

KNOWLEDGE AND POLICYMAKING COMPETENCES OF NURSING
PROFESSIONALS

BY

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Abstract

This study sought to understand the knowledge and policymaking competences of nursing professionals in Zimbabwe's public health institutions. In this study, three Zimbabwe Nurses' Association staff members, two Zimbabwe Medical Health Board staff members, and eight nurses were used as the research subjects. Interviews based on a self designed interview guide were used as the research instrument. Documentary review method was also used to provide a broadened base of information on nurses' involvement in policy making processes. The study showed that while nursing professionals in public institutions exhibit policymaking competences, the ineffective organisational structure of ZINA, resource constraints, legislative restrictions and gender disparity negatively affected nurses' involvement in PMPs. This study recommends that ZINA should establish an effective organisational structure that will allow nurses to engage in PMPs, nurses should engage development partners and the training curricula for nursing should include educational materials on PMPs and government processes. Finally, the study recommended that further research be undertaken in order to establish how evidence based public health policies can be formulated.

Declaration

This dissertation is my original work except where sources have been acknowledged.

The work has never been submitted, nor will it ever be, to another University in the awarding of a degree.

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Dedication

I dedicate this work to Tinashe, Tatenda, Clive and Nyasha, my children. You were very understanding and patient throughout my entire studies. I will always pray for you that through the sacrifices made, I will continue to set a good example for you all.

TABLE OF CONTENTS

ABSTRACT.....	I
COPYRIGHTS.....	III
ACKNOWLEDGEMENTS	IV
DEDICATION	V
LIST OF ACRONYMS	XII
CHAPTER I: Introduction to the study.....	1
1.0 Introduction	1
1.2 Background to the study.....	1
1.3 Statement of the problem	3
1.4 Purpose of the study	3
1.5 Significance of the study	3
1.6 Research objectives	4
1.7 Research questions	5
1.8 Assumptions.....	5
1.9 Delimitation	5
1.10 Limitations of the study	5
1.11 Definition of key concepts	6
1.13 Summary	7
CHAPTER II: LITERATURE REVIEW	8

2.0 Introduction	8
2.1 Nurses' involvement in policy processes.....	8
2.3 Need for nurses' participation in policy processes	11
2.4 The policy making process	14
2.4.1 Working definition of public policy.....	15
2.4.2 Problem identification.....	15
2.4.3 Agenda setting.....	16
2.4.4 Policy formulation.....	17
2.4.5 Policy legitimating	17
2.4.6 Policy implementation	17
2.4.7 Policy evaluation.....	18
2.5 CSO engagement in policy development.....	19
2.5.1 What are civil society organisations?.....	19
2.5.2 Role of csos in pmps	20
2.6 Role of ZINA in PMPS	21
2.7 Models of public policymaking	22
2.7.1 The rational comprehensive model	23
2.7.2 Define the problem.....	24
2.7.3 Determine evaluation criteria.....	26
2.7.4 Identify alternative policies.....	27

2.7.5 Evaluate alternative policies	28
2.7.6 Select the preferred policy alternative.....	29
2.7.7 Implement the preferred policy	30
2.8 Actors in the policy making process	30
2.8.1 Official actors.....	31
2.8.1.1 The legislature	31
2.8.1.2 The executive	32
2.8.1.3 The bureaucracy	32
2.8.1.4 Judiciary	33
2.8.2 Unofficial actors.....	34
2.8.2.1 The media.....	34
2.8.2.2 Political parties.....	36
2.8.2.3 Interest groups	37
2.8.2.4 Political consultants	38
2.9 Politically competent nurses	39
2.9.1 Dimensions of political competence	39
2.9.2 Social astuteness.....	40
2.9.3 Interpersonal influence.....	41
2.9.3 Networking ability	41
2.9.4 Political savvy	42

2.9.5 Communication skills.....	42
2.9.6 Influence tactics and strategies.....	43
2.9.7 Ingratiation	44
2.9.8 Self-promotion	44
2.9.9 Assertiveness.....	45
2.9.10 Networking and positioning.....	45
2.9.11 Coalition building	46
2.9.12 Other strategies.....	47
2.9.13 Issues arising from gaps in literature	48
2.9.14 Summary	49
CHAPTER III: METHODOLOGY	51
3.0 Introduction.....	51
3.1 Research paradigm.....	51
3.2 Research design.....	52
3.3 Study population	53
3.4 Sample selection.....	53
3.5 PARTICIPANTS	54
3.5.1 Key participants interviewed.....	55
3.6 Research instruments	56
3.7 Ethical considerations	57

3.8 Data collection procedures	58
3.9 Data analysis procedures	59
3.9 Data quality procedures.....	60
3.10 Challenges encountered in conducting fieldwork	62
3.10 Summary	62
CHAPTER IV: DATA PRESENTATION, FINDINGS AND ANALYSIS	64
4.0 Introduction	64
4.1 Research methodology of the study revisited	64
4.2 Knowledge and policymaking competences (KPMCS).....	65
4.4.1 Management and leadership.....	66
4.4.2 Perceptions of nursing professionals	66
4.4.3 Engagement in policy related dialogues	67
4.4.4 Partnerships and team building capabilities	67
4.3 Role of zina in health policy making processes	68
4.6 Factors that influence nps' participation in health pmps	71
4.6.1 Ability to build coalitions	71
4.6.2 Ability to collaborate with other stakeholders	73
4.6.3 Engagement in human capacity development.....	73
4.6.4 Gender disparity	74
4.6.6 Resource constraints.....	75

4.6.7 Organisational strength of ZINA	76
4.6.8 knowledge of legislative processes	77
4.4 The extent to which nurses influence the shaping of public health policy.	78
4.7.1 Retention incentives	78
4.7.2 Establishment of a Health Services Board	82
4.7.3 Formation of coalitions	82
4.7.4 Scheduled meetings on calendar	83
4.9 Organisational structures	84
4.5 Summary	85
CHAPTER V: SUMMARY, CONCLUSION AND RECOMMENDATIONS.....	87
5.0 Introduction	87
5.1 Summary	87
5.2 Participants.....	88
5.2 Findings.....	90
5.3 Conclusion	91
5.4 Recommendations	93
5.5. For practice.....	94
6.0 References	95

LIST OF ACRONYMS

ACNM	American College of Nurse-Midwives
CSO	Civil Society Organisations
HSB	Health Services Board
ICN	International Council of Nurses
ICO	Independent Clinics Organisation
KPMC	Knowledge and Policymaking Competence
MAPS	Midwifery Association Partnerships for Sustainability
MDA	Mass Drug Administration
MoHCC	Ministry of Health and Child Care
NAMAS	National Association of Medical Aid Societies
NP	Nursing professional
PSC	Public Service Commission
PCN	Primary Care Nurses
PMP	Policy Making Process
UK	United Kingdom
TAC	Treatment Action Campaign
USA	United States of America

WHO	World Health Organisation
ZACH	Zimbabwe Association of Church related Hospitals
ZCN	Zimbabwe Council of Nurses
ZMA	Zimbabwe Medical Association
ZINA	Zimbabwe Nurses' Association

Table of figures

Figure 1 Stages in the policymaking process..... 24

Appendices

APPENDIX 1 INTERVIEW GUIDE QUESTIONS	105
APPENDIX 2 INFORMED CONSENT FORM	109
APPENDIX 3 LETTER FROM AFRICA UNIVERSITY	113

CHAPTER I: INTRODUCTION TO THE STUDY

1.0 Introduction

This qualitative research study explores the dearth of knowledge and policymaking competences (KPMCs) in nurses, required to effectively affect public health policymaking processes (PMPs) in Zimbabwe. In this regard, this chapter presents the background of the study, statement of the problem, significance of the study, research objectives and research questions. The assumptions of the study, the limitations and the delimitations are also presented in this chapter.

1.2 Background to the study

The International Council of Nurses [ICN] (2001) posits that nurses must understand how the health policy is made in order to determine where and how to best make a difference. In fact, Taft and Nanna (2008) argue that, a compelling need exists for nursing professionals to understand and influence how health policy affects the lives of patients, families, nurses, and the health care system itself. Furthermore, Taft and Nanna observe that leaders of nursing professionals agree that nurses should be involved in policy development and that nursing's impact on the policy realm should be greatly strengthened. However, Gebbie, Wakefield and Karfoot (2000) posit that nurse participation in public policy making is suffering an undeserved neglect regardless of the broad consensus among nurses that they should also be on the policy table

In most developed countries including the United Kingdom (UK), nurses practising in clinical settings perceive health policy to be a nursing issue and are involved in policy debates (Toofany, 2005). Similarly, Hewison (2007) indicates that in the USA, practising nurses are striving to improve their level of influence in the policymaking process. Surprisingly, even though nurse participation in public policy formulation is critical, one hardly finds any literature linking nurses to policy making in developing countries such as Zimbabwe. This lack of involvement in policy making is attributable to lack of training in public policy.

