

Intersection of National Policies on Nurses' Work
in District Health Care Systems in Kenya

by

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Dedication

To my beloved children Ronny, Peggy and Brenda, for your patience and affection as I pursued my doctoral studies in Canada while you were back home in Kenya. To my dearest parents Charles and Helen, for your inspiration, guidance, utmost love and unparalleled support that have enabled me to achieve my educational goals. To my brothers and sisters, for your prayers and incessant encouragement throughout my studies. Finally, to all the nurses in Kenya, for your voices remind me of the passion and commitment you have demonstrated to the “caring work” despite tough and challenging work environments.

Abstract

Health policy reforms have dominated health systems in African countries for over three decades. However, the impacts of these policies on nurses' work, as well as the extent to which the nurses are involved in the policy decisions, have not been well documented. As the largest group of health professionals in the workforce, nurses' services are necessary to achieve population health outcomes. Thus, nurses' work concerns related to the reform of national policies should be identified and addressed. This study was carried out to examine how the national policy reforms have impacted on nurses' work in Kenyan district health care systems and how nurses have been involved in policy processes in the health care system. Critical theory and feminist critical policy analysis perspectives guided the study. The study was implemented in two phases. The first phase involved qualitative interviews with 32 decision makers and nurses in the public health care system. The second phase involved a comparative quantitative survey of nurses and nurse managers in two districts. A sample of 169 nurses was interviewed in two district hospitals to generate data for this second phase of the study.

This thesis contains three manuscripts. The first manuscript presents a qualitative analysis of the impact of policies on nurses' work (Chapter 2). The second manuscript presents qualitative results of how nurses were involved in policy processes at various levels of the health care system (Chapter 3). The third manuscript presents results of a quantitative survey of frontline nurses' experiences with the policy reforms, comparing two districts (Chapter 4). An integrative discussion of key findings from all these manuscripts forms the last chapter of the thesis.

The findings revealed that policies meant to enhance access to services like decentralization and primary health care were more enabling to nurses' work while those aimed at enhancing efficiency like structural adjustment programs were more constraining. The constraints included poor work environments, unchanging work conditions, increased responsibilities and dilemmas in providing care. These constraints were experienced more by nurses in the district that was poorly resourced and had poor health indicators than the district that had better resources and better health indicators. The results suggest that inadequate involvement of nurses in policy processes is a reason why their work concerns have not been addressed. There are recommendations to improve nurses' work in the context of policy reform and to improve nurses' abilities to participate in policy processes.

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List of Acronyms

AIDS= Acquired Immunodeficiency Syndrome

DFID= Department for International Development

DFRD= District Focus for Rural Development

GDP=Gross Domestic Product

GHI=Global Health Initiatives

HIV=Human Immunodeficiency Virus

IDRC= International Development Research Center

ICN=International Nurses Congress

KHPF=Kenya Health Sector Policy Framework

KMA=Kenya Medical Association

KSSP= Kenya Health Sector Strategic Plan

MDGs=Millennium Development Goals

MOH=Ministry of Health

NGOs= Non Governmental Organizations

PHC=Primary Health Care

PEPFAR= President's Emergency Plan for AIDS Relief

PRSPs=Poverty Reduction Strategy Papers

SAPs=Structural Adjustment Programs

STI= Sexually Transmitted Infections

SWAPs=Sector Wide Approaches

WHO=World Health Organization

Chapter 1

Introduction

Globally, nurses¹ form an important health care workforce whose contributions are necessary for better population health outcomes. Nursing services are critical for the successful implementation of health interventions that are considered necessary for the achievement of national and international health and development goals, including the Millennium Development Goals (MDGs)² 4, 5 and 6, (Aiken, 2008; Chen et al., 2004; WHO, 2002; 2006). However, nurses in Africa work within complex contexts that make the delivery of effective services particularly difficult. Among these difficulties are poor employment conditions and challenging working environments (Dovlo, 2005, 2007; Kober & Van Damme, 2006). Some of these challenges can be attributed to national policy reforms that have affected nurses' work situations. This study examined how national policies have influenced nurses' work in the Kenyan district health care systems, from the perspectives of policy and decision makers at all levels of the health care system and from the perspectives of frontline nurses and nurse managers at district levels.

The study was based on the premise that policies influence nurses' work. To ensure effective health system responses and to protect patient safety, national policies should create an enabling environment and conditions for nurses to work effectively. However, studies have shown that some national policies implemented in health sectors in African countries since the 1980s have impacted negatively on health care systems

¹ The term 'nurses' is used to include registered nurses, enrolled nurses and midwives

² Millennium development goal number 4 is reducing child mortality; goal 5 is improving maternal health; and goal 6 is combating HIV/AIDS, malaria and other diseases.

with further consequences on health workers including nurses (Blas & Liambala, 2001; Lethbridge, 2004; Marteneau & Buchanan, 2000; Seengooba et al., 2007). Another important premise underlying this study was that in addition to providing services, nurses should contribute to policy-making processes that will advance the planning and subsequent quality of health services delivered, enhance nurses' work and subsequently improve the health of populations served. However, several studies in various settings have shown that nurses' involvement in national policy decisions has been inadequate (Antrobus & Kitson, 1999; Antrobus, 2004; Hewison, 1999; Gebbie, Wakefield & Kerfoot, 2000; ICN, 2005; Spenseley, Reutter & Allen, 2006; WHO, 2001, 2002, 2004). Thus, there was a need to explore how nurses contribute to national policies that influence their work in Africa and to examine mechanisms that could enhance nurses' contributions to policy-making processes.

Problem Statement

In Kenya, nurses face many challenges in service delivery including insufficient resources and high workloads (MOH, 2007; Rakuom, 2010). A steady supply of adequately trained nurses is considered critical for enhancing access to health care and maintaining the health of the population. However, the Kenyan health care system does not have an adequate number of nurses to meet current population health needs. In 2006, there were 16,145 nurses in the public health sector for a population of 32 million people, while it was estimated that the system needed 61,618 nurses (MOH, 2007). The nurse shortage has been attributed to government failure to hire nurses in the system, migration of nurses to other countries and other sectors, nurses shifting to other careers, and the retirement of nurses from the workforce (MOH, 2007). Furthermore, nurses are unevenly distributed across regions, with some provinces having more nurses than others. The

majority of nurses work in district and provincial hospitals, leading to extreme understaffing of the primary care facilities where most community members seek care (MOH, 2005). A recent study by Rakuom (2010) indicates that almost every functional health facility is understaffed and that in over 500 of Kenya's 2,122 dispensaries there are no nurses. He estimated that an average of 500 nurses retire annually at age 55 without replacement, and between 300 to 400 nurses migrate abroad annually. These shortages pose a challenge to the provision of quality services, especially at the lower levels of care where the workload is high and nurses are forced to take up roles for which they were not trained. Nurse shortages and other work challenges in Kenya could be linked to policy reforms that have been implemented in the health sector over the years (Rakuom, 2010). Yet empirical studies that have examined these challenges in relation to policy reforms are scarce.

Studies from other settings (Buchan, 2002, 2006; Buchan & Calman, 2004; Connel, Zurn, Stilwell, Awases & Braichet, 2007; Dovlo, 2007; Kingma, 2007; Marchal, Brouwere & Kegeks, 2005; Marchal, Brouwere & Kegels, 2005; Mitchel, 2003) and international reports (USAID, 2006; ICN, 2006, WHO, 2006) have raised critical concerns about nurses' work including persistent shortages, inequitable and poor remuneration, poor skills mix, a weak knowledge base, and factors that lead nurses to migrate from the public system including limited options for career progression and poor work environments. These issues are linked to poor quality of care to patients. In addition, various studies in Africa (Armstrong, 2003; Berrer, 2004; Ehlers, 2006; Hall, 2004; Horseman & Sheerman, 1995; Kober & Van Damme, 2006; Marchal, De Brouwere & Kegels, 2005; Phaladze, 2003; Smit, 2004) have found that with the rise of HIV/AIDS, nurses experienced increased workloads, a high rate of exposure to

infection, lack of employer support, ethical dilemmas and secrecyes and stigma of disease, stress and burn out, absenteeism and inadequate resources to manage care. Again, these studies have not provided adequate insights into how these issues are related to and potentially exacerbated by broader policy reforms. With the current need to scale-up health interventions and improve the quality of services in Kenya, there was a need to examine nurses' work issues in relation to policy reforms.

Purpose and Research Questions

Purpose

The primary purpose of this study was to carry out a critical analysis of how national policies affected nurses' work in Kenyan district health systems, from the perspectives of policy and decision-makers at all levels of the health care system and from the perspectives of frontline nurses and nurse managers at the district level. The study applied a critical social theory lens and feminist critical policy analysis perspective to understand nurses' work in relation to influential health reform policies.

Research questions

The major research questions addressed by this study were:

1. How have national health policies influenced nurses' work in the district health care systems in Kenya?
2. How have nurses been involved in the development and implementation of national health policies that affect their work at the district levels in Kenya?

Policy and Policy-making Process

There are dozens of definitions of policy in the literature. Two broad definitions were relevant to understanding policy in this study. The first is the definition by Pal (2001) who described policy as "a course of action or inaction chosen by the public

authorities to address a given problem or interrelated set of problems” (p. 2). The second definition is by Longest (2006) who defined “policy as authoritative decisions made by branches of government that are intended to direct or influence the actions, behaviors or decisions of others” (p.7). In the first definition, the phrase “actions and inactions” draws attention to the fact that decisions to either address or not address policy-related issues are equally important. In relation to nurses’ work, actions may include government directives on conditions of employment or resource allocation, and these directives may have a positive or negative impact on nurses’ work. On the other hand, inaction may result from failure to address other existing nurses’ work concerns. In the second definition, the phrase “authoritative decisions” is crucial as it refers to decisions that are made by various actors in the government, including legislators, executives and the judiciary, all of whom may at least indirectly influence nurses’ work.

Policies operate at global, state, professional, organizational, and individual levels (Cheek & Gibson, 1997; Malone, 2005; Taft & Nana, 2008). Policies are also developed at macro and micro levels. Macro-level policies are those developed at global, national or state levels; they tend to address more than one individual set of circumstances (Tolson et al., 2005). Micro-level policies include organizational (institutional or workplace) policies and professional policies (Malone, 2005; Russell & Fawcett, 2005). Policies at higher levels can supersede or preempt those at lower levels. For instance, certain global policies and declarations influence how health policies at national levels are developed. Thus, nurses’ work is embedded within policies operating at multiple levels.

Various theories around policy-making process have been described including rational³, incremental⁴ and stage sequential⁵ approaches (Hanley & Falk, 2007; Lindblom, 1980; Ripley, 1985; Pal, 2001). Oyugi and Kibua (2004) argued that these theories explain the various approaches adopted by policy analysts, but they are limited in terms of understanding public policy-making in the wider society. The policy-making process is complex and dynamic, and is described as a cyclic process that involves problem/issue identification; policy formulation, which includes agenda setting and development of legislation; policy implementation, which includes rule-making and actual operationalization; and evaluation and modification (Longest, 2006; Hanley & Falk). Kingdon's model (2003) describes the policy-making process as a series of three streams including a problem stream, policy stream and political stream. The problems stream refers to broad societal problems and conditions that require public attention. The policy stream refers to the policy alternatives and proposals that are applied by policy makers to address the problems. Politics stream includes the political transitions, national mood and social pressure. Kingdon explained further that policies change when there is a window of opportunity for policy reform, which opens either because of a change in a political stream or because a new problem captures political attention. However, Kingdon stressed that such windows of opportunity are limited and do not last long. Sabatier (1999) described an "Advocacy Coalition Framework" that analyses policy development

³ A more abstract prescriptive model which identifies values, goals and selects best policy options based on comprehensive information including consequences, costs and benefits of each alternative. It focuses on ideal solutions in face of political pressures. This aspect renders it unrealistic (Hanley & Falk, 2007; Pal, 2001).

⁴ A process of bargaining between groups with different perceptions of facts and interests. Involves making small changes. Also known as the process of "muddling through" (Lindblom, 1980)

⁵ Policy process viewed as a sequential series of stages of functional activities. Policy moves from problem to program in a stepwise process (Ripley, 1985).

and dynamics of interaction within policy subsystems based on participants' values and beliefs over time.

Politics and power have been described as major influences on policy processes (Baker, 1996; Longest, 2004; Stone, 1998). Cheek and Gibson (1996) argued that policy is a political exercise that is often guided by values expressed by a politically dominant group, and that ideologies and language in policy documents represent the outcome of power in institutions that influence policies. Power is recognized as a key influence over policy development and implementation (Erasmus & Gilson, 2008). Baker argued that resources, ideas and technology are important in the policy process, but the way in which these are used depends upon the distribution of power in a society. Baker argued further that power provides dynamics for a policy process that is understood by examining how people relate to each other within organizations and the role people play in different structures. Systems theory has also been used in policy analysis to depict power play within the systems. Stewart and Ayers (2001) contended that existing social and political structures tend to force ill-considered decisions, which fail to bring system actors together in more productive ways.

The dynamic and inherent complexities in policy formulation processes presented here call for a critical analysis of policy consequences on various stakeholders, particularly on nurses who are the majority health care providers and implementers of these policies.

Literature Review

Purpose, scope and method

The literature on health policy reforms implemented in African countries was reviewed to identify the extent to which authors had addressed nurses' work issues. The literature was limited to those policies that were implemented from 1980 to date because most of the reform policies that impact on health services and nurses' work in most countries in Africa were introduced and implemented around or following the early 1980s. Another set of studies was reviewed to examine how nurses contributed to national policy processes. Articles were identified and retrieved from various databases including, CINAHL, MEDLINE and PubMed as well as search engines such as Google Scholar and SCIRUS. Specific journals were also hand searched including international journals on nursing, health services, policy, health administration and management. The key words used in the search either as single words or in combination included: public policies, nursing, health policies, health reforms, economic policies, macroeconomic policies, developing countries, Africa, and nursing regulation. Abstracts of published articles were read first and only relevant articles that seemed to address the research questions were retrieved for review. Tables were developed to abstract information from relevant articles for critique and evaluation.

Literature Review Findings

Findings of the literature review are summarized in the following sections. Policy reforms implemented in Africa, contextual influence on national policy reforms, nurses' work in the context of these policies and nurses' involvement in policy processes are described.

Policy Reforms Implemented in Africa

One of the major policy reforms implemented in African countries from the late 1980s was primary health care (PHC). PHC was adopted after the Alma-Ata Declaration on Health for All by the Year 2000 (WHO, 1978; Bennet, 1979). The Declaration stemmed from the need to move from failed vertical disease-oriented programmes such as malaria eradication to a more integrated and horizontal health systems approach. The Declaration also emphasized equitable health service provision as a fundamental human right (Smith & Bryant, 1988). This shift led to more international funding for PHC for low income countries but with an emphasis on essential elements of care rather than a comprehensive approach (Besner, 2004; Green, 1999; Sen & Koivusalo, 1998).

With the African governments support for PHC at the Alma Ata Conference in 1978, PHC became a major component of the health care systems in African countries (Amaah, 1989; Dugbatey, 1999). The emphasis of PHC in these countries was on preventive and curative interventions, local community involvement, and improvement of health as well as social environment through effective intersectoral action (Smith & Bryant, 1988; Amaah, 1989). Although this comprehensive approach to PHC was advocated for in Alma Ata, its implementation proved to be complex at local levels, given limited resources (Walsh & Waren, 1979; Rifkin & Walt, 1986). This contributed to the adoption of a selective PHC approach, which involved selective interventions that were viewed as efficient in reducing child mortality (Walsh & Waren, 1979).

Though there was some initial progress in improving certain health parameters, such as child health health for all was not achieved by any of the African countries including Kenya (Chotara & Tumusime, 2004; Frenk, 1994). This failure was also attributed to many factors including economic crises and neoliberal policy reforms that

reduced public sector financing and weakened human resource capacity as well as changes in public sector organizations (Ehlers & Phil, 2000; Gilson & Mills, 1995; Foster, 2005). Despite these limitations, PHC principles continue to guide health services planning as well as nursing practice. The current emphasis on revitalizing comprehensive PHC suggests better human resource planning, training and motivation (Bhatia, & Rifkin, 2010; Besner, 2004; Gilson et al., 2007; Lawn et al., 2008; Macdonald, 2004). This provides an opportunity to strengthen nurses' capacity to meet population health care needs in the context of PHC. Even though PHC has been the focus of health care systems in African countries, empirical literature on how this approach has impacted on nurses' work in Africa is scarce.

The World Health Organization (WHO) recognized the important role of nurses and midwives in PHC and passed a resolution in 1989 on strengthening nursing and midwifery in support of the health for all strategy (Besner, 2004). Nurses were to play a role in shifting services from a focus on illness and cure to a focus on health promotion and disease prevention. In Kenya, nurses' role in PHC included participation in health education, occupational health and safety, community midwifery, maternal and child health, and more recently, home-based care (MOH, 2007). While PHC activities require more engagement of nurses at community levels, nursing in Kenya has traditionally been heavily hospital-based (MOH, 2007).

Policies relating to structural Adjustment Programs (SAPs) have been widely critiqued in literature. The World Bank and the International Monetary Fund introduced these policies in African countries in the early 1980s as conditions for the provision of loans. These policy changes were introduced as a result of economic crises characterized by rising oil prices; higher interest rates; rising neoconservative politics in US, UK and

Germany; and a debt crisis that pushed some borrowing countries to default, and threatened the stability of major banks in industrialized countries (Labonte et al., 2004; Logie & Woodroffe, 1993). These changes included domestic market liberalization, currency devaluation, deregulation of prices on commodities, and a declining role of nation states in goods and service provision in favor of the private sector (Labonte et al., 2004). Literature on the implementation of SAPs reveals similar outcomes across African countries, including weakened public health care systems with adverse reductions in financial allocations to the public sector and constrained human and fiscal resources, which depleted working environments (Gilson, et al. 2003; Logie & McIntyre et al., 2007; Mwabu, 1995; Sahn & Berner, 1995; Woodroffe, 1993). In particular, there is evidence that these policies adversely affected the performance of health systems with regard to supply, with chronic underfunding of infrastructure and public health, reductions in the number and quality of health personnel including doctors and nurses, and worsening access to health care for the poor (Gilson, & McIntyre, 2005; Palmer, et al. 2004).

Even with increased international funding for HIV and other health interventions, the resource constraints have continued in the systems (Barker, 2010; McIntyre, Gilson, Dahlgren & Tang, 2007; Olesen, 2010). Nurses, who constitute the majority of health providers, continue to bear the burden of working under such resource constraints. While most studies have concentrated on the negative side of SAPs, Barker (1996) noted that the SAPs process was instrumental in bringing a positive relationship between developed and developing countries through development aid processes. A proportion of total resources for health interventions in African health care systems is from international aid.

More recently, a higher percentage of funding for HIV/AIDS came from Global Health Initiatives (Ghebreyesus, 2010; Oomman, Bernstein & Rosenzweig, 2007).

Following critiques of SAPs including lack of involvement of borrowing countries in decisions about the policies, the World Bank and International Monetary Fund introduced another set of policies in the form of Poverty Reduction Strategic Papers (PRSPs) for countries soliciting for debt relief and financial support (DFID, 2003; Laterveer, Niesen & Yazbeck, 2003). This change required affected countries to develop papers stating their macro-economic, structural and social policies for achieving economic growth, poverty reduction and major sources of finance through multi-sectoral approaches to address poverty issues. Again, many countries in Africa, including Kenya complied. A review of PRSPs in Africa showed that human resource issues in the health sector were not well addressed in the agendas set out in these papers (DFID, 2003; Marchal, De Brouwere, & Kegels, 2005). There is minimal documentation on the extent to which the goals have been achieved, or the extent to which the papers have addressed nursing service delivery and access to services by the poor. Furthermore, PRSPs were claimed to have taken the place of the SAPs as the content of these PRSPs turned out to be quite similar to the original content of SAPs (Labonte et al., 2004). More recently PRSPs have been implemented in the form of Sector Wide Approaches (SWAPS) aimed at strengthening partnerships at national levels to enhance external resource generation, planning and utilization (Else et al., 2005). The impact of poverty reduction strategies and a sector wide approach on nurses' work in Africa has not been examined.

Many authors have reviewed another important set of health sector reform policies focusing on decentralization, privatization and financing (Bossert & Beauvais 2002; Collins, Green & Hunter 1999; Gilson, 1995; Gilson et al., 2003; Homedes &

Ugalde, 2005; Hutchinson, Akin & Ssengooba, 2006; Mwabu, 1995; Mwabu, & Wang'ombe, 1997; Sahn & Berner, 1995; Sen & Koivusalo 1998; Oyaya & Rifkins, 2003; Owino et al. 2000). These reforms, spelt out in the 1990s, focused on enhancing efficiency through increasing competition, containing costs, and refocusing the role of government from direct delivery of health care services to regulating its delivery by non-governmental sectors (Barker, 1996). The literature on these changes indicated that the implementation of these reforms did not achieve much in enhancing access and quality care. The studies revealed various implementation problems and gaps including top-down implementation and lack of ownership among key stakeholders, inadequate resources and political support, and bureaucratic barriers. Furthermore, there was lack of recognition of the critical role of human resources capacity in enhancing quality services.

Contextual Influences on National Policies

The reform policies are products of a large number of determinants, including historical, political, socio-economic, geographic and technological contexts (Barker, 2006). These contextual factors may explain why certain national policies had a negative impact on nurses' work. The most obvious need for policy reforms has been to redress large and growing inequalities in health and health care access that mirror growing inequalities in wealth and power (Lister, 2005; Macdonald, 2004; Standing, 1997). However, wide inequalities exist between and within countries. For instance, sub-Saharan Africa had 24% of the global burden of disease, but only 3% of the global health workforce in 2006 (WHO, 2006). In contrast, the Americas had 10% of the global burden of disease and 37% of the global health workforce. Within countries, health inequalities exist between rural and urban areas, and rural populations often have poorer access to health services. Even though some of the reforms were intended to address these

inequalities and access issues, the literature reveals that the reform policies implemented in developing countries have instead increased inequalities and failed to address crucial health care concerns, including adequate resources for service delivery (Lister, 2005).

Changes in political and wider socio-economic contexts also influence decisions on national policy agendas, as well as policy formulation and implementation processes (Collins, Green, & Hunter, 1999; Walt & Gilson, 1994). A study on health care reforms in developing countries highlighted the historical context of the reforms, which stem from the colonial period; political contexts, which fuelled the implementation of the widely criticized structural adjustment programs; and ideological contexts, which drove these reforms (Sen & Koivusalo, 1998). Gilson et al. (2003) described how political transitions in South Africa and Zambia provided political leaders, specifically ministers of health, with windows of opportunity in which to introduce new policies. However, structures introduced with the policies created environments that constrained health reform design and service delivery. Furthermore, policy implementation received weak political support. A qualitative study by Ehlers and Phil (2000) described how a shifting political situation in South Africa since 1994 has affected nursing and health care practices through changes in laws, regulations, legislation and policies. Although nurses went on strike when the policies were introduced, their voices and concerns were not heard.

Another element that has influenced policy reforms in developing countries is globalization. The impact of globalization is seen through the interdependence of national economies within global economic systems (Labonte et al., 2005; Lister, 2005). While there are positive effects of globalization, including developments in technology, more disadvantages have been felt in developing countries, particularly through adoption of the

neo-liberal macro-economic policies driven by external international institutions (Frenk et al., 1997; Thomas & Thiede, 2004). The policies are said to have been designed by technocrats who did not take local contextual factors, such as political, economic and institutional cultures, into consideration (Oyaya & Rifkins, 2003; Walt & Gilson, 1994). The lack of consideration of local contexts resulted in implementation gaps on the frontlines of health care (Oyaya & Rifkin, 2003). Globalization has also facilitated the migration of health workers from Africa to higher income countries, leading to a greater shortage in the source countries (Buchan, 2006; Dovlo, 2004; Marchal & Kegels, 2003).

The persistent weaknesses and resource constraints in African health systems also led to corrective policy prescriptions (Streefland, 2005). Such prescriptions included commercialization of health services and decentralization and civil service reforms. However, these adversely affected the availability of human resources and the quality of service delivery (MOH, 2007). Another health system challenge was brought about by political structures, which gave ministries of health minimal power in making certain decisions regarding their operation, such as decisions on human resource recruitment, which are often influenced by other government sectors (Vujik & Pascal, 2006). The health care systems in Africa have been weakened further by the changing epidemiological trends and high morbidity and mortality resulting from increased communicable and non-communicable diseases. Furthermore, some communicable diseases such as HIV/AIDS have also become chronic diseases (Frenk, Bodalilla, Sepulveda & Lopez, 1989). These trends have produced high demands on the health care system, further straining health care resources.

Nurses' Work in the Context of Policy Reforms

Very few studies have examined the impact of the foregoing policy reforms on nurses' work in African countries. In South Africa, Gilson & Walker (2004) conducted a case study on perceptions of 113 nurses on the free care policy in South Africa. Nurses in their study reported that the policy led to increased curative service utilization but reduced preventive services, increased workloads and working hours with little or no monetary compensation, and resulted in lower morale and worse attitudes towards patients among nurses. Similar effects of national policy reforms were found in a qualitative study in Zimbabwe (Basset, Bijlmakers & Sanders, 1997) where nurses were retrenched, leading to shortages and difficult working conditions, high workload, and subsequent challenges to implementing policies. The nurses' work environment did not support the professional values they had been taught. Communities expressed dissatisfaction with nurses' attitudes and with the quality of nursing services, especially in urban areas.

Studies focusing on human resources for health care (Chen et al., 2004; Dussault & Dubois 2003; Fritzen, 2007; Glennard & Annel, 2003; Haaland & Vlassof, 2001; JLI, 2004; Marchal, Brouwere, & Kegels, 2005; Martinez & Martinue, 1998; Parent et al., 2005; USAID, 2003; Wharad & Robinsons, 1999) reveal complex challenges that are pertinent to nurses' work in the context of policy reforms. These challenges include: inequities in resource distribution, massive imbalances, and chronic underinvestment in human resources, poor work conditions, and weaknesses in current approaches to human resource management. Most of these studies emphasize the severity of these issues in Africa. They have attributed the existing scenario to political and socio-economic changes as well as to gaps in national policy implementation. However, these studies do

not provide an in-depth analysis of interactions between specific policy reforms and nurses' work.

Some authors have suggested using management-oriented options for improving health workers' situation. Options most commonly described include improving the interaction between supply and demand of health workers, setting workplace norms and codes of conduct, adequate information and communication, adequate infrastructure, good management and leadership, education and continuous training and improving working conditions (Dussault & Dubios, 2003; Martinez & Martineu, 1998; Vujik & Pascal, 2006; WHO, 2006). While these suggestions are pertinent to improving nurses' current work situations, these options can only be achieved if supported strongly by broader national policy reforms. Such reforms require political will and the active participation of health workers in policy decisions.

International organizations, such as World Health Organization and International Congress of Nurses (ICN), provide continuous policy directives related to nurses' work in Africa (WHO, 2002; 2004). More recently, WHO has proposed three areas for improving the nursing situation including scaling up nursing and midwifery capacity, enhancing skills mix of existing and new cadres of workers, and creating positive workplace environments (MOH, 2007; WHO, 2002). These proposed options have not been adequately addressed in African countries. Furthermore, some of the suggested quick fixes, like shortening training periods and increasing employment of untrained nurses, are contrary to calls by professional nursing organizations for more professionally-trained nurses in the system to ensure better quality of care and to reduce the mistrust of people towards the health care system (Banschbach, 2003; Oulton, 2006).

Involvement of Nurses in Policy Processes

Despite many international recommendations for nurses to participate in health systems' decision-making at all levels, studies from a number of countries reveal that nurses do not contribute substantially to national policy decisions (Abood, 2007; Antrobus, 2004; Antrobus & Kitson, 1999; Boswell, Cannon & Miller, 2005; Buchan & Calman, 2004; Deschaine & Schaffer, 2003; Hewison, 1999; ICN, 2005; Reutter & Allen, 2006; Reutter & Duncan, 2002; WHO, 2001; WHO, 2004). These authors have attributed nurses' underengagement in national policy formulation to lack of professional status, gender-based biases in the health care system, and nurses' lack of knowledge about policy processes.

Even though studies on nurses' involvement in policies in Africa are scarce, studies from other contexts suggest that various strategies could enhance nurses' involvement in policy processes. Strategies include integrating policy courses in nurses' regular training, or offering internship or fellowship programs which emphasize a broader understanding of policies and policy influence (Hannigan & Burnard, 2000; Leavette, Chafee & Vance, 2007; Reutter & Duncan, 2002; Taft & Nana, 2008). Others have suggested developing leadership competencies to influence policies (Antrobus & Atkinson, 1999; Banschbach, 2008; Borthwick & Galbally, 2001; Cook, 2008; Ferguson, 2002; Ferguson & Drenkard, 2003). Several studies have emphasized the need to strengthen nurses' capacity in utilizing research to inform policy decisions (Edwards et al., 2009; Lee, Tinevez & Said, 2002; O'Brien-Pallas & Bauman, 2000; Shaibu, 2006; West & Scott, 2000). Enhancing nurses' capacity in research would enable nurses to have credible information to influence health policies in the system.

Summary of Literature Review

National policies implemented in Africa from the 1980s have been widely criticized for their negative consequences on health service delivery in Africa with further negative impacts on nurses' work. Many studies have reported critical concerns about nurses work situation in Africa. However, studies reporting in-depth interaction between specific national policy reforms and nurses' work were scarce. Furthermore, most of the reported studies have been undertaken in the southern region of Africa and not Eastern African region where this study was conducted. Given that these policies have shifted the distribution of health human resource and influenced changes in health professional roles, and given major differences in the economic, socio-cultural and political milieu of countries in the southern and eastern regions of Africa, there is a critical need for research on the effects of these policies on nurses working in East Africa.

Studies on policy reforms examined government documents and viewpoints of policy makers but not viewpoints of nurses. There was inadequate application of critical theory and feminist perspectives in analysis of nurses work situation. In addition very few studies applied mixed methods in understanding nurses work situation in relation to policy reforms.

Theoretical Underpinnings

Knowledge generation is guided by various knowledge claims and levels of understanding. The paradigmatic knowledge claims described by Guba and Lincoln (1994) include positivism and post positivism, critical social theory, and constructivism. Each knowledge claim provides varied perspectives on what constitutes the nature of reality (ontology), what counts as knowledge (epistemology), how we understand reality (methodology) and how evidence can be collected on reality (methods). In this study,

critical social theory provides the overall paradigm of inquiry (Guba & Lincoln, 1994; 2000; Maggs-Raport, 2001). This section highlights the epistemological and ontological understanding of critical theory that guided the inquiry processes. The focus is on the nature of reality and what counts as knowledge in understanding how policies affect nurses' work. In addition, feminist perspectives incorporated in the policy analysis are described. Socio-ecological theory guided the original conceptual framework and this is also discussed in this section.

Critical Social Theory

Critical social theory is associated with a group of philosophers from the Frankfurt school (Horkheimer 1895-1973, Marcuse, 1898-1979; and Adorno, 1903-1969) interpreting Marxist philosophy of the 1920s (Campbell & Standing, 1991). The theory evolved to address the effects of domination in social relationships, and the emancipation of individuals from all forms of social domination (Campbell & Standing, 1991). The early thinkers of critical social theory believed that exploration for social change would only come through an understanding of reality (Maggs-Rapport, 2000). The most recent work in critical theory is drawn from interpretations of the work of Jurgen Habermas (Grumley, 2005; Mill, Marion & Marrow, 2000; Nielsen, 1990; Ray, 1994). In this context, a researcher's view of reality is varied, and thus allows for application of different ways of inquiry or methods in addressing specific research problems.

