a law has been passed and is perceived to be detrimental to nursing. Nurses need to be proactive rather than reactive to legislation (Stevens, 1985:155). However, this author does not mention any political strategies that could be learned by nurses.

The role of the nurse leader was described by Booyens (2008) and Tomey (2009) as being to make decisions regarding nursing practice, set strategic goals, improve the work environment, and to create and influence institutional and public policies. These authors also discuss policy role at an institutional level. The nurse manager's role is seen as that

of implementation, evaluation and monitoring of policies and decisions regarding nursing practice for adherence to applicable professional standards. From this information, the researcher could deduce that this is how far nurses are taught when it comes to policy development. They are not socialised to see themselves advocating for their profession beyond the organisational level. Hence, they leave policy to others (Tomey, 2009; Booyens, 2008).

Peters (2002) argues that nurse managers see policies as affecting almost every aspect of their lives. They are under-represented in the policy arena and decisions are made without their input. In the event of financial constraints, nursing care was perceived as expenditure, not as an income generator, and thus was an area where cuts were frequently made. Nurse administrators are put in a dilemma whereby they are expected to implement decisions of cost containment while, on the other hand, they need to ensure a quality service. The inequality in the distribution of health resources requires a group of initiators who are willing to work towards eliminating it. For transformation to take place there is a need for nurse leaders who are dedicated to the profession and are prepared to be strong political activists, able to speak about health problems to policy-makers. What policy-makers often fail to recognise is that nursing is an independent, autonomous discipline, with distinct knowledge and skills (Peters, 2002).

Studies (Juma et al, 2014; Robinson, 2013; Kunaviktikul et al, 2010; Shariff and Potgieter, 2012 and Antrobus and Kitson, 1999) have shown that nurses' role in the health policy development process is limited. However, findings revealed that nurses played a huge role in the policy implementation phase. They were familiar with the ways that policies are cascaded down from the macro level for execution at the operational level. Participation in this phase was described in a variety of ways, such as implementing policies from the Ministry of Health in hospitals, harmonising them with the agency's work, and creating a joint understanding among those who were introducing the policy for implementation.

Findings from in-depth interviews of 26 nurse leaders in Thailand revealed that some nurse leaders participated in health policy formulation as part of their work position, such as a leadership position in a professional organisation or a staff position in an educational institution related to research work. Therefore, participation at that time implied research, finding information, and attending seminars at the discipline level. Others participated indirectly through meetings of professional organisations, by discussing problems and

seeking their recommendations on how to resolve them (Kunaviktikul et al, 2010). However, it is not clear what the nurse leaders' role was. Knowledge was also limited as to the extent of their participation at all levels or stages of policy development. Involvement in seminars and meetings is a distortion of participation in policy development. Meetings could be turned into mediums for one-way communication in which superficial information is provided and questions are discouraged or irrelevant answers given. In short, most nurses in Thailand did not participate at any level of policy development. However, because of this exposure ("participation in meetings"), they may be motivated to advocate for genuine levels of participation.

A study conducted by Antrobus and Kitson (1999) aimed at critically examining contemporary nursing leadership within the context of health policy. Findings showed that nursing leadership has been viewed as an internal professional concern and not in the main as being influenced by external events relating to politics or the economy, nor as having an external focus. Nursing leadership studies have rarely taken into account the impact of the wider context, nor have they examined how nursing leadership roles have been influenced by health policy.

Robinson (1991), cited in Antrobus and Kitson (1999), drew attention to the political vacuum in which nursing exists. Health policy is often formulated with little input from nurses, except at the level of "grassroots" implementation. Analysis revealed that leaders were performing an interpretation and translation role in order to bridge the divide between policy context and nursing practice. Nursing was not appreciated, nor considered a priority. Leaders interpreted nursing issues. The author concluded by recommending restructuring of career pathways for nurses. Nurse leaders needed to be in positions which would enable them to influence and shape policy and practice (Antrobus and Kitson, 1999).

A study was conducted in East Africa (Shariff and Potgieter, 2012) with the aim of exploring the extent of nurse leaders' participation in health policy development. A Delphi survey was applied. The expert panelists included national nurse leaders in leadership positions in nursing professional associations, nursing regulatory bodies, ministries of health and universities in East Africa. The findings of the study showed that nurse leaders participated in health policy development although it was limited and not constant across all stages of health policy development. A gap in knowledge about the extent of nurse leaders' participation in health policy development and the facilitators or barriers to this was

identified. The authors suggested that the participation of nurse leaders in health policy could only be strengthened if this phenomenon is understood through evidence-based knowledge and information. A significant proportion of nurse leaders were not part of the policy development process. In fact, doctors were given the majority of policy development positions and nursing issues were represented by other health professionals at health policy development forums (Shariff and Potgieter, 2012).

Shariff and Potgieter (2012) found that the majority of the expert panelists (95 percent) belonged to their professional organisation, but their role was limited to being members. The benefits of nurse leaders' inclusion in the health policy development process were undermined due to negative publicity about nursing. Their potential contribution to this process was not recognised as significant and they were excluded by policy-makers. A gap in this study was the exclusion of leaders from hospitals (nursing practice experts). Clinically and administratively, nurse leaders are well positioned in their clinical and administrative roles to recognise and define issues, problems and system gaps. Major decisions that affect nurses are made and approved formally by policy-makers without including them. The study concluded that nurses are not given an opportunity to influence the way policies are designed.

Between 2007 and 2012, Jamaica, Barbados, Kenya, Uganda and South Africa collaborated on a 5-year programme of research and capacity building. Sub-Saharan Africa and the Caribbean are the two regions of the world with the highest HIV prevalence rates. Findings from a study conducted in these countries showed that although nurses played a leading role in the prevention of HIV and AIDS, their involvement in policy development was limited. Nurses in all the participating countries remarked on their lack of participation in policy development. Added to this, they were not consulted on the ground. Their primary role was to implement policies. Nurses were also not knowledgeable about the policy development process. They reported that they did not know what policy-making entailed or what was required to start making a policy. Nurses in all of the participating countries remarked on their lack of participation in policy development. Moreover, they were not consulted on the ground. Their primary role was to implement policies. Nurses were also not knowledgeable about the policy development process. They reported that they did not know what policy-making entailed or what was required to start making a policy (Richter et al, 2012).

A South African nurse manager believed that they (frontline staff) were not actively involved in policy-making, but they were informed and trained, and the nurse managers cascaded the information down and ensured that the policies were implemented. Their major role was monitoring if the policy was well implemented and if there were any obstacles regarding the policy which needed to be revised (Richter et al, 2012). This statement is a clear indication that even the leader's role is only at the implementation stage. They cascaded a policy but were not involved in its development. They saw this as active involvement without having the power to affect the outcome of the process. They admitted that they usually used policies that had been forwarded from ministry of health headquarters. The authors concluded by expressing the need for nurses and all other stakeholders to lobby for nurses' participation in policy development (Richter et al., 2012).

A study was conducted on the involvement of nurses in HIV policy development in Nyanza Province, Kenya (Akunja et al., 2012). A case study design was adopted, applying qualitative methods. The participation of nurses in policy development was perceived to be at different levels of the health system. The major benefit of being involved in policy development was forming connections and partnerships. The government had a key role in directing policy issues. Other key stakeholders that were mentioned included NGOs, learning institutions and communities. Participants recognised that they had participated in policy issues at sub-district and district levels of the health system. They also appreciated that they participated in policy issues especially in their institutions, but felt that reaching the provincial and national levels was still a challenge. Findings revealed that participants still lacked the confidence and interest to be involved in the policy process, although they associated participation with nursing care. Barriers to participation in policy formulation were identified as conflicting priorities, lack of time, and limited knowledge and skills. Most participants cited that negative attitudes and lack of interest in policy development limited their participation (Akunja et al., 2012).

The research on the state of nursing (RESON) in 2008 was aimed at exploring nursing policies, practice and management issues in South Africa. The discussion yielded a wide range of talking points. Gaps in nursing policy development, leadership and management, and inadequate linkages among the key stakeholders responsible for nursing policy development were some of the key nursing challenges that were identified. The participants also commented on the Nursing Charter. The perception was that it was designed by the leaders and a top-down approach had been followed in its development.

There was a lack of transparency in the process around the Nursing Charter. The issue of meaningful involvement and participation by a broader range of stakeholders in decision-making was a recurring theme throughout the discussions. Lack of participation and consultation is seen even when nurse leaders are pushing their own professional agendas (Rispel, 2008).

A study conducted by Ditlopo et al (2014) analysed the dynamics, strengths and weaknesses of nurses' participation in four national policies: the 2008 Nursing Strategy, Review of the Scope of Practice for nurses, the new Framework for Nursing Qualifications, and the Occupation-Specific Dispensation (OSD) financial incentive policy. The nature of nurses' participation in policy processes was described using two main classifications: individual and collective participation. Individual participation refers to instances where the participants felt that they were invited to participate in a personal capacity, and not representing any specific interest group in nursing. Collective or representational participation occurred when participants regarded their invitation to participate as representing a specific nursing interest group, such as the National Nursing Association, educators or academia.

Findings revealed that participants blamed themselves for adopting a passive role in the policy-making process. A unified voice for nurses was silenced by a lack of unity or a lack of collective action among different nursing professionals, which included the National Nursing Association, professional interest groups, university nursing academics, college nursing educators, nursing managers, the nursing council and private sector nurses (Ditlopo et al., 2014). The study looked at the extent and nature of participation, whereas the current study examined their knowledge of the policy process in depth, looking at the different stages and how nurse leaders participated. The study also looked at their level of awareness of the above-mentioned policies, and of their role in health policy development.

Although health policy has largely been informed and imposed with limited input from nursing, there are notable exceptions to this. From the 1980s, nurse leaders in the USA adopted a proactive rather than reactive stance, engaging with public policy. In addition to technical and managerial competence, they recognised that they needed to develop political and policy capability. Furthermore, a number of professional organisations or universities offer policy and political-related seminars and short programmes which interested nurses are encouraged to attend. A range of professional journals such as the

Journal of the American Academy of Nurse Practitioners routinely publish articles designed to encourage nurses to develop their policy and political skills (Fyffe, 2009).

As with the USA, there are a number of professional forums and professional organisations in the UK seeking to influence and shape policy, addressing particular specialist areas of practice and patient care. Health policy fellowships are available in the UK, although the uptake by nurses on such programmes is low. Nurses from these countries have opportunities that would empower them to influence policy at all levels and in a range of arenas (Fyffe, 2009). The reason for the low uptake of health policy programmes was not stated. No study that explored this phenomenon could be located.

Abood (2007) and AbuAlRub and Foudeh (2016) stated that many state nursing and specialty nursing organisations sponsor annual state legislative days, offer policy internships or fellowships and conduct policy workshops. All these programmes are designed to give nurses the opportunity to learn more about current healthcare issues and the legislative process. Nurses who are interested in participating in the policy process, even those with limited time and resources, are empowered to become confident advocates. As a result, it is said that very few policy changes are effected without the joint efforts of many policy advocates. Nurses are therefore informed of the policy process. They also get exposure to the policy arena and get out of their clinical comfort zone. There is limited knowledge about the availability of such programmes in South Africa. Therefore, knowledge cannot be imported from other countries, but there are lessons that can be learned.

2.4.1 Barriers to participation of nurse leaders in health policy development

Research has shown that the low level of involvement of nurse leaders in policy development is greatly influenced by the primary responsibility that nurses assume in the delivery of health services to patients. Etowa et al (2016), Chase (2013) and Deschaine and Schaffer (2003) agreed about the absence or invisibility of nursing advocacy at the policy level. They found common barriers in different countries representing rural, suburban, and urban population areas. Barriers that prevented Primary Health Nursing (PHN) leaders and nurses in general from influencing public health policy development included political factors, gender issues, deep-seated historical splits among the nurses, shortage of resources, lack of skills training in policy development, lack of academic preparation, lack of political power linked to policy development tasks, lack of leadership

skills and research utilisation to influence policy-making. The image and status of nursing were also found to influence the inclusion of nurses in the policy development process. The period in which these studies were conducted is widely spread but the findings are similar. Little progress has been made globally to involve nurse leaders at the decision-making tables (Etowa et al, 2016; Chase, 2013; Deschaine and Schaffer, 2003).

According to Kunaviktikul et al (2010), nurses were not legitimate members of the committees for policy formulation. Their ability to clarify and to promote what nurses do was compromised because they lacked skills in public relations. Furthermore, they had limited knowledge and skills required in the policy process, and did not receive support from other sectors, such as the political sector, government officials or professional organisations. Ditlopo et al. (2014) identified barriers that were internal to the nursing profession. Barriers to nurses' participation or involvement in broader health policies included the perceived reactive approach of nursing leadership; submissiveness and an impression of "victim mentality", even when they held senior provincial government positions; lack of political and advocacy skills; and a lack of cohesion amongst different nursing stakeholders.

According to Rispel (2015), the nursing curriculum did not support nurses to take a policy role, hence their participation in the policy process is limited. Oden et al (2000) have a similar view that nurses must receive continuous education about health policy and politics. This was further supported by Kunaviktikul et al (2010) who argued that nursing educational programmes would have to include a curriculum that prepares nurses to assume an active ongoing role in the policy process. Peters (2002), differs from the other authors and believes that nurse administrators are capable of influencing policy. They have strong analytical thinking and problem-solving skills, and the ability to form partnerships and collaborate with a multidisciplinary team. All these skills put nurse leaders in a position to be effective policy advocates and their voice should be heard. Nurse leaders would be able to effectively influence the policy arena because they already have the education, skill and ability.

Leavitt (2009), supported the view that nurses had the experience and the knowledge of what is needed. However, Leavitt suggests that the problem is with them (the nurses). They do not recognise that their practice is dependent on decisions made in the public policy arena. They also have no understanding of how nursing experts can shape those

decisions. Nurses do not regard themselves as having much power in public policy, despite the growing body of research regarding the impact of nursing (Leavitt, 2009). What could be identified is a problem with their mind-set, which creates a barrier. This may be due to their socialisation, always seeing themselves as subservient to other healthcare professionals.

Although nurses are generally well educated and play leadership roles within clinical, educational, research and managerial areas, their contribution to the health policy process has been limited. This is due to a lack of research training and mentoring, limited access to research funding, and few opportunities for interaction with policy-makers (Edwards et al, 2009). This is supported by the literature on research utilisation that was mentioned earlier. Hall-Long (2009) suggested that use of research findings, along with individual or practice outcome case examples, is paramount in order to successfully influence or lobby for change.

Leavitt (2009) also identified barriers to participation in policy development as being poor communication from the top down, poor sharing of reports, and unavailability of resources to implement the policy requirement. This author suggested that strong support from the management teams is necessary to facilitate nurses' involvement in policy development. This view is supported by Brega et al (2013) who found that the major barriers to nurses' proactive health policy-making in Slovenia were lack of education opportunities, largely uninvolved health managers and necessary but insufficient nursing research.

2.4.2 Strategies for enhancing participation of nurse leaders in health policy

If nurses are to become a real part of the health policy process, they need to understand all components of the process and select appropriate strategies for effective involvement. It is important for nursing schools, scholars, executives, and professional nursing organisations to participate actively in the development of health policy and regulation (ICN, 2005). Although gaps exist in knowledge about how to advocate at the political level, barriers mentioned earlier showed that there are also challenges at the interface of policy and nursing practice domains. There are several strategies that could be applied to enhance nurses' engagement in policy processes:

2.4.2.1 Political awareness

The critical approach to politics and policy in nursing requires an awareness of a range of structural factors and the political ideology of the health care system underpinning the emergence of policy. This could shape nursing leadership, whether it is a political, clinical, academic, or management leadership (Mason et al 2016; Aarabi et al, 2014). Developing this awareness, Clifford (2000) suggested exploring nursing's relationship with both specific and general government policies on health and its own internal policies. It is important to have an understanding of ideology and power when studying policy and the socioeconomic context in which policies arise and in which nursing is practiced. Nurses in South Africa need to collaborate proactively as the largest group to be affected by the political realities of the country and its people. For their voice to be heard, nurses need to engage in political debates, otherwise they might become an increasingly, under-recognised and toothless profession in South Africa. However, this suggests that nurses have to be taught about politics and policy.

The participation of nurses in the policy process should be at individual and professional levels. This requires awareness of the legal framework for nursing practice, and knowing the sources and the process of policy-making. Basic health policy literacy means having some understanding of the ways in which policy issues have been shaped and how they were addressed in the past. When nurses acquire policy acumen, they can actively analyze organizational process and health care services (Aarabi et al, 2014). This type of support is found in professional nursing organisations. The easiest approach is to network with peers to share ideas and concerns. Belonging to a professional organisation provides an opportunity to learn the issues and participate as a group or a coalition (Sheehan, 2010).

2.4.2.2 Advocacy and professional nursing organisations

Nurses are well positioned to take on a grassroots advocacy role and accelerate change in the healthcare system. They have long been known as patient advocates. Their task is to convert daily clinical issues into policy issues. They also need to be active in the political process of their countries. Nurses leaders as advocates should know that when they want to influence decision makers, they need to understand that they are working in an "open system," so they are affected by many factors. As advocates, nurse leaders should ensure that everything influencing decision makers for developing a plan has been understood and considered. (Arabi et al., 2014). According to Brewah (2009) there is greater chance

of influencing policy change as a group, although any nurses can effect change. The ICN guidelines (2015) also encourage nurses to join special interest organisations that match their interests. Sheehan (2010), agrees that joining organisations such as credible nursing associations is important. A united voice is more influential than tackling issues as individuals. However, organisations must lobby government and policy-makers to ensure the inclusion of nurses. Effective advocacy involves making a plan to mobilise the concerned members in support for a specific issue. This mobilisation should be done in such a way that the beginner learns from it and would be able to take over and succeed.

According to the ICN (2015), the participation of nursing in local, national and international health decision-making and policy development bodies and committees must be encouraged and supported by professional nursing organisations. These have an obligation to assist nurse leaders to fully participate in policy-making by ensuring that they receive sufficient training. There are numerous strategies that they could adopt in order to implement effective policy development. These should include monitoring the utilisation of the nursing workforce; integrating new models and management strategies; continually promoting a positive image of nursing to key management and policy stakeholders nationally and internationally; disseminating relevant research findings; and developing and maintaining relevant networks to enable cooperative working relationships with governmental and non-governmental organisations (ICN, 2015).

2.4.2.3 Training in policy development

There are formal nursing leadership-development programmes in South Africa; however, none of these focuses on policy. Career pathing is limited to nursing leadership within clinical practice. This, according to Antrobus and Kitson (1999) is detrimental to the development of nursing knowledge. They further argued that it limits the role of clinical leaders' interpretation of nursing knowledge when collaborating with other leadership domains. Nurses are forced to rely on their own experiences or other policy programmes due to the lack of formal training in health policy in many nursing programmes (Harrington et al, 2005).

However, some lessons can be learned from developed countries. For instance, the United States of America (USA) has successfully developed and implemented policy leadership programmes. Many professional organisations and Universities offer seminars and short

programmes that are policy and politically related. The Royal College of Nursing (RCN) designed a leadership programme tailored to enable nurses to understand and influence the micro-political context and develop nursing policies. This project couples clinical development with strategic leadership development. Furthermore, a number of policy journals are available to provide nurses with an avenue for policy thinking (Brewah, 2009; Fyffe, 2009).

As with the USA, the United Kingdom (UK) has a number of professional forums and professional organisations aiming at influencing and shaping policy, and addressing particular specialist areas of practice and patient care. The UK also offers health policy fellowships programmes; however, uptake on such programmes by nurses is low. Nurses from these countries have opportunities that would empower them to influence policy at all levels and in a range of areas (Fyffe, 2009).

Comprehensive preparation in public policy for nurses is an essential element of graduate education. The incorporation of leadership development in basic and post-basic nursing curricula and continuing education programmes is essential (Harrington et al., 2005). While health policy has been advocated for at the undergraduate level, Conger and Johnson (2000) argued that a master's course in health policy is a way to develop nurses' health policy skills. Undergraduate students may be only slightly or not at all aware of the implications of political activity in nursing. It would also be good to learn if these programmes have been formally evaluated and what the findings were.

2.4.2.4 Leadership development

Nurses must be able to display their value and motivate others through their influence. This would enable them to participate and to be effectively utilised in health planning and decision-making, as well as health and public policy development. This suggests that the scope of their preparation for management and leadership, including their knowledge of political and governmental processes, has to be increased. It may also involve increasing nurses' exposure through management and leadership roles and positions in both nursing and other healthcare services, thereby motivating them to participate in government and political affairs (ICN, 2015).

2.4.2.5 Nursing education partnering with nursing practice

The literature (AbuAlRub and Foudeh, 2016; Fyffe, 2009; Hall-Long, 2009; Short, 2008) has shown that there is a growing need for nurses to specialise in health policy research and analysis. This need arises from the leadership roles in advocacy, research, analysis, as well as policy development, implementation and evaluation that nurses are undertaking. However, teaching them theory is not enough; nursing education needs to correlate with nursing practice. The foundations for a professional understanding of healthcare policy and policy-making should be incorporated in formal education and correlated with practice and work environments. Without the correlation of theory to practice, i.e. a synthesis of policy concepts as related to the practice environment, nurses have no basis for further exploration and may remain naive about the influences of policy throughout their career.

2.4.2.5.1 Policy practicum

One strategy to help graduate health service students who are doing research and advanced practice is the health policy practicum, whereby nursing students learn how to participate in an interactive model with policy-makers, is. This is a block of time during which the graduate student spends time in a policy setting. The aim of the policy practicum is to provide students with the opportunity to interact with policy-makers to increase their understanding of the policy process, in order to identify factors that shape the policy-making environment. They also gain practical experience working with policy-makers and have a general idea of how government works. Students are exposed to activities such as critical analysis of research evidence, grey literature synthesis, primary data collection, briefings, public policy forums, and stakeholder consultations (DiCenso et al, 2012).

A number of nursing graduate programmes in the United States and Canada have incorporated the policy practicum into their curriculum. Students are exposed to theoretical and practical content on how to effectively express policy ideas to multiple audiences, including how to prepare concise policy briefs, longer policy analyses, editorials, position papers, media soundbites, public speaking, and other communication strategies. Participation in a mock press conference, for example, follows media training content and media advocacy theory and design (Brewah, 2009).

Similarly, the nursing PhD programme specialty in health policy requires students to finish a 6-credit, semester-long health policy internship. This experience is designed to advance their development as analysts and leaders in health policy. The internship provides an

opportunity to observe and participate in policy development and implementation in settings such as government agencies, professional nursing organisations, private think tanks, and administrative and policy offices of large healthcare organisations and private non-profit foundations (Ellenbecker, Fawcett and Glazer, 2005, cited in Dicenso et al, 2012).

2.4.2.5.2 Mutual policy identification

Those involved in education and practice need to develop collaborative relationships to identify and address mutual policy issues. According to Brewah (2009), an interest in relevant policies provides nurses with the necessary information for planning strategies, and gives them a chance to exercise influence on behalf of themselves, their services and patients. Academic partners analyse current healthcare and education issues that will affect the nursing profession. Practice partners disseminate their analysis widely within practice avenues. Issues can be suggested from within the academy or service. Academics can also teach nurses how to analyse the healthcare problems they see and turn it into a policy dialogue. Arabi et al (2014) support that nursing leaders must translate new research findings to the practice environment and into nursing education and from nursing education into practice and policy. They must speak the language of policy and engage in the political process effectively, and work cohesively as a profession.

2.4.2.6 . Informing policy-makers

Academics can collaborate with clinical nurses to write opinion editorials stressing issues and platforms, to influence public opinion and awareness of nursing. They need to write and publish articles in highly visible journals as well-placed research articles can influence opinion. This would enable the nursing profession to retain the best work and benefit from the opportunity for implementation. This work could be used by those who are engaged with policy to substantiate policy alternatives. Power comes from expertise as well as numbers. Policy experts in academia should coach clinical leaders on presentations and reports to policy-makers and regulators. This includes developing a plan to provide media training for recognised clinical nurse experts, informing nurses that policy support services are available (Short, 2008).

2.4.2.7 Networking

For nurses to become involved in the decision-making process, they need to network. It is important to know the key players such as politicians and officials in local, regional and national government. Knowing the nurses in key positions that could be influential and in networks outside nursing, such as NGOs and voluntary organisations, can also be advantageous in achieving goals. These groups can be useful in pushing the nurses' agenda. Nurse leaders need to communicate their position through committees or boards, making submissions and meeting with people in positions of influence (ICN, 2005).

2.4.2.8 Communication skills

Nurse and nurse leaders need to grasp the tools of communication. Continuing education programmes may be run by employers or by nurses' associations. These programmes could assist in preparing nurse leaders to develop skills such as public speaking, negotiation, strategic thinking and planning, and the policy process (ICN, 2005).

2.4.2.9 Succession planning

Nurse leaders need to have strategies that enable them to respond to the ever-changing healthcare environment, including organisational prospects and variations in local and national policy. Their core values should inform leadership style with mentorship, coaching and supervision (Frankel, 2008). Preparation of younger nurses for leadership roles in influencing health policy is essential. Therefore, leaders must use strategies that individuals find motivating in order to empower them, and emphasise the importance of the nursing role. Senior nurses should also apply leadership skills in motivating staff to use critical reflection to facilitate new understanding. One method of achieving this is through the process of structured mentorship. The purpose of mentorship should be to develop younger nurses for leadership roles based on the attainment and mastery of new skills. A stable and supportive environment must be created, which encourages professional growth through effective role modelling (Frankel, 2008). According to the ICN guidelines (2005) young nurses need to be prepared for policy positions.

Frankel (2008) stated that the goal of mentorship should be to produce empowered nurses who are eager to implement evidence-based practice. The younger nurses could attend policy forums so that they get exposure to the process, environment and key players (ICN, 2005). They have to be given additional responsibilities such as leading the teams, which

would enable them to develop skills such as decision-making, assertiveness and leadership. Furthermore, they have to be provided with opportunities to attend leadership programmes. This will help them master the skills and confidence they need to be successful for a role in policy-making. Empowered nurses, according to Frankel (2008), are highly motivated, well informed and committed to organisational goals, and thus deliver patient care with greater effectiveness. These nurses must use their leadership behaviour to optimise patient outcomes, advocate for the nursing profession and have a positive effect on policy initiatives. Nurses need to be in the forefront of healthcare policy-making and future nurse leaders must lead this change (Hall-Long, 2009).

2.5 CONCEPTUAL FRAMEWORK

A number of frameworks were reviewed and are potentially useful for the research. These include: systems influencing the participation of nurses in health policy development; the policy cycle (CNA, 2008 in Buse et al, 2012); the data-driven policy-making model (Hinshaw and Grady, 2010); the policy triangle (Walt and Gilson, 1994, in Walt et al, 2008). The conceptual framework that was adopted for the current study was the policy triangle.

2.5.1 The policy triangle framework

The policy triangle framework, illustrated in Figure 2.1, suggests that four sets of factors (i.e. actors, content, process and context) interact to shape policy-making. In any country, the nature of policy-making and policy modification, as well as policy changes, are shaped by contextual factors: the actors (individuals, organisations or government) and their actions concerning policy change; the processes through which policies are recognised, formulated, negotiated, communicated, implemented and evaluated; and the nature and design of specific reforms (Walt et al., 2008).

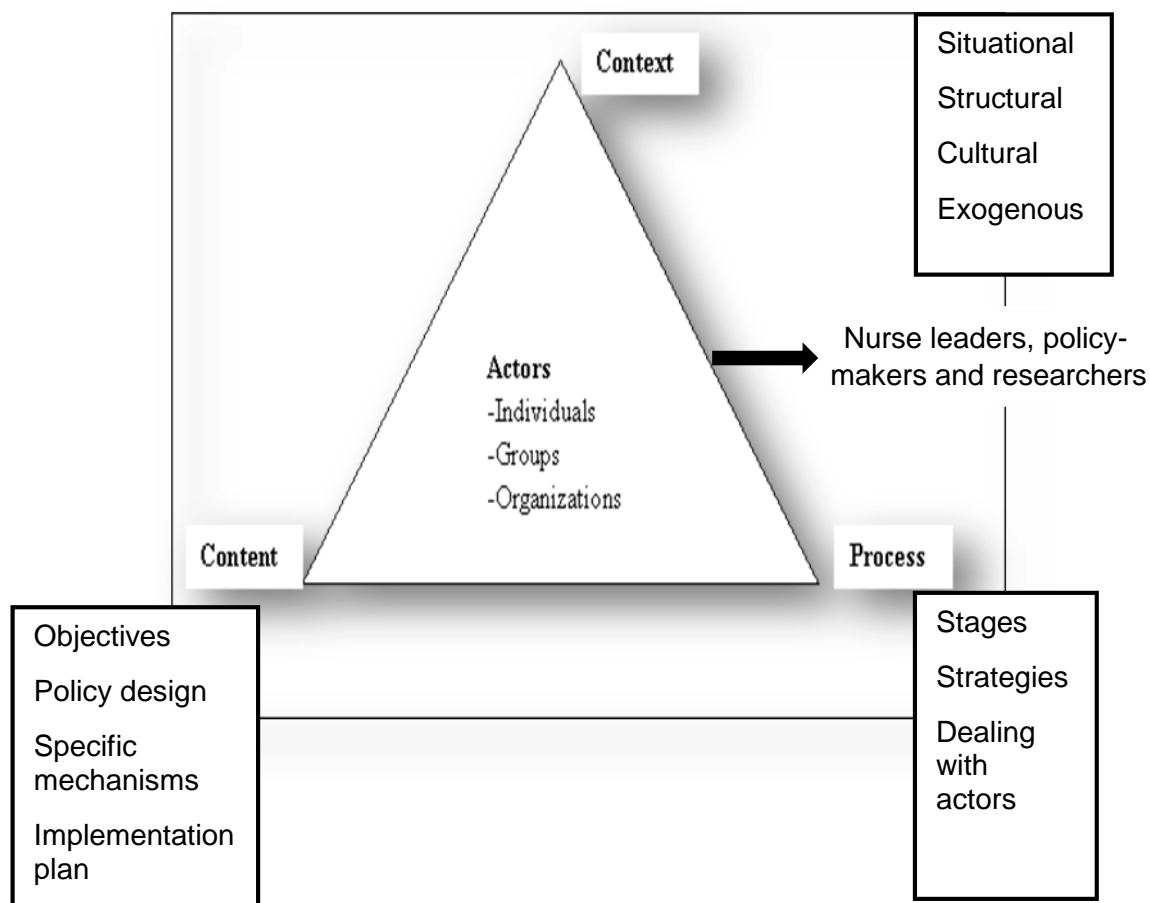


Figure 2.1: The Policy Triangle Framework (Walt and Gilson, 1994)

The focus of the study was the actors' participation in policy development, including process and contextual aspects. This was relative to both their roles, which are politically and technically related, and how these roles influence the policy-making process. Policy development belongs in the process corner of the framework. Therefore, understanding the process can explain why the desired outcomes fail to be realised. For the health policy analysis framework to be effective, it is preferable not to focus only on reform content (the "what" of policy), but also on actors, context and process (the "who" and "how" of policy) (Buse et al, 2012). This framework has been used to analyse a large number of health concerns, including mental health, health sector reform, tuberculosis, reproductive health, and antenatal syphilis control (Gilson and Raphaely, 2008).

This framework was chosen because it takes a holistic approach to policy development that can accommodate a wide variety of research methods. The model helped to direct and organise knowledge-gathering and analysis. Buse et al. (2012) define **actors** as individuals, organisations or the state, whose actions have implications for health policy. All actors have their own interests and agendas (Buse et al, 2012). For the purpose of the

current study, the term actors refer to policy-makers, researchers and nurse leaders. The study looked at the extent of participation of nurse leaders as actors in the policy process. It was also imperative to analyse how the other actors have engaged nurses in the process.

Context means systematic factors, i.e. political, economic and social or cultural factors, both national and international, which may affect health policy. The study had to identify factors (internal or external to nursing) that influence or limit the participation of nurse leaders in health policy development, such as politics, structural factors, situational factors and health system reforms. **Process** refers to the way in which policies are initiated, formulated, negotiated, communicated, implemented and evaluated (Buse et al, 2012). The study focused on all the stages of policy development, and on how nurse leaders had participated or could enhance their participation at all stages. **Content** mainly refers to the substance/design of the policy. The study attempted to analyse how the content affected implementation and how it could be improved, with input from the relevant actors.

2.6 CONCLUSION

This chapter presented the background to the study, which aimed at establishing the extent of participation of nurse leaders in health policy development. The rationale for the paradigm shift from recognising nurse leaders as implementers of policies to actors in the process has been traced. Various contextual backgrounds have been presented, including the more recent calls from WHO (2012) and ICN (2015) on nurses to proactively participate in the policy development process. Problems highlighted in this chapter are that there is limited involvement of nurse leaders in health policy development and research processes, barriers to participation and the facilitators thereof. The involvement of nurses in the policy arena has been seen as insignificant to the academic enterprise and consequently, nursing researchers in SA have ignored it as a potential area for conceptual, as well as empirical, inquiry. This underscores the need for a study on the participation of nurse leaders in the process of developing health policies in South Africa.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Jonker and Pennink (2010) define a methodology as a domain or a map, while a method refers to a set of steps to travel between two places on the map. A methodology refers to a model to conduct research within the framework of a specific paradigm. It encompasses the fundamental sets of beliefs that guide a researcher to select one research method. A research method comprises a set of specific techniques, instruments and methods to gather and analyse data. Therefore, while a method entails the practical application of doing research, its theoretical and conceptual foundation is a methodology. A research design then becomes important to link a methodology and an appropriate set of research methods in order to tackle research questions and/or hypotheses that are established to examine social phenomena (Neuman, 2011). This chapter explains the philosophical basis for the study and how the research activity proceeded. The research design and procedures for sample selection, data collection and data analysis are described.

3.2 PHILOSOPHICAL UNDERPINNINGS

The two main philosophical features to characterise existing research paradigms are *ontology* and *epistemology*. They relate to the nature of knowledge and the development of that knowledge, respectively (Wahyuni, 2012).

3.2.1 Ontology

According to Mack (2010), ontology is the study of contentions and beliefs about the nature of social reality. It involves claims about what exists, how it looks, the characteristics that form it and how these units relate to each other. In other words, if someone studies ontology they study what we mean when we say something exists (Mack, 2010). The assumption is that individuals construct multiple realities. Each of us experiences a different reality. Reality is based on unique understanding, as each of us understands and makes sense of our own world as we see and experience it (Berger and Luckman, 1966; Gergen, 1999, 2001a, 2001b in Roots, 2007). The researcher acknowledges that individual perceptions of meaning and effect of experience can differ. Therefore, the uniqueness of participants was acknowledged while at the same time permitting areas of sameness. Ontologically, the participation of nurse leaders in health policy development is an inadequate phenomenon.

3.2.2 Epistemology

If ontologists study the meaning of existence of something, then an epistemologist studies what we mean when we say we know something (Mack, 2010). Epistemology is a set of beliefs on the way to generate, understand and use information that is believed to be acceptable and valid. For example, epistemologically, the researcher believes that nurse leaders each have knowledge that they have acquired from their own experiences and practice. The researcher and subject are interdependent hence knowledge is subjective and biased (Wahyuni, 2012). According McNiff and Whitehead (2011), individuals have to discuss their meanings with other knowing individuals. In search for knowledge the researcher worked with the selected nurse leaders in addressing the phenomenon of common interest, which is participation in health policy development. Cognitive interaction and shared knowledge construction were considered as the fundamental features in the process of the study. The study reasoning was inductive and deductive, using mixed methods to answer the research question. The belief is that knowledge is generated inductively from data, flowing logically from specific to general explanations. Wahyuni (2012) added two other basic viewpoints that affect the way we investigate reality. These were *axiology* and *methodology*. Axiology is concerned with ethics, encompassing the roles of values in the research and the researcher's stance in relation to the subject studied. This is dealt with under ethical considerations. A methodology refers to a model for undertaking a research process in the context of a particular paradigm as described in the introductory paragraph.

3.2.3 Theoretical perspective

The theoretical perspective adopted in the study was **constructivism**. The researcher's belief is aligned with the constructivist viewpoint that the social world is constantly changing and is continually constructed by participants. According to Krauss (2005) constructivism refers to the form of research encompassed within the interpretative paradigm. Creswell (2014) agrees that constructivism is a perspective or an approach that is often combined with interpretivism. Reality is created by and between people who experience it as opposed to positivism, which contends that an individual produces his or her own reality. Therefore, reality is a result of the context in which action occurs. Since the cultural, social and political norms that operate within that context and time shape reality, perceptions of reality are relative.

Constructivist researchers address the processes of interaction among individuals. They focus on the context in which people live and work, in order to understand the history and cultural background of the participants (Creswell 2014). The environment and context influence how one views reality (Roots 2007). This supports the conceptual framework (Policy Triangle) on which this study is based. It is believed that the context and process of health policy development influence the participation of nurse leaders.

Assumptions identified in constructivism

- i. It is believed that as human beings engage with the world they are interpreting, they construct meanings.
- ii. The historical and social standpoints are the bases on which humans connect with their world and make sense of it. Through visiting the settings and gathering information personally, the researcher is able to understand the context. The researcher in the current study also applied this assumption. The researcher's personal experience also shaped the interpretation of the findings.
- iii. The basic generation of meaning is always social, arising in and out of contact with a human community (Creswell, 2014).

The researcher's position is that the knower and known are co-created. She recognised that the individual perception of meaning and effect of experience could differ (Krauss 2005). Therefore the belief is that the nurse leaders need to participate in health policy development to some extent so as to better understand and express its surfacing properties and features (Healy and Perry, 2000 in Krauss, 2005). The researcher engaged with the participants to construct knowledge; however, different value perspectives were accommodated. The goal was to rely as much as possible on the participants' views of the situation being studied.

3.2.4 Research paradigm: pragmatism

A research paradigm is a set of fundamental assumptions and beliefs as to how the world is perceived. It then serves as a reasoning framework that guides the behaviour of the researcher (Jonker and Pennink, 2010). Some writers Creswell (2009) and Neuman (2011) stress that the importance of questioning the research paradigm to be applied in conducting research because of its influence on how the researcher undertakes a social study in relation to the framework and understanding social phenomena. A pragmatic paradigm underpins the study. The use of quantitative and qualitative methods is the

defining characteristic of **pragmatism**. This allows the research to switch between different perspectives in order to answer the research question. Pragmatism does not encourage a single system of thinking or truth. It is therefore specifically applicable in a mixed-methods approach because the focus is solution-generative. According to Creswell (2014), for the mixed methods researcher, pragmatism allows the use of multiple methods, different worldviews and different beliefs, as well as various forms of data collection and analysis.

The pragmatists believe in understanding reality through action. Thus the relationship between the process of scientific theoretical perspectives and practical application is dialectical and cooperative (Kyrö, 2004). The study aimed at conceptualising the process of participation of nurse leaders in health policy development in order to advance the theoretical discussion in this field. Conceptualisation will lead to better practical application. For many pragmatists, knowledge claims arise out of activities, circumstances, and consequences rather than preconceived conditions. Pragmatism is concerned with applications, in other words what works or what the solution for a problem is. Pragmatism merges reality with experience, which is the satisfaction of subjective interests of the informed subjects. Pragmatism is consistent with action research that is more focussed on the application of existing scientific knowledge versus creation of new scientific knowledge. Hence it could be argued that pragmatism is a more grounded approach to research (McNiff, 2013).

3.3 RESEARCH DESIGN

3.3.1 Action research (AR)

A research design is the “general plan for finding answers to the questions being investigated” (Polit and Beck, 2008:49). The research design maximises the control over factors that could interfere with the validity of the study findings. It also assists the researcher to overcome difficulties faced during the research process (Burns and Grove, 2005). Before the researcher could decide on a research design it was necessary to determine the knowledge claims that contributed towards the study, which strategies of enquiry to follow to clarify procedures, and which methods of data collection and analysis would be required (Creswell, 2012).

The action research design with **convergent mixed methods** underpins this study. The convergent mixed methods is a type of a design in which qualitative and quantitative data collection run parallel, analysis is done separately, and then data is merged in the

interpretation. The two databases were compared to integrate the results to develop a more complete understanding of the research problem (Creswell, 2014). The founder of “Action Research” is Kurt Lewin, a German-born social psychologist and educator. For Lewin, the major goals of action research were to create a change in practice and to develop or refine existing theory. He signified AR as an intervention that dealt with the improvement of intergroup relations (Bradbury, 2015). According to Bradbury and Reason (2006), action research can be defined as both a methodology and an ideology. As a methodology, it stipulates how data should be collected and interpreted. As an ideology, it is fixed in the democratic thinking of promoting individual welfare in a humanistic way. Knowledge created through scholastic research and knowledge created while involved in practice is the basis for this philosophy (Bargal, 2008).

McNiff and Whitehead (2011), further stated that the action research approach to capacity building assumes that the professional is not a novice who needs to be dependent on trainers, rather she needs the support of a critical friend who is also learning in the process of facilitating the professional’s development. The ability of the nurse leaders to learn from the study’s experience is essential for continuous professional development. Therefore, the objective of the study, which was to identify and collaboratively implement strategies to increase participation of nurse leaders in health policy development, using the action research approach is relevant for professional development. Action researchers are primarily concerned with research that will have implications for public policy, whether tackling particular practical problems or changing the broader social structure (Kwok and Ku, 2008). Lewin shifted the role of the researcher from being a distant observer to involvement in concrete problem solving (Bradbury, 2015).

The core features of action research are: **Partnership and participation** – engagement of the researcher with stakeholders; **Reflexivity** – about how change efforts are unfolding; **Technical, practical and emancipatory** – empowering employees as members of knowledge creation efforts; **Emphasis on creating transformative change** by taking purposeful action (Huang, 2010). Action research is therefore especially relevant in nursing because it bridges the gap between theory, research and practice. The academic integrity of AR depends both on the ability to solve relevant problems and at the same time thoroughly examine experiences from the field engagement, in order to impart research-based findings. This dual perspective (action and reflection) distinguishes AR from most conventional social science practices (Levin, 2012).

3.3.1.1 Action research outcomes

Action research is unlike other methods of research as there is less concern for the universality of findings, and more significance is placed on the relevance of the findings to the researcher and local collaborators. According to Riel and Lepori (2011), action research has three outcomes, on the personal, organisational and scholarly levels. At the personal level, it is an organised set of methods for interpreting and evaluating one's actions with the goal of improving practice. The researcher focuses inward, reflecting on changes in skills, knowledge and identity. At the organisational level, action research is about identifying the system of interactions that define a social context. The researcher develops an understanding of the factors that control change and result in group or organisational change.

According to Bradbury (2015), Lewin proposed action research as a method of understanding social systems or organisational learning. Lewin maintained that understanding is best tested by trying to effect change. At the scholarly level, the action researcher produces confirmed or proven findings. It is his or her responsibility to communicate the findings arrived at with participants in the study setting to the larger community. The researchers appreciate that many people gain expertise in their workplace, but that the process of expanding knowledge through ongoing discussion about the nature of their findings is the most valued aspect. Engaging in this discourse, through publishing or presenting at conferences, is part of the process of action research (Riel and Lepori, 2011).

3.3.1.2 Rationale for action research in this study

Action research was applicable to the study since experience and the literature review enabled the researcher to have a reasonable idea of the problems to be investigated (French, 2009). It allowed involvement of the researcher in her own study and collective, in that it involved other people as part of a shared enquiry. It is research *with* rather than research *on*. The participants were engaged from the initial phase to the implementation stage, while trying out an intervention that emanated mainly from their recommendations during data collection. One of the objectives of the study was to collaboratively identify and implement strategies that would enhance the participation of nurse leaders in health policy development.

Action research involves a self-reflective spiral of planning, acting, observing, reflecting and re-planning (McNiff, 2013). This process is relevant, as change in practice (participation of nurse leaders in policy development) is justified. The study incorporated both qualitative and quantitative methods. The typical politician welcomes action research reports that are made directly by community representatives because they are more useful and actionable than are rigorous numbers (Huang, 2010). The strategy implemented (a policy brief) was developed by the community of nurse leaders for presentation to the policy-makers.

3.3.1.3 Approaches to action research

There is no consensus on the approach to action research, as there is no absolutely right or exclusive approach to it (McNiff and Whitehead, 2011). However, action research allows the researcher to consider and work on what is applicable in her particular circumstances. According to McNiff (2013), Lewin identified four types of action research:

- **Diagnostic action research** which was intended to yield a needed plan of action or intervention in an already existing situation. The researcher diagnoses the problem, and recommends remedial measures.
- **Participant action research** in which the affected community must be involved in the research process from the beginning. They realise the need for the proposed improvement and support the programme.
- **Empirical action research** was primarily a matter of keeping records and adding experiences in day-to-day work, ideally with a succession of similar groups.
- **Experimental action research** called for a controlled study of the relative effectiveness of various techniques in nearly identical social situations to test hypotheses and generate scientific knowledge (Adelman, 2006). O'Brien (2001) identified other types, which are:
 - **Traditional action research** that is applied in areas of organisational development. It is more conservative and resistant to change in power structures. The primary focus of traditional action research is to acquire more knowledge about an area of interest. The researcher only engages other participants at the implementation stage, while trying out an intervention that was pre-determined without the involvement of the participants.
 - **Educational action research** is an approach where educational experts work inside or outside an educational setting to attend to problems relating to curriculum development, professional development and applied learning in a social context, with the active participation of people who are affected by the phenomenon of interest (McNiff, 2013).

The current study employed the participant action research approach. The participants were involved from the initial to the implementation stages of the study. A research team validated data collection tools, assisted during data collection, and identified and participated in the implementation of strategies that could enhance the participation of nurse leaders in health policy development.

3.3.1.4 Action research guiding principles

What gives action research its unique quality is the following principles that guide the research.

- *Action research is cyclical or spiral.*

Some steps of AR recur in the same pattern at various stages of the research process (McNiff, 2013). The cyclical process of planning, observation, reflection and action was followed in all phases of the study. The starting point for the study was the identification of a practical problem, which was limited participation of nurse leaders in health policy development. The purpose of the preliminary phase was to define the current situation, with the objective of visioning and planning the phases of the action research. The second phase, the capacity building policy workshop, built on the findings from the first phase.

- *Action research is collaborative and participative.*

Working together between the researcher and other participants is of utmost importance in AR, although the degree of participation expected from the researcher and the participants differs from one project to another. It ranges from a total absence of difference between role players to obvious separation of roles. The researcher in AR is the facilitator, guider, formulator and summariser of knowledge and raiser of issues (Cohen and Crabtree, 2006). McNiff and Whitehead (2011) stressed the need to recognise, appreciate and respect the rights and values of all participating individuals and their goals and aspirations. The role of the researcher in this study was that of a facilitator, supporter and co-learner. The researcher and participants collaboratively identified and implemented strategies that could be used to enhance participation of nurse leaders in health policy development. In spite of the differences in their responsibilities and professional expertise, partners in action research should appreciate each other as colleagues (McNiff and Whitehead, 2011).

- *Action research accommodates mixed methods*

AR works more frequently with language than numbers. However, some research may be a combination of qualitative and quantitative data collection methods as was the case with this study. This study also employed mixed methods whereby qualitative data were collected through in-depth interviews and through questionnaires (Greenwood and Levin, 2007).

- *Action research is reflective*

Analysis of each cycle takes place to consider the results produced by the planned activities (McNiff, 2013). The critical reflection on the cycle of planning, action and evaluation at each phase of the research process is fundamental for moving toward the desired change for improved practice. In this study, the researcher and the participants undertook the reflection process as part of learning and professional development.

- *Action research solves practical problems and leads to change in practice.*

AR focuses on specific problems within specific settings for improving practice. Furthermore, if the desired change is outside the researcher's scope, s(he) should be realistic and aim to address some smaller aspect of the work and not to give up altogether. Participation of nurse leaders in health policy development is quite broad. However capacitating the participants with knowledge of the health policy development process that was limited was a step to initiate change in their practice (McNiff 2013).

McNiff (2011) suggested that, rather than starting with a rigid assumption, the researcher works through the various stages of the research process to see if her desire is satisfied. From the findings, the researcher either develops a new theory or works on a previous one. This study considered a number of theories for understanding and analysing the characteristics of participants. There are basic steps that are followed in action research, which are described in many ways. McNiff (2011) identified eight steps of action research as follows: reviewing current practice; identification of aspects to be investigated; imagining way forward; trying it out; taking stock of what happened; modifying what one is doing in the light of findings; continuing to work in the new way. Different authors agree that action research is not linear (Hayes, 2012; Greenwood and Levin, 2012; McNiff, 2011). Some describe it as spiral and others as cyclical. The model in Figure 3.1 summarises the action research process that was followed in the study.