Nevertheless, public policy plays a crucial role in health service delivery and the work of nurses in Zimbabwe cannot be divorced from health policies which are part of public policy. As a result, nurses need a supportive health policy that is a product of their inclusive and active participation in its formulation. For example, Hewison (2007) acknowledges that in the United States of America (USA), nurses and their professional associations actively influence health policy that facilitate the provision of quality nursing care in addition to improving working conditions for the health personnel. Against this background, continued lack of involvement of nurses in the policy process is an issue of concern in Zimbabwe that need to be addressed. In this regard, nurse leaders in Zimbabwe, supported by their professional organizations, must identify ways in which they can become active in the policymaking process.

1.3 Statement of the Problem

There is a dearth of literature on the involvement of nursing professionals in the policymaking process. Also, while the Zimbabwe Nurses' Association (ZINA) claims that its role is to influence health policy and conditions of service, there is no empirical evidence to back this up. This lack of literature on nurses' participation in policymaking processes points to lack of policymaking competences which are critical for active participation in the policy process. Accordingly, these gaps could only be filled by nurses input which would result in the enrichment of the health policy.

1.4 Purpose of the study

The purpose of this study was to explore and understand through the obtaining of information from key participants, practising nurses and members of ZINA, what they can contribute to the health PMP. Generally, the study was aimed at drawing on nurses' expertise and field experience to clarify nurses' involvement in policy development, identify competence gaps in order to make recommendations for nurses' meaningful involvement in health policy processes.

1.5 Significance of the study

The research study was of particular significance to the understanding of knowledge and policymaking competences of nurses in affecting public health policy. In this regard, the study highlighted the importance of having good knowledge and

policymaking competences by nurses in affecting policymaking processes. In addition, the research study added value to the body of knowledge and literature relating to the role played by ZINA in shaping the public health policy. In fact, given due consideration by relevant authorities and stakeholders, the study can act as a basis for stimulating policy and scholarly debates on participation of nurses in developing sound public health policies. In other words, the study added the missing link in the literature and debates on the involvement of nurses in public health policy processes in Zimbabwe and other developing countries.

1.6 Research objectives

The primary objective of this research was to explore and understand the knowledge and policymaking competences that affect nurses' ability to influence public health policy development. Other resultant objectives of the research are:

1. To examine the extent to which nurses in Zimbabwe use their influence to shape health policy.
2. To establish the role played by ZINA in the health policymaking processes.
3. To identify factors that influence nurses to participate in the health policymaking processes.
4. To investigate whether nurses have the requisite knowledge and policymaking competences.

1.7 Research questions

1. To what extent do nurses use their influence to shape public health policy?
2. What are the roles played by ZINA in health policymaking processes?
3. What are the factors that influence the participation of nurses in health policymaking processes?
4. What knowledge and policy-making competences do nurses have?

1.8 Assumptions

The first assumption was that, nurses are expected to play a role in the development of health policies. Secondly, the study assumed that, through nurses and ZINA's participation in policymaking processes, nurses are expected to make significant contributions towards improvement of the health policy.

1.9 Delimitation

This qualitative case study focused on obtaining information on the policymaking processes of nurses who are both, employed in the public service and are members of ZINA. In this regard, the study was carried out in Harare, the capital city of Zimbabwe, and involved ZINA officials, officers from the Health Services Board and nurses from various hospitals in Harare.

1.10 Limitations of the study

A significant limitation of the study is related to its focus on NPs who are employed in public health facilities in the capital city, while excluding nurses in private and

church related health facilities. By nature nurses in public hospitals in capital cities like Harare, are highly qualified and often more exposed to government programmes and processes than their counterparts in private and rural settings (Grant, 1986). In this regard, other researchers intending to carry out a study along these lines should consider using nurses in other regions other than Harare to unravel more information.

In addition, there are limited resources and documented study materials on nurses' involvement in policy development processes relating to developing countries such as Zimbabwe. Nevertheless, the results of this study can be assimilated and the methodology of research replicated to public health sectors such as private and church related hospitals. In addition, the resultant product would be more informative when generated through a mixture of qualitative and quantitative techniques in the gathering, analysis and interpretation of requisite data. The above methodological weaknesses are due to time limitations as the researcher had to abide by the set time lines.

1.11 Definition of key concepts

The following terms will be defined and used in the study as follows:

Nursing professionals are a distinct group of health professionals who apply their expertise to prevent disease transmission, diagnose, treat and rehabilitate people of all ages and all specialities.

Political competence is the skills, perspectives, and values needed for effective political involvement within nursing's professional role. This definition by Warner (2003) will be adopted in the study.

Public policy is government's rules and regulations that govern people's way of life.

Politics is the process of making and influencing decisions about allocation of resources.

1.12 Structure of the study

Chapter I deals with information on the background of the study, statement of the problem, the assumptions, research objectives and research questions. The significance, delimitations and limitations of the study are also presented in chapter I. Chapter II presents information from different authorities on the research topic under study and the theoretical framework. Chapter III deals with the methodology used to sample, collect, present and analyse data. The major finding of the study are analysed and presented in chapter IV while the summary, conclusion and the recommendations are presented in chapter V.

1.13 Summary

This chapter presented the basis for the research study on exploring and understanding the knowledge and policymaking competence that affect nurses' ability to influence public health policy development. This was done by discussing the background of the problem, the statement of the problem, the research objectives and questions, the research assumptions, the significance of the study, the limitations and delimitations of the study. The next chapter focuses on presenting the literature reviewed in this study and the theoretical framework.

CHAPTER II: LITERATURE REVIEW

2.0 Introduction

This chapter deals with literature on nurses' involvement in policymaking, the policymaking process, the theoretical framework, actors in the policy process, civil society organizations' engagement in the policy process, role of ZINA in health policy formulation and gaps in the literature.

2.1 Nurses' involvement in policy processes.

Nursing has been political from its historic foundation to its essential core such that inclusion of political participation in nursing's professional role has been evident in the development of the profession and in the evolution of the healthcare system (Milstead, 1999). According to Warner (2003) this fact needs to be emphasised and understood to the extent needed for the public's health and for the maximisation of

the nursing profession's capability. For example, throughout history, nursing has advocated for particular choices, sought to influence decisions and promoted values consistent with health and healing as well as use of resources. To this end, historic examples include Nightingale, Wald, Milio and Burke (Leavitt, 1998, Leavitt & Marson 1998 and Milio, 1970) who used their influence and persuasion towards specific ends at work and in their communities.

In fact, nursing's collective political development emphasise political awareness and a call to arms, to self-interest related to nursing issues, to political sophistication and active work on health issues beyond nursing (Warner, 2003). In this regard, for the nursing profession to continue to advance in political development an examination of preconceived notions about appropriate political behaviour that brings new vision to nursing and political action is needed (Cohen, Mason, Kovner, Leavitt, Pulcini and Sochalski, 1996). Indeed, Amick, Blovine, Tarlov, and Walsh (1995) suggest that, the most compelling rationale for nursing's involvement in policy derives from a broad understanding of the nature of health which is linked to factors that are outside the health care arena. These include psychological factors, environmental conditions, gender stratification and cultural economic issues.

Furthermore, Reutter and Duncan (2002) who place a great emphasis on nurses' involvement in the reforming the social factors that influence health, argue that nurses need to engage in political work to influence the determinants of and the environments of health. Similarly, Leininger (1995) identifies a linkage among

nursing, health and politics that is in the cultural context and argues that the power and politics embedded in each culture strongly influences many factors that are importantly related to health. To this end, Leininger finds family social structure, religious traditions and accepted norms or behaviours as factors that are influenced by culture. Additionally, Warner (2003) indicates that to effectively promote health and prevent diseases in a culturally effective way, nursing professionals need to understand the sources of power and patterns in politics.

Indeed, Delli, Carpini and Keeter (1996) who designate political knowledge as the currency of citizenship consider political knowledge as a significant resource for meeting the role of the politically active and involved citizen. Accordingly, the understanding of power and politics affects nursing practice and is the rationale for the need for nursing's political involvement in shaping the profession and delivery of health care (The Pew Health Professions Commission, 1991). However, to intervene appropriately and improve the quality and accountability of the health care system, nurses should have the requisite political skills (Warner, 2003). Furthermore, Sigma Theta Tau International (1996) posits that nurses should collaborate in three ways that require political competence in the creation of new and improved delivery health care systems. For example, nurses should collaborate with individuals in the process of care, with communities in the creation of health and with their health care colleagues in the development of service. In addition, Gebbie, Wakefield and Kerfoot (2000) suggest that nurses should bring knowledge of how policy decisions affect real lives that have grounding in clinical practice.

Furthermore, Gebbie, Wakefield and Kerfoot (2000) indicate that nurses' orientation toward policy action to enable people to help themselves emanates from the nurses' strong belief in the capacity and importance of people in caring for themselves. Accordingly, this distinguishes nurses from other health professions that share many of the same skills, such that the voice of nurses in policy making processes can expand and enrich the policy decision making process. No wonder why Warner (2003) argues that, as the contemporary health care becomes increasingly politicised, nurses' political competence is vital to improving the health of the public. Hence, political skills will be crucial in improving the health care system, maintaining a strong profession and bringing nurses' values convincingly into policy formation (Warner, 2003).