According to Guba and Lincoln (2000), the ontological stance of critical theory is "*historical realism in which reality is shaped by the social, political, cultural, economic, ethnic, and gender values crystallized over time, and therefore there is no one objective reality*" (p. 110). Thus, in this study it was assumed that nurses' work is shaped by various contextual factors; however, factors related to historical policies that affect

nurses' work in the current context were of particular concern. The epistemological stance of critical theory is that knowledge is transactional and subjective and is generated through structural and historical insights (Guba & Lincoln, 1994, 2000). Thus, critical policy analysis can enhance our understanding of how policies reflect certain realities on nurses' work, and the social structures that influence these realities, as well as sources of power and control that underpin them (Cheek & Gibson, 1997). In this study, the interaction between nurses' work and national policies was understood through nurses' experiences with policies, and through nurses' perceptions about the structures and processes that influenced policy decisions.

In understanding policy issues, many authors have argued for a broad critical policy analysis that involves looking at policy context, content, and process (Cheek & Gibson, 1997; Collins, Green & Hunter, 1999; Duncan & Reutter, 2006; Gilson & Mills, 1995; Walt & Gilson, 1994). Critical policy analysis helps in exposing the realities and interactions among policy contexts, contents and processes (Walt & Gilson, 1994). The policy context includes political, social and historical influences on policy making; policy processes include values, actors and agenda setting; and policy contents include proposed and implemented problems and instruments (Reutter & Duncan, 2006; Walt & Gilson, 1994). In the context of critical theory, policy analysis exposes ideology and values underlying policy issues and their proposed solutions, interests and assumptions (Reutter & Duncan, 2006). In matters concerning health provision, critical theory helps in understanding how providers of health care experience the reality of policy problems and solutions in their work. The theory provides a general framework and methodological approach for research, as well as a basis for considering the implications of national policies on nurses' and health care outcomes (Mill, Marion & Marrow, 2001). In this

study, critical theory was applied to analyze how national policies had influenced nurses' work in the district health care systems in Kenya. The theory helped in understanding contexts in which national policies affecting nurses' work were formulated, the processes by which the national policies were implemented, the ideas and values guiding these processes, and nurses' contributions to policy-making processes.

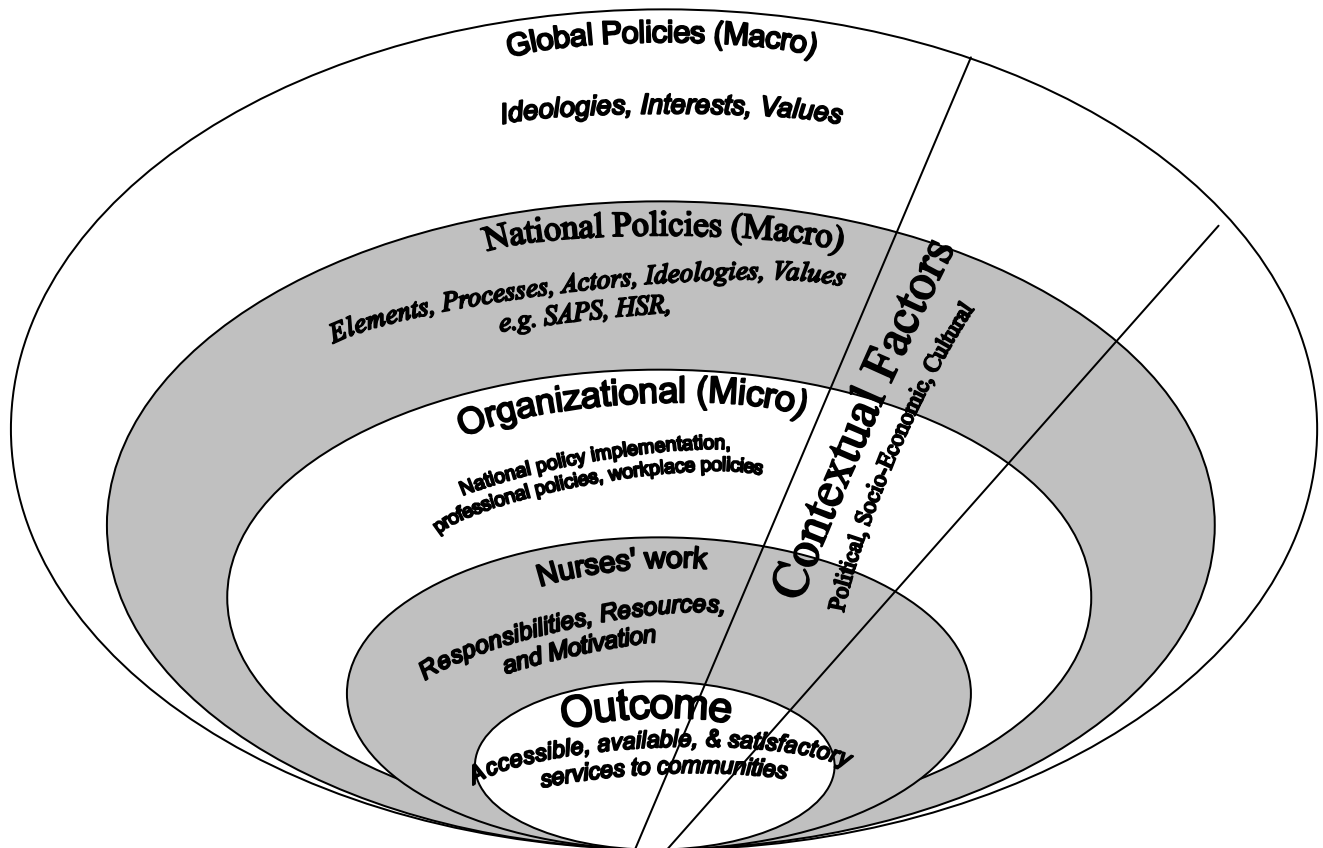
Feminist theory

Feminist theories are related to critical theory but focus on gender domination and discrimination within patriarchal societies (Cook & Fonow, 1990; Reinharz, 1992). Policy analysis using a feminist lens illuminates gender issues that place women at the margin of policy as well as present barriers to women's access to opportunities (Shaw, 2004; Marshal, 2000; Standing, 2004). Gender is built into organizations and formal power structures that create or maintain gender inequality, thereby systematically advantaging men over women (Kanter, 1998; Meyers, Anderson & Risman, 1998; Orloff & Palier, 2009). Thus, feminist theories aim to address any form of exploitation and oppression of women by these structures and institutions in order to enhance empowerment and transformation for change (Cook & Fonow, 1990; Olesen, 2000). Even though various institutions have historically created conditions that favor men over women, Standing (2004) argued that women have made some important inroads into existing structures, notably through the nursing profession. Feminist perspectives to policy analysis were applied in this study to determine the gender-based elements of policies that affect nurses' work, as well as policy actions or inactions with discriminatory implications for nurses whether they are men or women.

Conceptual Framework

A socio-ecological model also guided development of the conceptual framework for this study (McLeroy, Bebeau, Skeckler & Glanz, 1988). The model purports that changes in the social environment including organizational, workplace, community and public policies will produce changes in individuals (Edwards, Mill & Kothari, 2004; McLeroy, Bebeau, Skeckler & Glanz, 1988). In examining an issue related to health and health care, this model helps in describing the underlying contextual (determinants) factors and layers of interaction among them. Issues are nested within these factors. In the case of nurses' work, policies that influence their work are made at global, national, and organizational levels. The macro policies formulated at global and national levels influence how decisions about service delivery are made and by whom, how health sector policies are developed in the country, and in turn, how these policies give directives regarding human resources. The model infers that it is important to study the influence of policies from multiple levels. The model is congruent with critical theory in that it looks at the historical influences of a phenomenon. However, the socio-ecological model does not give adequate directions on enquiry processes (Edwards, Mill & Kothari, 2004). Thus critical social theory and feminist perspectives have been integrated to enhance the methods and results of the study. The overall conceptual framework used to guide the study is illustrated in Figure 1 below:

Figure 1. Conceptual framework of the interaction between nurses' work and policies



Description of Elements in the Conceptual Framework

In this framework, the outer layer represents global health policy reforms, which have been shown to influence the development of national policies that eventually affect nursing services. Global policies like those linked to health sector reforms may also affect nurses' work directly and indirectly. The second layer represents the national (macro) policies. In Kenya, a broad set of economic and health sector reform policies have been implemented at macro and micro levels and have had an impact on nurses' work in district health care systems. These global policies and their development processes have been influenced by different ideologies, values and interests of many players. These policies influence how decisions are made and by whom at other system levels, how

health policy foci change over time, and how these policies direct national and district level decisions about health human resources and service delivery. The next layer shows the organizational policies, which include professional regulations and workplace policies and rules. These intersect with national policies to influence nurses' work. The contextual factors cut across all levels of policies, and they include both global and domestic political, socio-economic, and cultural factors.

Beyond the multi-level influences on nurses that are highlighted by this framework, the nesting of nurses within different levels of contextual factors and policies is a highly pertinent feature of the framework. It is this feature that broadens our understanding of how policy context and processes affect nurses' work. The other important characteristic is the intersection of these policies and their interaction with nurses' work. These interactions may cause both positive and negative effects on nurses' work. Addressing negative interactions would result in improving nurses' work. The outcome would include enhanced quality of services to the community, measured in terms of availability and accessibility, as well as long-term improvements in general health status of the population.

Methodology and Implementation

This study was a two-phased mixed methods study. The objectives for the first phase were to: 1) analyze how national policies influenced nurses' work in the district health care systems in Kenya; and 2) examine how nurses were involved in policy development and implementation processes in the health sector from the perspectives of nurses and decision-makers at all levels of the health care system. The second phase involved a comparative quantitative survey of nurses and managers in two districts. The

objectives for this comparative phase were to: 1) determine which national policies were most enabling or most constraining on nurses' work in the district health care system, and 2) determine the extent to which nurses engaged in national health sector policy processes and 3) determine whether nurses experienced more national policy-related constraints in a district that was resource constrained and had poor health indicators (Kisumu) in comparison with a district that had higher resources and better health indicators (Nyeri).

Mixed Methods Design

The study applied a mixed methods design in data collection and analysis. Mixed methods research is recognized as a third research paradigm along with qualitative and quantitative research paradigms (Johnson, Onwegbuzie & Turner, 2007). The design was based on the premise that researchers can combine different research methods (that is, qualitative and quantitative) and different techniques for data collection, analysis and interpretation in a single study (Creswell, 2003; Morse, 2003; Sandelowski, 2000; Tashakkorri & Teddlie, 2003). A premise of mixed methods design is that social phenomena and lived realities are multidimensional and our understanding of them may be inadequate if we view them only on a single dimension (Mason, 2006). In this study, the phenomenon of interest is nurses' work in relation to national policies and the perspectives of nurses and decision-makers were sought. The design was consistent with the orientation of critical theory and feminist perspectives, which both emphasize analyzing data from various sources and examining the experiences of those who are being studied. In this study data was from decision makers at all levels, nurse leaders, frontline nurses and managers as well as policy documents in the health sector.

Both qualitative and quantitative methods of data collection and analysis were applied to obtain rich information about the influence of national policies on nurses' work. Qualitative method was the dominant method driving this study process. The mixed method design was sequential with qualitative data collection occurring during the first phase and quantitative data collection occurring during the second phase (Creswell, 2003). Qualitative data also informed the development of a quantitative tool for the second phase of the study. Analysis of data and presentation of the results followed theoretical perspectives from critical social theory and feminist perspectives.

Study Setting and Sampling

The study was carried out in the Kenyan public health care system (government sector), because this sector is where the majority of nurses worked. The Kenyan government is the major health provider, responsible for about 55% of service provision and the private sector (including church based facilities) is responsible for about 45% of service provision (MOH, 2005). The health delivery system is organized in a pyramidal structure with six levels of care. The community is the first level, followed by dispensaries and medical clinics, health centres and nursing homes, primary hospitals at the district level, secondary hospitals at the provincial level and tertiary hospitals at the national level. The majority of Kenyan nurses work within the districts.

At the national level, the Ministry of Health headquarters was included because of its central mandate of developing policies. At the provincial level, two provinces (Nyanza and Central) were selected purposively on two characteristics. One province had poor health indicators and few health service resources, while the second province had better health indicators and more health service resources (DHS, 2004). Two districts in each

of the provinces were selected, followed by a convenient selection of the main district level public hospitals. Decision-makers at national, provincial and district levels were sampled purposively (Sandelowsky, 2000; Teddlie & Yu, 2006), based upon their positions in policy development and/or in overseeing policy implementation. Nurses and nurse managers in the hospitals were selected based on a sufficiently long work history to have familiarity with many of the policy changes affecting health system and nurses' work in Kenya.

Study Implementation

The study was implemented in two phases. In phase one, concurrent data collection and analysis started in October 2008 following receipt of ethical approvals and institutional permissions (Appendix A). Study participants were sent letters of invitation and information sheets (Appendix B). The researcher then followed up with participants to arrange interview dates and times. After sharing and signing the consent form, the participants shared their views on how national policies impacted on nurses' work at the district health care systems. Key informant guides for each participant group were used during the interviews (Appendix C). Data were analyzed using established qualitative data analysis methods. The detailed description of analysis and findings for this phase are presented in Chapters two and three.

Phase two commenced with the development of a quantitative survey tool using qualitative data that had been collected during phase one (Appendix E). A detailed description of the tool development process is provided in chapter four. After ethical approval for this phase, data collection was carried out in December 2009 and January 2010. A total of 169 out of 180 nurses and nurse managers approached completed and

returned the questionnaires the selected two district level hospitals. The data were analyzed using SPSS (version 12.0). Details regarding methods and findings are presented in chapter four.

Ethical and Organizational Approval

Ethical approvals were obtained from the University of Ottawa and Great Lakes University in Kenya (Appendix D-Ethical approval certificate for phase two).

Organizational approvals were obtained from the Kenyan Ministry of Health headquarters, the provincial health offices, district offices and the two hospitals from where study participants were recruited.

Ethical considerations included ensuring that all participants were fully informed and that participation was voluntary. Study participants were invited by a letter of information and requested to participate in the study (Appendix E). All the participants who were willing to participate in the first phase signed consent forms. Participants' privacy was maintained during interviews and information shared with the participants was kept confidential. No revealing information was kept in the transcripts. Any identifying information in audiotapes was excluded from the transcripts. Participants were reminded to say only what they chose to say and that they could withdraw from the study at any point if they wished to, without any repercussions. Participants were asked for permission to use their quotes as part of consent procedures. Their names and place of employment were not identified with their quotes.

For the survey, participants indicated their consent by completing the survey questionnaire after reading the study information. Anonymity, privacy and confidentiality

of the participants were observed. Unique numerical codes were used for all the institutions and the respondents.

Outline of the dissertation

The dissertation is divided into five chapters. Chapter one has provided the general introduction, including the background, literature review and methodology applied in the study. The next three chapters present the results in three manuscripts. The first manuscript presented in chapter two focuses on results from the phase one qualitative findings. The paper is titled; “*Health sector reform policies: Realities of nurses’ work at the district levels*” and it will be submitted for publication to the Journal of Health Policy and Planning. This manuscript addresses the first objective of the study, which looked at the impact of policies on nurses’ work in district health care systems. Chapter three consists of the second manuscript, which provides additional findings from the qualitative phase, examining how nurses have been involved in policy processes. The paper is titled “*Nurses’ involvement in national health policy processes in Kenya*”. This paper will be submitted to the Journal of Health Services Research. The fourth chapter presents the third manuscript that focuses on the quantitative survey findings, comparing perceptions of frontline nurses and managers working in two districts of Kenya. The manuscript is titled “*Frontline nurses’ perceptions about health policies in Kenya*”. This paper will be submitted to the Journal of Policy, Politics and Nursing Practice. The last chapter is an integrative discussion of the study findings presented in the three papers. It also presents and discusses a framework that has emerged from study results. It includes conclusions and recommendations.

Chapter Two

Manuscript 1: Health Sector Reform Policies: Realities of Nurses' Work at the District Levels

Potential Journal: Health Policy and Planning

Background: The Kenyan health care system has experienced significant policy reforms over the past three decades. Nurses are the major provider of health care services in the country whose work is affected by changes in policy reforms.

Purpose: The purpose of this study was to examine how national health sector policies have impacted on nurses' work in district health care systems in Kenya, from the perspectives of national and provincial level decision-makers, nurse leaders and front-line nurses.

Methods: A mixed methods design applying both qualitative and quantitative methods of data collection and analysis was applied. This paper presents qualitative findings. Data about reform elements were captured from policy documents. Interviews were conducted with a purposive sample of six non-nursing decision-makers at national and provincial levels of the health care system, seven provincial level decision makers, three national nurse leaders, and 14 frontline nurses and managers in two provinces.

Results: Study revealed that policy agendas of primary health care, decentralization and structural adjustment programs impacted on nurses' work both positively and negatively. The positive impacts included increased opportunities for skills training and for nurses' participation in service delivery decisions in the decentralized systems. The negative impacts included deteriorating work environments, increased responsibilities and unchanging nurses' employment conditions.

Conclusion: Results highlight the importance of considering the effects of policy reforms on nurses who are responsible for implementing reforms.

Key words: Kenya, health sector, policy reforms, nurses' work, critical policy analysis

Introduction

African countries, including Kenya, have been implementing major global policy reforms over the past three decades. These reforms include primary health care (PHC), structural adjustment programs (SAPs), decentralization and privatization of health services, as well as policies aimed at poverty reduction (Collins, Green & Hunter 1998; Dugbatey, 1999; Hummer & Berman, 1998; Sahn & Bernier, 1994). There is a considerable body of literature describing the general impact of these policies on health service delivery and health outcomes in Africa. Results of these policies have been mixed. For instance, SAPs resulted in similar outcomes across countries, including weakened public health care systems with adverse negative reductions in financial allocation to the public sector, freezing of human resource recruitment and depleted working environments (Gilson, et al., 2003; Logie & Woodroffe, 1993; Mwabu, 1995; Sahn & Berner, 1995; Sekwat, 2003). The deteriorating quality of health services in health facilities in many African countries has been attributed to these policy changes (Penn-Kekana, Blauuw & Schneider, 2004). More recent studies report a lack of clear measurable gains in health performance and health indicators despite policy reforms in the health care systems of African nations (Barry et al., 2009; Bossert & Beauvais, 2002; Mbekeani, 2009; McIntyre et al., 2007)

Other studies have examined these global policy reforms in relation to health human resources in general (Blas & Liambala, 2001; Franco, Bennet & Kanfer, 2002; Lethbridge, 2004; Marteneau & Buchanan, 2000; Seengooba et al., 2007). These studies have found various health human resource challenges in the context of reforms including: poor working conditions, shortages, and poor distribution and weak management of available health personnel. However, very few studies have examined how reform

policies have specifically impacted nurses' work. To contribute to a better understanding of how health reform policies affect nurses' work, this two phased study focused on Kenyan health policy reforms. Specifically, it examined the impacts of reform policies on nurses' work in Kenyan district health care systems, from the experiences and perspectives of policy-makers at various levels of the system, as well as nurses and nurse managers at the district level. The study focused on the public health care system, as this is where the majority of Kenyan nurses work. The paper focuses on phase one the study, which involved qualitative data collection and analysis.

Critical Theory and Critical Feminist Perspectives in Policy Analysis

Critical theory provided an overall framework and methodological approach for this research (Ray, 1992; Guba & Lincoln, 1994, 2000; Maggs-Raport, 2001), thereby exposing the interactions among policy context, process and content (Cheek & Gibson, 1997; Collins, Green & Hunter, 1999; Gilson & Mills, 1995; Walt & Gilson, 1994). Thus, in this study, the context influencing policy reforms, the policy content that influenced nurses' work, and the processes of policy development in Kenya were analyzed. Related to critical theory are feminist theories, which focus on gender domination, discrimination and oppression within patriarchal societies, with an aim of transformation for change (Cook & Fonow, 1990; Reinharz, 1992). Thus, feminist critical policy analysis perspectives were applied in the analysis to illuminate the gender-related policy issues that affect nurses' work in district health care systems (Marshall, 2000; Shaw, 2004). From feminist perspectives, policy issues that affect female workers include resource allocation and participation in decision-making.

Methods

Study Design

A mixed methods design (qualitative methods in phase one and quantitative methods in phase two) was used to examine how national policies in the health sector had affected nurses' work in the district health care systems in Kenya and how nurses had contributed to the national policy processes in the health sector. The study was implemented in two phases. The first phase involved qualitative data collection and analysis, while phase two involved quantitative data collection and analysis. This paper presents results from the qualitative analysis. The focus of this analysis was how policies impacted on nurses' work in the district health care system in Kenya.

Sampling

To understand policy contexts, processes and actors it was necessary to interview policy decision makers at all levels of the health care system. To understand the effects of policies on nurses it was necessary to interview the nurses themselves as well as decision makers who work in the health care system. Study participants were selected from the national level of the health care system and within two provinces in Kenya (Nyanza and Central). These two provinces were purposively selected because of their varied geographical locations, differences in health indicators and economic status (MOH, 2004). One district was then selected purposively in each province and the main district level public hospital in each of these districts was the site for interviews of nurses and nurse managers.

At each study site, participants were identified purposively and through convenience sampling (Sandelowsky, 2000; Teddlie & Yu, 2006). At the national,

provincial and district levels, decision-makers and nurse leaders were identified according to their positions and roles in policy decisions. A combined purposive and convenience sampling was used to recruit frontline nurses with long-term work experience in the two hospitals. Policy documents were retrieved from the Kenyan Ministry of Health website and some were obtained from libraries. These documents included the health sector policy framework, strategic plans and annual operational plans and reports.

A total of 32 interviews were conducted. The respondents included non-nursing decision-makers at the national level (n=5), a World Health Organization representative (n=1), national level nurse leaders (n=3), provincial level decision-makers (Nyanza Province, n=4 and Central Province, n=3), and frontline nurses and nurse managers at hospitals (n= 16, 8 in each district).

Data collection

The period of data collection for the qualitative phase was October 2008 to September 2009. Two methods were used in data collection. The first method consisted of a desk-review and analysis of national health policy documents to capture the reform elements implemented since 1980s. The second method was comprised of qualitative interviews.

The participants at national and provincial levels were identified through their positions. Frontline nurses and nurse managers who had been employed in the facilities for an extended period were identified by their supervisors. All participants were visited in their units and interviews were scheduled at their convenience. Open-ended interview guides were used to conduct face -to-face interviews. The participants were first asked

about the major national policies that had been implemented in the health sector. Then they were probed on specific policies like PHC, decentralization and structural adjustment policies if they had not mentioned them. They were then asked how each of the policies had affected nurses' work in the past years and what could be done to improve the nurses' work situation. In addition, nurses were asked to share their experiences with national policies at their places of work and how these policies influenced their ability to provide quality care. Interviews took 45 to 60 minutes, and were audio-taped with participants' consent. Field notes containing observations and reflections and analytical decisions were also maintained and used in analysis. The documents identified were added to the database. The documents were reviewed and information extracted regarding major policy content, contextual factors influencing policy formulation, and descriptions of how policies were implemented.

Data analysis

Transcribed interviews were analyzed using established qualitative data analysis procedures including coding, and identification and interpretation of themes (Lincoln & Guba, 2000; Miles & Huberman, 1994; Patton, 1999). Each transcript was read and re-read several times to gain a sense of the whole interview. The transcripts were grouped into four batches; those from: non-nursing national level decision-makers, national nurse leaders, provincial level decision-makers, and frontline nurses and managers. The data were initially coded into categories according to these groupings. The categories were first developed with the main areas covered during the interviews. Transcripts were re-examined and further coding was done followed by development of matrices, which were used to compare the emerging categories among groups (Creswell, 2003; Miles &

Huberman). Themes were identified from the clustered codes of each group, by examining repeated perceptions and expressions (Ryan & Bernard, 2003). Field notes and findings from the policy documents that were relevant to the study objectives were also integrated in the analysis. Documents were analyzed by identifying texts that referred to the policy context, content and processes in the Kenyan health sector. This included actors in policy development and the values and principles underpinning the policy contents.

Ethics

Ethical approval was obtained from the University of Ottawa Health Sciences Research Ethics Board and the Ethics Board of the Great Lakes University in Kenya. Permission to conduct the study was obtained from the Ministry of Health headquarters, provincial health offices, the district offices and the two hospitals. Study participants gave informed written consent before the interviews. Privacy of the participants was maintained during interviews and the information shared by the participants was kept confidential.

Results

The analysis revealed that all non-nursing decision-makers at national and provincial levels were males, two national nurse leaders were males, nurse representatives at the provincial levels were all female and the majority of nurses at the district level were female. The results are presented in three sections. First, the description of national policy reform content and contexts in the health sector are summarized. The second section presents views of decision-makers on how policies

affected nurses' work and, finally, the views and experiences of frontline nurses and managers on how they were affected by the national policies are summarized.

Content, Contexts and Process of Policy Reforms in Kenyan Health Sector

The review of policy documents revealed that (Table 1) primary health care was a one of the major policy reforms implemented in Kenya in the 1980s following the Alma Ata Declaration on Health for All by the year 2000 (MOH, 1986). Based on the principles of accessibility, equity, community participation and intersectoral collaboration, Kenya developed an essential care package focusing on disease prevention and health promotion. This was implemented with the support of non-governmental organizations (MOH, 1986; MOH, 1994). The PHC policy reform defined Kenya's essential package of care, which initially included eight elements: the supply of essential drugs, safe water and sanitation, food and nutrition, maternal and child health, immunization, treatment of common ailments, prevention of endemic diseases, and health education. Others were added at a later date such as mental health, dental care and finally HIV/AIDS. Frontline health providers, including nurses, were re-orientated on the essential package of care. Nurses were involved in the implementation of primary health care in all health facilities in the districts. In addition, nurses participated in outreach services to provide basic care and health education services to the communities. Findings from a Ministry of Health services review in 2005 identified gaps in achieving PHC; specifically, service delivery was found to be still heavily focused on curative services, with poor access by the majority of community members (MOH, 2005). Policy documents also yielded details regarding structural adjustment programs (SAPs) (MOH, 1994, 2005). Following SAPs, government expenditures in the health sector were

reduced and a cost-sharing policy was introduced from 1992 to increase resources for health facilities. In addition, there were civil service reforms, which led to a retrenchment of certain cadres of health workers and a freeze on nurse employment in 1996 (MOH, 1994; MOH, 2007).

Another policy implemented in the health sector was decentralization and privatization of health services. Inception of decentralization in Kenya started in 1983 with the introduction of District Focus for Rural Development (DFRD). In the mid 1980s, lower level facilities were empowered in planning and decision-making in service delivery, while policy formulation and human resource planning remained core functions of the central system (MOH, 1994). The new governance and management structures that came with decentralization were district health management boards, district health management teams, hospital management boards and other health facility management committees. These structures had a mandate of overseeing service management and delivery within districts and facilities. At the same time, the private sector was encouraged to develop services for which patients would pay.

More recent policies include poverty reduction policies, initially developed as Poverty Reduction Strategic Papers, but later developed as an economic recovery strategy incorporated in the Kenyan government's Vision 2030 document to guide all sectors. Another reform emphasized in the documents reviewed was the Sector Wide Approach (SWAp). This was developed in response to a multiplicity of poorly coordinated donor projects in the health sector. Thus, the SWAp approach was adopted to guide the national health planning and coordination of activities amongst partners (MOH, 2005). The documents included mention that the SWAp approach would encourage transparency, accountability and address corruption in the health sector. Table 1

summarizes these policy reforms, comparing their key policy elements, the time period for implementation and the resulting government actions.

Table 1. Major policy reforms implemented in health sector in Kenya (1980-2009)

Policy and Goal	Key Policy Elements	Time/ Period and Government Actions
Primary Health Care <u>Goal</u> <i>Provision of comprehensive, accessible and equitable health care to achieve HFA by the year 2000</i>	<ul style="list-style-type: none"> ▪ Building sustainable and well-coordinated health system ▪ Appropriate and affordable services and cost effective technology. 	<p>1980- 2000</p> <ul style="list-style-type: none"> ▪ Developed essential package of health care based on essential elements of PHC ▪ Worked with NGOs like UNICEF and AMREF to orientate health personnel and implement PHC activities ▪ 2006 -2009: Revitalization of PHC with more emphasis on the Community Strategy
Decentralization <u>Goal</u> <i>Transfer authority and responsibility to lower levels of service delivery to enhance efficiency & cost effectiveness of services.</i>	<ul style="list-style-type: none"> • Enhance local control over and accountability of health care services • Provider autonomy • Privatization 	<p>1983-2009</p> <ul style="list-style-type: none"> • 1983: District focus for rural development • Decentralization of planning, purchasing & management of health services • 1987: Kenyatta National Hospital granted autonomy in its operations • 1996: decentralized financial and administrative authority to the districts • 1992: District health management boards created to oversee cost sharing • 1994: Private sector encouraged to develop curative services that patients would pay for
Structural adjustment programs <u>Goal</u> <i>Enhance efficiency and control of public expenditures</i>	<ul style="list-style-type: none"> • Market liberalization • Currency devaluation • Commodity price deregulation • Reducing role of states in goods and service provision in favor of the private sector • User fees • Civil service reforms 	<p>1992-2009</p> <ul style="list-style-type: none"> • 1992: Introduction of user fees in government facilities • Reduction of state spending on health care • Health insurance schemes to draw in extra resources for health care • 1998: Health personnel retrenched • 1996: Freeze on hiring nurses in public sector
Poverty Reduction Strategic Papers <u>Goal</u> <i>Poverty reduction</i>	<ul style="list-style-type: none"> • Economic recovery • Employment creation • Poverty reduction 	<p>2005-2009</p> <ul style="list-style-type: none"> • Poverty Reduction Strategic Papers developed under Ministry of Planning • Developed economic recovery strategy paper linked to Millennium Development Goals • Vision 2030 that guides current planning
Sector Wide Approaches 1990s <u>Goal</u> <i>Improve management of Donor funding</i>	<ul style="list-style-type: none"> • Aid coordination • Pool funding • Resource allocation and priority setting at national level 	<p>2005-2009</p> <ul style="list-style-type: none"> • Involvement of multiple partners in planning at national level • Development of joint program of work and funding • Annual Operational Plans: Districts plans integrated into national plans • Joint reviews of progress

The policy reforms have been implemented against a backdrop of complex historical, economic, political and social contexts (MOH, 1994). The historical context reflects a Western medical model of care inherited from the colonialist period. The inherited system was centrally planned with institutionalized curative services that were mainly located in urban areas. The gaps in the system included poor health infrastructure and inadequate health personnel. The policy focus in this sector from the time of Kenyan's independence (1963) was an expansion of health infrastructure to the rural areas and training of various cadres' health personnel including frontline nurses.

However, the prevailing economic context thwarted these efforts to enhance service delivery. Although the economy grew steadily from independence in 1963 until the late 1970s, from 1978 onwards, Kenya experienced a declining economy characterized by a high inflation rate and a stagnating GDP growth rate of 5% in the 1980s followed by even lower growth rates in the 1990s. The decline was partly attributed to the international economic recession, caused by the oil crisis of the 1970s and early 1980s, and the implementation of structural adjustment policies in the 1990s (MOH, 1994). More recently, the overall national policy has emphasized economic improvement, which was to be achieved through broader development goals, including the Millennium Development Goals (MDGs) and the Kenyan Development Vision 2030. Poverty reduction strategies and sector-wide approaches to health were the major agendas, which were linked to the development goals.

The political context includes external and national level political influences. The external influences led to a push for primary health care (Alma Ata Declaration in 1978) and the push for governments to increase their health budgets (Abuja Declaration, in 2001), which set the target of public spending on health to 15% of the GDP. In addition,

ideologies and principles reflected in the policy framework, such as cost-containment, efficiency and equity, relate to those of broader global institutions like World Bank.

The social context reflected in the documents was related to demographic and epidemiological factors. Increases in population growth, disease burden and poverty levels shaped the context for health service delivery. Among the health problems were preventable diseases, like malaria, tuberculosis and HIV/AIDS, which further stressed an already weakened health care system. Increases in maternal and child mortality rates were also observed with the highest rates reported in the 2003 demographic health survey (MOH, 2004). These indicators were alarming since Kenya was reverting to the rates reported in the 1970s. Thus, the health sector strategic plan 2005-2010 focused on reversing these health indicators (MOH, 2005).