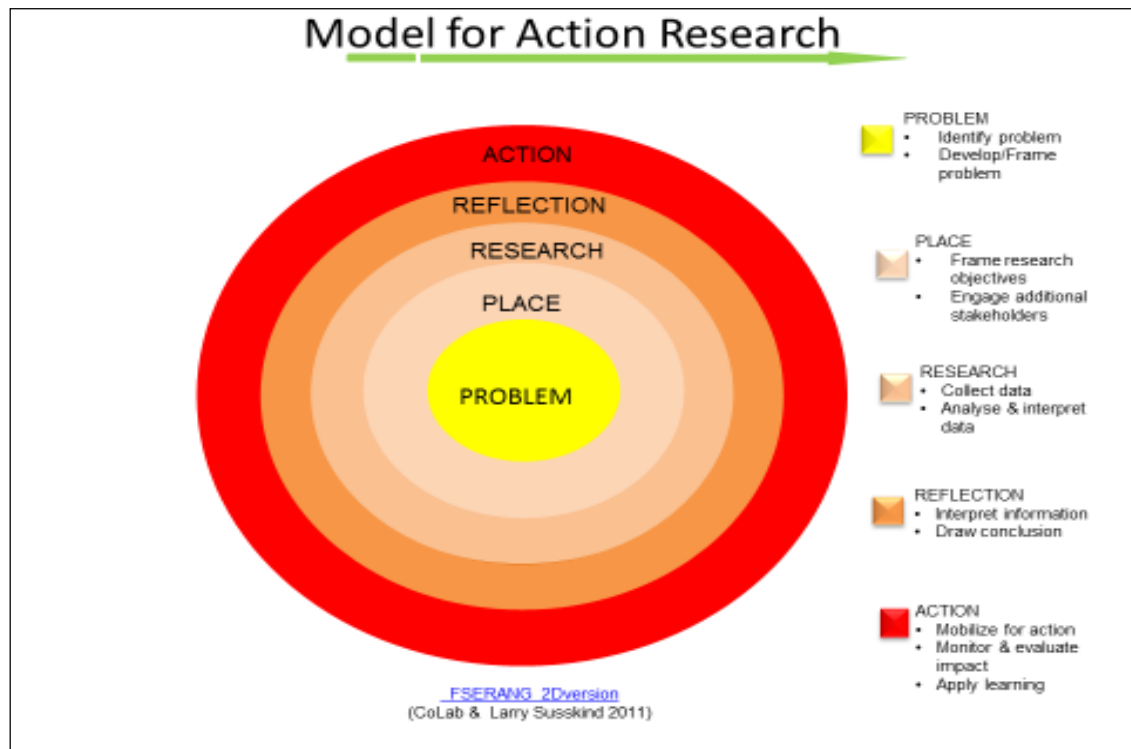


Figure 3.1: Action research model

3.4 THE STUDY SETTING

The study was conducted in South Africa, in the province of KwaZulu-Natal (KZN). South Africa has 9 (nine) provinces, one of which is KZN. With a total area of 94 361 square kilometers, KZN is the country's third-smallest province, consisting of 7.7% of South Africa's land area. The province stretches from Port Edward in the south to the borders of Swaziland and Mozambique to the north. It has the second-largest population of 10,92 million (mid-year population estimates, 2015), constituting 19.9 percent of South Africa's population ([about/geography/kwazulu-natal.htm#. V3Q-6Hn77ml](http://about/geography/kwazulu-natal.htm#.V3Q-6Hn77ml)).

STUDY AREA: COUNTRY (SOUTH AFRICA)

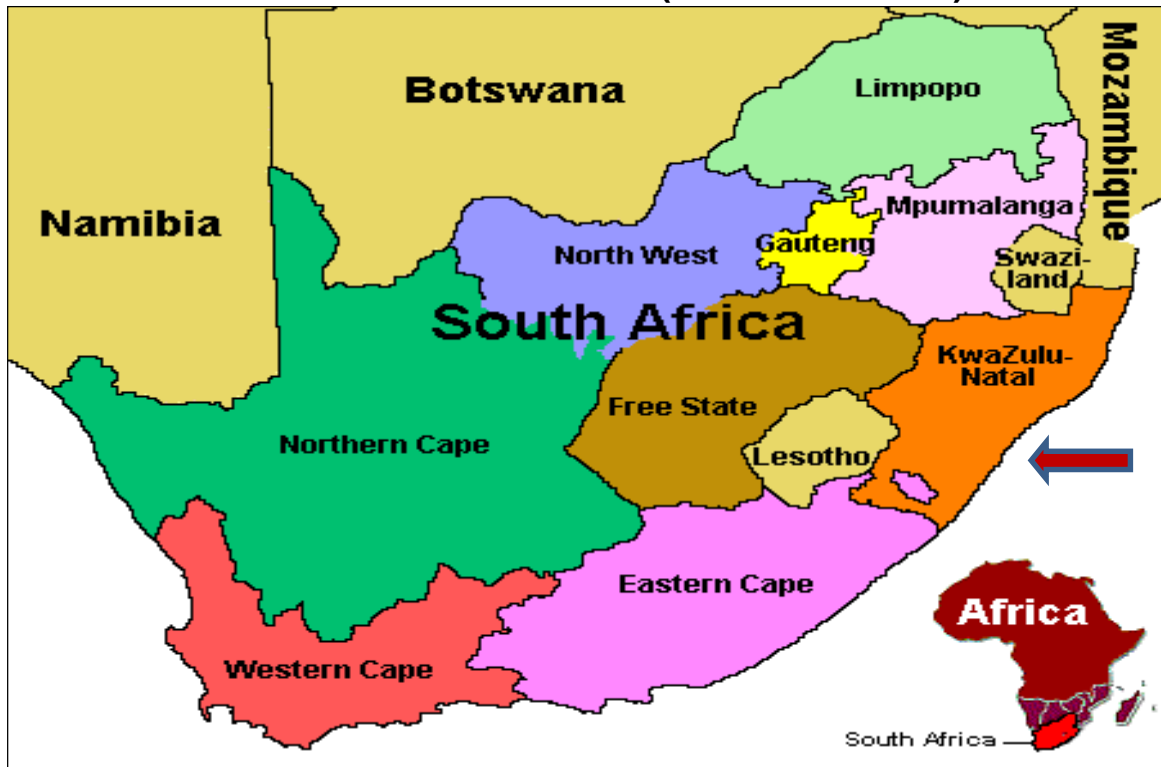


Figure 3.2: Map of South Africa

The map shows the nine Provinces including KwaZulu-Natal, where the study was conducted.

KwaZulu-Natal has eleven (11) health districts as illustrated in Figure 3.2. In these health districts public hospitals provide different levels of care: tertiary, regional, district and specialised hospitals. The study was conducted in regional and tertiary hospitals. Seven (7) out of eleven districts have these levels of hospital. The study was conducted in five (5) out of the seven districts: Amajuba, eThekweni, ILembe, uGu, and uThukela districts. UMgungundlovu and uThungulu districts were excluded because a support letter could not be obtained from relevant officials before the study commenced.

KWAZULU-NATAL PROVINCE: HEALTH DISTRICTS

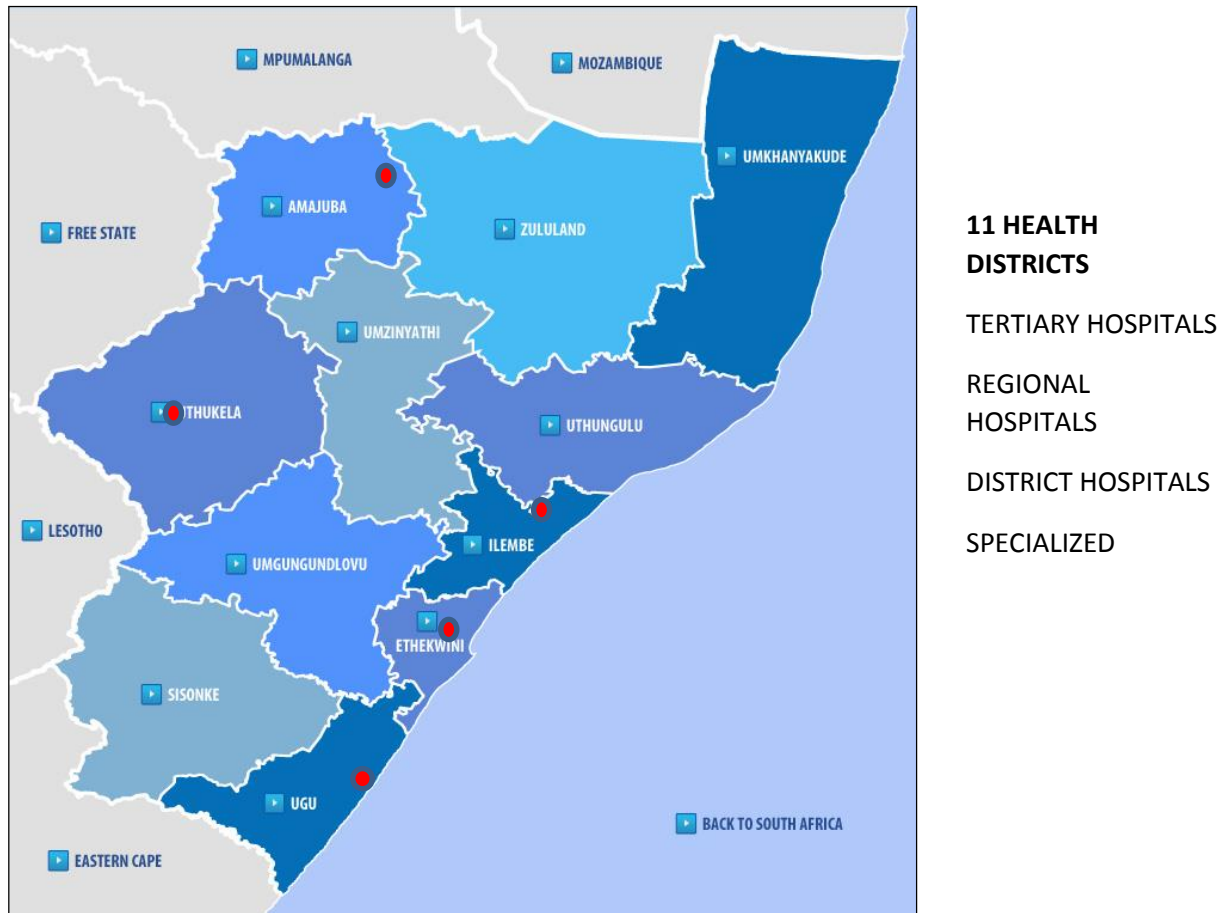


Figure 3.3 Eleven KZN Health Districts

3.5 POPULATION

The study population comprised nurses in management positions employed by the KZN DOH in selected regional and tertiary hospitals, nurses in leadership positions at district, provincial (Senior Nursing Officer) and national level such as the Chief Nursing and Midwifery Officer (CNMO) and nurse leaders who have worked in the policy-making environment such as the South African Nursing Council (SANC) and the NDOH Human Resources for Health (HRH). 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 are included in the study (Burns and Grove 2005).

3.5.1 Target Population

The target population consisted of nurse leaders (Managers) in the upper level of the organisational structure, nurse managers (NM) and assistant nurse managers (ANM),

nurse leaders from Organised Labour, KZN DOH, national department of health and the SANC.

3.6 SAMPLING

Sampling is a process of selecting a segment of the population which is an entire aggregate of cases (Polit and Beck, 2012). For the researcher to understand a much larger set of cases and learn from them, selection of cases for detailed examination is done when sampling. The main use of sampling in quantitative studies is to produce a representative sample and generalise the findings to the entire population. Whereas, in qualitative studies the selection of participants is determined by their relevance to the research topic rather than their representativeness (Neuman, 2011). Sampling includes selecting groups of people, events, behaviours or other elements with which to conduct a study (Burns and Grove, 2005). In view of the pragmatic paradigm which allowed mixed methods, both quantitative and qualitative samples were drawn. However purposive sampling was used for participants in the study based on the researcher's knowledge of the population (Polit and Beck 2012). The prospective participants were recruited (after obtaining permission from the facility) and their cooperation was requested.

3.6.1 Sampling Frame

A list of all the districts and hospitals in KwaZulu-Natal was obtained from the KZN health Intranet website. A list of all ANMs and NMs from the selected sites and nurse leaders at the district health offices was accessed from the PERSAL control system. It was used to estimate the number of potential respondents.

3.6.2 . Quantitative Sampling

A multi-stage sampling was applied. Multistage sampling is a complex form of cluster sampling in which two or more levels of units are rooted one in the other. It involves the repeat of two main steps, which are listing and sampling. Typically, at each stage the cluster gets smaller in size and in the end, subject sampling is done (Wahyuni, 2012). The initial sample was selecting districts that had the regional and tertiary hospitals. The study was conducted in five health districts namely, Amajuba, eThekwin, ILembe, uGu, and uThukela districts. Eleven hospitals participated in the study. Table 3.1 illustrates the facilities and participants that were available for the study.

Table: 3.1: Participants in the respective institutions

Facility	Total number of ANMs	Total number of nurse managers	Total responded to questionnaire	Nurse managers	ANMs
EThekweni District					
R K Khan	9	1	8	1	7
Addington	8	Nil (acting ANM)	5		5
Prince Mshiyeni	10	1	7		7
Inkosi Albert Luthuli	12	Nil (acting ANM)	10		10
King Dinuzulu	14	1	11		11
King Edward (KEH)	10	1	10		10
ILembe District					
Stanger	8	1	5	1	4
Amajuba District					
Madadeni	9	1	6		6
Newcastle	6	1	1	1	0
UGu District					
Port Shepstone	10	1	9	1	8
UThukela District					
Lady Smith	8	1	9	1	8
TOTAL	104	9	81	5	76

The nurse leaders consisted of nurse managers and assistant nurse managers. Five nurse managers participated in the quantitative study. One nurse manager was recruited from each participating health district. The total number of assistant nurse managers (ANM) that was available was 104 in the five districts. Seventy six ANMs out of the 104 were enrolled for the study. In two facilities namely KEH and Ladysmith, all ANMs participated in the study, making up at total of 18. In the remaining institutions, a simple random sampling was conducted.

The overarching aim of the study was to determine participation of nurse leaders in the four broad stages of policy development, namely: problem identification and agenda

setting; policy formulation; policy implementation and policy evaluation. The purpose was to identify and analyse the gap in their participation.

3.6.3 .1 Analysis of variance (ANOVA)

An ANOVA test had the potential to determine differences in involvement of participants at different stages of policy development. The null hypothesis (basic assumption) was that there was no statistically significant difference in participation of nurse leaders in policy development from one stage to the other. The ANOVA would either accept or reject the null hypothesis. Therefore if the P value of the ANOVA is < 0.05 , it means there is a statistical significance. If the P value is > 0.05 ANOVA accepts the null hypotheses. Rejection of the null hypothesis would result in the use of a post-hoc test to ascertain at which level participants involve themselves most.

A statistical tool called G-power was used to calculate the number of participants in the study. G-power was used to calculate the number of ANMs. The following parameters were used:

a) Effect size of 0.39 (large effect size)

The effect size is a standardised index that is independent of the sample size and quantifies the magnitude of the difference between populations or the relationship between explanatory (independent) and responsive (dependent) variables. In the interest of analysis of variance, the effect size can be viewed as the population standard deviation.

b) Type 1 error (Alpha error) = 0.05 (5%) (Recommended for a medical study).

c) Type 2 error (Beta error) = 0.02 (20%) (Recommended for a medical study).

Statistical power = $1 - \beta$. $1 - 0.2 = 0.8$ (80%).

d) Critical F value (value at which F should be to get a significant result) = 2.73

On the basis of the above parameters the researcher and statistician arrived at the sample size of 76 ANMs and 5 nurse managers, $76+5= 81$ participants. Therefore the quantitative sample for the study consisted of 81 participants. According to Polit and Beck (2010), the quantitative researchers should select the largest sample possible so that it is representative of the population.

3.6.4 Qualitative sampling

Purposive non probability

Purposive sampling refers to the sample being selected purposefully and is subject to the researcher's judgment, in line with the aim of the study, regarding whom he/she considers to be typical of the population and is particularly knowledgeable about the issues being studied (Polit and Beck, 2008; Keeney et al, 2010). Sampling was purposive because the intention was to include participants who were knowledgeable about the phenomenon under study. In searching for meaning, the researcher was looking for the sample that could best provide the required data. Participants were selected who were likely to have a genuine interest in the topic, or who were part of, or should be part of, the health policy development process (Keeney et al., 2010). According to Neuman (2011), for clarity, insight and understanding about issues or relationships in the social world, few participants must be selected. The aim of sampling is to uncover new theoretical understandings, show characteristics of people and the social environment, or expand knowledge of complex conditions or events.

The sample size in qualitative approach is usually small. The qualitative sample consisted of eight participants. This is in line with the guidelines for sample sizes in qualitative research which according to Short (2008), should be at least six. According to Byrne (2012), the researcher could consider sample sizes used in previous published studies, the scope of his or her study and the resources available to him or her. No similar study was found using action research or mixed methods. Sampling was done until data saturation occurred. Saturation of data occurs when additional interviews provide no information to identify themes and subthemes (Burns and Grove, 2005). Purposive sampling was adopted because of the small population of nurse leaders in a hospital. Furthermore, the number was reduced when people were on vacation or sick leave or working shifts.

3.6.5 Sample inclusion and exclusion criteria

The inclusion criterion for participating in both the first and second phase of the study was being an ANM or Nurse Manager working in the selected regional and tertiary hospitals in the KwaZulu-Natal Province, and senior nurses in leadership positions working at provincial and national level. The second phase of the study expanded the inclusion and allowed the nurse educators to be included in the sample. This was done to strengthen partnerships between the nurse leaders from practice and the nurse educators to help

realize improvements. The researcher appreciates that they need to speak the language of policy and work cohesively as a profession. Nursing leaders must translate new research findings to the practice environment and into nursing education and from nursing education into practice and policy. Participation in the study was voluntary. Nurses, who were not in managerial positions in the selected hospitals, were excluded. The district and specialised hospitals were also excluded from the study.

3.7 DATA COLLECTION METHODS

Action researchers have a common understanding that action research does not require any specific method of data collection. Greenwood and Levin (2007) agree that all methods are acceptable such as surveys, statistical analysis, interviews, focus groups, ethnographies, if they are used in a way that does not oppress the participants. The study incorporated a convergent mixed-methods approach to address the research questions. Both qualitative and quantitative data sources were used, given equal emphasis and equal weight. The concepts that were measured quantitatively were also asked about during the qualitative data collection process.

Both data sources were collected concurrently (Creswell, 2014). The timing of data collection was planned so that an appointment for collecting both the qualitative and quantitative data would coincide on the same day. The questionnaires were distributed to the participants during the researcher's visit to the institution to collect data. While waiting for completion of the questionnaire, the researcher would conduct an interview with the nurse manager of that facility. This made it convenient for the researcher because of the long distances that had to be travelled to visit some districts.

The assumption is that both forms of data collection have strengths and limitations. The strengths could be combined to develop a stronger understanding of the research question as well as overcome the limitations. The 'mixing' or blending of data therefore provides richer information than a single method (Creswell, 2014). Data were gathered from different sources so as to embrace different perspectives. Data collected from different sources compensate for each other's weaknesses (Tekin and Kotaman, 2013). A pragmatic paradigm allows the research to switch between viewpoints so as to answer the research question. Therefore, it allows combining elements from the Action Research projects with the quantitative and qualitative elements (Janssen et al., 2013).

3.7.1 Qualitative data collection

Eight face-to-face in-depth interviews with a minimum length of 20 minutes were conducted. The interviews consisted of a list of semi-structured open-ended questions based on the focus areas the researcher intended to study. The broad areas to be dealt with were informed by the overall objectives of the study and the particular stakeholder being interviewed. The interview schedule was developed and used for asking questions and recording answers during the interviews. This allowed the researcher to control the line of questioning (Creswell 2014).

Follow-up questions were asked to explore the particular themes, concepts, ideas and unexpected thoughts provided by the interviewees. The probes were used to clarify some discussion points by soliciting more details or examples of what had been said. The tape recorder was used to record information from the interviews. Handwritten notes were also taken by a research assistant as a backup system in case the tape recorder failed. The research assistant was trained prior to commencing the first interview on how to take notes. The researcher self-monitored the appearance and performance of the research assistant. The same research assistant was used for the duration of the study. The advantages of using interviews to collect data were that participants could provide historical information. The researcher was able to clarify some questions where she could assess that there was misunderstanding. However, there are also limitations with conducting interviews. The researcher's presence may bias the responses. The fact that not all people are articulate and perceptive is also a disadvantage (Creswell, 2014). See Annexure 3B for the interview schedule.

3.7.2 Quantitative data collection

Data were collected through self-administered questionnaires to participants to allow for generalisation. In order to address the objectives of the study, the researcher developed a structured questionnaire adopted from the existing tools used by Shariff (2012) and Salvador (2010) as a method of data collection. According to the authors the instruments were pre-tested for construct and content validity as well as internal and stability reliability. However, the tool was reviewed by the researcher and the school statistician. A Cronbach's Alpha test for the instrument was carried out by the school statistician using SPSS version 23.0. The Cronbach alpha is a measure of internal consistency, that is, how closely related a set of items are as a group. It is considered to be a measure of scale reliability. The rating of the different sections of the tool was the same, indicating high levels

of internal consistency in questioning. The instrument had a high level of stability reliability. The overall Cronbach alpha correlation coefficient score was 0.882, as illustrated in Table 3.2.

Table 3.2 Cronbach's Alpha results

Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.882	.874	43

The questionnaires offered the possibility of anonymity, which was crucial in terms of obtaining information. This method was appropriate especially because the sample was widely dispersed within different districts.

The questionnaire consisted of items to measure involvement of nurse leaders in the health policy development process, knowledge of the policy process, perceived barriers and facilitators to participation in health policy development, as well as questions to obtain demographic information. For questions that aimed to gather information about their level of agreement or disagreement (strongly agree; agree; undecided; disagree; strongly disagree), a Likert scale was used. 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 and Grove, 2005). The closed-ended questions in all the sections of the questionnaire were included to ensure comparability of responses and to facilitate analysis. Close-ended questions offer response options from which respondents must choose the one that closely matches the appropriate answer (Polit and Beck, 2012). Open ended questions were designed to allow people to respond in their own words. These open ended questions allowed participants to provide richer information from their experience on how nurse leaders are participating in all stages of policy development. Adequate space was provided in the tool to permit full response.

The research information package was sent beforehand via e-mail when the researcher sought permission and at the time of booking an appointment for data collection with the nursing management teams. The researcher then delivered the self-administered

questionnaires personally to the participating institutions. The questionnaires were administered to the participants after obtaining their consent. In some participating facilities, especially those that were far from eThekweni district, the researcher had to wait for the questionnaire to be completed on the same day. This assisted in ensuring an acceptable response rate. The questionnaires offered some anonymity because the name of the participant was not required. However, for data analysis purposes, the name of the institution was required. Using a questionnaire was convenient because a larger group of participants could be reached at a time. Bias was minimal as the researcher was not present in the room where the participants were completing the questionnaire. The main limitation of using a questionnaire was missing information, as some questions were left unanswered.

3.8 VALIDATION / RESEARCH TEAM

According to Mc Niff (2011), a validation group consists of a few people who critically review the work and offer suggestions from time to time, though the researcher is fully responsible for the final decision. A team of professionals in leadership positions were consulted and requested to help the researcher by recognising and critically analysing the issues of subjectivity which are inherent in action research. A team was formed consisting of two assistant nurse managers, a nurse educator (campus principal) and a quality assurance manager (QAM) in a regional hospital. They were given copies of the research proposal. They were given the information sheet and completed the informed consent form. They were then given a chance to review the instruments individually.

Prior to conducting the formal interviews, the researcher had a mock interview with one of the validation team members (principal) to fine-tune the interview schedule and for the researcher to gain confidence. As a result, some expressions and words were changed to make the questions clearer. The structure of the main questions was reordered to improve the flow of the discussion during the planned interviews. An ice breaking question but relevant to the topic under study was suggested. The principal also analysed the interview session and suggested how to improve conducting the planned interviews. The other team member (QAM) at some stage accompanied the researcher to collect data and assisted with distribution of the questionnaires. She also observed the interactive sessions that the researcher held with the study participants. The team was responsible for coordinating of the capacity- building workshop. The researcher had scheduled discussions with each

individual member when necessary and considered their suggestions (McNiff, 2013). Refer to Annexure 3A for the research questionnaire.

3.9 DATA ANALYSIS

The mixed-methods data were analysed with a parallel mixed-data analysis. Analysis of the qualitative and quantitative data was done separately. According to Fielding (2012) parallel analysis allows for a more complete and separate qualitative and quantitative understanding before findings of the quantitative analysis are compared and contrasted to the qualitative findings. In the event where qualitative data provided new or meaningful insights into the findings from the quantitative study, these findings are reported (Fielding, 2012). Data integration is a crucial element in mixed methods analysis and conceptualisation. It has three major purposes: illustration, convergent validation (triangulation), and the development of analytic density or “richness.” Statistical data can be dry, and a clip from an interview can bring the issue alive. Equally, qualitative data can be dense, and a statistic can provide focus (Fielding, 2012).

3.9.1 Qualitative data analysis

Qualitative data analysis involves dismantling, segmenting and reassembling data to form meaningful findings in order to draw inferences (Wahyuni, 2012). The research questions and research aim were used to guide the process of cutting the collected texts into pieces and logically recombining them. Analysis of data proceeded with data collection. The researcher did not wait to finish all the interviews before starting to analyse. As the process continued, the researcher analysed an interview that was conducted earlier. Memos that would be included as narratives in the final report were written. The researcher then collated and analysed data using thematic analysis. This is a systematic process of looking at data from different angles, with a view to identifying codes in the transcripts that will assist the researcher in understanding and interpreting raw data. Thematic analysis is an inductive and iterative process in which the researcher looks for similarities and differences in the text that contribute to rich descriptions of, in this study, the extent of participation of nurse leaders in health policy development (Creswell, 2014).

Transcription

The researcher transcribed all audio recordings and notes personally. Listening to the voice recordings and reading of field notes was done over and over again to gain

understanding of the content before coding (Creswell, 2013). This helped to recall observations and experiences until the researcher became immersed in the data.

Coding

Transcribed data were coded by reading again through each transcript to get a sense of emerging patterns. Data were hand colour coded. The related words, phrases and sentences were identified in the texts and assigned colours. They were highlighted in each interview text as many times as they occurred. Information provided by the participants that was not directly related to the study was omitted. The result of initial coding is the identification of numerous concepts relevant to the subject under study. After initial coding, the researcher tried to summarise and organise the data. This step resulted in refining and revising initial codes, categorising and searching for relationships and patterns in the data.

Establishing themes

The next step was to combine related codes into themes, and each theme was assigned identifying words (Babbie 2010). Themes were derived from words, phrases and sentences related to the research questions emerging from transcripts. A brief description of each theme was written down and outstanding quotes were marked with a coloured highlighter. The whole process was iterative, as the researcher moved back and forth through the data.

3.9.2 Quantitative data analysis

The quantitative data generated in this study came from self-administered questionnaires. The analysis sought to identify if there were any statistically significant changes in participation of nurse leaders at different stages of the health policy development. The nurse leaders were analysed individually (intra-individual variance) and as a group (inter-individual variance). Data were analysed using the Statistical Package for the Social sciences (SPSS) Version 23. Results were presented using tables, graphs, frequencies and percentages. The processing of data followed these steps:

Editing: The researcher had to ensure that data collected were usable. All questionnaires were examined at the point of collection or receipt for completeness.

Coding: The open-ended responses in the questionnaire were coded in preparation for data entry.

Data entry: Raw data from responses to all questions were entered into the computer using SPSS version 23. Statistical commands for analysis were used to produce frequencies, cross tabulations, graphs and correlation statistics. The data outliers were taken out.

Sorting: Hard copies of the instrument were grouped according to the facilities where they were collected. Facility instruments were labelled. The data for facilities from the same district were put together and a district batch was created.

3.9.3 Data triangulation

Triangulation of data took place as illustrated in Figure 3.4. Triangulation refers to checking to see whether information from different sources or different data collection techniques correspond or are parallel (Lapan and Quartaroli, 2009). Triangulation provides a wider perspective from participants and supports validity (Tekin and Kotaman, 2013). The two data sets were analysed separately, then compared and converged at interpretation and discussion stages with a view to providing corroborating evidence for the conclusions drawn.

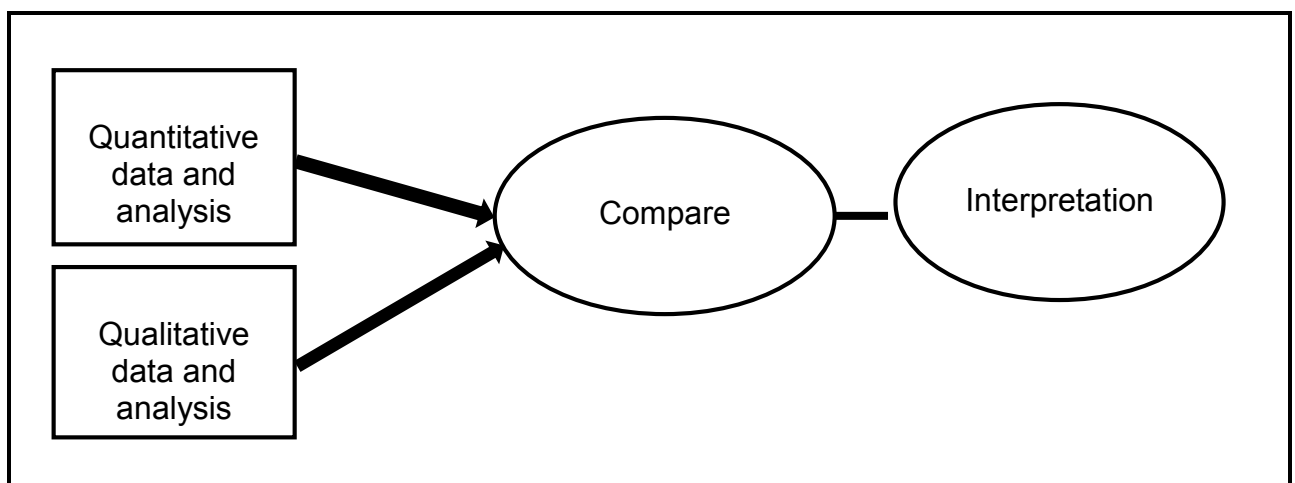


Figure 3.4: Data triangulation (Creswell, 2014)

3.9.4 The capacity-building workshop

The results of the study were shared with the research team for verification. The team brainstormed the interventions. It was agreed that a capacity-building policy workshop for nurse leaders was required based on the findings. The team also agreed on the topics to be covered during the workshop, including developing a policy brief. For cost containment, the workshop was planned to run on the same date as the presentation and verification of data with a larger group of nurse leaders. A consultant working at the Centre for Health Policy Studies at a reputable university was approached to facilitate the workshop.

3.9.4.1 Selection of participants

The planning of the workshop began with a process of selection and preparation of participants. Every effort was made to locate individuals and groups who have a legitimate interest or say in the matter under consideration. All facilities and individuals that had participated in the study were recruited for the workshop. Three nurse leaders were invited per facility. The nurse educators were also invited to the workshop. The invitations were sent via e-mail and telephonically.

3.9.4.2 The workshop programme

The researcher, in consultation with the research team, developed the programme for the workshop. It was informed by the research results, after analysing the gaps in the participation of nurse leaders in health policy development. The programme was emailed to the facilitator to ensure that the critical topics were covered during her presentations.

3.9.4.3 Venue

The workshop took place at Glenmore Pastoral Centre in Durban (KZN). The setting was somewhat retreat-like, permitting the participants to separate themselves from their daily lives briefly and focus intensively on the problem at hand. The researcher had to visit the place prior to the workshop to ensure that it was conducive for the event. The room was large enough for plenary discussions and for the participants to move around freely. The setting also contained ample space for working in small groups. In preparing for the workshop, close cooperation with some of the local participants was important. They assisted in preparing the workshop venue in the morning and were assigned to take notes during the workshop.

3.9.4.4 Equipment

A laptop was used for presentations. The data projector, microphone (to project the sound), flip chart and screen provided by the venue were also used.

3.9.4.5 Data collection

Data were collected during the course of the workshop by taking notes of all the proceedings and discussions. Records were captured using various data sheets (Cano, 2009) such as the registration form, attendance register and evaluation forms.

3.9.4.6 Data analysis

Grundy and Kemmis (1981) suggested that it is during the reflective stage of the AR cycle that data analysis occurred. This stage provided the researcher with important insights with which to move the process forward. The practitioner is the sole arbiter of interpretation (French, 2009). Consequently, the interpretation of others was vitally important because they provided insights that were not obvious to the researcher. These insights were elicited through discussion or through the deliberation of participants.

3.10 DATA MANAGEMENT

According to Wahyuni (2012), raw data, in the format as they are generated, need to be managed so that they are ready to be analysed. Data collected in qualitative research are primarily text-based, as opposed to data generated from quantitative research, which is mainly numerical. Data management has three important aspects: data storage, transcribing audio sources, and cleaning the data. A neat archive is essential for storing data if the researcher is using multiple sources of data. Good storage enables easy retrieval for various formats of collected data (Wahyuni, 2012). In line with the ethical requirements for conducting research, hard copies of collected data were stored in a locked filing cabinet in the researcher's office. Electronic data were stored in a computer that is password-protected. On completion of the study, the audiotape recordings were deleted. All data tools will be kept safe for a period of five years, in line with university policy, and thereafter destroyed.

3.11 ACADEMIC RIGOUR

Rigour in research refers to the establishment of confidence in the truth or credibility of the findings of the study (Polit and Beck, 2012). To ensure rigour throughout the research study, the whole research process needs to be evaluated against a set of criteria. Both quantitative and qualitative data collection and analysis methods based on the mixed-methods triangulation design were employed in the study. Both quantitative and qualitative approaches needed to deal with different threats to validity, and each approach has its own specific techniques to ensure validity.

3.11.1 Validity and reliability of quantitative data

There might be some errors when collecting data, therefore **reliability** is applied with the aim of achieving greater truth (Klopper and Knobloch, 2010). According to Burns and

Grove (2005), reliability means that if the instrument is repeated on the same participants at different periods, the results of the questionnaire will be the same. The more reliable a measure is, the fewer research participants are needed for the study.

Validity of the questionnaire refers to two aspects, namely whether the questionnaire measures the concept in question and whether the concept is measured accurately (Klopper and Knobloch, 2010). Face validity implies that the instrument looks as though it is measuring the appropriate concepts (Polit and Beck, 2008). 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, 2010). This includes the questionnaire being readable, exhibiting clarity of content and language, and being unambiguous and clear. In this study, the literature guided the researcher concerning the development of the main concepts and an interview guide was developed. The Cronbach alpha test of the questionnaire suggested a high level of reliability.

Content validity refers to the judgments of nurse leaders about the extent to which the content of the questionnaire appears logically to examine, and comprehensively to include, the characteristics of the domain being explored. The objectives, questions and instrument were compared to ensure consistency of questions with objectives as illustrated in Table 3.3.

Table 3.3: Content validity

RESEARCH QUESTION	RESEARCH OBJECTIVE	INSTRUMENT
1. How informed are nurse leaders of their role in health policy development?	1. To establish the level of nurse leaders' knowledge of their role in health policy development	8, 14, 19, 20, 20.1–20.8
2. How have nurse leaders participated in the health policy development process?	2. To analyse the level of participation of nurse leaders in the health policy development process	10, 11, 12, 18
3. What factors facilitate participation of nurse leaders in health policy development?	3. To determine factors that facilitate participation of nurse leaders in health policy development	16, 22.1–22.9

4. What factors limit participation of nurse leaders in health policy development?	4. To determine factors that limit participation of nurse leaders in health policy development	15, 21.1–21.10,
5. What strategies could be adopted to enhance nurse leaders' participation in health policy development?	6. To identify strategies for enhancing nurse leaders' participation in health policy development	22.1–22.9

Attrition

This was borne in mind by the researcher as it would be a threat to the validity of the study. This was done by selecting participants who would be interested in the topic under study. The sample included all the participants that were available for the purpose, and therefore could not add further to attrition. The Hawthorne effect was addressed by ensuring ethical considerations throughout the duration of the study. Neuman (2011) describes the Hawthorne effect as a reactivity result that occurs when participants are aware that they are being studied.

3.11.2 Qualitative rigour (validity and reliability of qualitative data)

Qualitative validity means that the researcher employs certain procedures to check for accuracy of findings. On the other hand, qualitative reliability implies that the approach used by the researcher is consistent across various projects (Gibbs, 2007, cited in Creswell 2014). The reliability of the findings is enhanced from the perspective of the participant, researcher or reader of the research. Qualitative researchers advocate the use of terminology tailor-made for qualitative studies, such as trustworthiness. Qualitative data are ascertained by trustworthiness (Polit and Beck, 2008). Trustworthiness ascertains the value of qualitative data (Polit and Beck, 2008). Qualitative data collected at various stages included data from in-depth interviews and from the data recording sheets. Polit and Beck further suggested that criteria for judging the soundness or trustworthiness of qualitative research as an alternative to more traditional quantitative oriented criteria (validity and reliability), are helpful. These criteria include: credibility, transferability, dependability, confirmability and authenticity.

Credibility

This refers to results that are interpreted accurately by the researcher and trusted by the participants (Polit and Beck, 2008). According to Cohen and Crabtree (2006), credibility

may be ascertained through prolonged engagement, persistent observation, triangulation, peer debriefing and member checks. These facilitate openness and ensure that phenomena of interest are accessed and observed. In this study, multi-data sources and collection methods were used. Furthermore, data collected were reviewed and discussed by the participants, validation group members and the researcher. This review was also necessary because the action research approach was used for the study, and the findings from one phase formed the basis for planning and intervention in the second phase.

Transferability

According to Polit and Beck (2008), transferability means that findings drawn from research in a certain context could be applied or transferred to other settings or contexts. Research findings are transferable when they are appropriate to contexts outside the study situation. The degree of transferability is determined by the degree of correspondence between the two contexts. Seale et al (2005), asserted that transferability is realised by making a detailed, rich description of the settings studied, to provide the reader with enough information to be able to recognise the applicability of the findings to other settings that they know. A detailed sequence of events was maintained by keeping notes of the whole process, to allow the prospective researchers to make a judgment on whether the data were applicable to their own context. To allow for transferability of findings to other similar contexts, the researcher used purposive sampling, gave a detailed description of the context or setting, and provided detailed descriptions of the whole process of the research study, including the research procedures and findings.

Dependability

Dependability has to do with consistency (Polit and Beck, 2008). This was ensured with the use of multiple data sources that were quantitative and qualitative. Consistency considers that if the interviews are repeated on the same participants in a similar context, the result will address the same objective. All sources used in the study are identifiable as described in the study. Data were collected from various hospitals and different contexts, which were hospitals and provincial and national offices. Information from all data sources was triangulated. The aim was to identify common understandings of the experiences of focus, as well as differences of opinion. Analysis and interpretation combined the two forms of data to seek convergence among the results (Creswell, 2012).

Confirmability

Confirmability refers to the objectivity or neutrality of results and the extent to which they could be confirmed in terms of accuracy, relevance and meaning (Polit and Beck, 2008). The results were analysed and discussed with participants and others emailed. Reviewing the results during reflection and by conducting capacity-building workshops also ensured confirmability.

Authenticity

Authenticity is the extent to which the researcher clearly presents findings with all the associated emotions and realities, portraying the real lives of the participants. In the presentation of qualitative data, the researcher used narratives to provide a fair description of the experiences of the participants. The researcher was immersed in the data through data collection; therefore, validation occurred throughout the research process. Validity strategies were also employed. Member checking was used to determine the reliability of the qualitative findings. The major findings were taken back to the participants during the capacity-building workshop and they were given an opportunity to comment on the findings.

3.11.3 Credibility and validity in the intervention phase

Greenwood and Levin (2007) define *credibility* as the arguments and the processes necessary for having someone trust research results. The authors further distinguished two different types of credible knowledge, internal and external credibility.

Internal credibility refers to knowledge that is reliable or believable to the group generating it. This kind of knowledge is fundamentally important to AR because of the collaborative nature of the research process. Its direct consequences in altered patterns of social action constitute a clear test of credibility, a test that many abstract social science frameworks lack. Members of communities or organisations are unlikely to acknowledge the “objective” theories of outsiders as credible if they cannot recognise their connection to the local situation, or because local knowledge suggests that the frameworks are either too abstract or simply wrong for the specific context. The participants willingly participated in the study and collaboratively acted during the capacity building workshop. This resulted in ownership of the knowledge and the policy generated.

External credibility refers to knowledge capable of convincing someone who did not participate in the inquiry that the results are believable. This is a complex matter. Because AR depends on a combination of reflection and action and the cogeneration of new

knowledge in specific contexts, conveying effectively the credibility of this knowledge to outsiders is a difficult challenge (Greenwood and Levin, 2007). Narratives were central to AR. Thus, according to the authors, individual cases and stories, the stuff of many AR writings, have immense power to alter theories. This is the crux of the credibility-validity issue in AR.

Heikkinen et al (2012), however, identified principles for validation in action research which were applicable in the policy workshop.

- *The principle of historical continuity:* The occurrence of action does not begin in a vacuum, and action never ends. The researcher therefore paid sufficient attention to the historical background of the topic through literature reviews and data collection and expressions of the workshop participants on how they had participated in health policy development.
- *The principle of reflexivity:* The principle of reflexivity is based on the belief that reflective thinking is crucial for an action researcher. Reflexivity means that the researcher is aware of the impact of his/her personal experiences while interacting with the other participants in the action research. The principle of reflexivity also stresses that the research should be transparent; that is, the material and methods should be described in some way in the report.
- *The principle of dialectics:* The principle of dialectics is based on the impression that social reality is constructed as a dialectical process in interpersonal discussion. The researcher respected this principle by giving optimal space to different voices and interpretations of the events.
- *The principle of evocativeness:* From this viewpoint, good research awakens and provokes thought about things in a new and different way. The most significant learning experiences are always both cognitive and affective in nature. The researcher and participants were capacitated in the health policy development process and development of the policy brief. New knowledge gained provoked their thought processes and they had meaningful deliberations (Heikkinen, Huttunen et al, 2012).

3.12 ETHICAL CONSIDERATIONS

3.12.1 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 UKZN Biomedical Research Ethics Committee (BREC). Ethical clearance to conduct the study was also obtained from the KZN DOH Ethics Committee after submitting letters of support from the participating districts. Permission was also sought from the CEOs and the nurse managers of the participating facilities. Refer to Annexure 1A to Annexure 1H.

3.12.2 Ethical principles

Competence

Polit and Beck (2012) describe competence as having the ability to make autonomous decisions when participating in a study. The study participants were nurses who were registered with the South African Nursing Council and in management positions. They thus had the competence to make autonomous decisions. The experience of the researcher contributed to effective decision-making to direct the research process and to allow participants autonomous decision-making in the study.

Confidentiality and informed consent

According to Brink et al (2006), informed consent means that there is an agreement between the researcher and the participants stipulating that they received essential information regarding the study conducted. Informed consent meant that the participant has freedom of choice in making the decision whether to participate or not. The researcher ensured informed consent by providing a voluntary consent form to be signed by the participants before completing a questionnaire before the interview began, and for participating in the policy workshop. The participants were given an information sheet detailing their participation in the study (introduction to research activities, description of risks, discomforts, and benefits, disclosure of choices, assurance of anonymity and confidentiality, compensation for participation in research, offer to answer questions, non-coercive disclaimer, option to withdraw, consent to incomplete disclosure) so that they could make informed decisions. See Annexure 2A and Annexure 2B.

The researcher ensured that all participant information was handled confidentially with no names written on interview sheets and questionnaires (Burns and Grove, 2005). No participant identity was required in all data collection tools. 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.

Privacy

All interviews with participants were held in a private room. Adherence to access control and dissemination of personal information helped to protect mental or psychological integrity.

Right to beneficence

The researcher guarded against non-compliance with the right of beneficence. While conducting the study the participants were not exposed to any form of discomfort or harm (Burns and Grove, 2005).

Openness

All participants were encouraged to be open and express their opinions. Participants were allowed to ask for clarification and all ideas were treated as worthy of consideration.

Empowerment

All participants had an equal right to be informed, and to engage in any decision directly affecting them.

3.13 CONCLUSION

This chapter presented a discussion of the research design, the study approach, research paradigms, setting, population and sampling strategy, data collection, data analysis, academic rigour and ethical considerations. The quantitative and qualitative findings of the study are discussed in the next chapter.

CHAPTER 4

PRESENTATION OF FINDINGS

4.1 INTRODUCTION

The research design for this study was based on action research, which incorporated mixed methods. The aim of the presentation and analysis of data is to provide a sense of direction for the purpose of this study, which was to analyse the extent of nurse leaders' participation in health policy development. The data presented in this chapter were the result of "slices of data" from the multiple sources (participant interviews and questionnaires) that were used in this study (Glaser and Strauss, 1967).

4.2 QUANTITATIVE DATA ANALYSIS

The total number of participants for the quantitative survey was 81. All information used in the analysis was derived from the questionnaire data. Data were analysed using the computer software Statistical Package for the Social Sciences (SPSS) Version 23. Descriptive statistics were used to explain demographic and background characteristics. Results are therefore presented using sample frequencies, percentage tables and graphs. Frequencies refer to the number of instances where a specific response was given, while percentage distribution reflects what proportion of the respondents chose a specific answer.

When a value was missing in the EROS scale, the completed responses were totalled and divided by the total number of participants. Interpretation was drawn from the statistical test. The data analysis section firstly presents a demographic profile of the nurse leaders in order to understand the context of the samples (Polit and Beck, 2008). Thereafter, the extent of nurse leaders' participation in health policy development is presented. The Fisher's exact test was used to correlate different valuables.

4.2.1 Presentation of data

Data were collected from the regional and tertiary hospitals in five health districts in KZN, namely eThekweni, iLembe, uGu, uThukela and Amajuba districts. Eleven hospitals participated in the study as illustrated in Table 3.1.

4.2.2 Quantitative demographic data

4.2.2.1 Gender of participants

Demographically, most of the respondents were females constituting 86.4 percent (n=70), whereas males constituted 13.6 percent (n=11). See figure 4.1.

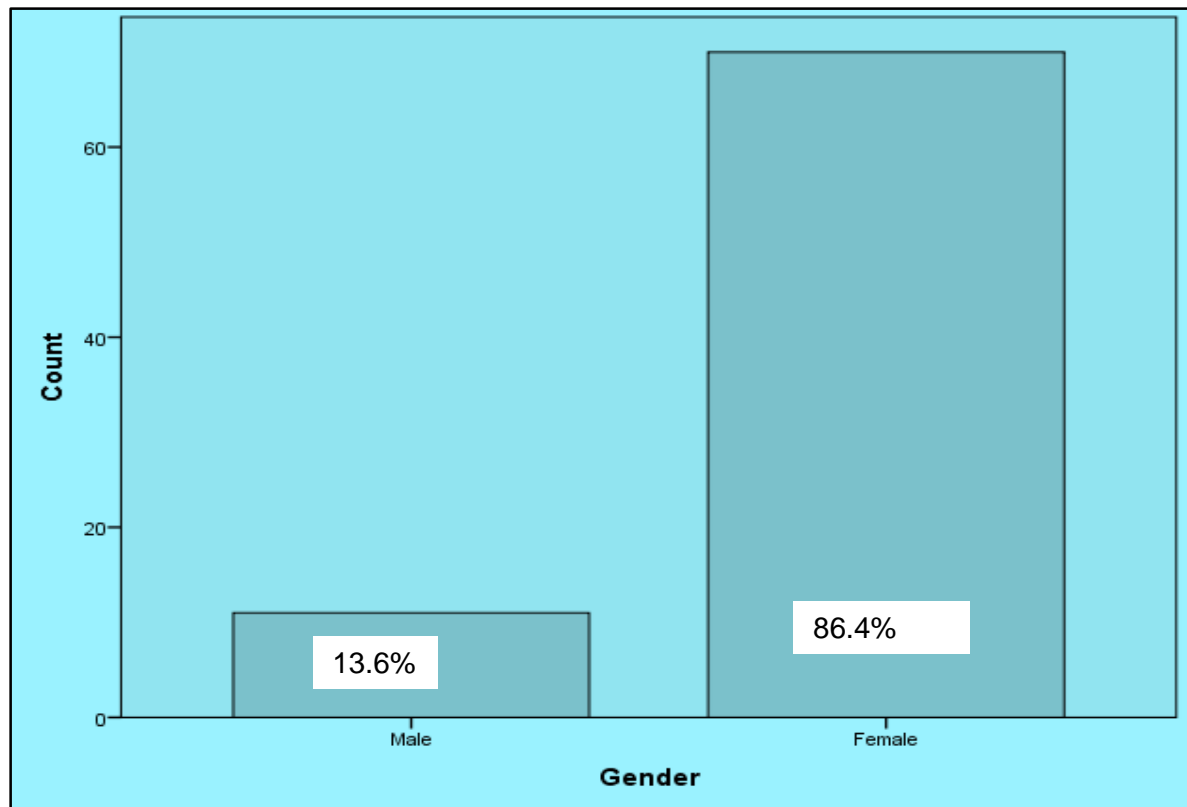


Figure: 4.1: Gender distribution (n=81)

4.2.2.2 Age distribution

According to figure 4.2, the majority of the participants [44.4 percent (n=36)] were between 51 and 60 years of age, while 21 percent (n=17) were over 60 years old. Middle-aged participants who were 41–50 years constituted 30 percent (n=24).