2.3 Need for nurses' participation in policy processes

All over the world, health reforms, limited resources, and reduced access to health care for vulnerable people are rapidly influencing changes in the health care environment (Deschaine & Schaffer, 2003). To this end, the U.S. Public Health Service (1993) identified policy development as a core public health function that includes policy implementation, evaluation and community mobilisation. Hence, to assume a leadership role in the health profession, nurses require skills and expertise in political competence and knowledge of the policymaking process (Longest, 2002). Against this background, Longest explains that politically competent nurses can set the policy agenda by helping to define the issues to be addressed, participate in the

development of possible solutions to the problems and help create the political circumstances that would turn problem solving possibilities into action policies.

Drawing lessons from the mass drug administration (MDA) that took place in Zimbabwe in 2012 and 2013, it is apparent that nurses in the country could have used available data and community assessments to set agendas, propose policy changes and influence the MDA legislative language in a variety of ways. For example, Tagwireyi (2013) indicates that parents expressed concerns about praziquantel, the drug that was administered to school children in schools, because there was not enough sensitisation about its side effects. In addition, warnings by the WHO that inclusion of young children in mass treatment campaigns could prove disruptive and unsafe as there was no appropriate paediatric formulation of the veterinary drug were ignored. This resulted in some children falling sick and some dying after being administered with the drug, a situation that could have been avoided if nurses were politically competent to the extent of influencing the mass drug administration policy or guidelines. In fact, Deschaine and Schaffer (2003) posit that politically competent nurses can influence public health emergency preparedness and propose policy changes to suit the proper delivery of health care services.

Furthermore, Warner (2003) explains that involvement of nurses in policy processes brings expert nursing knowledge to the policymaking environment and makes use of the nurses' persuasive abilities to influence the policy process. For instance, the treatment action campaign (TAC) of South Africa worked with scientists, academics and health professionals to pressure the South African government to provide AIDs

treatment through the use of the media and public events to raise awareness and fight the stigma (Heywood, 2003). Again to show how critical the use of political competences is in policymaking processes, Heywood posits that TAC turned efforts toward labour unions, business leaders and government officials to jointly convene a national event on the issue of HIV/AIDs and discussed a possible treatment programme.

In addition, Heywood (2003) further shows the importance of policymaking competences, in indicating that TAC commissioned research papers that looked at the effects of the national treatment programme on HIV/AIDS related mortality and analysed budget-based costing to demonstrate that the cost of providing comprehensive ARV treatment was affordable. Generally, Heywood argues that TAC's advocacy and lawsuits directly forced the South African government to implement a program to prevent mother-to-child transmission of HIV. According to Heywood, other knowledge and policymaking competences shown by TAC which nurses in Zimbabwe can also use to influence health policies include:

Commissioning research and proposing program design, grassroots AIDS awareness and treatment literacy programmes, hosting public events and using mass media to raise awareness, building alliances with global organisations to increase international pressure, garnering support from private sector leaders and trade unions, civil disobedience, using cost and budget to counter the affordability argument, keeping open the option for

collaboration when it presents itself, carrying out long-term holistic estimates of cost and identifying under-spend budget items (p.5)

In Zimbabwe, nurses' lack of political knowledge and a sense of powerlessness contributes to nurses' non-involvement in political issues affecting the nursing profession (De Jardin, 2001), hence the lack of literature on nurses' involvement in policy processes. This further accentuates a sense of oppression that leads to political inaction because Zimbabwean nurses' working environments do not encourage involvement in political processes. Therefore, Zimbabwean nurses need workshops on policy skill development that emphasise problem analysis and information gathering techniques, identification of stakeholders for given health issues, the process by which laws are enacted, accessing and persuading decision makers and advocacy or lobbying strategies (Badovinac, 1997).

2.4 The policy making process

Policy making exercises require participation and public choice, involving representation, empowering and active decision making (Cloete, Wissink and De Coning, 2006:30). In this regard, interest groups have a great deal more power than other actors in the policymaking process because of their political position and their ability to influence policy process outcomes (World Health Organisation [WHO], 1980:22). For instance, mainstream medical interest groups are usually listened to by members of parliament, such that they can shape the public agenda more often by mass media (WHO, 1980).

2.4.1 Working definition of public policy

Public policy is a purposive course of action followed by an actor or set of actors in dealing with a problem or matter of concern (Anderson, 2005:3). This implies that, nurses need to understand that public health policies do not just happen, but result from decisions to enact a law on some topic, its implementation and enforcement. In addition, understanding public health policy is the basis for clarifying the relationship between government, the nurses and their professional associations.

2.4.2 Problem identification

Generally, the policy process can be viewed as a series of political activities which include problem identification, policy formulation, policy legitimating, policy implementation and policy evaluation (Dye, 2002:24). During the problem identification stage, many factors including methods of getting issues on or keeping them off the agenda, political ideology, special interests, the mass media and public opinion play a role in influencing the identification of health policy problems and opportunities (Pearson, 2010:13). In addition, opposing demands are made for government action by various actors in the policymaking process (Cochran, Meyer, Carr & Cayer, 2013). These demands upon public officials in the political system for action or inaction on perceived problems are made by private or official actors in the policy process.

The social give-and-take that results coalesces into a perception that policymakers must deal with the issue and the problem competes with other problems for the attention of policymakers (Cochran et al., 2013). Worth to note is the fact that, problems that fail to sustain attention fail to make it to the policy agenda while those that rise to prominence get onto the agenda. Therefore, it is imperative that nurses understands the various demands and perspectives of different people concerned when creating an agenda of alternative health policy proposals relevant for dealing with issues at hand.

2.4.3 Agenda setting

Agenda setting is characterised by group struggles for the power to control the agenda and is the first critical step in the policy making process. Accordingly, to get to the agenda, problems must come to policy makers' attention (Pearson, 2010:13). Therefore, it is imperative that ideological and interest groups compete to broaden the agenda to include their issues or narrow the agenda to exclude issues that they do not want to be taken into consideration (Considine, 1994). As a result, it is vital for nurses to note that agenda denial also takes place during agenda setting because non-decision occurs when powerful individuals or groups suppress an issue fearing that focusing public attention on it may make their best interests suffer (Bachrach as cited in Pearson, 2010). For instance, Pearson (2010) highlights that, powerful medical bodies have blocked considerations of initiatives for Medicare and Medicaid for many years, while powerful healthcare lobbies are continuing to block proposals for government sponsored national health insurance.

2.4.4 Policy formulation

During policy formulation, decision makers, interest groups, policy experts and constituency debate and bargain over alternative policy solutions and settle on an alternative to respond to the problem (Cochran and Malone, 1995:38). The policy decisions made at this stage authorise and give content to public policy actions (Anderson, 2005:4). For instance, the public health policy on mass drug administration authorises and clearly states how it is going to be carried out, the intended targets and the resources to be utilised including the source of funding for the programme during this stage.

2.4.5 Policy legitimating

Policy legitimating refers to policy adoption or the making of a decision that brings a policy into force. According to WHO (1980), public health policies are often adopted by means of a decision of the cabinet that legitimises the policy through public statements, executive orders, budgets, laws and appropriations, rules and regulations that set policy directions (Pearson, 2010:7)

.

2.4.6 Policy implementation

Policy implementation includes actions and mechanisms whereby health policies are brought into practice and what is written in legislation or health policy document is turned into reality (WHO, 1980:8). Also, Kingdon (1995) observes that, policy decisions are implemented through steps that put the policy statements into practice

to achieve the desired goals. Hence, during policy implementation, the content of the policy and its impact on those affected may be modified substantially or even negated. Hence, in analysing health policies, nurses need to examine how, when and where the particular health policies are to be implemented in order to exert their influence. This will allow nurses to know whether public health policies accomplish what they are intended to accomplish by directing their attention to the outcomes and impacts of public health policies.

2.4.7 Policy evaluation

Policy evaluation includes monitoring, analysis, criticism and assessment of existing or proposed policies (WHO, 1980 and Anderson, 2005). In addition, policy evaluation involves collecting and analysing information about the efficiency and effectiveness of policies to determine whether goals of the policies have been achieved as well as to improve policy performance (Cochran et al., 2010). This implies that, during public health policy evaluation, nurses need to appraise the policy content, its implementation and impacts, to determine its effectiveness and efficiency in delivering public health services. Similarly, it is imperative that, the nurses consider the health policy's intended effects on the target group and its unintended consequences too.

2.5 CSO engagement in policy development

Civil society organisations (CSOs) make a difference in policy development through providing humanitarian relief, innovate in service delivery, build local capacity and advocate with and for the poor (Court, Mendizabal, Osborne & Young, 2006). In addition, there is a potential for the formation of progressive partnerships between CSOs and policymakers in developing countries (Court et al., 2006). Furthermore, Kuruvilla (2005) posits that, acting alone, CSOs' impact is limited in scope, scale and sustainability such that they need to engage in government policy processes effectively

2.5.1 What are civil society organisations?

Civil society as a sphere of influence of social interaction between the household or family and the state which is manifested in the norms of community cooperative structures of voluntary association and networks of public communication (Vaneklasen, 1994:2). Furthermore, civil society is composed of autonomous associations which develop a dense, diverse and pluralistic network (Connor, 1999:11). Accordingly, nurses and ZINA as part of civil society must establish links with local groups and specialised organisations with the object of augmenting civil society's corrective voice in governance. Furthermore Ghaus-Pasha (2004:3) espouses that, progressive CSOs have distinctive key characteristics that separate them from the state and market. For example, only people who have common needs, interests and values like tolerance, inclusion, cooperation and equality form CSOs.