All the foregoing process of policy reforms emerged from broader global policy changes and were adopted in the health sector in Kenya. Although these global changes were taking place in the 1980s, Kenya did not develop its first Health Policy Framework (KHPF) until 1994. This framework guided implementation of the policy reforms (MOH, 1994). Kenya has since developed two five-year health sector strategic plans. An evaluation of the first five-year plan (KSSP I, 1999-2004) revealed many gaps in policy implementation with a continued worsening of health indicators. Inadequate resources, staff shortages and poor work environments persisted in the public sector as the number of hospitalized patients diagnosed with HIV/AIDS continued to increase. The second health sector strategic plan (KSSP II, 2005-2010) was developed with the aim of reversing the downward trend in health indicators (MOH, 2005). This plan emphasized community-based health care and an essential package for health that focused on maternal and child health, malaria, HIV/AIDS/STI and tuberculosis.

Decision-Makers' Views on Policies that Impacted on Nurses' Work

During the interviews, all decision-makers were asked to identify national policies that impacted nurses' work at the district level and to share their views on how these policies affected such work. The decision-makers easily identified policies related to structural adjustment programs, decentralization, primary health care, and privatization as impacting nurses' work, as well as newer reforms such as the sector wide approach to service delivery, restructuring of the health sector and performance contracts. The analysis focused on the changes resulting from three major policies that were most often mentioned by participants: primary health care, decentralization and structural adjustment.

Primary Health Care

PHC was regarded positively by all decision-makers as it brought new programs, which led to higher demands for new knowledge and skills for nurses. Nurses were given short- term trainings in various areas to improve their ability to implement PHC interventions. PHC was also integrated into the main nurses' national training curriculum. Some decision-makers noted that PHC enhanced nurses' interactions with other health professionals, thus improving their capacity to work with other health care team members. More recently, more of the training opportunities offered by non-governmental organizations that are funding health projects in Kenya have been available to nurses. As one provincial level decision-maker said *"Nurses have benefited a lot in that a number of them have been trained or received updates trainings and others [have been] supported to attend conferences to exchange ideas"*.

Decision-makers also observed some PHC implementation limitations, which affected frontline nurses' work. Nurses in rural areas who were tasked to implement PHC activities described being neglected in terms of training opportunities and career advancements, as they worked far away from decision-makers. They also noted that the retention of nurses in rural areas was difficult since nurses migrated back to the urban areas, thus causing shortages in some rural facilities. One of the reasons for the migration was that nurses in rural facilities experienced more challenges due to a lack of basic infrastructure facilities and service networks:

Our nurses would be happier working in dispensaries with piped water, good roads, electricity, they would like to work in dispensaries that are very well connected and intertwined with the communities. Many issues hinder nursing services in the rural [areas]. (Provincial level decision-maker)

Participants also observed inadequate funding for PHC activities such as health promotion and disease prevention, as more funding was channeled to curative services. This resulted in more sick people coming to the health facilities, with nurses bearing the burden of care at health facilities.

Decentralization

Decision-makers mentioned positive effects of decentralization, including a better geographic distribution of nurses, and the creation of opportunities for nurses to participate in health service and decision-making programs. This made it possible for provinces to justify an increased allocation of nurses to districts that were in need. The policy also introduced changes in nurse management roles. In lower level facilities, more nurses were in charge, giving them authority to make decisions.

Managerial levels have expanded, and this has given nurses new positions.

Initially even at the provincial level, there used to be one nurse manager but with decentralization, there were other activities like logistics management, reproductive health, home based care programs that needed more nurse managers to improve coordination and management at provincial and district levels, so the changes have expanded the nurses' capacity in management. It has also increased their skills and interaction with others. (National Nurse Leader)

Even though more opportunities were created for nurses to participate in decision-making through their representation in the provincial and district governing and management structures, nurses' contributions to decisions at district and hospital levels were still perceived to be inadequate. Decision-making powers continued to rest primarily with doctors who held higher authority positions within the district health care systems. Nurse leaders observed that hospital administration changed, with doctors and administrators having more authority in financial decision-making. Their decisions did not consider nurses' resource allocation priorities.

Further tension over decision-making powers arose with regards to partial implementation of decentralization. Aspects such as human resources planning and allocation were still vested with the central government. Although nursing positions increased at the district level, shortages persisted and there was uneven distribution of nurses across the districts. Nurse leaders at the provincial level cited their lack of control over the transfer of nurses to where they were most needed. Another concern was interference from central level decision-makers on lower level decision-making, as one provincial leader said:

We have the tendency for the national level interfering with what is happening at the district level. Even though there is decentralization, the central level still holds certain powers, so the district managers have not been given full responsibility to make decisions. This interference is still a challenge to the decentralization process (Provincial non-nursing decision maker).

Even though there was a lot of emphasis on planning at district levels, nurses and other health care workers did not have adequate knowledge and competency in planning and managing a decentralized system. In part, this was because nurse leaders at the district and facility level were deployed by seniority rather than by competency, as stated by another provincial level decision-maker:

One of the challenges we are experiencing is the technical competencies of the managers at the district and facility level. Some of our senior nurse managers are deployed not according to competencies one has but according to the number of years one has served. They do not have the knowledge or the skills on how to manage human resources (Provincial non-nursing decision-maker).

Structural Adjustment Policies

The decision-makers expressed consistently negative views of SAPs. These policies shifted public spending to other sectors while reducing expenditures on health. This led to poor financing of the sector and insufficient resources for service delivery - a major challenge to nursing service delivery. Poor financing of the health sector continued even as the country was experiencing a high disease burden, as emphasized by one non nursing national decision-maker below:

SAPs was a huge disaster, which shifted a lot of government and partner investment away from social services to so-called more productive sectors. We could not hire the health workers needed, our production of health workers was slowed down...., we had increases in disease burden because the country was in epidemiologic transition at the time. Our worries increased and the sector was not able to respond. Now we are trying to catch up with the impact and to get the system back and running, it's time to recover but it will take quite a while

(National Non-Nursing decision-maker)

Decision-makers further noted that SAPs led to the freezing of nurse employment in the mid 1990s, resulting in increased nursing shortages in public health facilities. A report (MOH, 2007) from the nursing office indicated that in 2009, almost every functional health facility was understaffed, with no nurses in over 500 of Kenya's 2,122 dispensaries. The nurses who remained in the system became strained and demoralized. The interviewees expressed concerns that the shortage of nurses would become even more acute, noting that nurses were still migrating from the public to the private sector or to other high-income countries and, in addition, the number of nurses who would reach retirement age in the next five years was huge. The nursing report indicated that an average of 500 nurses had been retiring annually at age 55 without replacement and between 300-400 nurses migrate abroad annually, while others were making a career shift.

Participants noted that the nursing shortage in facilities would be partially offset by the government's review of retirement policies and their decision to change the retirement age for nurses from 55 years to 60 years. Interviewees also noted that plans were underway to employ new nurses but the numbers to be employed were considered

inadequate given the estimated shortage. Failure to employ new nurses and having many old nurses in the system was considered problematic. As one national level decision-maker commented, *“there is a memory lapse, as the tradition of old nurses mentoring younger nurses has been lost. Younger nurses have less commitment and competencies”*.

Another element of Kenyan SAPs was cost sharing. Participants commented positively on the role of cost sharing funds to supplement government financial allocation, resulting in more funds for facility improvement and purchase of essential supplies. However, they noted low revenue collection due to a reduced utilization of services. Provincial level participants noted that this reduced revenue collection adversely affected the ability of these facilities to purchase supplies for nurses' work. As a result of pressure to abolish user fees to enhance access, the government, in 2004, reduced user fees in lower level facilities and replaced them with a minimum low flat rate, exempting special groups like children and patients presenting with prevalent diseases, like malaria.

Decision-makers at all levels felt that nurses at the facilities experienced many challenges as these policies were implemented, including staff shortages, reduced supplies and less control over financial decisions affecting supplies. Some decision-makers felt that as a result of these challenges nurses had developed poorer attitudes towards patients. One non-nursing decision-maker put it that, *“the virtue of the good nurse was lost”*. They felt that nurses' poor relationships with patients had been noted over the years and this was one of the reasons for reduced service utilization. Other decision-makers noted that new changes introduced in the sector, from 2006, including performance contracts, improvements in drug supplies and strengthened supervision had

led to some improvements in nurses' attitudes, which, in turn, had attracted more patients to the public sector. These changes are reflected in the comment below:

Before, many nurses had [an] 'I don't care' and relaxed attitude, they used abusive or unpalatable language, which would scare patients away. Queues became shorter. But today queues are too long, patients [are] crowded in health facilities the whole day, the government facilities are more highly utilized. Nurses have become friendlier to patients. This has also been seen in the rate of deliveries conducted by skilled personnel and more referrals (Nurse manager).

Nurse leaders mentioned that many nurses were still getting orientation on the performance contract, including target setting for service delivery at the facility level and annual appraisal of individual nurses' performance. It was hoped that the performance contract and enhanced supervision would improve service delivery in the districts.

Frontline Nurses and Managers' Views on the Impacts of National Policies on their Work

Frontline nurses and nurse managers were asked to mention national policies that affected their work at district levels, how they experienced these policies at their work place, and whether the policies enabled them to achieve their care objectives. As opposed to national level decision-makers who readily mentioned broader national policies, most of the frontline nurses and managers found it difficult at first to speak about national policies. With probing, the nurses realized that they had implemented several policies including decentralization, primary health care, cost sharing and freezing of human resource employment, as well as service delivery policies such as those related to HIV/AIDS and infection prevention and control. Some nurses complained that they did

not understand these policies because they were made at higher levels of decision-making and just brought to them to implement. The emerging themes from nurses' experiences included: the decreasing nursing workforce, increased workload and longer working hours, increasing resource challenges, increasing policy directives and programs, unchanging working conditions, job dissatisfaction, and inadequate involvement in decision-making.

Decreasing Nursing Workforce

The frontline nurses and managers experienced an increased shortage of nurses at the district level facilities following implementation of SAPs. The interviewees were concerned that low nurse-patient ratios led to poor quality of care. They said that they worked longer hours, but were unable to provide the required standards of care:

Since the government stopped employing nurses there have been shortages, and the care of patients has gone down. Sometimes we have 40 patients in the ward with one nurse on duty, so you can imagine one nurse serving the 40 patients. Definitely you cannot give effective and good standard of care with such shortages; some patients will miss your care. (Nurse manager)

Nurses are leaving, others have died, the ones who are retiring are not replaced; therefore it affects us and the quality of services (Frontline nurse)

The shortage of staff nurses challenged the ability of nurse managers to perform in their managerial role:

As a manager, I am supposed to manage the ward, but due to shortage of staff, sometimes we have to do the work on the ground. When I am alone on duty, I give treatment, I make sure the ward is clean and I will not be perfect. This affects my

managerial duties. People start blaming you, saying that the [nurse] in charge of a certain ward has problems when the actual problem is a result of understaffing (Nurse manager).

Increased Workload and Longer Working Hours

Frontline nurses and managers experienced an increased workload and longer working hours. Most of the nurses attributed the high workload to nursing shortages. Another reason was the increased number of ill patients as a result of an increased burden of disease, particularly HIV/AIDS, and improved utilization of services due to health education and community outreach services provided through PHC. One frontline nurse commented; *“we work for long hours and we are few and we have so many ill patients, so we end up giving the quality of care that we are not supposed to give.”* Due to the high workload, the nurses’ role in providing comprehensive care changed, as they could not carry out all the required procedures. As a result, relatives rather than nurses were attending to some of the patients’ care needs in the wards.

The introduction of cost sharing also added to the administrative workload of nurses who were already overwhelmed with clinical work. Nurses had to ensure that patients paid money by verifying receipts and keeping records on their wards. On nurses manager further noted that *“cost sharing, apart from introducing financial dimensions which nurses have never been prepared on... raised issues of ethical practice, and availability and use of commodities. When there is no money, people have to buy drugs”*. The ethical dilemma noted here arose when nurses had to play the role of both fee collector and health provider, potentially refusing treatment to those who were in need but unable to pay.

Increasing Resource Challenges

Frontline nurses and managers experienced insufficient resources including infrastructure, equipment, drugs and other essential supplies. Some equipment were old and worn out, yet they were not replaced. Insufficient supplies led to poor quality of care as nurses took short cuts and improvised materials to work with. One nurse said; “*you lack supplies so you are forced to do shoddy things*”. Another one said that “*you take shortcuts and improvise so many things*”. Patients were expected to buy certain items while in the hospital. The shortage of supplies also led to delays in caring for patients and poor standards, as another frontline nurse commented: “*Sometimes you have shortages of supplies like syringes and gloves, so services are delayed and you might not be that professional ..., you don’t perform the way you are supposed to perform. It compromises the standards.*”

Even though inadequate, given increased service demands, nurses noted that cost sharing had supplemented government funds in the facilities and the funds were used to buy certain essential supplies. They also mentioned that, through SWAp approaches, some non-governmental organizations (NGOs) contributed resources to the facilities, particularly for HIV/AIDS care. The frontline nurses acknowledged the NGOs’ contribution, but there were worries about sustainability of this support. As one of the frontline nurses said:

We are relying too much on NGOs and donors for financial support and supplies. In our setup, anything to do with HIV/AIDS relies on NGOs, what if the NGOs pull out? It means everything will collapse (...) we are not prepared as a country to solve (the) HIV problem.

Frontline nurses noted one positive change with regard to the distribution of available supplies after the introduction of decentralization. They noted that they could now place their orders for supplies within the district, unlike previously when they had to place orders centrally. This change had shortened the length of time required to receive the orders. However the supplies were not adequate despite the shortened time for procurement.

Changing Patient Pattern and Care Dilemmas

Frontline nurses and nurse managers experienced increased numbers of ill patients in the facilities. Many patients sought care late in their illnesses; nurses thus received very sick patients leading to more complex care provision and longer hospital stays. This negative change in health seeking behavior was attributed to the cost sharing policy, which required patients to contribute payment towards their services. Frontline nurses were always in a dilemma as many patients were unable to pay for certain services or buy drugs. Nurses felt that they were obliged to provide quality care and save lives, yet they were not doing enough. In the end they were blamed for the poor quality:

Sometimes patients feel services are too expensive and they don't have the money. They try other places or cheap drugs from the market and by the time they come it is already too late and complicated. It becomes a problem because some are very sick. They stay around and just say they don't have the money, but you have to make sure they get the service. (Nurse manager)

When patients are not able to buy some drugs from outside when the hospital doesn't have, and you know quite well the patient will do better on that drug and

there is nothing else that can be done, [I] feel like I have not worked. (Frontline nurse)

Another frontline nurse said: *“Sometimes patients come assuming that they are not going to pay, but you have to save life. Sometimes [there are] care delays, and at the end of the day, it is the nurse that is blamed.” (Frontline nurse)*

Unchanging Nurses’ Working Conditions and Job Dissatisfaction

The predominant view of frontline nurses and managers was that nurses experienced poor working conditions and job dissatisfaction as national policies were being implemented. Nurses raised concerns about their low salaries, which affected their personal needs. One nurse talked about insufficient basic needs such as education of her children. Another nurse talked about her inability to live in a good house or manage her own household chores:

Our salaries are so little such that if you don’t live on loans you cannot teach your child and if you cannot teach your child, you and your child will be poor. (Frontline nurse)

I am not paid well, it means I am not comfortable; I can’t stay in a good house or employ somebody to assist with work at home. You strain right from your house, like when I talk to nurses; somebody says that I have worked over the weekend - now I am exhausted. (Nurse Manager)

Many nurses’ commented on their inequitable treatment, with doctors getting more pay and better employment opportunities than them. Even nurses with degrees earned much less than doctors. In addition, frontline nurses said their work involved a lot

of risks, yet they were not recognized or given a risk allowance equivalent to that of doctors. Nurses experienced poor morale due to these differences:

The difference between what the doctors and the nurses are paid is really big and demoralizing. If you are a BScN with a degree doing (an) internship, no one cares where you stay, what you eat, you are not even anything. After employment, you are paid almost half of what a doctor is getting, maybe you were in the same college, graduated together, but when you go to the field even getting a job itself is a problem, but for the doctor it's automatic. (Nurse Manager)

The scheme of service should look at nurses' work and the related risk. While doctors are paid over fifteen thousand [in] risk allowance, nurses get about three thousand. Yet most of the time the nurse is always with the patients for long, taking the risk ...doctors are there for a short time. (Frontline nurse)

Nurses' views also reflected gaps in nurses' progression in terms of promotion and support for training. Many nurses stayed in the same job group for a long time without moving to the next level. Other nurses had upgraded from a certificate to a diploma, but stayed in the same job without upgrading. More advanced training opportunities existed but nurses rarely received support to go for further training. In addition, frontline nurses raised concerns about the inconsistent recruitment of nurses for short-term skills training:

Having a lot of nurses stay in a job group without progress demoralizes. [For example], all of us have gone to upgrade but nothing changes. It motivates if we progress every three years. Now when you come with certificate you are not

recognized for a salary increment unlike doctors who get an increment and job upgrade. (Frontline nurse)

Progression has been very slow and discouraging. A nurse works in the same job group for more than ten years without promotion to the next level. Also sponsorship for further training is very rare; nurses have to dig deep into their pockets to pay tuition for trainings. They finish and come back with more work, but no incentives are given in terms of additional income. And when a nurse lands into problems, very little support is offered. (Nurse manager)

Respondents indicated that these negative conditions made nurses feel demoralized. They felt they were working hard, yet they were neither appreciated by the system nor valued by society.

Inadequate Involvement in Decision-Making at District and Facility Levels

Frontline nurses and nurse managers expressed concerns that they were not adequately involved in decision-making at the district and facility levels. One major tension related to decision-making regarding the utilization of finances at the facility level. The hospital superintendent, who was legally required to be a doctor and the administrator, had overall control of financial decisions. Nurse managers were expected to participate in the management of funds; however, they described their involvement in major financial decisions as minimal. The nurses felt they should be more involved in making financial decisions.

Nurses help to generate a lot of money in the facility but they cannot use this money directly to improve services. The money is handled and controlled by the

administrative officers. Sometimes we have issues that should be addressed but they are not seen as a priority. Clients pay a lot of money in the facilities but services are not improved. (Nurse manager)

Increasing Policy Directives and Competing Programs

In addition to the above challenges, multiple policies and programs converged at the district levels. This was not necessarily a critique of the policies themselves, so much as with the frequency of change. Nurses working at these levels experienced these policies as an overwhelming set of requirements with a lot of top-down directives. The array of new policies and programs made it hard for nurses to cope with other planned tasks, especially since nurses, who were already few in numbers, were constantly moved to work in new programs with no replacement in their units. In addition, some nurses moved to stand alone NGO projects, which increased staff shortages.

There are competing piles of programs to be implemented. When these are placed upon a single nurse it becomes very difficult and it compromises quality of services offered. The programs come on a push method. Implementation of district work plan is usually interrupted by the upcoming programs which are pushed from up. (Nurse manager)

Another nurse manager commented:

Policies are good but they are becoming too many. When policies are made people attend training workshops, which are too many. At times we are not able to send people because of the shortage. If nurses are increased it will be easier for us even to learn more on policy-making and implementation.

Discussion

This study reveals that national policies implemented in the health sector in Kenya from the 1980s had direct impacts on nurses' work at the district levels. The reforms that led to major consequences on nurses' work were primary health care, neo-liberal policies leading to structural adjustment programs and decentralization. Importantly, the nurses did not experience these policies in isolation from each other. In this section, the values inherent in these policies and their effects on nurses' work are discussed. Emerging gender concerns are also described.

Intersecting Policy Values and Effects on Nurses' Work

Study findings draw attention to values inherent in these policy reforms and how these interacted with nurses' work. Primary health care reflects values and principles that are consistent with the values underlying nurses' practice (Besner, 2004). Meeting the goals of PHC required re-orienting health worker capacity, which led to an improvement in nurses' skills in the provision of health services and enhanced their ability to work with other professionals. Even though the implementation of PHC was challenging due to inadequate resource allocation and insufficient co-ordination among stakeholders, nurses felt their capacity to implement PHC was improved and that the PHC activities implemented were necessary for better service provision. Yet, structural adjustment policies focused on efficiency, which was to be achieved through market forces, and favored reductions in financial allocation to the health sector, along with user fees and a freeze on human resources employment. This adversely affected the health care environment by increasing resource shortages and high workloads. Nurses bore the burden of scarce resources at their places of work, making it difficult to provide services.

These factors have been established as contributing to nurses' poor morale and the poor quality of care (McIntyre & Klugman, 2003).

While PHC is based on principles of access and affordability of care by communities served (Barnes et al., 1995), the implementation of cost sharing brought in a contrary situation making care less affordable to patients. Participants had observed detrimental changes in service utilization and access following introduction of the cost-sharing policy in Kenya. Patients were seeking care late in their illness trajectory and being admitted when their illness had progressed. As a result, nurses had to deal with longer patient stays in hospitals and an increased acuity and complexity of care. There is evidence from other studies that user fees have created barriers to access among disadvantaged communities and caused negative impact on staff and service delivery (Gilson, 1997; Mwabu, Mwanzi & Liambila, 1995; Nanda, 2002). The evidence has led to pressure to remove or reduce user fees in public health sectors, with increased government funding to facilities (Campbell, Oulton, McPake & Buchan, 2009; Chuma et al., 2008). However, the removal of user fees without considering staff factors can lead to unintended consequences. In South Africa, for instance, free care policy led to high utilization, a shortage of resources and an inability of nurses to provide quality health care (Walker & Gilson, 2004). In this study, participants observed that the removal of user fees in low level facilities led to reduced funds for essential supplies, thus further compromising quality of service.

With respect to policy agenda setting, PHC represents a policy that was adopted through inter-ministerial deliberation thus reflecting more horizontal intergovernmental participation and agreements. On the other hand, policies influenced by the IMF and World Bank were tied to conditions to get loans thus representing more of a top down

imposition from global actors on Kenya. Participants in this study regarded PHC more positively given its potential impact on enhancing nurses' capacity and improving quality of care. In contrast, they described SAPs as having weakened nurses' capacity by worsening work environment. This indicates that policies developed on a more participatory basis like PHC have more positive effects than policies that are vertically pushed to the system through the pressures of global actors like SAPs.

Nurses' Experiences with Policy Reforms

Study results reveal that nurses experienced many policy reforms and shifts in programs that followed. The increase in international funding to support policy reforms and health interventions led to the introduction of multiple programs at the district level. Nurses felt that policies and programs were introduced without consideration being given to front-line work challenges. Those working on the front-lines observed various adjustments to policies as service utilization patterns changed. A major concern was the competing demand for training and orientation to policy, which tended to take nurses time away from clinical work, thus increasing the workload for those who remained.

Nurses were central to policy implementation but this placed them in the difficult position of having to take on roles that were both professionally demanding and for which they were at times ill-prepared, as well as roles that involved the implementation of unfavorable rules such as the collection of user fees. The new policies introduced tasks in areas in which they had not been trained, such as management of finances. In addition, many patients could not afford the services they required; and at the same time health facilities lacked adequate resources to deliver certain services. This placed nurses in an ethically compromising position. The findings are similar to those of a study by

Miles & McGilvray (2006), which revealed that nurses experienced legal and ethical dilemmas as a result of inadequate considerations of the impact of policies on their work, especially when they had to take up professional roles for which they were not trained. Ethical dilemmas arise when nurses are required to implement policies that conflict with nursing theory and practice as well as patient needs (Aroska, Moldow & Good, 2004; McLeod & Spee, 2003). Thus, nurses have been viewed as an important resource for policy-makers in development of policy that affect patient care.

Participants in this study were more concerned with the negative effects of policy reforms on nurses' work environment. More particularly, they were concerned with the reduced nurse staffing, financial and material resources, which led to high workloads and long working hours. Nurses in this study expressed that they were not able to achieve their professional goals of providing quality of care to the patients due to these factors. Inadequate nurse staffing was a major dilemma in the provision of quality care. Even though there is substantial international evidence to show that high nurse staffing impacts on quality care and improved patient outcomes (Flynn, 2009; Lankshear, Trevor, Sheldon & Maynard, 2005) these findings reveal that little effort has been put into improving nurse staffing in health facilities at all levels. Generally, nurses' views reveal that they value the quality of care they provide to patients; however, they were unable to achieve this during the reforms. Similar findings were observed in Zimbabwe where reform policies following structural adjustment prompted nursing shortages, contributed to the decline in work conditions and increased nursing workloads (Basset, Bijlmakers & Sanders, 1997).

Negative effects of health sector policy reforms on nurses' work have also been reported in studies from developed countries. Some of these studies include qualitative

analyses of health sector reform in Canada, which suggested that restructuring of work environments has reduced the supply of nurses, increased patient acuity and produced a complex work environment with a high workload (Meagher-Stewart et al., 2007; O'Brien-Pallas & Baumann, 2000; Spitzer, 2004). In Australia, a critical hermeneutic study in long-term care by Venturat, Kellet and Windsor (2006) and a review by Gibb (1998) revealed conflicts between nurses' traditional values and practice roles and those supported by health policy reforms. The authors advocated for nursing leaders and managers to renegotiate roles, responsibilities and values within an evolving health care system. In Kenya, the nurse leaders have negotiated for better work conditions through their professional associations (Rakuom, 2010). However, the extent to which their efforts have been addressed have not been documented. Guevara and Mendias (2002) examined changes in nursing practice and nursing-practice environments in five South American countries as a result of health sector reforms. Their study revealed increased work stress due to changes in the distribution and mix of nurses, greater emphasis on cost control, a shift of work from hospital to community, and changes in patient needs.

Emerging Gender Concerns in the Context of Reforms

Feminist perspectives on policy analysis draw attention to work challenges faced by female gendered professionals in the context of policy reforms. Nursing is mainly perceived as a female gendered profession. In this study, challenges facing the nurses included inadequate allocation of human and material resources leading to high workloads and long working hours. These factors hindered nurses' potential to achieve their professional objectives. In addition, nurses identified poor employment conditions like low salaries, delayed promotions and lack of support for their progress in education,

which were reasons for their job dissatisfaction as reforms were being implemented. The female gendered nursing professionals experienced worse employment conditions than male gendered medical professionals (doctors) who earned higher salaries while spending less time in the hospitals. Nurses earned considerably less, and some participants indicated their salary did not allow them to meet their basic expenses. Even though these conditions might not have been a direct effect of the three policies mentioned above, nurses' complaints reflect the failure of policy-makers to consider the employment conditions through a gendered perspective and how this might affect the successful implementation of these policies. Similar findings were revealed in South Africa where the majority of frontline health workers were women, who received lower salaries and had fewer opportunities than their male counterparts who generally rose to higher levels of decision-making (Dussault, & Dubois, 2003). Suggestions to improve human resource work conditions in the context of reforms include: developing human resource policies and strategies to address improvements to education, training, salary scales and performance appraisals for better health workers' performance (Martinez, & Martineu, 1998; Mathauer & Imhoff, 2006). In addition, a gender equity lens needs to be used to assess policies and their implications for nurses, with further implementation to address emerging gender issues.

In addition to poor employment conditions, gender inequity was also observed in decision-making within the decentralized districts. Decentralization created structures that included nurses as members of committees. Although this change provided nurses with an opportunity to participate in decision-making, frontline nurses and managers had limited decision-making power with regards to finances and priority setting. The findings indicate that doctors, who are part of a traditionally male gendered profession,

were placed in higher decision-making positions as opposed to nurses who are part of a female gendered profession. This inequitable treatment of nurses was a source of their demoralization and may have influenced their professional care giving roles negatively in the context of policy reforms.

Conclusion

The study results suggest that any reforms in the health care system should consider the impact of the reforms at the implementation level. This includes impacts on nurses carrying out work in the districts. While some policy reforms have caused constraints to nurses' work environments and reduced job satisfaction, the bottom line is that these policies have also adversely impacted the quality of care provided to communities. The participants' views indicate that a decreasing nursing workforce, increased workload, decreasing resources and changes in the nature of clients seeking care were major reasons for poorer quality of care. Thus, human resource requirements should be addressed in future policy reforms to enhance quality of health care and population outcomes.

Furthermore, the study shows the importance of examining not only a single policy reform in isolation but also co-existing policy reforms because each of these reforms have differing, yet intersecting ideologies. This study has shown how values inherent in different policy reforms bring changes to nurses' work. While policies that focused on enhancing access to service delivery like PHC and decentralization improved some aspects of nurses' work, SAPs caused financial constraints and eventual downsizing of the nursing workforce, which subsequently adversely impacted on nurses' work environments.

Feminist perspectives in the analysis revealed some gender issues that need policy attention and further in-depth analysis. As reforms are being implemented, further examination of gender issues within the health workforce is required. In particular, future research should carry out in-depth analyses to compare the differential working conditions of nurses, doctors and other health professionals to see what influence this has on implementation of national health policy reforms. In addition, there is need to examine social constructions of gender and how this interfaces with professional roles, which are also gendered.

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Chapter Three

Manuscript 2: You Cannot Just Tell me, “Now Cook!” : Kenyan Nurses and National Policy-making

Potential Journals: Health Services Research

Abstract

Purpose: The purpose of this study was to critically examine how nurses had been involved in national policy processes in the Kenyan health sector.

Design: This paper reports on qualitative results from a two-phase mixed methods study, which involved qualitative data collection in phase one and quantitative data collection in phase two.

Method: National non-nursing decision-makers and nurse leaders, provincial and district managers and district frontline nurses from two Kenyan districts were purposefully selected for interviews. The interviews asked about national policy processes and nurses involvement in same, barriers to nurses’ engagement in policy processes and ways to enhance nurses’ involvement in policy processes. Data analysis included coding, categorizing and further analysis using matrices to identify shared and different perceptions among participant groups.

Findings: Nurses’ involvement in policy processes was limited. Only three nursing leaders were involved in national policy committees as a result of their positions in the sector. Frontline nurses and managers described their role as that of policy implementation. Hierarchies and structural factors, gender issues and nursing professional issues emerged as factors hindering nurses’ involvement in policy processes.

Conclusion: There is a need to engage more nurses in policy processes at all levels of the system to enhance quality of services to communities. Policy-makers should address factors hindering nurses’ participation in policies making processes. Nurses should be more pro-active in health policy matters and develop capacity and strategies to enhance their participation in policy processes.

Key words: Nurses, Kenya, Policy involvement, health care system,

Introduction

With the global debates around health policy reforms, there have been increasing calls for nurses to be actively engaged in national policy processes (Abood, 2007; Gibb, 1998; Hewison, 1999; ICN, 2001, 2008; Spenseley, Reutter & Allen, 2006; WHO, 2002). This engagement has been encouraged for two main reasons. First, nurses comprise the majority of the global health care workforce, working closely with patients and their families in a variety of settings. Thus, nurses' experiences and insights can help improve the quality of health service delivery and inform health systems strengthening. Second, many health sector policies have an impact on nurses' professional practice. Given the importance of the work environment for nursing practice, nurses' input on health sector policies could help ensure that supportive work environments for clinical practice are taken into account when policies are reformed. Given nurses' pivotal role in health care delivery, their engagement in policy changes in the system has been described as both a moral and professional obligation as well as a responsibility to the people they serve (Aroska, Maldow & Good, 2004; Ballou, 2000). The engagement of nurses in national policy processes is especially important in lower income settings where nurses comprise an even larger proportion of the workforce and where the largest burden of illness exists. This paper examines how nurses have been involved in national health policy processes in Kenya, from the perspectives of nurses and decision-makers at various levels of the health care system.

Nurses and Policy Influence

Nurses have historically lacked influence on national policy and political decisions that affect health service delivery (Antrobus, 2004; Antrobus & Kitson, 1999;

Hewison, 1999; Gebbie, Wakefield & Kerfoot, 2000; WHO, 2001, 2004). Literature reveals several reasons for their under-engagement in policy including: lack of awareness of policy related issues and processes, inadequate knowledge and skills on how to contribute to policies, and lack of opportunities to contribute to policy decisions (Hannigan & Burnard, 2000; Fiffe, 2009; Spenceley, Reutter, & Allen, 2006; Whitehead, 2003). In Kenya, these factors have been attributed, in part, to an inadequate policy focus in undergraduate and graduate nursing programs (Rakuom, 2010).