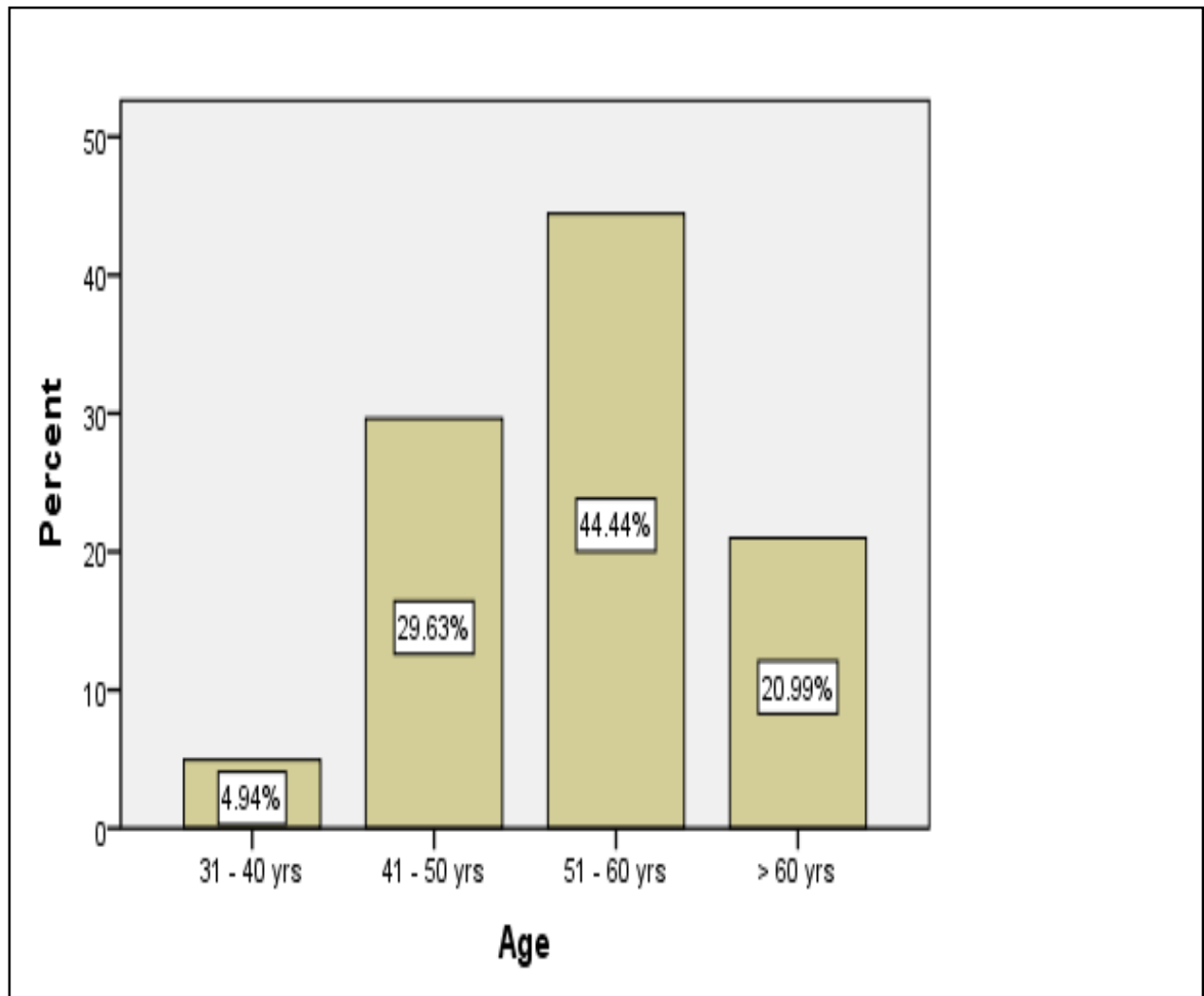


Figure 4.2: Age distribution of participants (n=81)

4.2.2.3 Experience in nursing

The findings revealed that none of the participants had less than six years' experience in nursing. The majority of participants [53 percent (n=43)] had 26–35 years' experience in nursing, whereas participants who had 16–25 years' experience constituted 29 percent (n=23). See figure 4.3

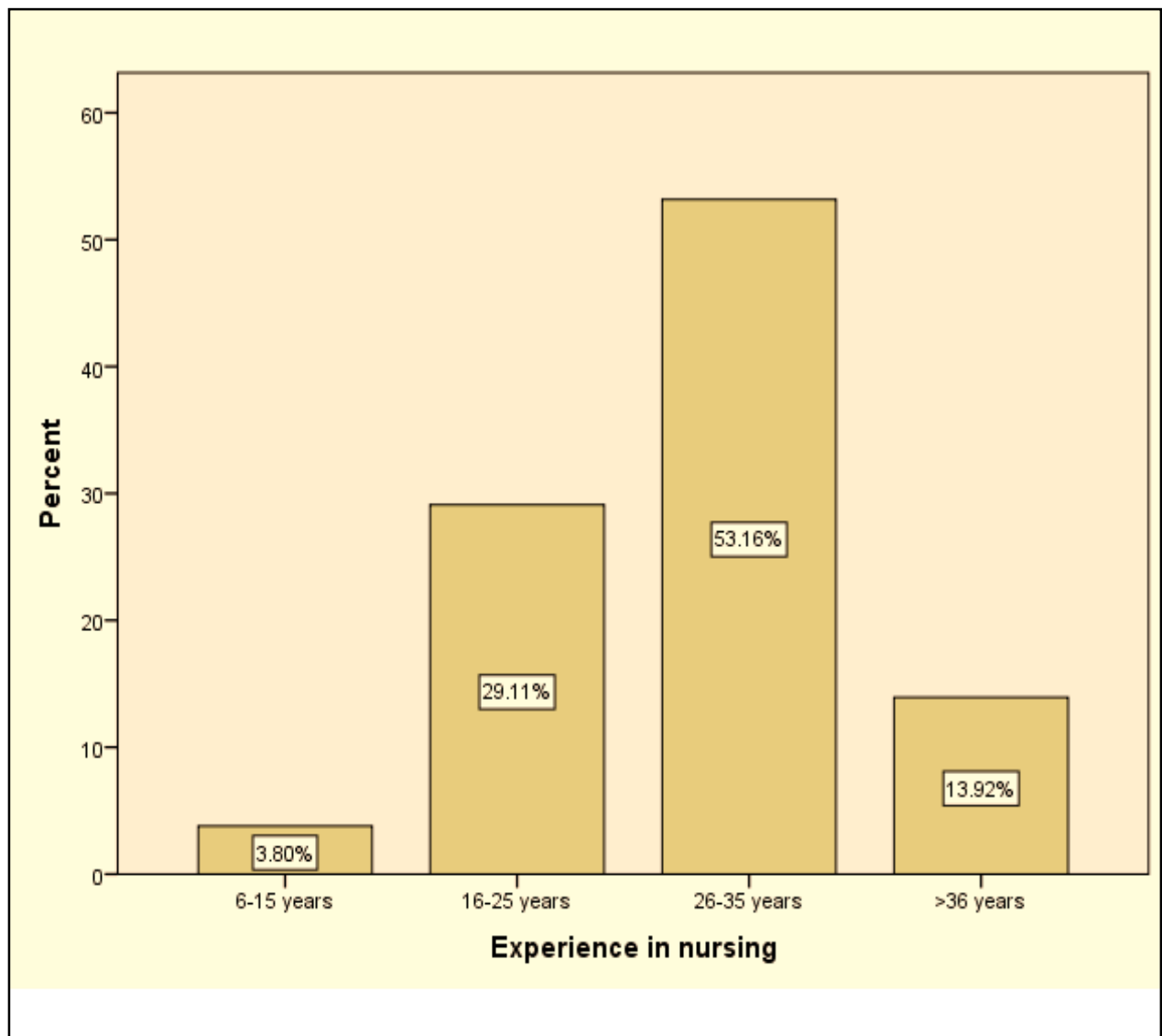


Figure 4.3: Experience in nursing (n=81)

4.2.2.4 Experience in current position

Fifty-one percent (n=41) of participants had less than five years' experience in their current position. Forty-nine point four percent (n=40) had 6–15 years' experience in their current position. See figure 4.4.

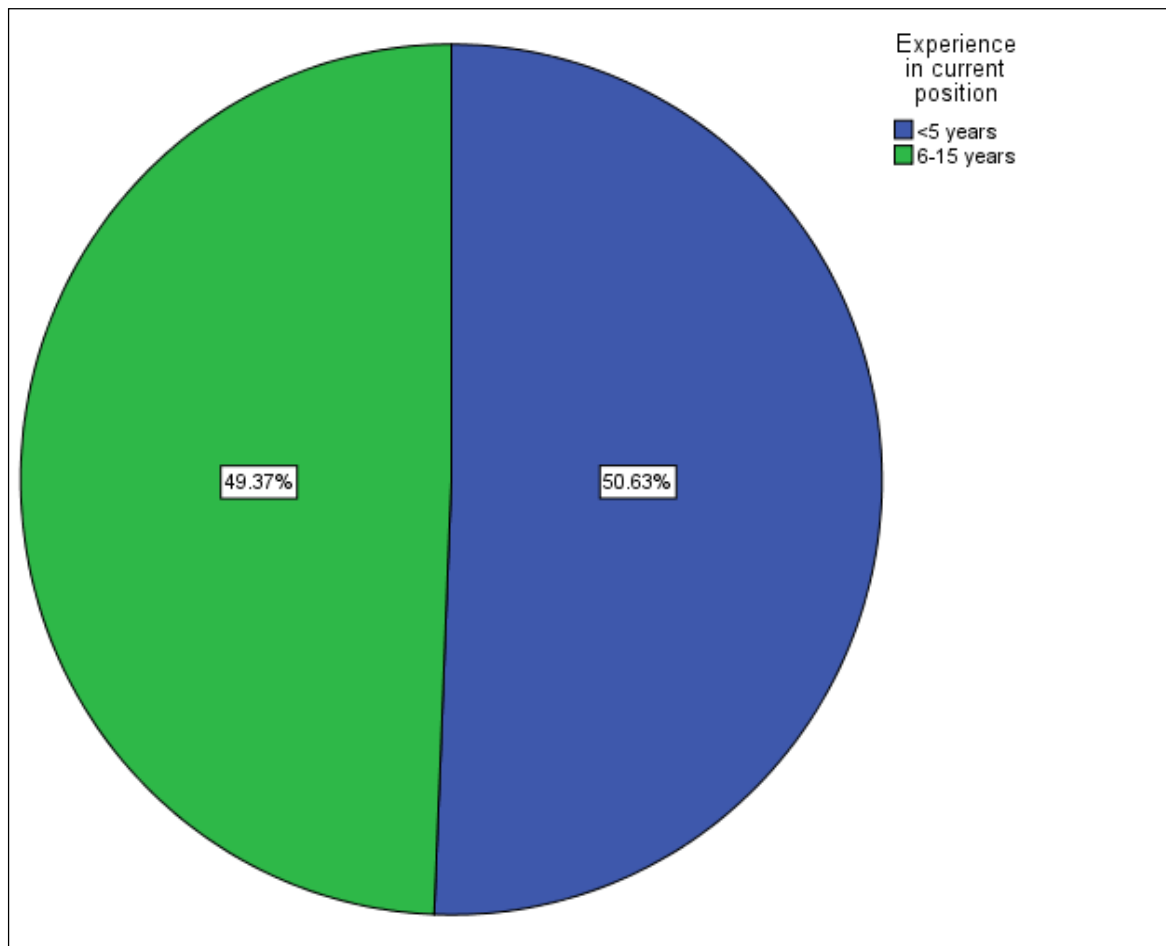


Figure: 4.4 Experience in current position (n=81)

4.2.2.5 Highest level of education

The results as illustrated in figure 4.5 show that 63.8 percent (n=52) had a bachelor's degree as the highest educational qualification, whereas 33.8 percent (n=27) had diplomas as their highest level of education.

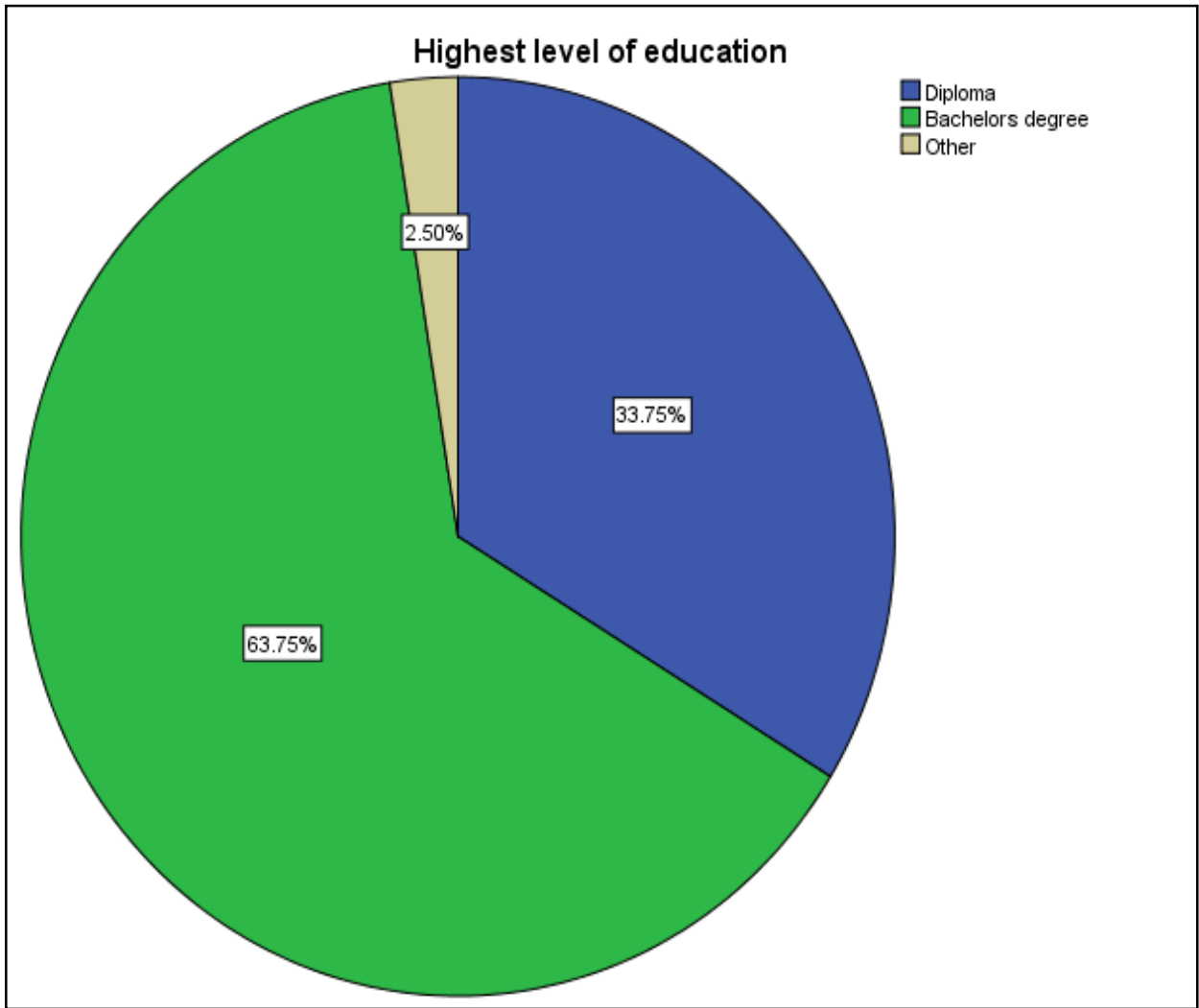


Figure 4.5: Highest level of education (n=81)

4.2.3 Cross tabulation by gender

4.2.3.1 Experience in nursing by gender

Figure 4.6 illustrates that the majority of female participants [48 percent (n=38)] had 26–35 years' experience in nursing, whereas male participants who had similar experience constituted five percent [5 per cent (n=4)]. A significant number of females [22.8 per cent (n=18)] also had 16–25 years' experience as opposed to males who constituted six percent (n=5).

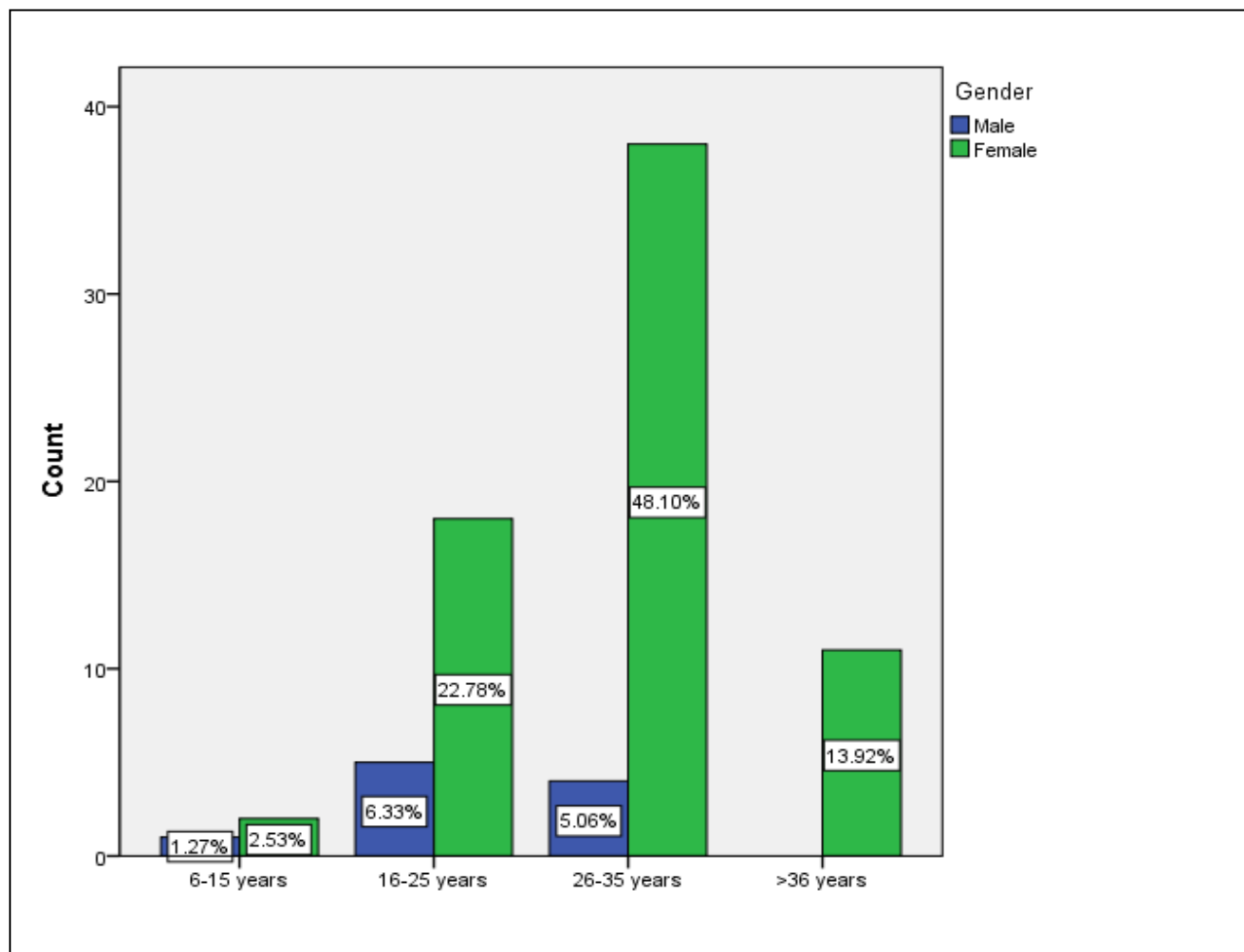


Figure 4.6: Experience in nursing by gender (n=81)

4.2.3.2 Experience in current position by gender

Eleven percent (n=9) out of eleven males had less than 5 years' experience in the current position, whereas 46.8 percent (n=38) females had 6–15 years' experience in the current position, as illustrated in figure 4.7

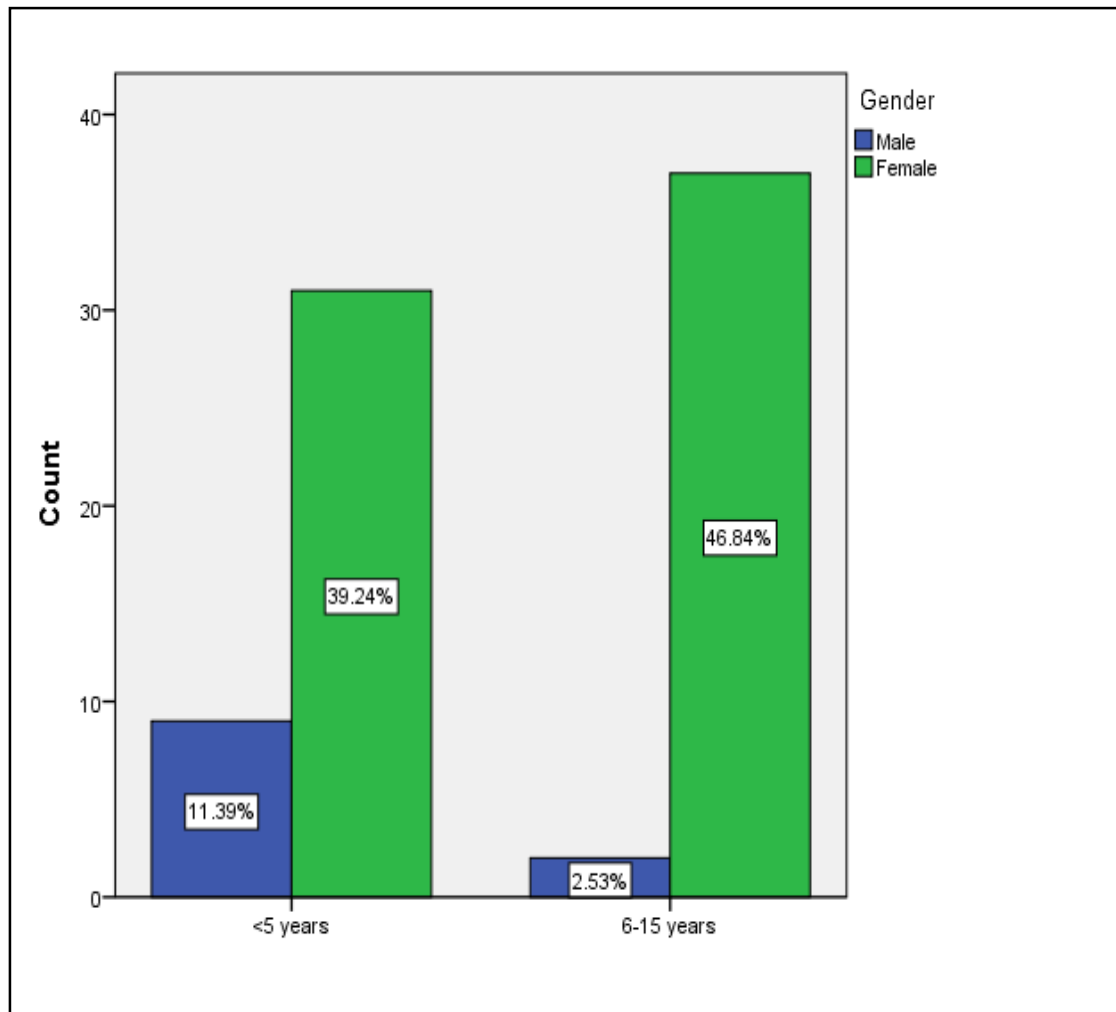


Figure 4.7: Experience in current position by gender (n=81)

4.2.3.3 Highest level of education by gender

The level of education was also looked at in terms of gender. The findings showed that the number of males with diplomas as their highest level of education was equivalent to those that had bachelor's degrees. They constituted six percent (n=5). Fifty-eight percent (n=46) females had bachelor's degrees and 28 percent (n=22) had diplomas as their highest level of education. One percent (n=1) male participants and one percent (n=1) female participants indicated other qualifications, which were not specified. See figure 4.8

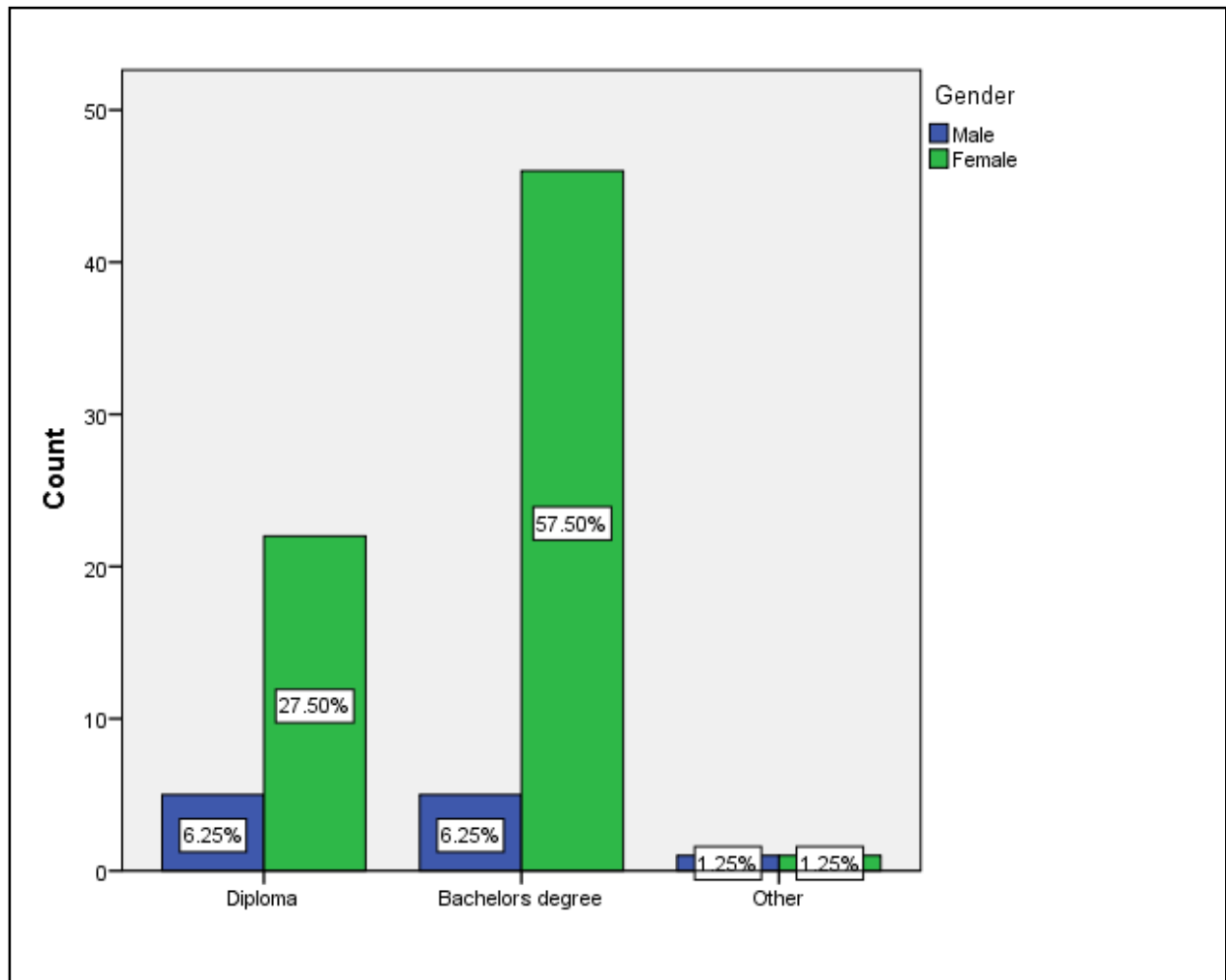


Figure 4.8: Highest level of education by gender (n=81)

4.2.4 Professional organisations

The participants were asked if they belonged to any professional organisations. They also had to describe their roles in the organisation. There were two missing values on this question. Ninety-eight percent (n=79) reported that they belonged to professional organisations. They all reported that they had a membership role only.

4.2.5 Participation in forums

Sixty-eight percent (n=55) had not participated in forums where policies are discussed. Thirty-two percent (n=26) reported that they had a chance to participate in forums where policies are made. The participants were also asked if they had any network for support, e.g. leadership forums where they shared policy related experiences.

4.2.6 Level of participation in health policy development

The participants were asked an open-ended question where they were asked to describe (from their experience) how nurse leaders participate in the health policy development

process. Responses that appeared frequently were that: they develop policies at the institutional/departmental level; they serve as members of the policy formulation committees in the institution; they ensure availability, communication and implementation of policies; they are not involved in policy development.

Participants were asked to rate their level of involvement in health policy development using a scale of one (1) to five (5) , with 1 being no involvement, 2 below average, 3 average, 4 above average and 5 being very involved. They had to rate themselves in relation to the following aspects:

- i. Problem identification and agenda setting;
- ii. Drafting legislation; policy formulation;
- iii. Policy implementation;
- iv. Policy analysis and/or evaluation;
- v. Work on a committee or coalition so action could be taken on a health policy issue;
- vi. Mobilise resources for policy-making activities, e.g. financial, material and human;
- vii. Making evidence-based presentations to policy-makers.

4.2.6.1 Problem identification and agenda-setting

Table 4.2 illustrates that 50.6 percent (n=41), had never participated in the initial stages of the policy development process which is the problem identification. Twenty-seven point two percent (n=22) rated themselves as average. The responses were widespread.

Table 4.1: Problem identification (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	31	38.3	38.8	38.8
	Below average	10	12.3	12.5	51.2
	Average	22	27.2	27.5	78.8
	Above average	11	13.6	13.8	92.5
	Very involved	6	7.4	7.5	100.0
	Total	80	98.8	100.0	
Missing	System	1	1.2		
Total		81	100.0		

4.2.6.2 Policy formulation

The results show that more than half of the participants [53.3 percent (n=43)] were predominantly not participating in the policy formulation stage. Twenty-two percent (n=18)

rated average. A minimal percentage, 20 percent (n=20), indicated that they had been involved. This applied at an institutional level. See table 4.2

Table 4.2: Policy formulation (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	40	49.3	49.3	49.3
	Below average	3	4.0	4.0	53.1
	Average	18	22.2	22.2	75.3
	Above average	13	16.0	16.0	91.4
	Very involved	7	8.6	8.6	100.0
	Total	81	100.0	100.0	
Missing	System				
Total					

4.2.6.3 Drafting legislation

Table 4.3 shows widespread consensus, 86.4 percent (n=70) of participants had never been involved in drafting legislation.

Table 4.3: Drafting legislation (n=80)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	64	79.0	80.0	80.0
	Below average	6	7.4	7.5	87.5
	Average	4	4.9	5.0	92.5
	Above average	4	4.9	5.0	97.5
	Very involved	2	2.5	2.5	100
	Total	80	98.8	100	
Missing	System	1	1.2		
Total			100		

4.2.6.4 Policy Implementation

The results show that 85.1 percent (n=69) predominantly participated in the policy implementation stage, as illustrated in table 4.4.

Table 4.4: Policy Implementation (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	9	11.1	11.1	11.1
	Below average	3	3.7	3.7	14.8
	Average	7	8.6	8.6	32.1
	Above average	18	22.2	22.2	54.3
	Very involved	44	54.3	54.3	100.0
Missing	System				
Total		81	100.0	100.0	

4.2.6.5 Policy analysis

Table 4.5 illustrates that the responses were widespread. However, the majority [82.7 percent (n=67)] indicated that they had not participated in policy analysis as opposed to 5 percent (n=4) who reported to have been involved.

Table 4.5: Policy analysis (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	41	50.6	50.6	50.6
	Below average	16	19.8	19.8	70.4
	Average	10	12.3	12.3	82.7
	Above average	10	12.3	12.3	95.1
	Very involved	4	4.9	4.9	100.0
Missing	System				
Total		81	100.0	100.0	

4.2.6.6 Working on a committee or coalition

Ninety-two and half percent (n=75) of participants had not worked in a committee where action relating to policy could be taken. However, in the open-ended question 32 percent (n=26) of participants claimed to have participated in institutional policy development committees where policies are formulated. Findings revealed that a representative from nursing management is sent to the institutional policy development committee. See illustration in table 4.6.

Table 4.6: Participation in committees/coalitions (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	48	59.3	59.3	59.3
	Below average	10	12.3	12.3	71.6
	Average	17	21.0	21.0	92.6
	Above average	3	3.7	3.7	96.3
	Very involved	3	3.7	3.7	100.0
Missing	System				
Total		81	100.0	100.0	

4.2.6.7 Mobilising resources for policy-making activities

Table 4.7 shows a minimum of 7.4 percent (n=6) of participants who reported to have been involved in mobilisation of resources for policy-making activities as opposed to 92.5 percent (n=75) that had not been involved.

Table 4.7: Mobilisation of resources (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	53	65.4	65.4	65.4
	Below average	12	14.8	14.8	80.2
	Average	10	12.3	12.3	92.6
	Above average	4	4.9	4.9	97.5
	Very involved	2	2.5	2.5	100.0
Missing	System				
Total		81	100.0	100.0	

4.2.6.8 Making evidence-based presentations to policy-makers

The results are consistent, as table 4.8 illustrates, that 93.8 percent (n=76) have not been involved in making evidence-based representations to policy-makers. Only six percent (n=5) reported to have been involved.

Table 4.8: Presentation to policy-makers (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not involved	53	65.4	65.4	65.4
	Below average	8	9.9	9.9	75.3
	Average	15	18.5	18.5	93.8
	Above average	3	3.7	3.7	97.5
	Very involved	2	2.5	2.5	100.0
Missing	System				
Total		81	100.0	100.0	

4.2.7 Cross tabulation of gender and participation in health policy development

The participants were asked to rate their level of involvement in health policy development on a scale of 1-5. A Fischer's exact test was done to show association between gender and participation of nurse leaders in various stages of the health policy development process. The results showed that there was no statistically significant correlation between gender and participation at all the stages. These results were expected as fewer males participated in the study.

4.2.7.1 . Gender in relation to policy identification and agenda setting

Table 4.9 illustrate a p-value= 0.985, indicating that there is no association between gender and participation in health policy development.

Table 4.9: Policy identification in relation and gender (n=80)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.363 ^a	4	.985
Likelihood Ratio	.357	4	.986
Linear-by-Linear Association	.181	1	.671
N of Valid Cases	80		

a. 5 cells (50, 0%) have expected count less than 5. The minimum expected count is, 83.

4.2.7.2 . Gender in relation to policy formulation

Based on the Chi- Square test results illustrated in table 4.10 the p-value =0.189, there is no statistically significant association between gender and participation in policy development.

Table 4.10: Policy formulation and gender (n=81)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.142 ^a	4	.189
Likelihood Ratio	7.845	4	.097
Linear-by-Linear Association	.175	1	.676
N of Valid Cases	81		
a. 5 cells (50, 0%) have expected count less than 5. The minimum expected count is, 95.			

4.2.7.3 . Gender in relation to policy implementation.

There was no relationship between gender and policy implementation. The results showed a p-value=0.180. Refer to table 4.11

Table 4.11: Policy implementation and gender (n=81)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.270 ^a	4	.180
Likelihood Ratio	7.902	4	.095
Linear-by-Linear Association	1.120	1	.290
N of Valid Cases	81		
a. 5 cells (50, 0%) have expected count less than 5. The minimum expected count is, 41.			

4.2.7.4 . Gender in relation to policy evaluation

The p-value of 0.633 as illustrated in table 4.12 shows that there was no statistically significant association between gender and policy evaluation.

Table 4. 12: Policy evaluation and gender (n=81)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	2.567 ^a	4	.633
Likelihood Ratio	3.823	4	.430
Linear-by-Linear Association	.652	1	.420
N of Valid Cases	81		
a. 5 cells (50, 0%) have expected count less than 5. The minimum expected count is 54.			

4.2.8 Cross tabulation of experience in nursing and participation in health policy development

4.2.8.1 Experience in nursing in relation to networks of support

A Fisher's exact test was run to see if there was any relationship between the number of years of experience in nursing and having networks of support, where nurse leaders could share experiences on policy related issues. The results showed that there was no association between the two variables. Refer to table 4.13

Table 4.13: Years of experience in nursing and networks

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.213 ^a	3	.975
Likelihood Ratio	.208	3	.976
Linear-by-Linear Association	.052	1	.820
N of Valid Cases	78		
a. 3 cells (37, 5%) have expected count less than 5. The minimum expected count is 77.			

4.2.8.2 Experience in nursing in relation to problem identification.

According to the Chi-square results, there was no correlation between the years of experience in nursing and participation of nurse leaders in problem identification and agenda setting. See table 4.14

Table 4.14: Experience in nursing and problem identification (n=78)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	18.005 ^a	12	.116
Likelihood Ratio	19.060	12	.087
Linear-by-Linear Association	.622	1	.430
N of Valid Cases	78		
a. 15 cells (75, 0%) have expected count less than 5. The minimum expected count is 23.			

4.2.8.3 Experience in nursing in relation to and policy formulation

The Chi-square table 4.15 shows that there was no statistically significant result between the years of experience and participation of nurse leaders in policy formulation.

Table 4.15: Experience in nursing and policy formulation (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	9.809 ^a	12	.633
Likelihood Ratio	11.961	12	.449
Linear-by-Linear Association	.623	1	.430
N of Valid Cases	79		
a. 14 cells (70, 0%) have expected count less than 5. The minimum expected count is, 27.			

4.2.8.4 Experience in nursing and policy implementation

The Fischer's exact test showed that there was a statistically significant correlation between the years of experience in nursing and participation of nurse leaders in policy implementation. The p-value= 0.027 as illustrated in table 4:16.

Table 4.16: Experience in nursing and policy implementation (n=79)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	23.146 ^a	12	.027
Likelihood Ratio	20.737	12	.054
Linear-by-Linear Association	2.186	1	.139
N of Valid Cases	79		

a. 16 cells (80, 0%) have expected count less than 5. The minimum expected count is .08.

4.2.8.5 Experience in nursing in relation to policy evaluation

The results showed that there was no statistically significant association between experience in nursing and participation of nurse leaders in policy evaluation. The p-value= 0.554 as shown in table 4.17. This result was unexpected since they are at the institutional level where implementation takes place.

Table 4.17: Experience in nursing and policy evaluation (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	10.707 ^a	12	.554
Likelihood Ratio	11.238	12	.509
Linear-by-Linear Association	1.959	1	.162
N of Valid Cases	79		

a. 14 cells (70, 0%) have expected count less than 5. The minimum expected count is .08.

4.2.9 Correlation between years of experience in current position and participation.

4.2.9.1 Experience in current position network of support

The results (p= 0.299) showed no statistically significant result that nurse leaders have networks of support where they share their experiences on policy related issues. Refer to table 4.18

Table 4.18: Experience in current position and network of support (n=78)

Chi-Square Tests					
	Value	Df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.626 ^a	1	.429		
Continuity Correction ^b	.278	1	.598		
Likelihood Ratio	.628	1	.428		
Fisher's Exact Test				.599	.299
Linear-by-Linear Association	.618	1	.432		
N of Valid Cases	78				

a. 0 cells (, 0%) have expected count less than 5. The minimum expected count is 9, 50.

4.2.9.2 Experience in current position in relation to problem identification

The p-value= 0.203 shown in the Chi- Square table 4.19 indicates no statistically significant relationship between the years of experience in current position and participation of nurse leaders at problem identification stage.

Table 4.19: Experience in current position and problem identification (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.954 ^a	4	.203
Likelihood Ratio	7.144	4	.128
Linear-by-Linear Association	.720	1	.396
N of Valid Cases	79		

a. 4 cells (40, 0%) have expected count less than 5. The minimum expected count is 1, 48.

4.2.9.3 Experience in current position in relation to policy formulation

Based on the results shown in table 4.20, the p-value=0.171 indicates no significant correlation between years of experience in current position and participation of nurse leaders in policy formulation.

**Table 4.20: Experience in current position and policy formulation
(n=79)**

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.402 ^a	4	.171
Likelihood Ratio	6.554	4	.161
Linear-by-Linear Association	.904	1	.342
N of Valid Cases	79		
a. 2 cells (20, 0%) have expected count less than 5. The minimum expected count is 3, 46.			

4.2.9.4 Experience in current position in relation to policy implementation

The Fisher's exact test shows that there is a statistically significant association between the years of experience in the current position and policy implementation. The p-value= 0.007 suggesting high correlation between the two variables. Refer to table 4.21

**Table 4. 21: Experience in current position and policy implementation
(n=79)**

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.177 ^a	4	.007
Likelihood Ratio	16.674	4	.002
Linear-by-Linear Association	3.850	1	.050
N of Valid Cases	78		
a. 4 cells (40, 0%) have expected count less than 5. The minimum expected count is 2, 92.			

4.2.9.5 4.2.9. 5 Experience in current position in relation to policy evaluation

There was no correlation found between years of experience in current position and policy evaluation as illustrated in table 4. 22

**Table 4.22: Experience in current position and policy evaluation
(n=79)**

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	6.755 ^a	4	.149
Likelihood Ratio	6.905	4	.141
Linear-by-Linear Association	3.128	1	.077
N of Valid Cases	79		
a. 4 cells (40, 0%) have expected count less than 5. The minimum expected count is 1, 97.			

4.2.10 Correlation between experience in current position and confidence in participation in policy development.

The participants were asked to rate their confidence levels in policy development activities using a scale from 1 to 5, with 1 being no confidence, 2 below average, 3 average, 4 above average and five indicating total confidence. Participants had to rate their confidence in relation to the following aspects:

- Knowledge and skills at all stages of the health policy development process
- Experience necessary for active participation in health policy development process
- Analysing nursing concerns or health issues that can be addressed through policy intervention or reform
- Analyse health policies and/or make recommendations about them to policy-makers
- Awareness of role if given an opportunity to actively participate in the policy process
- Research and analytical skills to inform research with evidence.
- Dissemination of research findings to policy-makers.

A Fisher's test was done to determine any statistically significant correlation between years of experience in current position and the level of confidence of nurse leaders in different variables. The results showed that there was no correlation between the years of experience in current position and confidence levels.

4.2.10.1 Current position in relation to confidence in knowledge and skills

The Fisher's test conducted indicated no statistically significant correlation between the years of experience in current position and the nurse leaders' confidence in the knowledge and skills required for policy development. Refer to table 4.23

Table 4.23: Current position and confidence in knowledge and skills (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	1.719 ^a	4	.787
Likelihood Ratio	1.727	4	.786
Linear-by-Linear Association	.108	1	.743
N of Valid Cases	79		
a. 4 cells (40, 0%) have expected count less than 5. The minimum expected count is 2, 96.			

4.2.10.2 Current position in relation to confidence in experience

Table 4.24 shows that, there was no statistically significant correlation between the number of years in current position and confidence in experience necessary for the nurse leaders to participate in health policy development. The p-value =0.586.

Table 4.24: Current position and confidence in experience (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	2.836 ^a	4	.586
Likelihood Ratio	2.877	4	.579
Linear-by-Linear Association	1.442	1	.230
N of Valid Cases	79		
a. 2 cells (20, 0%) have expected count less than 5. The minimum expected count is 3, 46.			

4.2.10.3 Current position in relation to confidence in health policy analysis

The P value of 0.228 illustrated in the Chi-Square table 4.25, shows that there is no association between the number of years in current position and confidence of nurse leaders in analysing policies.

Table 4.25: Current position and confidence in health policy analysis (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.639 ^a	4	.228
Likelihood Ratio	5.777	4	.216
Linear-by-Linear Association	3.125	1	.077
N of Valid Cases	79		
a. 2 cells (20, 0%) have expected count less than 5. The minimum expected count is 2, 47.			

4.2.10.4 Current position and confidence in awareness of their role in policy

The results showed no correlation between the years of experience in current position and being confident that they were aware of their role in policy development ($p=0.466$). See table 4.26

Table 4.26: Current position and confidence in awareness role (n=79)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	3.576 ^a	4	.466
Likelihood Ratio	3.617	4	.460
Linear-by-Linear Association	3.107	1	.078
N of Valid Cases	79		
a. 0 cells (, 0%) have expected count less than 5. The minimum expected count is 5, 43.			

4.2.10.5 Current position in relation to confidence in in research analysis

Table 4.27 shows that there was no statistically significant association between the number of years in current position and confidence of nurse leaders in analysing research findings ($p=0.123$).

Table 4.27: Current position and confidence in research analysis (n=79)

Chi-Square Tests			
	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	7.249 ^a	4	.123
Likelihood Ratio	7.407	4	.116
Linear-by-Linear Association	4.340	1	.037
N of Valid Cases	79		
a. 4 cells (40, 0%) have expected count less than 5. The minimum expected count is 2, 47.			

4.2.10.6 Current position and confidence in dissemination of research findings

The p-value of 0.259 illustrated in table 4.28 shows that there was no correlation between the number of years in current position and the confidence of nurse leaders in disseminating research findings.

Table 4.28 Confidence in dissemination of research findings (n=79)

Chi-Square Tests			
	Value	Df	Asymptotic Significance (2-sided)
Pearson Chi-Square	5.287 ^a	4	.259
Likelihood Ratio	5.366	4	.252
Linear-by-Linear Association	2.872	1	.090
N of Valid Cases	79		
a. 2 cells (20, 0%) have expected count less than 5. The minimum expected count is 3, 46.			