Thus professional associations which are forms of CSOs go a long way in putting in the public interest the nurses' cause.

2.5.2 Role of CSOs in PMPs

Civil society, as an essential third sector, can have a positive influence on public health policy through the promotion of good governance and advocating for transparency, effectiveness, openness, responsiveness and accountability. In this regard NPs need to heed Ghaus-Pasha (2004) who says:

Civil society can further good governance, regulate and monitor state performance, building social capital and mobilise particular constituencies, particularly the vulnerable and marginalised sections of masses, to participate more fully in politics and public affairs (p.6).

CSOs are also engaged in service functions such as education and social welfare services including child welfare, services for elderly and handicapped, emergency and relief services and income support and maintenance. In addition, Shahab (2006) explains that CSOs play an important advocacy role in policy development processes. In this regard, Shahab indicates that CSOs can identify unaddressed health problems and bring them to public attention, protect human rights and give voice to political, environmental, social and community interests and concerns. Also Vaneklasen (1994) explains that, beyond political and policy concerns, CSOs provide the vehicle through which artistic, spiritual, cultural, ethnic, occupational, social and recreational sentiments find expression. Against this background,

professional associations such as ZINA must operate as an active forum that enriches nurses' human existence by contributing to the social and cultural vitality of nurses' community life.

Furthermore, Vaneklasen (1994) indicates that CSOs create social capital or the web of associations, networks and norms such as trust and tolerance that enable cooperation of people for the common good. Accordingly, ZINA can capitalise on these institutional arrangements and values which make up social capital that constitute the foundation for good governance, economic prosperity and health societies.

2.6 Role of ZINA in PMPs

De-Renzio (2005) indicates that CSOs are increasingly demanding involvement in PMPs and are playing a major role in the implementation of policies that deal with sustainable development and poverty alleviation. In this regard, for the Zimbabwean government to formulate policies that are appropriate for public health services delivery, ZINA's involvement is necessary for it to make important contributions that affect outcomes of policy processes. Furthermore, Ghaus-Pasha (2004) suggests that through its involvement, ZINA can increase its likelihood to understand policies fully thereby ensuring that policies are appropriate to the needs of nurses, feasible and implementable on the ground. In addition, nurses can use their grassroots experiences and innovations to improve policies and strengthen local capacities and structures for ongoing public participation in policy development processes.

Similarly, nurses can provide vital information for the development of health policies that are appropriate to the respective communities served by the policy. Based on Luttrell's (2006) observations, ZINA acting as a watchdog, can apply pressure on the Zimbabwean government to ensure that appropriate health policies are enacted and implemented. Furthermore, Blagescu and Young (2005) observe that CSOs like ZINA can monitor the implementation of laws and design programmes that complement government policies such as the Millennium Development Goals (MDGs).

Edwards (2001), also suggests that ZINA can initiate the development of close working relationship with government in policymaking that allows for grassroots groups and support organisations to help give voice to nurses and those who have been marginalised. Furthermore, Curran (2005) and Edwards (2001) contend that, CSOs play a pivotal role in strengthening democracy and the skills of citizenship essential to healthy societies. However CSOs' inclusion in policymaking depends on their institutional strength and the perceived legitimacy of their participation, a point which ZINA should strive to achieve.

2.7 Models of public policymaking

Many models exist to analyse the creation and application of public policy and to identify important aspects of the policy process, as well as explain and predict policy and its consequences. In this study the rational comprehensive theory is extensively

discussed as it is the basis for other models of policy analysis. Other models of policymaking which are used in policymaking and policy analysis are also briefly discussed. To this end, the institutional model, the process model and the group model are briefly discussed in this study.

2.7.1The rational comprehensive model

Simon (1957) describes rationality as a style of behaviour that is appropriate to the achievement of given goals, within the limits imposed by given conditions and constraints. In this regard, the rational model of decision-making is a process for making logically sound decisions in policy making in the public sector which makes a series of assumptions in order for it to work, For instance, the proponents of this model assume that, the model must be applied in a system that is stable, the government is a rational and unitary actor and that its actions are perceived as rational choices, the policy problem is unambiguous and there are no limitations of time or cost (Simon, 1957, Lindblom,1959, Diesing, 1962, Allison, 1971 and Jones, 2003).

However, the rational classic economic theory assumes that the decision maker has extensive and intensive knowledge relative to the decision-making environment that enables him to choose the best alternative (Lindblom, 1959). In this regard, Wandling (2011:5) explains that Simon after concluding that real and empirical human rationality does not achieve the demanding standards of the classic economic model castigated the rational model. On the contrary, Patton and Sawicki (1986) dismiss the argument that there is no standard approach to resolving problems and state that the rational model is the answer. In this regard, Patton and Sawicki

propose a rational model that follows six steps in sequence to be used in the policymaking process. These include definition of the problem, determination of evaluation criteria, identification of alternative policies, evaluation of alternative policies, selection of the preferred policy and implementation of the preferred policy.

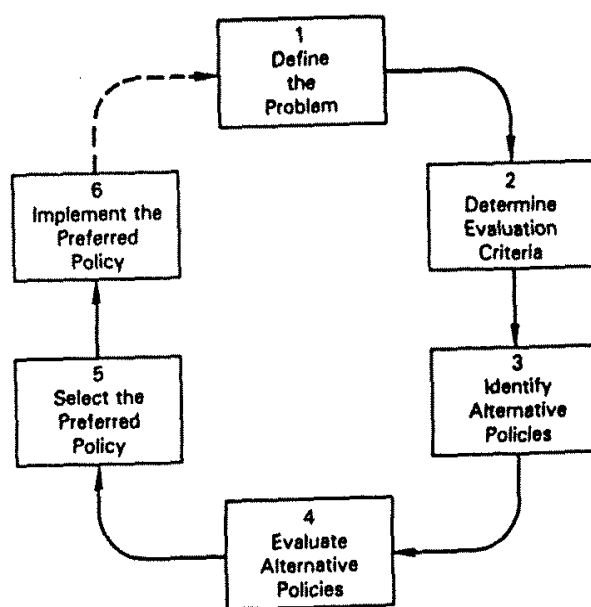


Figure 1 Stages in the policymaking process.

(Adapted from Patton and Sawicki, 1986)

2.7.2 Define the problem

Patton and Sawicki (1986) argue that problem identification involves an analysis of data and the information gathered that show the existence of a problem particularly when there is a gap between what is expected to happen and what actually happens. Pursuant to the fact that contextually, rational models are intended to achieve maximum social gain, Simon (1957) observes that, problem identification involves intelligence gathering. With regard to health policy, data, potential health problems

and opportunities are identified during problem definition. In other words, during the problem definition stage, nurses must comprehensively organise and analyse available information and understand it in order to be able to frame the problem such that it can get onto the policy agenda. As Hogwood and Gunn (1984) posit that in a completely rational world, actors in policymaking processes continually and systematically scan their horizons, seeking to identify all present and potential problems and opportunities relevant to their interests.

Taking cognisance of the foregoing, Bryson (1995) contends that nurses taking part in health policy development should begin by developing a concise statement that clearly articulates the issues or problems to be considered in order to build support. For instance, Ginter, Duncan and Capper (1992) posit that, the key components of nurses' issue statement must include the health condition or risk factor being considered, the population affected, the size and scope of the problem, prevention opportunities and potential stakeholders. Hence, in public health policymaking, problem definition is similar to the initial steps in a strategic planning process which involve describing the mission, internal strengths and weaknesses, external opportunities and threats as well as the vision for the future (Brownson, Gurney & Garland, 1999:5). As such, there is need for nurses to appreciate that only a well articulated problem definition can constitute a policy demand that can get onto government agendas.

2.7.3 Determine evaluation criteria

The rational comprehensive model by Patton and Sawicki (1986) calls for the identification of the decision criteria that is important in solving the problem. Similarly, WHO (1980) highlights that identifying the basis on which the merits of alternative policies or programs can be judged and the central nugget of the problem is essential in determining evaluating criterion.

Consequently, the determination of evaluation criteria involves the identification of the relevant factors to take into account when making a decision. To this end, Simon (1957) suggests that when considering evaluation criteria the policymaker needs to relate consequences to societal values. For instance, Simon asserts that with all decisions and policies there will be a set of values which will be more relevant and that can be expressed as a set of criteria, against which performance or consequences of each policy alternative can be judged. For example, the evaluation criteria for the selection of a policy alternative for implementation include its economic feasibility, administrative feasibility, political feasibility and acceptability as well as its potential to effectively solve the problem at hand. Similarly, Mayer, Daalen and Bots (2000) posit that criteria for good policy analysis include policy validity, reliability, consistency, fairness, equity and openness.