In addition, nurses' limited participation in policy processes has been attributed to gender differences in the health care system (Boswell, Cannon & Miller, 2005; Buchan & Aiken, 2008). Nursing is predominately viewed as a woman's occupation involving caring for others, while men are typically seen in positions of power and decision-making (Boswell, Cannon & Miller, 2005; Wicks, 1995). Thus, men are more likely than women to be involved in public policy and to influence policy decisions.

The low participation of nurses in health-related policy decisions has been documented in both developed and developing countries. In the United States of America, this limited participation has been attributed to heavy workloads, gender differences and lack of political skills (Boswell, Cannon & Miller, 2005; Oden et al., 2000). These studies revealed that even though nurses were highly educated and held senior positions in government, active involvement in public policy decisions was low.

How nurses can engage in policies

Nurses can influence health policy at various system levels including global, national, and organizational and community (Cheek & Gibson, 1997; Hardie, 1997; Russell & Fawcett, 2005; Malone, 2005; Mason, Leavit & Cheffee, 2007). Globally,

nurses can contribute to international policy agendas, and nationally or at the state level, nurses can influence government policies, legislation related to health care service delivery and licensing of health professionals. At the organizational level, nurses can influence the setting of standards and workplace policies, and at the community level, nurses can engage in community advocacy activities. More emphasis has been laid on involving nurses in resource allocation decisions in the system (Sarikonda-Woita & Robinson, 2002; Walker & Gilson, 2004). Walker and Gilson add that nurses can engage in resource planning and identification, addressing concerns and continuous monitoring and evaluation of service delivery within health organizations.

Literature provides several strategies that can be applied to enhance nurses' engagement in policy processes. To influence the policy development process, nurses must develop an understanding of policy and politics (Banschbach, 2008; Cook, 2008; Ferguson, 2001; Taft & Nana, 2008). This can be achieved by integrating policy courses in nurses' training (Hannigan & Burnard, 2000; Reutter & Duncan, 2002). Nurses can also learn about policies and policy influence through internship and fellowship programs (Leavette, Chafee & Vance, 2007).

Other studies have emphasized nursing leadership as the way through which policies can be influenced and shaped (Antrobus & Atkinson, 1999; Borthwick & Galbally, 2001). Nurses can engage in policy processes directly by assuming formal leadership positions in the health care system, and indirectly through lobbying and advocacy with policy-makers via professional organizations. Nurse leaders can identify issues strategically, work with decision-makers, and understand who holds the power in the health care organization and workplace and who controls the resources for health care (Ferguson, 2002). Examples of programs developed to enhance nurses' competency in

leadership and policy influence exist mainly in developed countries (Hewison, 2001; Ferguson & Drenkard, 2003; Spenceley, Reuter & Allen, 2006). For instance, Ferguson and Drenkard (2003) described a program developed in the US to train nurse leaders who would influence policy. The training helped the nurse leaders to understand how policy reforms affect health care, the policy formulation process, and the challenges affecting health care including access, quality and care as well as the role of media.

Nurses in general can engage in policy advocacy to address improvements in their work situation as well as to speak for patients, families and communities in areas where those in need of care have little or no voice (Gebbie, Wakefield & Kerfoot, 2000; Spenceley, Reuter & Allen, 2006; Vaartio & Kilpi, 2005). The advocacy role of nurses has been described by these authors, as a way to preserve care values and ethics such as advocacy for reforms that better address the needs of vulnerable patients, and as a moral act of identifying human needs and protecting human rights in the healthcare context by talking for the clients.

Several studies have emphasized the need for nurses to utilize research to inform policy decisions (O'Brien-Pallas & Bauman, 2000; West & Scott, 2000). Research evidence enables nurses to have a credible influence on health policy reforms (Lee, Tinevez & Said, 2002). However, it has been argued that nurses from low and middle-income countries, have inadequate training and mentoring in research and scarce resources for conducting research (Edwards et al., 2009; Shaibu, 2006;). Thus, there is a need to strengthen nurses' research abilities in these countries to enhance knowledge generation for policy change.

Theoretical underpinning

This study was guided by critical theory and feminist perspectives in policy analysis. Critical theory aims to examine hierarchies, power and domination inherent in policy processes as well as how policies are experienced by people in their environments (Marrow, 1994; Duncan & Reutter, 2006). These hierarchies may influence how people participate in policy decision-making. Thus, in this study, critical theory helped in identifying these hierarchies in relation to nurses' involvement in policies. Feminist theories are related to critical theory but focus on gender domination and discrimination within patriarchal societies (Cook & Fonow, 1990; Reinharz, 1992). From feminist perspectives, analysis examines formal power structures that create or maintain gender inequality, thereby systematically elevating men above women (Kanter, 1998; Meyers, Anderson & Risman, 1998). Critical and feminist perspectives can generate transformative knowledge leading to social change (Racine, 2002). These perspectives of critical theory and feminist perspectives guided the study process.

Methodology

The overall study applied a two-phased mixed methods design to examine the influence of policies on nurses' work in district health care systems. Phase one involved a qualitative design and phase two used a quantitative design. The impacts of policies on nurses work is reported in the first paper. This paper focuses on results of the qualitative phase, describing how nurses were involved in national policy processes in the Kenyan public health sector.

Study setting

The study was carried out in the Kenyan public health care system, since this sector has more responsibility for policy development and service provision than the private health system. The health delivery system is organized in a pyramidal structure with six levels of care. The community is the first level, followed by dispensaries and medical clinics, health centres and nursing homes, primary hospitals at the district level, secondary hospitals at the provincial level and tertiary hospitals at the national level. Major decision-making structures exist at national, provincial, and district levels, all of which include nurse representation. The majority of Kenyan nurses work within the districts and in the public sector.

Sampling

Decision-makers employed by and working at the Ministry of Health headquarters were eligible for selection. The Ministry has a central mandate of policy development. At lower levels, two provinces were selected purposively because of their varied geographical locations, and differences in health indicators. Nyanza province had poor health indicators and few health service resources, while the Central province had better health indicators and more health service resources (MOH, 2004). One district was then purposefully selected from each of the provinces and the two main district public hospitals were the sites for sampling district-level nurses and managers. Decision-makers at national, provincial and district levels were purposively sampled based on their positions involving policy development or implementation (Sandelowsky, 2000; Teddlie & Yu, 2006). Nurses and nurse managers in district hospitals were selected based on a

sufficiently long work history which gave them potential familiarity with many of the policy changes affecting nursing and health system reforms in Kenya.

Data Collection

Data were collected by the first author through face-to-face interviews between October 2008 and December 2009. Open-ended interview guides tailored to participant groups were used with all key informants. Three different tools were used: one for national level decision-makers, one for decision-makers at provincial and district levels and one for frontline nurses and managers at the hospital level. Participants were asked questions on national policy-making processes; nurses' engagement in policy-making and implementation processes; and improving nurses' involvement in policy processes. Questions on policy-making processes were only directed to national decision-makers and national nurse leaders. In addition the researcher kept field notes during the visits. Interviews took 45 to 60 minutes and were audio taped with participants' consent.

Data analysis

Audio-taped data were transcribed verbatim and analyzed simultaneously with data collection. Transcripts from each participant were read repeatedly before and after coding to gain a sense of the whole interview. Data were clustered in three groups including non-nursing decision makers, nurse leaders, and nurses and nurse managers. Using an inductive analysis approach, the data were initially coded into categories according to the groups. Matrices were then used to compare categorized responses of national level non-nursing decision makers, national nurse leaders and frontline nurses and managers (Miles & Huberman, 1994; Creswell, 2003; Maxwell, 2003). Similarities and differences in the participants' responses were also identified by groupings (Ryan &

Bernard, 2003). Data were analyzed and interpreted in the context of critical and feminist perspectives. This analysis included identification of historical hierarchies and structures as well as gender-related issues affecting nurses' participation in policy processes.

Ethical Approval

Ethical approval was obtained from relevant ethics boards in Canada and Kenya. Administrative approval was also obtained from the Ministry of Health in Kenya, provincial health offices, district offices and the two hospitals, where study participants were recruited. Informed consent was obtained from each participant. Participants' privacy was maintained during interviews and information shared by the participants was kept confidential. No personal identifying information was included in the transcripts.

Findings

A total of 32 interviews were conducted. At the national level, five interviews were conducted with non-nursing decision-makers at the Ministry of Health, one interview with the World Health Organization country representative and three interviews with national nurse leaders. Each of the three national nurse leaders had risen up the ranks from the district level to the national level and had worked for more than 20 years in public service. At the provincial level, two non-nursing decision-makers and two nurse leaders were interviewed in Nyanza and one non-nursing decision-maker and two nurse leaders interviewed in Central province. At the district level, one nurse manager in each district office and seven frontline nurses and managers in each hospital were interviewed. Table 1 presents a summary of the number of participants.

Table 1: Study participants

Levels	Non-nursing decision makers	Nurse leaders	Front line nurses and managers	Total
National	6	3	-	9
Provincial				
<i>Nyanza</i>	2	2		4
<i>Central</i>	1	2	-	3
District				
<i>Nyanza</i>	-	-	8	8
<i>Central</i>		-	8	8
Total	9	7	16	32

The findings include an overview of actors in the policy formulation process, the views and perspectives of the participants on the extent to which nurses participate in policy processes; reasons for nurses' under-engagement in policies; and suggestions to enhance nurses' participation in policy as well as policy communication, implementation and feedback.

Actors in Policy Formulation

There were multiple actors influencing policy reforms in the health sector. International organizations, including the United Nations and other multi-lateral agencies, particularly the World Health Organization, World Bank and the International Monetary Fund, have pushed policy agendas, which have been adopted in Kenya. At the national level, the government was the main actor responsible for policy formulation in the health sector. Participants described increasing external and internal stakeholder involvement in national health sector policy formulation in the past five years. The roles of donors, civil society and other sectors (e.g. education, environment, finance and social sectors) were emphasized. Professional bodies like the Kenya Medical Association (KMA) and the

Kenya Nurses Association were represented in some policy and strategic planning meetings. One non-nursing decision-maker related the involvement of many stakeholders to a cooking pot:

“It is like a cooking pot, ideas come from many internal and external areas and they get cooked. What comes out is then totally owned within the system.

Suggestions come from everywhere (....), World Bank, WHO and the government would each put some suggestions on the table, and what we do is to look at all these suggestions to see what would address our objectives”.

Nurses’ Involvement in National Policy Formulation Processes

Only three nursing leaders from the offices of the Chief Nurse, the Nursing Council and the National Nurses Association had been invited to participate in national policy committees as part of their jobs. The nurse leaders’ roles revolved around representation of nurses’ issues at selected policy tables, communication of policies to nurses and regulation of nursing education and practice. The Chief Nurse was charged with the highest responsibility of representing all Kenyan nurses at policy meetings. The other two nurses attended only a few meetings. Two of the non-nursing decision-makers felt that nurses were adequately involved in national policy-making processes through the nurse leaders’ representation. In contrast with this view, all nursing participants felt that the representation of nurses by only three nurse leaders in those structures was inadequate given the large number of nurses in the country.

Even though nurse leaders did have opportunities to participate in national policy formulation processes, their contributions were considered inadequate by both the nurse leaders and non-nursing decision-makers. While non-nursing decision makers attributed

nurses' inadequate contribution to their singular focus on nurses' issues, the nurse leaders attributed their inadequate contribution to their inadequate representation on national policy committees. Representation was mainly by heads of departments, the majority of whom were doctors. The Public Health Act, which allows doctors to be the heads of ministerial departments, as well as provincial and district health offices, affords doctors this role.

Normally the heads of the various departments sit down; many of them are headed by doctors because of the Public Health Act. There would be a nurse representative and others would be doctors and the technical people; nurses and other health officers are not well represented. (National nurse leader)

The dominance of doctors in policy decision-making at the national level was also reflected in the nurse leaders' uneven participation in policy meetings. According to nurse leaders interviewed, nurses only attended those policy meetings requiring reports on nurse situations, while doctors were active in every policy meeting regardless of the policy content. Furthermore, nurse leaders noted that many of the final policy decisions had been made without nurse leaders being present. Nurse leaders attributed their low contribution at the policy tables to the fact that previously, nurses had not been involved at all in the policy process, noting that many nurse leaders did not have adequate skills to influence policy decisions. While frontline nurses and managers recognized the role of their national nurse leaders in representing them at policy tables, they felt they had not done this adequately, since nurse leaders did not consult with them when policies were being made.

In general, the participants felt that nurses had not been adequately involved in policy formulation processes. They felt strongly that nurses should actively participate in

all policy processes. Even though policy making was considered a national level activity, nurses at the frontline felt that they could provide input for action by policy-makers, since nurses comprised the majority of health workers on the ground. They added that their contribution was important since nurses better understood the care environment.

Generally nurses have not been fully involved right in policy formulation. I believe nurses need to know the reason behind the formulation of specific policies. Many a time nurses are involved after policies have been formulated, and maybe just a few nurses [Nurses leaders] at the headquarters; the province is just informed later that this is happening, but really there has been no good input from nurses. (National nurse leader)

Nurses should be consulted before policies are started because we are the majority. They decide for us (...). Nurses have everything that they need, if education they have, if brains they can think, but they lack chance to air views. They stamp on what is already decided. We should decide and give the feedback at national level right from lower level. (Provincial nurse leader)

Reasons for Low Involvement of Frontline Nurses and Managers in National Policy Processes

The participants gave several reasons as to why there was inadequate frontline nurses' participation in policy processes. One reason was that policy making primarily followed a top down approach from central level. This approach denied nurses' opportunities for direct involvement in national policy decisions because most nurses are

employed at lower levels of the health care system. Nurses viewed policies as prescriptions from above that they were supposed to follow. As one nurse manager said *“for me policy-making is a thing for those at the top, whether they are doing the right thing or not, to them it doesn’t matter”*. Another frontline nurse commented that; *“Policies are made from above, they are not made according to how you discuss or want things to be done, they are just brought and you are supposed to follow them”*.

Another reason for nurses’ low engagement was lack of knowledge about the policy-making process and lack of skills to engage in this process. Non-nursing decision-makers described policy making as a complex process, which required knowledge and skills that many nurses did not have. The decision-makers blamed the nursing profession for its tradition of being a “closed” professional group, concerning themselves only with professional issues and not broader issues affecting the health care system. A few of the decision-makers felt that nurses were isolating themselves from other health professionals and failing to market themselves as important providers in the health care system. In addition, they felt that nursing had a hierarchical system that hindered junior nurses from participation as reflected in the following comment:

Nurses are allergic to change. They behave like the military in uniform and they take orders. Nursing profession discourages nurses from thinking because it’s the matron who decides, leaving little room for other nurses (...). They have put a self-imposed mind block by relying on another person to make decisions (...) They go through a very hierarchical system unlike other professions. While a nurse will still report to a nursing officer, she cannot make decisions on her own, it is the biggest weakness, there is no freedom and they maintain the status quo. (Non-nursing national decision-maker)

Nurse leaders concurred that nurses did not understand the broader issues outside nursing that were necessary to influence policies. This was blamed on nursing education. One nurse leader emphasized that basic nursing training did not include policy issues. Others felt that nurses' low participation was due to the general design of the health care system, which excluded nurses from policy-making structures.

It is by design of health system that nurses are not brought at the policy tables.

Number two is that majority of nurses lack knowledge and skills. When you bring the nurse on the table, does he have the knowledge and skills to support that policy? The thing is to bring people who would add value; therefore nurses should be made to add value when opportunity comes for them to sit on the policy-making tables, not to be a passenger but to be a participant. (National nurse leader).

Another limitation was the inability of nurses to bring forward research evidence to policy formulation. Nurse leaders commented that nurses had inadequate skills for generating and utilizing data and research evidence to influence policy.

Frontline nurses complained that a further impediment was the failure of nurses to take united action to influence policy. They had different professional associations (the Kenya Registered Nurses' Association and Kenya Professional Nurses Association), which served different nursing groups and tended to divide nurses and their leaders.

Enhancing nurse participation in policies

Several suggestions emerged regarding how nurse participation could be enhanced. First, participants commented on what decision-makers could do to enhance nurse participation in policy processes. Suggestions here included: creation of more

opportunities for nurses to contribute to policy processes, as well as addressing issues of under-representation of nurses in policy-related structures. Others added that the public health law should be reviewed to allow nurses to compete for leadership positions in the system.

Frontline nurses said that nurse leaders should be given “more voice” at the policy table. For instance, these respondents felt that national policy-makers should consult frontline nurses when developing national policies. It was their view that this would enhance bottom-up policy making. As one frontline nurse said:

I believe there is a way of channeling suggestions until they reach the national level, maybe through the nurses in charge of hospitals to the provincial then to the national level through writing and meetings.

Second, participants described actions that could be taken by nurses themselves to enhance their participation. Nurse respondents suggested that the nursing profession should empower nurses, through training, to enable them to better understand and participate in policies. As one nurse leader commented:

The foremost is to empower nurses with knowledge and skills to enable them to participate in policy forums. It includes redesigning the nurse curriculum, retraining and motivating nurses to have a lifelong learning. When you talk of policy you need to think of things beyond nursing skills, because we need to see things in our own perspectives and from the others' perspectives, and that requires a very broad knowledge.

Another nurse leader emphasized the importance of knowledge in the way the government operates stating:

The bottom-line is that you must be knowledgeable, you may be a real nursing guru, (....) your contribution should not only be based on care, of course care is very critical, but you must have general knowledge like how the government operates. Just like members of parliament, you find somebody sits in parliament but his contribution is low. Majority of nurses don't want to know anything apart from nursing, but you are supposed to have general knowledge, like when we talk about the IMF policies, how does it affect us?, what happened?

Other areas identified for skills-building were: political skills needed to engage the government to address policy gaps that affected nurses' work, and data management and research skills needed to bring evidence to policy. One nurse leader suggested:

Data management and data utilization is very critical. We need to sensitize nurse managers at the district levels on nursing research. That is part of the process of empowerment so that they can be able to start using the data and participate actively in decision-making process and that is the earliest stage to start promoting them to be involved in policy-making.

Some nursing participants mentioned that the opinion of frontline nurses could be sought through research and regular meetings, and then brought to policy-making processes.

Non-nursing decision-makers strongly suggested that nurses themselves should take the lead to change their situation. They mentioned that nurses should market themselves, progress in their careers, diversify, venture outside the nursing profession and broaden their curriculum in order to understand broader policy related issues.

There is what we call building of empires around nurses (....). Nurses must be free to venture into other areas of health provision and be seen to be competent in

those areas and not tied to nursing. The ball is in nurses' court. We are ready to embrace and support (...). The medical profession is much more marketized than nursing. More often, you find doctors in areas, which are not related in any way to medicine and they fit well. They don't have to link strongly to their profession, they are more independent. (National non- nurse decision-maker)

Congruent with this decision-maker's opinion, nurse leaders added that more nurses should position themselves to take up leadership roles in the system. They indicated that nurses should diversify, be united to build a strong voice, collaborate and network within and beyond the country and be assertive on what they want. They added that the nursing council and the professional association should be strengthened to enhance their role in influencing national policies that affect nurses' work.

Frontline nurses added that nurse leaders should be more proactive in policy activities so as to influence policy-makers. The nurse leaders should advocate for better work conditions for nurses. Some frontline nurses felt that addressing their work issues would be an incentive for their participation in decision-making in the sector. As their representatives, the frontline nurses felt that nurse leaders should come to the ground more often and get views from frontline nurses to include in policies:

Nurse leaders are at the top, when there are issues to be discussed, they can come down, involve us in discussions and gather information, so that when they make these policies they know it is something that has been discussed, it has been understood and it is needed, because occasionally I am told there are policies that have been made [and] when they come down here they don't even work.

In the workplace, nurses felt that all nurse managers and ward representatives should be actively involved in policy decision-making in the hospitals through regular

meetings. A common view, among frontline nurses, was that they were excluded from policy decisions even in the workplace. This illustrates the hierarchical decision-making in the system. Another frontline nurse expressed this concern:

We are not involved, yet we are the ones who really are on the ground, we are the backbone of the hospitals. The other people come to write papers and go away (...). We are like a mother in the kitchen, we are the ones who know how much we need, so we should be really involved in every step, because you cannot just tell me ‘now cook’ and even I was not there in the shopping but you want to see what I am cooking; it is very difficult, we should be involved from the word go.

Policy Communication Implementation and Feedback

Participants were asked how policies were communicated to frontline nurses. Many policies were brought to the facilities as brief circulars describing the changes to be implemented. Frontline nurses also received policy directives through their immediate supervisors. Major policy documents, including strategic plans, rarely reached frontline health workers and managers. According to a non-nursing decision-maker, distribution of the plans to lower levels was too expensive, and the strategic plans were considered complex documents that were only appropriate for use at the national level. Some frontline nurses felt they did not get adequate orientation on these policies. Consequently, these nurses felt that they lacked adequate information about national policies and the implication of these policies for their work.

Participants at all levels noted misinterpretations of national policies. One decision-maker commented that *“it is the issue of skills (...) even at the national level, policy interpretation is an issue. Provincial level interpretation gets less, at the district*

level interpretation is even lesser". One provincial level decision-maker added that policies were occasionally misinterpreted and sometimes certain policies were rejected by senior and frontline workers, including nurses at the district levels, leading to poor implementation.

At the frontline, the majority of nurses participated as policy implementers. However, interviewees observed that frontline nurses and managers were not adequately involved in policy decisions at the workplace. Due to their inadequate involvement, nurses felt that their work-related issues such as staff shortages, motivation, and resource inadequacies had not been addressed, yet they were expected to deliver quality services. They felt that policies were just pushed on them, so they sat back and watched or did only what they could, as one provincial nurse leader commented:

Lack of nurses' involvement in formulation is the cause of poor implementation. Policies are pushed on them, owning them becomes a challenge. They are not positive towards it, but since they have to comply, they do it but not in the right way. When you are involved from the beginning, you understand and own it, and during implementation, you have inward drive to accomplish what you planned (....). We feel like we are pushed at the corner, so we remain there and watch things as they are done, or do things because they must be done, not that we feel motivated to do them.

Another issue of concern with policy implementation was the lack of a feedback mechanism. Frontline workers, including nurses, did not give or receive feedback on policies they implemented, as one provincial level decision-maker commented:

You disseminate the policies to the grassroots, and there is no specific timeline for feedback (...) there is a danger of not getting feedback; when you get feedback

immediately and feedback to the source, it is easier to correct the gaps, sometimes the feedback is not got at all, or it may just come up when you are discussing other issues at the head quotas. We don't have a well laid system of giving out feedback and getting it back. (Provincial level decision-maker)

Discussion

From a critical perspective, two major issues influencing nurses' involvement in policy processes emerged. These issues are hierarchies and structures influencing decision-making in the health sector; and nurse and nursing professional issues. These issues are discussed below.

System Hierarchies and Structures

This study revealed three intersecting hierarchies that hinder nurses' active engagement in policy processes in Kenya: health systems hierarchies, inter-professional hierarchies and intra-professional hierarchies. The organization of decision-making in the Kenyan health care system follows political administrative levels including central headquarters, provincial and district levels. The political structures mandate the central administration as the policy making and service planning level. The Kenyan health policy framework of 1994-2010 emphasized that policy formulation was the role of the central office (MOH, 1994). This top-down policy-making process limited nurses' opportunities to engage directly in policy formulation in the health care system. Nurses described their role as that of policy implementers and not of policy formulators. Findings from this study are consistent with those reported in a South African study (Walker & Gilson, 2004), which identified an absence of bottom-up policy perspectives from "street level

bureaucrats”, in this case, the nurses. Given the top-down nature of policy-making processes in the health sector, particularly with the many stakeholders and foreign donors involved, the findings speak to the importance of finding ways to give front line nurses some voice in decision-making at lower levels.

The inter-professional hierarchy emerged from the findings with doctors being the dominant policy decision-makers at various levels of the health care system. The social constructs of race and gender help to explain these hierarchies. As mentioned above, the Kenyan health care system illustrate that the rationalization and gendering of the health care system emerged from colonial days (Rakuom, 2010). The racial influence on health systems could be explained through the development of systems of care around institutions that favored a male-dominated medical profession over a female-dominated nursing profession, by the white colonialists. The education system prepared doctors with first degrees while nurses acquired certificates and later diplomas. This placed doctors in a higher class with more decision-making authority in the system as opposed to nurses whose education and status were considered low. This precluded nurses from being placed in higher decision-making positions.

Another contemporary factor that has sustained the inter-professional hierarchy is the legal system, specifically the Public Health Act, which led to the systematic exclusion of nurses from senior leadership positions at various levels of the health care system in favor of doctors. According to the Act, doctors were placed as the heads of various departments, as administrative directors of districts and hospitals or as those in charge of various programs, while nurses were only placed in positions to represent nurses, thus limiting their participation in policy and other health care decisions. This reflects how legislation legitimizes the role of one particular profession over another. In addition, this

is an important factor that has also limited the types of issues nurse leaders have brought to the policy table. Another tension was the nature of nurse leaders' participation at policy tables, which was considered *nursing centric* by both nursing and non-nursing leaders. While a majority of the decision-makers blamed nurse leaders for nursing centric participation, this kind of participation was shaped by the system, which mandated nurse leaders to report only on nursing issues. This is consistent with a global study (Salmon & Rambo, 2002) of nurse leaders focusing on Chief Nursing Officers, which revealed that even though these nursing leaders had varied responsibilities associated with their positions, they were only asked to provide nursing-related advice.

Other international studies have observed that the design of the healthcare system is masculine and bureaucratic with greater power accorded to doctors to make service delivery decisions, thus silencing nurses' voices (Antrobus, 1997; Valentine, 1996). More generally, the nursing profession, in many parts of the world, has been caught between the patriarchal powers of the medical profession, bureaucratic systems and political structures, which sustain inequities in decision-making (Bunting & Campbell, 1990; Van Der Merwe, 1999). In addition, nurses' work has been associated with women's duty of caring and a notion that nurses have less knowledge, leading to segregation and oppression within the health care system (Reverby, 1987; Valentine, 1996; Wicks, 1995). For these reasons, nurses have lacked power and remained subordinate to doctors in the healthcare system, both at practice and policy-making levels (Melchior, 2004). In Botswana, a strong medical establishment was the main reason why nurses were excluded from policy processes and service planning, leading to further neglect of their issues (Phaladze, 2003). These studies and the present study reveal that as nurses are relegated to subordinate positions through existing legislation and through

the strength of medical associations, doctors continue to hold positions of influence and to make policy decisions that sometimes fail to address nurses' work concerns.

A strong intra-professional hierarchy also exists within the nursing profession. In this study, nurse leaders at the national level were the overall representatives in policy decisions for other nurses in the country. Hierarchies influenced channels of policy communication to frontline nurses who received new policy directives from their supervisors at every level of the system. With only a few nurses operating at the national level, the hierarchy within the nursing profession limited the majority of nurses from participating in policy activities. This limitation and continuous state of powerlessness in decision making reflects the behaviors of those with power and those with less power (Van Der Merwe, 1999). The oppression of lower cadre nurses by higher cadre nurses in decision-making has been documented previously (Daiki, 2003; Materson & Boby, 2007). In the absence of feedback from the grassroots on policy implementation, as identified by participants in this study, the voices of nurses at lower levels might be suppressed further. More participatory approaches could be introduced by enhancing bottom up planning and decision-making in a decentralized system. This would increase the way in which those who have less power in a hierarchy get voice.

Nurses and Nursing Profession

Both nursing and non-nursing participants attributed nurses' under-engagement in policy to issues related to the nurses and the nursing profession. Respondents consistently indicated that nurses had inadequate policy knowledge, and this limited their contributions to policy processes. This deficiency was because the profession had not incorporated policy issues into nurses' training curriculum, thus maintaining a status quo.

Studies in other contexts have revealed how lack of policy content in nursing training contributes to nurses' lack of understanding of policy (Kunaviktikul et al., 2010). Given the need to strengthen nursing leadership to influence policies, other programs have emerged to train nurse leaders in ways to influence policy. In the African context, many nurse leaders have been enrolled and trained in a leadership training program offered by International Council of Nurses. This participation would strengthen the nurses' competency in engaging in national health care decision-making.

Even though policy specific knowledge is necessary to engage in policies, studies in other contexts have suggested that nurses have a vast amount of knowledge from their education and practice experiences regarding service delivery problems and potential solutions that may be relevant to policy (Anrobus & Kistson 1999; Gebbie, Wakefield & Kerfoot, 2000). Nurses in the present study suggested that given the opportunity, they would play a role in decision-making on resource allocation and client needs. They understand the care environment, through their work experiences, and this understanding is necessary to guide effective policy change. While knowledge embedded in nursing practice is important in addressing patients' needs, it is also very important for nurses to understand the policy cycle and other broader health system issues; this might enhance their ability to contribute at the policy table.

Study findings also reveal that nurses had inadequate advocacy, research and political skills required to influence policies. These issues are similar to what has been identified in studies from developed countries (Antrobus, 2004; O'Brien-Pallas & Bauman, 2000; Reutter & Duncan, 2002; Spensely, Reutter & Allen, 2006; Taft & Nana, 2008). In these studies, the profession is seen to have been slow in incorporating these issues in nursing education. Non-nursing decision-makers in this Kenyan study felt that

the profession had reinforced its own weaker professional status by failing to enhance nurses' abilities to influence decisions at strategic levels in the system. Their comments reflected an openness to incorporate nurses' views if nurses were competent in policy processes and more knowledgeable about general health care issues.

This study also reveals passivity of nurses in policy-related activities. This lack of engagement may be due to the prolonged exclusion of nurses from policy-making processes; thus, nurses considered themselves a powerless group who only act on what they were told to do. The passiveness and the notion of powerlessness among nurses has been an issue of discussion in the literature (Abood, 2007; Banschbach, 2008). The studies reveal that nurses have not taken advantage of their power of numbers and expertise to influence decisions. Nurses have been urged to be assertive and to use their potential powers within the health care system to advocate for policy and institutional changes to improve their work and the health of communities in the context of policy reforms. Banschbach (2008) emphasized that nurses should find a voice in influencing policies to address social and economic problems in society. She commented that *"nurses typically have taken a reactive, traditional approach to politics rather than adopting a proactive approach. Thus, our voices remain largely silent until we are forced to react to issues that directly affect our practice, leaving the power of our influence largely untapped. Nurses should keep abreast with policies and political changes and develop strategies and competencies to influence policy change"* (p. 347). This perspective is also relevant to nurses in Kenya and the need for them to be more proactive in developing their ability to influence policy decisions at all levels of the health care system.

Nursing was also described as a closed profession that was only concerned with professional matters. Non-nursing decision-makers felt that nurses had built boundaries

around themselves, which they are not venturing out of to explore other areas of the health sector. With the emphasis on professional transformation towards equality and diversity (Kuhlmann & Bourgeault, 2008; Kuhlmann, 2011), nurses cannot continue to build walls around themselves. The findings emphasize that nurses should diversify their activities and find ways of working competitively with other professionals in the system. This would require nursing champions to take up leadership in policy influence. While leadership competencies have been recognized as key attributes to shaping and influencing policy (Antrobus & Kitson, 1999), in this study nursing leadership was viewed as internal to the nursing profession, with concerns about the focus on nurses' work issues and not general health care issues. This study did not carry out an in-depth examination of the competencies held by nurse leaders that would be useful for policy change, thus future research should examine these aspects.

Conclusion and Recommendations

Although there have been calls for nurses' participation in public policy processes, nurses in Kenya have not been adequately involved. There are only three nurse leaders representing nurses at policy formulation tables when nurses status is to be reported . It will take concerted efforts to enhance nurses' capacity for leadership and policy influence, political skills and use of evidence to inform policy-making to significantly address nurses' lack of involvement in policy-making. Furthermore, existing structures and hierarchies of authority both within and outside of nursing must be addressed if nurses' input on policy-making is going to be significantly altered. The policy makers should address power, domination and gender issues inherent in the health

care system and establish mechanisms through which the views of nurses could get to national level decision-makers when policies are being formulated.