4.2.11 Barriers to participation in health policy development

With regard to factors that are barriers and facilitators of participation in health policy development, the nurse leaders were required to rate themselves on a scale of 1 to 5, with 1 being strongly disagree, 2 disagree, 3 not sure, 4 agree and 5 strongly agree. A list of nine (9) barriers was provided for respondents to tick all those that applied to them. These barriers were assigned a code BTP as follows:

BTP1. Lack of recognition of nurse leaders by policy-makers, for the important contribution nursing can make to policy issues

BTP2. Lack of opportunity that is afforded by policy-makers for nurse leaders to participate in the health policy process

- BTP3. Most appointments into policy-making positions are given to other health care professionals
- BTP4. Institutional structures and systems are such that they exclude nurse leaders from being part of the policy process
- BTP5. Gender and inequality; male dominance in the health policy forums
- BTP6. Low status awarded to female dominated professions
- BTP7. Lack of relevant knowledge and skills necessary to participate in the policy development process
- BTP8. Lack of experience necessary for active participation in the health policy development process
- BTP9. Most health policies are developed at national level then forwarded to nurse leaders for implementation
- BTP10. Lack of consultation by policy-makers

4.2.11.1 Lack of recognition of nurse leaders by policy-makers

Findings suggest that the respondents strongly agreed with all the aspects that were listed. Most participants perceived barriers to participating in health policy development. Seventy-two percent (n=58) agreed that lack of recognition of their contribution by policy-makers prevented them from participation as opposed to 11 percent (n=9) who were in disagreement as illustrated in figure 4.9

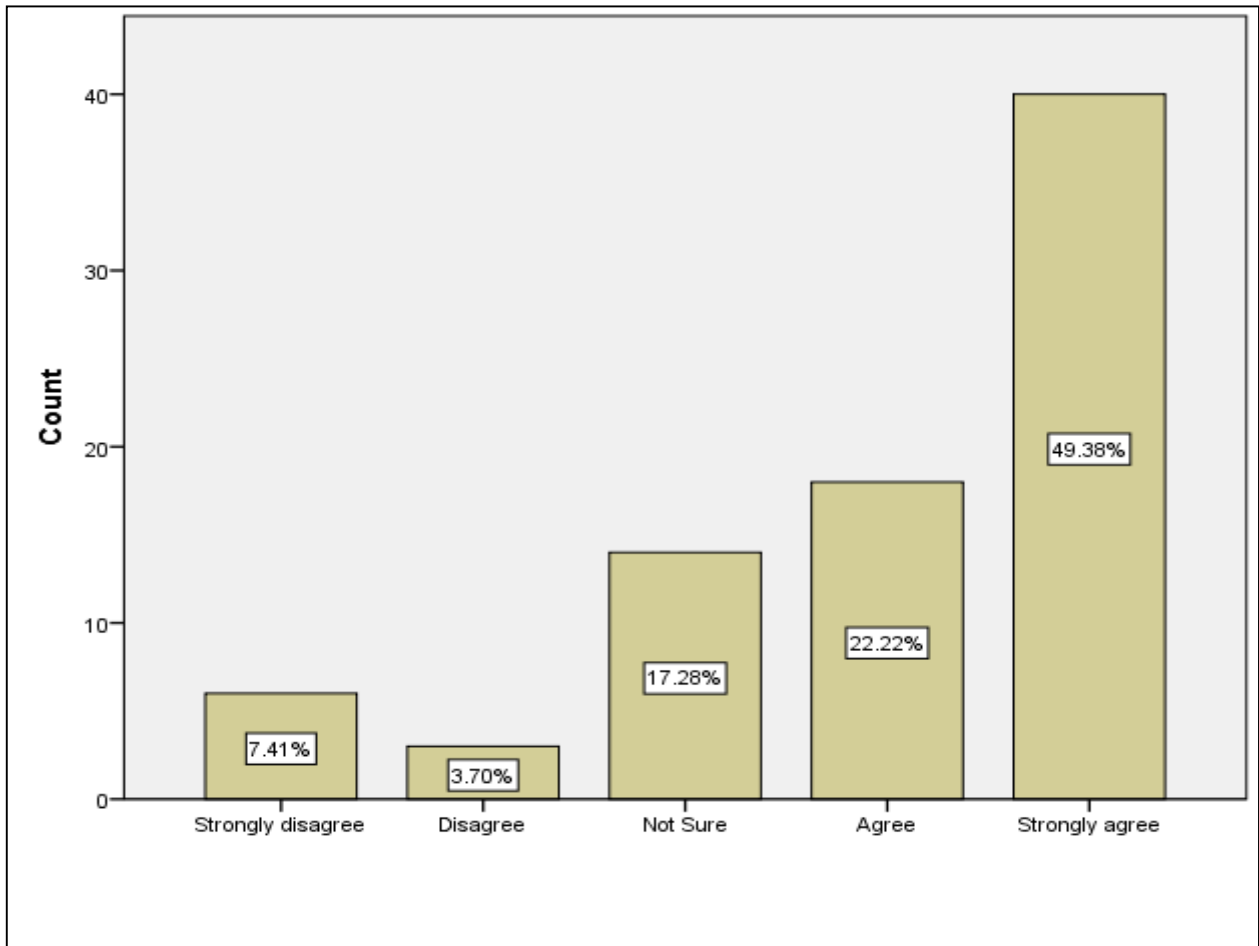


Figure 4.9: BTP 1 Lack of recognition (n=81)

4.2.11.2 Lack of opportunity to participate in the policy process

The majority of responses [77 percent (n=62)] agreed that the lack of opportunity to participate in the policy development process was a barrier, whereas only 10 percent (n=8) did not agree and 14 percent (n=11) were not sure. See figure 4.10

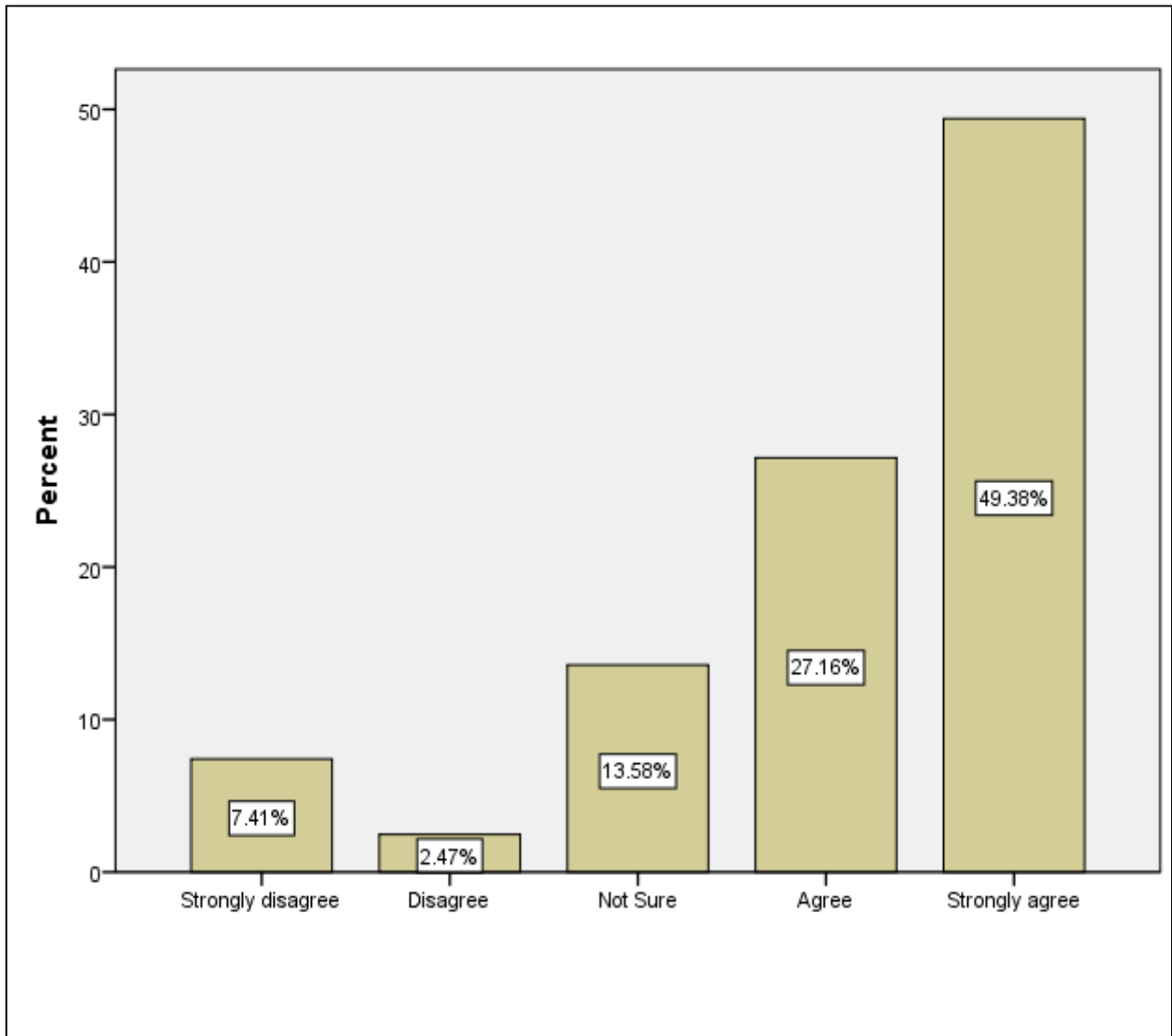


Figure 4.10: BTP2 Lack of opportunity (n=81)

4.2.11.3 4.2.11.3 Appointments in policy-making positions

There was consensus on the issue that most of the positions in the policy-making arena are occupied by other professionals. Figure 4.11 shows that 67 percent (n=54) agreed as opposed to 11 per cent (n=9) that did not agree, with 21 percent (n=17) not sure responses.

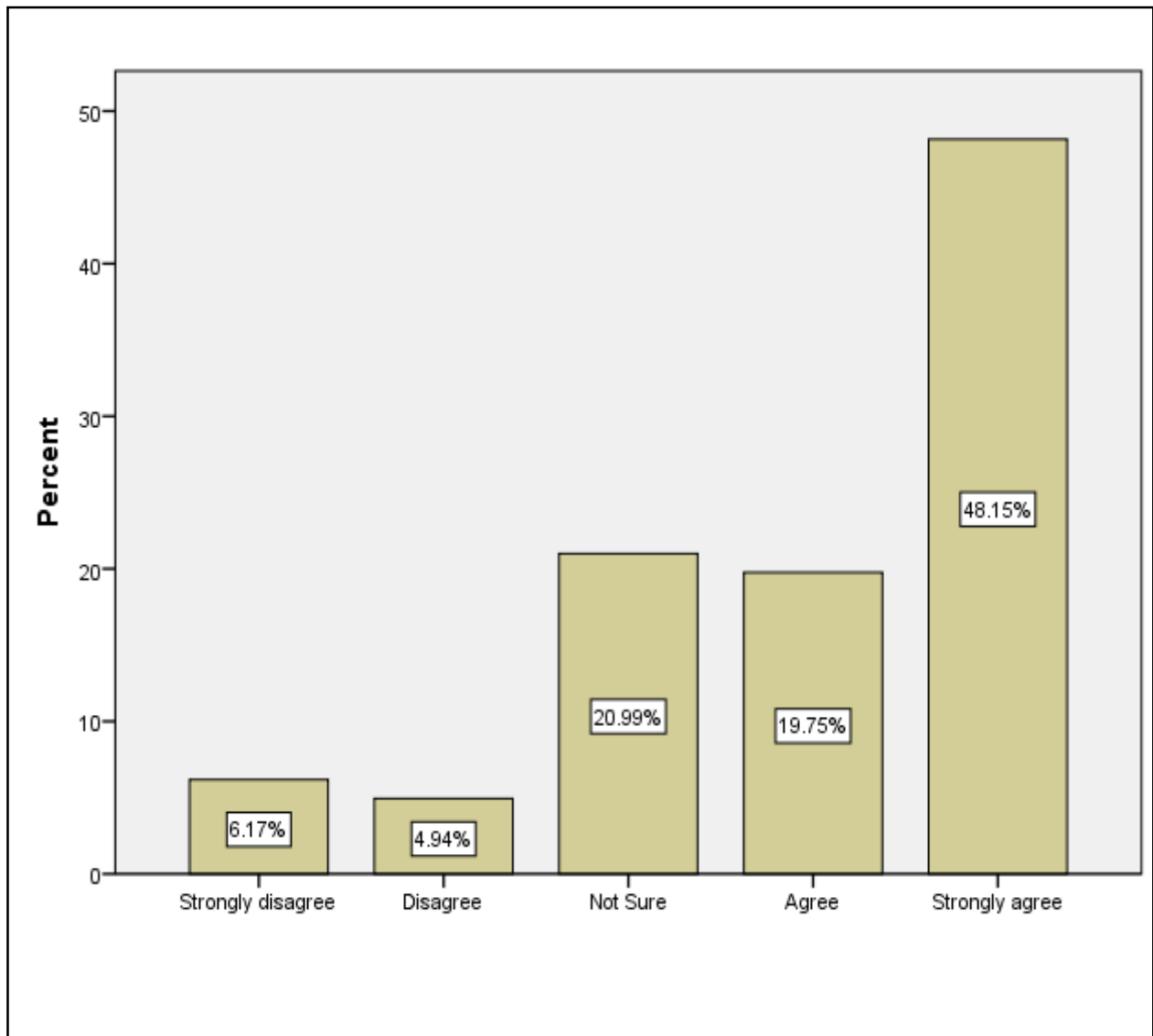


Figure 4.11: BTP3 Policy-making positions (n=81)

4.2.11.4 Exclusion from the policy process by institutional structures/ systems

There was a wide spread of responses on the issue of institutional structures and systems limiting nurse leaders' participation in health policy development. There was no consensus on the variable, as illustrated in figure 4.12.

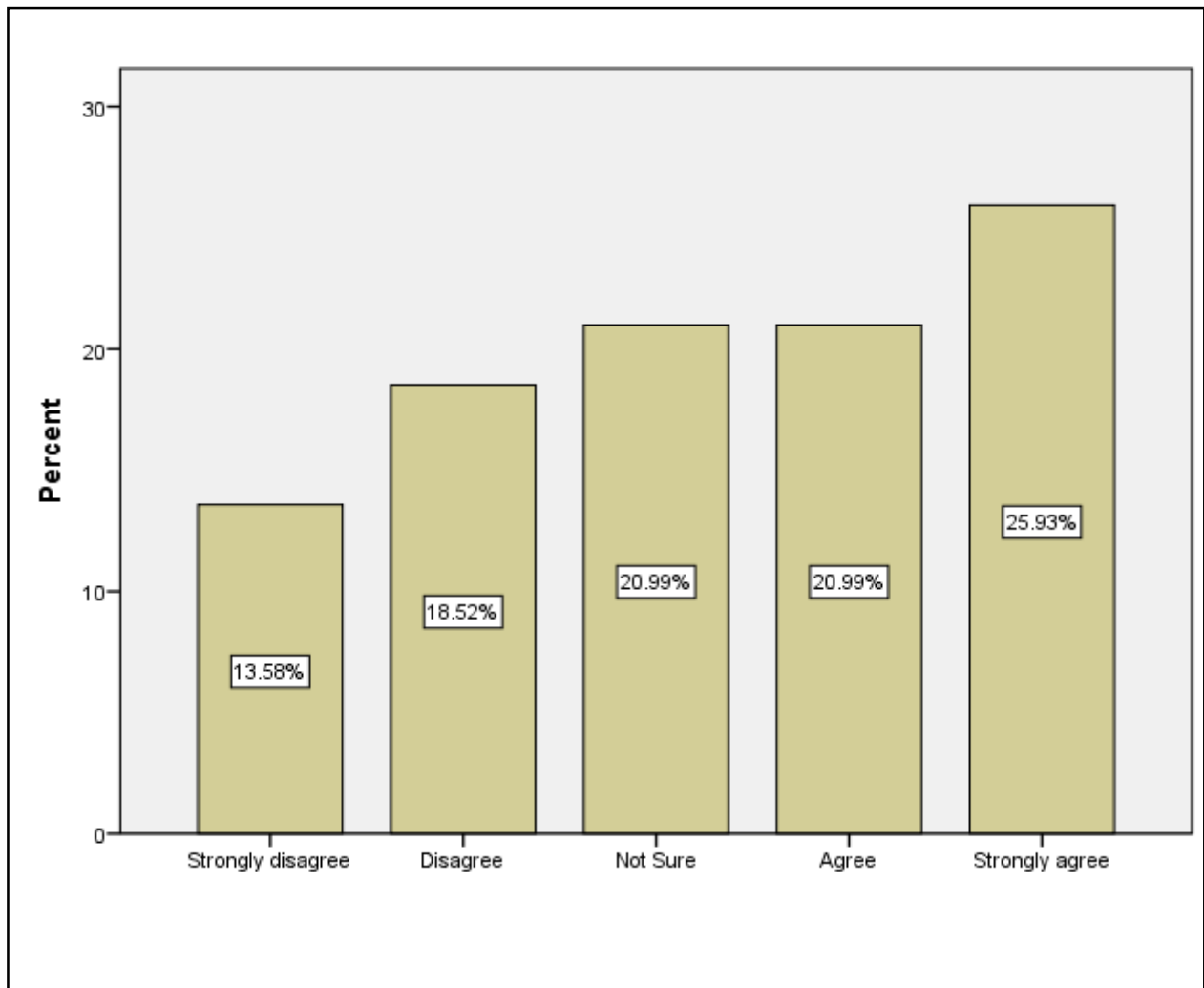


Figure 4.12: BTP4 Institutional structures (n=81)

4.2.11.5 Male dominance in health policy forums

The majority of responses [34.6 percent (n=28)] were mostly not sure whether gender and inequality were barriers to participation of nurse leaders in health policy development. However, 37 percent (n=30) did not agree and 28 percent (n=23) agreed. Refer to figure 4.13 below.

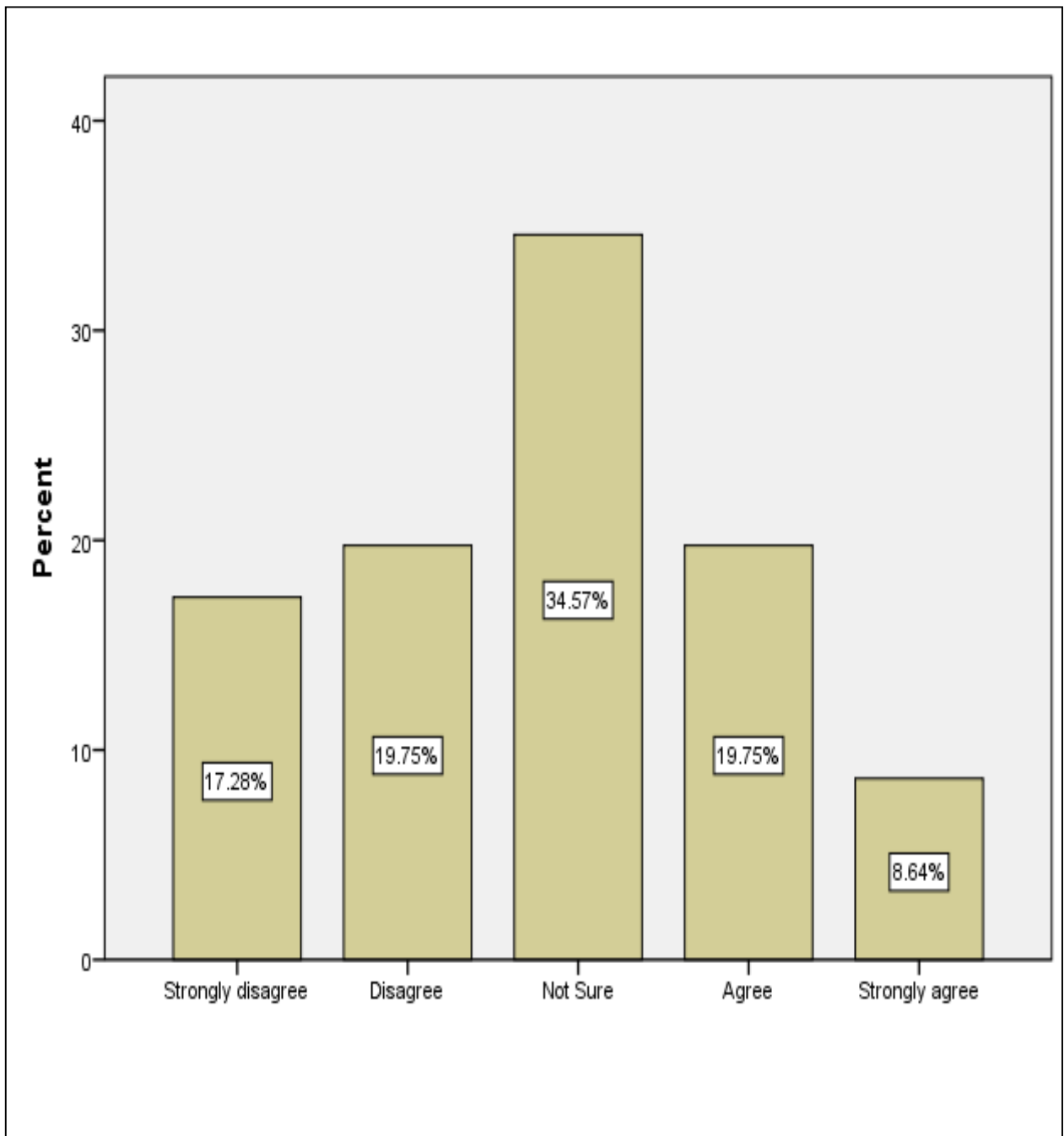
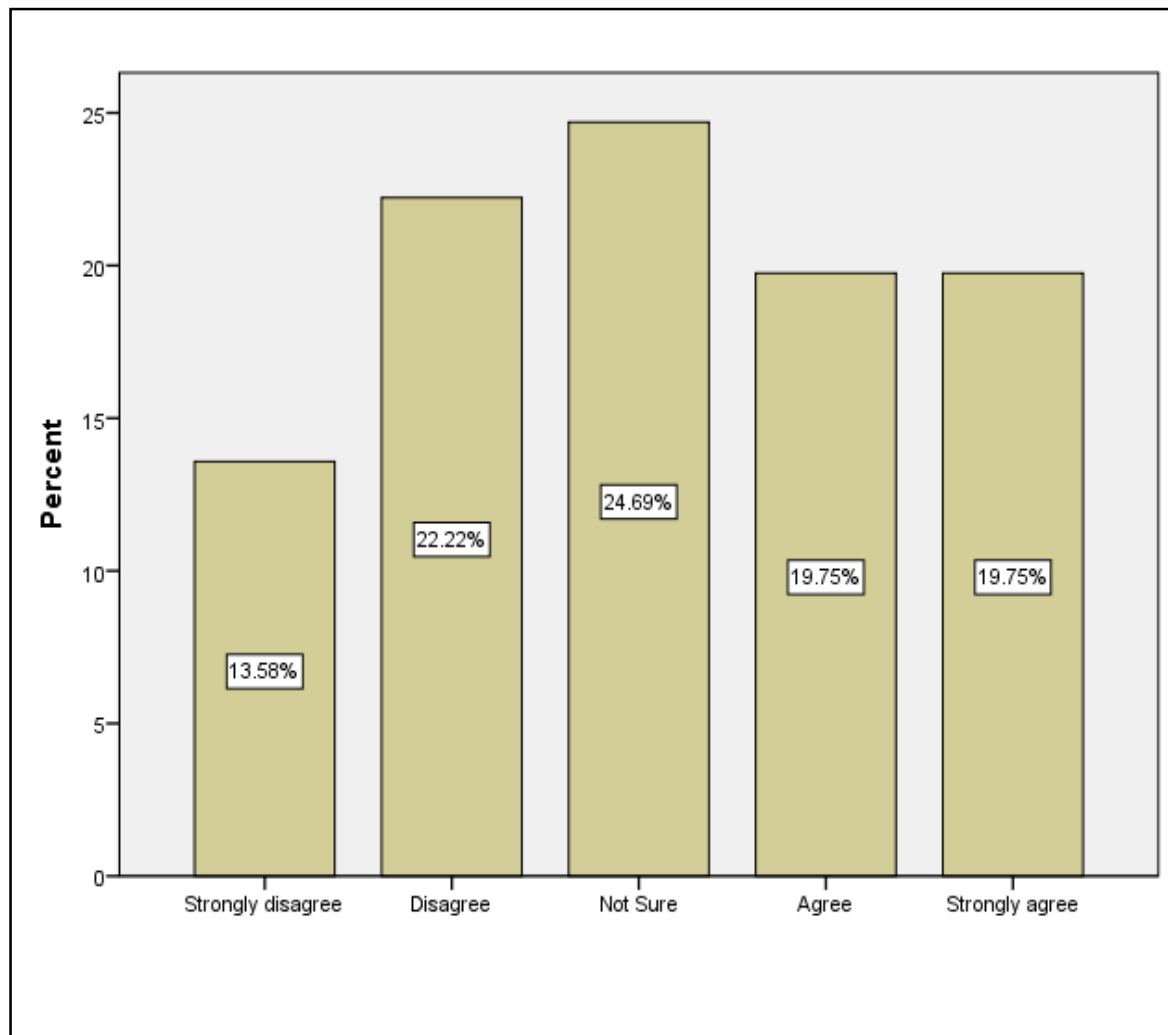


Figure 4.13: BTP5 Gender and inequality (n=81)

4.2.11.6 Low status awarded to female dominated professions

Figure 4.14 illustrates a wide spread of responses and no consensus on viewing whether the low status awarded to female dominated professions was seen as a barrier to participation in the health policy development process.



**Figure 4.14: BTP6 Low status assigned to female-dominated professions
(n=81)**

4.2.11.7 Lack of the knowledge and skills required to participate in the policy development process

More than half the responses [59 percent (n=48)] indicated that lack of the knowledge and skills necessary to participate in the policy development process limited their participation. Refer to figure 4.15.

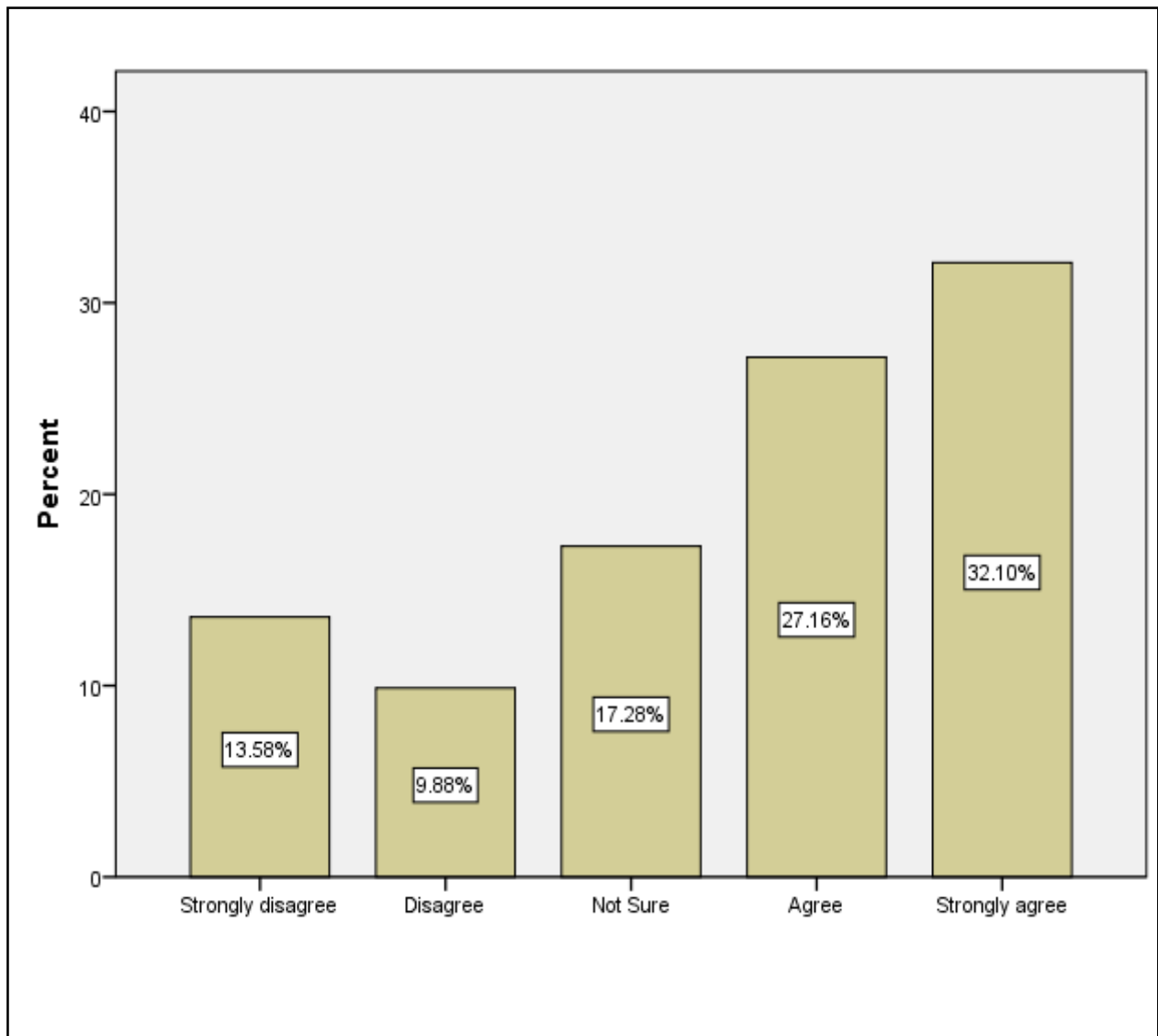


Figure 4.15: BTP7 Lack of knowledge and skills (n=81)

4.2.11.8 Lack of the experience required for participation in the policy process

Sixty eight percent (n=55) predominantly agreed that the lack of necessary experience posed a barrier to participation as opposed to 21 percent (n=17) that did not agree, as illustrated in figure 4.16.

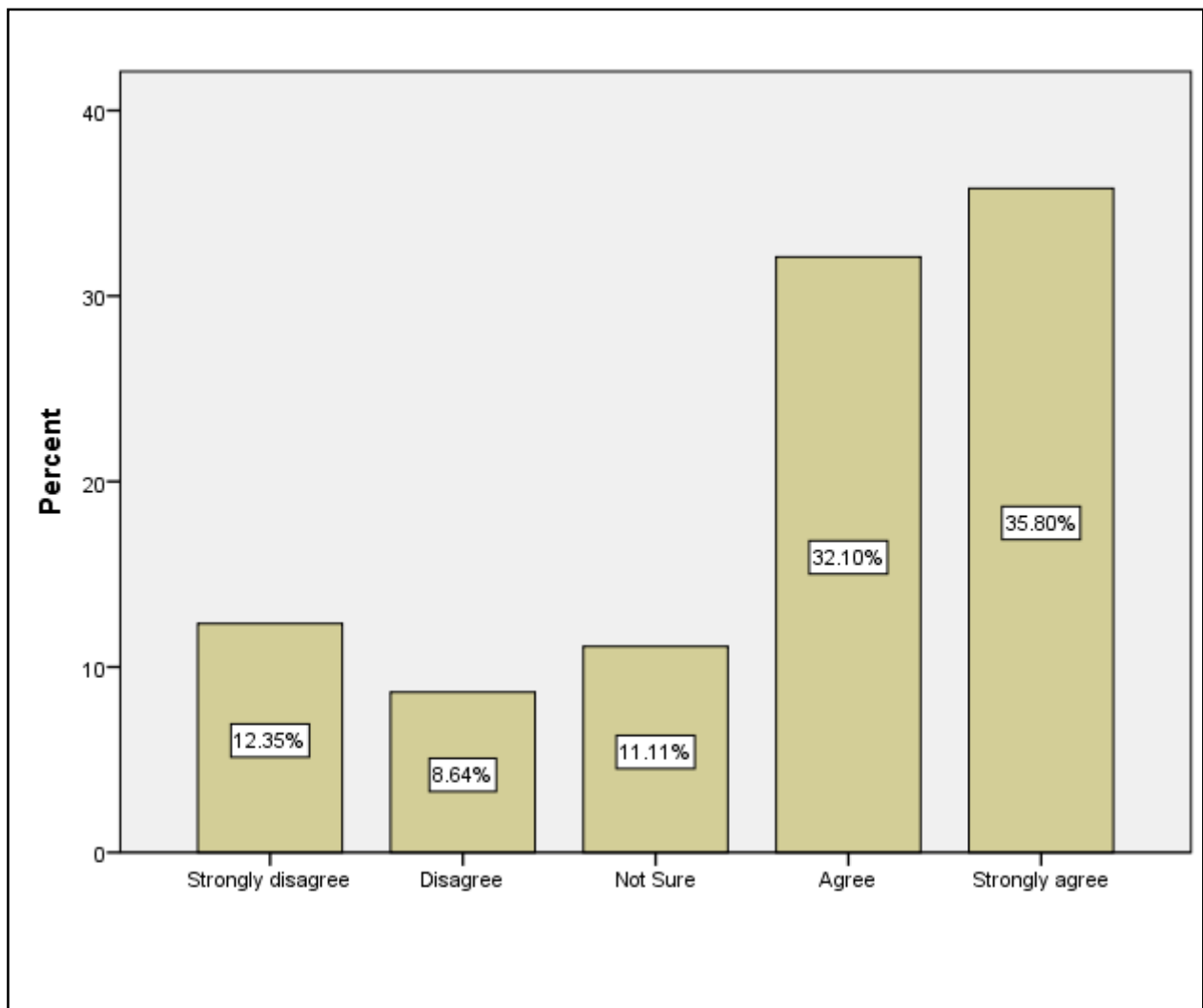


Figure 4.16: BTP 8 Lack of experience (n=81)

4.2.11.9 Top-down approach to health policy development

There was consensus as the majority of respondents [85 percent (n=69)] agreed that policies were developed from the top (national level) and forwarded down to the institutions for implementation. See figure 4.17.

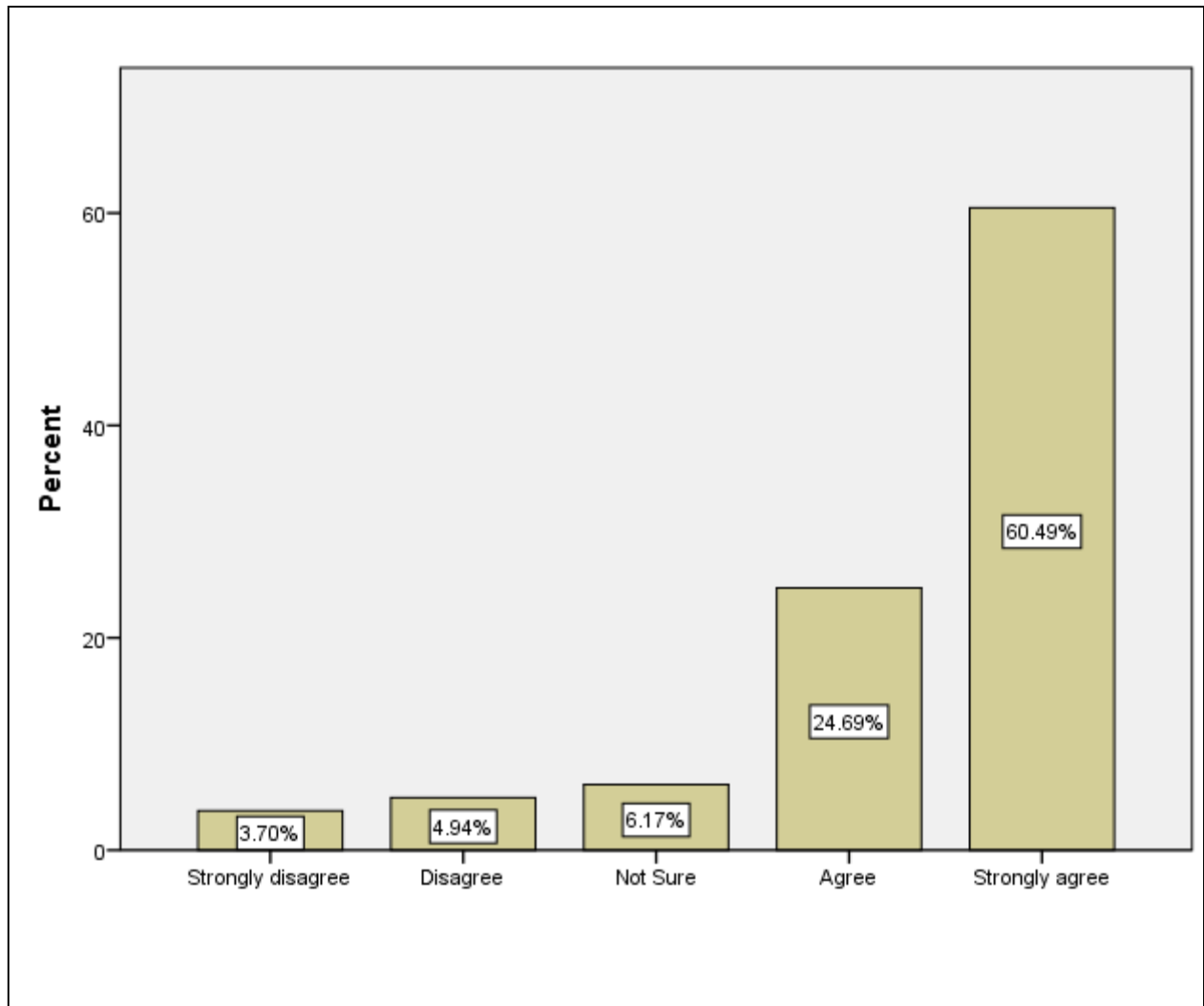


Figure 4.17: BTP9 Policies developed from top down (n=81)

4.2.11.10 Lack of consultation by policy-makers

Figure 4.18 illustrates that 82 percent (n=66) agreed that lack of consultation is a barrier to participation in health policy development, as opposed to 13 percent (n=10) and 6 percent (n=5) that were not sure.

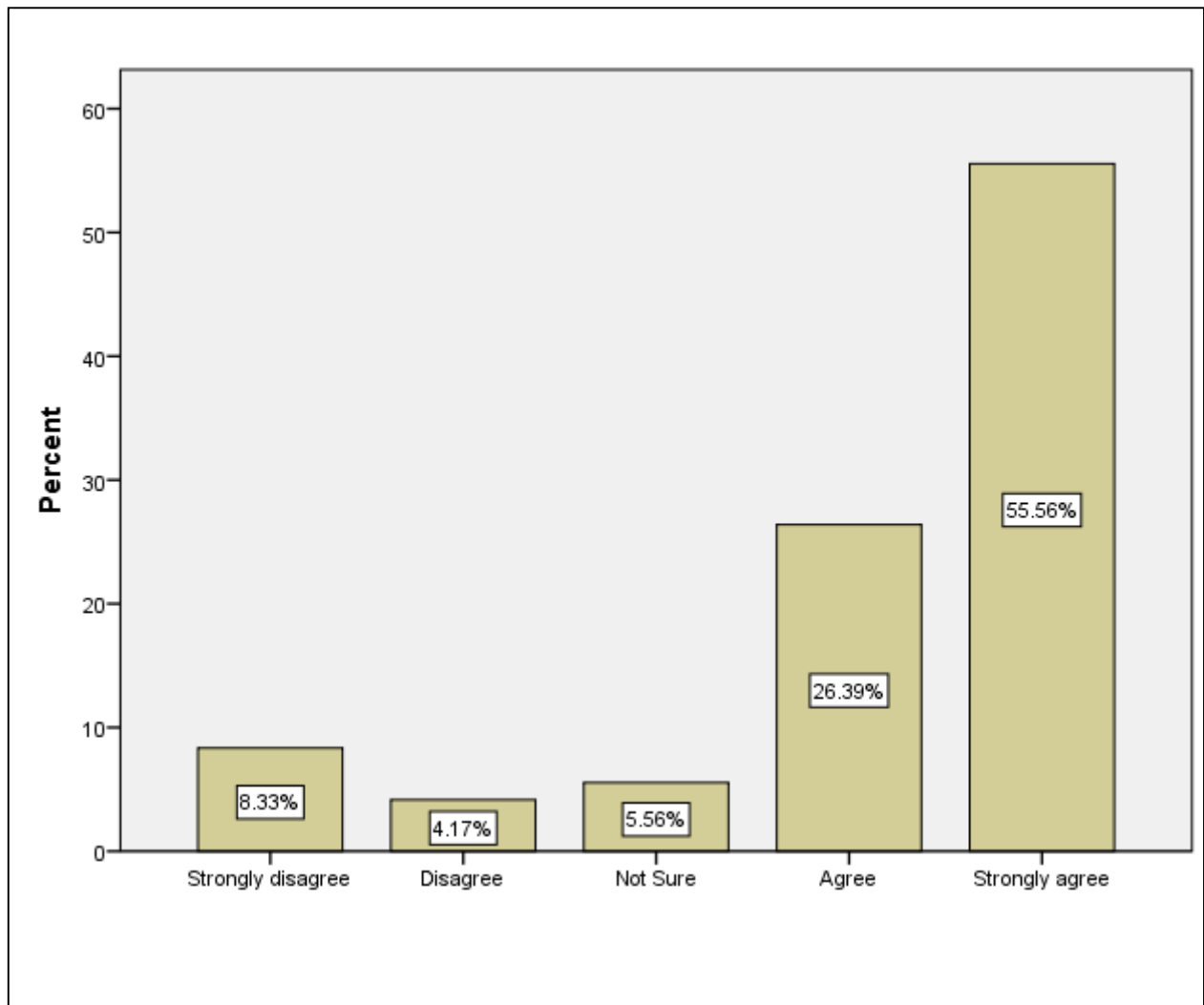


Figure 4.18: BTP9 Lack of consultation (n=81)

These findings are consistent with question 15 (open-ended) of the questionnaire, where they reported factors from their experience that were the major barriers to nurse leaders' participation in health policy development. The barriers that appeared frequently were: lack of knowledge and experience in policy-making; lack of opportunities; work overload; representation by certain leaders that are not nurses; lack of consultation; unavailability of

forums; being excluded and not taken seriously; apathy. Some described nurse leaders as not being proactive in addressing issues that affect them.

4.2.12 Facilitators to health policy development

The participants were asked to rate their perceptions on facilitators of participation in health policy development using a scale of 1 to 5, with 1 being strongly disagree, 2 disagree, 3 not sure, 4 agree, 5 strongly agree. The facilitators were assigned codes as FFP. They had to rate themselves in relation to the following:

- FFP 1. Knowledgeable and skilled in the health policy-making activities at all levels.
- FFP 2. Inclusion of policy development content in their basic nursing education curriculum in order to prepare them for this role
- FFP 3. Availability of policy leadership training e.g. courses/workshops
- FFP 4. Having opportunities to participate in forums where policies are formulated by policy-makers
- FFP 5. Adequate representation of nurse leaders at national policy-making level
- FFP 6. Having nurse leaders' input respected by policy-makers
- FFP7. Being politically astute e.g. able to lobby with policy-makers and influence policy of concern to the nursing profession
- FFP 8. Having a gender balance (in terms of appointments) at policy-making forums
- FFP 9. Networking with peers and forming coalitions so as to lobby for policy makers to ensure the inclusion of nurse leaders in health policy processes

4.2.12.1 Knowledge and skills in the health policy development.

Table 4.29 below shows that there was consensus on this variable, as 91 percent (n=74) agreed that being knowledgeable and skilled in policy-making could facilitate participation

in the process. Three percent (n=2) strongly disagreed with this variable, whereas five percent (n=4) were not sure.

Table 4.29: Knowledge and skill in health policy development (n=81)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	2	2.5	2.5	2.5
Not Sure	5	6.2	6.2	8.6
Agree	13	16.0	16.0	24.7
Strongly agree	61	75.3	75.3	100.0
Total	81	100.0	100.0	

4.2.12.2 Inclusion of health policy content in the nursing curriculum

The majority of responses [75 percent (n=61)] strongly agreed and 16 percent (n=13) agreed with inclusion of policy content in the nursing curriculum in order to prepare nurses for a role in health policy processes. Refer to table 4.30

Table 4.30: Inclusion of policy content in the curriculum (n=81)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	2	2.5	2.5	2.5
Not Sure	5	6.2	6.2	8.6
Agree	13	16.0	16.0	24.7
Strongly agree	61	75.3	75.3	100.0
Total	81	100.0	100.0	

4.2.12.3 Availability of policy leadership training such as courses/ workshops

Policy leadership training was predominantly supported, as table 4.31 shows that 91 percent (n=74) agreed with leadership training on policy development as a facilitator to participation, as opposed to 3 percent (n=2) that strongly disagreed.

Table 4.31: Policy leadership training (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	2	2.5	2.5	2.5
	Not Sure	5	6.2	6.2	8.6
	Agree	13	16.0	16.0	24.7
	Strongly agree	61	75.3	75.3	100.0
	Total	81	100.0	100.0	

4.2.12.4 Opportunities to participate in policy formulation forums

Table 4.32 shows consensus in responses agreeing to participation in forums where policies are made as a facilitator to participation. Ninety-four percent (n=76) predominantly agreed with this statement.

Table 4.32: Participation in forums (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	1	1.2	1.2	1.2
	Not Sure	4	4.9	4.9	6.2
	Agree	18	22.2	22.2	28.4
	Strongly agree	58	71.6	71.6	100.0
	Total	81	100.0	100.0	

4.2.12.5 Representation of nurse leaders at national policy-making level

Seventy nine percent (n=64) strongly agreed, as opposed to one percent that strongly disagreed with adequate representation of nurse leaders at national policy-making level. See table 4.33.

Table 4.33 : Representation at National policy-making level (n=81)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	1	1.2	1.2	1.2
Not Sure	4	4.9	4.9	6.2
Agree	12	14.8	14.8	21.0
Strongly agree	64	79.0	79.0	100.0
Total	81	100.0	100.0	

4.2.12.6 Respect of nurse leaders' input by policy-makers

Table 4.34 shows 93 percent (n=75) agreeing responses, as opposed to 3 percent (n=2) strongly disagreeing with respect to nurse leader's input by policy-makers.

Table 4.34: Respect for nurse leaders' input (n=81)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	2	2.5	2.5	2.5
Not Sure	4	4.9	4.9	7.4
Agree	14	17.3	17.3	24.7
Strongly agree	61	75.3	75.3	100.0
Total	81	100.0	100.0	

4.2.12.7 Being politically astute

The responses varied, as 14 percent (n=11) were not sure, 6 percent (n=5) did not agree, and 80 percent (n=65) agreed with being politically astute as facilitating participation in policy development. Refer to table 4.35 below.

Table 4.35: Understanding politics (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	3	3.7	3.7	3.7
	Disagree	2	2.5	2.5	6.2
	Not Sure	11	13.6	13.6	19.8
	Agree	18	22.2	22.2	42.0
	Strongly agree	47	58.0	58.0	100.0
	Total	81	100.0	100.0	

4.2.12.8 Gender balance at policy-making forums

The responses showed that 22 percent were not sure and 67 percent agreed with gender balance (in terms of appointments) when appointing officials at the policy-making forums. Refer to table 4.36 below.

Table 4.36: Gender balance at the policy-making level (n=81)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	4	4.9	4.9	4.9
	Disagree	5	6.2	6.2	11.1
	Not Sure	18	22.2	22.2	33.3
	Agree	19	23.5	23.5	56.8
	Strongly agree	35	43.2	43.2	100.0
	Total	81	100.0	100.0	

4.2.12.9 Networking with peers and forming coalitions

Only 2 percent (n=2) did not agree, whereas a significant number [89 percent (n=72)] agreed with networking with peers and forming coalitions to lobby for inclusion of nurse leaders in the health policy process. Refer to table 4.37.

Table 4.37: Networking with peers and forming coalitions (n=81)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Strongly disagree	1	1.2	1.2	1.2
Disagree	1	1.2	1.2	2.5
Not Sure	7	8.6	8.6	11.1
Agree	20	24.7	24.7	35.8
Strongly agree	52	64.2	64.2	100.0
Total	81	100.0	100.0	

Most of the respondents strongly agreed that all the factors listed could facilitate their participation in health policy development. This is also consistent with their views as reported in question 16 (open-ended), where they reported on their views of what the facilitators in their participation in health policy development could be. The most frequently appearing factors were: nursing management forums; opportunity to participate; training and development of leaders; appointment of more nurses in the national department of health; motivation and recognition of nurse leaders' input in policy development.

The results showed that 92.6 percent (n=75) of the nurse leaders would be interested to participate if the opportunity arose.

4.3 QUALITATIVE DATA ANALYSIS

Qualitative data analysis can be defined as the process of non-numerical analysis of transcriptions and field notes in order to find underlying patterns of relationships in order to draw a conclusion (Babbie, 2010). The design of the study used action research incorporating mixed methods. Eight face-to-face interviews were conducted. The nurse leaders were purposively selected from different levels, namely the institutional level (KZN regional and tertiary hospitals), and the KZNDOH up to the highest level, the NDOH. Some leaders had experience of working for the South African Nursing Council (SANC). These were found appropriate to answer research question 5, on how policy-makers have involved nurses in the health policy development process.

The analysis is based not on an individual, but on their role as nurse leaders in health policy development and participation therein. It was important to get the diverse insights of individuals who have most likely participated in health policy development to aid in

achieving the objectives of the study. The analysis provides detailed, useful quotes that bring realism to this study.

The data from different nurse leaders were recorded using a tape recorder with their permission, and writing notes as they responded to questions on the processes of health policy development.

4.3.1 . Participant profile

All the participants that were interviewed were female and most were 51-60 years old. The highest educational qualification for the participants was a PhD degree. Codes were used to identify the participants, such as PD (Provincial Department), RH (Regional Hospital) and NC (National and South African Nursing Council). Refer to Table 4.38 for the demographic profile of the participants.

Table 4:38 Participant profile

PARTICIPANT	GENDER	AGE RANGES	EXPERIENCE IN NURSING – RANGES	EXPERIENCE IN CURRENT POSITION – RANGES	LEVEL OF EDUCATION
PD 1	Female	51-60 years	26-35 years	<5 years	Not indicated
RH 1	Female	51-60 years	16-25 years	<5 years	Masters
RH 2	Female	41-50 years	16-25 years	6-15 years	Masters
RH 3	Female	41-50 years	16-25 years	< 5 years	Bachelor's degree
NC 1	Female	>60 years	26-35 years	6-15 years	Masters
NC 2	Female	51-60 years	26-35 years	<5 years	Doctoral degree
RH 4	Female	>60 years	26-35 years	6-15 years	Bachelor's degree
RH 5	Female	51-60 years	26-35 years	6-15 years	Bachelor's degree

4.3.2 Data analysis process

The researcher then collated and analysed data using thematic analysis adapted from Creswell (2014). Data analysis followed the following steps:

4.3.2.1 Data organisation

Data organisation started during data collection, as the notes were written and a tape recorder was used. Data were organised into easily retrievable sections which were according to questions on the interview schedule. Each participant was given a code as illustrated in the demographic profile. Field notes were identified by date of the interview.