Furthermore, the determination of the evaluation criteria may involve identifying appropriate measures for shaping the outcome of a policy option. In this regard Anderson (2005) cautions that outcomes can be intended or unintended such that policy outcomes in the health sector may include improved health service delivery,

low mortality rates and long life span as well as increased costs of health services. At the same time, Allin, Mossialos, McKee and Holland (2004:31) observe that, public health decision making currently involves multiple players acting in a disjointed fashion, institutes and other governmental bodies with overlapping functions and little evaluation of effectiveness. In this regard, Allin et al (2004) suggest that priority areas for public health policy must be selected on the basis of:

Significance in terms of burden of illness; fit with societal values and priorities; evidence of inequalities in health outcomes for the condition or problem within the country; and current state of knowledge about the condition or health problem's etiology, determinants or risk factors, treatment options and the effectiveness of actions to impact upon it (p.31).

2.7.4 Identify alternative policies.

Hogwood and Gunn (1984) argue that several policy responses or behaviour alternatives are usually possible when a problem or an opportunity is perceived. Hence, during this stage, lists of the possible policy alternatives or options that can succeed to resolve the problem are generated (Patton & Sawicki, 1986). Similarly, Anderson (2005) observes that, this stage encompasses the creation, identification, or borrowing of proposed courses of action for resolving or ameliorating public problems. Consequently, nurses interested in influencing the health policy need to know who participates in policy formulation, how alternatives for dealing with a

problem and the difficulties and biases inherent in formulating policy proposals are dealt with as well as understand how to influence decision makers.

2.7.5 Evaluate alternative policies

According to Patton and Sawicki (1986), a critical analysis and evaluation of each policy option is done using the predetermined criterion. For example, tables displaying the strength and weakness of each alternative are drawn and used for comparative purposes. In addition Pearson (2010) observes that, the decision maker weights the previously identified criteria in order to give the alternative policies a correct priority in the policy decision making process.

However, Patton and Sawicki (1986) urge actors in the policymaking process to focus on the central decision criterion of the problem through considering various factors. These include factors of the problem most important to beneficiaries from the policy alternative, the criteria on which decisions are based and the cost of implementation. For instance, nurses need to bear in mind that actors in health policy development or analysis processes assess whether available policy alternatives result in more effective and efficient usage of funds allocated to an activity to enhance health services delivery (Wandling, 2011). In this regard, Wandling argues that this is done in order to consider broadening the base of those being served by a health service program.

Furthermore, Patton and Sawicki (1986) explain that, public policies often have multiple and competing objectives which are often extraordinarily ill defined. Similarly, Hogwood and Gunn (1984) underscore the fact that, while it is necessary to know what would happen if a policy option is adopted, this perfect knowledge essential to complete rationality is unattainable in real life. This implies that, nurses should appreciate what happens during policy evaluation to guard against choosing a goal that can be defined and measured most easily while ignoring more important but less quantifiable goals and impacts as well as forgetting about who pays and who benefits from the policy.

2.7.6 Select the preferred policy alternative

Simon (1957:22), Hogwood and Gunn (1984:46) explain that the decision maker chooses the preferred option given the full understanding of all the problems, opportunities, the consequences and the criteria for judging options. Similarly, Mayer, Daalen and Bots (2000) note that, when sufficient data and information have been gathered, the decision maker focuses on translating the available knowledge into new policy by making recommendations. In this regard, Anderson (2005) posits that selection of the preferred policy alternative involves deciding which proposed alternative, including taking no action, will be used to handle a problem. Also Patton and Sawicki (1986) argue that the decision-maker evaluates each alternative against the criteria and selects the preferred alternative.

Typically, the recommendations for a preferred policy alternative are a result of a comparison of the effects of different policy alternatives considered and weighing of the options based on the predetermined criteria. Hence, it is imperative for nurses who want to affect public health policy outcomes to know how a policy alternative is adopted or enacted, the requirements that must be met, the adopters and the content of the policy to be adopted, for them to be able to influence policy adoption.

2.7.7 Implement the preferred policy

Policy implementation is concerned with what is done to carry into effect or apply the adopted policy alternative (Anderson, 2005). In this regard, Anderson also observes that, who is involved, what, if anything is done to enforce or apply a policy and how implementation shape or determine the content of the policy is key to policy implementation. This is so because, often further development or elaboration of policies will occur in the course of their administration. Similarly, Patton and Sawicki (1986) posit that, policy implementation refers to how the selected policy alternative is brought through.

2.8 Actors in the policy making process

These are individuals or groups both formal and informal, who seek to influence the formation and implementation of public solutions (Cahn, 2012:199). In this regard, formal individuals or groups in the policymaking process are called official or institutional actors while informal individuals or groups are referred to as unofficial or non-institutional actors.

2.8.1 Official actors

Anderson (2005) indicates that official policy makers are those who possess legal authority to engage in the formation of public policy. For instance, the legislature, the president, the executive agencies of government and the courts are official actors in policymaking processes. As a result, nurses have the minister of health at their disposal as an official policy actor whom they can use as a direct link to affect outcomes of policy decisions.

2.8.1.1 The Legislature

The legislature is the central institution in the policymaking process because of its legislative authority (Cahn, 2012:15). In other words, the legislature is concerned with the central task of law making and policy formation in a political system even though it does not have independent decision making functions (Anderson, 2005:36). Similarly, Cahn observes that the legislature is responsible for the initial review of draft legislation in addition to debating and voting on bills.

However, the complicated nature of public policies necessitates that technical inputs from various experts in the form of inter-sectoral working groups, technical advisory committees or research institutions becomes important. Consequently, Koon, Nambiar and Rao (2012) argue that the very structure of the technical assistance and the way it interacts with larger socio-political forces often plays a substantial role in the execution of successful policy initiatives. Consequently, nurses need to identify and align themselves with the most influential legislators to have their interests

incorporated in public health policies. For instance, legislators are primarily concerned with achieving re-election, maximising their individual political futures and their ability to govern in the national interest is severely limited (Cahn, 2012). Indeed, legislators need to satisfy constituent interests over national interests.

2.8.1.2 The executive

The effectiveness of government in policy formation and in policy execution depends substantively upon the executive leadership, such that, the president's authority is clearly established and accepted as a necessity (Anderson, 2005). As a result, the legislature delegates significant policy making authority to the president especially in developing countries. In addition, Pearson (2010) posits that the executive is responsible for legitimising public policy and setting policy direction. For instance, policy is legitimised as a result of the public statements or actions of executive government officials, both elected and appointed in all branches and at all levels of government (Cahn, 2012). This includes executive orders, budgets, laws and appropriations, rules and regulations, and decisions and interpretations that have the effect of setting policy directions.

2.8.1.3 The bureaucracy

Christensen and Laegreid (2001) observe that the bureaucracy is responsible for the provision of policy advice, regulation and control, ownership and purchasing services. In addition, Schick (2002) contends that while ministers are responsible for setting policies, civil servants are in charge of making it happen and have the

autonomy to get it on. Furthermore, Vershuere (2008) notes that administrative actors focus on policy implementation, rather than on being involved in the policy decision making process. In this regard, there is a gap between the administrative tasks of implementing policies and political tasks of preparing and deciding on policies and the bureaucratic agencies of government are primarily involved in decisions made during the implementation stages of the policy. Accordingly, the bureaucracy enjoys less involvement in the preparation and determination stages of the policy cycle but is highly involved in the implementation of the policy.

However, Svava (1998) explains that there is ongoing interaction, reciprocal input, and mutual deference between elected officials and administrators. On one hand, administrators help to shape policy and give it specific content and meaning in the process of implementation, while on the other hand, elected officials oversee implementation, probe specific complaints about poor performance and try to fine tune in performance problems (Svava, 1998:180). To this end, nurses can influence public health policy decision outcomes by availing credible information to administrators that can be used to shape public health policy to give it content and meaning in order to effectively address the nurses' concerns.

2.8.1.4 Judiciary

The judiciary settles disputes according to law, including disputes about how the executive and legislative powers which are handled through the interpretation of laws. Also, the influence of judges in interpreting laws has a significant impact on

policy as judicial policy power has critical policy influence in several areas, including abortion and civil rights policy (Cahn, 2012). To this end, nurses can affect the health policy by testifying or giving credible evidence in courts, that can have an impact on court decision and ultimately on health policy. In addition, Glazer (1975) suggests that an activist court can be used to the advantage of NPs in situations where the legislative seems to be doing nothing on salient health issues such as human rights issues based on clinical and medical grounds.

2.8.2 Unofficial actors

Anderson (2005) explains that, regardless of how important or dominant they maybe in various situations, unofficial actors, such as political parties, interest groups, political consultants and the media, do not usually possess legal authority to make binding decisions. However, Cahn (2012¹) argues that public policy is not merely the result of independent policy-making institutions because unofficial actors also play a significant role. For instance, the public elects legislators and executives, the media influences policy through its inherent agenda setting function, political parties influence policy through influencing the composition of legislative and executive bodies and organized interest groups lobby elected officials and nonelected policy makers (Cahn 2012:45). Consequently, public policy is a result of institutional processes influenced by non-institutional processes meaning that nurses can affect the public health policy if it is in their best interest to do so.