To influence policies, nurses should understand the broader contexts influencing national policy processes, the strategies through which they can influence policies and their unique role in contributing to the achievement of these policies in all domains of nursing including leadership, education, practice and research. Nurses' training curriculum should integrate policy courses to enhance their competency in policy influence. Investments in higher education and policy programs are key in developing nurse's ability to influence policies. In addition, nurses' ability to conduct research, and to use and apply research to influence policy and practice, should be strengthened. Research funders should encourage policy-relevant research and researchers should use knowledge synthesis approaches that are pertinent to policy related questions. In addition, resources to conduct research and to inform policies at all levels should be provided.

Nurses should be more active in determining their destiny in the health system by influencing policy change through formal and informal leadership. This involvement requires competent leadership skills (Antrobus & Kitson, 1999; Cummings et al., 2008; Sorafelli & Brown, 1998). To be effective leaders in policies, nurses should be aware of not only contemporary issues in nursing practice, but also other broader health and social issues affecting service delivery. Furthermore, nurses should be aware of the patriarchal structures that hinder their potential to influence policies that affect service delivery in the system. They should unite to gain power in the health care setting in which they are the majority workforce and challenge policies that hinder their ability to provide quality services to the communities.

This is one of the first studies examining the perspectives of both nurses and non-nurses at different system levels regarding nurses' involvement in national policy-making processes. Studies that focus on nurses' involvement in policy processes in African countries are sparse. Therefore, comparison of the study findings with previous investigations from this African has been limited. Although gender issues influencing nurses' participation in policy have emerged from the analysis, this area requires further examination since participants were not asked specific gender questions.

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Chapter Four

Manuscript 3: Frontline nurses' Perceptions about Health Policies in Kenya
Potential Journal: Journal of Policy Politics and Nursing Practice

Abstract

Purpose: The purpose of this study was to investigate the perceptions and experiences of frontline nurses and nurse managers with national health policies, the extent of their involvement in policy processes and whether nurses working in a district with fewer resources and poor health indicators experienced more negative policy constraints than nurses working in a district with more resources and better health indicators.

Methods: The paper reports on results from a quantitative phase of a mixed methods study. A self-administered questionnaire was developed by the author, from qualitative data collected in the first phase. All eligible nurses and nurse managers working in two purposively selected district-level hospitals in Kenya were invited to participate in the survey. Content validity and internal reliability of the questionnaire were examined.

Analysis: Using Chi-square, t-tests and Fisher's exact tests, responses of nurses in the two districts were compared to test the hypothesis that more negative policy constraints would be identified by nurses in a district with fewer resources and poor health indicators than in a district with more resources and better health indicators.

Results: A total sample of 169, out of 180 nurses and nurse managers approached, completed and returned the questionnaires, yielding a response rate of 94%. Policies that were aimed at strengthening service delivery were more enabling of nurses' work, while policies that introduced changes in financial and human resource allocation had more constraining impacts. The negative constraints were more often experienced by nurses in the district with fewer resources and poor health indicators than in the one with more resources and better health indicators. Nurses reported being excluded from policy formulation processes but playing a major role in policy implementation.

Conclusion: Implications of national policies on nurses' work should be addressed during policy formulation and implementation processes.

Key words: Nurses, Kenya, national health policies, district health care systems

Introduction

Nurses comprise the majority of the health care workforce in most developing countries. Their work is critical for the successful implementation of health care interventions and for the improvement of health and well being of populations (Buchan, 2006; Buchan & Aiken, 2008; Lankshear, Sheldon, & Maynard, 2005). However, nurses in African countries, including Kenya, work within challenging contexts that threaten effective service delivery. Among the issues are heavy workloads, poor working environments, inadequate resources, an insufficient knowledge base and an illness burden that has worsened with HIV/AIDS (Dovlo, 2007). These challenges can be attributed, in part, to national policies that have influenced nurses' working situations and failure to involve nurses in decision-making in the health care system.

This paper presents findings from a comparative survey of nurses in two district level hospitals in Kenya. The objectives were to determine: 1) which national policies were most enabling or most constraining on nurses' work in the district health care system, 2) the extent to which district nurses engaged in national health sector policy processes, and 3) whether nurses experienced more national policy-related constraints in a district that had fewer and had poor health indicators (Kisumu) in comparison with a district that had more resources and better health indicators (Nyeri).

Background

In Kenya, various health policy reforms have been implemented since the 1980s. Primary health care policy was implemented to improve access and equity in service delivery (MOH, 1994). Other policy reforms have emphasized structural changes such as decentralization, and privatization of the health care services to enhance efficiency and

cost effectiveness of services (MOH, 1994; Oyaya & Rifkin, 2003). In the 1990s, Kenya implemented structural adjustment programs (SAPs), which led to reductions in financing the health care system and in health personnel and the introduction of cost sharing (MOH, 1994). More recently, policies aimed at poverty reduction were introduced as a guide for health sector planning (MOH, 2005). With an increase in health sector actors, Kenya also adopted the Sector Wide Approach to Health (SWAp) to improve coordination of donor funding and health sector planning. Nurses have continued to work within the context of these reforms.

Despite the government's efforts and the heavy support from international organizations and donor communities to implement reforms, Kenya continued to report poor quality of health services in the public sector and poor health indicators for most of the population (MOH, 2005; MOH, 2004, 2008). For instance, in the past few decades, there has been a high prevalence of HIV/AIDS and other resurging diseases, such as tuberculosis. The national HIV/AIDS prevalence among adults aged 15-49 years in Kenya peaked at 20% in the late 1990s but reduced to 6.3 % in 2008 (MOH, 2008). It was estimated that over one million adults in Kenya were living with HIV/AIDS in 2006 (UNAIDS/WHO, 2007). Some regions faced worse scenarios as HIV/AIDS was compounded by poverty, very high child and maternal mortality rates, and poor health system infrastructure (MOH, 2004). As a result of this increased disease burden, the demand for nursing services has increased tremendously over the past two decades. However, the Kenyan health care system does not have sufficient numbers of trained nurses to meet current population health needs. This hinders the efforts to achieve the health-related millennium development goals

The Kenyan national nurses' policy document (MOH, 2007) has raised concerns about nurses' capacity in terms of numbers, migration of nurses to other countries, education, motivation and overall nursing structure. A major concern has been the persistent shortage of nurses in the health sector. There has been a huge shortage and an uneven distribution of nurses across Kenya's regions (MOH, 2007). Recent estimates indicate a total of 29,000 nurses are in active practice in Kenya's private and public sectors (Rakuom, 2010). This provides a density of 1 nurse per 1,345 population against the WHO recommendation of a minimum of 2.5 nurses per 1,000 population (Rakuom, 2010; WHO, 2006). Although the government's efforts to train nurses continue, with an average of 1,300 new nurses trained every year, a strange paradox developed with over 7,000 nurses remaining unemployed during the past two decades (Rakuom, 2010). This is because the government stopped hiring public sector nurses in 1996 following the structural adjustment policies. The persistent shortage of nurses and other work constraints pose challenges to the provision of quality care. With the need to improve quality of services in the country, it is important to examine these nursing issues in relation to the broader policies that influence them.

Literature review

Despite the documented influences of national policy reforms on nurses' work, there are gaps in the literature. Few studies have asked frontline nurses about their perceptions of the influence of broader policy reforms on their work and how they contribute to policy decisions. Relevant policy studies relating to nurses' work have primarily been undertaken in higher income countries. Only two policy studies involving nurses in African countries were found. The first was a qualitative study in Zimbabwe

where researchers determined that government policies prompted nursing shortages, contributed to declining work conditions and increased nursing workloads (Basset, Bijlmakers & Sanders, 1997). The other was a mixed methods study by Gilson and Walker (2004) in South Africa, which looked at the impact of free care policy on nurses. They found that nurses were excluded from policy processes, and that social, financial and human resources were insufficiently addressed during policy implementation. The study recommended improvements in central level policy-making, and recognized that implementers of policies, such as nurses, could be resources as well as obstacles to achieving the aims of policy change.

Recognizing that national policies impact on nurses' work has resulted in a push by nursing scholars, the International Council of Nurses (ICN) and the World Health Organization to have nurses provide input in policy development processes. This is in response to studies showing that nurses in many countries have not had a strong voice in determining either changes to service delivery or policy decisions that affect their work (Gibb, 1998; Anrobus & Kitson, 1999; Ferguson, 2001; Reutter & Duncan, 2002; Buchanan & Calman, 2004; Deschaine & Schaffer, 2003; Banschbach, 2008; WHO, 2001, 2002, 2006). These authors reveal that strategies to enhance nurses' ability to influence health and health care policies are in place and they can be applied in health settings globally. Furthermore, these authors have emphasized the need to improve nurses' knowledge and skills about policies and policy influence. This would include developing programs to enhance nurses' competencies in understanding how to influence the policy process (Reutter & Duncan, 2002; Short, 2008). The literature also emphasizes the need for nurses to participate in research to influence policy (Lee, Tinevez & Saeed, 2002; O'Brien-Pallas, & Hayes, 2008; Scott & West, 2001). With the current emphasis on

evidence-based policy (DePalma, 2002; Hewison, 2008; Nannini, & Houde, 2010) nurses can make a contribution to policies directed at improving service provision. The literature also emphasizes the need to develop nurses as leaders in policy and politics (Antrobus, & Kitson, 1999; Deschaine, & Schaffer, 2003; Leavitt, 2009). This is particularly relevant in the context of the current rapid health care changes and health policy reforms that are affecting nursing service delivery (Brothwick & Galbally, 2001; Clarke & Gottlieb, 2008).

According to Longest (2006), all health workers should understand policies and policy processes that affect their work. The Longest model for policy process includes the formulation phase, the implementation phase, and the evaluation and modification phase. Nurses can contribute to any of these phases (Russel & Fawcet, 2005) and these phases are applicable in all settings. Thus, it is essential that nurses understand how policies impact their work and how they can influence policy decisions to improve quality of care. Hewison (2008) provides a framework to enhance nurses' ability to influence policy at every stage of their career. The framework involves a continuum from policy literacy, through policy acumen, policy competency to policy influence.

Method

The survey described in this manuscript was part of a mixed methods study design that was implemented in two phases. The first phase involved qualitative data collection and analysis on how policies influenced nurses' work at the district health care systems in Kenya. Results of this first phase are reported elsewhere. The second phase involved a comparative survey of nurses and managers employed in two district hospitals to determine their perceptions regarding national policies that influenced their work, the

policy constraints experienced in their work, and the extent to which they were involved in policy processes. This paper reports findings of this second phase of the study.

Two main district level public hospitals were purposively selected for this study in two different provinces. The purposively selected districts were Kisumu district in Nyanza province and Nyeri district in Central province. The provinces were selected with a view to testing the main study hypothesis, which indicated that nurses working in a district with fewer resources and poor health indicators would report more negative policy constraints than nurses working in a district with more resources and better health indicators. Nyanza province had poor health indicators and few health service resources; while the Central province had better health indicators and more health service resources (MOH, 2004). For instance, in 2008, Nyanza the HIV prevalence was 14% in Nyanza province compared to 4.6% in Central province (MOH, 2008). Similarly, the infant mortality rate in Nyanza was 206/1,000 live births compared to 54/1,000 live births in Central province in 2003 (MOH, 2003).

Sample

The study population consisted of registered and enrolled nurses working in the two district level hospitals located in study districts. In Kenya, registered nurses are nurses with three years or more of diploma training and/or a bachelor's degree, while enrolled nurses have two and a half years of certificate training. Within the hospitals, a sampling frame of all frontline nurses and nurse managers was obtained from the administrator. All nurses who had worked in the hospital for one year or longer were invited to participate in the study.

Instrument

The survey questionnaire was developed during a pre-pilot stage. Socio-demographic items were derived from a tool used in a previous study by Juma & Kaseje (2006) that examined factors influencing quality of health care at the district level hospitals. The socio-demographic factors assessed were: sex, training background, current designation; job position; and length of working as a nurse, in the current position and in the facility.

The remaining items measured the perceived impact of policies on nurses' work and nurses' involvement in policy processes. Participants were asked to respond using four-point Likert-type scales (Streiner & Norman, 2003). Items for the survey scales were generated in part from qualitative responses obtained from nurses during the first phase of the study. The tool had seven scales. The first scale asked about the extent to which national policies impacted on nurses' work. The policies included were: primary health care policy, decentralization, the freeze on nurses' employment, cost sharing, sector wide approaches to health and poverty reduction. The responses for this first scale were: strongly negative impact (1), negative impact (2), positive impact (3) or strongly positive impact (4). The second scale asked about nurses' work situations influenced by the national policies while the third scale measured nurses' work situations influenced by policies related to structural changes. The response choices for these two scales were: strongly disagree (1), disagree (2), agree (3) or strongly agree (4). The remaining four scales focused on nurses' involvement in policy processes. Items for these scales were based on the Longest model of policy development process (Longest, 2006). One scale measured the extent of nurses' involvement in policy activities and had the response choices of never (1), rarely (2), sometimes (3) or always (4). A second and third scale

measured factors influencing nurses' involvement in policies and consequences of inadequate involvement. Response choices were: strongly disagree (1), disagree (2), agree (3) or strongly agree (4). The final scale measured views on what should be done to enhance nurses' participation in policy activities with choices ranging from not important (1), moderately important (2) important (3) to very important (4).

Face and content validity of the tool were reviewed by five policy and research experts as well as the thesis committee members. They were asked to evaluate the items with respect to wording, accuracy, relevance, completeness and quality (Streiner & Norman, 2003). Following revisions, the tool was further validated (mock-tested) using five peers who were also PhD students with nursing, statistics and behavioral sciences backgrounds. The students completed the questionnaire and provided feedback on quality, accuracy and wording of the tool. The tool was then pilot tested with a sample of ten nurses and nurse managers recruited from a hospital in Kenya that was not included in the study. The inclusion criteria, recruitment and data collection procedures followed the steps described for the main study. The questionnaire was distributed to ten nurses in different units. A face-to-face review of the items was done with the first two nurses. The other eight nurses returned their questionnaires the following day and then shared their experiences completing the tool with the researcher. Final changes were made to the questionnaire based on this input.

Reliability

Three of the scales measuring nurses' involvement in policy, consequences of nurses' limited involvement in policy and enhancing nurses' involvement in policies had overall alphas between 0.75 and 0.90. All items from these scales were included in the

analysis, apart from the one on enhancing nurses' participation, which was excluded because it lacked response variability. The scale on impact of policies on nurses' work did not perform well ($\alpha = .49$), however, items were retained for analysis because they were independent and were considered useful to compare districts. The rest of the scales measuring influence of policies on nurses' work situation ($\alpha = 0.56$), changes relating to structural policies on nurses work ($\alpha = 0.60$) and factors influencing nurses' participation in national policies all had a level of reliability below the accepted .70 value. However, the items on these scales are also presented in this analysis because they reflected the views of nurses from the qualitative data that were collected initially, and therefore were considered important in providing comparisons between the two districts and addressing overall research objectives.

Data collection

Data collection was carried out in December 2009 and January 2010. After approval from the hospital administrators, the nurse managers heading each unit were informed about the study through an information letter. Using the sampling frame, the researcher distributed the information letters and the self-administered questionnaire to all nurses who met the inclusion criteria within their units. In each facility, 90 questionnaires were distributed and participants were given one to two days to bring back the tool if they agreed to participate. The researcher was available at each facility to collect the completed questionnaires and address any issues.

Ethical considerations

Ethical approval was obtained from the University of Ottawa Health Sciences Research Ethics board and the ethics board of the Great Lakes University in Kenya.

Permission to conduct the study was obtained from the Ministry of Health, the two provincial health offices, and the two hospitals. The return of a completed questionnaire indicated a participant's consent. No identifying information was included in the questionnaire. Unique numerical codes were used for all respondents and facilities.

Data analysis

The data were cleaned and analyzed using SPSS (version 12.0). The level of statistical significance was set at $p < .05$, two-tailed. Descriptive statistics, including frequencies, means and standard deviations, were used to summarize the respondents' characteristics within districts. Internal consistency of the Likert scales was assessed using Cronbach's alpha (Streiner & Norman, 2003). Using the guidelines of Nunnally (1978), an alpha of 0.70 was considered an acceptable level of internal reliability.

The four levels of Likert-type responses were collapsed: strongly and moderately negative opinions were collapsed to 'Negative Opinion'; moderately positive and strongly positive were collapsed to 'Positive Opinion'. Respondents were categorized as registered or enrolled nurses. Chi-square and T-tests were then used to compare differences in responses between the nursing cadres and between the two districts. Where the expected values were small ($n < 5$), Fisher's exact test was used. The significant values were adjusted following Bonferroni correction (Pett, 1997). Nurses who did not have an opinion of any issue were excluded from the comparisons.

Results

Sample Characteristics

A total of 169 out of 180 nurses and nurse managers approached completed and returned the questionnaires. This yielded a high response rate of 94%. Table 1 summarizes the demographic characteristics of the nurses who completed the questionnaire. Most of the nurses were female (85%). Just over half (56.5%) had diploma level training, 30.6% had certificate level training, 9.4% had upgraded from certificate to diploma, while only 3% had degrees. The majority of the respondents had nursing work experience of 15-27 years. Nurses in Nyeri had worked for a significantly longer time period in their current position than those in Kisumu (5.7 versus 4.4 years, respectively, $p=.01$). However, the mean number of years the participants had worked as nurses was not statistically different between the two districts (Kisumu=17.0 versus Nyeri = 14.8 years, $p=0.052$).

Table 1: Characteristics of Study Participants (N=169)

	N(%)	Kisumu- N=85 N(%)	Nyeri,+ N=84 N(%)	<i>p</i>
<i>Gender</i>				
Female	144 (85.2)	73(50.7)	71 (49.3)	.8
Male	25 (14.8)	12(48.0)	13 (52.0)	
<i>Training Back Ground</i>				
Enrolled Nurse	64	26(30.6)	38(45.2)	.17
Diploma	84	48(56.5)	34(40.5)	
Cert-Diploma	18	8(9.4)	10(11.9)	
Degree	5	3(3.5)	2(2.4)	

Years in Current Position

Range	1-27	0.2-22	0.3-27.5	.01
Mean	5.1	4.4	5.7	
1-4	93(55.0)	48(56.5)	54(53.6)	
5-9	43(25.4)	27(31.8)	16(19.1)	
10-14	23(13.6)	8(9.4)	15(17.9)	
15-27	5(3.0)	1(1.2)	4(4.8)	
28 and above	5(3.0)	1(1.2)	4(5.8)	

Years in Nursing

Range	1-32	2-32	2-27.5	.052
Mean	15.9	17.0	14.80	
1-4	8(4.7)	4(4.7)	4(4.8)	
5-9	23(13.6)	11(2.9)	12(14.3)	
10-14	38(22.5)	15(17.7)	23(27.4)	
15-27	92(54.8)	48(56.5)	44(52.4)	
28 and above	8(4.7)	7(8.2)	1(1.2)	

Impacts of National Policies on Nurses' Work***Policies Impacting on Nurses' Work***

Respondents indicated that national policies had had both positive and negative impacts on nurses' work (Table 2). The majority of participants (n=147, 87.5%) had a positive opinion about the impact of primary health care policy on nurses' work. Other policies that had positive impacts on nurses' work included decentralization (n=140, 85.5%), poverty reduction (n=92, 59.4%), sector wide approach (n=118, 73.3%) and performance contract (n=103, 62.4). Opinions about the impact of cost sharing were more evenly split with just over half (51.8%) reporting a negative impact. In contrast, the policy on freezing nurses' employment had the strongest negative impact (n=142, 82%). There were no significant differences in responses for any of these items between registered and enrolled nurses. Chi square tests revealed significant differences between the two districts on two items (sector wide approach $p = .009$, and performance contract policies $p = .0009$) with nurses in the less resourced district with poorer health indicators

(Kisumu) being more than twice as likely to have a positive opinion about these policies as those in high resourced district with better health indicators (Nyeri District). (OR= 2.4, 95% CI: 1.2-4.5 for performance contract policy and OR=2.7, 95% CI: 1.2-6.4 for cost sharing policy). The p-value for performance contract remained significant even after Bonferroni correction for multiple tests $p=.021$, while the p-value for sector wide approach was not significant ($p=.082$).

Table 2. Policies impacting on nurses' work compared by districts

Policy	Overall N=169 N (%)	Nyeri + N=84 N (%)	Kisumu- N=85 N(%)	Unadjusted Odds ratio (95% CI)	P value
Primary health care policy					
Negative impact	21(12.5)	14(16.7)	7(8.3)	2.2(0.8-5.8)	0.10
Positive impact	147(87.5)	70(83.3)	77(91.7)		
Decentralization					
Negative impact	23(14.1)	11(13.6)	12(14.6)	0.9(0.3-2.2)	0.85
Positive impact	140(86.0)	70(86.4)	70(85.4)		
Freezing of Nurses' employment					
Negative impact	142(82.0)	68(81.0)	74(87.1)	0.6(0.3-1.4)	0.27
Positive impact	27(16.0)	16(19.1)	11(12.9)		
Cost sharing					
Negative impact	83(49.7)	43(51.8)	80(47.6)	1.3(0.6-2.6)	0.59
Positive impact	84(50.3)	40(48.2)	44(52.4)		
Poverty reduction					
Negative impact	63(40.6)	33(41.3)	30(40.0)	1.3(0.6-2.8)	0.87
Positive impact	92(59.4)	47(58.8)	45(65.6)		
Sector-wide Approach					
Negative impact	43(26.7)	29(35.8)	14(17.5)	2.7(1.2-6.4)	0.009
Positive impact	118(73.3)	52(64.2)	66(82.5)		
Performance contract					
Negative impact	62(37.6)	39(47.6)	23(27.7)	2.4(1.2-4.5)	0.009
Positive impact	103(62.4)	43(52.4)	60(72.3)		

Kisumu(-) =low resources, poorer health indicators; Nyeri (+) Better resources, better health indicators.

Nurses' work situation as influenced by policies

Participants were also asked about changes that had occurred in nurses' work situations as a result of national policies. A majority of nurses strongly disagreed with

the statements that there were enough nursing staff to meet the required standards of care (n=138, 94.5%), nurses had adequate resources to deliver quality services to patients (n=126, 86.3%), and that the infrastructure including equipment and supplies in the facilities enabled the provision of good quality nursing care (n=118, 80.8%). With regard to care provision, most of the nurses (n=96, 65.8%), felt that they were unable to use their professional knowledge to deliver quality care. However, the work environment also did not allow most of the nurses to achieve their caring objectives (n=80, 54.8%). Workload was perceived to be high by almost all nurses (n=133, 91.1%). The majority (n= 92, 63.1%) also experienced work dilemmas due to rapid changes in policies. Although nurses in both districts agreed that resources were not adequate to deliver quality care, negative perceptions were significantly stronger among nurses in Kisumu district (p= 0.003). The value was even strongly significant after Bonferroni correction tests (p=0.0001). Registered and enrolled nurses had similar responses to all items.

Table 3. Nurses' work situation as influenced by policies compared by districts (N=146)

	Overall N=146 (N, %)	Nyeri (N=72) N(%)	Kisumu N=74 N,(%)	Unadjusted Odds ratio (95% CI)	P value
Have enough nursing staff					
Strongly agree/Agree	8(5.5)	5(6.9)	3(4.5)	1.8(0.4-7.7)	0.3
Strongly disagree/Disagree	138(94.5)	67(93.1)	71(96.0)		
Have adequate resources					
Strongly agree/Agree	20(13.7)	16(22.2)	4(5.4)	5.0(1.6-15.8)	0.003
Strongly disagree/Disagree	126(86.3)	56(77.8)	70(94.6)		
Enabling infrastructure					
Strongly agree/Agree	28(19.2)	18(25.0)	10(13.5)	1(0.9-5.0)	0.07
Strongly disagree/Disagree	118(80.8)	54(75.0)	64(86.5)		
Use professional knowledge					
Strongly agree/Agree	50(34.3)	26(36.1)	24(32.4)	1.8(0.6-2.3)	0.64
Strongly disagree/Disagree	96(65.8)	46(63.9)	50(67.6)		
Achieving caring objectives					
Strongly agree/Agree	66(45.2)	31(43.1)	35(47.3)	1.2(0.62-3)	0.60
Strongly disagree/Disagree	80(54.8)	41(56.9)	39(52.7)		

Have high workload					
Strongly agree/Agree	133(91.10)	63(87.5)	70(94.6)	0.4(0.1-1.4)	0.13
Strongly disagree/Disagree	13(8.90)	9(12.5)	4(5.4)		
Experience work dilemmas					
Strongly agree/Agree	92(63.0)	46(63.9)	46(62.2)	1.1(0.5-2.1)	0.83
Strongly disagree/Disagree	54(37.0)	26(36.1)	28(37.8)		

Nurses' work situation as influenced by structural policies

In general a majority of nurses had fairly positive perceptions about policies that introduced structural changes such as decentralization (Table 4). According to many respondents, (n= 93, 59.6 %), the policy had created more senior leadership and management opportunities for nurses in the districts, and collaboration between nurses and other health care workers increased as well (n=113, 66.9%). It was felt that most of the nurses, (n=106, 62.7%), were contributing substantially to general management and service provision decisions (n=115, 68.1%), and a majority (100, 59.2%) were actively involved in the planning of health services in the district due to structural policy changes. Several nurses (52.7%) indicated that they had adequate opportunities for training and that there was work competition between nurses and other professionals due to structural policies (53.7%). However, most of the respondents felt that nurses were not well trained in management of cost sharing funds (n=124, 75.6%), and that nurse managers were not participating in financial resource management (n=94, 58.7%). There were no statistically significant differences between cadres of nurses. However, there were differences between districts with respondents in Nyeri indicating nurses were more likely to assume leadership and management positions than respondents in Kisumu (p=0.029); although nurses in Kisumu reported significantly more opportunities for continuous training than nurses in Nyeri (p=. 04). These differences were not significant with the Bonferroni correction (p=0.0220)

Table 4. National policies relating to structural changes in the health care system

Issues	Opinion	Overall N=169 N (%)	Nyeri+ N=84 N (%)	Kisumu- N=85 N(%)	Unadjusted Odds ratio (95% CI)	P value
Senior leadership & management	Agree	63(40.3)	23(.38)	40(47.1)	0.4(0.2-0.8)	0.029
	Disagree	93(59.6)	54(64.3)	39(45.9)		
Improved collaboration	Agree	113(67.7)	52(61.9)	61(73.5)	0.6(0.31-1.1)	0.10
	Disagree	54(32.3)	32(38.1)	22(26.5)		
Contribute to management decisions	Agree	106(66.2)	49(61.3)	57(71.3)	0.6(0.3-1.2)	0.18
	Disagree	54(33.75)	31(38.75)	23(28.75)		
Contributing to service provision decisions	Agree	115(70.6)	56(67.5)	59(73.6)	0.7(0.4-1.5)	0.37
	Disagree	40(29.5)	27(32.5)	21(26.3)		
Opportunities for continuous training	Agree	88(52.7)	37(44.6)	51(60.7)	0.5(0.3-0.9)	0.04
	Disagree	79(47.3)	46(55.4)	33(39.3)		
Competition with other health workers	Agree	84(53.5)	45(56.3)	39(50.7)	1.3(0.7-2.3)	0.48
	Disagree	73(46.5)	35(43.8)	38(49.4)		
Adequate skills for management functions	Agree	122(73.9)	56(68.3)	66(79.5)	0.6(0.3-1.1)	0.10
	Disagree	43(26.1)	26(31.7)	17(20.2)		
Participating in planning of health	Agree	100(60.2)	50(59.5)	50(61.0)	0.9(0.5-1.8)	0.84
	Disagree	66(39.8)	34(40.5)	32(39.0)		
Trained in cost sharing funds management	Agree	40(24.4)	22(26.5)	18(22.2)	1.3(0.6-2.6)	0.52
	Disagree	124(75.6)	61(73.5)	63(77.8)		
Managers participate in resource allocation	Agree	66(41.3)	37(44.6)	29(37.7)	1.3(0.7-2.5)	0.37
	Disagree	94(58.8)	46(55.4)	48(62.3)		

Participation of nurses in policy processes

Nurses' involvement in national policy formulation and implementation

Few nurses had participated in activities related to national policy formulation and implementation (Table 5). Overall, almost all nurses responded that they had rarely or never participated in national level meetings to discuss national policies and a similar response was provided for the item regarding attendance at management meetings to discuss national policy directives in their workplace. Registered nurses more often reported participating in management meetings to discuss policy directives than enrolled nurses ($p = .0002$). A majority of nurses ($n=145$, 85.8%) had never contributed to the

development of health policy guidelines, and only (n=23, 13.6%) had commented on how national policies should be implemented. Half of the nurses responded that they had sometimes or always implemented national policies.

A majority of the nurses interviewed, (n=142, 84%) and (n=150, 88.6%) had rarely or never participated in evaluating national policies or participated in research to inform policies. With regard to policy advocacy, a majority of the nurses (n=101, 59.8%) had rarely or never participated in advocacy for national policy change. Chi square tests revealed only one significant difference between the districts. Nurses in Kisumu were more than twice as likely to report implementing national policies as those in Nyeri ($p=0.003$).

Table 5. Nurses' involvement in national policy processes

Issues	Opinion	Overall N=169 N (%)	Nyeri + N=84 N (%)	Kisumu - N=85 N (%)	Unadjusted Odds ratio (95% CI)	P value
Attended management meetings	Sometimes/Always Never/Rarely	2(1.2) 167(98.8)	0(0.0) 84(100.0)	2(2.4) 83(97.7)	N/A	0.49
Attended national meetings	Sometimes/Always Never/Rarely	0(0.0) 169(100.0)	0(0.0) 84(100.0)	0(0.0) 85(100.0)	N/A	N/A
Contributed to development policy guidelines	Sometimes/Always Never/Rarely	8(4.7) 161(95.3)	2(2.4) 82(97.6)	6(7.1) 79(92.9)	0.3(0.1-1.6)	0.28
Commented on implementation of Nat policies	Sometimes/Always Never/Rarely	2(1.2) 167(98.8)	0(0.0) 84(100.0)	2(2.4) 83(97.7)	N/A	0.50
Implemented national policy directives	Sometimes/Always Never/Rarely	43(25.4) 126(74.6)	13(15.5) 71(84.5)	30(35.3) 55(64.7)	0.3(0.2-0.7)	0.003
Evaluated impact of national policies	Sometimes/Always Never/Rarely	4(2.4) 165(97.6)	1(1.2) 83(98.8)	3(3.5) 82(96.5)	0.3(0-3.2)	0.31
Participated in research	Sometimes/Always Never/Rarely	1(0.6) 168(99.4)	1(1.2) 83(98.8)	0(0.0) 85(100.0)	N/A	0.31
Advocated for national policy change	Sometimes/Always Never/Rarely	22(13.0) 147(87.0)	8(9.5) 76(90.5)	14(16.5) 71(83.5)	0.5(0.2-1.3)	0.17

Factors influencing nurses' involvement in policy processes

Table 6 shows participants' opinions on factors that influenced their participation in national policies. Overall, almost half of the nurses felt they lacked knowledge about the policy making process. In general, nurses were not consulted when policies were made or reviewed (n=132 , 78.1%) and the majority reported having no opportunities to engage in policy-making processes (n=118 , 69.8%). Furthermore, many nurses had not united in one voice to influence policies (n=103, 60.9%). According to several nurses, the existing committees and boards in the districts did not allow nurses to participate in decisions about policies. Most of the nurses, (n=111, 65.7%), felt that their scope of practice did not include participation in national policy making. There were no significant differences in responses to any of these items between nurses' carders or districts.