4.3.2.2 Reading data

The researcher read through all data from transcripts. She also listened to the voice recordings repeatedly to familiarise herself with the depth and breadth of the data. According to Creswell (2014), reading of data is done to get some sense of the information and an opportunity to reflect on its overall meaning (Creswell, 2014).

4.3.2.3 Coding data

Transcribed data were hand coded by dividing the transcript into meaningful analytical units. A combination of emerging and predetermined codes was used. Prior codes were used having derived them from the wording of questions from the interview schedule and literature review. This option was chosen so that data generated addressed the central concerns. Related codes were then combined into themes. The themes were based on converging perspectives from participants (Creswell, 2014).

4.3.2.4 Interrelating themes and interpretation of data

The description of themes was presented in qualitative narratives. The last step was to interpret data based on the meaning derived from the findings.

4.3.3 Presentation of findings

4.3.3.1 Leadership as described by nurse leaders

The question that the participants were asked, as an ice breaker, was to describe leadership in the nursing context. All the participants expressed similar descriptions of a leader in the nursing context. A leader was described as a person who gives direction or guidance in the nursing component. It is someone who initiates actions guided by the objectives. Leadership was also seen as giving strategic direction. Some of the participants described leadership as follows:

“A person who influences people into the operation of nursing”

(RH 3)

“Leadership is someone who is going to give direction to the company, ensuring that the processes are there. People tend not to buy in to something that they do not understand, so as a leader you make sure that there is an understanding of issues. Also ensuring that you are there for the people and visible to the people.” (PD1)

“Leadership is going in front, showing followers how to do things. You have to be visionary so you have to develop a strategy.” (RH 2)

“Leadership is an act of motivating people towards realisation of the mission and objectives of the institution.” (RH 5)

One participant gave another perspective of what leadership is.

“Nursing cannot be isolated from the broader health care system. If you look at leadership and limit it in the nursing context you tend to isolate nursing from the broader main stream of policy development. Nurse managers do not see themselves as leaders because of isolation of nursing from the main stream of health systems development. Leadership gets pronounced when nurses act as a collective, then individuals emerge and demonstrate leadership such as, when nurses are lobbying for recognition or resources. Individual leadership is more pronounced in academia and is limited to lecturers and students versus influencing policy.” (NC 2)

The general feeling in all their descriptions was that there is a difference between a leader and a manager. All participants viewed leadership as being in the forefront and steering nursing

“Leadership is someone who is going to give direction to the company, ensuring that you are there for the people that you are leading (guidance). Making sure that there is an understanding.” (PD1)

“A leader is a person who gives direction and coaches her followers on how things are done.” (RH 3)

4.3.3.2 Expected leadership role

Most of the participants described their role in terms of their key performance areas according to their job descriptions. They were more generic in terms of the day to day activities in their managerial duties, such as staff development, ensuring that policies and protocols are there, recruitment and selection, etc. Most descriptions of the role of nurse leaders did not include explicit language on policy development activities. Most of them had to be prompted in order to describe their roles in relation to policy. It became evident that their roles were to: ensure that policies are available, communicated, implemented;

formulate operational policies; identify gaps that required policies. The participants expressed their expected leadership roles in these excerpts:

“As a leader and manager I have to look at practice and education, put these together to produce a good calibre of nurses. I am expected to look at the recruitment policy. Research is part of what I need to do for evidence-based practice.” (PD 1)

“To provide a strategic direction that is translated into nursing operations. Implementation of the current nursing strategy, staff development and career pathing.” (RH 1)

“My role is to take the nursing component forward. I have to see that the guidelines and protocols are there.” (RH 3)

“I assist to see that there is information that is available. Practical sorting, try to ensure that the environment you are working in conducive and implementing changes.” (RH 4)

“Ensure that there is observance of nursing policy, give guidance and coaching, do quality checks, development of nurses, implementation of the nursing strategy.” (RH 5)

After probing the participants to describe their role in relation to policy, the participants made the following observations:

“I am expected to participate from the beginning of policy development. I need to research, do fact finding and involve other stakeholders. I need to ensure that policies developed are based on the Acts and prescripts. I need to cascade policies for people to check and make inputs. People should know from the beginning to get buy-in, so that they own it or else they will push it aside.” (PD 1)

“Ensure that policies are known to staff, identify gaps from adverse events and knowledge gaps and formulate operational policies. Ensure that we are covered in terms of availability of policies and we are not exposed if there is litigation.” (RH 1)

“Ensure that policies are customised or operationalised and communicated to staff.” (RH 2)

Two of the participants used explicit language describing policy development responsibilities in the role descriptions. It was revealed that the leadership roles for participants at national level mainly dealt with policy issues. Policy was the core business when they described their roles. They expressed their roles in these excerpts:

“Looking after all the councils and ensuring that they have got a representative from the NDOH. The department has an oversight on all councils because they are established by law. So policy development becomes your key performance

area (KPA). My job was to look at legislation from the policy point of view. Need to ensure that it happens. The highest level is the Act of parliament. Acts are policies". (NC1)

"To advise the ministry of health on how nursing and nursing interventions can be packaged in a manner that responds to the burden of diseases. Develop policy statement in each of the nursing compositions. Assist the ministry in developing a policy framework in all elements of the nursing strategy." (NC2)

4.3.3.3 Participation in health policy development

i. Policy development phase

Participants were asked if and how they had participated in developing a health policy during policy formulation, implementation and modification stages. Most of the participants stated that they had not been exposed to the health policy development process. All the interviews revealed that participants had limited knowledge of how the policy development process unfolds, especially at provincial and national level. Participants also reported that they do not even know the people who are part of the process. They shared the following sentiments:

"I have never participated in the National policies even when I was a nurse manager." (PD 1)

"I don't even know where it starts and who decides which policy is required at any given time." (RH1)

"We don't even know who develops them. All we know is that they are from Province or National and we have to comply. Nurses are left behind and decisions are taken on their behalf." (RH 2)

"I know of the nursing act that came for us to have input. We did not make any input because no one was behind us. We do not know even the composition of the group that makes policies. We do not know who is representing us." (RH 3)

Most of the nurse leaders had participated at institutional level. This was through identification of problems and drafting policies in the form of standard operating procedures (SOPs). They also represented the nursing components in the institutional Policy and Procedure committees. They mentioned the following:

"How it is developed no. You just learn on the job how to develop operational policies. Even there it is not formal, you are just given a template that will guide you." (RH 1)

"There isn't much involvement. We customise already available policies. We adapt them and develop a standard operating procedures. In the public service

we are involved in communicating the policies. Where there is none we develop our own standard operating procedure.” (RH 2)

“We do participate in our institution. We identify gaps especially from the adverse incidence and thereafter develop policies.” (RH 3)

“We only develop them at departmental level. With the generic institutional ones, a representative from nursing sits in the policy and procedure committee.” (RH 5)

Some were involved only indirectly through meetings of professional organisations, by discussing the problems, and seeking their recommendations on how to address these problems. Even when they had the opportunity to join in the policy process, they did not use this to present their own opinions. They shared the following sentiments:

“Four years ago, I was a representative at a national nursing summit where the Minister of Health also addressed us. I had the opportunity to express my opinions but I didn’t do it because there were so many people.” (RH5)

Two participants had knowledge of the health policy development process, since they were directly involved as they were in leadership positions at national level. They had participated extensively in health policy development during the time of health system reform in South Africa. Participation at that time meant research, finding information, joining in seminars at the field level and other activities. The portfolios that they held required them to be involved. They stated the following:

“One of my KPAs was formulation of the new nursing act. I had to inform people about the object, functions, and the role. I had to go to various structures of parliament to present. It starts with the portfolio committee for health, presenting it chapter by chapter. Continue through the state law advisors, present until the portfolio committee is happy then pass to the National Council of Provinces.” (NC 1)

“I do have experience outside the current job. I was part of the team that was advising government on the transformation of health. I also participated in the development of the choice of pregnancy policy. We did interviews collecting evidence, case studies throughout the country and parliamentary presentations.” (NC 2)

ii. Policy Implementation

Most participants thought that nurses were involved a great deal in the policy implementation phase. They were familiar with the ways that policies are brought down from the national and province level for implementation at the institutional level. They reported that their role was interpreting policies and ensuring that they were implemented. The issue of being implementers was recurrent. They shared the following sentiments:

“Policies are “pushed down” for us to implement, without understanding. No one explains anything or checks if the policy is understood. I have been involved at lot in implementation.” (PD 1)

“We are never asked about policies that we think are required. A policy will come, we are told that here is a policy for you to implement. No one explains the policy.” (RH1)

“When it comes to implementation we are number one. The policy comes and you are given time frame for implementation.” (RH 3)

“We just implement what we have been given, we are used to carrying orders anyway.” (RH4)

“I would say nurses come at the end to implement. We do question policies but do not know where those queries could be forwarded to and don’t write anything formal so that it could be presented somewhere” (RH 5)

“Bringing the formulated policy down to the implementation level is our main function. Mostly the policies are integrated with nursing. So we have to communicate them and monitor implementation.” (RH6)

iii. Policy modification and evaluation

Most participants thought that the nurses had limited involvement in this phase and they were not aware of any formal processes or guidelines that they had to follow when evaluating policies. However, some of the participants stated that they had participated in the policy evaluation phase. They identified gaps in policies that they have received. They then sent motivations to head office about the impact of the policy. They then made their recommendations to the task team. However, findings revealed that this only applied to the OSD policy.

“To some extent we do evaluate policies but especially the operational ones that we make ourselves. The national and provincial policies, we just monitor implementation and report challenges such as, to HR if it is an HR policy and they would advise us. But most of the time they would tell us that they are going to write to head office but nothing changes.” (RH 1)

“I have evaluated although sometimes it is not formal. You just see by the look of things that the policy has made some changes or not.” (RH 2)

“We do question policies but do not know where those queries could be forwarded to and don’t write anything formal so that it could be presented somewhere.” (RH 5)

4.3.3.4 Perceptions about policy and nursing

The participants were asked to share what influenced their thinking about nursing and policy. They also had to share their experience in nursing leadership in relation to policy. Findings revealed that participants had similar views about nursing and policy in general. All the participants knew that policies were there to guide them. The general feeling was that nurses were not involved in health policy development. All eight participants stated that there was limited participation of nurse leaders in health policy development. The finding was that policies were formulated without an understanding of what happens at grassroots level. All interviews revealed that nurses were viewed as the receivers and implementers of policies. This was seen as resulting in varied interpretation of policies. Some policies were said to be interpreted and implemented differently by various institutions because they were not explained to them. They expressed their perceptions in these excerpts:

“Nurses are represented by people who do not understand our needs and how we work. I think nurses are a silent group when it comes to policy development issues. They receive and implement.” (PD 1)

“You know, policies just emerge like the nursing act. They do not want input from us before. We are never invited or consulted when a policy is formulated”. (RH 1)

“Nurses are the receivers of what should be done. We are told what we must do. When it comes to policy issues really we are nowhere. Hmm but what can I say about policies is that some nurses don’t even look at them.” (RH 4)

“Like OSD, we were not involved. We do not know even the representative that represented us. We implement because we are used to carrying orders.” (RH 3)

“I would say nurses come at the end to implement. They do question policies but do not know where those queries could be forwarded to and don’t write anything formal so that it could be presented somewhere.” (RH 5)

The participants from national level also viewed participation as limited. They expressed this in these excerpts:

“Of course nurse leaders have always been seen as the implementers. However, they do participate in policy development, for instance the Nursing Strategy. Nurses were given a platform in the nursing summit not only to lament but guided on how to

formulate resolutions. They took resolutions that culminated to a policy rather than factors that do not result to policy. Resolutions are building blocks to policy. Resolutions transferred to a strategy which will then lead.”(NC 1)

“Nurse leaders are involved in policy development although it is limited. There is always consultation, for instance my first project was locating nursing education to higher education. Two nurses did a country wide collection of information. Recommendations were made and submitted to the Minister of Health.” (NC 2)

4.3.3.5 Perception of barriers to participation in policy development

Participants were asked to identify barriers they experienced in health policy development. The following themes resulted from the analysis of participants’ comments about barriers to policy development: political factors, structural factors, communication factors and gender factors.

Table 4.39: Perceived barriers to participation in health policy development

LIMITED PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT				
COMMUNICA TION FACTORS	POLITICAL FACTORS	HUMAN RESOURCE DEVELOPMENT FACTORS	STRUCTURAL FACTORS	MOTIVATIONAL FACTORS
-Poor communication -Lack of consultation -Lack of invitation -Lack of input from relevant people	-Lack of political awareness -Poor representation at legislative levels -Lack of political skills -Lack of recognition by policy-makers	-Lack of formal policy development training programmes -Limited knowledge and skills -Inadequate experience in policy development -Inadequate in-service education for managers	-Poor representation in committees -Representation by people other than nurses -Ineffective structures -Poor organisation of managers- absence of forums	-Lack of interest -Limited participation even when invited -Not being proactive on professional issues

I. Communication factors

Findings from the qualitative data showed that poor communication between the policy-makers and the people on the ground was a major problem and a recurrent factor. The participants stated that they were not consulted for input when a policy was being developed. They were not invited to participate. Even when they had received the policy for implementation, they did not know who to contact if there was something that they did not understand or if they saw a need for modification. Since no one explained the policies, they ended up interpreting them the way they understood them. This sometimes resulted in the unintended consequences of a policy. They maintained that involvement would boost their confidence. They expressed the following opinions:

“Nurses are not invited, not informed and are not capacitated.” (PD 1)

“We have never been invited as clinical leaders, for instance in the OSD policy the nurse educators represented us. There is that tendency to think that educators are more informed than us and yet clinically it’s vice versa.” (RH 2)

“Acceptance of input is limited to people who approve the policies. We are not invited and yet we are the end users.” (RH 3)

“Communication is always a challenge. No one invites us even to discuss that very policy that is downloaded to us but we are expected to comply.” (RH 5)

On the other hand, the participants from national positions thought that consultation was available. If there was any health policy, the SANC as the body of nurses was consulted by the government for inputs. Again, it appeared that the SANC as a body is afforded an opportunity to present its own policies in parliament for debate. However, the presentation is done by the Minister of Health. The SANC officials such as Registrar or Chairperson are there only to advise the minister, they do not talk. The SANC consults nurses through a countrywide collection of information. Nurses are even referred to the SANC website so that they can make their inputs.

“There is always consultation. At national you cannot do anything involving that particular profession without involving it. Policy is taken to the SANC as a body for the nurses. There is a SANC consultative process that is followed.” (NC 1)

The “SANC does participate in National policies. Development of competency is the role of the council. The SANC is an enabling structure. Council informs the Minister of Health. The council also uses consultative forums. They understand lethargy amongst nurses. However, nurses need to be proactive in their forums. People wait for council instead of council synthesising what comes from the nurses.” (NC 2)

“There is always consultation. My first project was locating nursing education to higher education. Two nurses did a country wide collection of information. Recommendations were made and submitted to the Minister of Health.” (NC 2)

The participants also concurred that the consultation of nurses in general by the SANC is not sufficient when it comes to policy issues.

“There are communication barriers by nature. If you want to introduce a policy in a country a sufficient consensus is needed. The country is vast, making it impossible to reach everybody and the staff is limited. Certain things can be communicated fairly easy and others are not. We discovered that much as we worked so hard, people do not know.” (NC1)

ii. Training and development factors

The participants revealed that they had limited knowledge of the policy development process and this was seen as an obstacle to participation in health policy development. Furthermore, they were not capacitated. Six participants felt least prepared in policy development and claimed to have no skills. Findings revealed that they had never received any formal training on policy development. They learnt policy-making on the job. The six informants identified self-learning, trial-and-error experiences, and asking a lot of questions as an informal means of learning about policy development. They learnt to develop more guidelines and standard operating procedures. Findings revealed that there was limited in-service training for the nurses at management level. It appeared that there were no planned staff development programmes for them. They stated that:

“No I have never been trained on policy-making. I just read from books. There are nurses’ forums and generic policy-making committees at institutional level. If people are involved in that policy they would throw in their ideas. In my portfolio we already have forums with terms of reference, looking at staff development, policy formulation.” (PD1)

“It is not studied in any nursing course that I did. There was very little, I think definition of what a policy is. But how it is developed no. You just learn on the job how to develop operational policies. Even there it’s not formal you are just given a template that will guide you.” (RH 1)

“No I have not been trained. I do not have any formal training in policy development. I don’t remember even when I did my nursing management post basic course. The process part of policies has never been taught. However, we do have our in-service training on how to formulate and document a policy.” (RH 3)

Two participants reported having received some form of training and experience on policy issues. However, one participant claimed that even if they were told to formulate a policy they always consulted people or went to the university. They expressed this in these excerpts:

"Yes I did receive training on policy issues. My Masters was in policy. I did legal policies." (NC 1)

"I did receive training. It was quite early in 1994. I was part of the team for an organisation which was to assist the government in developing policies since it did not have capacity." (NC 2)

iii. Political factors

Findings revealed that participants also related their limited participation in policy issues to the political status of nursing. They saw themselves as a group that was undervalued or undermined.

"Nursing has always been a group that is undervalued and undermined." (PD 1)

"Mmmh I think we did not have "isithunzi" (dignity). Now that we have senior people they will start maybe recognising us." (RH 1)

"People underestimate the education of nurses." (RH 2)

"No. Maybe they do not see a need to involve or they think if they wait for our input there will be delays I don't know. Another thing is that actually we have not been exposed to working with politicians where policies are made." (RH 4)

The experienced participants viewed the nature of the policy process as complex and highly political. There was no way that it could be removed from politics in the sense of vested interests by the people that are developing policy. The participants viewed themselves as marginalised, with other people speaking on their behalf. Some participants expressed this in these excerpts:

"Most policies are not pro nurses because they are developed by people other than nurses. Their role has never been as key. But nurses have never challenged their exclusion. They don't take interest; they don't even know that they need to shape the final detail of policy. Policy-makers find a way to consult unions because they pose a threat. There is a fear that the policy would be rejected." (NC 2)

"Maybe previously there was no recognition of nursing as a profession." (RH 1)

"We have never been invited as clinical leaders e.g. in OSD the nurse educators represented us. There is that tendency to think that educators are more informed than us and yet clinically it's vice versa." (RH 2)

“Nurses are represented by people who do not understand our needs and how we work. I think nurses are a silent group when it comes to policy development issues. They receive and implement.” (RH 3)

The inability of the nurse leaders to engage with the technical aspects of policy formulation was mentioned as a barrier; for instance, when policies were sent out for public comment.

“Nurse Leaders do not participate even if they are invited. SANC does hand out policies for public comment and very few are received. However, the impact of non-participation on a policy does not influence the impact of the policy. (NC 1)

iv. Structural factors

The participants stated that they had not until recently had structures to represent them at provincial and national levels. This was seen as one of the things that limited their involvement. However, there seems to be hope that with the new developments an improvement will be seen. The lack of formal structures or forums for nurse leaders, such as the nurse manager's chapter or association, also contributed to their exclusion. One of the participants insisted that the nurse leaders need to be represented in the legislature.

“Another barrier is that nursing is not organised. They cannot speak in one voice. They are not proactive and they don't think that they can have a great influence on policy changes in the country.” (RH4)

“Nurse Managers are not organised like the educators. We do not have formal structures that are recognised like NEA where we could share policy issues. That would also help so that implementation is uniform all over, unlike OSD.” (RH 5)

“So far we do not have forums on policy identification, formation, implementation and evaluation which I believe would be a good starting point.” (RH 3)

v. Motivational factors

Lack of interest was also mentioned as a barrier to participation in health policy development. Nurses did not participate even if they were invited. Findings also revealed that they were not proactive and vocal about matters that affected them. Some participants said:

“You know when policies are there, they do not even look at them.”

(PD1)

“Nurse Leaders do not participate even if they are invited. The SANC does hand out policies for public comment and very few comments are received. When the SANC asks for input, they do not comment.” (NC1)

“But nurses have never challenged their exclusion. They don't take interest; they don't even know that they need to shape the final detail of policy.” (NC2)

“I also think nurse leaders are lazy to study. If we could involve ourselves in research like you are doing, we can be able to present our evidence to the policy-makers and that could inform decision-making.” (RH 5)

“I know of the nursing act that came for us to have input. We didn’t make any inputs because no one was behind us.”(RH3)

“They are not proactive and they don’t think that they can have a great influence on policy changes in the country.” (RH4)

4.3.3.6 Strategies to facilitate participation in health policy development

Participants were asked to suggest strategies that could be identified and implemented in order to overcome barriers to their participation in health policy development. Most of the participants felt that nurse leaders need to be organised as a formation from the top in order to have their voices heard. Findings revealed that the nurse leaders had no support network to discuss policy issues. The nurse leaders have a wealth of information and potential to influence policy. The participants argued that if nurses were to be invited, they would have substantial inputs. That would also boost their confidence. However, one participant felt that the nurse leaders need to start organising themselves at institutional level. They need to discuss policies that have direct impact on nursing at that level.

“They need to start participating in policy issues such as quality improvement and clinical audits. They cannot claim to be excluded nationally when they are not seen to be actively participating locally. They need to be proactive and not wait for the SANC. They can also shape and inform policy, it is not only the SANC prerogative.” (NC 2)

“Nurse leaders and management forums, representative of managers at all levels.” (RH 2)

A recurring response was that the policy development process needs to be part of the curriculum (7 participants). One of the issues mentioned was that when you are qualified, you are expected to develop SOPs in your unit. There is a gap in knowledge because they are never prepared for this role. It is missing. Much as the findings were consistent on the issue of the curriculum, the level at which policy must be taught differed. Some thought at basic level and others said at post-basic level.

“Policy needs to be part of the curriculum. You should come out having a clue. As it is, some professional nurses don’t know about policies.” (RH 3)

“Definitely it should be part of the curriculum for nurse managers. For those already in positions, they need to be workshopped. However, nurses must

understand that they are not at planning level, I mean ordinary nurses in the ward.” (PD1)

“There must be some induction or training so that we are able even to explain to the younger nurses what processes are followed when these policies are developed.” (RH 6)

“But I think the starting point should be gathering us and workshop us on the proper process.” (RH 5)

“Our pace is too slow in terms of reviewing the curriculum. Even the SANC, it’s more reactive than proactive. We are the owners of our own curriculum. Planning curriculum for various programmes including nurse leaders is important.” (NC 1)

Policy-makers should start recognising nursing. Participants asserted that if they were informed and consulted, this would enable them to participate and that being involved would boost their confidence. As knowledgeable people, they could draw from their experience. Improving communication would also assist. The policy-makers must ensure that a large number of nurse leaders are reached for inputs. Excerpts from some participants were as follows:

“We need to come out of our shell and claim our status in the government. We can make them see that we are knowledgeable and can better inform policy.” (RH 4)

“Nurses have to be involved in politics so that they can talk for us.” (RH 1)

4.3.3.7 Perceived issues that need to get to the policy agenda

Participants were asked if they had identified any issue that needs to get to the policy agenda. Uniform policy was a common issue (5 participants); policy on management of risks (2 participants); regulation of nursing education (3 participants); selection criteria for nurses who are sent for training considering age (1 participant) and allocation of bursaries. All participants gave an indication that they would be interested to participate if given an opportunity.

4.4 CONCLUSION

This chapter presented the results and analysis of the quantitative and qualitative findings of the study. Findings were summarised and presented in narratives, tables and graphs. Findings from both data sources are consistent with the quantitative data, adding validity

to the study. This was the **first phase (diagnostic)** in which the extent of participation of nurse leaders in health policy was determined and analysed. Interpretation and reflection on the findings took place, leading to the plan for the second phase of the study. The intervention based on the available findings is discussed in the next chapter as phase two of the study.

CHAPTER 5

PHASE TWO INTERVENTION: CAPACITY-BUILDING WORKSHOP

5.1 INTRODUCTION

The intervention phase took the form of a capacity-building workshop to share the findings and propose an intervention which would be implemented by the nurse leaders. These findings were initially shared with the research team, who then brainstormed the interventions. The researcher, together with the team, planned a workshop that would include a wider community of nurse leaders. A one-day workshop was organised to present and verify the study results, and to capacitate the recruited nurse leaders on health policy development. The aim of the capacity-building workshop was to address the identified gaps in knowledge, skills, confidence and other practices related to the participation of nurse leaders in health policy development.

The workshop provided an opportunity to discuss policy issues with a wide range of nurse leaders (including managers and educators). The format of the workshop placed an emphasis on sharing the expertise and perspectives of all participants. The workshop comprised presentations, breakaway groups, debates and networking. Both the plenary session and the breakaway group reports raised issues that transcended the framework of the study. They stressed the importance of understanding the policy development process and the role that the nurse leaders could play. Both sessions also explored the delicate balance between policy development and implementation, as well as weaknesses in current health policy systems that leave out important actors (nurse leaders) in the process. Together, these stakeholders reviewed the scope for joint and individual action and collectively suggested a way forward. Codes were used for the quotations to indicate whether the response was from nurse leaders from education or practice, Educator (Ed) and Managers (Mng).

5.1.1 Invitation to the workshop

Thirty-three (33) nurse leaders were recruited from the participating hospitals to attend the workshop. Each hospital was requested to send a maximum of three representatives. The number was limited due to limited funds for running the workshop. Invitation letters to participants were sent via e-mail three weeks before the workshop to the CEOs and nurse managers. All potential participants were also provided with background information of the workshop by e-mail. The invitation indicated how participants would benefit and the policy areas that would be covered in the workshop. The participants had to arrange with their

institutions regarding travelling and special leave to participate in the workshop. After agreeing to participate, participants were sent the programme for the workshop. The research team members were also invited formally so that they could request leave from work on the day of the workshop. A consultant from a reputable university, who specialises in policy research, was invited to facilitate the workshop.

5.1.2 Date and venue

The workshop was held on the 19th of February 2016 at the Glenmore Pastoral Centre in Durban, KZN, South Africa.

5.1.3 Programme and registration

A programme of activities during the workshop was prepared as shown in Annexure 6. The workshop lasted from 08h30–16h00. A thirty-minute tea break was observed and lunch was served on completion of the programme. Participants were registered on arrival, filling in registration forms. The following information was captured on the form: name; rank, institution, contact address, telephone number and e-mail address; years of experience in nursing; years of experience in current position; highest level of education; and purpose for attending the workshop (see Annexure 5). The participants received training packs with a writing pad, a pen, an information sheet, a consent form, an evaluation form and the workshop programme. The participants had to sign an informed consent form for participating in the workshop for ethical purposes. They were then provided with a blank sheet of paper and a marker so that they could write their preferred names which were used for identifying and addressing them during the session. One of the participants was assigned to take notes of all the proceedings of the day. The other members chaired the plenary sessions. An early morning tea was provided because some participants had travelled long distances.

5.1.4 Attendance

Twenty-four participants registered for the workshop. The other people invited either could not participate because of other commitments, or did not reply to the invitation. Amongst the attendees, there were nurse educators. One social worker was also present, as an observer. She came out of interest after hearing about the workshop from a nurse manager at the regional hospital where she works.

5.1.5 Mode of delivery of the workshop

The mode of delivery of the workshop was interactive, as opposed to the traditional lecture method. The participants were stimulated to discover more productive ways of doing their

work (McNiff, 2009). One of the research team members facilitated the plenary sessions. In order to take full advantage of the wide range of perspectives, the presentations were rich in information but brief, and accommodated discussion as a means to greater understanding between the different parties, increased collaboration, and concrete recommendations for improving current practices. Discussions took place at the end of each session, giving participants the opportunity to ask questions and express their opinions.

5.2 DEMOGRAPHIC DATA ON PARTICIPANTS

The profile of the workshop participants is illustrated graphically below for greater clarity.

5.2.1 Gender

The workshop was attended by more females than males. Female participants constituted 87.5 percent ($n=21$), whereas the males formed 12.5 percent ($n=3$), as illustrated in figure 5.1.

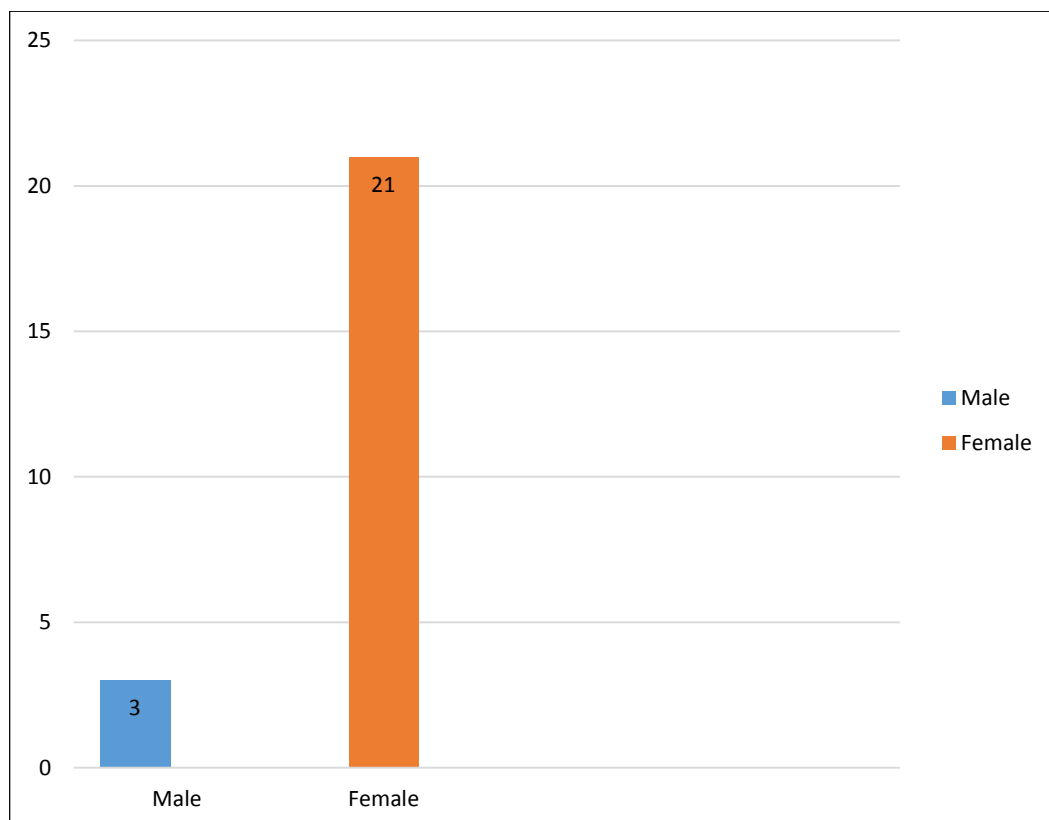


Figure 5.1: Gender (n=24)

5.2.2 Age distribution

There was equal representation of participants who were between 41 and 50 years and those between 51 and 60 years. Each age group constituted 42 percent (n=10). Seventeen percent (n=4) of the participants were between 31 and 40 years. See figure 5.2.

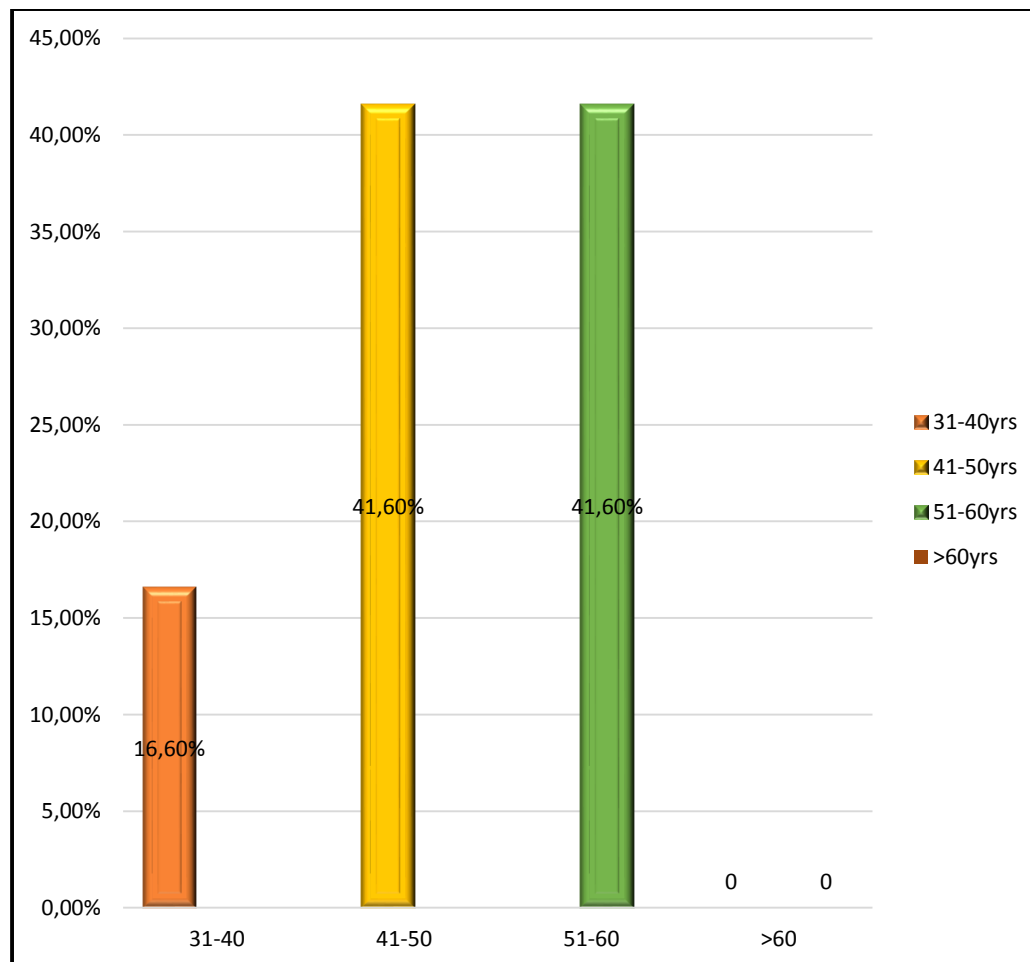


Figure 5.2: Age distribution (n=24)

5.2.3 Experience in nursing

The majority of participants [38 percent (n=9)] had experience in nursing ranging between 26 and 35 years. Thirty-three percent (n=8) had 16–25 years' experience in nursing. See figure 5.3 illustrating years of experience in nursing. There was one missing value as a result of the social worker that was present. This information did not apply to her. However, the percentage is based on the total number of participants.

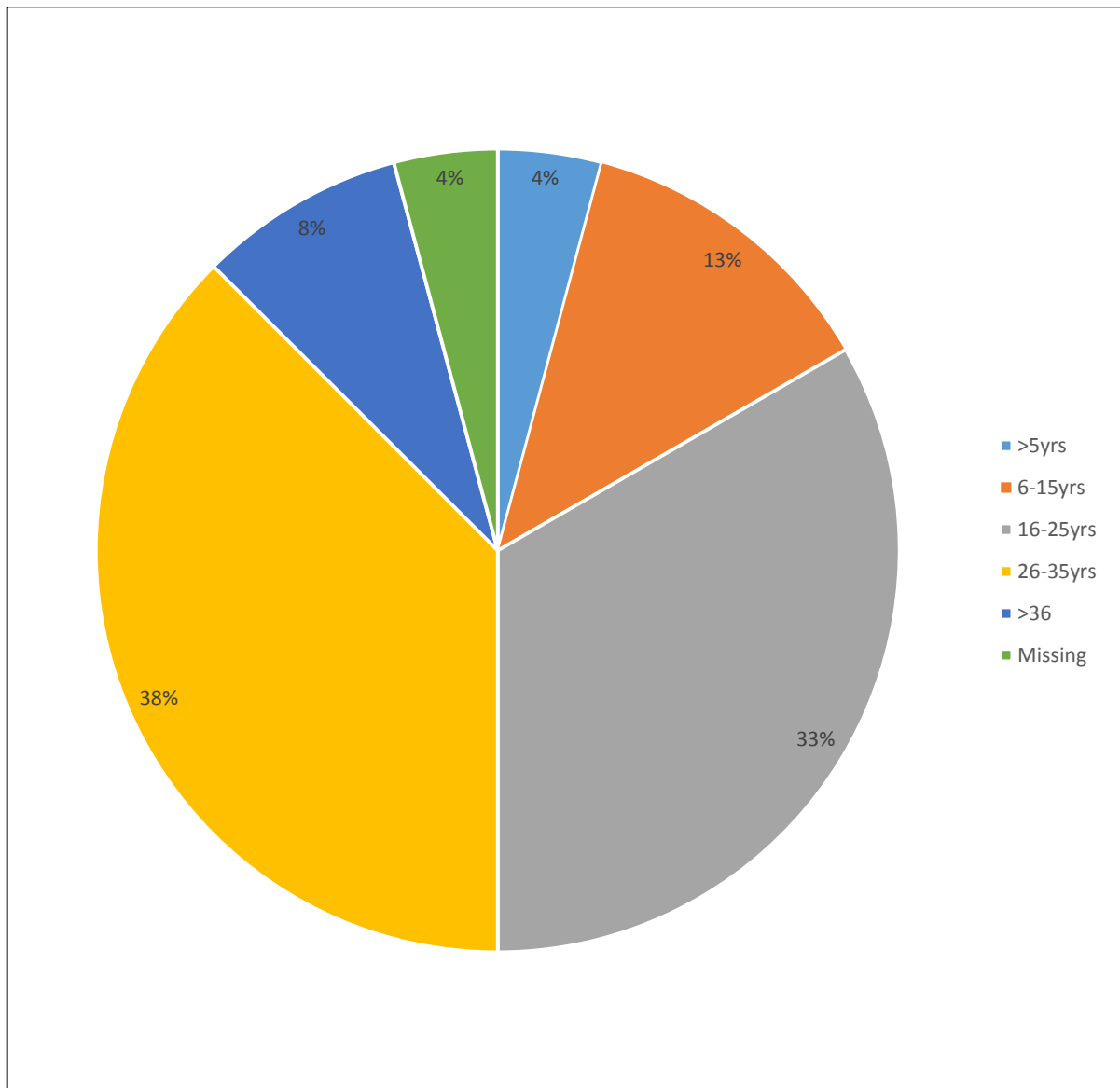


Figure 5.3: Experience in nursing (n=23)

5.2.4 Experience in current position

Forty-two percent (n=10) of participants had 6 years of experience in the current position. Forty-six percent (n=11) of participants had below five years of experience in the current position. Refer to figure 6.4.

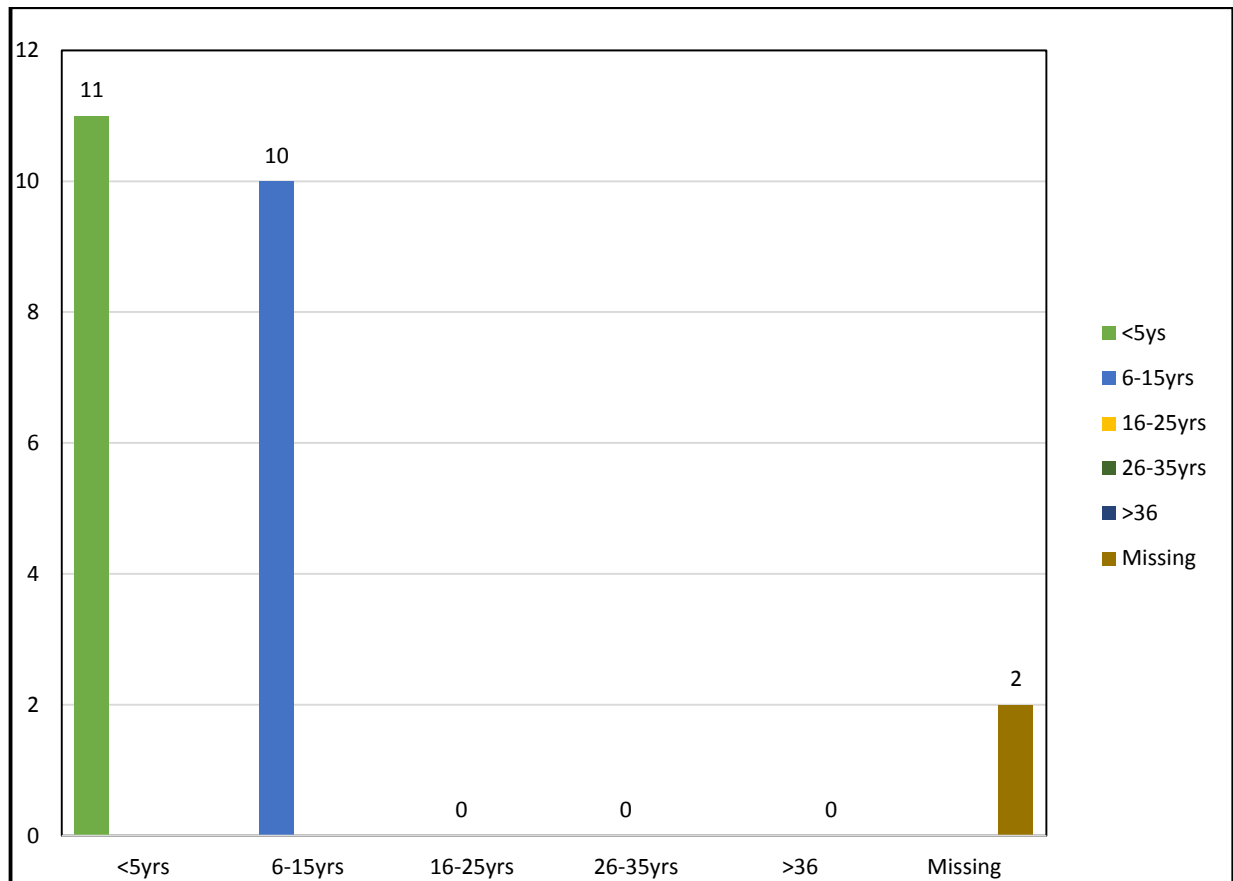


Figure 5.4: Experience in current position (n=23)

5.2.5 Highest level of education

Most of the participants [54 percent (n=13)] had bachelor's degrees as their highest level of education. Eight percent (n=2) participants had PhD degrees and 12 percent (n=3) had diplomas. See Figure 5.5 below.

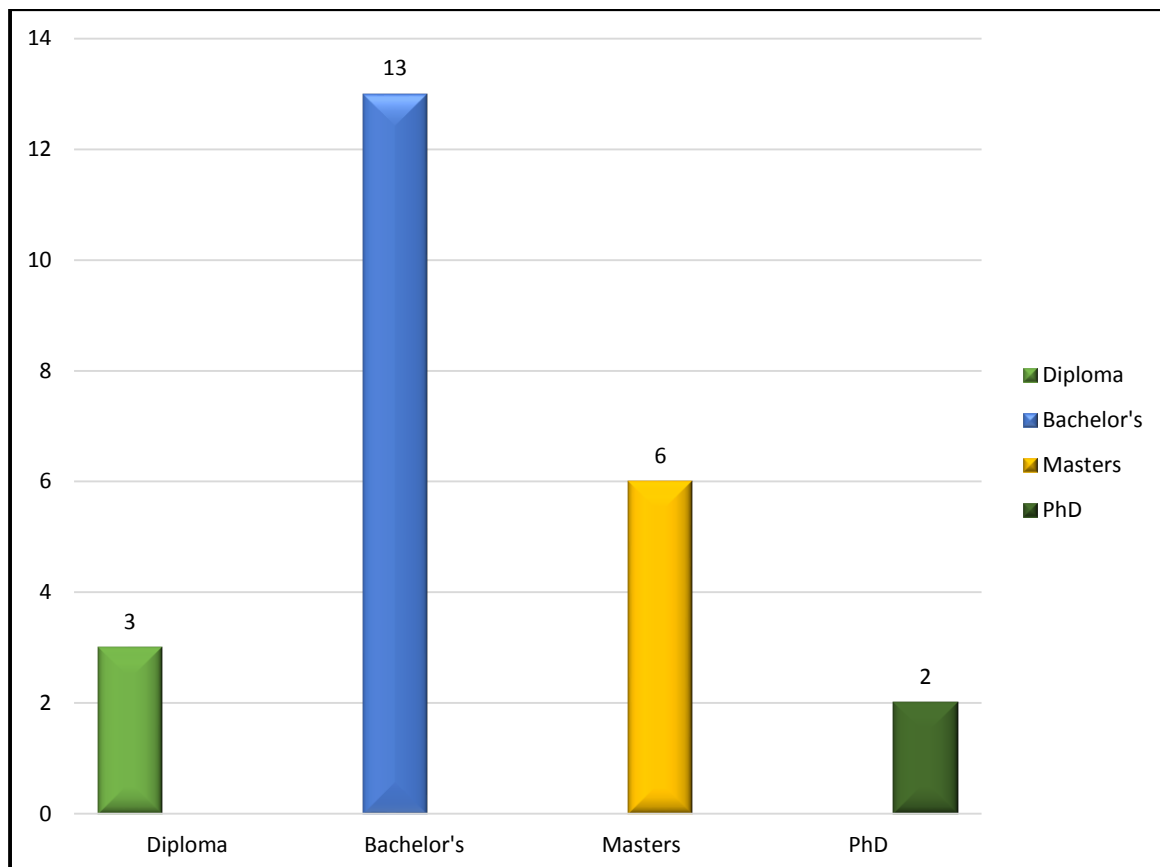


Figure 5.5: Highest level of education (n=24)

5.3 FIRST SESSION OF THE WORKSHOP

The day's activities started with an opening prayer by one of the participants. The participants were then welcomed to the workshop by a professor from the University of KwaZulu-Natal (UKZN). She gave a brief overview on participation of nurse leaders in policy development from the literature that she had reviewed. She mentioned that according to the WHO nurses do not participate in policy development and are more involved in implementation. Furthermore, available nursing programmes, both basic and post-basic, do not teach nurses about policy development issues. She added that most of the people in the group had a qualification in nursing management; however, none of the assignments given were on development or reviewing of policies such as infection prevention and control policy. The audience supported that statement, and concluded that the blame goes on academia as participation in policy issues at that level would improve in the areas of practice.

The welcome was followed by individual introductions. The participants were asked to introduce themselves by stating who they were, where they came from and how they had been involved in policy development. Some of the participants said that they had never participated, some had little involvement and others full involvement. Some had participated in the development of standard operating procedures at facility level. Only two participants reported that they had participated in policy development beyond the institutional level. They had worked at provincial level. Participants stated:

“I was actively involved in policy development during the COHSASA accreditation period. I had to move to the Provincial office in 2012 and was very involved in the development of provincial policies, aligning them with the national ones.” (Mng)

“I have been involved at provincial level because of the position that I hold.” (Ed)

Other participants expressed:

“We were told that policies come from national. What we develop are Standard Operating Procedures (SOPs). Now it’s confusing for us.” (Mng)

“I have never participated except by developing operational policies for my department. Even then there is no guide that you follow.” (Mng)

One participant commented that policies are developed at different levels. Nurses do participate in policy development without being aware of doing so. An example is participation in the Integrated Management of Childhood illnesses (IMCI) at PHC level, which is part of policy development. The chairperson for the session commented that much as she had participated at local level, she felt that policy development was a top-down process. She was however involved in initiating policies, as she was a member of the provincial policy development committee. The group was asked to reflect if they had ever seen policies being circulated for input. Some participants mentioned that they had seen them. Two participants commented:

“I have attempted to send input before but could not see it in the final policy”. (Ed)

“I have seen maybe one or two but I can’t remember what they were about. I think it was something that did not affect us directly but I never commented.” (Mng)

5.3.1 Presentation of research results

The first presentation was done by the researcher. The purpose of the day was stated, which was both the basis of an extended research project and to capacitate nurse leaders in health policy development. The origin of the workshop itself was highlighted. The results of the study were then presented. See Annexure 7 for the presentation.

The components of the presentation of results were:

- The **title** was stated in order to give the participants an idea of what the research was about.
- The **introduction** explained what the research was about, outlining the purpose and the problem statement.
- A brief **literature review** was given to highlight what is already known about the topic and where the current study fits into the wider picture. It was also explained how the study filled any gaps in knowledge and corroborates what other studies have found.
- **Methodology** outlined how the research was conducted, which methods were used, and the types and numbers of people that were involved. However, their anonymity was maintained.
- **Findings** from quantitative and qualitative data were presented. The quantitative presentation included graphs and tables. The qualitative presentation included quotes from the interviews.
- The **conclusion** briefly summarised the key messages and concluded the report.

The participants were invited to ask questions or comment after the presentation of results. A question was raised relating to the duration of the data collection. The researcher explained that the process took almost a year. The delay was due to many factors. One of the challenges was an inability to gain access to facilities after obtaining permission from the relevant authorities. Some nurse managers either did not respond to requests for appointments for data collection or were slow in responding. One participant commented that the results were a true reflection of what was happening in nursing.