2.8.2.1 The media

According to McQuail (1979), the media are influential to policy outcomes because they help define social reality. Similarly McCombs and Shaw (1977) assert that, the media influences the salience of issues because people's perceptions of reality are to greater extends based on media portrayals of reality. In addition, Graber (1988) argues that the way people process information makes them especially vulnerable to media influence because they tend to pare down the scope of information before them, think schematically and fit that information into pre-existing schema. In the same vein, Iyengar and Kinder (1987) reveal that the media to a great extent defines which problems the public considers most serious through priming.

Due to the selective coverage of only certain events and the selective way in which those events are covered, there is no way to cover all events, or cover any event completely and selective decisions must be made by the media (Cahn, 2012:203). Accordingly, priming certain aspects of national life while ignoring others, the media sets the terms by which political judgments are rendered and political choices made (Iyengar & Kinder, 1987:4). Consequently, health problems and policy alternatives that gain significant media recognition are much more likely to get onto the agendas of government in the policy making process. As such, nurses can make a great difference in affecting the health policymaking process outcomes by getting media coverage of their problems, opportunities and alternative solutions.

2.8.2.2 Political parties

Political parties seek to get their own members elected to policy-making positions and exert influence on a wide spectrum of policy issues such that parties develop issue platforms, draft candidates, campaign on behalf of candidates, and work to get out the vote (Cahn 2012:203). In short, political parties group together citizens of similar ideology and opinion under a common banner such that while a political party's activism is most visible during election cycles its policy influence extends beyond campaigns. As Eldersveld (1982) accurately points out that those parties continue to play a dominant role in policy outcomes since the party that emerges popular determines the direction taken by public policy.

Furthermore, Cahn (2012) observes that the president who is subordinate to the party that elected him or her pursues some of the policy objectives articulated at the party level. Similarly, congress distributes committee membership and chairmanships according to party affiliation (Cahn, 2012). Consequently, the general direction of congressional policy is directly tied to the ideology of the larger party despite the necessity of negotiation and compromise. In this regard, Domhoff (1983) argues that political parties maintain policy influence in critical areas such as elections, patronage appointments, legislative committees, and national policy discourses. Consequently, to affect the health policy, nurses can increase their visibility in most of these critical areas through participating in elections, attending legislative committee meetings and engaging in national policy discourse.

2.8.2.3 Interest groups

Citizens use interest groups as a fundamental partner in policy making to participate in the policy process by communicating with policy makers individually and collectively through letters to elected representatives. In this regard, Madison (1961) observes that interest groups facilitate collective communication such that the propensity for individuals to factionalize in an effort to maximize political influence is high. Furthermore, Dahl (1961) argues that in an open society all persons have the right to press their interests and to the extent others share these interests, collective pressure may allow greater policy influence.

However, Dahl (1961) observes that while issues that have greater salience have greater interest group representation, the strength of that representation is not tied to the strength of the issue's salience but may be a consequence of interest group action. Consequently, nurses willing to influence policy outcomes need to identify the policy actors and make use of the political resources they use. For instance, these resources include bureaucratic knowledge, a network of contacts, citizen backing or size of constituency, an ability to make political contributions, and an ability to mount a public relations or media campaign (Cahn2012:204). As Domhoff (1983) notes that while no group utilizes all of these resources, the ability of an organized group to utilize one or more of these resources is critical for policy influence.

However, Lowis (1979) argues that interest groups' influence threatens the democratic basis of government. For instance, if interest groups provide a

framework for interaction between government and citizens, and interest groups are based on individual self-interest, there is little opportunity for pursuing a meaningful national interest (Cahn, 2012:204). Furthermore, corporate interest groups, trade unions and the structure of the policy-making establishment accept private think tanks as democratic institutions (Dye, 2002). In this regard, Cahn observes that think tanks are neutral policy consultants and are thus extended great access to the policymaking arena even though they have strong foundations in the same community with nurses.

Thus ZINA can channel its influence to the public health policymaking arena by making coalitions with interest groups in their communities, who can jointly frame and give significant meaning to nurses' problems and alternative solutions. In that way, the nurses problems and alternative policy solutions can be considered on the agenda of government and culminate into policy decisions that influence the national public health policy.

2.8.2.4 Political consultants

Political consultants have significant influence on the outcomes of the policymaking process as they give advice to actors in the policymaking process. In this regard, Cahn (2012) observes that political expertise is purchased by those with the need and the resources. In addition, Sabato (1981) exposes the fragile relationship between articulating ideas in a political market place and manipulating public opinion.

Accordingly, Sabato argues that it is virtually impossible to win at the policy game without the marketing skills held by consultants and strategists. However, Cahn posits that, political consultants are costly and only those with greater economic resources enjoy a policy advantage. Thus, ZINA which commands a significant membership of nurses in Zimbabwe can source financial resources and engage political consultants to affect the public health policy making process in such a manner that nurses' interests find their way to the agenda.

2.9 Politically competent nurses

Ferris, Treadway, Perrew, Brouer, Douglas and Lux (2007:13) posit that politically skilled nurses combine social astuteness with the capacity to adjust their behaviour to different and changing situational demands. Hence, endowed with political competence, nurses can inspire support and trust. At the same time, nurses can effectively influence and control the responses of other stakeholders during health policy deliberations to suit nurses' interest. As Ferris, Treadway et al. (2007:14) argue that political skill is about competencies that are manifested in work-relevant situations that reflect both dispositional antecedents and situational variability.

2.9.1 Dimensions of political competence

There are four critical dimensions of political skill requisite in nurses' work namely social astuteness, interpersonal influence, networking ability, and apparent sincerity

(Ferris, Treadway et al., 2007: 293). In addition, communication skills play a pivotal role in nurses' endeavours to influence public policy decision outcomes.

2.9.2 Social astuteness

NPs possessing political skill are astute observers, keenly attuned to diverse social settings, have high self awareness, understand social interactions and accurately interpret varied types of behaviour (Ferris, Treadway et al., 2007). In addition, Pfeffer (1992) views social astuteness as being sensitive to others, and suggests that it is the ability of ZINA to identify with others which is critical to obtaining things for themselves. Consequently, nurses need to be socially astute in order to be ingenious in dealing with other actors in the public health policy development process in order to realise their interests.

Burt (2005) differently treats social astuteness not as a question of whether to trust but who to trust in competitive environments. In this regard, Burt views social astuteness as one's ability to identify the nuances of social interaction. Specifically, Burt suggests that politically skilled nurses must be able to perceive how other actors in health PMPs enhance or diminish their social interaction. Generally, nurses must understand the motives of others, and the level of reliability in reciprocating information, resources, and favours. This reduces the nurses' contact with other social actors who are not valuable members in their social network, enhances and solidifies relationships with valuable and trustworthy social network members (Pfeffer, 1992).

2.9.3 Interpersonal influence

Politically skilled individuals have an unassuming and convincing personal style that exerts a powerful influence on others around them (Ferris, Treadway et al., 2007). Essentially, interpersonal influence allows nurses to adapt and suite their behaviour to different problem situations in order to obtain the desired responses from others. In this regard, Pfeffer (1992) refers to interpersonal influence as flexibility involving an adaptation of one's behaviour to different targets of influence in different contextual settings to achieve one's goals. Hence, nurses can use interpersonal influence to gain the attention of actors at different stages of the policy making process.

2.9.3 Networking ability

Ferris, Treadway et al. (2007:294) posit that individuals with political skill are adept at identifying and developing diverse contacts and networks of people who tend to hold assets seen as valuable and necessary for successful personal and organizational gains. Because of their typically subtle style, politically skilled individuals easily develop friendships and build strong, beneficial alliances and coalitions. Furthermore, individuals high in networking ability ensure they are well positioned to both create and take advantage of opportunities (Pfeffer, 1992). Also individuals high in networking ability are often highly skilled negotiators and deal makers who are adept at conflict management. For instance, Warner (2003) observes that,

networking is not for its own sake but to enable change, to assemble the crucial assortment of policy players, or to link ideas and people.

Basically, nurses must network in order to establish and maintain relationships which are the backbone of success in policy development processes. Furthermore, relationships borne out of networking can result in support for what nurses intent to accomplish when affecting public policymaking outcomes. As Warner (2003) rightly observes that, people support you because they have a relationship with you, they trust you and they believe you.

2.9.4 Political savvy

Political savvy suggests adeptness at the intuitive aspects of politics in organizations (Ferris, Treadway et al., 2007:294). Furthermore, Chao, O’Leary-Kelly, Wolf, Klein, and Gardner (1994) identify a politics dimension of socialization which measures political savvy or understanding. In this regard, Chao et al. (1994) suggest that nurses who are politically savvy focus on learning how the policymaking processes are articulated, identifying who the most influential people are, and developing a sound understanding of the motives behind the actions of people in their organizations.

2.9.5 Communication skills

Communication skills are very important to nurses who want to effectively play a role in the policymaking process. For example, Lazenby (as cited in Zhang & Yang,

2013:341) identifies listening skills as the most critical communication skills, followed by compromising and consensus building skills and face to face communication skills. Consequently, Milstead (2004) suggests that nurses must understand verbal and non verbal patterns, perception of space, language interpretations and other cultural components of communication they encounter in their attempts to influence policy. Similarly Kingdon (2011:178) suggests that nurses' good communication and writing skills are imperative during the problem definition and agenda setting stages, as they have to present their facts in the best appealing manner to policy makers for them to warrant consideration.