Table 6. Factors influencing nurses' involvement in policy processes

Items	Opinion	Overall N=169 N (%)	Nyeri (N=84) N (%)	Kisumu N=85 N(%)	Unadjusted Odds ratio (95% CI)	P value
Lack knowledge about policy-making processes	Agree	70(41.2)	40(47.6)	30(35.3)	1.7(0.9-3.1)	0.10
	Disagree	99(58.6)	44(52.4)	55(64.7)		
Are consulted by national policy makers	Agree	37(21.9)	16(19.1)	21(24.7)	0.7(0.4-1.5)	0.40
	Disagree	132(78.1)	68(80.9)	64(75.3)		
Have opportunities to engage in policy making	Agree	51(30.2)	23(27.4)	28(32.9)	0.8(0.4-1.5)	0.43
	Disagree	118(69.8)	61(72.6)	57(67.1)		
Committees don't allow nurses' participation in decisions	Agree	82(48.5)	40(47.6)	42(49.4)	0.9(0.5-1.7)	0.80
	Disagree	87(51.5)	44(52.4)	43(50.5)		
No use of health information to advocate for policy changes	Agree	122(72.2)	64(76.2)	58(68.2)	1.5(0.8-2.9)	0.24
	Disagree	47(27.8)	20(23.8)	27(31.8)		
Not united to influence policies	Agree	66(39.1)	33(39.3)	33(38.8)	1.0(0.5-1.9)	0.95
	Disagree	103(60.9)	51(60.7)	52(61.2)		
Scope of practice exclude participation in policy	Agree	111(65.7)	50(59.5)	61(71.8)	0.6(0.3-1.1)	0.09
	Disagree	58(34.3)	34(40.5)	24(28.2)		
Well informed about national policies implemented	Agree	67(39.6)	33(39.3)	34(40.0)	1.0(0.5-1.8)	0.92
	Disagree	102(60.4)	51(60.7)	51(60.0)		

Consequences of nurses' limited involvement

The respondents were asked to give their opinion on the consequences of limited involvement of nurses in national policy processes (see Table 7). Overall most of the nurses (n=110, 65.1%) perceived that national policies did not reflect the concerns nurses had about their day-to-day work. They also indicated that they did not have a good working environment (n=118, 69.2%), that nurses were demoralized (n=144, 85.2%) and that they experienced ethical dilemmas when patients were not able to pay for care (n=100, 59.2%). There were statistically significant differences between the districts, with more nurses in Kisumu agreeing that they had a poor working environment ($p=0.03$), were demoralized ($p=0.02$), and experienced more work dilemmas ($p=0.0002$) than nurses in Nyeri. These differences remained statistically significant with Bonferroni correction (work environment $p=0.0251$ and ethical dilemma, $p=0.0059$)

Table 7. Consequences of nurses' limited involvement in national policy processes

Issues	Opinion	Overall N=169 N (%)	Nyeri+ N=84 N (%)	Kisumu- N=85 N (%)	Unadjusted Odds ratio (95% CI)	P -value
Policies do not reflect nurses day-to-day work concerns	Agree	110(65.1)	56(66.7)	54(63.5)	1.2(0.6-2.2)	0.7
	Disagree	59(34.9)	28(33.3)	31(36.5)		
National policy implementation is poor	Agree	75(44.4)	32(38.1)	43(50.6)	0.6(0.3-1.1)	0.10
	Disagree	94(55.6)	52(61.9)	42(49.4)		
Nurses hardly achieve their professional goals and values	Agree	74(43.8)	34(40.5)	40(47.1)	0.8(0.4-1.4)	0.40
	Disagree	95(56.2)	50(59.5)	45(52.9)		
Nurses do not have a good work environment	Agree	118(69.2)	52(61.9)	66(77.7)	0.5(0.2-0.9)	0.03
	Disagree	51(30.2)	32(38.1)	19(22.4)		
Nurses are demoralized	Agree	144(85.2)	66(78.6)	78(91.8)	0.3(0.1-0.8)	0.02
	Disagree	25(14.8)	18(21.4)	7(8.2)		
Policies do not reflect patients & community needs	Agree	79(46.8)	40(47.6)	39(45.9)	1.1(0.6-2.0)	0.82
	Disagree	90(53.3)	44(52.4)	46(54.1)		
Nurses are not trusted by the communities	Agree	19(11.2)	9(10.7)	10(11.8)	0.9(0.3-2.3)	0.82
	Disagree	150(88.8)	75(89.3)	75(88.2)		
Nurses experience ethical dilemmas	Agree	100(59.2)	38(45.2)	62(72.9)	0.3(0.2-0.6)	0.0002
	Disagree	69(40.8)	46(54.8)	23(27.1)		

Discussion

The first objective of this study was to determine which national policies were enabling or constraining nurses' work in the district health care system. Policies that had strong positive impacts on nurses' work were those that were meant to improve service delivery and access. These policies included primary health care, decentralization and sector wide approaches to health. Thus, the findings suggest that these policies brought changes that were more enabling of nurses' work. The enabling factors included more leadership and management positions for nurses, improved nurse collaboration with other health workers and increased participation in service delivery decisions. With the global emphasis on inter-professional practice to enhance service delivery (Ginsberg, & Tregunno, 2005; Freeth, 2001; Zwarenstein, & Bryant, 2007) these changes could have increased nurses' abilities to contribute to work with other professionals in management and planning for service provision decisions at the facility levels. Another enabling factor was the availability of skills training opportunities for nurses. With new care challenges such as those brought by HIV/AIDS and resistance to disease, these skills training opportunities are necessary to enhance nurses' abilities to address these challenges and improve quality care. Even though these changes have been observed by the participants, a good percentage of nurses reported having yet to see their impacts at their workplace.

Policies that introduced changes in financial allocation and staffing had strong negative impacts on nurses' work. The two main policies that brought these changes were freezing of nurses' employment and a financing policy that led to cost sharing. These were part of the Structural Adjustment Programs implemented in the 1990s. Nurses' responses indicated that these policies caused constraints on nurses' work and potentially reduced quality of care. The responses indicated that the freeze on nurses' employment

led to a shortage of nursing staff and high workloads. In addition, changes in financing of the facilities also had an unfavorable impact on nurses' work due to inadequate financing of the facilities, which contributed to insufficient resources including infrastructure and equipment. At the same time, nurses were expected to help manage the cost sharing of funds, yet they had not been trained in financial management. These factors indicate that nurses were not able to achieve their work objectives.

Study findings are consistent with those of other African studies on the negative effects of financial reforms on nurses' work environments (Basset, Biljamakers & Sanders, 1997; Penn-Kekana, Blaauw, & Schneider, 2004). In these other studies, frontline nurses experienced scarce resources and poor working conditions, leading to poor quality of services and community dissatisfaction. In South Africa, Walker and Gilson (2004) found similar effects on the nurses' work situation as a result of free care policy, which did not consider nurses' work environments.

The second objective was to compare whether nurses experienced more policy-related constraints in a district that was resource constrained and had worse health indicators than one that had more resources and better health indicators. Nurses in both districts experienced negative constraints of policies as mentioned above. However, and consistent with the study hypothesis, nurses in the district with fewer resources and poor health indicators (Kisumu) were more likely to experience more negative effects of the constraining policies at their workplace than nurses in the district with more resources and better health indicators (Nyeri). The significant negative effects were resource shortages, poorer working environments and more workplace dilemmas. The difference between the two districts likely reflected Kisumu's low resource allocation and higher burden of disease, which would proportionately require more resources to address. These

differences reflect lack of attention to differential needs in Kenyan districts when national policies are made and implemented. Other studies have pointed to the need to establish information systems and develop equity measures that can be used for the basis of resource allocation to decentralized districts (Standing, 1997; Noor et al., 2004).

The final objective was to determine the extent to which nurses were involved in national policy processes that affected their work. In this study, very few nurses had participated at the level of national policy formulation. Even though the study suggests that nurses at the district levels were less likely to participate in national policy processes due to the perceived lack of opportunities and consultations by policy-makers, literature reveals that nurses at lower level of practice can still influence policies as “street level bureaucrats” (Walker & Gilson, 2004; Lipsky, 1980). Another reason for the limited involvement of nurses might be inadequate knowledge about general health care system and policy-making processes. A majority of nurses in Kenya still have diploma or certificate level training which gives them only clinical skills and keeps them in clinical areas, with little general knowledge provided by advanced nursing programs.

Even though there is little explanation in the literature for lack of active involvement of frontline nurses and managers in policy-making processes, studies have attributed inadequate knowledge about policies and lack of status in the policy arena to the absence of nurses in policy-making processes (Lange & Cheek, 1997; Kunaviktikul et al., 2010). As a consequence, nurses’ inadequate engagement was perceived as the reason for the failure of policy to address their day-to-day work concerns. Furthermore, the real needs of communities were not finding their way to the policy tables. Greater engagement of nurses in national policy-making processes could strengthen consideration of their workplace concerns, such as staff and resource shortages, within such policies.

Even though direct involvement in policy-making by frontline nurses might not be practical, nurses could participate by giving feedback on constraining effects of policy directives on their work and demanding for change.

In contrast with the policy development stage, many nurses had participated in policy implementation at the district level. Even though nurses were not asked about specific implementation activities, their responses indicated that actions on policy implementation occurred at the district level. Similar results were also found in a study in Taiwan where nurses had not participated in policy formulation but played a major role in policy implementation (Kunaviktikul et al., 2010). However, results from the present study suggest that nurses were implementing policies without contributing to major decisions on how policies brought down to them should be implemented at their workplace. Contribution of nurses to policy decisions at this level could facilitate effective policy implementation since prevailing service delivery challenges would be addressed.

Most of the nurses indicated that they had not participated in the evaluation stage of the policy process. Since this stage requires evaluation and/or research skills, nurses might have been left out due to their inadequate capacity in research. Studies have revealed that many nurses are aware of the importance of research in health policy decisions (Lee, Tinevez, & Saeed, 2002). A few studies have also reported that nurses, particularly from low- and mid-income countries, have inadequate research capacity due to inadequate training and mentoring in research as well as scarce resources for conducting research (Shaibu, 2006; Edwards et al., 2009).

Conclusion and recommendations

In this study, nurses have identified both positive and negative constraints of policy reforms on their work. To ensure quality of care across the country, negative policy constraints on nurses should be considered and addressed in policy reform processes. Adequate resources should also be allocated at district levels to enable nurses to implement national policies effectively. Resource allocation according to regional needs address the different contextual challenges and improve nurses' work. Vulnerable districts with higher burdens of disease and historically lower levels of resources should receive proportionately greater resources to improve work environments and quality of care.

Greater participation in policy decisions by nurses at all levels is necessary to address nurses' day-to-day work challenges and quality of care. To do so, nurses need opportunities to participate in policy decisions at all levels. Greater awareness and literacy about national policies is needed to enhance nurses' participation in policy processes. Decision-makers should solicit for views of nurses at the frontline with regard to policies that might affect their work and quality of care. To enhance nurses' awareness, literacy and competency in policy, nursing educators should introduce a course on policy and policy processes in the nursing training curriculum. They should also strengthen frontline nurses' research skills to be able to participate in evaluation and other research activities that might generate evidence to influence policies. Leadership and advocacy skills should also be developed within nursing to enhance nurses' abilities to carry out policy advocacy at all levels. To enhance their role in advocacy, nurses should unite to build a strong voice to advocate for improvements in national policies that affect their work and quality of care. In addition, nursing regulators and educators should be clear

that policy involvement is part of nurses' scope of practice. The results of this study will be useful to health care organizations that are seeking to enhance nurses' capacities and roles in decision-making in the health care system.

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Chapter Five

Integrated Discussion

Introduction

Health care systems are embedded in global policy reforms focusing on financing, organizational change and service delivery. Thus, health experts globally are concerned with the impacts of policy reforms on service delivery and health outcomes. Of increasing concern is how reform policies impact on health service providers including nurses and how providers contribute to policy decisions (Marteneau & Buchanan, 2000; Lethbridge, 2004; Blas & Liambala, 2001; Ssengooba et al., 2007). Nurses comprise the largest proportion of health care providers in the health care system. Any major reform in the health care system will affect nurses either directly or indirectly. This study focused on the impacts of national policy reforms on nurses' work and the extent to which nurses were involved in policy decisions in the Kenyan public health care system.

A qualitative analysis of the impacts of policies on nurses' work was presented in chapter two of this thesis (Manuscript 1). The third chapter presented the qualitative findings describing how nurses were involved in policy processes at various levels of the health care system (Manuscript 2). Chapter four presented comparative quantitative results of nurses' experiences with policy reforms in two different districts (Manuscript 3). In this chapter, I provide an integrative analysis of findings and a brief overview of the conceptual and theoretical underpinnings that guided this analysis. Then I discuss a framework that has emerged from study results. Features of the framework are described followed by a brief description of the interaction between policy contexts and policy agendas and the dynamic policy changes affecting nurses' work. I further present the contributions made to knowledge, the implications of knowledge generated for health

systems and policy and for the discipline and profession of nursing, as well as implications for further research. Finally, limitations of the study and conclusions are presented.

Conceptual and Theoretical Underpinnings

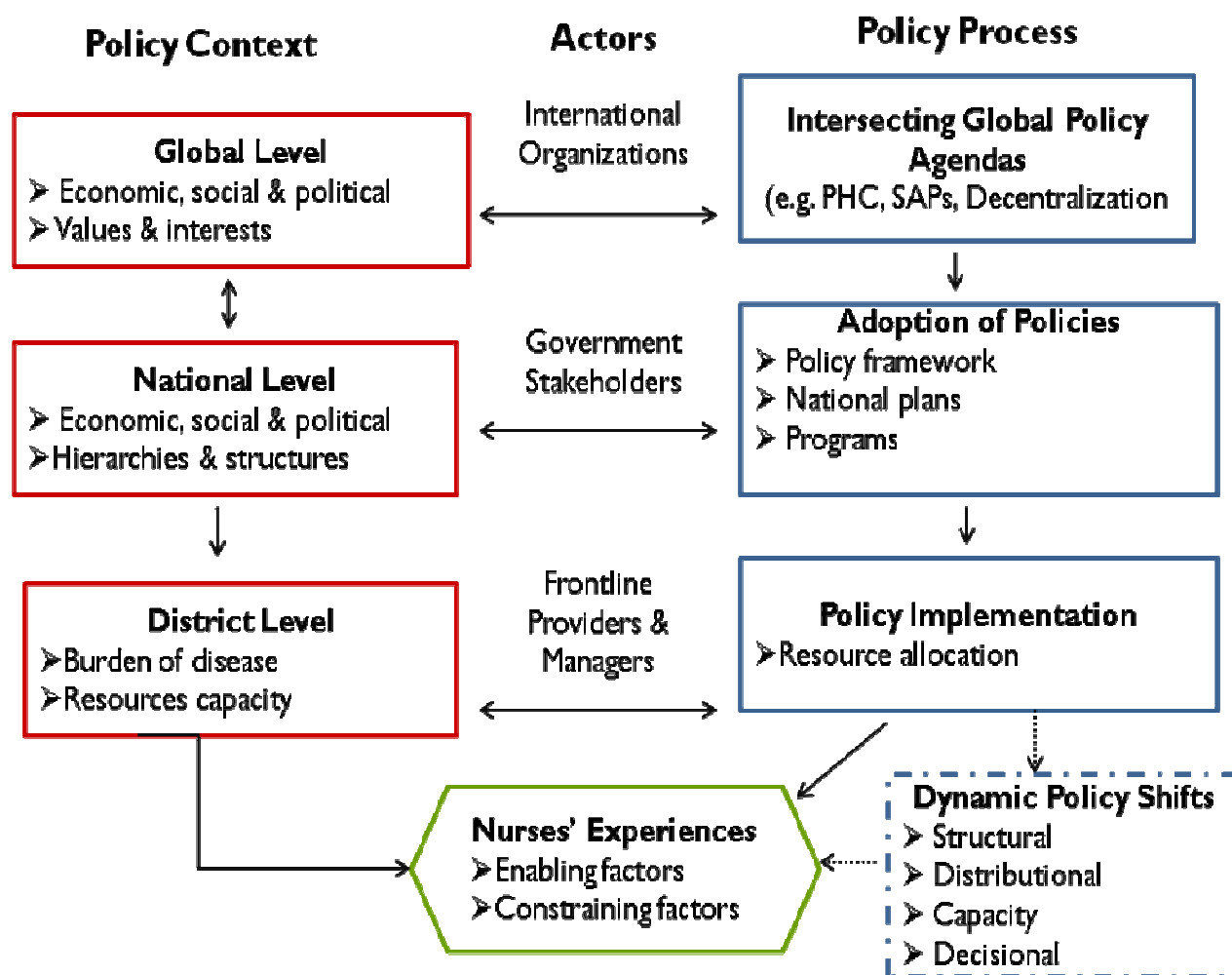
The results of this study are situated within the broader theoretical and conceptual frameworks that guided the overall research process, including the socio-ecological model, critical theory and feminist theory. Identifying contextual determinants of policy reforms and their levels of influence was the key element of the socio-ecological model applied in this study. The premise of critical theory that guided the analysis was an examination of the interaction between policy contexts, contents and processes (Walt & Gilson, 1994; Gilson & Mills, 1995; Cheek & Gibson, 1997; Collins, Green & Hunter, 1999). Critical theory also helped to deepen the analysis of how providers experience the reality of policy problems and solutions in their work (Mill, Marion & Marrow, 2001; Duncan & Reutter, 2006). The analysis of policies reflects certain realities on nurses' work; therefore, factors underpinning these realities should be examined (Cheek & Gibson, 1997). Finally, a feminist perspective to policy analysis (Marshall, 2000; Shaw, 2004; Standing, 2004) was applied to determine the gender-based elements of policies that affected nurses' work, as well as policy actions or inactions with discriminatory implications for nurses, whether they are men or women.

Influences on Policy Change that Affect Nurse's Work

The integrated study results yield an emerging framework that shows how external contexts interact with national contexts to influence policy reforms, and how this policy reforms then impact on the work of nurses at the district health care system level

in Kenya. The framework evolved from the analysis of participants' perceptions and experiences as well as Kenyan health sector policy documents. The framework begins to illuminate some pathways of policy influence on nurses' work. The pathways include the emergence of policy reforms that have affected nurses' work from global contexts to national level and further to the district levels. It further explains how policy shifts have had both positive and negative impacts on the work of nurses (Figure 2.). The framework helps in understanding these impacts and identifying ways to improve nurses' work situation in the context of policy reforms, as well as their ability to participate in decision-making in the health care system.

Figure 2. Conceptual framework of policy influences and impact on nurses' work



As shown in figure 2, the framework contains three key policy elements (policy context, actors and policy processes) and three levels of policy influence (global, national and district). Contextual factors (shown on the left side of the diagram) are operative at each system level and they include economic, social and political factors as well as values and interests of policy-makers. Actors (shown in the middle of the framework) are also identified at each system level. Processes (shown on the right side of the

framework) include the intersecting policy agendas generated at the global level, which then influence policy agendas at the national level. The policy change process is dynamic and results in policy shifts, with both positive and negative impacts on nurses' work. Arrows are used in the diagram to show relationships among framework elements. Bi-directional arrows represent interactive effects between system levels. Each of these elements and the relationships among them are described in more detail below. Supporting evidence for each element is provided.

Policy Context

The national policy reforms that have influenced nurses' work in Kenya over the past three decades were a result of interactions of economic, social and political contexts both within and between global and national levels. These contextual factors were reflected in most of the health sector policy documents reviewed, including plans and reports (MOH, 1994; MOH, 2005; MOH, 2009). The most significant political and economic contexts were linked to the global neo-liberal policies introduced in developing countries from the 1980s. These included the Structural Adjustment Programs, which introduced changes in financing of the health system and civil service reforms that brought more constraining changes on nurses' work. The social context influenced the development of primary health care, which has become an agenda of focus in reforming the health care system. These contextual influences included the need to address district level social and health challenges, such as an increasing disease burden exacerbated by HIV/AIDS and population growth. The imperative of enhancing equity in access to care was another feature of the global primary health care movement, highlighting inequities in health status at the local level.

In addition to political, social and economic contexts, the historical context was operative at the national level. The historical context relates to establishment of the historical hierarchies and structures within the health care system that have influenced policy processes in the health sector over the years. These include colonial structures that established the medical model of care with levels of service delivery, and political and legal structures that have sustained hierarchies in decision-making.

Another contextual factor relates to values and interests that drove the reform agendas. Of major interest in this study were the values of neo-liberal policy reforms (eg SAPs) and primary health care. The neo-liberal policies are concerned with the values of efficiency and cost containment, which leads to cuts in financial and human resource allocation in the system. Thus, nurses' work environment is affected negatively by these cuts. On the other hand, primary health care, which focuses on the values of equity, access and quality provide more enabling environments for nurses' work. Findings suggest that global neo-liberal policies predominated over global calls for primary health care in the policy reforms adopted by the Kenyan government. Furthermore, the implementation of primary health care was negatively constrained by neo-liberal reforms. Cuts in financial resources and a freeze on human resources led to inadequate resource allocation for implementation of primary health care activities, which in turn had a detrimental effect on nurses' work.

Actors

Multiple actors at both global and national levels influenced policy reforms. In relation to the policies examined in this study, prominent actors at the global level who leveraged political weight and control were international funding institutions (International Monetary Fund and World Bank) and the World Health Organization

(WHO). The WHO influenced primary health care through inter-ministerial deliberations to enhance equity in access to health care. The international funding institutions pushed the SAPs, resulting in financial budget controls, civil service reforms and the introduction of user fees in the public health sector.

Policy actors at the national level included the central government with its power and influence exerted through existing hierarchies and structures; as well as stakeholders including civil society, private sector and health professional associations that participated in policy formulation. Nurses are represented at the national level but their participation as actors is weak relative to other actors involved in the policy formulation process at the national level. Their weak participation was attributed to the small number of nursing representatives and their singular focus on nursing specific issues while at policy tables. At district level, actors included health managers and providers. Again, at the national level, only doctors had overall decision-making powers created by virtue of their positions as district directors. In contrast, nurses and other professionals were minimally represented in the structures with minimal direct decision-making. Thus, the power and influence of nurses was constrained by existing hierarchies and structures.

Policy Processes

The policy processes reflect the policy cycle, which is at play at global, national and district levels. This includes policy formulation at global and national levels, and planning and implementation of the policy content at the district level. From national decision-makers' views and documents reviewed, the policy reforms were designed at the global level and proposed to developing countries including Kenya. At the national level, the process included adoption, ownership and designing a framework (Kenya Health Policy Framework 1994-2010) to guide implementation of the global policy reforms. The

global policy agendas formed the policy content that guided development of national strategic plans and instruments for implementation with the support of local partners.

The policy adoption process also reveals power dimensions. Power was concentrated at the macro levels (global and national). The interests and commitments of these macro actors were aligned with the values of neo-liberal policies that achieved political support during implementation. However, the concerns and responsibilities of lower level actors, including nurses, were more aligned with PHC values. This was reflected in their positive views about the PHC policies. This discrepancy may suggest that powerful actors at the national level had minimal support for PHC. According to the participants' views, power was also observed in the context of decentralization.

Devolution of power through a decentralization process sounded like rhetoric, since major decisions with regard to resource allocation and mode of delivery were still being made by central decision-makers. Lower level actors, such as nurses, were marginalized in decision-making within the districts; thus their work concerns were neglected.

Most policy implementation occurred at the district level. Nurse participants experienced policy change as dynamic, with both negative and positive consequences for their work. As is discussed in more detail in the next section, these dynamic changes resulted in structural, distributional, capacity, and decisional shifts. These shifts created both enabling and constraining impacts on nurses' work at the district level. The enabling changes included enhanced knowledge and skills and decision-making opportunities at district and facility levels, while the constraining changes included insufficient resource allocation, poor work conditions, and reinforced "voicelessness" among nurses in policy decisions at the district level.

Policy Shifts and their Impacts on Nurses' Work

The impact of policies on nurses' work can be understood through four major policy shifts including structural, distributional, capacity and decisional shifts that had direct impact on nurses' work. The study results suggest that the shifts follow a dynamic policy change process where the change is either positive or negative. In the context of organizational change, dynamic change processes can be constraining or enabling (Greenhood & Hinings, 1996). Thus policies that were regarded more positively by participants were more enabling on nurses' work than those that were viewed negatively.

Structural shifts

From both the documents reviewed and participants' interviews, major shifts in the health care system were described as structural in nature. Among the shifts has been restructuring of health service organizations. Decentralization of health services and promotion of private sector service provision has been the most common form of restructuring. Decentralization led to a reorganization of service delivery into tiers and the creation of governing and management structures at all levels of health care delivery. The district level became responsible for service planning and management, while the central level continued to play a role in policy development, human resource development, regulation enforcement and resource generation (MOH, 1994).

Participants were of the view that the governing and management structures set up in decentralized districts provided an opportunity for nurses to participate in managing and planning health services. In addition, the decentralization of purchase and management of supplies improved the timeliness of supply distribution and therefore nurses could receive supplies faster than when they had to order them from the national level. While decentralization was considered a desirable policy by the participants, its

implementation was considered weak with less resource support, inadequate funding and limited capacity of managers to plan and manage services. Thus, overall, these changes did not lead to a better work environment for nurses. These findings are consistent with those of other researchers who have found that decentralization has created structures that provide opportunities for service providers including nurses to participate in health planning and decision-making (Rifkin & Oyaya, 2003; Elsey, Kilonzo, Tolhurst & Molyneux, 2005). However, nurses' participation in these structures was limited due to the dominance of other cadres. In some contexts, restructuring has been linked to nurses' job dissatisfaction due to a failure to meet service delivery needs (Forsyth & McKenzie, 2005).

Distributional shift

This shift refers to the distribution of resources for service delivery in the context of reforms. Shifts in financial and human resource distribution occurred when the Kenyan government reduced financial resources allocated to the health sector and introduced cost sharing at facility levels from the early 1990s as a result of SAPs. From participants' views, cuts in health care funds led to insufficient staffing, poor infrastructure, and inadequate equipment and supplies. These increased workloads and introduced more complexity in the work of nurses at the district level. Nurses and decision-makers described how these factors led to poor work environments for nurses and inadequate quality of care. Poor work environments and work conditions have been associated with poor quality of care and nurses' job dissatisfaction in other studies (Forsyth & MacKenzie, 2005; Nemcek & James, 2007). These factors have also been identified as "push factors" that encourage nurses to migrate from developing countries to developed countries (Buchan, 2006; Dovlo, 2007; Kingma, 2007; Rakuom, 2010). Decision-makers

and some frontline nurses in this study mentioned that many nurses were migrating from the public sector to the private sector due to these factors.

Even though the Kenyan health care system lacked adequate resources in previous years, a further decrease in health sector resources was highly attributed to the neo-liberal reforms and a generally poor economic status in the country (MOH, 1994). Another challenge was inequitable resource allocation to the districts. From the survey results, frontline nurses and managers working in a resource constrained district experienced some worse effects of constraining policies than nurses in a district with better resources. During qualitative interviews, provincial decision-makers also reported better implementation of primary health care activities and improved health indicators in the region with better resources in the previous years. A strong sense of inequity in resource distribution for health services arises when policies do not consider the regional differences in resource availability and vulnerabilities to disease (Standing, 2001). The challenge of achieving resource and service provision equity in Kenya has been attributed to weaknesses in establishing geographic information systems to inform resource targeting and for monitoring the impact of health sector reforms on equity (Noor et al., 2004). Such information would be useful for planning and guiding resource allocation for Kenya's most vulnerable districts.

In addition, participants described the problem of corruption, which further constrained financial resource allocation in the health system. For example, corruption was identified as a factor that adversely influenced procurement and distribution of drugs and supplies. The health sector plan document and another study in Kenya have also noted lack of accountability and poor management of resources as a reason why health facilities have had persistent resource challenges (MOH, 2005; Oyaya & Rifkin, 2003).

The results also revealed that in areas more affected by poor indicators and resource challenges, donors and NGOs have provided a stop-gap to supplement the government's scarce resources. The policy documents clearly showed that health services had been supported by resources from both the government and external donors. Kenya has been a beneficiary of Global Health Initiatives (GHI) developed in response to disease challenges in developing countries and to the achievement of the MDGs. Even though the global funding initiatives have been critiqued for weakening the health systems due to their focus on selective interventions (Kallings, 2008; Stillman & Bennet, 2005), these funds have provided opportunities for improvements in resource allocation as well as human resource capacity development. A recent WHO review of global health initiatives in member countries revealed that the initiatives have increased the work burden on health workers and the overall attrition of health workers. Nevertheless, positive outcomes have been reported, including overall strengthening of the nursing workforce in various countries through in-service training, and improving retention of some workers through incentives like salaries (WHO, 2007).

In most cases, global funds have focused on improving capacity of existing staff rather than hiring new staff (Anand & Barnighausen, 2004; Brugha et al., 2010). Only on a few occasions have specific global funds been used to hire staff in the public sector for HIV/AIDS initiatives. Of particular relevance to the nursing workforce in Kenya was emergency funding provided through the Clinton Foundation, Global Fund and PEPFAR to employ nurses on a short-term basis between 2004 and 2007 (Rakuom, 2010). The focus was on addressing acute shortages in areas with a high prevalence of HIV/AIDS and malaria. This shortage was partly due to the freeze on public sector employment of nurses in 1996 – a condition imposed through structural adjustment policies (MOH,

2007). Despite this contribution to resource capacity, a major challenge experienced by participants was that global initiatives led NGOs to actively recruit and employ nurses from the public system, further reducing the number of nurses in the public sector. This phenomenon has been observed in other African countries, where staffs have migrated from the public sector to NGOs (Brugha et al., 2010).

Capacity Shifts

Capacity shifts related to changes in nurses' knowledge and skills due to new training opportunities. These changes were required to address new health problems. Both qualitative and quantitative results showed that primary health care implementation led to knowledge and skills building opportunities for nurses. Nurses in the public sector benefited from training in various areas, mainly offered by partnering NGOs. However, the responses of frontline nurses suggested that the training had focused on care initiatives, with very little attention given to competencies in policy, service management and planning. This may help explain why some of the changes requiring competencies in policy influence and service management were inadequate.

Participants' responses suggested that nurses' capacity enhancement came with more responsibility, as they were to work within new health programs following training programs such as those related to HIV/AIDS. Thus, while participants had some positive views regarding these new work requirements and new opportunities, they were concerned about increases in nurses' workloads. Given the increasing health care problems, various programs exist to train nurses to address new health interventions. There are lots of studies that have assessed nurses' knowledge and attitudes following these training initiatives (Harrowing, 2009; Ezdinachi, 2002; Bektas & Kulakac, 2007).

However studies looking at the link between nurses' training, resource support and nurses' involvement in decision-making are scarce.

Decisional Shifts

Decisional shifts refer to changes in power and decision-making in policy processes. The Kenyan health care system was highly centralized until decentralization of power and authority to the districts was introduced in the 1980s. Both qualitative and quantitative results suggest that decentralization created more opportunities for nurses' representation in the governance and management structures at the district level. However, nurses had limited decisional space with regard to financial and resource allocation, as these were largely controlled by doctors and hospital administrators. There were examples of how lack of nurses' consultation with regard to financial decisions led to neglect of nurses' priorities and needs in service delivery. Frontline nurses perceived themselves as policy implementers who only acted on what was pushed to them even with the service delivery challenges they were facing.

Decentralization was perceived by participants as a good policy that had been implemented poorly due to power dynamics between actors at different health system levels and among health disciplines. Policy-making and resource allocation powers were concentrated among political leaders and policy elites at the national level, while lower level decision-makers endorsed, supported and communicated decisions made at higher levels to frontline providers including nurses. At the district level, doctors tended to have more power in major decision-making than nurses and other health cadres. While doctors in Kenya are still in control of financial decisions at the district level, studies in other contexts show that restructuring has led to hiring of professional administrators, and that the introduction of this cadre of manager has reduced medical dominance (Hancock,

1999; Blythe, Baumann & Giovanetti, 2001). Furthermore, participants in this study observed that managers did not have full decision authority since the central government continued to make most of the decisions including those related to human resources. These findings are similar to those reported in other African countries (Beyer, 1998; Bossert & Beuvais, 2002; Oliff et al., 2003). In these latter studies, the weakness in the decentralization process was attributed to weak administrative structures, poor communication with higher level decision-makers, and failure to give adequate power to all district health managers.