A comment made relating to quantitative data was that terminology needs to be explained to the participants. This would enable them to understand the question and answer properly. If they do not understand the question they just rate any question as average. The nurse educators mentioned this because they teach and also supervise research. The age of the nurse leaders that participated also triggered a discussion. Most of them were above the age of fifty (50). The feeling was that the nurse managers are an ageing workforce. There is a need to start developing a new generation of nurses. There must be succession planning programmes. The challenge raised was the issue of organised labour/unions. The argument was that the unions would question if a younger person who is less experienced is put into a high position leaving experienced individuals behind. The

best way that was seen was making the succession planning process transparent in the organisation.

5.3.2 Presentation by the facilitator

The researcher then introduced the facilitator (policy specialist) for the workshop. The facilitator was going to take the participants through the policy development process. She was from the School of Public Health, in the Centre for Health Policy of one of the universities in Gauteng province, South Africa.

The presenter first highlighted the objectives of the first session which were:

- Distinguish between “policy” and “health policy”
- Understand the inter-linkage of policy development and implementation processes
- Identify factors influencing policy development and process
- Recognise the complexity of the overall policy process

She gave some perspectives from her experiences of working in nursing research.

Policy was defined, quoting from the literature, as a proposed course of action of a person, group or government within a given environment (Anderson, 1997) whereas the WHO (1999) defines health policy as an agreement or consensus on the health issues, goals and objectives to be addressed, the priorities among those objectives and the main directions for achieving them. The importance of health policy was highlighted, as decisions impact on the lives of people. The distinction between policy, health policy and SOP was clarified.

5.3.2.1 The policy-development process

The complexity of the policy development process was presented at length. This ranged from the different types of policies, the different forms of policy and where and how policy is made. A policy framework adapted from Tarlov (1999) was used to describe the policy-making process. This framework involves four stages, namely, problem identification and issue recognition, policy formulation, policy implementation and policy evaluation. Refer to Figure 5.6.

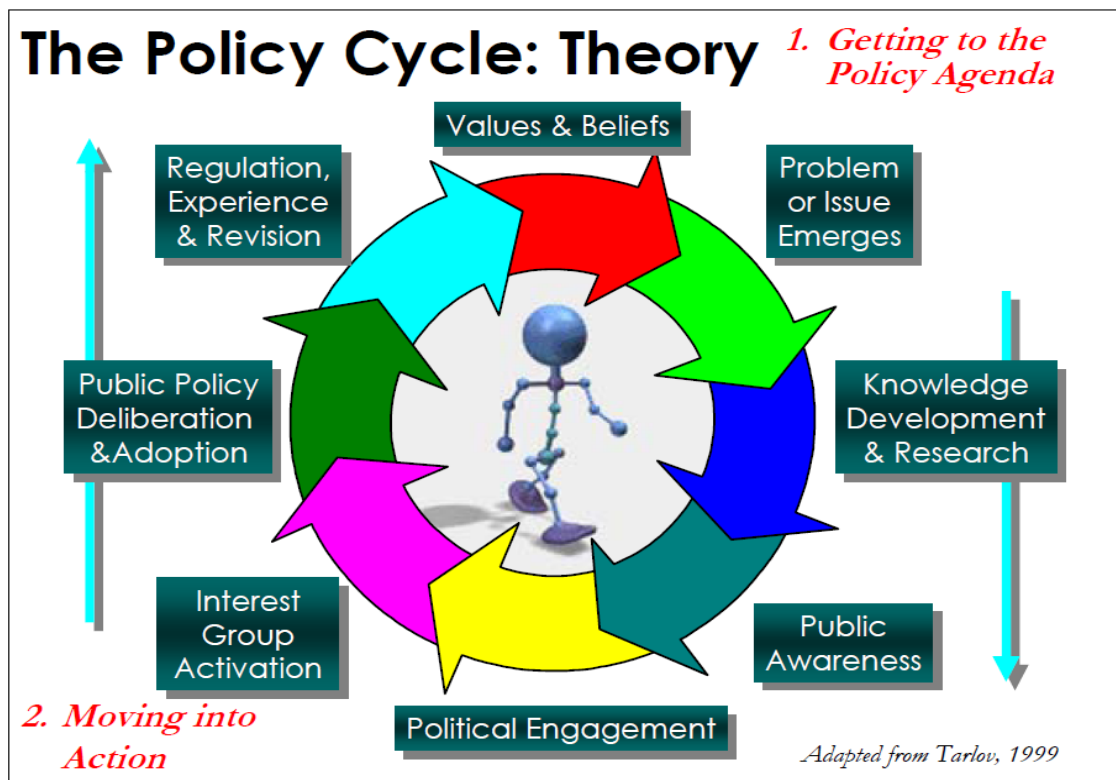


Figure 5.6: Policy Cycle Framework (Tarlov, 1999)

5.3.2.2 Conducting health policy analysis

A framework developed by Gilson and Walt (1994) for conducting policy analysis was presented and discussed. Examples of nursing case studies from the Research on the State of Nursing (RESON), such as the nursing strategy and OSD, were used to show how a policy is analysed using the framework. Refer to Figure 5.7.

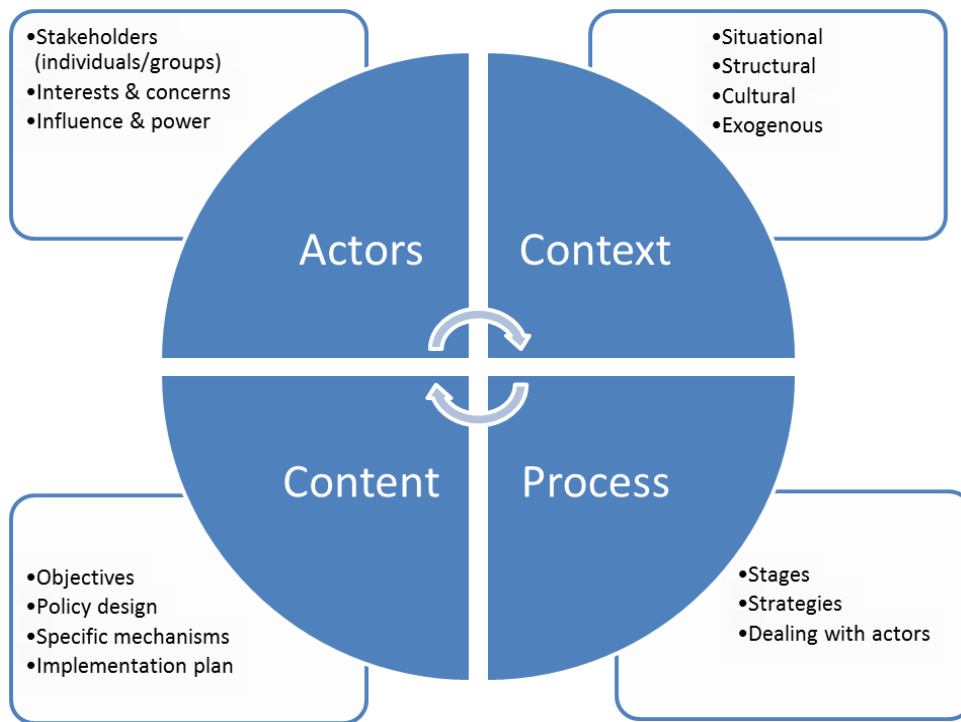


Figure 5.7: Policy Analysis Framework (Gilson and Walt, 1994)

The participants were allowed questions and comments after the presentation. They said that they had gained a lot of information from the presentations. Most of the participants commented about and showed interest in the policy analysis framework. They commented that it would be useful if they could use it in their workplaces. One participant commented:

“I wish that this workshop took place before the Continued Professional Development (CPD) policy came out for comments.” (Ed).

Participants also appreciated the clarity given on the levels of policy-making. The discussion that followed raised questions about who really represents nurses in policy decisions. The participants stated that there were lot of professional issues that had to be dealt with in order for nurses to work as a united front. They agreed that there is a lot of division among nurses and the issues were debated. Poor communication between the different levels in nursing was also raised. The facilitator supported this statement. She referred to a study that they had done on nurses regarding policy. The findings showed that the lower the categories, the less likely that they knew about policies. One of the comments was:

“We can shape the system because of the power of our numbers.”
(Mng)

The issue of policy development being part of the curriculum was also a recurring one. Participants expressed the opinion that there is a need to start grooming the next generation of nurse leaders. The facilitator's comment was:

“You need to make your position statements, based on research, even if you have not personally done that research but through systematic reviews.” (Fac)

5.4 SECOND SESSION OF THE WORKSHOP

The second session of the workshop followed a less traditional format than the morning's proceedings. It was designed to elicit the maximum contribution from all the participants, and consisted of two main sections, each aiming in different ways to promote reflection and deeper exploration of the themes that emerged from the morning's presentations and discussions. These three sections comprised: breakaway groups; reports from the breakaway groups; the way forward and the concluding plenary discussion session.

The facilitator continued with the presentations and stated the objectives of the second session as follows:

- Understand the key policy issues facing nurses globally, with particular focus on Sub-Saharan Africa
- Discuss the reasons why nurses and nurse leaders need to be involved in policy-making
- Identify the role nurses can play in policy-making processes

5.4.1 Policy issues facing nurses globally

The key policy challenges that are facing nurses globally were highlighted. These factors were divided into two, namely, external driving forces and factors internal to nursing, presented in diagrammatic form as illustrated in Figure 5.8.

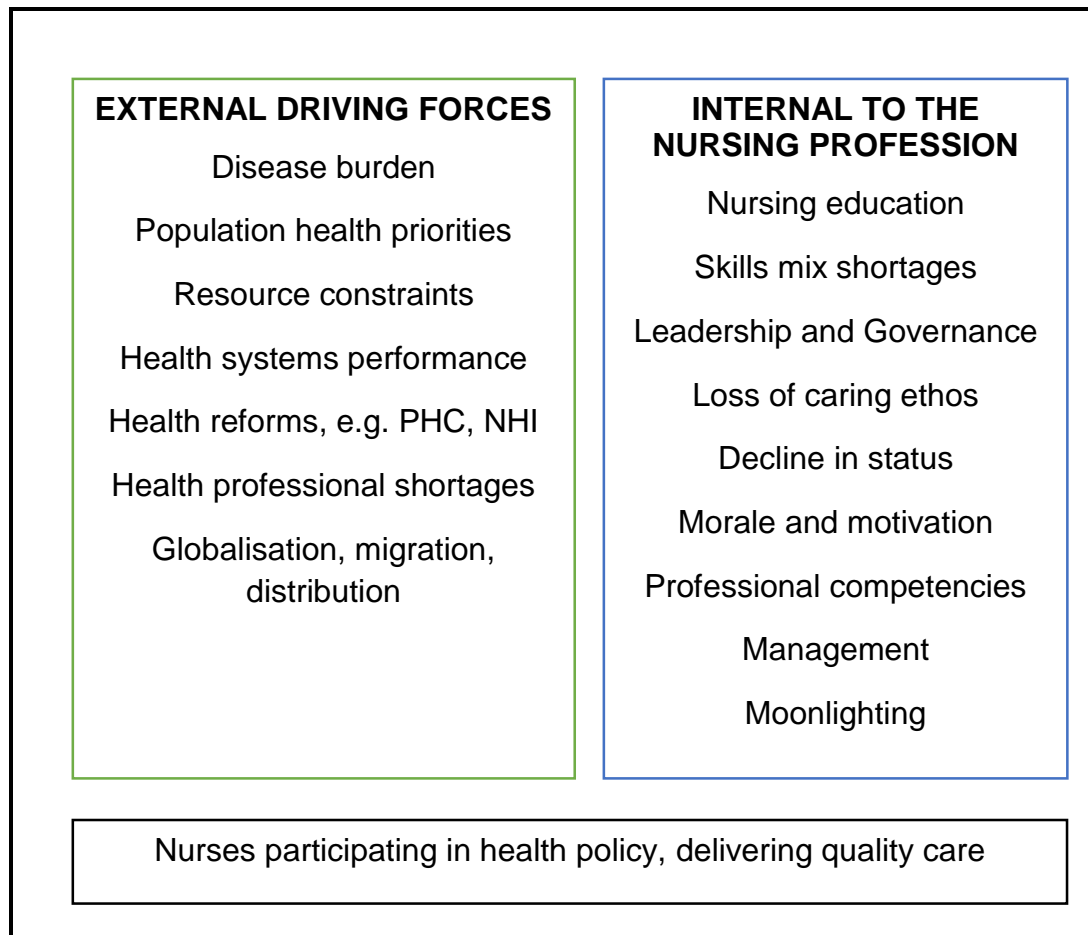


Figure 5.8: Policy challenges for nurses

5.4.1.1 Policies affecting nurses in South Africa

The facilitator also looked at nursing policies in South Africa. Policy initiatives were highlighted and also the challenges.

Policy Initiatives:

- Nursing Act (Act no. 33 of 2005)
- HRH Strategic Plan (2006)
- NDOH financial incentives
 - Scarce skills allowance
 - Rural allowance
 - Occupational Specific Dispensation (OSD)
- Nursing Strategy for South Africa (2008)
- Updated Scope of Practice
- New Qualifications Framework
- Nursing Summit (2011)
- Nursing Compact

5.4.1.2 Challenges

Below are some of the policy challenges that the nurses are faced with in SA.

- Length of time to develop policies
- Stalling of some key initiatives
- Significant gap between policy development and implementation
- Weak leadership and governance
- Poor coordination between key actors
- Significant disjuncture between national policy discourse and experiences of frontline nurses

5.4.2 Why nurses need to participate in health policy development

It was stated in the presentation that, globally, nurses form the majority of the health workforce, hence health services cannot function without them. Their participation in health policy development would ensure that nurses' status is not neglected. Since they are in the frontline of service delivery, they have a better understanding of community needs. They can therefore bring knowledge of how policy decisions affect real lives. Nurses are said to have "untapped" strength. This referred to the different sources of power that they have, such as: power of numbers; expert power, as they are in a position to identify issues and possible solutions; and legitimate power, which is having authority to speak out on health issues.

The presenter referred to a study that she conducted on participation of frontline nurses in four policies that affected nurses in SA. She shared barriers that were identified by that study which were mainly: lack of policy and political skills; nurses feeling uncomfortable with leadership roles; following orders rather than leading; internalised oppression of the nursing profession and low self-esteem (Ditlopo, 2014). She also highlighted strategies for nurses to facilitate their participation in health policy development. These were: unifying nurses to build a strong voice; developing research skills to enable them to have expertise to inform policy-making decisions; introducing a course on policy and policy processes as well as policy influencing in the nursing training curriculum and position statements based on research evidence.

5.4.3 Reflections and exploration

After the facilitator had presented the role of nurses and how they could influence policy, the floor was open for comments. The discussions that followed were about where the

nurses are and the lessons taken on their role moving forward. The facilitator's comment was that nurses are not vocal enough about policy issues. An example cited was that of the National Health Insurance (NHI). None of the participants had made input to the policy and yet it will affect nurses. The facilitator suggested:

"It is not too late to start engaging with the current policy reforms. It boils down to confidence and leadership." (Fac)

The participants felt that it could be said that nurses are the backbone, but policy-makers do not see it that way. Instead, nurses always come second to doctors. Other participants expressed that:

"Most of these policies are shoved down on our throats." (Mng)

"Everything is about the doctors. It is like somebody has muted us with a big plaster so that we can keep quiet." (Mng)

The issue of the policy-makers undermining the power of nurses came out. Others felt that no one cared about nursing issues.

"When a nurse is vocal about something, they are labelled as rude." (Mng)

"The question is what are nurses doing about all these issues? No one wants to listen to the issues of nurses." (Mng)

Participants themselves also deliberated on the challenge of dealing with nursing issues as a united voice. They agreed that they work in silos as institutions. They even look down upon each other instead of sharing best practices. A comment from one participant was:

"If we can be sorted as nurse leaders it would be better. We do not even share best practices. It must be unity first. We need to destroy all the barriers" (Mng)

5.4.3.1 Potential solutions

i. Establishment of a forum

After discussing the challenges related to participation in health policy development, the group discussed potential solutions that would help to mitigate the key difficulties. Participants recognised that it was important to identify and share policies with colleagues at the workplaces and even at different forums where they meet. They acknowledged that to be involved in policy development, it is necessary to identify existing policies that affect one's work as a health professional. The argument made by participants was that for effective participation in policy development, it was necessary to have knowledge of

existing policies to make effective change. To increase their level of involvement, participants mentioned that they required more knowledge and skills in policy issues.

The participants thought about the potential establishment of the nurse leaders' forum. Excerpt from participant:

"We need to get into action, push and have a voice." (Mng)

The assistant nurse managers (ANMs) reported that they do not have any forums where they meet and discuss issues affecting nursing. The nurse managers do have meetings at district level. The participants had different suggestions as to who should be in the forum. Some believed that the existing discussion groups for nurse managers should be expanded to include ANMs. Others believed that a new forum needed to be established. One participant pointed out that the existing district meetings were mainly for nurse managers to share challenges from their facilities. No issues pertaining to policy or moving the profession forward were discussed. A suggestion was that a restructuring was needed. The issue of action and having one voice recurred in all the discussions. The feeling was that a forum would bring a solution to the challenges that nurses face. It would unify nurses and fill existing gaps. Some comments were:

"We have been quiet for a long time and relied a lot on unions (COSATU). People need to unfold in this profession." (Mng)

"If we action this, eventually we will have one union." (Mng)

Other participants suggested that unity among nurse managers is required first, since they have a lot of differences. It is also important to bring in the younger generation of nurses. They must be invited to participate in all aspects of issues. Another view was that before a forum is established, they need to decide who the nurse leaders are, and the structure of the forum and issues that would be discussed there. The forum would need to have clear terms of reference. The Senior Nursing Officer was identified as the person who should drive the process. One of the nurse managers who was present was also identified as the person who could assist in influencing nurse managers in the eThekweni district about the issue of the forum.

ii. Training

Participants expressed the view that another workshop or training session would be beneficial. They also felt strongly that providing this training to students should be a priority (potentially as part of their graduate curriculum), as it would help the next generation to develop their policy development skills. The academics reported that they would start

discussing the issue of incorporating policy development into the curriculum in their structures.

ii. Writing a policy brief

The researcher had already agreed with the research team members that a policy brief was one of the immediate solutions to empower nurse leaders to exercise their role in policy participation.

5.4.4 Developing a policy brief: Facilitator

The facilitator did a presentation on writing a policy brief. She began by stating the objectives of this presentation:

- a) Understand what a policy brief is and its intended objectives
- b) Describe the characteristics of a policy brief
- c) Describe the structure and contents of a policy brief
- d) Identify the do's and don'ts of a policy brief

The policy brief was described, citing the literature that the facilitator had reviewed. It was described as a short document that presents the findings and recommendations of a research project to a non-specialised audience. It is a stand-alone document, focused on a single topic. It is further described as “a vehicle for providing policy advice” (IDRC, n.d). “Policy briefs are front-loaded; the conclusions are on the front page” (Kopenski, 2010:1). A brief outline was given on how a policy brief could or should be written. This is done to convince the target audience of the urgency of the problem at hand and the need to adopt the preferred alternative or course of action (Young and Quinn, n.d). A policy brief is also important to “evaluate policy options regarding a specific issue, for a specific policy-maker audience” (Eisele, n.d).

5.5 . Types of policy briefs

Information was given on two types of policy briefs, namely, the **Advocacy Brief**, which argues in favour of a particular course of action, and the **Objective Brief**, which gives balanced information for the policy-maker to make up his or her mind. The presenter stated the important aspects that should be considered when designing a policy brief. The writer has to decide on the type of policy brief and the potential readers. It was also highlighted that it is important to choose the content, focusing on a single topic, clearly defining the

purpose and identifying salient points that support the aim. The facilitator made use of different examples of policy briefs in her presentation. See Annexure 8.

5.5.1 . The break-away session

The participants were divided into two groups. Members of each group were mixed to represent different facilities. A note-taker was selected for each group to help in this process. It was agreed that the nurses need to be able to make their position known about their participation in health policy development. Both groups were assigned the same topic for discussion after the facilitator had started off the discussion. The topic for discussion was to: *Develop a policy brief on participation of nurse leaders in health policy development.*

Instructions of steps to be followed were given by the facilitator. The groups debated the topic for about forty-five minutes and then drew together the main threads for report-back to the plenary session.

5.5.1.1 Report- back from breakaway session

Each group chose a representative to report back on what they had discussed. The policy brief that each group had developed was presented. Both group discussions embraced two main themes. Firstly, the beneficial role of the nurse leaders in health policy development. Secondly, how a united voice in influencing policy decisions at the strategic level could be developed. However, the general conclusion was that policy development must involve nurses at all levels of the process. Each group was given 10 minutes to present.

5.5.1.2 Policy brief presentation: GROUP ONE

TITLE OF THE POLICY BRIEF:

NURSE LEADERS TAKING A LEAD IN HEALTH POLICY DEVELOPMENT

EXECUTIVE SUMMARY

It has been identified that the nurse's status and capabilities have been undermined due to lack of involvement in policy-making, thus leading to dissatisfaction and poor health care outcomes.

RECOMMENDATIONS

Nurses should take an active role in policy development through the following:

- Change management strategies. There needs to be mind-set shift at all levels
- Current policy reviews. Nurse leaders have to look at the existing policies and use the policy analysis mode to review them. (prioritise and make recommendations)
- Establishment of effective policy committees at all levels.
- Incorporate a policy development curriculum for nurse training
- Succession planning (capacity building)
- Extensive consultative measures in place
- Influence policy formulation from grass roots.

CONCLUSION

Participation of nurse leaders in policy development is crucial for the health system. Their contribution can help to ensure that policies that are developed have minimal complications when implemented.

5.5.1.3 Policy brief presentation: GROUP TWO

TITLE OF THE POLICY BRIEF:

ENHANCING NURSE LEADERS' PARTICIPATION IN POLICY DEVELOPMENT FOR IMPROVED HEALTH SERVICE DELIVERY AND HEALTH OUTCOMES

EXECUTIVE SUMMARY

Nurses constitute the majority of health care professionals and yet they are under-represented at all levels of health policy development. This has led to nursing issues not being adequately addressed. There is also a disjuncture between policy and practice. Participation of nurse leaders in health policy development needs to be increased in order to allow their concerns to be considered and for recognition of their expertise.

IMPLICATIONS AND POLICY RECOMMENDATIONS

- All nursing programmes to have some aspects of policy development in the curriculum.

- Policy development to form part of the continuous professional development (CPD) for Nurse Managers
- Actual involvement in policy development at all levels
- Use nurse forums to share best practices
- Cascading of policies at all levels from top down
- A structured process for responding to drafted policies is required, e.g. input from nurse managers' forums when giving responses

CONCLUSION

It is important to strengthen the capacity of nurse leaders in health policy development and their influence on policies in general. Their participation is essential in creating effective policies as they are the main implementers. This will consequently contribute towards improved health outcomes and effective health service delivery.

5.5.2 Evaluation of the workshop

A group evaluation was done at the end of the workshop. Participants had to comment on how they felt about the workshop. Generally, the group reported to have benefited a lot from the workshop. The sessions were described as interesting and stimulating. The facilitator was good and knew what she was talking about. Most of the participants appreciated the opportunity to be invited to the workshop and engage on policy issues. However, they all expressed a need for another workshop of this kind to deliberate on the issues that were raised, such as the establishment of the forum. They reported to have a better understanding of the policy process. The evaluation of the individual participant's experience of the workshop was done using the evaluation form.

5.5.2.1 Workshop evaluation form

The workshop evaluation form was used to determine the views of the nurse leaders about the various activities during the workshop and the achievement of objectives. The form had four main aspects that were evaluated: programme, speaker, take-home message and overall comments by the participant. A rating scale of 1–5 was used, to indicate the extent to which the participants agreed or disagreed with each statement by circling the number that applied. One (1) was No (disagree), 2 = below average, 3 = So-so (average), 4 = above average and 5 = Yes (agree). Twenty (20) forms were completed and returned.

Four (4) were missing. Only one participant had reported during tea break that she had to leave before the end of the programme (social worker). None of the questions were rated 1 and 2. The ratings ranged from 3–5. Refer to table 5.2 illustrating the number of responses per question in the workshop evaluation form.

Table 5.2: Workshop evaluation summary

ITEM	RATING		
	3	4	5
1. Programme			
Workshop well organised.	-	3	17
Workshop met your expectations/ objectives	-	5	15
Role in relation to policy clarified	-	6	14
Knowledge in health policy development increased.	-	2	18
Confidence level in relation to participation in policy issues increased from before the workshop.	-	7	13
2. Speaker			
Knowledgeable about subject	-	1	19
Material presented informative and understandable	-	2	18
Questions and discussion handled to your satisfaction	-	2	18
3. Taking it with you			
Overall, was the workshop worthwhile	-	-	20
Taking action(s) on what you learned about the policy development issue	-	3	17
Network with others whom you expect to hear from in future	2	2	16
Interested to be part of a forum that will discuss policy issues	1	3	16

5.5.2.2 Overall comments, feedback and suggestions

The evaluation form provided a space where the participants were asked to make overall comments and suggestions emanating from the workshop. The participants' comments were that the workshop was informative (5), an eye opener (4), relevant (3), well done (4). Most of the participants suggested that a follow-up workshop needed to be conducted. Some participants expressed the following:

“This was time worth invested. The presentations equipped me on how I can contribute in policy development, analysis and evaluation. Having a policy topic in our CPD programme will assist.” (Ed)

“Well executed. Difficult concepts were broken down to improve better understanding of policy development. Approach was thorough, innovative and participatory.” (Ed)

“It came as a surprise all to be involved in a programme which I have been dying to be involved in. Think I need more!” (Mng)

“I have thought that barriers to my involvement in policy are external but internal barriers are existent in me. I also realised that I must make it my business to contribute and voice my opinions on policy rather than wait for it to be delivered from top.” (Mng)

“This workshop has a potential to yield great results for the profession in the region.” (Ed)

5.6 CONCLUSION

The variety and richness of discussion at the workshop enabled the researcher to draw together in the final discussion all the insights, observations and proposals for action that had emerged during the course of the day. The collective conclusions and recommendations from the workshop set out a formidable agenda for action but say little about ways and means. The expectation is that individuals and organisations would have been motivated by these discussions to take up the themes most appropriate to their sphere, and create more developed plans of action. Some themes may be taken forward through joint action in partnership with contacts made at the workshop. The findings of the workshop have wide-ranging implications for policy. The researcher and the validation team developed a final policy brief based on the contribution by the workshop participants as illustrated in Figure 5.9. This action formed part of recommendations to policy-makers.

HEALTH POLICY BRIEF

DATE: JULY

2016

PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY: IMPROVING HEALTH OUTCOMES

EXECUTIVE SUMMARY

Health care services in South Africa are under increasing demands placing higher pressure on nurses who are in the forefront and the largest group in the health care sector. Nurses are closest to the patients and their families with the main responsibility of providing quality care. Nursing is therefore uniquely positioned to influence the health care priorities nationally yet they are underrepresented at all levels of health policy development. They are mainly implementers of policies. It is important that nurses understand and influence the health policy process in order to improve health outcomes.

INTRODUCTION

Nurses are the majority of health care professionals but they have been undervalued in the decision making circles that inform the nation's health policy. Given the complexity of S.A health care system reform they must be equipped to perform their leadership role so as to facilitate quality health care service delivery. Proactive participation in the policy arena is a key to excellence in clinical practice and education for nursing.

Literature ((Khunou and Davhana-Maselesele 2016; Ditlopo et al. 2014; Juma et al., 2014; Ditlopo et al., 2014; Shariff and Potgieter 2012; Richter, Mill et al. 2012,) shows that nurses' role in health policy development is limited. Health policy is often formulated with little input from nurses, at the implementation level. Studies also maintain that policy making is "Top Down" in nature. Nurse leaders are implementers of policies, much as the researcher would like to see them involved at all the stages of the health policy development process. There are also challenges with the implementation of policies.

Policies are interpreted and implemented differently by various institutions e.g. OSD (Ditlopo et al., 2014). This could result from the absence of policy implementation guidelines. The policies are also not explained. The findings also suggest that the implementation difficulties stem partly from absence of the key actors (nurse leaders) at the policy development stage that would provide input on the operational mechanisms required for implementation. There was also no formal system of communicating gaps identified in the policy that affect implementation. The absence of feedback from grassroots policy implementers might lead to further suppression of the voices of nurses at the lower level (Juma, Edwards et al. (2014). Factors contributing to lack of participation of nurses in health policy development include political factors, gender issues, financial issues, limited resources; lack of skills training in policy development; image and status of nursing; leadership competency; and the inability to use research to influence policy making. (McAskill 2009), Kunaviktikul, Nantsupawat et al. (2010), (Chase 2013, Robinson 2013).

Nurse leaders are a vital resource for shaping health policy.

It is important to strengthen the capacity and participation of nurse leaders in health policy development to create effective policies as they are the main implementers. This would contribute to improved health outcomes and effective health service delivery. Since currently nurse leaders are prominent in implementation, the following policy options should be considered.

Policy Options

1. Enhancing participation of nurse leaders in the policy development process by increasing representation of nurses in the policy structures.
2. Deploying nurse leaders per province to participate in the policy development process so that they could facilitate implementation. Identify them from organised structures e.g. forums. Development of communication strategies for representatives. This option is costly which might be a barrier to its implementation.
3. Development of policy implementation guidelines for each policy. This would enhance

policy implementation. This option is cost effective as it will eliminate the risk of failed execution of a policy which could result to a lack of success

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Figure 5.9: Final Health Policy Brief

CHAPTER 6

DISCUSSION OF QUANTITATIVE AND QUALITATIVE FINDINGS

6.1 INTRODUCTION

This chapter will discuss and interpret the findings of the first phase of the study. The study utilised the policy triangle as a framework for considering participants' accounts of participation in health policy development. The study employed convergent mixed methods. Quantitative and qualitative results were analysed separately. The quantitative and qualitative approaches were triangulated to provide a more holistic understanding. The findings answer the following research questions:

- How informed are nurse leaders about their role in health policy development?
- How have nurse leaders participated in the health policy development process?
- What factors facilitate participation of nurse leaders in health policy development?
- What factors limit participation of nurse leaders in health policy development?
- How do policy-makers involve nurse leaders in the health policy development process?
- What gaps exist in the nurse leader's participation in health policy?
- What strategies could be adopted to enhance nurse leaders' participation in health policy development?
- What strategies could be implemented to enhance nurse leaders' participation in health policy development?

The discussion and interpretation draw from literature reviewed in chapter two and new literature in order to establish the meaning of the findings and add completeness to the emerging description of the phenomenon of interest, which in the context of this study is participation of nurse leaders in health policy development.

6.2 . DISCUSSION OF FINDINGS

This section firstly presents a demographic profile of the nurse leaders in order to draw conclusions based on the context of the participants from both data sources. Thereafter, the extent of nurse leaders' participation in health policy development is discussed.

6.2.1 Demographic data

6.2.1.1 Gender

Demographically, both quantitative and qualitative data sources revealed that the participants were predominantly female. According to the latest statistics from the South

African Nursing Council, the number of male nurses has increased over the past 10 years (SANC, 2016). However, in KZN there is still a wide gap, as the number of male nurses compared to females is less than a tenth (DENOSA, 2013). While males are making inroads into the profession, the results of the study showed that there are still very few occupying leadership positions. This is also seen in other countries. For example, in a similar study in East Africa males were found to be fewer than females in nursing leadership positions (Shariff and Potgieter, 2012). The history of nurses as a profession dominated by females can make it easier for policy makers, other health professionals, and the public to view them as “functional doers” who carry out the orders of others rather than “thoughtful strategists who are informed decision makers (IOM, 2017: 223). However, the current study showed no correlation between gender and participation in health policy development.

6.2.1.2 Age distribution

Data revealed that nursing has an ageing workforce. Most of the participants ranged between 51 and 60 years of age. Some were above the normal retirement age of 60 years. This is in line with the latest SANC statistics, which showed that South African nurses between the ages of 50 and 59 formed 31%, and those aged between 60 and 69, formed 15% of the overall number of nurses in the country (SANC, 2016). The findings showed that the more advanced the ages of the nurse leaders were, the more experienced they were in nursing.

6.2.1.3 Experience in nursing and current position

The findings revealed that none of the participants had less than 6 years’ experience in nursing. Most of the participants had 26–35 years’ experience in nursing. This suggests that they are experts in the nursing field, which would enable them to make valuable inputs into health policy. This is supported by the ICN (2005), which stated that the nursing profession must draw on its expert knowledge and experience to improve health care by helping to shape effective health policy. However, the findings of the study showed that there was no correlation between years of experience in nursing and participation in health policy development at all stages. The nurse leaders use their experience to create policies or protocols at institutional level.

Both the quantitative and qualitative data showed that all nurse leaders had less than 16 years’ experience in the current position. Data also revealed that even those who had more than 36 years of experience in nursing had fewer years of experience in the current

position. This suggests that nurses get to management positions at a late stage of their career. They spend the prime time of their career, when they are still young and active, at operational level rather than at management level. This might account for their limited experience in the health policy development arena. There was no correlation between years of experience in nursing and the level of involvement in health policy development and knowledge thereof. There was also no correlation between the years of experience in the current position and participation in the policy process. Findings were similar among those who had more experience in nursing and those who had less experience nursing.

Nurse leaders' confidence levels on policy development issues were also low, irrespective of their years of experience in nursing and in their current position. These findings differed from those shown in a study by Spitzer and Golander (2001), cited in Kunaviktikul et al (2010), where the amount of work experience had a positive correlation with the level of confidence. More work experience afforded the opportunity to gain additional knowledge, expertise and confidence (Kunaviktikul et al, 2010).

6.2.1.4 Highest level of education

All data sources revealed that more nurse leaders possessed bachelor's degrees than diplomas. Only a few participants had a Master's degree. They were only among those who participated in the qualitative interview. This suggests that the nurse leaders had limited research skills, which are necessary to inform evidence-based practice and policy. This explains the high percentage of participants that had never submitted evidence to policy-makers and were not confident in that regard. These findings confirm the argument by Campbell et al (2009) that nurses' research knowledge can be used effectively to shape health policy and health service delivery, yet the research skills of nurses need further development.

The education of nurses puts them in a position to discover and acknowledge health problems and health system problems that may demand intervention by policy-makers. The highest level of education among the qualitative participants was a PhD, while none of the participants from the participating institutions had PhDs. Results also showed that different levels of education have no impact on the participation of nurse leaders in policy development. However, the PhD-qualified participants reported that they had participated in the policy development process. This was related to the positions that they held at national level.

6.2.2 Membership of professional organisations

All the participants reported to be part of a professional organisation. However, they only played membership roles in the organisation, with none of them playing a leadership role. They also did not participate in activities related to shaping health policy development and political activism. Ideally, being a member of a professional organisation should provide a space for nurses to be more politically active and to participate in health policy development. Professional nursing organisations are the vehicles through which nurses can lobby for their involvement in health policy development. They can make health policy activities a major area of focus (ICN, 2015). Shariff and Potgieter (2012) suggested that they can also play an important role in making policy development part of nurses' competencies and thus ensure their increased knowledge and skills in this regard. However, the study found no relationship between membership in organisations and participation of nurse leaders in health policy development. The findings do not show convincingly that the existing organisations are promoting health policy activities among their constituents, as well as providing education and training to increase their health policy skills.

Benton (2012) maintains that nursing associations can serve as key agents for driving policy, both nationally and globally. Transformation in the nursing profession could result from the organised commitment of individuals working under the auspices of nursing associations. A perfect example of this is the ICN, which works to influence health policy at the global level. It publishes, disseminates, and regularly informs a series of position statements, including many aspects of professional practice, regulation, and socio-economic welfare. The ICN advocates for policies that contribute to the health of populations, sustainable development, and the safety and fair treatment of nurses and healthcare professionals (Benton, 2012).

6.2.3 Participation in policy forums

All of the findings showed that most of the nurse leaders had not participated in forums where policies are formulated at provincial and national level. They did not have support networks to share experiences on policy-related issues. ICN (2005) suggested that it is important to identify and network with nurses in influential nursing positions, such as in health ministries, so that individuals or organisations might use them to have input into policy. In the current study, it is suggested that nurse leaders need to network with the Chief Nursing and Midwifery Officer (CNMO). Nurses in influential positions outside

nursing (voluntary and non-governmental organisations) were seen as useful to help nurses in driving their policy goals (ICN, 2005). Hall-Long (2009) supported networking and recommended that nurses could form political action committees or become lobbyists. The author also suggested that a coalition of educators, leaders from practice and researchers could better advocate for nurses, patients and the public good.

It was recognised that nurse leaders do participate in the development of policies at an institutional level. Participation at this level means developing their own standard operating procedures emanating from external policies or from needs that they had identified. They also participate in the institutional policy and procedure committees. This is encouraged by the researcher because starting small and bringing issues to light is a step towards reshaping the profession to engage in broader health policies.

6.2.4 Training in policy development

Both data sources indicated that nurse leaders had not received any formal training on policy development issues. Areas in which they received most preparation included managing personnel, clinical skills, planning and programme development, assessment and planning, and leadership. They learn about policy development on the job through trial and error. The profession is perceived to have been slow in incorporating policy issues into nursing education. Studies in other contexts have shown that the absence of policy content in nursing training contributes to nurses' lack of understanding of policy. Similar findings were reported in a study conducted by Shariff and Potgieter (2012). This is also supported by Rispel (2015), who stated that nurse leaders are never formally prepared for a process that requires careful consideration of existing resources and the factors influencing change.

The above observations are supported by the qualitative findings, which revealed that only two participants had received training on policy development issues. Neither of them had received this training from South African nursing programmes. Harrington et al. (2005) confirmed that there is lack of formal training of nurses in health policy in many nursing programmes. This, according to the authors, often forces nurses to rely on their own experiences or other policy programmes. The ICN (2005) stated that if nursing is to be an effective part of the health policy process, nurses must understand all components of it and select suitable strategies to enhance their participation. Nursing schools, scholars, executives and professional nursing organisations must actively contribute to the

development of health policy and regulation. This suggests that nurse leaders have to be well prepared and capacitated in policy development to respond to reforms in the health care environment. This is supported by Longest's (2002) theoretical framework of public policy-making. Longest suggested that policy competence, knowledge of the policy-making process, leadership skills, and core education in policy development are factors that affect the ability to effectively formulate, implement, and modify health policy.

6.2.5 Awareness of role in policy development

These results indicate that nurse leaders are not aware of their professional responsibilities relative to health policy. Most of them described their role in terms of managerial functions. Regarding the policy process, they described their role as that of interpreting and communicating policy, and ensuring the availability of policies and guidelines. A similar study measuring the self-rated level of public policy involvement of advanced nurse practitioners showed that advanced practice nurses did not see the role of political activist as central to their practice. Furthermore, the nurses doubted that they possessed the skills necessary to be effective in the political arena. As a result, there were some nurse practitioners who were very active in public policy (participated in seven or more public policy change activities) and others who were not active at all (participated in no public policy activities) (Milstead, 2013). Hall-Long (2009) asserted that every aspect of nursing practice is influenced directly or indirectly by public policy. Therefore, participation in the policy process is an integral part of nursing and a mechanism for excellence. The role in policy is just as important as serving as a clinician, researcher or educator. If nurses want to advance the profession; they need to participate in health policy. The ICN (2015) confirmed that nurse leaders have an important role and need to be active in health policy development to be able to control their practice. Awareness of the importance of their role in health policy is a key aspect for nurse leaders. They need a clear understanding of how policy relates to nurses, as well as how their exceptional knowledge of patient care is crucial for policy development. That must be strengthened at the institutional level. Kunaviktikul (2014) suggested that nurse leaders can organise policy and political meetings, workshops or training programmes so that nurses can better understand their role and influence on policy and politics. Organisations should also support staff to attend policy-related events and training.

6.2.6 Participation at different stages of policy development

The nurse leaders were asked to share their perceptions on nurses and policy, their experience and how they have participated at different stages of the policy development process. The responses were grouped together in the discussion as they were talking to the same issues. A similar open-ended question was asked in the quantitative questionnaire.

6.2.6.1 Policy formulation

All data sources showed that none of the nurse leaders had participated in the initial phases of the policy development process, namely, problem identification and agenda-setting. Most participants stated that they had not been exposed to the health policy development process. Exclusion of important actors during the setting of the agenda limits the debating of issues. People feel powerless if they do not have any contribution to make to key decisions simply because they cannot find an arena to express their views or feel unable to express them.

The researcher experienced a difference between interviewing nurse leaders who were from national level and those who were from the institutions and the provincial office. The nurse leaders from national level had a clear understanding of the processes they were expected to follow, though no explicit policy development guidelines were reported. This could be because they had received training on policy issues, and by default because the positions that they occupied required them to participate in policy development, though not from the nursing perspective. However, there was limited understanding of these processes by the other participants from provincial down to facility level.

The data showed that nurse leaders had no confidence in their knowledge and skills at different stages of the policy development process. Their limited knowledge also resulted in low confidence in their research and analytical skills to provide evidence to inform policy. Hence, they reported that they had never been involved in submitting evidence-based presentations that would inform policy to the policy-makers. Generally, the participants had limited participation in health policy development. The results of the study are similar to the findings by Akunja et al (2012) in Kenya, where nurses were found to be involved in HIV policy development at different levels but their involvement was negligible at provincial and national levels.

The findings were also supported by a study that explored nurses' engagement in the AIDS policy in six countries, namely, Canada, Jamaica, Barbados, Kenya, Uganda and South Africa. Nurses in all participating countries remarked about their lack of participation in policy development. Resources were usually not available to carry out the policy requirement (Richter et al, 2013). However, these findings differ from Shariff and Potgieter (2012), who found that in East Africa more nurse leaders participated at the national levels of health policy development, as compared to provincial, regional and global levels. Analysis revealed that leaders were performing an interpretation and translation role. However, results were similar in the sense that fewer nurse leaders participated throughout the health policy development process. Their contribution was greatest at the policy implementation stage.

The issue of being represented by people other than nurses was recurrent in all the data sources. Some participants reported that they did not even know the people who were part of the process. They stated that they were represented by nurse educators in the development of policies such as OSD. The health policy development process appears to be influenced largely by role-players other than nurses. Participants mentioned that policy-makers do not recognise their expertise and the valuable input they may have. This suggests that policy-makers do not know what nurses do or the actual dimensions of their role. It could also mean that nurse leaders from practice are still seen to belong to the bedside rather than the boardroom. This is congruent with the findings of a study conducted by Ditlopo (2014), where frontline nurses believed they were not included in policy processes because policy-makers did not recognise the importance of their clinical knowledge and expertise in informing policies. Nurse leaders' jobs require them to be part of the policy development process at policy formulation and implementation levels, but their role is largely managerial. The low involvement in policy development is influenced by the fact that nurse leaders see their work as primarily that of supervising patient care (Sundquist, 2009).

The majority of participants had never participated in policy analysis. This aspect required a great deal of background knowledge on the national-level policy process, which they lacked. The findings also showed low confidence levels among nurse leaders in this phase. Nurse leaders believed that they were not prepared, or might have had only a small role in the formulation and analysis phase of the policy process. Research skills are necessary in this phase, and the nurses had no confidence in that area. Furthermore, the questions

in this phase were somewhat theoretical in nature and depended on having prior basic knowledge about policy matters.

6.2.6.2 Policy implementation

All data sources revealed that nurse leaders participated mostly at the level of policy implementation. This could be because policies are implemented in hospitals at different levels, and nurses are primarily responsible for putting policies into practice. Policy-making is still viewed as taking a “top-down” approach. Nurse leaders are receivers and implementers of policies. Therefore, they participate in various activities, such as communicating policies, identifying problems, observing and reporting on challenges and obstacles in implementation. The results from both quantitative and qualitative groups were consistent. These findings were similar to those obtained by Richter et al. (2012), where nurses in all of the participating countries reported lack of involvement in policy development. Policies were imposed from the top down for them to implement, despite not having participated in their development. The area of policy development has always been the area of slowest progress for nurses (WHO, 2011). The nurses’ role is perceived as that of implementing policies and programmes, rather than participating in and bringing the nursing viewpoint, experience, knowledge and skills to policy decisions and healthcare planning (Benton, 2012).

Both qualitative and quantitative data sources revealed that there were challenges with the implementation of policies. When policies were received, they were interpreted and implemented differently by various institutions. This could have resulted from the absence of implementation guidelines for policies. Jasen et al. (2010) confirm that the implementation process is insufficiently monitored. There is no clear direction showing what, where, when, how and by whom activities are to be monitored. According to the WHO (2015), the key to ensuring ownership of a policy by health professionals is the guideline development process. Ownership motivates them to buy in and to ensure successful implementation and improved quality of care. The guidelines need to be implemented through the use of relevant tools or products, such as clinical pathways, training, audit and feedback, linkages with quality indicators and, where appropriate, payment for performance arrangements. Guidelines have to be linked with the implementation and monitoring of activities. Technical support has to be provided (WHO, 2015). The findings also suggest that the challenges of implementation are partly due to

lack of consideration of the key actors (nurse leaders) at the policy development stage that would provide input on the operational mechanisms required for implementation.

6.2.6.3 Policy evaluation

Data sources showed inconsistencies in responses to questions related to participation in the policy evaluation phase. Some participants reported that they did not participate at this stage. Others reported that they participated to a certain extent. This could be linked to a limited understanding of this phase. The issue of unavailability of guidelines for policy analysis and evaluation was raised. Participation at this stage was seen in terms of identifying gaps in policies during implementation. There was no clear direction on how those gaps would be addressed. However, they did acknowledge that they participated in policy evaluation at the institutional level. Jasen et al (2010) attest that many policy programmes are not evaluated at all. Even when evaluation is done the evaluation research results in many cases are not published or communicated as this might have implications for politicians.

6.2.7 Barriers to participation in health policy development

All participants, irrespective of their level, identified similar themes in terms of barriers to participation in health policy development and strategies that could enhance participation. All data sources revealed that the barriers to participation of nurse leaders in health policy development were: a lack of opportunity to be involved directly in policy formulation; limited knowledge and skills required in the policy development process; communication factors; organisational factors, and a lack of support from other sectors, such as the political sector, government officials or professional organisations. Similar barriers were found in both the quantitative and the qualitative data. The factors that appeared frequently in both the qualitative and quantitative data were: representation by leaders who are not nurses; lack of knowledge and experience in policy-making; lack of opportunities; lack of interest and unavailability of forums; being excluded and not taken seriously; apathy and lack of consultation.

There was no consensus in the quantitative findings in terms of gender and equality as a barrier to participation in health policy development. The qualitative findings supported this result, as gender was not raised as a barrier to participation. The low status awarded to females was not agreed upon. There were varied responses. Other authors (Shariff, 2012; Chase, 2013) refute this, as they argued that gender had serious implications in inhibiting

nurses from participating in health policy development. This is related to the low status assigned to women, mainly in African countries. Therefore, nursing, as a female-dominated profession, is affected by these power dynamics because the policy-makers are predominantly men.

6.2.7.1 Limited knowledge and skills

Findings from both data sources revealed that nurse leaders had limited knowledge required for participation in health policy development. Limited knowledge and skills in policy development is regarded as a stumbling block in terms of participation in the policy-making process. This results from lack of formal policy training and development programmes for nurses. There is also inadequate in-service education for leaders on the subject. This is supported by Brega et al. (2013), who found that the major barriers to nurses' proactive health policy-making in Slovenia are education opportunities, largely uninvolved health managers and insufficient nursing research.

Other authors concurred that knowledge on policy issues is an important requirement for participation of nurses in policy issues (McNichol et al, 2008). Milstead (2013) however, maintained that the clinical skills currently used by nurses on a daily basis are the same skills that can be used effectively in public policy. Aries (2011) stated that nurses must participate in the policy-making process because of their role as patient advocates and the knowledge they had acquired from learning nursing theories and frameworks. This would ensure an effective, high-quality healthcare system. While agreeing on the importance of knowledge that nurses gain through theory-based nursing research, Parse (2007) also emphasised the value of nursing knowledge for policy-making as essential to healthcare delivery systems.

6.2.7.2 Communication factors

Both data sources showed that inadequate communication and consultation hindered the participation of nurse leaders in health policy development. The qualitative interview supported the quantitative data where communication as a barrier was a recurrent factor. Similar results were found in a study exploring the policy-making process in relation to healthcare financing reforms that was conducted by Gilson et al (2003) in two countries, South Africa and Zambia, where inadequate communication and consultation with implementers was a common experience. However, the difference is that inputs were

obtained from district and hospital officials who were involved in making policies in the early days of health reform in Zambia. These findings were also supported by Taft and Nanna (2008), who reported that in Kenya nurses felt that national policy-makers did not consult nurses when developing national policies. Lack of communication from the top down and lack of information-sharing were mentioned as barriers to participation in policy development. The Kenyan nurses' view was that consultation with actors would enhance bottom-up input on policy-making.