2.9.6 Influence tactics and strategies

As already discussed above, political skill reflects the capacity to effectively exert influence over others at work. In this regard, Ferris, Treadway et al (2007) suggest that for nurses to be high in political skill they need to know which particular type of influence tactic or strategy to employ in each problem situation. Thereof, nurses must precisely execute specific tactics or strategies in a manner that demonstrates the desired effect, in order to ensure the success of the influence attempt. For example, Ferris, Treadway et al., highlight that ingratiation and self-promotion can be quite differently perceived and interpreted based on whether the actor is more, or less, politically skilled.

2.9.7 Ingratiation

According to Jones (2003), ingratiation refers to behaviours that are designed to get one on the good side of others and to be liked by them, as either an end in itself or so that one can receive some rewards. In this regard, nurses employing ingratiation as an effort to affect public health policy outcomes must understand how others in the policymaking process perceive it through the way the nurses effectively present it. Essentially using political skills, the nurses must appear to be sincere in their endeavours to influence others. This is so because what distinguishes the skilled execution of ingratiation from the perceived manipulative and failed attempt is political skill (Ferris, Treadway, et al, 2007).

2.9.8 Self-promotion

Again Jones (2003) observes that another frequently used influence tactic is self promotion, which has the objective of appearing to be competent and involves trying to show how one is accomplished. Obviously, self promotion can be difficult for nurses to effectively perform as Jones cautions that one appears to understate things and fail to impress people if too little emphasis is applied. On the contrary, if too much emphasis is made, one appears arrogant, conceited, and self-important, which society generally finds offensive (Jones, 2003).

To this end, it is ample clear that nurses need to understand that how self-promotion behaviour is interpreted and reacted to differs and depends on political skill. Over and above, it is imperative for nurses to bear in mind that political skill affects the

way influence tactics are perceived and interpreted. Consequently, nurses need to consider unreservedly the fact that political skill plays a key role in the dynamics of influence tactics and strategies as they are demonstrated and interpreted in policymaking processes.

2.9.9 Assertiveness

Kipnis, Schmidt, and Wilkinson (1980) contend that assertiveness involves demanding, ordering, setting deadlines, and checking up on others to exercise influence. In this regard, nurses need to understand that the use of assertiveness, as a way to influence others, can be intricate, and its effects can be positive or negative. However, Ferris, Treadway et al. (2007) suggest that nurses must possess a high degree of networking ability to employ assertiveness as a successful influence tactic. In other words, by virtue of the connections, alliances, and social capital they control, the nurses are well positioned to exert their influence. Furthermore, Ferris, Treadway et al., suggest that nurses must be socially astute to be able to read the temporal and social cues that determine the limited normative and interpersonal conditions under which assertiveness will be an effective tactic.

2.9.10 Networking and positioning

Social networks are a source of advantage to nurses. In this regard, Burt (2005) suggests that nurses must possess social networks characterized by open structure, heterogeneous contacts, and structural holes in order to develop information asymmetries. This provides the opportunity to engage in arbitrage and information

brokering between nurses and decision makers in policy development process. To this end Burt indicates that empirical evidence exists which show that individuals with a large number of intra and inter-organizational bridging ties in their social networks have higher performance evaluations than do peers with fewer bridging ties. Furthermore, Mehra, Kilduff, and Brass (2001) posit that empirical evidence suggested that high self-monitors obtain network central positions and subsequent high performance evaluations.

Consequently, nurses' ability to network is a primary aspect of their political skill that influences the degree to which its social network is efficiently structured. As Pfeffer (1992) notes that politically skilled individuals are competent at developing and using diverse networks of people who are valuable assets, important and necessary for successful personal and organizational functioning. Furthermore, Pfeffer suggests that to be politically skilled, nurses must possess a subtle style that allows them to easily develop friendships and build strong alliances and coalitions, resulting in social capital that can be leveraged. In fact Warner (2003) explains that nurses high in networking ability use their social astuteness to determine how and where they will position themselves to both create and take advantage of opportunities.

2.9.11 Coalition Building

Kipnis et al (1980) discussed coalition tactics as mounting co-worker or subordinate support to reinforce a position taken or resources requested and referred to it as counting on strength in numbers approach. In addition Ferris, Treadway et al (2007)

note that upward appeals calls for the support of individuals higher up in the organizational hierarchy and nurses need to establish and maintain a positive relationship with them. In fact, nurses' networking ability should be a precursor of the upward appeals influence tactic. In this regard, Warner (2003) suggests that nurses need to have strong networking ties to facilitate the enactment of upward appeal tactics. Such linkages can allow the nurses to operate from a position of greater strength through such connections and social capital.

2.9.12 Other strategies

Apart from the foregoing, Taft and Nanna (2008) observe that nurses interested in influencing public policy can select from among an extensive array of opportunities that include:

Joining a professional organisation that has an advocacy mission; writing letters to the print media, including countering biased reporting; becoming informed on public issues and sharing political recommendations with interested friends and colleagues; testifying to a state legislator on health legislation; working on political campaigns; donate money; conduct research that has policy implications and publish it; becoming an environmental personality; expressing one's perspectives through art and becoming active in the ICN (p. 280).

2.9.13 Issues arising from gaps in literature

Grant (1986) observed that in the global campaign to provide a decent level of health, nurses have been badly neglected, a fact that points to lack of literature on NPs' involvement in policy decision making. Partly because of the absence of literature on nurses' involvement in policy making, nurses have been frequently ignored or looked down upon. For example WHO (1980) posits that nurses in Zimbabwe have been maintained in their traditionally subordinate role and systematically excluded from decision making and community involvement.

Again, based on lack of literature on nursing involvement in policy making processes, WHO (1980) concludes that most developing countries have not involved nurses in critical decision making necessary for effective health care planning and health manpower development. This implies that other people, particularly physicians make important decisions that relate to nurses without benefiting from the nurses' input despite nurses holding an important key to the acceptance and expansion of primary health care. In fact, Grant (1986) rightly observes that nurses work closely with many people at all levels of society such that they can have a positive influence on the impact of health policies.

Furthermore, the ICN (2001) bemoans the absence of literature on nurses' participation in policy decision making processes and emphasises that, nurses have to modify their customary image in all areas of their competence including making clear visibility in literature. Nevertheless WHO (1980) notes that an important

positive influence on the image of nursing has been made as the role of women throughout the world is changing. For example, traditionally nursing was viewed as a vocation, a kind of divine calling for kind hearted ladies, a perspective that has evolved immensely (Grant, 1986).

There is need for nurses' influence on health policy outcomes through engagement in policy process to be clearly displayed in various literatures. As ICN (2001) opines that, as nurses assume their new, equal and policymaking role in health care, nurses' image is bound to be changed by their appearance in literature detailing the critical impacts they are exerting on policy outcomes. In addition, WHO (1980) argues that nursing associations must be more active in educating people, apart from increasingly becoming innovative and participative in programme planning, implementation and evaluation. This is so, because Grant (1986) argues that if nurses were to articulate their ideas and convictions about primary health care, and come together as a force, they can act as a power house for change in the health policy making arena.

2.9.14 Summary

This chapter has dealt with the review of literature and the theoretical framework of the study. In this regard, the policymaking process, models used in policymaking and actors in the policy making process were discussed. In addition, this chapter dealt with the conceptual framework by looking at the policy making competences and strategies, requisite for participation in policymaking processes. Finally,

implications of gaps in literature relating to involvement of nurses in policymaking processes were discussed.

CHAPTER III: METHODOLOGY

3.0 Introduction

This chapter deals with the methodology of the research study. In this regard, the chapter presents the research paradigm, research design, study population, sample selection, the participants and the research instruments. Also, the ethical consideration, data collection, data analysis and data quality procedures are presented in this chapter.

3.1 Research paradigm

The focus of this qualitative study was directed at identified nurses who have been in the public service for more than five years and who are members of ZINA. According to Rossman and Rallis (2003), entry by the researcher, a richness of participant potential and the opportunity to develop relationships with the participants are also essential criteria when selecting the site and participant location. Accordingly, the identified NPs have been in the public service for more than five years and are members of ZINA. The object was to tap into their lived experiences of policymaking processes. This was imperative for the researcher to be able to address the main research question relating to the availability of requisite knowledge and policymaking competences in nurses.

Furthermore, entry by the researcher relied to some extent on the good reputation of the university with which the researcher was a student. In addition, the target

population consisted of a reasonable number of potential participants from which the researcher interviewed and collected data in order to answer the study's research question. In this regard, the participants discussed with the researcher the perceptions of their work and professional practices during the interviews. The participants also confirmed their statements when they were given the occasion to add, delete or comment on the interview transcripts. This provided the researcher an opportunity to develop a relatively close relationship with each participant as data were collected and reviewed.

3.2 Research design

The study adopted a descriptive approach to qualitative research which is considered essential for describing critical findings in a rigorous way (Dziany, 2011). In addition, the researcher heeded Kincheloe and McLaren (1994) who hold that descriptive approaches to qualitative research produce detailed and non-quantitative accounts of small groups, in seeking to interpret the meaning nurses make out of their lives in their natural setting. Consequently, this study used an in-depth descriptive approach in order to obtain detailed information concerning the knowledge and policymaking competences of nurses.