Nurses' Voicelessness

Lack of nurses' voices in national policy-making emerged as a challenge to address nurses' work issues. Although respondents agreed that nurses need to be part of the policy development process, the study showed that policies were made with inadequate involvement of nurses. In reality, policy formulation occurred at macro levels (global and national) while implementation occurred at micro (district) levels. Only a few nurses worked at the national level, but even these nurses had limited input on policy formulation decisions. Frontline nurses and nurse managers voiced that their exclusion from policy formulation was the reason why their work concerns had not been adequately addressed by new policies. Nurses viewed themselves as an oppressed group whose voices are not included in decision-making, while explaining that their work issues were often ignored by existing policies and structural arrangements.

The results show that nurses' voicelessness in policy-making emerged from global forces that pushed for reforms and national level authorities who adopted and reformulated the policies in Kenya without nurses' input. It also appears that national non-nursing decision-makers have been marginalized in setting policy agendas, such as

those related to economic change, since the policy agendas are pushed by global actors. These global actors have also influenced policy-making process and donor funding utilization decisions at the national level. External influences on policy-making in African countries, the further weakening of powers of local actors, and the exclusion of major groups of health professionals in major decisions has been documented by others (Okunzi & Macrae, 1995). This has led to suggestions for more participatory policy-making with local ownership and consideration of local contexts.

Further, the study shows that nurses' voices are silenced by the hierarchical and patriarchal health care system. The system places nurses at lower levels of service delivery with very minimal opportunities to participate in decision-making. In other contexts, health systems that operate based on highly patriarchal structures have failed to adequately recognize the values held by nurses as professionals who have the capacity to enhance access to care (Van De Merwe, 1999; Hewison, 1999). Though decentralization processes provided opportunities for nurses to participate in decision structures, their voices were not adequately heard at the districts as evidenced in this study. The absence of feedback loops in the decision process was also a hindering factor since their views on policy implementation was not sought.

Another element linked to nurses' exclusion from policy decisions was gender inequity. The gender concerns stemmed from the historical hierarchies and structures that have sustained gender inequities in the healthcare system. While the historical structures have continued to place the male-dominated medical professionals in decision-making positions, nurses who were mainly female tended to be excluded from these positions. Even though nurses in Kenya are now advancing in education, through new undergraduate and graduate programs, their contributions may not be recognized as long

as legal structures continue to favor and give greater power to the medical doctors.

Kanter (1998) argues that hierarchical arrangements must be changed if we are to promote gender equity in health care systems.

Contribution to new knowledge

In this section, I will present the major insights arising from the study findings and describe how these contribute to the existing scientific knowledge base. First and foremost, this is the first study that has examined nurses' work in the context of health sector policy reforms implemented in Kenya since 1980, and it is the only study that has used a mixed methods design to examine the multi-layered influences of these reforms. This study considerably extends the work of other authors who have examined work-related issues for nurses in other African countries without examining how these issues relate to changes in broader policy contexts (Hall, 2004; Phaladze, 2003; Smit, 2004; Armstrong, 2003; Dovlo, 2007; Kober & Van Damme, 2006; Munjanja, Kibuka, & Dovlo, 2005).

A second contribution of this study has been the application of critical theory to examine broader contextual factors (historical, political, economic and social) that influenced policy agendas and processes and to consider how these policies interacted, and in turn, how these interactions affected nurses' work within districts. Obtaining the perspectives of actors at all levels of the system, from national decision-makers to frontline nurses, is an important strength of this study. This revealed the values and interests of different actors in the reform process, pointing to areas of convergence and divergence. Furthermore, the study is one of the first to examine a range of policy reforms with different ideological bases and their impacts on nurses' work in Kenya. For example, the values of neo-liberal policies differed from the values of primary health

care. Describing how the interaction of these policies was experienced by front-line nurses and nurse managers is an important study contribution.

The analysis drew attention to the dynamics of policy change that impacted on nurses' work. Change was observed through four non-aligned policy shifts including structural, distributional, capacity and decisional shifts. The most significant characteristic was the dynamic nature of the policy shifts. Each shift had both negative and positive aspects. Furthermore, the study shows how these shifts are interrelated and how these interrelationships play out in the work environment for nurses. This is the basis for reconceptualizing how we examine policy influences on the work environment, not only for nurses but also for other health professionals.

The differences found between the two districts suggest that equity in resource allocation should be a dimension of improving work environments. As reflected in this study, nurses in resource constrained areas tended to experience worse policy constraints on their work environment than nurses in areas with better resources. This raises the question of what is the minimum level of resource allocation required to improve work environments. Equitable resource allocation may leave all districts with resources that are below this minimum level, and thus lead to a situation where no districts achieve improved work environments. Thus, it is critical for policy-makers to consider measures for equitable resource allocation alongside requirements for a minimum level of resources needed to make work environments tolerable.

Finally, the study results have revealed that nurses in Kenya have been inadequately involved in policy formulation processes. Some of the reasons for this are similar to those described by researchers in other contexts including: lack of knowledge and skills in policy and policy processes, inadequate advocacy and political skills and

nurses' passivity in the health care system (Anrobus & Kistson 1999; Gebbie, Wakefield & Kerfoot, 2000; O'Brien-Pallas & Bauman, 2000; Reutter & Duncan, 2002; Anrobus, 2004; Spensely, Reutter & Allen, 2006; Abood, 2007; Banschbach, 2008; Taft & Nana, 2008). However, the mixed methods design of this study yielded new insights into another set of relevant factors. These include historical hierarchies and power structures that have undermined nurses' potential to participate in different phases of the policy cycle. Findings suggest that the existing decision-making structures have exacerbated policy constraints on nurses' work, while limiting nurses' inputs into the policy formulation process. This facet of the policy-making process has rarely been examined in relation to nurses.

In addition, the structures have also sustained gender inequities in relation to decision-making and the generally poor working conditions of nurses. The role of gender in policy reforms has received inadequate attention, particularly how gender relations in the health care systems are addressed by policy reforms. Another element that is central to critical feminist policy analysis is power relations in policy-making. Even though many studies have attributed nurses' powerlessness mainly to the dominance of doctors within the patriarchal health care system (Dussault, & Dubois, 2003), this study revealed an additional element - nurses' powerlessness is reinforced by powerful global actors who push for reforms without consideration of nurses' work situation.

Implications to Health Systems and Policy

This study reveals that nurses' work challenges have been exacerbated by policy reforms that have not been congruent with health system values of access and equity. Frontline nurses and managers felt demoralized due to these challenges and were not able to carry out their work efficiently. Maintaining a workforce that is demoralized would

only worsen health outcomes. Improving nurses' work concerns, such as staffing and resource availability, as well as work conditions pertaining to salaries and progression, should be at the center of policy-makers' consideration. This would enhance nurses' desire to strengthen the quality of their services and improve the population's health.

In designing policies, policy-makers should embrace a critical approach in which they consider not only the policy content but also the context for care delivery. This requires consideration of how the design of a policy may affect those responsible for their implementation, including nurses. To achieve the highly debated issues of access and universal coverage, policy-makers should pay more attention to local context and other factors that might influence policy implementation, such as availability of resources, workforce capacity in management and decision-making, and existing social and legislative structures that may perpetuate the status quo in decision-making.

A critical factor to consider is the availability of resources for service delivery. This can be achieved through better financing and equitable resource allocation among decentralized districts. Given experiences with the reforms, more domestic financial allocation to the sector would provide a sustainable solution. Attributes like lack of resource management capacity and corruption inherent in the health care system should be addressed to ensure better distribution and utilization of available resources.

Given the finding that primary health care and decentralization were viewed more positively by most of the participants, implementation of these policies should be strengthened. Urgent action is needed to address the gaps in decentralization processes as well as primary health care. Policy-makers should consider enhancing the capacity of nurses to provide care in decentralized districts. Capacity should be considered broadly to include enhancing nurses' knowledge and skills, availing necessary resources and giving

them authority to make decisions with regard to service delivery in the districts. More critical is the need to address the nurse shortages in the context of ongoing reforms. Several studies have identified strategies to address shortages, including the development of policies to enhance recruitment, motivation and retention of health workers (Buchan, 2006; Dovlo, 2007; Kingma, 2007). These strategies should be adopted in the health care system in the context of reforms to address nursing shortages.

Study results suggest the need to involve more nurses in decision-making in the system. In line with a feminist approach, barriers to nurses' participation in policies should be addressed (Marshall, 2000; Shaw, 2004; Standing, 2004). This can be achieved through more deliberate involvement of nurses in decision-making to enhance service delivery. For instance, nurse leaders' representation at national levels requires strengthening. Given their competencies, the leaders should be given more opportunities to lead key decision-making structures and be involved in a wider array of policies in the health sector and not only those that are focused on nursing. At provincial and lower levels, nurses should be consulted when health sector policies are made and their views considered in policy formulation. Frontline nurses should also be empowered to understand the policies developed in the system and given opportunities to participate in policy decisions in their areas of work. While programs to strengthen nurses' involvement in policies exist in developed countries like the United States, these programs are scarce in Africa. One example of a promising multi-country study examining how to engage nurses in decision-making is currently underway in three African countries and one Caribbean country (Edwards et al., 2007). The research program includes the engagement of nurses in leadership hubs that involve training in research and policy; and further capacity building to identify policy priorities and

windows of opportunities to influence policy, sharing, feedback and actions that would enhance service delivery. The overall study is quasi-experimental and outcomes that will be assessed include clinical and policy changes.

Changing hierarchical and structural arrangements that hinder nurses' participation in policies would enhance nurses' involvement in policy processes. In addition, gender and power issues inherent in the health care system should be addressed to ensure inclusive participation in policy processes. Actions towards gender inequality in health policies and health care have been emphasized by international organizations like ICN (ICN, 2005), and WHO (WHO, 2001). Issues of hierarchies, power and gender could be further addressed by enacting legislation in Kenya that would allow nurses with competencies in leadership and policy to hold senior positions in the health care system just like doctors. With governance opportunities created through decentralization of power in the health care system, and the need for more professional accountability and flexibility (Standing, 2001; Kuhlmann & Bournet, 2008), there is a need for all health professionals to have equal opportunities to be in leadership and management positions that are embedded within the decision-making structures in the health care system.

Finally, it is important to note that nurses' concerns related to policy reforms are not unique to Kenya. International organizations like WHO and ICN have put a lot of emphasis in the recent past on addressing nurses' work concerns and enhancing their capacity to provide quality care. These organizations have recently echoed the need to recognize nurses as important members of the workforce whose services and views are necessary for effective functioning of the health care system. Specifically, the ICN has developed a leadership training program for its members, in which some nurse leaders from Kenya have participated to enhance their skills in leadership and decision-making.

The recent Kampala Declaration and the United Nations' Agenda for Global Action on Health Workforce called for urgent actions to address the bottlenecks to a quality health workforce (WHO, 2008). Solutions include scaling-up education and training, increasing resource allocation to the sector and addressing inequities including gender. Results of the present study support these recommendations as results emphasize the need for policies to address improvements in nurses' work environments, employment conditions and contributions to decision-making.

Implications to the Discipline and Profession of Nursing

This study contributes to our understanding of the impact of policies on nurses' work and suggests that nurses can better position themselves to influence national policies in lower income countries. It provides further understanding of the complex and hierarchical health care system in which nurses, particularly in Africa, are working. Nurses' experiences suggest that some national health reforms such as those linked to SAPs have limited nurses' potential to achieve their professional goals and increased their marginalization in the health care system. Thus, nurses have a role to demand better work environments and contribute to the development of policies to address their work challenges and patients' needs. This can be achieved through advocacy and dialogue with decision-makers at all levels to address these critical concerns. To enhance their role in advocacy, nurses should unite to build a strong voice to advocate for improvements in national policies that affect their work and quality of care. They should challenge the status quo sustained by the hierarchical health care systems and policy elites.

The nursing profession should consider and implement strategies to strengthen nurses' capacity to contribute to policy decisions that would enhance service delivery. In order to effectively do this, nurses in Kenya will need to understand that the policy cycle

is complex and influencing policy decisions depends on having a sufficient understanding of the broader issues in the health care system, as well as knowledge and competencies in policy formulation, implementation and evaluation. Hewison's framework (2008) that involves developing nurses' capacity to influence policy at every stage of their career would be useful. The framework involves a move along a continuum from policy literacy, through policy acumen, to policy competency and policy influence (Hewison, 2008).

Leadership and advocacy skills should also be developed within nursing to enhance nurses' abilities to carry out policy advocacy at all levels. Advocacy could be carried out by nurses both in formal and informal leadership positions in the government. Nurses should be united through their professional association to carry out advocacy for better work conditions. Lack of unity among nurses has been an issue of discussion in the international literature and was mentioned by participants in this study. If nurses are united regarding the importance of their role in the health care system and their abilities to bring change in the policy arena, they would more likely be understood and provided with policy space by decision-makers.

In addition, the nursing profession should carry forward the notion of evidence-based policy-making. They should develop skills in research and conduct both health systems and clinical research to inform policy-making decisions. Research courses should be linked to policy courses and training curricula should include current and locally relevant examples of how evidence can be used to shape policies. This would include strategies for communicating research to policy-makers, like writing policy briefs and position statements based on research evidence.

Nurses, particularly at the frontline of care, should understand their role in the policy arena. They need to be aware of existing national policies in the sector and how these policies are affecting their work environment and patient outcomes. This would be an important step towards better communication of policy impact, creating a much needed feedback chain between those implementing policy and those formulating policy. As members of nursing associations, frontline nurses should encourage and support their nurse leaders to speak for nurses at the national policy tables. In their workplaces, nurses should actively engage in organizational policy decisions during policy implementation. In addition, nursing regulators and educators should clarify that policy involvement is a part of nurses' scope of practice.

Implications for Research

This study demonstrates how critical theory and feminist theory were useful in examining policy reforms that affect nurses' work in Kenyan health care system. Specifically, this theoretical approach provided insights into the interactions among multi-level contextual factors, policy processes, and agendas. This revealed how the policy interaction impacted on nurses' work both positively and negatively. Nurses in this study felt demoralized due to the negative effects of policies on their work environment. Further research applying critical theory and a feminist lens would deepen our understanding of issues emerging in this study, as reforms affecting the health care systems continue to be implemented. Promising areas for future inquiry include an examination of national policy reforms and how they interact with organizational features at the district level of service delivery. With the recent changes in the political structure and organization of the Ministry of Health in Kenya, there is a rich opportunity to

examine additional political dimensions of reforms and their impact on service management, nurses' work and patient outcomes.

Further examination of issues of hierarchy, gender, and power inherent in the health care system in the context of policy reforms is necessary. It is important to examine how these issues can be addressed in the context of ongoing policy reforms. The question is: How do we unravel the deeply embedded hierarchies and power processes that sustain the status quo in policy change process? Of particular importance is how the hierarchies affect the role and performance of actors at lower levels, and how local actors can influence global leaders to enhance more horizontal participation in the design of policy reforms. Further, in the absence of feedback loops between frontline workers and central level policy-makers, how do we ensure that they pay attention to the negative effects of policy shifts at district and facility levels as revealed in this study? How can we create and sustain feedback loops for effective policy review and modification? Such questions should be addressed with consideration of the values of an equitable health care system that values equitable treatment of health professionals such as nurses. Finding mechanisms to address these challenges would strengthen professional roles in decision-making and health service provision.

An emergent opportunity for research is policy shifts in the context of health care organizational change. In-depth examinations of the process of policy change over time, and how the change impacts on the quality of nursing services provided to the communities, is a promising area for study. Even though quality of care was not a major focus in this study, the participants' views suggested that negative policy consequences on nurses' work led to poor quality care. As noted above, this warrants further study in the context of ongoing reforms. A comparative study between different African countries

would provide stronger evidence in this area. At the time the study was completed, Kenya was reforming the health sector further with a focus on enhancing its Community Strategy for health systems improvement. Many health workers were receiving training in management and leadership, and changes were being made to financing mechanisms including consideration of direct funding to health facilities based on performance. These types of changes provide further opportunities to study the impact of previous and ongoing reforms on health workers including nurses. Further analysis of how these changes are influenced by both external and local contexts would yield a deeper understanding of the policy effects on health providers and how to counteract potential negative impacts.

The study focused on nurses at the district level. Further research should look at how nurses at all levels of the health care system and in other regions of the country experience the impact of these policies, and how policy decisions have impacted on their professional and personal lives. Specifically, a study looking at a wider range of districts, such as rural and urban districts as well as those in arid areas of Kenya, would be useful. These comparisons would further address issues of equity identified in this study.

Another factor to consider in future study is including views from more participants. Many studies have looked at nurses and policy issues from the experiences of nurses only. This study looked at the views of nurses and non-nursing decision-makers. This yielded a more in-depth understanding of nurses' work in relation to policies. For instance, decision-makers who were more conversant with the reforms than nurses were able to provide more information on policy context and processes and how these interacted with nurses' work. Thus, future studies on nurses and health policies should incorporate the views of decision-makers, nurses and the communities who are the

beneficiaries of policies. This would require a participatory research approach with a larger research team that encompasses experienced researchers in health systems and policy research working jointly with decision-makers and research users in the health care system.

Finally, the conceptual framework developed from a socio- ecological perspective presented important features that were addressed in this study including multiple levels of policy influence from global to organizational level (district level where nurses work); the interaction between different policies and how they intersect with nurses' work and the contextual factors influencing policy processes. The combination of socio-ecological perspectives, and critical and feminist perspectives enriched the analysis and yielded a broader framework, which depicts more elements such as hierarchies and structures influencing policy process and policy shifts that affected nurses' work. However, there are elements of the framework that were not adequately addressed and these could be pursued in future research. With regard to policy interaction, research is required to examine the interactions between national policies and professional and workplace policies at organizational levels and their influence on nurses' work. The most important contextual factors influencing policy reforms were mainly political and socio economic. Further analysis of other contextual factors, including cultural factors and how they influence policy decisions and service delivery at local level, would also be useful.

Accounting for gender in this study

Gender equity in health systems and policy research is important in feminist perspectives. Nursing today is still a female gendered profession operating in a hierarchical and gendered system. Therefore, this study looked at the effect of policies on the work of a female gendered profession. The feminist lens applied in the analysis of

data, generated important issues such as poor work environments, gender-related inequitable treatment and inequitable involvement in decision making. These factors have been influenced by policy makers and sustained by historical hierarchies and structures.

Gender issues emerging in this study are important, but they require further investigation and analysis. This is because the earlier design did not fully incorporate gender-based strategies. One limitation was that the explicit plans for sampling were not based on gender, and data collection questions did not include gender-specific questions. These might have excluded diverse perspectives on the influence of gender on policies. A study question to the nurse participants would include a direct question like: In what ways are your experiences with policies influenced by your gender? From a feminist perspective this would have provided a more in-depth analysis of oppression due to gender biases inherent in the health care systems. Thus, in future studies, gender-related sampling and data collection strategies that would generate a data set to support explicit gender-based analysis of policies are required.

In the study sample, the majority of the nurse participants were women. This was not an intentional selection bias but was due to the fact that majority of nurses are females so potential participants were unlikely to be males. On the other hand, non-nursing policy-makers were all males. Perhaps the views of female non-nursing policy-makers with regard to policy decision-making would have been different. This is another question with implications for gender-based sampling in future studies.

Enhancing Rigor

The relevance of the study was affirmed by the thesis committee and those who were knowledgeable of the study within the Ministry of Health and among nursing

leaders in Kenya. Credibility was enhanced throughout the study process by accurately collecting, analyzing and reporting data. Audiotapes and verbatim transcription preserved the accuracy of the data. Critical reflexivity involving cyclical and continuous comparisons were used throughout data collection and analysis. These included journaling and writing reflections on processes and decisions (Maxwell, 2003; Creswell, 2003). Transferability was enhanced by use of appropriate sampling methods including purposive recruitment of participants who would effectively describe their experiences with national policies. Thick descriptions of findings were obtained from varied perspectives (Maxwell, 2003). Triangulation of data from different sources was done making it possible to compare and confirm similar perceptions across different groups (Patton, 2002). Theoretical and methodological decisions were discussed with members of the research committee.

Study Limitations

The limitations of the study relate to the new reforms being introduced into the Kenyan health care system, the inclusiveness of the data collection process, and the time for fieldwork. The health care system was in a process of structural reform with many meetings going on to discuss policy issues to reform the ailing health care system and reduce the downward trend in health indicators. First, there were major reforms involving reorganization of service delivery with a focus on enhancing community involvement in service provision. Second, the Ministry of Health had just been split into two following the government elections in late 2007; this created two new Ministries of Health, one focused on public health and one on the medical system. For this reason, there were a lot of transfers at national and provincial levels, with new staff appointed from lower levels to upper levels and staff reassigned across provinces and districts. These changes affected

my field work since most of the appointments with decision-makers were cancelled or postponed several times because they were either attending meetings to discuss the new reforms or attending a training workshop for orientation on the reforms. Two potential national decision-makers could not be reached in the end. Due to transfers, some senior decision-makers with long-term experience in the health sector had moved to other ministries and been replaced. The new decision-makers could not be interviewed because they did not meet the inclusion criteria and they were not well versed with the historical policies in the system. At the provincial level, two decision-makers were not interviewed because they had only been in their new positions for a few weeks.

The fieldwork took a longer time than I had projected. Ethical approvals (from two sites and for two study phases), and the development of the quantitative tool used in phase two, also took more time than I had originally planned. I now better appreciate the fact that one needs a lot of time to design a survey tool, consult relevant experts, and conduct pre-testing. In anticipation of the longer time it would take and the changes in the system that had placed the lower level facilities in the new Ministry of Public Health, a decision was made to only focus on the hospital nurses and nurse managers for data collection. Health centres and dispensaries were excluded from the final sample. This exclusion did not limit the sample size but it excluded the views of nurses' working at these lower level facilities. Even though the decision-makers, including nurse leaders at national and provincial levels, shared their experience and opinions on how policies influenced nurses at all levels, our understanding of how national policies have influenced nurses' work at lower levels would have been enhanced if these nurses had been interviewed. In addition, this would have been consistent with a more

comprehensive application of the socio-ecological model that includes all levels of policy influence.

Conclusion

The dissertation has contributed new knowledge on the influence of national policies on nurse work. The results reveal how nurses' work has been undermined in the context of health sector policies. The policy constraints on nurses' work could result in poor quality of care provided to the communities. The results suggest the need for policy-makers and central level planners to consider the consequences of policies on frontline health workers. The study suggests the need for policy change that would enable nurses to work more effectively in the health care system. Implementing new policies should ensure adequate resource allocation, better conditions for nurses and opportunities for nurses to participate in decision-making in the health care system. Policy decisions should be coherent with sustainable resource allocation and health system values of quality and equity. These would lead to further systems' strengthening and better health outcomes.

Statement of Contribution

This thesis was written according to the guidelines of the Faculty of Graduate and Postdoctoral studies and the Faculty of Health Sciences, at the University of Ottawa. In this section I describe the contribution of those involved with the thesis.

The PhD candidate, Pamela Juma, led all aspects of the study including the design, implementation and write-up as part of the requirements of the doctorate degree in nursing. The candidate submitted all the documents for ethical review in Ottawa and in Kenya, developed all the study materials, recruited participants, and collected and analyzed all the data.

My thesis supervisor, Dr. Nancy Edwards, provided guidance and feedback on drafts from the initial stage of proposal design, tool development and implementation of the study to the final version of the thesis. The committee members provided feedback on early proposal drafts, tools, and guidance during study implementation and gave input on the manuscripts and the overall thesis draft. Two people were hired to assist with the transcription of the audio tapes during data collection.

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Appendix A Phase 1 Ethics Approvals



Université d'Ottawa University of Ottawa
UNIVERSITY OF OTTAWA

September 17, 2003

Nancy Edwards
 School of Nursing
 Faculty of Health Sciences
 University of Ottawa

Patricia Arhino Juma
 School of Nursing
 Faculty of Health Sciences
 University of Ottawa

**RE: Intersection of National Policies on Nurses' Work in the Context of HIV/AIDS
 in Kenya**

Dear Professor Edwards and Ms. Juma,

You will find enclosed the Health Sciences and Science REB ethical clearance for the abovementioned study.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until September 17, 2009. Please submit an annual status report to the Protocol Officer in September 2009 to either close the file or request a renewal of ethics approval. This document can be found at:

A copy of this approval will be sent to research services, if necessary.

If you have any questions, you may contact the undersigned at the number:

Sincerely yours,

Signature of Protocol Officer in Research

Protocol Officer, Health Sciences and Science REB

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Université d'Ottawa University of Ottawa

145 Jean Jacques Lussier Boulevard, Ottawa, Ontario K1N 6N5

September 17, 2008

Nancy Edwards
School of Nursing
Faculty of Health Sciences
University of Ottawa

Patricia Atieno Juma
School of Nursing
Faculty of Health Sciences
University of Ottawa

RE: Intersection of National Policies on Nurses' Work in the Context of HIV/AIDS in Kenya

Dear Professor Edwards and Ms. Juma,

You will find enclosed the Health Sciences and Science REB ethical clearance for the abovementioned study.

During the course of the study, any modifications to the protocol or forms may not be initiated without prior written approval from the REB. You must also promptly notify the REB of any adverse events that may occur.

This certificate of ethical clearance is valid until September 17, 2009. Please submit an annual status report to the Protocol Officer in September 2009 to either close the file or request a renewal of ethics approval. This document can be found at:

A copy of this approval will be sent to research services, if necessary.

If you have any questions, you may contact the undersigned at the number:

Sincerely yours,

Dr. Jean F. Levesque

Protocol Officer for Health Sciences

For Dr. Patricia Lagimodière, Chair of the Health Sciences and Science REB



UNIVERSITY OF ZIMBABWE

Form

Confirmation of approval of research proposal by
GEC/REC without review committee

Name: [REDACTED]
Study proposal title: [REDACTED]
Institution: [REDACTED]
Institutional approval date: [REDACTED]
Approved research date: [REDACTED]
Type of Review: [REDACTED]

The University of Zimbabwe Research Ethics Board (GEC/REC) is a regulatory body at the University of Zimbabwe (UoZ) responsible for the ethical review of research proposals involving human beings, animals and the environment. The objective of the board is to ensure that research is conducted with the highest standards of integrity and that the rights of research participants are protected. The board also ensures that research is conducted in a manner that is consistent with the principles of research ethics.

The above research proposal was reviewed and approved by the GEC/REC on 15th July 2018. The research proposal was approved on the following documents:

- A. All GEC/REC research ethics forms (the proposal)
- B. Institutional approval of research proposal
- C. Letter of approval of research proposal (signed by the principal investigator)
- D. Study protocol
- E. Letter of approval by the research ethics board

The research ethics board has reviewed the research proposal and the research ethics board has approved the research proposal on the following documents. The research ethics board has approved the research proposal on the following documents. The research ethics board has approved the research proposal on the following documents. The research ethics board has approved the research proposal on the following documents.

Signature

Dr. [REDACTED] (Principal Investigator)

198

Ministry of Health

Ministry of Health



GOVERNMENT OF INDIA

Ministry of Health

Ministry of Health

Ministry of Health

DSRS

18th August, 1966

Dr. A. V. L. Srinivas
Principal, Government
Medical College

Dr. A. V. L. Srinivas

RE: AUTHORITY TO CONDUCT RESEARCH

From the letter dated 17th July, 1966.

The Ministry has received a letter from you dated 17th July, 1966, regarding the proposed research work in the field of "VIRAL DISEASES IN KERALA".

You are requested to submit the details of the proposed research work to the Ministry of Health, Government of India, for the purpose of the proposed research work in the field of "VIRAL DISEASES IN KERALA".

Yours faithfully,
Dr. A. V. L. Srinivas

Dr. A. V. L. Srinivas
Principal, Government
Medical College

Principal, Government
Medical College

Principal, Government
Medical College

100

MINISTRY OF HEALTH

Minister of Health
 Hon. [REDACTED]
 Hon. [REDACTED]
 Hon. [REDACTED]
 Hon. [REDACTED]
 Hon. [REDACTED]



Minister of Health
 Hon. [REDACTED]
 Hon. [REDACTED]
 Hon. [REDACTED]
 Hon. [REDACTED]
 Hon. [REDACTED]

The Prime Minister,
 University of Jamaica,
 Kingston.

RE: JAMAICA'S NEW COVID-19 VACCINE CENTRE APPROVAL

The Ministry of Health is pleased to announce that the Ministry has approved the establishment of a COVID-19 vaccine centre at the University of Jamaica, Kingston. The centre will be used for the production and distribution of COVID-19 vaccines.

The Ministry of Health is pleased to announce that the Ministry has approved the establishment of a COVID-19 vaccine centre at the University of Jamaica, Kingston. The centre will be used for the production and distribution of COVID-19 vaccines.

The Ministry of Health is pleased to announce that the Ministry has approved the establishment of a COVID-19 vaccine centre at the University of Jamaica, Kingston. The centre will be used for the production and distribution of COVID-19 vaccines.

The Ministry of Health is pleased to announce that the Ministry has approved the establishment of a COVID-19 vaccine centre at the University of Jamaica, Kingston. The centre will be used for the production and distribution of COVID-19 vaccines.

[REDACTED]
 [REDACTED]
 [REDACTED]

[REDACTED]

CC:

Minister of Health
 Minister of Education

[REDACTED]
 [REDACTED]

Minister of Health and Minister of Education, Kingston.

The Prime Minister and Minister of Education, Kingston.

[REDACTED]

200

MINISTRY OF HEALTH

[REDACTED] [REDACTED] [REDACTED]
 [REDACTED] [REDACTED] [REDACTED]
 [REDACTED] [REDACTED] [REDACTED]
 [REDACTED] [REDACTED] [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]
 [REDACTED]

[REDACTED]

THE NATIONAL INSTITUTE OF HEALTH

[REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

[REDACTED]
 [REDACTED]

[REDACTED]

[REDACTED]
 [REDACTED]

[REDACTED]

[REDACTED]

Appendix B: Phase one Participant letters of invitation and Information sheets

National Level Participant Invitation and Information Sheet

Dear Participant,

You are being invited to participate in the above mentioned study. The study is being implemented by Pamela Juma who is a registered nurse in Kenya and a PhD Candidate at the University of Ottawa in Canada. Pamela is being supervised by Dr. Nancy Edwards who is a professor at the School of Nursing and Department of Epidemiology and Community Health, University of Ottawa.

Study purpose

The purpose of this study is to examine how national policies implemented in Kenya since 1980 have influenced nurses' work in the current context of HIV/AIDS. The study will explore the perceptions and experiences of decision makers, frontline nurses and nurse managers on how national policies have enabled or constrained nurses' work, and how nurses have contributed to the national policy making processes that influence their work in the current era of HIV/AIDS in Kenya.

Questions you might have:

What will I be asked to do?

You are being asked to participate in an interview to provide your perspectives about how national policies implemented in Kenya have affected nurses' work in the current era of HIV/AIDS and how nurses have been involved in the policy processes at various levels. The interview will take approximately 45 to 60 minutes, and will be conducted face to face by Pamela Juma. The interview will be tape-recorded if you allow us to do so.

Are there any risks from participating?

There are no major risks expected from your participation. However your participation in this study will entail that you volunteer information that may have minor risk such as emotional concern about negative repercussions that the information you share may have on the Kenyan national health care organization. These concerns may include speaking about issues such as and policy implementation gaps, poor quality of care or lack of nurses' involvement in decision-making or policy processes. The researcher will take every effort to minimize these risks. The information will be used to address the research objectives. You are free to say only what you are comfortable telling the interviewer and your decision to participate or not will not be disclosed to anyone. You are allowed to withdraw from the study at any time or to request to have portions of your interview removed from the transcripts, at the end of the interview. Quotes from this interview will be anonymized and will only be used if you give us permission to do so. Even though anonymity will be ensured by the researchers, there is a possibility that someone may deduce your identity in the study from a quote.



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infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Are there any benefits to participating?