Both quantitative and qualitative data sources revealed that there is limited consultation and therefore no input is invited from the nurses. The nurse leaders from national level disputed this. They argued that when some policies are sent out for public comment, nurses do not respond. For example, there is currently countrywide consultation around SANC policies, which includes nurses. Nurse leaders also do not give their comments or inputs. This could be linked to a lack of knowledge and experience in the policy process. Technology is also a communication barrier, as some nurse leaders cannot access the SANC website where the draft policies are communicated. Whatever the reasons, none of the data sources could confirm that there is adequate consultation with regard to NDoH policies.

There was consensus between both data sources that participants mentioned lack of recognition of their input by policy-makers as hindering them from participation in the policy process. This supports the finding that they have not been involved in making recommendations that are evidence-based to the policy-makers. The question that remains is how they have communicated their input. The qualitative findings support the lack of representation in the policy arena. Participants claimed that there is lack of feedback even from those who represent them on committees.

There was also no formal system for communicating gaps identified in policies that affect implementation. This is supported by a study conducted in Kenya by Juma et al (2014), which identified the absence of feedback from grassroots policy implementers, which the authors thought might lead to further suppression of the voices of nurses at the lower level. However, the authors agreed that more participatory approaches could be introduced to enhance nurses' potential for engagement in policy-making. That would improve bottom-up planning and decision-making because of the decentralised nature of the healthcare system in Kenya. Policy feedback would give nurse leaders "hands-on" experience of

communicating policy problems or gaps and how to lobby policy-makers to ensure the utilisation of such feedback to shape policies (Richter et al, 2012).

6.2.7.3 Motivational factors

All data sources revealed that participants lacked motivation or interest to participate in health policy development. This was shown in the quantitative open-ended responses and confirmed by the qualitative data. Some reported nurse leaders as not claiming their role in the profession. This is linked to the fact that they do not have networks where policy issues are discussed. Not making input when invited could also be linked to a lack of interest or limited knowledge. The barriers identified seemed to be interrelated. This is supported by studies (Juma, 2014; Akunja et al, 2012; Sherriff and Potgieter, 2012), which found that although participants relate nurses' participation in policy development to improvement in nursing care, they still lack the confidence and interest to be involved in the process. Many participants mentioned that negative attitudes and lack of interest in policy development prevent them from participating. Research conducted on behalf of the Scottish Executive concluded that nurses risk being excluded from the policy-making process because they lack the commitment to get involved (Trueland, 2005).

The findings showed that nurse leaders are not proactive in policy-related matters. They wait for policies to come from the top, instead of policy-makers synthesising what is coming from the nurse leaders. This is in line with findings by Ditlopo et al (2014), that internal barriers to nurses' participation or involvement in broader health policies included the reactive (instead of proactive) approach of nursing leadership; submissiveness and internalised oppression, even when they held senior provincial government positions; the limited number of nurses with policy or advocacy skills; and the lack of unity or lack of cooperative action among different nursing professionals (Ditlopo et al, 2014). Nurses need to move from being reactive to policy changes to having a planned, strategic approach in order to influence health policy (Abood, 2007).

6.2.7.4 Political factors

The findings showed that the policy process was seen as very political. It became clear that the low status awarded to nursing as a profession and under-recognition by the policy-makers was seen as a barrier to participation. The majority felt that they were a group that was undervalued. Underpinning their accounts were feelings of inadequacy and

powerlessness. However, the participants felt that they could use the power of their numbers and speak up for the nursing profession. This was supported by the open-ended questionnaires, where participants felt that they lacked political skills. According to Hall-Long (2009), a legacy of too many years of political helplessness is evident in the nursing profession. However, nurses could reduce this mentality and dependency behaviour if they unite and support each other. The nursing organisations and unions could be useful in this regard.

Des Jardin (2001), in Aries (2011) contended that a lack of political knowledge and a sense of helplessness contribute to nurses' non-involvement in political issues affecting the nursing profession. Nurses will not be able to influence the policy-making process, without understanding the legislative process. The mindset of oppression and powerlessness is further intensified by a lack of knowledge about the legislative process, thereby leading to political inaction. Ehlers (2000) also maintained that it is important for South African nurses to have political knowledge in order to survive as a profession. As the largest professional group in the health sector, they need to unite and collaborate proactively; otherwise, the nursing profession and nursing education might become inappropriate to the political milieu of the country. The author further asserted that nursing might become an increasingly toothless, unidentified and powerless female profession unless they engage in political debates and negotiate their rights (Mason et al, 2017).

6.2.7.5 Structural factors

Findings from both data sources revealed poor organisation of nurse leaders as being one of the barriers to participation in health policy development. Nurse leaders in organised formations, such as nursing forums, would mean more resources and a united voice. They would be able to strategise more effectively to bring nursing's perspective to health policy decision-makers as a collective rather than as individuals. Benton (2012) asserted that unity within the profession is the most important factor in influencing health sector policy. The author stressed the importance of cohesion within the nursing profession in ensuring that the nurses' voice is heard. Strong, well-organised nursing associations are powerful agents for influencing policy and achieving nursing's goals. Nurse leaders need to work through their national nursing associations. They need to bring all viewpoints to the policy discussion, and determine what the specific goal or purpose is. After robust debate, they then need to agree and support that position in public.

Much as nurse leaders participated in the policy development committees at institutional level, findings from the open-ended questionnaires showed that the representation had gaps. Some felt that it was not enough; staff from the support services dominated committees. There is no system for those who are representatives to give feedback to their nursing colleagues. It is important to ensure appropriate selection of representatives for boards or committees. They must be articulate, co-operative and knowledgeable, and be able to take an active part in discussions. They must also be willing to be guided and provide feedback on issues that arose during the policy-making process (ICN, 2005).

The appointment of the Chief Nursing and Midwifery Officer (CNMO) at the NDoH and the Senior Nursing Officer in the KZN province has brought hope to many nurse leaders, as these portfolios are new in the South African nursing structure. This came out repeatedly from data sources and this advancement was regarded by many as a long-awaited response to the invisibility of nursing and exclusion from the policy-making process. Participants thought that there would be improvement and the nurses' voices would now be heard. Ditlopo (2014) also viewed the appointment of the CNMO as a positive change for the better. Such an appointment in other countries has yielded positive results in unifying the nursing profession. The CNMO would provide leadership in terms of discussion and implementation of policies by the nursing profession.

6.2.7.6 Limited research involvement

A reason expressed for nurses' non-engagement in policy development was the inability of nurses to put forward research evidence to guide policy formulation. Nurse leaders stated that nurses had limited skills for generating and utilising research evidence to make presentations to the policy-makers so as to influence policy decisions at national level. Although there was inconsistency in the responses, the majority of nurse leaders reported average to no confidence in analysing nursing concerns or health issues that could be addressed through policy interventions. The majority were not confident of their research analytic skills. Improving research skills is important for nurses in general, and nurses in management positions in particular. They can suggest changes to policy based on evidence from policy research studies, thus providing important inputs to policy-makers.

The literature has shown that research utilisation among nurses is very low. In most countries the findings from studies showed that nurses were not active in conducting

research. Barriers to nurses' research have been extensively studied and the results are similar across countries. Factors that prevent nurses from implementing research findings include: lack of communication; lack of time; lack of institutional or financial support; inadequate support from colleagues; shortage of staff and resources; lack of appropriate capacity to disseminate knowledge; lack of generalisability of findings; lack of knowledge; personal scepticism; and the dependence of nurses on clinicians and managers in instituting changes in clinical practice (Chen et al, 2013; Tan et al, 2012, Estabrooks et al, 2011; Oh, 2008). The link between researchers and the users of research such as policy-makers, programme managers and beneficiaries is strengthened because of the mutual exchange of knowledge. This is facilitated by opportunities for researchers and policy-makers to engage in both research and decision-making activities during the health reform process (WHO, 2012).

6.2.8 Strategies to enhance participation in health policy development

The data analysis revealed no distinction between facilitators and strategies identified for enhancing participation of nurse leaders in health policy development. The researcher opted to merge these two main aspects and discuss them together. The strategies that could be identified and the ones that could be implemented were also merged, as there was no difference found. No strategies that support the nursing profession to maximise its potential for shaping and influencing health policy in South Africa have been documented or implemented. Fyffe (2009) suggested that it was opportune to consider strategies that will enable all categories of nurses, from all clinical practice disciplines, to contribute to the policy arena from local, national and international perspectives, particularly with regard to strategies that encourage a wider circle of nurses into the process.

The participants proposed strategies to enhance participation of nurses in health policy development. The findings of the study indicate that there was consensus on the factors that were identified. The most frequently appearing factors were: nursing management forums, being given an opportunity to participate; training and development of leaders; appointment of more nurses in the national department of health; motivation and recognition of nurse leader's input in policy development.

6.2.8.1 Knowledge and skills of health policy development

Findings from the quantitative data from the scale and open-ended questionnaire showed that the majority of participants felt that if they were knowledgeable and had skills in policy

development that could enhance their participation. A similar question was asked during the interviews and knowledge and skills as facilitators was recurrent. The replication of questions helped the researcher understand the consistency of the participants' views. This could be achieved through policy leadership training. If leaders are trained in policy development, it could improve their knowledge and confidence and therefore enhance their participation. Participants predominantly supported policy leadership training. Harper (2016) supports the view that involvement in policy requires skill sets and positions that nurses traditionally are not known for, though frequently they possess such abilities. Nurses must not only have the knowledge, ability and skills to influence policy, but also the needed confidence, professional presence, reputation and respect. However, they must also be appointed or elected to governance positions in order to contribute effectively in informing and directing policy decisions.

Nurse leaders through their education could also acquire the necessary knowledge and skills. Inclusion of content related to the policy development process in the nursing curriculum was recurrent. There was consensus from all data sources that participants needed a workshop to empower them on health policy development. There was consistency from all data sources regarding the workshop requirement. It was recurrent and the majority supported it. They thought that the workshop would help to orientate them on the policy development process. It would also enable them to ask clarity seeking questions as some cited inability to differentiate between a standard operating procedure and a policy. Nurses would become more interested as they gained confidence in their abilities, and were able to identify the many benefits associated with participation in health policy activities. It would naturally follow to be more involved and engaged in health policy activities. Nurses are encouraged to learn about health policy either through formal curricular courses or through continuing education meetings (Hall-Long, 2009). Nurses need participate in health policy at individual and professional levels. They need to be knowledgeable about professional issues and health policy processes (Sheehan, 2010).

6.2.8.2 Experience in health policy development

Having experience in health policy development was seen as a facilitator for nurse leaders to participate in the process. Experience included being offered opportunity or exposure and being invited to the policy development arena. Consistency of data is also seen in consensus regarding participation in forums where policies are discussed as a strategy to facilitate participation of nurse leaders in health policy development. In a study conducted

by Kunaviktikul et al (2010), the strategies suggested by nurse leaders for increasing involvement in policy development included having experience in policy development activities. The results of the current study showed that ninety three (93) percent of the nurse leaders would be interested in participating in health policy development if the opportunity arose. Much as participation was seen in the institutional policy development committees, the nurse leaders indicated that networking with peers and forming coalitions to lobby for participation would be an effective strategy to enhance their participation. Nurse leaders should synthesise policy concepts that relate to the practice environment. They need to engage in in-depth policy discussions in their work environments (Short, 2008).

6.2.8.3 Communication

There was consistency in findings from all data sources that for nurse leaders to be able to actively participate in health policy development, communication between the policy-makers and the implementers has to be improved. Implementers should also be actors in the process. The general feeling was that consultation is important so that nurse leaders could also forward their input. Improving communication at the institutional level was also seen as a facilitator to participation. Ditlopo et al (2014) and Arabi et al (2014) suggested a policy feedback loop with nurse leaders who can explain the problems experienced with the policy. Relevant actors must also make sure that communication channels are in place to communicate the reaction of the National Directorate to the policy feedback. This would expose nurse leaders to the policy process and there would be recognition of their input. It would also balance the top down approach to policy-making with the bottom up approach.

Abood (2007) stated that individuals or groups with a stake in the future of a health policy use different communication strategies to influence policy in the political arena to obtain their desired outcomes. These strategies include using negotiation, conflict resolution, analytic thinking and decision making skills. ICN (2005) advocated that employers and organisations run continuing education programmes for nurse leaders. These would be designed to develop communication skills such as public speaking, diplomacy, data management, strategic thinking and planning. These skills would enable nurses to be articulate and effective leaders.

6.2.8.4 Nursing leadership forums

The data showed that nurse leaders believed that they could bring their strength in numbers to the policy arena. There was consensus in all data sources that they needed to establish forums where policy issues could be deliberated. Organising themselves could enhance their influence in the policy process in ways that the actions of a single person could not. The ability of an individual nurse to influence policy is greater in an institution than in the macro context. The macro context will usually demand greater numbers of, and organisation by, nurses. Taft (2008) stated that working with colleagues or professional organisations would extend an individual nurse's potential impact to larger contexts. According to Peters (2002), nurse leaders need to unite into formations in order to establish their support base. This would also enable them to draw on their strengths as a collective to educate and influence decision-makers. Several authors supported the power of numbers and speaking with a common voice as necessary for advocacy. Nurses could generate power and successfully change the healthcare system based on numbers alone (Mason et al, 2017; Kostas-Polston, 2014; Sheehan, 2010; Abood, 2007; ICN, 2005).

6.2.8.5 Nursing curriculum

None of the participants reported to have been prepared academically in the health policy development process. They therefore strongly agreed that health policy development content needs to be included in the nursing curriculum. This was also recurrent in the listed strategies identified by participants in the quantitative data. This suggests that nurse leaders have limited involvement in the policy process because the nursing curriculum does not support them having a policy role. The current nursing curricula at undergraduate or postgraduate level at most educational institutions in South Africa do not include subjects related to policy and political involvement. This was confirmed by the nurse leaders from academic institutions who attended the policy workshop. Inclusion of policy as a subject in the nursing curriculum would develop nurses' policy competence to redress this situation. This perception is in line with studies by Shariff and Potgieter (2012); Kunaviktikul et al (2010) and Muller (2010), who suggested that there is need to introduce the fundamentals of health policy in both Bachelor's and Diploma programmes for nursing students.

A strategy that is linked to the curriculum is exposure to the policy-making process through experiential learning, known as policy practicum. This programme is designed for placement of students for a certain number of hours in the policy world, such as the

legislature. The students are provided with an opportunity to participate in the formulation of health policies and to understand the potential role of nurses in health policy development. The students get a chance to interact with policy-makers to increase their understanding of the policy process and to recognise factors that shape the policy-making environment (DiCenso et al, 2012). Most participants expressed a desire to participate in health policy development if they were given an opportunity. However, their concern was the lack of knowledge of their role and the policy process, which affected their confidence.

6.2.8.6 Issues identified to be taken to policy agenda

Nurse leaders were asked if they had identified any issues that could be carried through to the policy agenda. Different issues were raised, but the most common ones were nurses' uniforms, private nurse training, and staffing norms.

Nurses' uniforms

Participants indicated that the nurses' uniform is of great symbolic importance to them. The uniform signifies a range of meanings, including service, care, compassion, obedience and femininity. It could also be a response to pressure from policy-makers for nurses to wear white uniforms. Albert et al (2008) conducted a study in which nurses posed in eight different uniforms. The findings showed that the significance of the nurses' uniform increased in relation to the age of the patients. For instance, adult patients based their perceptions of professionalism on the uniform's colour and style. White uniforms showed the highest traits of nursing professionalism according to the ratings. However, those who wore white uniforms were feared most by pediatric patients. No correlation was found between the nurses' white uniforms and an improvement of patient and family satisfaction with nursing care.

Clarke (2013) reported that patients felt that nurses appeared professional and were easily identified by a standardised uniform style and colour. No strong evidence supports patients' choice of a specific style and colour of uniform. Similar findings were identified by Clavelle (2013), when patients showed no support for colour-coded uniforms, but scored the nurses high for nursing image, appearance and identification. While the uniform has an impact on the appearance of nurses, it has been shown that colour does not matter. A nurse's character cannot be defined by the colour of the uniform.

Private nurse training

The quality of nurses produced in private institutions has been questioned. Reynolds et al (2013) conducted a systematic review on the role of the private sector in the training of nurses in India, Kenya, South Africa and Thailand. Common findings revealed that nursing colleges in these countries were inappropriate for training nurses due to an acute shortage of facilities, and that nursing qualifications from private institutions have been of a lower quality than those from public institutions. The reason, according to the authors, might be that private institutions admit students of a lower calibre than those accepted at public institutions. The study also found insufficient evidence to determine the full extent to which private nursing education contributes to current health systems. It was recommended that governments should ensure that nursing graduates from both public and private institutions are of good quality and meet the health needs of their populations. This can be achieved through effective government oversight and policies to ensure the quality of nurse graduates, and upgrading the capacity of teaching staff in nursing production institutes (Jaratdao et al, 2013).

Staffing norms

Continuing and worsening shortages of nurses have been a matter of concern for some time. This is linked to adverse incidents, which compromised patient safety, and resulted in litigation and a high turnover of nursing personnel. Staffing norms are required for workforce planning in order to ensure equitable distribution of healthcare providers. Nursing human resource planning would be difficult for the country without approved evidence-based nurse patient ratios. Planning of the workforce cannot be based on international norms, but should be based on the policy goals of each country. Currently, there is no health policy-based workforce plan in South Africa (Uys and Kloppe, 2013). That points to a critical gap in effective policy advocacy to move nursing workforce issues higher on the national agenda. While policy-makers perceive the current shortage of nurses to be insignificant, they have greater fears about envisaged shortages in the future.

6.2.9 CONCLUSION

The findings of the qualitative and quantitative findings, which was the first phase of the study were discussed and interpreted in this chapter. The findings relate to the research questions that guided the study. Data from both sources were merged and consistency in data sets was recognised. The findings diagnosed that the participation of nurse leaders

in health policy development is limited. Inadequate knowledge of the policy development process was also identified. These findings led to a second phase, the policy workshop, which was an immediate intervention. Findings from the workshop are discussed in the following chapter.

CHAPTER 7

DISCUSSION OF FINDINGS FROM PHASE 2: POLICY WORKSHOP

7.1 INTRODUCTION

Following analysis of the qualitative and quantitative data, the researcher embarked on the second phase of the study, which was the intervention phase. A one-day policy workshop was conducted with the purpose of reporting the results of the study and capacitating nurse leaders in health policy development. This knowledge transfer emanated from the results, which showed a consensus that nurse leaders required a workshop on the policy development process. The workshop was also important to ensure the trustworthiness of the study in terms of confirmability of the findings. Indeed, the findings of the workshop also confirmed the results of the first phase of the study.

7.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS

Most of the workshop attendees were female. Out of 24 participants, 21 were female, as opposed to three males. This was to be expected, since most of participants in the study were female. Women constitute a majority in the nursing profession. This is so in SA as well as the rest of the world. However, according to the WHO (2010), women are generally under-represented in positions of health systems governance and in senior positions in educational institutions. "Nursing, as a predominantly female profession, has remained isolated, in SA, from the 'men's world' including politicians" (Ehlers, 2000:79). According to Harper and Vlasich (2016) nurses are frequently overlooked for board positions because of their perceived lack of understanding of nurses' roles as decision makers.

The majority of participants were between the ages of 41 and 60 years. This confirms the findings of the quantitative and qualitative data, which revealed that nurses in leadership positions are ageing. There was consensus that there is a need to start developing the leadership skills of the new generation of nurses. This would prepare them to take over when the older generation of nurse leaders has left. The ICN (2005) asserted that younger nurses should be prepared for leadership roles in influencing policy. This could be done through giving them additional responsibilities and exposing them to decision-making environments.

The participants were predominantly experienced in nursing as most of them had between 6 and 25 years' experience. The participants held different positions. Findings indicate that

they have vast knowledge and experience to draw on in order to impact health policy in South Africa (Ditlopo, 2014). Harper and Vlasich (2016:29) asserted that “the reality is nurses bring a full set of skills not found in other professions.” However, experience alone does not offer sound solutions. Nurses also need the ability to analyse and translate these experiences so that they are able to inform health policy and advocate for changes. Nurse leaders have an obligation to develop or strengthen skills that would enable them to influence health policy so that they can improve health service provision (WHO, 2010). Greater and more meaningful participation of nurses in decision making on health is needed so that their experience can help to inform policy.

The highest level of education among participants was a PhD. Fifteen participants had bachelor’s degrees and six had master’s degrees, while only three had diplomas as their highest level of education. The data revealed that there were more participants who were skilled in research, as compared to the participants in the first phase. This means they would be able to analyse nursing issues and submit evidence to policy-makers. They had the potential to use the window of opportunity at the initial stages of the policy development process. However, they reported very limited involvement in the policy process, and had never submitted any research for policy consideration. As the findings of this study have shown, although nurses are generally well-prepared educationally and play a leadership role within their respective clinical environments, their contribution to research and policy development is very minimal. To date, the research component in nursing and midwifery has been given insufficient attention and resources, and needs to be strengthened. According to WHO (2012) operations as well as academic research are important and valid.

7.3 PARTICIPATION IN HEALTH POLICY DEVELOPMENT

The group was asked to express their sense of what would happen if they do not take action (to influence health policy) to improve their future. This part of the process is sensitive, according to Greenwood (2007), because a negative view of the future is usually easier to articulate than a positive view, and often corresponds to the participants’ worst fears. The group needed to deal openly with these fears because naming their worst concerns contributed to the sense of a need for real change. The task was to develop action ideas and strategies that support the attainment of valued goals.

The majority of participants reported that they had never participated in the process. However, they had been involved at an institutional level. This finding is consistent with the quantitative and qualitative data. They were informed of the processes that were followed in their own institutions, but no specific policy development guidelines were reported. However, they had little understanding of these processes beyond the institutional level, suggesting that greater transparency (including documentation and communication of the policy processes) might improve their participation.

There was consensus that the nurse leaders participated more at the implementation level. The workshop participants also described the policy development process as a top-down approach. This is also congruent with the quantitative and qualitative findings. “While nurses might imagine that policies are made elsewhere, sometimes far removed from practice, in reality there is considerable scope for nurses to get involved” (Prince, 2010:39). Communication and consultation around any change in policy and practice is critical to engaging nurses’ professional commitment in support of it, and must be related to their understandings and perspectives. According to Walker and Gilson (2004), policy-makers must acknowledge alternatives that frontline health workers have implemented and allow them flexibility. They must not expect implementers to conform. For policy-makers to appreciate why policies do not achieve the expected outcomes, they need to understand the implementation systems and the actors responsible for implementation (de Satgé, 2009).

Two participants reported that they had been very involved in policy development at the provincial and national level because of portfolios that they held. This showed that nurse leaders do participate in the process to some extent. The nurse leaders who get this exposure learn on the job when occupying positions where policy development is part of their key performances, such as the NDOH and the SANC. However, very few nurses are appointed to these positions.

Most participants agreed that they had seen policies posted for general public comments. However, they had never responded. This confirms the finding from the qualitative data that nurse leaders do not participate even when invited. This could also mean that the policy processes are unclear to the outsider. A better understanding of these processes could assist other policy actors in engaging with them. The opening discussion laid a good foundation for the presentations by the policy specialist. It gave her insight into the level of

knowledge and how much to unpack when addressing policy issues. The participants also raised a challenge related to the status of nursing limiting them from participation in the health policy process. They felt that there was a lack of recognition of the nursing profession, as well as a lack of input by policy-makers. However, the nature of the policy development processes (how policies are formulated and the role-players) affects their appropriateness and often their implementation.

The issue of medical dominance and the relative lack of nurses' influence was also raised during the workshop. This suggests that traditional power relations between nurses and doctors still exist. Nursing leadership is often perceived to be afforded lower status than the leadership of other health professions, due to the complexity of gender and inter-professional power relationships. Ditlopo et al (2014) noted that there was no nursing directorate in the National Department of Health in South Africa. A medical doctor headed the Human Resource division. Furthermore, no nurses were involved in the four policies that mainly affected them. Buse et al (2012) also found that doctors were often more influential in public health policy either as civil servants or as health ministers. Likewise, Shariff and Potgieter (2012) found that nurses were mostly absent and other health professionals, particularly doctors, influenced the health policy agenda in Kenya, Uganda and Tanzania. Gender discrimination can also affect the learning environment, working conditions, attitudes and expectations (WHO, 2010). Nurse leaders had never questioned their non-participation. These findings support the results of the quantitative and qualitative data.

7.4 PERCEIVED STRATEGIES FOR ENHANCING PARTICIPATION IN HEALTH POLICY

A presentation was done on the role of nurse leaders in influencing policies and designing a policy brief. This assisted in achieving research objectives 7 and 8, which were:

- To identify strategies for enhancing nurse leaders' participation in health policy development
- To collaboratively implement strategies for enhancing nurse leaders' participation in health policy development.

7.4.1 Leadership forums

A robust discussion took place on the challenges regarding policy issues. The main challenge that was highlighted and agreed upon was the lack of cohesion among nurse leaders. It was discovered that there were no formal forums where policies and professional issues were discussed. There was consensus that they needed one voice, as they agreed that they were not vocal about nursing issues. A strategy that was supported unanimously was the establishment of a nursing leadership/management forum. It is important for nurses to be well organised and coordinated, so that they can benefit politically. If nurses are to make any successful standpoint politically, they should present as a united, not a divided, front. Literature (AbuAlRub and Foudeh, 2016; ICN, 2015; Benton, 2014; Ehlers, 2000) support the fact that nurses need to unite, communicate and join forces to build a strong voice to advocate for improving national health policies that address issues of healthcare services cost, quality of care and access to health care. Organised labour was not an option because they belonged to different trade unions.

7.4.2 Training

The training of nurse leaders in health policy development was also identified as a strategy to enhance their participation in health policy development. They all strongly agreed that the nursing curriculum has to include policy content. This would empower nurses to be confident and effective leaders with a powerful voice at all levels of the healthcare system, from policy-making to the service level. The issue of having more workshops was recurrent. Some felt that even students in the basic nursing programmes should have an insight into policy issues, as they would be the future nurse leaders. According to the ICN (2015), nurses need to select appropriate training programmes that will prepare them effectively for management, policy development and leadership in various settings and at different stages of their professional and career development. Several authors (Juma et al, 2014; AbuAlRub and Foudeh, 2016; Harper and Vlasich, 2016) support the inclusion of health policy science in the curricula of undergraduate and graduate nursing programmes, continuing professional development programmes and training courses in health policy development.

The nurse educators present confirmed that there was no policy content covered in either the undergraduate or the postgraduate nursing programmes that were offered in their university. This finding was supported by Rispel (2015) who asserts that the SA nursing curriculum is outdated and unresponsive to the needs of the rapidly changing health

system. It does not prepare nurses for effective roles in health policy development. Lessons could be learnt from other countries, such as the United States of America. Abood (2007) explained that nursing organisations in the USA sponsor annual state legislative days, offer internships and fellowships, and conduct policy workshops. Participation in all these programmes provides nurses with an opportunity to learn more about current healthcare issues and the law-making process.

7.4.3 Policy brief

There was consensus that nurse leaders needed to make their position known. After the presentation on the policy brief, they felt strongly that they needed to start developing policy briefs. They agreed that a policy brief on the issue of limited involvement in health policy development was needed as an urgent action. That would be another way of having a voice in the development of ideas and policies that affect health care and the nursing profession. Having that say is a basic freedom entrenched in the Constitution of South Africa (Act 108 of 1996). They felt that they needed to grasp the opportunity after being empowered with knowledge of how to develop a policy brief. The main audience for the policy brief would be policy-makers such as the NDOH and SANC. According to Lavis (2009), policy briefs support evidence-informed policy-making. They address policy-makers' need for inputs to the policy development process. A similar recommendation was made by AbuAlRub and Foudeh (2016), who found that nurses in Jordan have strategies of communicating evidence to policymakers through writing policy briefs and position statements based on research.

7.4.4 Succession planning

This requires identifying young nurses with a potential for leadership. These nurses would be exposed to leadership development programmes (ICN, 2005). Young nurses should also be exposed to meetings and policy development environments. They should be encouraged to give reports and make presentations about their departments. This would ensure that they develop the communication skills and confidence required for influencing policies. A stable and supportive environment must be created which encourages professional growth through effective role modelling (Frankel, 2008). According to the ICN guidelines (2005), young nurses need to be prepared for policy positions. There are other strategies that were not identified by the participants but are critical to enhance their participation in health policy development. These are mentioned below.

7.4.5 Advocacy

According to Arabi (2014) advocacy is an important attribute of policy influence. The role of advocacy goes beyond patient advocacy and incorporates professional advocacy as well. While nurses are expected to advocate for improvement of the quality of care, many of them lack the organisational and individual power necessary for advocating for patients' rights. Hahn (2009) suggested that nurses are specialists in providing clinical care and can therefore move into the role of policy advocates to influence change. Effective advocacy involves developing a strategy to organise membership to lobby for a specific issue. This mobilisation should be such that an emerging advocate learns from it and is able to take the process forward (Sheehan, 2010).

7.4.6 Political awareness

The practice of nursing and the delivery of health care are influenced by political decisions and health policy initiatives. Nurses, therefore, need to have political understanding. According to Stevens (1985:155) "Nurses' naiveté in politics" leads to their exclusion from participating until a law has been passed, and is perceived to be detrimental to nursing. Nurses need to be proactive rather than reactive to legislation. Mason et al (2016) and Hall-Long (2009) argued that nurses should be educated for the political journey. The communication, advocacy, listening, problem solving and reflection skills that nurses possess are essential in intense times of political compromise. They need to capitalise on these skills and use them effectively to influence policy.

7.4.7 Power dynamics

Nurse leaders have strengths that they may or may not be aware of, which would assist them in pushing their agenda forward. Nurses, as the largest group of health professionals, have power in numbers. They need to "raise their voice" and speak as a united front. They possess expert power. Their unique position as both providers and consumers of care enables them to identify issues and possible solutions. Their legitimate power enables them to have the authority to speak out on health issues. Nursing has gained the trust and credibility of the public, which amounts to referent power (Mason et al, 2016; Huber, 2012; Ditlopo et al, 2014; Arabi 2014).

7.5 CONCLUSION

The workshop brought people together and provided them with the opportunity to think through and plan elements of their own future through engaging in meaningful discussions. It integrated the following processes:

- It created discussion where participants shared different interpretations of history.
- A common vision (goals) for the future was developed, including what will happen if the future is not addressed creatively.
- The participants engaged in searching for strategies to reach the desired goal of participating in health policy development.
- It facilitated a collective prioritisation among action issues/strategies identified for enhancing the participation of nurse leaders in health policy development

Group evaluation and evaluation forms indicated that the participants' knowledge of the health policy development process had increased as a result of the workshop. This positive evaluation indicates that the programme could be scaled up from the sample to the whole of KZN.

CHAPTER 8

CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS

8.1 INTRODUCTION

The purpose of this study was to determine and analyse the extent of nurse leaders' participation in the health policy development process. To achieve this goal, it seemed appropriate to adopt the action-research approach. The relevance of this approach was guaranteed because the focus of the study was determined by the researcher, who is also the consumer of the findings. AR was found to be an empowering experience for both the researcher and the participants. This chapter presents the conclusions, recommendations and limitations of the study.

8.2 CONCLUSIONS

The major conclusions from the study were drawn in the context of the conceptual framework (Policy Triangle) for the study and the research aim.

8.2.1 Context

The context refers to the setting or situation in which policy development and implementation occurs. It could include international, national and local settings. It also includes harder issues (structures, resource levels) and softer issues (ideas, values), (Buse, 2012). The wider social and political contexts influence the ways in which policies are developed, implemented, monitored and reviewed. The study has shown that nurse leaders need to be informed about health policy in order to meet the demands of the rapidly changing healthcare environment. Participation in healthcare policy formulation requires substantive research outcomes, coupled with knowledge of the political process and strategies that could have a positive influence on policy-makers' decisions regarding public health (Grady, 2010).

The policy process was found to be visible in institutions as nurse leaders participated at this level. However, nurses do not utilise research knowledge or strong supportive evidence to drive items on the political agenda to influence health policy. The political nature of the policy environment excludes actors from policy decisions. It also limits them from making inputs into the feasibility of implementation. This hierarchical pattern of decision-making within nursing may be exacerbated by the fact that there are very few nurses in strategic national positions. This limits the scope of nurses' policy influence at

national level and prevents them from being involved more proactively at the district level or in the front line in policy-oriented debates. In addition, nurses at lower levels felt oppressed by senior nurses who made most of the decisions. In the absence of feedback from the grassroots on policy implementation, as identified by participants in this study, the voices of nurses at lower ranks might be further suppressed.

8.2.2 Actors

There are various actors (both individuals and organisations) with different levels of power, who are involved, or would like to be involved, in policy processes. According to Buse (2012), actors have a role in identifying problems or issues as worthy of attention and shaping the design of proposed policies. This study identified that not all relevant actors are always involved. Nurse leaders from provincial and institutional levels, responsible for implementation, had limited participation in the health policy development process. They participated mostly at the implementation stage. Greater involvement of actors who are responsible for implementation in policy development could encourage ownership of the policy, and allow better assessment of policy feasibility. Nurse leaders did not prioritise policy development as their expected leadership role. This suggested that they did not think policy formulation was one of their functions. They also saw themselves mainly as implementers.

8.2.3 Process

There is inadequate evidence that nurses play a role in policy development commensurate with the size of the profession. The “top-down” policy approach excludes nurse leaders from the policy table. Policy initiatives appear to be flawed, as many stakeholders are alienated, particularly those responsible for implementation. Nurse leaders also felt that people without nursing backgrounds were involved, which was a possible explanation for policy challenges. The findings confirm that the implementation difficulties stem partly from insufficient consideration of the key informants at the policy development stage, who could provide input on the operational mechanisms required for implementation (de Satgé, 2009). Furthermore, the nurse leaders’ knowledge of the policy cycle was too limited to enable them to utilise the process to improve policy decisions.

The policy development process had some shortcomings, such as the reach and depth of consultation, and absence of relevant forums where nurse leaders develop and negotiate policy alternatives. Further, the failure to engage with affected professionals at the outset

of the policy process, in the identification of objectives and approaches, by making policy documents available and distributing these extensively for inputs, raises questions about the participatory nature of these processes. Most processes present fixed positions and programmes for limited feedback or information sharing only, or create only limited opportunities for nurse leaders to raise concerns, and therefore make very little substantive difference to policy decisions. Findings also revealed concerns that no inputs were elicited at the outset, when problems and solutions were being developed. There is an increasing perception among nurse leaders of being side-lined and marginalised, excluded and disempowered. Above all, the focus needs to be placed on enabling the voices and interests of nurse leaders to influence policy-making, from the framing of policy issues to the deliberation of policy options.

8.2.4 Content

The content of policies often fails to get to the heart of problems that disrupt the process of delivering high quality nursing care. This is due to limited involvement of the actors who are responsible for implementation. The study has shown that policies are cascaded down for implementation without the necessary implementation guidelines. Data revealed that policies are interpreted and implemented differently by various institutions. This often results in unintended consequences of a policy. However, the study did not focus on the policy content as no specific policy was analysed.

8.3 SUMMARY OF FINDINGS

Overall, the findings of the study represent an additional contribution to the wider (but limited) literature that suggests that nurse leaders have limited participation in health policy development. The findings of the study suggest that there is an increasing disconnection between policy and implementation. Policy and policy implementation are separate concepts and the intentions of the policy are not always achieved during implementation. This gap acts as a barrier to involving the people in the front line, who are responsible for delivering results, in policy development. The involvement of actors who are expected to implement policies in the policy development process could promote ownership and allow better assessment of policy feasibility. Policy failures should prompt policy-makers to engage in a fundamental rethink of their beliefs and seek out participants with new ideas. An inclusive health policy-making processes, in which nurse leaders are important actors, is required. Their participation can strengthen policy processes by bringing new perspectives.

Economically speaking, according to Roux (2002), the South African Government cannot afford miscalculations when embarking on comprehensive executive programmes. If those involved in policy and decision-making processes were fully knowledgeable about the theory and practice of policy related issues, mistakes could be avoided. The best option to develop personal capacity and a critical mind-set, necessary when costly decisions have to be taken, is to provide training and education in policy management at selected tertiary institutions in South Africa (Roux, 2002).

8.4 RECOMMENDATIONS

In view of the findings in this study and the discussions in light of the literature, as well as the conclusions outlined, the researcher presents the following recommendations for consideration by relevant agencies of government and professional bodies.

8.4.1 Recommendations for policy

- Nurses are at the heart of health care delivery. They are also a significant resource and provide drivers for scaling up health interventions necessary for meeting national health targets. They are responsible for providing care with the aim of realising the vision of better health outcomes for all. Therefore, their role within the health care system needs to be acknowledged by policy-makers. Urgent action is thus imperative in order to enhance the participation of nurse leaders in health policy development and strengthen their contribution. This requires policy-makers to change their viewpoint about implementers. Instead of seeing them as merely executors of programmes, they should recognise implementers as an integral part of the policy process. Explicit and publicly-available guidelines for the policy process and mechanisms and known criteria for actor involvement might motivate and enhance wider involvement.
- Currently the policy-making process is not inclusive of all the important actors required. Diverse stakeholder engagement mechanisms have to be introduced to inform the design and implementation of policies. These include creating more opportunities for nurses to contribute to policy processes by increasing nurses' representation in policy-related structures, and allowing nurses to compete for leadership positions in the system.
- Nurses need to have relevant skills to participate effectively in the political process. An appropriate first step would be for the SANC as an accrediting body to recognise health policy as a core competency for nursing management.

- Since the study found that nurse leaders were more prominent at the implementation stage, it is recommended that when policies are being developed, they should be cascaded down with suggested implementation guidelines for response by those charged with implementation.
- Nursing representatives from different provinces must be invited to participate in health policy development at national level. The same representatives must be trained in the implementation process. This will allow for uniformity in implementing a policy throughout the country.

8.4.2 Recommendations for nursing practice

- To ensure that nursing plays its vital role in rendering quality care for patients, and that the profession adjusts to the healthcare environment of the 21st century, the profession should take the initiative in seeking to shape its future, and decide the role it wants to play and the difference it wants to make.
- Nurse leaders need to inform the public and policy-makers about the contribution that they can make to health policy development. This could be done through talking about their role in improving patient outcomes. They have been found to be less visible in the policy spaces. This further emphasises the need for nurse managers to develop their policy competence to rectify this situation.
- Nurse Managers should start driving policy from service level. The first step is to start engaging with policy documents critically. This would help improve their understanding and shaping of policy. They should help guide the development of institutional policies and procedures to create a more detailed representation of what constitutes evidence-based nursing practice.
- There needs to be a conscious capacity development programme targeting nurse managers. There might be resources that are untapped. The CNMO needs to check with the national human resources development (HRD) council what the HRD plan is and the professional categories that have been identified for development. A strong motivation needs to be made for the nursing profession to be put on the priority list for the HRD council. The main focus should be on leadership development programmes that will empower and prepare nurse leaders for a role in policy development. The leadership training programmes, the Global Nursing Leadership Institute (GNLI) and Leadership for

Change (LFC) provided by the International Council of Nurses (accessible in <http://leadership.icn.ch>) could be used for benchmarking. However, in the meantime, enrolling South African nurse leaders in the ICN programmes is recommended. Participating in these programmes may help strengthen the nurses' ability to take part in national healthcare decision-making. The same leaders would be used to facilitate the programme in South Africa.

- Nurse leaders, through their professional organisations and their positions, need to lobby and create a space that will stimulate their participation in the policy arena. There is a need to establish nurse leaders' management forums representative of managers at all levels. This will enable them to organise themselves, speak collectively with one voice, thereby enabling them to turn around the debate.

8.4.3 Recommendations for nursing education

- The study showed that the current nursing curricula at undergraduate or post-graduate level at most educational institutions in South Africa do not include subjects related to policy and political involvement. Given the importance health policy plays in the nursing practice environment, higher education should be leading the way in educating future nurses to be knowledgeable and confident participants in the policy process. Inclusion of policy development content in the nursing curriculum is therefore imperative. The introduction of basic health policy at undergraduate level is recommended. This would allow students an opportunity to learn about and become competent in basic health policy skills.
- More intensive education can continue concurrently with student levels to increase competence in previously acquired skills. Nurses would then have a solid basis of knowledge and skills to successfully traverse the political process.
- It is recommended that the universities run policy and politics-related seminars and short programmes. Likewise, nursing faculties must be given the proper assistance to improve and carry out policy research so that policy-makers and administrators can draw from the evidence base when developing policies.
- The nursing management programs should enable students to select subjects such as Political Science, African Politics, Statistics, English and Financial Management as optional subjects.

- Policy communication skills are essential in multiple policy settings to create and sustain coalitions and build support for policy initiatives. It is recommended that students be exposed to theory and content on how to effectively convey policy ideas to multiple audiences, including preparing concise policy briefs.
- Investing in academic collaborative networks such as FUNDISA is one important way to expand the effective participation of nursing in health policy development. FUNDISA as an interest group could play a role in analysing the current nursing programmes with a vision of producing science which informs the broader health policy arena.

8.4.4 Recommendations for research

- Nurses should be encouraged to conduct policy-related research, to anticipate and build on clinical data that can influence health policy.
- The study should be replicated in other S.A provinces and African countries with a similar sample of nurses, utilising other research methodologies to build on the knowledge gained from the study.
- Future research could advance 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.

8.5 LIMITATIONS OF THE STUDY

- The researcher had planned to interview some representatives from labour unions such as DENOSA and nurse leaders from the health district offices but they were not available for interviews, despite constant communication with them.
- The study was conducted in the one province (KZN) out of the nine provinces in South Africa. This may have biased the study to some extent.
- A certificate of attendance was not issued to the workshop participants. This could be used as evidence for participants' continuing education efforts.

8.6 CONCLUSION

In summary, it is imperative for nurses at all levels and from all contexts to understand and be knowledgeable about nursing policy and politics, and to be involved in the policy process. A paradigm shift must take place within the nursing profession to emphasise the

importance of policy and nurses' role in development and implementation of it at all levels. Nurse leaders need to have this space in the political environment and use the window of opportunity to participate in the policy development process. Although many barriers to participation were identified, facilitators were also identified. This suggests that there is potential for nurse leaders to participate in the health policy development process.

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Annexure 1A Provisional approval: BioMedical research Ethics

RESEARCH OFFICE
BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 260-4609
Email: BREC@ukzn.ac.za
<http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>

26 November 2014

Mrs Zanele Dlamini
14 EL Torero
Lewis Drive
Amanzimtoti
4126

Dear Mrs Dlamini

PROTOCOL: Participation of Nurse Leaders health policy development. An action research approach: Degree Purposes (PhD). BREC REF: BE397/14.

PROVISIONAL APPROVAL

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your response dated 31 October 2014 to BREC letter dated 21 October 2014.

The study is given **PROVISIONAL APPROVAL** pending a response to the following:

1. KZN Provincial Health Research Committee approval

Only when full ethical approval is given, may the study begin. **Full ethics approval has not been given at this stage.**

PLEASE NOTE: Provisional approval is valid for 6 months only - should we not hear from you during this time - the study will be closed and reapplication will need to be made.

Your acceptance of this provisional approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

Yours sincerely

Ms A Marimuthu
Senior Administrator: Biomedical Research Ethics

Annexure 1B Approval of Research Proposal KZN Health Research Committee



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street

Website:

Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM319/14
Enquiries: Mrs G Khumalo
Telephone : 033 – 395 3189

Dear Ms Z Dlamini

Subject: Approval of a Research Proposal

1. The research proposal titled '**Participation of nurse leaders in health policy development**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at the selected facilities at Ugu, Uthukela, Amajuba, eThekweni, Ilembe & Uthungulu. *The study can only commence at Umgungundlovu District once a support letter has been obtained from the district.*

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mrs G Khumalo on 033-395 3189.

Yours Sincerely


Dr. E Lutge

Chairperson, KwaZulu-Natal Health Research Committee

Date: 02/12/14

uMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Annexure 1C Permission to conduct research at Stanger Hospital
KZN BIOMEDICAL RESEARCH ETHICS COMMITTEE

Enquiries: DR.G.Lopez
EXT: 6015
DATE: 23/10/2014

Mrs Zanele Dlamini
14 El Torero
Lewis Drive
Amanzimtoti
4126

RE: PERMISSION TO CONDUCT RESEARCH AT STANGER HOSPITAL.

Dear Mrs. Dlamini,

I have pleasure in informing you that permission has been granted to you by Stanger Hospital to conduct research on "PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT.AN ACTION RESEARCH APPROACH".

Please note the following:

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research.
4. Stanger Hospital will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to Stanger Hospital.

Thanking you;



Senior Manager: Medical Services
Stanger Hospital

Annexure 1D Permission to conduct research at Ugu District facility



UGU HEALTH DISTRICT OFFICE
Private Bag X 735, Port Shepstone, 4240
41 Bissett Street, via Main Entrance of Nelson Mandela Drive
Tel.: 039 688 3000,
Fax.: 039 682 6296
Email.: comfort.nguza@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mr C Nguza
Ref: UGUDHO research
Date: 05 November 2014

Principle Investigator: Ms Zanele Dalmini
Address 1:
Address 2
Address 3


Re: PERMISSION TO CONDUCT RESEARCH AT DISTRICT/FACILITY

I have pleasure in informing you that permission has been granted to you by the District Office/Facility to conduct research on "**Participation of Nurse Leaders in the health policy development: An action research approach.**"

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence with your research.
4. The District Office/Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office/Facility.

Thanking you.
Sincerely


Mr Comfort Nguza
Acting District Manager
Ugu Health District Office

Annexure 1E Letter of Consent: Uthukela Health District



health

Department:
Health

PROVINCE OF KWAZULU-NATAL

UTHUKELA DISTRICT

60A Midblock, Corner Alexander Street,
Ladysmith

P/Bag X9958, Ladysmith, 3370

Tel: 036 6312202

Fax: 036 6310530

E-mail: thandeka.zulu@kznhealth.gov.za

www.kznhealth.gov.za

31 October 2014

Ms Zanele Ngema

RE: APPLICATION FOR SUPPORT TO CONDUCT A STUDY IN UTHUKELA HEALTH FACILITIES

Please be informed that I have acknowledged your request for conducting research on Participation of nurse leaders in health policy development.

Please note the following:

1. Your letter received on 29 October 2014 refers.
2. Uthukela District must ensure adherence to all the policies, produces, protocols and guidelines of the Department of Health with regards to this research.
3. Your research will only commence once this office has received confirmation of the approval by HOD from the provincial Health Research Committee in the KZN Department of Health.
4. However your research is hereby supported.
5. I trust that you will find all to be in order.

Yours faithfully

MRS M T ZULU
DISTRICT MANAGER
UTHUKELA HEALTH DISTRICT

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Annexure F Letter of Support Amajuba District



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

MEMORANDUM

Tel: 034 328 7000 / 2
Fax: 034 312 3123
E-mail: pravina.naidoo@kznhealth.gov.za
www.kznhealth.gov.za

TO	: ZANELE DLAMINI
FROM	: DISTRICT MANAGER MRS. A. M. E. T. TSHABALALA
DATE	: 27 OCTOBER 2014
INDEX NO.	: 08/10/2014
FILE REF	: 9/2/3
RE	: LETTER OF SUPPORT TO RESEARCH ON PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT

I have pleasure in informing you that permission has been granted to you by Amajuba District Office-Department of Health to Research on Participation of Nurse Leaders in Health Policy Development

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to these clinic visits.
2. Please ensure this office is informed before you commence your clinic visits.
3. The Amajuba District Office-Department of Health will not provide any resources for these clinic visits.
4. You will be expected to provide feedback on your findings to the Amajuba District Office-Department of Health.
5. The clinic visit will be conducted at Newcastle Clinic corner of Murchison and Sutherland Streets.

Thank you,

MRS. A. M. E. T. TSHABALALA
DISTRICT MANAGER
AMAJUBA DISTRICT

uMnyango Wezampilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Annexure 1G Permission to conduct research Uthungulu District



health

Department
Health
PROVINCE OF KWAZULU-NATAL

MEMORANDUM

Uthungulu District Office

No 2 Durrheim Avenue & Chrome Crescent QG
Private Bag 920004
Empangeni, 3660
Tel: 035 287 0633
Fax: 035 287 0644
Email: sindisiwe.mabaso@kznhealth.gov.za
www.kznhealth.gov.za

Date: 14 July 2014

Enquiries: Ms. SCC Mabaso

Ref: 25/1

To: Zanele Dlamini

(0789065153/ 0835290100/031-20/8135/ Zanele.ngema@kznhealth.gov.za)

Cc: Dr. E Lutge

RE: PERMISSION TO CONDUCT RESEARCH AT UTHUNGULU DISTRICT

"PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT"

1. I have pleasure in informing you that permission has been granted to you by Uthungulu District to conduct research on "participation of nurse leaders in health policy development" at any of the institutions in the district.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed in writing before you commence your research.
4. The Uthungulu District will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thanking you.

Yours Sincerely

Ms. Sindisiwe CC Mabaso
District Manager
Uthungulu District

Umyango Wezemphelo . Departement van Gesondheid
Fighting Disease, Fighting Poverty, Giving Hope

Annexure 1H Permission to conduct research: ETekwini Health District



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Postal Address: Private Bag X54318 Durban 4000
ss: 83 Jan Smuts Highway, Mayville, Durban 4001
Tel. 031 2405308: Fax. 031 2405500
Email: penny.dladia@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Ms Ntombifuthi Mthethwa
Tel: 031 240 5342
Date: 12 November 2014

Attention: Zanele Dlamini

E-mail : Zanele.ngema@kznhealth.gov.za)

REQUEST TO CONDUCT RESEARCH:

PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT

Support is hereby granted to conduct research on the above topic.

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regard to this research.
2. This research will only commence once this office has received confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Ms. N.B. Mthethwa

For The District Manager
EThekwin Health District
Telephone: 031 2405342
Fax: 031 2405501
Email: ntombifuthi.mthethwa@kznhealth.gov.za

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

Annexure 2A

Information Sheet and Consent to Participate in Research

Date: 12.08.2014

Dear Sir/Madam

My name is Zanele Dlamini a PhD student from UKZN School of Nursing (0789065153/ 0835390100/031-9078135/ zanelefnd@gmail.com).

You are being invited to consider participating in a study that involves research on participation of nurse leaders in health policy development. The aim and purpose of this research is to determine and analyse the extent of nurse leader's participation in the health policy development process in order to identify strategies to enhance participation and implement one. It will involve an action research approach. The study is expected to enrol an estimated number of 120 participants in the KZN Regional/Tertiary hospitals. The duration of the interview is 20-40 minutes. The questionnaire will take 25-30 minutes. I may request you to be part of the research team that will take the project further but will again seek your permission. The study is self-funded. No risks are involved in the study.

Participation in this research is voluntary and you may withdraw participation at any point. In the event of refusal/withdrawal of participation you will not incur penalty. The researcher could be notified in writing of withdrawal from the study. You are free not to answer any question that you are not comfortable with.

No costs might be incurred by you as a result of participation in the study. There are no incentives or reimbursements for participation in the study.

Information obtained from you in the study will not be shared with others without your consent. If there is a need to share the information, it will not be linked to you. Your name will not appear in any publications, reports or other reports pertaining to this research project. All information collected (audiotapes, interview transcripts, notes) will be kept in a locked filing system in the researcher's office. The audiotapes will be destroyed on completion of the study. All computers on which study data would be stored will be password-protected.

This study has been ethically reviewed and approved by the UKZN Biomedical Research Ethics Committee (approval number BE/397/14)

For further information or questions you may contact me at (0789065153) or e-mail my supervisor Professor Bhengu at (Bhengub2 @ ukzn.ac.za) In the event of any problems or concerns you may contact the UKZN Biomedical Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

Annexure 2B Informed Consent

INFORMED CONSENT

I have been informed about the study entitled Participation of nurse leaders in health policy development by Zanele Dlamini (researcher).

I understand the purpose and procedures of the study.

I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without any penalty/adverse consequences.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at ([0789065153/zanelefnd@gmail.com](tel:0789065153)) or the supervisor at (0836615563/Bhengub2@ukzn.ac.za).

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001
Durban
4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Email: BREC@ukzn.ac.za

Signature of Participant

Date

Annexure 3A Research Questionnaire

Participation of Nurse Leaders in Health Policy Development

RESEARCH QUESTIONNAIRE

Please answer all questions by either ticking the relevant boxes or writing your answers in the spaces provided.

SECTION 1

1. Please indicate the organization that you represent (*Org*).

National Ministry of Health offices 1 ☐ S.A Nursing Council 3 ☐
Nursing Association 2 ☐ Hospital 4 ☐
Other (specify) 5 ☐ _____

2. Gender (*Gen*)

Male 1 ☐ Female 2 ☐

3. Age:

< 30 1 ☐ 31 – 40 2 ☐
41 – 50 3 ☐ 51 – 60 4 ☐ >60 5 ☐

4. Please state your current job position?

5. Number of years of experience in nursing (*Expr*).

< 5 1 ☐ 6 – 15 2 ☐
16 – 25 3 ☐ 26 – 35 4 ☐ > 36 years 5 ☐

6. Number of years of experience in the current position (*Ycp*)

<5 1 ☐ 6 – 15 2 ☐
16 – 25 3 ☐ 26 – 35 4 ☐ > 36 years 5 ☐

7. Highest level of education (*Ed*)

Diploma 1 ☐ Bachelor's degree 3 ☐
Master's degree 2 ☐ Doctoral degree ☐ 4 ☐ Other 5 ☐
Specify _____

8. Are you a member of any nursing professional organization? (*Porg*)

Yes ☐ No ☐

8.1 If yes, specify_____

9. Briefly describe, your role in the professional organization?

10. Have you ever participated in policy development at (tick all relevant levels)?

	1 Yes	2 No
Global level (e.g. WHO, ICN) (GL)	<input type="checkbox"/>	<input type="checkbox"/>
National level (NL)	<input type="checkbox"/>	<input type="checkbox"/>
Provincial level (PL)	<input type="checkbox"/>	<input type="checkbox"/>
Institutional Level (IL)	<input type="checkbox"/>	<input type="checkbox"/>

11. Please rate your participation in trying to influence health policy in the past four years (tick the number that corresponds to your involvement) 1=No involvement, 2=Below average, 3=Average involvement, 4= Above average, 5= Very involved

	1	2	3	4	5
11.1 Problem identification and agenda setting					
11.2 Draft legislation					
11.3 Policy formulation					
11.4 Policy implementation					
11.5 Policy analysis and/or make recommendations about them to policy makers.					
11.6 Work on a committee or coalition so action could be taken on a health policy issue					
11.7 Mobilize resources for policy making activities e.g. financial, material and human					
11.8 Making presentations, that are evidence based, to policy makers.					

12. How would you rate yourself in relation to health policy development activities (SR)?

1 =No confidence, Below average confidence, 3= Average, 4= Above average, 5 = Total confidence

	1	2	3	4	5
12.1 Knowledge and skills at every stage of the health policy development process <input type="text"/>					
12.2 Experience necessary for active participation in the health policy development process					
12.3 Analysing nursing concerns or health issues that can be addressed through policy intervention/reform					
12.4 Analyse health policies and/or make recommendations about them to policy makers.					
12.5 Draft legislation					
12.6 Awareness of your role if you could be given an opportunity to actively participate in the policy process.					
12.7 Research and analytical skills to inform the agenda with evidence					
12.8 Dissemination of research findings to policy makers and stakeholders					

13. Have you had an opportunity to participate in forums where policies are formulated by policy makers (Frms)? Yes 1 No 2

14. Do you have any networks for support and to share experiences on policy related issues (e.g. leadership forums, nurse's chapter) (Ntwk)?

Yes 1 No 2

15.1 If yes, specify_____

16. Does the South African Nursing Council have a policy regarding nurses being involved in health policy issues (SANCP)?

Yes 1 No 2 Not Sure 3

17. Have you received any training on health policy development (Info)?

Yes 1 No 2

17.1. If yes, where have you received this training?_____

18. Do you personally find the following factors to be **barriers** to participation in health policy development (BTP)

1=Strongly disagree; 2= Disagree; 3= Not sure; 4= Agree; 5 =Strongly agree

	1	2	3	4	5
18.1 Lack of recognition of nurse leaders by policy makers, for the important contribution nursing can make to policy issues.					
18.2 Lack of opportunity afforded by policy makers for nurse leaders to participate in the health policy process.					
18.3 Most appointments into policy making positions are given to other health care professionals.					
18.4 Institutional structures and systems are such that they exclude them from being part of the policy process					
18.5 Gender and inequality. Male dominance in the health policy forums.					
18.6 Low status awarded to female dominated professions.					
18.7 Lack of relevant knowledge and skills necessary to participate in the policy development process					
18.8 Lack of experience necessary for active participation in the health policy development process					
18.9 Most health policies are developed at the national level then forwarded to nurse leaders for implementation					
18.10 Lack of consultation by policy makers					

19. The following factors could **facilitate** Nurse Leaders' participation in health policy development at Global, Regional, National and Provincial level (FFP)

1 =Strongly disagree; 2= Disagree; 3 =Not sure; 4 =Agree; 5 =Strongly agree

	1	2	3	4	5
19.1 Being knowledgeable and skilled in the health policy making activities at all levels					
19.2 Inclusion of policy development content in their basic nursing education curriculum in order to prepare them for this role					
19.3 Availability of policy leadership training e.g. courses/workshops					
19.4 Having opportunities to participate in forums where policies are formulated by policy makers					
19.5 Adequate representation of nurse leaders' at national policy making level					
19.6 Having nurse leaders' input respected by policy makers					
19.7 Being politically astute - e.g. able to lobby with policy makers and influence policy of concern to nursing profession					
19.8 Having a gender balance (in terms of appointments) at policy making forums					
19.9 Networking with peers and forming coalitions so as to lobby for policy makers to ensure the inclusion of nurse leaders in health policy processes					

20. In your experience, how do nurse leaders participate in health policy development?

21. In your experience, what are the major barriers to nurse leaders' participation in health policy development at all levels?

22. In your view, what factors would facilitate nurse leaders' participation in health policy development at all levels?

23. Is there any issue that needs to get into the policy agenda?

23.1 If yes, specify_____

24. If you were given an opportunity, would you be interested to participate?

Yes 1 ☐ No 2 ☐

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
0789065153/ zanelefnd@gmail.com

Annexure 3B Interview Schedule

PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT

INTERVIEW SCHEDULE

1. What are your expected leadership roles? Would you describe them?
2. What influence you're thinking about policy and nursing.
3. Tell me about your experience in nursing leadership in relation to policy development, implementation and or evaluation.
4. Have you participated in the process of developing any health policy e.g. PHC Re-engineering? If yes, how have you participated in the following processes?
 - 4.1 Policy formulation
 - 4.2 Policy implementation
 - 4.3 Policy modification
5. If you have not participated what were the causes or obstacles that limited your involvement.
6. From your experience, what actions should be taken to overcome barriers?
7. What kind of roles or strategies do you think that nurse leaders should employ to change or influence national health policy development.
8. Have you identified any issue that needs to get into the policy agenda?
9. If afforded an opportunity, would you be interested to participate?

Annexure 4A

Information Sheet and Consent to Participate in the Workshop

Date: 19.02.2016

Dear Sir/Madam

You are welcome to the Health policy development workshop. This workshop emanated from a study that was conducted on participation of nurse leaders in health policy development. The aim and purpose of this research was to determine and analyse the extent of nurse leader's participation in the health policy development process in order to identify strategies to enhance participation and implement one. The workshop will last 7-8hours. I may request you to be part of the research team that will take the project further.

Participation in this workshop is voluntary and you may withdraw participation at any point. However your input is valuable. You are free not to answer any question that you are not comfortable with. Information obtained from you in the workshop study will be used for the study and to improve practice but it will not be linked to you. Your name will not appear in any publications, reports or other reports pertaining to this research project. All information collected such as registration form, evaluation form, workshop transcripts will be kept in a locked filing system in the researcher's office and will be destroyed on completion of the study.

For further information or questions you may contact me at (0789065153/0835390100) or e-mail my supervisor Professor Bhengu at (Bhengub2 @ ukzn.ac.za). In the event of any problems or concerns you may contact the UKZN Biomedical Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Annexure 4B

Workshop Informed Consent

I have been informed about the study entitled Participation of nurse leaders in health policy development by Zanele Dlamini (researcher).

I declare that my participation in this workshop is entirely voluntary and that I may withdraw at any time without any penalty/adverse consequences.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at ([0789065153](tel:0789065153)/[0835390100](tel:0835390100) zanelefn@gmail.com) or the supervisor at (0836615563/ Bhengub2@ukzn.ac.za). If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604769 - Fax: 27 31 2604609

Signature of Participant

Date

Signature of Witness

Date

(Where applicable)

Annexure 5 Workshop Registration Form



WORKSHOP REGISTRATION FORM

WORKSHOP: Health Policy Development

DATE: 19.02.2016

VENUE: Glenmore Pastoral Centre

PERSONAL DETAILS

Title (Prof, Dr, Mr, Mrs, Miss, Ms)

Surname_____

Names_____

Gender: Male ☐ Female ☐

Age: < 30yrs ☐ 31 – 40 ☐ 41 – 50 ☐ 51 – 60 ☐ >60yrs ☐

Rank/ Designation_____

Experience in nursing: < 5yrs ☐ 6 – 15 ☐ 16 – 25 ☐ 26 – 35 ☐ > 36yrs ☐

Experience in current position:>-5yrs ☐ 6–15 ☐ 16–25 ☐ 26–35 ☐ > 36 ☐

Highest level of education Diploma ☐ Bachelor's degree ☐ Master's ☐

PhD ☐ Other ☐ specify_____

Contact Details:

Business_____

Cell_____

Email Address_____

Institution Name_____

Objectives for attending the workshop_____

Annexure 6 Policy Workshop Programme




POLICY WORKSHOP PROGRAMME

DATE: 19.02.2016

	PLENARY SESSION CHAIR	Dr SZ Mthembu (Principal KZNC)
TIME	ACTIVITY	RESPONSIBLE PERSON
08h00–08h30	Registration and tea	
08h30–8h45	Welcome and Introduction	Professor N. Mtshali (UKZN)
08h45–8h50	Purpose of the workshop	Ms. ZF Dlamini (Researcher)
08h50–9h20	Presentation of research findings	Ms. ZF Dlamini
9h20–9h30	Questions and answers	
9h30–10h20	Policy development process	Ms. Prudence Ditlopo (Wits: Centre for Health Policy)
10h20–10h30	Questions and answers	
10h30–11h00	Tea break	
	PLENARY SESSION CHAIR	Dr.SZ Mthembu
11H00–11h30	How nurse leaders can influence policy / their role	Ms. Prudence Ditlopo
11h30–11h50	Development of a policy brief	Ms. Prudence Ditlopo
11h50–12h30	Breakaway session	
12h30–13h00	Feedback session	
13h00–13h45	Lunch break	
13h45–14h00	Reflection and way forward	
14h00–14h15	Evaluation and closure	

Annexure 7: Presentation of Research Results

<p>1</p> <div data-bbox="271 244 869 699">  <p>PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT: AN ACTION RESEARCH APPROACH</p> <p>Student: Zanele Dlamini Supervisor: Professor Busi Bhengu</p> </div>	<p>2</p> <div data-bbox="884 244 1395 699"> <p>PRESENTATION OUTLINE</p> <ul style="list-style-type: none"> ❑ Introduction and background ❑ Statement of the Problem ❑ Purpose of the study ❑ Objectives ❑ Research Design ❑ Study population and Sampling ❑ Data collection methods ❑ Quantitative Data Analysis ❑ Qualitative Data Analysis ❑ Discussion ❑ Conclusion </div>	<p>3</p> <div data-bbox="1426 244 2009 699"> <p>INTRODUCTION AND BACKGROUND</p> <ul style="list-style-type: none"> ❑ Health care services in South Africa are under increasing demands in terms of <ul style="list-style-type: none"> ▪ Complexity of diseases ▪ Human resource challenges ▪ Policy reform ❑ Pressure on nurses who are the largest group and in the forefront of the health care sector. <ul style="list-style-type: none"> ▪ nurses= 80% of health professionals (NDOH,2011) </div>
<p>4</p> <div data-bbox="271 790 840 1276"> <ul style="list-style-type: none"> ❑ Nursing is uniquely positioned to influence healthcare priorities nationally- health outcomes ❑ Nursing leadership is currently the vehicle through which both nursing practice and policy can be influenced and shaped McElmurry BJ, Kim S, and Gasseer N (2004) ❑ Therefore it is important that nurses understand and influence the public policy process (Hall-Long, 2009). </div>	<p>5</p> <div data-bbox="884 790 1395 1276"> <ul style="list-style-type: none"> ❑ Contribution to health care delivery, however seldom involved in policy development (WHO 2009:8). ❑ Globally nurses are not optimally participating in the policy formulation process (Edwards, <i>et al.</i>, 2007:34). ❑ Little is known about the types of leadership development programs that most effectively prepare nurse leaders for policy participation (MacPhee, Skelton-Green et al 2012). </div>	<p>6</p> <div data-bbox="1426 790 2056 1276"> <ul style="list-style-type: none"> ▪ leadership programs available but none are focusing on health policy (CNA 2005). ▪ excellent doctorate programs in nursing with strong research component, but even the best may not offer training programs for those who seek to specialize in health policy research and analysis (Forman et al. 2008). </div>

7

PROBLEM STATEMENT

- ❑ Nurses' undervalued in decision making circles that inform health policy
- ❑ Nursing relegated to the margins (Tarlov 1999)
- ❑ Studies - (Fyffe,2009; Hall Long,2009; Marquis & Huston 2009; Grady, 2010; Kunaviktikul & Nantsupawa et al, 2012; Pfeifer,2012; Richter & Miller 2012; Chase 2013; Bregar & Branko et al 2013) :
 - Limited role in the health policy development process

8

- Involved in policy adoption and implementation phase,
- Interpretation and translation role.
- Lack of knowledge of the policy process.
- No consultation on the ground.
- Policymaking process is described as politicised and top down in nature

9

- ❑ Scanty literature, understudied in Africa
- ❑ scanty literature that explores the views of nurse leaders (Gebbie, Wakefield et al.2000)
- ❑ Imperative to study how nurses have participated in the transition in S.A
- ❑ uniqueness - shift the focus from causes to identifying strategies and action.
- ❑ dimension will bring further understanding to research already available and lead to further areas of reform.

10

PURPOSE

- To determine and analyze the extent of nurse leader's participation in the health policy development process in order to identify strategies to enhance participation and implement one

11

METHODOLOGY

RESEARCH DESIGN- ACTION RESEARCH

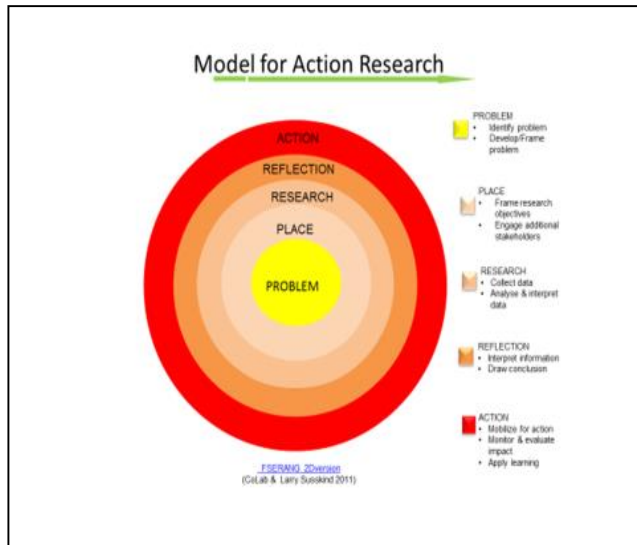
- Systematic enquiry focusing on practice aspects in order to find out more about them, and eventually to act in ways that are seen as better or more effective' (Ngwerume and Themessl-Huber, 2010; Hayes 2012).
- Founder- Kurt Lewin in the 1940s
- The best way to move people forward was to engage them in their own enquiries into their own lives.

12

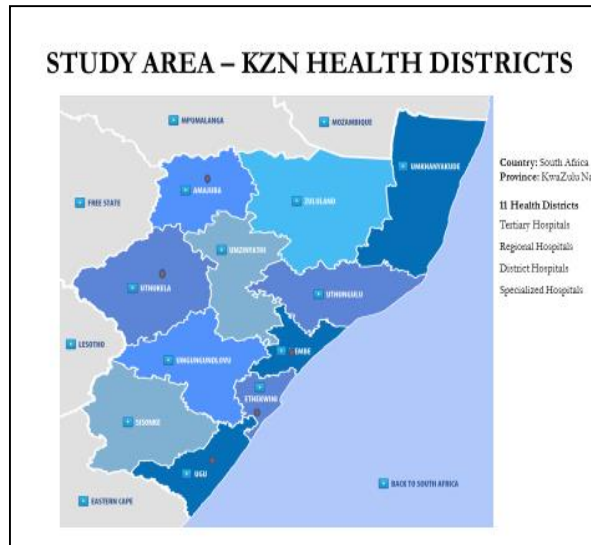
Design continue....

- major goals of action research were to create a change in practice and to develop or refine existing theory (McNiff,2013)
- Shift of researcher's role from being a distant observer to involvement in concrete problem solving.
- Action research is learning by doing.

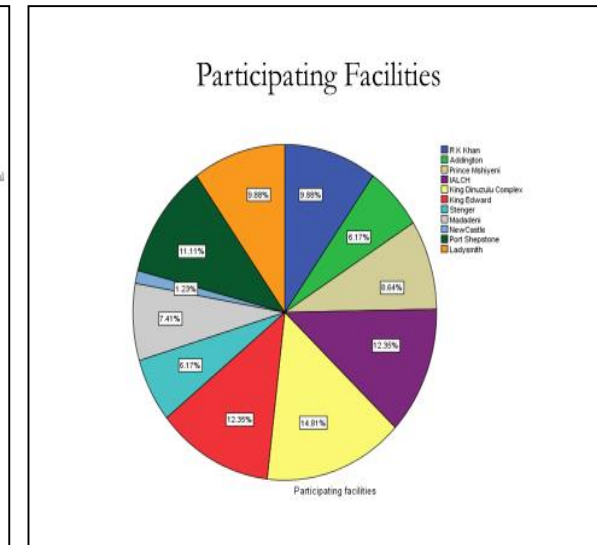
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14



15



16

TARGET POPULATION

- ANM & DNM/Nurse Managers in KZN DOH in selected Regional and Tertiary/ Central hospitals, District, Provincial and National level
- South African Nursing Council (SANC) and the National Department of Health (Human Resources for Health).

17

SAMPLING

- Purposive and homogenous
- Likely to have a genuine interest in the topic, who are part of, or should be part of the health policy development process were selected.

(Polit and Beck, 2008; Keeny McKenna et al, 2010).

18

DATA COLLECTION METHOD

- Study incorporated a concurrent mixed-methods
 - to embrace different perspectives.
- Qualitative data** -
 - Face to face interviews =8
 - semi-structured questions
- Quantitative data**
 - self administered questionnaire=81
 - structured questions

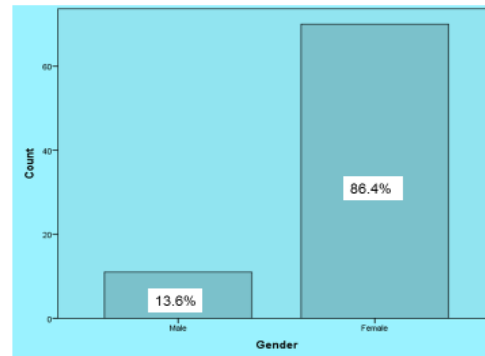
19

DATA ANALYSIS

- Quantitative data
 - computer program (SPSS) version 23.
- Qualitative analyses
 - Thematic analysis
- Data triangulation

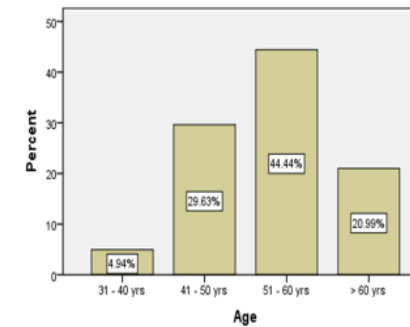
20

RESULTS- QUANTITATIVE



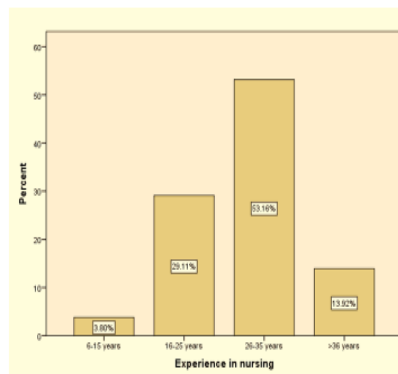
21

Age distribution



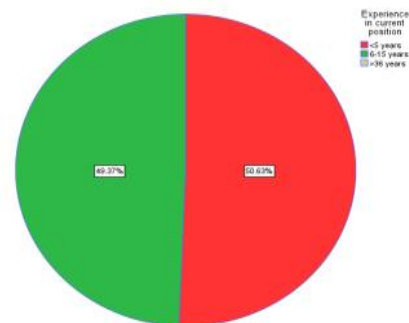
22

Experience in nursing

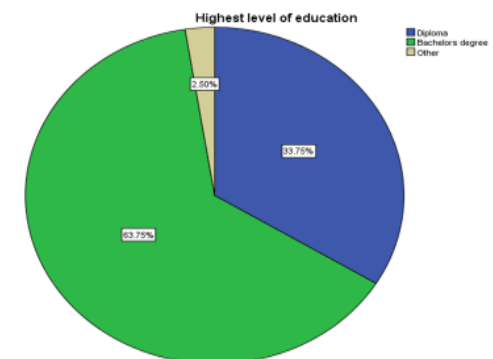


23

Experience in current position



Level of education



25

LEVEL OF INVOLVEMENT

Policy stage	1 Not involved		2		3		4		5 Very involved	
F=Frequency P= Percentage	F	P	F	P	F	P	F	P	F	P
1. Agenda setting	58	71.6	5	6.2	8	9.9	6	7.4	4	4.9
2. Draft legislation	64	79.0	6	7.4	4	4.9	4	4.9	2	2.5
3. Policy formulation	48	59.2	10	12.3	9	11.1	8	9.9	6	7.4
4. Policy implementation	9	11.1	3	3.7	7	8.6	18	22.2	44	54.3
5. Policy analysis	41	50.6	16	19.8	10	12.3	10	12.3	4	4.9
6. Work on a committee or coalition	48	59.3	10	12.3	17	21.0	3	3.7	3	3.7
7. Mobilize resources for policy making activities	53	65.4	12	14.8	10	12.3	4	4.9	2	2.5
8. Making presentations, that are evidence based, to policy makers.	54	66.7	8	9.9	14	17.3	3	3.7	2	2.5

28

FINDINGS- QUALITATIVE

- ❑ Expected leadership roles
 - did not include explicit language on policy development activities.
 - ensure that policies are available, communicated, implemented, formulate operational policies, identify gaps that required policies.
 - 2 participants- KRAs

26

Confidence Level

F=Frequency	1.No confidence		2		3		4		5. Total confidence	
P= Percentage	F	P	F	P	F	P	F	P	F	P
SR 1. Knowledge and skills at every stage	50	61.7	12	14.8	9	11.1	6	7.4	4	4.9
SR 2. Experience necessary for active participation	18	22.2	20	24.7	23	28.4	13	16.0	7	8.6
SR 3. Analysing nursing or health issues	16	19.8	14	17.3	27	33.3	14	17.3	10	12.3
SR 4. Analyse health policies and/or make recommendations	36	44.4	8	9.8	16	19.8	15	18.5	6	7.4
SR 5. Draft legislation	58	71.6	10	12.3	7	8.6	4	4.9	2	2.4
SR 6. Awareness of role if opportunity could be given	41	50.6	11	13.6	16	19.8	11	13.6	12	14.8
SR 7. Research and analytical skills	49	60.4	14	17.3	11	13.5	4	4.9	3	3.7
8. Dissemination of research findings to policy makers and stakeholders	49	60.4	11	13.6	10	12.3	6	7.4	5	6.2

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Experience

- Never participated at National
- Implementers recurrent
- Limited knowledge of the policy development process
- Participation at facility level- Policy & Procedure committees

27

Barriers

- lack of knowledge and experience in policy making, lack of opportunities, time constraints, work overload, represented by certain leaders that are not nurses, lack of consultation, unavailability of forums, being excluded and not taken seriously by policy makers, apathy
- ❑ 92.6% (n=75) of the nurse leaders would be interested to participate if the opportunity arise

30

Percepts

- "I don't even know where it starts and who decides which policy is required at any given time. We are never asked about policies that we think are required. Policy will come, we are told that here is a policy for you to implement. No one explains it anyway."
- "We just implement what we have been given, we are used to carrying orders anyway."
- "One of my KPAs was formulation of the new nursing act. I had to inform people about the object, functions, and the role. I had to go to various structures of parliament to present. It starts with the portfolio committee for health, presenting it chapter by chapter. Continue through the state law advisors, present until the portfolio committee is happy then pass to the National Council of Provinces."

31

Limited participation

- nurses are not involved in health policy development
- Policies are formulated without an understanding of what happens at the grass root level
- receivers and implementers of policies
- Different interpretation and implementation
- some of the participants have participated in the policy evaluation phase-OSD

32

Percepts:

"You know, policies just emerge like the nursing act. They do not want input from us before. We are never invited or consulted when a policy is formulated".

"We don't even know who develops them. All we know is that they are from Province or National and we have to comply. Nurses are left behind and decisions are taken on their behalf."

National different: percepts

"Nurses leaders are involved in policy development although it is limited. There is always consultation e.g. my first project was locating nursing education to higher education. Two nurses did a country wide collection of information. Recommendations were made and submitted to the minister of health."

33

Communication Factors

- Poor, no consultation, policies not explained
- do not know who to contact if there is something that they do not understand
- SANC consult nurses through a country wide collection of information & SANC website

SANC does participate in National policies. Development of competency is the role of the council. SANC is an enabling structure. Council informs minister. Council also uses consultative forums. They understand lethargy amongst nurses. Nurses need to be proactive in their forums. People wait for council instead of council synthesizing what comes from the nurses."

34

- communication barriers by nature.
- If you want to introduce a policy in a country a sufficient consensus is needed. The country is vast making it impossible to reach everybody and the staff is limited.

35

Training and development

❑ No formal training(6)

▪ 2 Trained

"Yes I did receive training on policy issues. My Masters was in policy. I did legal policies."

"I did receive training. It was quite early in 1994."

- No skills, self-learning, trial-and-error experiences (6),
- mostly involved in the development of SOPs
- limited in-service for the nurses at management level.

36

Barriers

- political factors (4 informants); structural factors (5 informants), communication factors (8 informants), and gender factors (2 informants)

"Another barrier is that nursing is not organized. They cannot speak in one voice. They are not pro- active and they don't think that they can have a great influence on policy changes in the country."

"Most policies are not pro nurses because they are developed by people other than nurses. But nurses have never challenged their exclusion. They don't take interest; they don't even know that they need to shape the final detail of policy. Policy makers find a way to consult unions because they pose a threat. There is a fear that the policy would be rejected."

Conclusion

“There are risks and costs to a program of action, but they are far less than the long-term risks and costs of comfortable inaction.” President John F. Kennedy

It is therefore important that nurses understand and influence the public policy process.


(Hall-Long, 2009)

Conclusion

- Necessary to strengthen their or empower them in health care policy development globally and particularly in South Africa.
- Proactive - start developing policy proposals
- Hence – this workshop




Annexure 8: Policy Brief Presentation



Integrating research, policy, practice, training and advocacy

WITS School of Public Health



IDEAS FOR DEVELOPING A POLICY BRIEF

Prudence Ditlopo
Centre for Health Policy
School of Public Health
University of Witwatersrand

1

Session Objectives

By the end of the session, you should be able to:

- Understand what a policy brief is and its intended objectives
- Describe the characteristics of a policy brief
- Describe the structure and contents of a policy brief
- Identify the do's and don'ts of a policy brief



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2

What is a Policy Brief?

"A short document that presents the findings & recommendations of a research project to a non-specialised audience" (IDRC, n.d.)

"...a vehicle for providing policy advice" (IDRC, n.d.)

"A stand alone document, focused on a single topic" (IDRC, n.d.)

"Policy briefs are front-loaded – the conclusions are on the front page" (Kopanski, 2010)



University of the Witwatersrand, Johannesburg

3

What is the Purpose of a Policy Brief?

- To convince the target audience of the urgency about the problem at hand & the need to adopt the preferred alternative or course of action (Young & Quinn, n.d)
- To "succinctly evaluate policy options regarding a specific issue, for a specific policymaker audience" (Eisele, n.d)
 - Policymakers need to make practical decisions under time-constraints, the brief should provide evidence & actionable recommendations



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4

Policy Brief versus Research Report (Tsai, 2006)

Policy Brief

- Geared towards readers who have limited amount of time to make a practical decision

Research Report

- More 'academic' – pays attention to scholarly roots of particular arguments & judges their merit on intellectual and logical criteria



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5

Types of Policy Briefs

Advocacy Brief

- Argues in favour of a particular course of action
- E.g. urges the National Department of Health to provide HIV treatment

Objective Brief

- Gives balanced information for the policymaker to make up his or her mind
- E.g. presents some problems caused by rising food prices & suggest ways policy makers might respond



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6

Designing a Policy Brief (2) (Young & Quinn, n.d.)

Research Approaches & Findings	<ul style="list-style-type: none"> How did you go about producing the evidence? What has been uncovered by your study about the issue? Viewpoints of the stakeholders involved
Implications & Policy Recommendations	<p>Aims to provide detailed & convincing proposal of how the failings of the current approach needs to be changed. What do these findings mean? What actions and appropriate roles could or should be different to address the issue? Your recommendations might not suggest best policy but instead the most viable one. This section includes:</p> <ul style="list-style-type: none"> A breakdown of the specific practical steps or measures that needs to be implemented A closing paragraph re-emphasising the importance of action
Limitations & further research	<ul style="list-style-type: none"> What are the limitations of the research findings? How do these limitations impact the implications or recommendations provided? What knowledge gap still remains Why is it important that further research be conducted to investigate these knowledge gaps?

Planning your Policy Brief (IDRC, n.d.)

- What type is your policy brief?
- Who are your potential readers?
 - Who am I writing this brief for?
 - How knowledgeable are they about the topic?
 - How open are they to the message?
- Choosing content
 - Focus on single topic
 - Clearly define your purpose
 - Identify salient points that support the aim



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8

Designing a Policy Brief (1) (Young & Quinn, n.d.)

Title of the Brief	Aims to catch the attention of the reader; needs to be descriptive, punchy, and relevant
Executive Summary	<p>Must convince the reader that the brief is worth in-depth investigation; to see the relevance & importance of the brief (1-2 paragraphs). Commonly includes:</p> <ul style="list-style-type: none"> Description of the problem addressed A statement on why the current approach/policy option needs to be changed Your realistic recommendation for action
Context & Importance of Problem	<p>Aims to convince the audience that the current problem exists & requires action and it includes:</p> <ul style="list-style-type: none"> A clear statement of the problem or issue in focus A short overview of the roots of the problem A clear statement of the policy implications of the problem

9

What a Persuasive Policy Brief Should Be Like (1)? (Young & Quinn, n.d.)

- Targets a particular audience for your message
 - Common audiences are policymakers / decision makers
 - BUT for advocacy initiatives, target audience could be journalists, diplomats, administrators, and researchers
- Is your audience an individual (e.g. Minister of Health) or an organisation (DoH as a whole)?



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10

What a Persuasive Policy Brief Should Be Like(2)? (Young & Quinn, n.d.)

- Identify the relevant actors for the issue you are dealing with; this is essential to produce a good assessment of the context
- Identify what are the actors' interests? Which of the relevant actors have similar interests? Which one's have different interests?
- Understand the limitations of the research findings, be mindful of over-generalising, simplifying or falsely attributing the cause



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12

What a Persuasive Policy Brief Should Be Like(3)? (Young & Quinn, n.d.)

Strategically focused	The argument provided must build on what the audience know about the problem, provide insights about what they don't know & use language that will convince them
Solution-oriented	Audience interested to know the writer's perspective on the problem & potential solutions based on new evidence
Evidence-based	Audience will be convinced by argumentation supported by evidence that the problem exists and the consequences of adopting particular alternatives
Limited	The focus of the brief needs to be limited to a particular problem
Succinct	Policy briefs should not exceed 2-4 pages in length usually not longer than 1,500 words
Accessible	The writer should subdivide the text using clear descriptive titles to guide the reader
Promotional	Policy brief should catch the eye of the potential audience in order to create an impression (e.g. use colour, quotes etc.)
Practical & feasible	Policy brief is an action-oriented tool targeting policy practitioners, arguments must be based on what is happening in practice & propose realistic recommendations

Examples of Policy Briefs



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Policy Brief Challenge

- Trade-off between providing depth of context & delivering something that is succinct, targeted & digestible

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Do's and Don'ts (Kopinski, 2010)

- Avoid technical, legalistic, economic & academic jargon
- Use correct grammar & spelling, and appropriate spacing, font, headings and subheadings
- Facilitate readability through images, catchy phrases, and the provision of data as graphs or charts
- Presentation needs to be professional

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Policy Brief Checklist

- Is the title interesting, clear, succinct & descriptive?
- Are headings of all sections & sub-sections chosen effectively? Do they provide a clear overview of your brief?
- Is the executive summary a good representation of your brief?
- Do you clearly state out what your project sets out to do?
- Are conclusions supported by findings?
- Are recommendations practical? Is there a recommendation to match each conclusion?

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HEALTH POLICY BRIEF

DATE: JULY 2016

PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY: IMPROVING HEALTH OUTCOMES

EXECUTIVE SUMMARY

Health care services in South Africa are under increasing demands placing higher pressure on nurses who are in the forefront and the largest group in the health care sector. Nurses are closest to the patients and their families with the main responsibility of providing quality care. Nursing is therefore uniquely positioned to influence the health care priorities nationally yet they are underrepresented at all levels of health policy development. They are mainly implementers of policies. It is important that nurses understand and influence the health policy process in order to improve health outcomes.

INTRODUCTION

Nurses are the majority of health care professionals but they have been undervalued in the decision making circles that inform the nation's health policy. Given the complexity of S.A health care system reform they must be equipped to perform their leadership role so as to facilitate quality health care service delivery. Proactive participation in the policy arena is a key to excellence in clinical practice and education for nursing.

Literature (Khunou and Davhana-Maselesele 2016; Ditlopo et al. 2014; Juma et al., 2014; Ditlopo et al., 2014; Shariff and Potgieter 2012; Richter, Mill et al. 2012.) shows that nurses' role in health policy development is limited. Health policy is often formulated with little input from nurses, at the implementation level. Studies also maintain that policy making is "Top Down" in nature. Nurse leaders are implementers of policies, much as the researcher would like to see them involved at all the stages of the health policy development process. There are also challenges with the implementation of policies.

Policies are interpreted and implemented differently by various institutions e.g. OSD (Ditlopo et al., 2014). This could result from the absence of policy implementation guidelines. The policies are also not explained. The findings also suggest that the implementation difficulties stem partly from absence of the key actors (nurse leaders) at the policy development stage that would provide input on the operational mechanisms required for implementation. There was also no formal system of communicating gaps identified in the policy that affect implementation. The absence of feedback from grassroots policy implementers might lead to further suppression of the voices of nurses at the lower level (Juma, Edwards et al. (2014). Factors contributing to lack of participation of nurses in health policy development include political factors, gender issues, financial issues, limited resources; lack of skills training in policy development; image and status of nursing; leadership competency; and the inability to use research to influence policy making. (McAskill 2009), Kunaviktikul, Nantsupawat et al. (2010), (Chase 2013, Robinson 2013).

Nurse leaders are a vital resource for shaping health policy.

It is important to strengthen the capacity and participation of nurse leaders in health policy development to create effective policies as they are the main implementers. This would contribute to improved health outcomes and effective health service delivery. Since currently nurse leaders are prominent in implementation, the following policy options should be considered.

Policy Options

1. Enhancing participation of nurse leaders in the policy development process by increasing representation of nurses in the policy structures.
2. Deploying nurse leaders per province to participate in the policy development process so that they could facilitate implementation. Identify them from organised structures e.g. forums. Development of communication strategies for representatives. This option is costly which might be a barrier to its implementation.
3. Development of policy implementation guidelines for each policy. This would enhance consistency and standardization of

'Nurse Leaders could define the direction of the health policy'

policy implementation. This option is cost effective as it will eliminate the risk of failed execution of a policy which could result to a lack of success

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KZN Nurse Leaders (Nurse Manager's,
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Annexure 10: Workshop Evaluation Form

Workshop Title: Health Policy Development

Date: 19.02.2016

Please indicate the extent to which you agree or disagree with each statement by circling the number that applies.

1. Programme

NO! So-so YES

Was the workshop well organised?

1 2 3 4 5

Did the workshop meet your expectations/ objectives?

1 2 3 4 5

Was your role in relation to policy clarified?

1 2 3 4 5

Did the workshop increase your knowledge in health policy development?

1 2 3 4 5

Has your confidence level in relation to participation in policy issues increased from before the workshop?

1 2 3 4 5

2. Speaker

NO! So-so YES

Knowledgeable about subject?

1 2 3 4 5

Was the material presented informative and understandable?

1 2 3 4 5

Were the questions and discussion handled to your satisfaction? 1 2 3 4 5

3. Taking it with you.....

NO! So-so YES

Overall, was the workshop worthwhile?

1 2 3 4 5

Will you take action(s) on what you learned about the policy development issue?

1 2 3 4 5

Did you network with others whom you expect to hear from in future?

1 2 3 4 5

Would you be interested to be part of a forum that will discuss policy issues

1 2 3 4 5

Overall comments, feedback and realistic suggestions

.....

.....

.....

Annexure 11 Data Analysis Process

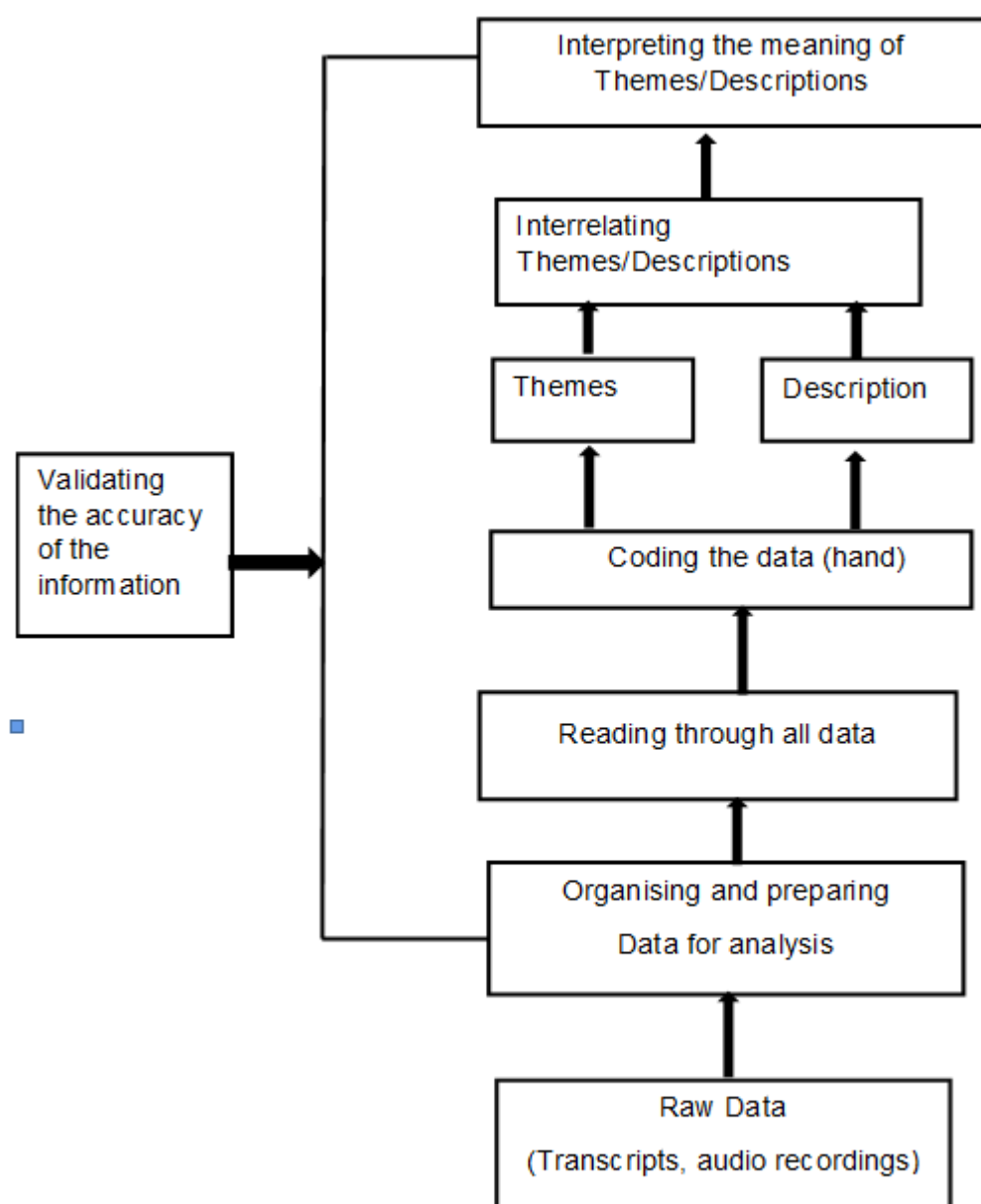


Figure 4.27 Data analysis process (Adapted from Creswell, 2014)

Annexure 12: List of KZN Health Districts and Hospitals

uGu (DC 21) Dunstall Farrell Hospital G.J. Crookes Hospital Murchison Hospital Port Shepstone Hospital** St. Andrews Hospital	uMgungundlovu (DC 22) Appelsbosch Hospital Edendale Hospital Doris Goodwin Hospital Fort Napier Hospital Grey's Hospital Northdale Hospital Richmond Hospital Townhill Hospital Umgeni Hospital	uThukela (DC 23) Emmaus Hospital Estcourt Hospital Ladysmith Hospital **	uMzinyathi (DC 24) Charles Johnson Memorial Hospital Church of Scotland Hospital Dundee Hospital Greytown Hospital
Amajuba (DC 25) Madadeni Hospital ** Newcastle Hospital** Niemeyer Memorial Hospital	Zululand Benedictine Hospital Ceza Hospital Itshelejuba Hospital Nkonjeni Hospital St. Francis Hospital Thulasizwe Hospital Vryheid Hospital	uMkhanyakude (DC 27) Bethesda Hospital Hlabisa Hospital Manguzi Hospital Mosvold Hospital Mseleni Hospital	uThungulu (DC 28) Catherine Booth Hospital Ekombe Hospital Eshowe Hospital Lower Umfolozi War Memorial Hospital Mbongolwane Hospital Ngwelezana Hospital Nkandla Hospital KwaMagwaza Hospital
iLembe (DC29) Montebello Hospital Stanger Hospital ** Umphumulo Hospital Untunjambili Hospital	Harry Gwala (Sisonke) (DC 43) Christ the King Hospital E.G and Usher Memorial Hospital Rietvlei Hospital St. Apollinaris Hospital St. Margaret's Hospital UMzimkhulu Hospital	eThekweni (Durban) Addington Hospital ** Charles James Hospital Clairwood hospital Don McKenzie hospital Ekuhlengeni Care Centre FOSA Hospital Hillcrest Hospital Inkosi Albert Luthuli Central Hospital ** King Dinuzulu Hospital Complex ** King Edward VIII Hospital** KZN Children's Hospital Mahatma Gandhi Hospital McCord Hospital Osindisweni Hospital Prince Mshiyeni Hospital ** R. K. Khan Hospital ** St. Aidan's Hospital Wentworth Hospital	** Participating Regional and Tertiary hospitals

Annexure 13: Confirmation of editing



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22 November 2016

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Zanele Dlamini

EDITING OF DOCTORAL THESIS OF ZANELE DLAMINI

I have an MA in English from University of Natal (now UKZN) and have been performing editing services through my company for eleven years. My company regularly edits the research dissertations, articles and theses of the School of Nursing, Environmental Studies and various other schools and disciplines at the University of KwaZulu-Natal and other institutions, as well as editing for publishing firms and private individuals on contract.

I hereby confirm that Shirley Moon edited the doctoral thesis of **Zanele Dlamini** titled "*PARTICIPATION OF NURSE LEADERS IN HEALTH POLICY DEVELOPMENT: AN ACTION RESEARCH APPROACH*" on behalf of WordWeavers cc and commented on the anomalies she was unable to rectify in the MS Word Track Changes and review mode by insertion of comment balloons prior to returning the document to the author. Corrections were made in respect of grammar, punctuation, spelling, syntax, tense, referencing and language usage as well as to sense and flow. There were many corrections to be made prior to the document being considered polished.

I trust that the document will prove acceptable in terms of editing criteria.

Yours faithfully

C Eberle

Catherine P. Eberle (MA: University of Natal)