Your participation in this study will not have a direct benefit to you, however, the information you share will help in enhancing general understanding of how national policies and their development processes affect nurses' work. The information is intended to be shared with relevant stakeholders so that it can be used to address policy issues related to nurses' work and to enhance the quality of nursing services for the population in the current era of HIV/AIDS.

Are my answers confidential and anonymous?

Any information you share will remain strictly confidential. The information will be used only for the purpose of the study and confidentiality will be maintained. The content will only be discussed with the researcher, her research assistant, supervisor and research committee members. Your name will not be recorded with your responses or identified in any way. A unique code number will be assigned to you to identify your taped interview and interview transcripts. Your institution will also have a unique code and the name of your institution will not be used in presenting results. Your identity will not be revealed in any reports or publications emerging from this study. Your participation in this study will not be revealed to anyone. However, there is a possibility that someone may deduce your identity in the study from a quote.

Conservation of data:

All information collected (audiotapes, interview transcripts, field notes) will be kept in a locked filing system in the project office at Great Lakes University of Kisumu. The computer on which study data will be stored will be password-protected. The data will be accessible only to the student conducting the study and her research assistant and the supervisor. The list with the names and codes for participants will be kept in a different filing cabinet than the other study data. The electronic version of the participants' names and codes will be password protected on a password-protected computer and kept in a separate file directory than the data transcripts.

The study data will be stored for seven years following completion of the study, after which time all paper transcripts will be destroyed. The audio- tapes will be destroyed one year after transcription.

Compensation:

There will be no monetary or other compensation for your participation in the study.

Voluntary Participation:

You are under no obligation to participate, and if you choose to participate, you can withdraw from the study at any time and /or refuse to answer any questions, without suffering any negative consequence. If you choose to withdraw from the study, you may request that all data gathered until the time of your withdrawal be destroyed.

Provincial/District Level Decision Makers and Frontline Nurses and Nurse Managers' Information and Consent Form



Université d'Ottawa
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de la santé
École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences
School of Nursing

Researcher: Pamela. Juma, [REDACTED] School of Nursing,
University of Ottawa and Great Lakes University of Kisumu.

Supervisor: Dr Nancy Edwards, [REDACTED], University of
Ottawa.

Invitation to participate: I am being invited to participate in the above-mentioned research study conducted by Pamela Juma, who is a doctoral student at the University of Ottawa. Pamela is being supervised by Dr Nancy Edwards of University of Ottawa in Canada.

Study purpose: The purpose of this study is to examine how national policies implemented in Kenya since 1980 have influenced nurses' work in the current context of HIV/AIDS. The study will explore the perceptions and experiences of decision makers, frontline nurses and nurse managers on how national policies have enabled or constrained nurses' work, and how nurses have contributed to the policy making processes of national policies that influence their work in the current era of HIV/AIDS in Kenya.

Participation: I am being asked to participate in an interview to provide my perspectives about how national policies implemented in Kenyan Health sector since 1980s have affected nurses' work in the current era of HIV/AIDS and how nurses have been involved in the policy processes at all levels. The interview will take approximately 45 to 60 minutes, and will be conducted face to face by Pamela Juma.

Risks: There are no major risks expected from my participation. My decision as to whether or not to participate in this study will not have any negative repercussions for me. However my participation in this study will entail that I volunteer information that may cause me to feel potential emotional and psychological discomfort, and concerns about repercussions that may follow if I speak about issues such as poor working conditions and policy implementation gaps, poor quality of care and lack of nurses' involvement in decision-making or policy processes. I have been reassured by the researcher that every effort will be taken to minimize these risks. And that the aim of this study is to address policy issues related to nurses' work and to enhance the quality of nursing services for the population in the current era of HIV/AIDS. Therefore talking about these issues will not cause me to be dismissed from my job or intimidated by my seniors, but will help in achieving the study objectives. In addition, all the transcripts and quotes used in this study will be anonymized and no identifying information will be used in the study reports and other publications. I am informed that I can withdraw from the study at any time or request to have portions of my interview removed from the transcripts, after the interview. I can state only what I am comfortable telling the interviewer and my decision to participate or not will not be disclosed to my employer or any other senior officer in the Ministry of health. The interview will be held in a location of my choice.

Benefits: My participation in this study will not have a direct benefit to me, however, the information I share will help in enhancing general understanding of

how national policies and their development processes affect nurses' work and determine options for addressing nurses work concerns that relate to national policies. My participation would also help in determining strategies to strengthen nurses' role in decision policy processes and decision making in health service delivery. The information is intended to be shared with relevant stakeholders so that it can be used to address policy issues related to nurses' work and so enhance quality of nursing services to the population in the current era of HIV/AIDS.

Confidentiality and anonymity: I have received assurance from the researcher that any information I share will remain strictly confidential. I understand that the information will be used only for the purpose of the study and that my confidentiality will be protected. The content will only be discussed with the research supervisor and research committee members. Anonymity will be protected by not recording my name with my responses or identified in any way. A unique code number will be assigned to me to identify my taped interview and interview transcripts. My institution will also have a unique code and the name will not be used in presenting results. My identity will not be revealed in any reports or publications emerging from this study. I can also choose to withdraw my quotes at any time. At the end of the interview, I will be asked if there are any portions of what I have said that I do not want to be quoted on, and that this will be recorded on tape and in a written note by the interviewer. Although my name was provided to the researchers by another contact person, the researchers will not reveal to that person whether or not I participated in this study.

Conservation of data: All information collected from me (audiotapes, interview transcripts, field notes) will be kept in a locked filing system in the project office at Great Lakes University of Kisumu. The computer on which study data will be stored will be password-protected. The data will be accessible only to the student conducting the study and her research assistant and the supervisor. The list with the names and codes for participants will be kept in a different filing cabinet than the other study data. The electronic version of the participants' names and codes will be password protected on a password-protected computer and kept in a separate file directory than the data transcripts.

The study data will be stored for seven years following completion of the study, after which time all paper transcripts will be destroyed. The audio- tapes will be destroyed one year after transcription.

Compensation: There will be no monetary compensation for my participation in the study.

Voluntary Participation: I am under no obligation to participate and if I choose not to participate, I can choose to withdraw from the study at any time and /or refuse to answer any questions, without suffering any negative consequence. If I choose to withdraw from the study, I may request that all data gathered until the time of my withdrawal be destroyed.

By agreeing to participate, you agree to complete a consent form. Please read and fill in the consent form on the next page.

'Participants' Invitation to Participate in the Study Consent Form



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École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Dear Participant,

You are being invited to participate in the above mentioned study. The study is being implemented by Pamela Juma who is a registered nurse in Kenya and a PhD Candidate at the University of Ottawa in Canada. The student is being supervised by Dr. Nancy Edwards, professor, School of Nursing and Department of Epidemiology and Community Health, University of Ottawa.

Study purpose

The purpose of this study is to examine how national policies implemented in Kenya since 1980 have influenced nurses' work in the current context of HIV/AIDS. The study will explore the perceptions and experiences of decision makers, frontline nurses and nurse managers on how national policies have enabled or constrained nurses' work, and how nurses have contributed to the national policy making processes that influence their work in the current era of HIV/AIDS in Kenya.

Questions you might have:

What will I be asked to do?

You are being asked to participate in an interview to provide your perspectives about how national policies implemented in Kenya have affected nurses' work in the current era of HIV/AIDS and how nurses have been involved in the policy processes at various levels. The interview will take approximately 45 to 60 minutes, and will be conducted face to face by Pamela Juma. The interview will be tape-recorded if you allow us to do so.

Are there any risks from participating?

There are no major risks expected from your participation. Your decision as to whether or not to participate in this study will not have any negative repercussions for you. However, your participation in this study will entail that you volunteer information that may cause you to feel potential emotional and psychological discomfort, and concerns about repercussions that may follow if you speak about issues such as poor working conditions for nurses, policy implementation gaps, poor quality of care and lack of nurses' involvement in decision-making or policy processes. Every effort will be taken to minimize these risks. The aim of this study is to address policy issues related to nurses' work and enhance the quality of nursing services for the population in the current era of HIV/AIDS. Therefore talking about these issues will not cause you to be dismissed from your job or intimidated by your seniors, but will help in achieving the study objectives. In addition, all the transcripts and quotes used in this study will be anonymized and no identifying information will be used in the study reports and other publications. You can withdraw from the study at any time or request to have portions of your interview removed from the transcripts, after the interview. You can state only what you feel comfortable telling the interviewer and your decision to participate or not will not be disclosed to my employer or any other senior officer in the Ministry of health. The interview will be held in a location of my choice.

Are there any benefits to participating?

Your participation in this study will not have a direct benefit to you, however, the information you share will help in enhancing general understanding of how national policies and their development processes affect nurses' work. The information is intended to be shared with relevant stakeholders so that it can be used to address policy issues related to nurses' work and to enhance the quality of nursing services for the population in the current era of HIV/AIDS.

Are my answers confidential and anonymous?

Any information you share will remain strictly confidential. The information will be used only for the purpose of the study and confidentiality will be maintained. The content will only be discussed with the researcher, her research assistant, supervisor and research committee members. Your name will not be recorded with your responses or identified in any way. A unique code number will be assigned to you to identify your taped interview and interview transcripts. Your institution will also have a unique code and the name of your institution will not be used in presenting results. Your identity will not be revealed in any reports or publications emerging from this study. Your participation in this study will not be revealed to anyone.

Conservation of data:

All information collected (audiotapes, interview transcripts, field notes) will be kept in a locked filing system in the project office at Great Lakes University of Kisumu. The computer on which study data will be stored will be password-protected. The data will be accessible only to the student conducting the study and her research assistant and the supervisor. The list with the names and codes for participants will be kept in a different filing cabinet than the other study data. The electronic version of the participants' names and codes will be password protected on a password-protected computer and kept in a separate file directory than the data transcripts.

The study data will be stored for seven years following completion of the study, after which time all paper transcripts will be destroyed. The audio- tapes will be destroyed one year after transcription.

Compensation

There will be no monetary or other compensation for your participation in the study.

Voluntary Participation:

You are under no obligation to participate, and if you choose to participate, you can withdraw from the study at any time and /or refuse to answer any questions, without suffering any negative consequence. If you choose to withdraw from the study, you may request that all data gathered until the time of your withdrawal be destroyed.

For More Information:

If you have any questions regarding the ethical conduct of this study, you may
 contact the Protocol Officer for Ethics in Research, University of Ottawa,



Université d'Ottawa
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 École des sciences
 infirmières

University of Ottawa
 Faculty of Health
 Sciences
 School of Nursing

Chair, Institutional Ethical Review Committee,
 Great Lakes University of Kisumu

[REDACTED]

Consent Form.

I have read and understood the information on the Participant Invitation
 Information Sheet and I understand the information in this Consent
 Form.

_____ agree to participate in the above
 research study conducted by Pamela Juma of the University of Ottawa,
 Kisumu and Great Lakes University of Kisumu, which is under the
 supervision of Dr Nancy Edwards

I agree to allow my interview to be audio-taped

I agree to be quoted but all personally-identifying information shall be
 removed to protect my anonymity.

If I have any questions about the study, I may contact the researcher [REDACTED]
 [REDACTED] her supervisor

If I have any questions regarding the ethical conduct of this study, I may
 contact the Protocol Officer for Ethics in Research, University of Ottawa,

[REDACTED]

[REDACTED]

Chair, Institutional Ethical Review Committee, Great Lakes

[REDACTED]



There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____

Date:

Researcher signature: _____

Date:

Appendix C: Phase 1 Key Informant Guides

A) Questions for national level decision makers

- 1 What is your role in this Department/ Division/Section/?
- 2 How long have you worked in this department/division/section? ____years
- 3 Please describe how your current work relates to policy development in the health sector
- 4 Would you please describe briefly, your experience in relation to national policy development and implementation processes in this country?
- 4 In your opinion and experience, what are the main national policies that have affected nursing service delivery in this country since the 1980s?

Probes:

- i. Primary Health Care.
- ii. Structural adjustments policies
- iii. Health Sector Reforms (Decentralization; Privatization; Financing)
- iv. Poverty-Reduction policies (Probes for PRSPs and SWAPS).
- 5 In your opinion, how have these policies affected nurses' work within the district health care system?

Probes

- i. Specific policies and specific elements within each policy
- ii. Direct and indirect positive effects
- iii. Direct and indirect negative effects
- iv. Effort made at national level to address the negative policy concerns of nurses
- 6 In your experience how were these national policies developed within the country?
 - i. Who were the major actors and drivers when the decisions regarding policy agendas, objectives and instruments were decided?
 - ii. What were the broad contextual influence on policy decisions?
- 7 In your experience, how have nurses been engaged in national policy formulation and implementation within the health sector?

- i. How have the policies been communicated to the nurses at the district level?
- ii. How can nurses' engagement in policy formulation and implementation be improved?

B) Questions for provincial and district level decision makers

- 1 What is your role in this province/district?
- 2 How long have you worked in this province/district? ____years
- 3 Please describe how your current work relate to policy development in the health sector
- 4 In your opinion and experience, what are the national policies that have affected nursing services delivery in this country since the 1980s?

Probes for:

- i. Primary Health Care.
 - ii. Health Sector reforms (Decentralization, Privatization, Financing)
 - iii. Poverty-Reduction policies (PRSPs)
 - iv. SWAPS
 - v. Other
- 8 How has your office been involved in formulation and implementation of these policies?

Probes

- i. Who were the key actors when the decisions regarding policy agendas? Objectives and instruments were decided at the provincial/district level?
 - ii. How were nurses involved in the policy processes at this level?
 - iii. How have the policies elements or directives been communicated to the nurses at the district level?
- 9 What is your understanding of primary health care policy?
Probe: What constitutes the elements of primary health Care policy
 What is the implementation status of primary health care policy in this province/district)?
 - 10 In your opinion, how has primary health care policy affected nurses' work within the district health care systems?

Probe:

- i. Ways in which primary health care policy has positively affected nurses' work in the districts?
 - ii. Ways in which primary health care policy have negatively affected nurses' work within the district health care systems?
 - iii. How have they impacted on nurses' ability to provide HIV/AIDS services in the district?
- 4 What is your understanding of health sector reforms policies?
 - 5 Which elements of health sector reform are being implemented in this Province/District?

Probes:

- i. Decentralization,
- ii. Privatization,
- iii. Financial reforms
- iv. Others

What is the implementation status of the health sector reform elements in this Province/district)?

In your opinion, how has health sector reforms affected nurses' work within the district health care systems?

Probe:

- i. Ways in which reform elements have positively affected nurses' work in the districts (*each specific policies elements mentioned*)?
- ii. Ways in which the reform elements have negatively affected nurses' work within the district health care systems?
- iii. How have they impacted on nurses' ability to provide HIV/AIDS services in the district?

What you understanding by poverty reduction policies?

Probe:

- i. Specific elements being implemented in the Province/District?
- ii. PRSPS
- iii. SWAPS

1 What is the implementation status of the poverty reduction policies in this Province/district)? (*Fully implemented, partially implemented, implementation not started*)

2 In your opinion, how has the implementation of the poverty reduction policies affected nurses' work within the district health care systems?

Probe:

- i. Ways in which poverty reduction policy (*elements mentioned*) positively affected nurses' work in the districts (each specific policies element mentioned)?
- ii. Ways in which the poverty reduction policy (*elements mentioned*) negatively affected nurses' work within the district health care systems?
- iii. How have they impacted on nurses' ability to provide HIV/AIDS services in the district?

Would you please comment on the involvement of nurses in policy formulation and implementation decisions at various levels of the health care system ?

Probes:

- i. Are the nurses adequately involved in policy formulation and implementation?
- ii. How can they be adequately involved?

B) Interview questions for frontline nurses and managers

Demographic characteristics

1 Gender?

- ☐ Female
☐ Male

2 What is your training background (tick all that apply)

1. Enrolled Nursing
2. Diploma (KRN/KRCHN)
3. baccalaureate degree
4. master's degree (specify specialty) _____

5. doctoral degree (specify specialty) _____
 6. Others specify _____
 7. Other major trainings taken _____
3. What is your current employment designation?
 8. Enrolled Community Health nurse I
 9. Enrolled Community Health nurse II
 10. Enrolled Community Health nurse III
 11. Nursing Officer I
 12. Nursing Officer I
 13. Nursing Officer I
 14. Others Specify _____
 - 3 How long have you worked as a nurse? ____years
 - 4 If you are a nurse manager, how long have you worked as a manager? ____years
 - 5 How long have you worked in your present position? ____months ____years
 - 6 How long have you worked in this Facility? ____months ____years
 - 7 Please describe your current work related to care of people with HIV/AIDS
 - 8 Please describe your current work setting _____

Interview Questions

- 9 In your opinion what are some of the changes in the health care system that have affected your work as a nurse?
- 10 What do you understand by the term national policies?
- 11 In your opinion and experience, what are the major national policies that have affected nursing service delivery in this country since the 1980s?

Probes:

- i. Primary Health Care.
 - ii. Decentralization; Privatization; Financing
 - iii. Poverty-Reduction policies (PRSPs)
 - iv. SWAPS.
 - v. Any other
- 12 How have the policy elements or directives mentioned affected your work in provision of care to people living with HIV/AIDS in this health facility?

Probes

 - a. How these policies have helped in facilitating your work in HIV/AIDS at facility level (specific policies elements mentioned)?
 - b. How the policies have been restrictive on your work in provision of care to people living with HIV/AIDS in this health facility?
 - c. Any other major challenges with the policies?
 - 13 Given your professional goals and values of caring do you find these policies promoting your abilities to achieve your professional goals? (Reasons for response)

Nurse's involvement in policy processes

- 14 How have the national policies been communicated to you?
- 15 Have you been involved directly in policy formulation or implementation decisions at any level of the health system?

If yes, probe

- i. How did you participate? Please explain. (e.g. *Implemented policy directives, research that informed policy, meetings to discuss policy directives at the national office etc*)
- ii. How did you feel as you participated?
- iii. What supported you in that involvement?

If not, Probes:

- iv. If not, what are the reasons why you have not engaged in efforts to formulate or implement national policies that affect your work?
- 16 In your opinion, what could be done to involve nurses more fully in formulation and implementation of national policies that affect service delivery and nurses' work?
- Probe:*
- i. At national level,
 - ii. Workplace

- 17 What role could nurse leaders and professional associations play in enabling nurses to be more involved in national policy development?
- i. At national
 - ii. At workplace

Appendix D: Phase 2 Ethics Approval



Date (mm/dd/yyyy): 10/07/2009

Université d'Ottawa **University of Ottawa**
 Service de subventions de recherche et d'éthologie Research Grants and Ethics Services

Ethics Approval Notice
Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Nancy	Edwards		
Patricia	Juma		

File Number:

Type of Project: PhD Thesis

Title: Intersection of National Policies on Nurses' Work in the Context of HIV/AIDS in Kenya (Phase II)

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
10/07/2009	10/06/2010	1a

(1a: Approval, 1b: Approval for initial stage only)

Special Conditions / Comments:
 N/A



Date (mm/dd/yyyy): 10/07/2009

Université d'Ottawa University of Ottawa
 Service de subventions de recherche et déontologie Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:

[Redacted]

[Redacted]

If you have any questions, please do not hesitate to contact

[Redacted]

Germain Zongo
 Protocol Officer for Ethics in Research
 For Dr. Daniel Lagarec, Chair of the Health Sciences and Sciences REB

[Redacted]



Université d'Ottawa
Faculté des sciences
de la santé

École des sciences
infirmières

University of Ottawa
Faculty of Health
Sciences

School of Nursing

Phase II Respondent Invitation and Information Form

Researcher: Pamela A. Juma, School of Nursing, University of Ottawa .

Supervisor: Dr Nancy Edwards, School of Nursing, University of Ottawa.

Reason to participate

You are being invited to participate in the above-mentioned study conducted by Pamela Juma, who is a doctoral student at the University of Ottawa and a lecturer at Great Lakes University of Kisumu.

Study purpose

The purpose of this study is to examine how national policies implemented in Kenya since 1980, have influenced nurses' work in the district health care system. The study is exploring the perceptions and experiences of frontline nurses and nurse managers on how broader national policies that have been implemented in the health sector have helped or constrained nurses' work. The study is also examining the extent to which nurses have been involved in formulation and implementation of national policies that influence their work in the district health care systems in Kenya.

Participation

You are being asked to participate by filling in a questionnaire to provide your experiences and opinion on how national policies implemented in Kenya have affected nurses' work in the current era of HIV/AIDS and how nurses have been involved in the policy processes. The questionnaire will take approximately 30 to 40 minutes to fill. An envelope has been provided for you to put your completed questionnaires. You can then give the envelope to the researcher or her assistant when she visits your unit.

There are no major risks expected from your participation. Your decision whether or not to participate in this study will not have any negative consequences for you. However your participation in this study will entail you answering questions that might make you feel anxious or upset about your involvement in policy and this may cause you some potential emotional discomfort. You are re-assured that every effort will be taken to minimize these risks. The aim of this study is to address policy issues related to nurses' work and to enhance the quality of nursing services to patients in the current era of HIV/AIDS. All the questionnaires and other information used in this study will be anonymized and no identifying information will be used in the study reports and other publications. Permission has been obtained from the Ministry of health, the provincial health office and institutional administration to request staff to participate in the study. You can leave a question

unanswered if it creates emotional discomfort, makes you feel upset or anxious. You can also stop filling the questionnaire if you feel uncomfortable with it.

Benefits:

Your participation in this study will not have a direct benefit to you; however, the information you share will help in enhancing general understanding of how national policies and their development processes affect nurses' work and determine options for addressing nurses work concerns that relate to national policies. Your participation would also help in determining strategies to strengthen nurses' role in policy processes and decision making in health service delivery. The information is intended to be shared with relevant stakeholders so that it can be used to address policy issues related to nurses' work and so enhance quality of nursing services to the population in the current era of HIV/AIDS.

Confidentiality and anonymity:

You are reassured that any information you share by filling this questionnaire will remain strictly confidential. The information will be used only for the purpose of the study and your confidentiality will be protected. The content will only be discussed with the research supervisor and research committee members. A unique code number will be assigned to identify the questionnaire. Your institution will also have a unique code and the name will not be used in presenting results. Aggregate results will be published so your identity will not be revealed in any reports or publications. Although your name was provided to the researchers by another contact person, the researchers will not reveal to that person whether or not you participated in this study.

Conservation of data:

All information collected from you will be kept in a locked filing system in the project office at Great Lakes University of Kisumu. The data will be accessible only to the student conducting the study and her research assistant and the supervisor. The members of the research committee may also access the data. The list with the names and codes for participants will be kept in a different filing cabinet than the other study data. The study data will be stored for seven (7) years following completion of the study, after which time the questionnaire will be destroyed.

Compensation

There will be no monetary compensation for your participation in the study.

Voluntary Participation:

You are under no obligation to participate and if you choose not to participate, you can choose not to answer all questions or refuse to answer any questions, without suffering any negative consequence. If you choose to withdraw from the study, you may request the questionnaire be destroyed.

For more information about the study you can contact the researcher [REDACTED]

If you have any questions regarding the ethical conduct of this study, you may contact the Protocol

Officer for Ethics in Research, University of Ottawa, [REDACTED]
[REDACTED]

Or

The Chair, Institutional Ethical Review Committee, Great Lakes University of Kisumu; [REDACTED]
[REDACTED]

Appendix F: Phase 2 Survey Questions for Frontline Nurses and Managers

Section A: Socio-demographic profile

- 1 Sex
2. What is your training background (*If you have upgraded please indicate all the levels of upgrading*)
 15. Enrolled Nursing
 16. Diploma (KRN/KRCHN)
 17. Bachelors degree in nursing
 18. Master's degree (specify specialty)
 19. Other major courses (specify)
3. What is your current designation?
 - i. Enrolled Community Health nurse I
 - ii. Enrolled Community Health nurse II
 - iii. Enrolled Community Health nurse III
 - iv. Nursing Officer I
 - v. Nursing Officer II
 - vi. Nursing Officer III
 - vii. Others Specify
4. What is your current job title or job position?
5. How long have you worked as a nurse? ____years____months
6. How long have you worked in your present position? ____years ____months
7. How long have you worked in this Facility? ____years ____months

Section B: Impact of policies on nurses' work

1. The following key national policies have been implemented in the health sector. Please indicate the extent to which the policies have impacted on nurses' work in health facilities and whether they have had a positive or negative impact.

For each statement below, please circle the response option to indicate whether the policy element has had a strongly negative impact, moderately negative impact, moderately positive impact, or strongly positive impact on nurses' work in this health facilities or this district.

	Strongly negative impact	Moderately negative impact	Moderately positive impact	Strongly positive impact	Don't know
1. Primary health care policy	1	2	3	4	5
2. Decentralization of health service management and administrative authority from central to district level	1	2	3	4	5
3. Civil service reform which stopped hiring of nurses in late 1990s	1	2	3	4	5
4. Cost sharing of health care services	1	2	3	4	5
5. Poverty reduction policy	1	2	3	4	5
6. Sector-wide approach which brings stakeholders to work together at all levels	1	2	3	4	5
7. Performance contract for health workers	1	2	3	4	5

COMMENTS (optional). Please elaborate on your reasons for any or all your choices above.

2 .The following statements are about nurses' work situation as influenced by national policies. We are interested in your opinion and experiences on how national policies have influenced your current work situation.

For each statement below, please circle the response option to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement.

	Strongly Disagree	Disagree	Agree	Strongly agree
1. There are enough nursing staff to meet the required standards of nursing care in this health care facility.	1	2	3	4
2. Nurses have adequate resources to deliver quality services to patients in this health care facility	1	2	3	4
3. The infrastructure including equipment and supplies in this facility enables the provision of good quality nursing care	1	2	3	4

For each statement below, please circle the response option to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement.

	Strongly Disagree	Disagree	Agree	Strongly agree
4. Nurses in this health facility are not able to use their professional knowledge and skills to deliver quality care	1	2	3	4
5. Nurses in this health facility are not able to achieve their caring objectives	1	2	3	4
6. Nurses in this health care facility have a very high workload	1	2	3	4
7. Nurses in this facility experience work dilemmas due to rapid changes in policies	1	2	3	4

COMMENTS (optional) Please elaborate on your reasons for any or all your choices above.

3. The following statements are about national policies relating to structural changes in the health care system in Kenya. We are interested in your opinion on how some of these structural changes have influenced nurses' work in this district.

	Strongly Disagree	Disagree	Agree	Strongly agree	Don't know
<i>For each statement below, please circle the response options to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement</i>					
1. There are more senior leadership and management opportunities for nurses in this district due to structural policy changes	1	2	3	4	5
2. There is improved collaboration between nurses and other health care workers in this district due to structural policy changes	1	2	3	4	5
3. Nurses in this district contribute substantially to general management decisions like other health care professionals due to structural policy changes	1	2	3	4	5
4. Nurses in this district are contributing to service provision decisions substantially with other health care professionals	1	2	3	4	5
5. Nurses have adequate opportunities for continuous training in this district due to structural policy changes	1	2	3	4	5
6. There is competition between nurses and other health workers in service provision decisions in the district due to policy changes	1	2	3	4	5

For each statement below, please circle the response options to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement

	Strongly Disagree	Disagree	Agree	Strongly agree	Don't know
7. Nurses have adequate skills to carry out management functions in this district due to structural policy changes	1	2	3	4	5
8. Nurses are actively participating in planning of health services in this district due to structural policy changes	1	2	3	4	5
9. Nurses are well trained in cost sharing funds management due to structural policy changes	1	2	3	4	5
10. Nurse managers are participating in financial resource allocation decisions in the district due to structural policy changes	1	2	3	4	5

COMMENTS (optional) Please elaborate on your reasons for any or all your choices above.

Section C. Nurses' participation in policy processes

4. The following statements are about your involvement in national policy-related activities in the health sector in the past. We are interested in your experiences with policy formulation and implementation activities and processes.

For each statement below, please circle the response options to indicate frequency of your involvement, either never, rarely, sometimes or always

	Never	Rarely	Sometimes	Always
1. I have attended management meetings in this health facility to discuss the implementation of national policy directives	1	2	3	4
2. I have attended meetings at the national level to discuss national health policies and directives	1	2	3	4
3. I have contributed to the development of national health service policy guidelines	1	2	3	4
4. I have been asked to comment on how national policies should be implemented	1	2	3	4
5. I have implemented national policy directives in this health facility	1	2	3	4
6. I have been asked to evaluate the impact of new national policies on service delivery in this facility	1	2	3	4
7. I have participated in research to inform national policy formulation	1	2	3	4
8. I have advocated for national policy change on issues affecting nurses' work	1	2	3	4

COMMENTS (optional) Please elaborate on your reasons for any or all your choices above.

5. The following statements are factors that may influence nurses' participation in national health policy-making activities in the health care system. We are interested in your opinions.

<i>For each statement below, please circle the response options to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement</i>	Strongly Disagree	Disagree	Agree	Strongly agree
1. Nurses in this district lack knowledge about national policy-making processes	1	2	3	4
2. Nurses in this district are consulted by national policy makers when national policies are made or reviewed	1	2	3	4
3. Nurses in this district have opportunities to engage in national policy making processes	1	2	3	4
4. Existing health committees and boards in this district do not allow nurses to participate in decisions about national policies	1	2	3	4
5. Nurses in this district do not use existing health information to advocate for national policy changes	1	2	3	4
6. Nurses in this district have not united to influence national policies that affect their work	1	2	3	4
7. Nurses' scope of practice does not include participating in national policy-making processes	1	2	3	4
8. Nurses are well informed about national policies that are being implemented at the district level	1	2	3	4
9. The terminologies used in national policy documents are too complex for nurses to understand	1	2	3	4

COMMENTS (optional) Please elaborate on your reasons for any or all your choices above.

6. The following statements are about some potential consequences of nurses' limited involvement in national policy processes. We are interested in your opinions.

<i>For each statement below, please circle the response options to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement</i>	Strongly Disagree	Disagree	Agree	Strongly agree

<i>For each statement below, please circle the response options to indicate whether you strongly disagree, disagree, strongly agree or agree with the statement</i>	Strongly Disagree	Disagree	Agree	Strongly agree
1. National health policies do not reflect the concerns that nurses in this district have about their day-to-day work	1	2	3	4
2. National health policy implementation in this district is poor	1	2	3	4
3. Nurses in this district hardly achieve their professional goals and values of caring for patients	1	2	3	4
4. Nurses in this district do not have a good work environment	1	2	3	4
5. Nurses are demoralized	1	2	3	4
6. National health policies do not reflect the needs of patients and communities in this district	1	2	3	4
7. Nurses in this district are not trusted by the communities where they work	1	2	3	4
8. Nurses in this district experience ethical dilemmas when patients are not able to receive care	1	2	3	4

COMMENTS (optional) Please elaborate on your reasons for any or all your choices above.

7. The following statements are about enhancing nurses' involvement in national health policy processes nationally and within the district. We are interested in your opinion

<i>For each statement below, please circle the response option to indicate whether the factor is not important, moderately important, Important and very important</i>	Not important	Moderately important	Important	Very important
1. Nurse educators should introduce a course on policy and policy processes in the nursing training curriculum	1	2	3	4
2. National leaders in the health system should make nurses more aware of new national policies implemented in the health sector	1	2	3	4
3. National leaders in the health care system should consult frontline nurses when developing policies that affect nurses' work	1	2	3	4
4. National level policy makers should create opportunities for nurses to engage in policy decisions at all levels of health care	1	2	3	4

For each statement below, please circle the response option to indicate whether the factor is not important, moderately important, Important and very important

	Not important	Moderately important	Important	Very important
5. Researchers should encourage nurses to carry out studies that would inform national policies	1	2	3	4
6. Adequate resource should be allocated to this district to enable nurses' to implement national policies effectively	1	2	3	4
7. Nurses should unite to build a strong voice to advocate for improvements in national policies	1	2	3	4
8. Nurses should be more engaged in policy advocacy in their work places	1	2	3	4
9. Nurses who in leadership positions should be recruited based on their competencies in policy processes	1	2	3	4

Please elaborate on your reasons for any or all your choices above.

Please suggest any other changes you would like to see in nurses' work in relation to national policies that affect their work .