The in-depth descriptive approach was imperative for the researcher to understand issues relevant to establish whether nurses have requisite knowledge and skills to participate in policy processes. In fact, the research methodology was instrumental to explore the extent to which nurses are involved in policymaking processes, factors

that influence participation and the effectiveness of nurses in influencing outcomes of health policy decision processes. Furthermore, this approach was very important because it provided sufficient information and an opportunity for looking at different aspects of the problem (Miles & Huberman, 1994, Creswell, 2003 and Kothari, 2006).

3.3 Study population

Public health policy affects all people in a society, however nurses constitute the study population because the execution of nursing's duties is affected by the power and politics embedded in each culture that strongly influence factors related to health, such as family social structure, religious traditions and accepted norms and behaviours (Warner, 2003). In this regard, the researcher drew conclusions for the entire population of nurses in the civil service who have the potential to influence public health policy decision outcomes in Zimbabwe. According to the Zimbabwe Statistics bulletin of 2013, there are 64 000 registered nurses in Zimbabwe and these constitute the study population. In addition, this study involved other stakeholders in the public health sector such as ZINA and ZIMHB officials.

3.4 Sample selection

The research used purposive sampling to recruit participants for the research study. This involved selecting the research participants according to the needs of the study (Morse, 1991). Also, taking heed of Patton (1980), the researcher chose participants

who gave a richness of information that was suitable for the research study. To this end, the selection criteria called for the inclusion of professionals who were leaders in nursing and ZINA who could articulate their experiences as it relates to KPMCs of nurses. In all, in-depth interviews were carried out with thirteen participants who constituted the sample using a self designed interview guide with open ended questions.

3.5 Participants

The participants were purposefully selected to include those with at least five years of experience in nursing. In this regard, the researcher conducted a pilot study using the interview guide and asking open-ended questions to gain awareness about the participants' knowledge in policymaking and experience as nurses. Also, information on nurses and ZINA officials' views relating to how nurses can affect outcomes of health policy decision making processes to accommodate the interests of nurses was sought during the pilot exercise.

To arrange for the interviews, each participant was contacted and convenient locations and times for the interviews were mutually determined by the researcher and participants. Prior to the interviews, the researcher explained the purpose of the interview and asked each of the participants to carefully read as well as understand the information on the consent form before signing it. Finally, the researcher assured the participants that, the transcribed interview will be availed to them to read and approve before the final study findings are compiled.

3.5.1 Key participants interviewed

Table 1 below shows the schedule of key participants interviewed, indicating the location and the date they were conducted. In order to protect the personal identity of the participants, the researcher preferred to use their locations instead of their job titles and names.

DATA COLLECTION SCHEDULE (KEY PARTICIPANTS INTERVIEWED)			
Interview with	Number of interviewees	Date	Organisation
ZINA officials	2	19/03/15	Zimbabwe Nurses Association
ZMHB officials	2	20/03/15	Zimbabwe Medical Health Board
ZINA officials	1	23/03/15	Zimbabwe Nurses Association
Nurses (ZINA members)	3	26/03/15	Parirenyatwa Hospital
Nurses (ZINA members)	3	26/03/15	Harare Hospital
Nurses (ZINA members)	2	27/03/15	Chitungwiza Hospital

Table 1 Data collection schedule for key participants interviewed

3.6 Research instruments

The research study deployed in-depth face-to-face interviews conducted using a self-designed semi-structured interview guide to allow for extensive probing and discussion of the participants' responses. This is in agreement with Rossman and Rallis (2003) who consider interviews as the primary and most beneficial means by which a researcher can obtain information about the participants' lived experiences pertaining to the issue at hand. In addition, documentation perusal was done to establish the underlying concepts and information as a way of gaining insight into the involvement of nurses in public policymaking.

In-depth interviews are considered to be a holistic approach to study the lived experiences of the participants because they provide a forum for participants to communicate their own understanding, perspectives and attribution of meaning (Creswell, 2003). As such, the qualitative interviews were designed to reveal the essence of shared experiences as the participants were encouraged to use their own words in describing their experiences. Therefore, interviews permitted the researcher to understand specific individual experiences from the perspective of the participants and made it possible for the researcher to successfully assess the knowledge and policymaking competences of nurses.

3.7 Ethical considerations

Before the commencement of this study, the researcher submitted a research protocol to the Africa University Research and Ethics Committee (AUREC) for clearance, particularly in terms of the requirements of research work that involve human subjects. In the proposal, it was acknowledged that the researcher had an obligation to take all measures possible to protect participants from physical, emotional or social harm. The research protocol was assessed by AUREC and permission to carry out the study was granted.

For instance, Saddlemire (1996) posits that appropriate measures have to be taken to ensure that participants understand and consent to the manner in which the study would be carried out. Hence, the researcher met with participants individually and privately to explain the purpose of the study as outlined in the consent form, see appendix 2. By going through the consent form with each participant, the researcher was assured that the participants understood their rights during the exercise and went on to ask the participants to sign two consent forms after discussing areas of concern to the participants. One of the forms was retained by the participant while the other was taken by the researcher.

In addition, participants were made aware that, audio taped face-to-face interviews would be held with them and that where necessary a follow-up interview would be done to clarify issues discussed in the previous interview. Importantly, participants were informed that the researcher would exercise high standards of confidentiality with reference to the participants' names and personal information. To further

strengthen the confidentiality and exclusive rights norms in research, participants were guaranteed that information collected during interviews would be used for no other purpose other than the study, without express permission from the participant. Furthermore, the researcher took heed of Moustakas (1994) and advised the participants that, they were free to withdraw from the study at any given time while reserving the right to furnish reasons to the researcher. Similarly, the researcher paid attention to Davis (2002) and Saddlemire (1996) who emphasise that the researcher was ethically bound to indicate to intended participants that their involvement in the project was voluntary and, as such, they were free to participate or not on their own accord.

Finally, with regard to the issue of benefits and reciprocity (Miles & Huberman, 1994), it was mutually discussed and agreed that the study had a potential to add to the body of knowledge and activate both scholarly and political debates on nurses involvement in policymaking. Also, no material or financial benefits were promised to be availed to the participants in this study and the participants consented.

3.8 Data collection procedures

A protocol consisting of a self designed interview guide with open ended questions was used to obtain the data. In this regard, interviews were conducted to discuss and ask the participants to answer and explain their ideas in more detail on what they know and have experienced in relation to health policymaking. During the interview, the researcher deployed a non-directive interviewing style to allow the

participants to autonomously direct the pace and focus of the interview. Additionally, when found necessary, the researcher applied a more directive questioning style to get more clarification on information that the participants had provided.

In all the interviews held, the researcher recorded the information both by making hand-written notes and using an audio tape recorder. In addition some participants were interviewed twice to assess reliability through test-retest reproducibility. Furthermore, some of the questions were asked in more than one way to assess internal consistency. Finally, during validity testing acceptability was determined by asking the participants how they found answering the same questions they had answered in the previous interviews.

3.9 Data analysis procedures

Data analysis was conducted in the course of the research process. Accordingly, the audio-recorded interviews were subsequently transcribed by the researcher. Thereafter, the transcriptions were reviewed in their entirety and compared with hand written notes. This was to allow the research to evolve as newly identified issues were clarified (Davis, 2002, Moustakas, 1994 and Saddlemire, 1996). Hence, to manage and analyse the data, the recorded interviews were transcribed verbatim for use as the primary source of information.

The analysis of the data resulted in systematic grouping and summarising of descriptions according to themes to provide an explanation of various aspects of nurses' knowledge and policymaking competences (Holstein & Gubrium, 1995).

For example, the researcher studied all notes and transcripts relating to the data that was collected during the interviews, to get a general sense of the ideas presented. Thereof, significant information pertaining to nurses' knowledge and policymaking competences was extracted from each transcript to formulate meanings from identified significant statements. These meanings were organized into themes that were evolved into theme clusters, and eventually into theme categories. This was also done to heed Dziany (2011) who contends that, data collected is summarised and simplified to facilitate application of a selective focus on relevant parts of the data. In addition, the data was summarised to transform and condense it in such a way that it could be handled easily.

Based on the theme categories the researcher wrote a rich and exhaustive description of the lived experiences of the nurses on knowledge and policymaking. In order to solicit validation of the written descriptions, the researcher asked the participants to compare the researcher's descriptive results with their lived experiences. In addition, triangulation from different data sources was used to build a coherent justification for the themes.

3.9 Data quality procedures

In a qualitative study, trustworthiness of data refers to the ability of the research findings to be credible, dependable and confirmable (Lincoln & Guba, 1985). To achieve these, various methods and procedures were applied. Firstly, the interview guide was designed in a way that allowed verification of information provided by participants. For example, information pertaining to the extent to which nurses

influence health policy could be verified and confirmed by comparing information from nurses, officials from ZMHB and ZINA.

Secondly, common themes emerging from interviews and documents on various areas of inquiry were substantiated. In this regard, the researcher checked for inconsistencies or omissions in the transcriptions and compared the findings with documented information in order to validate identified themes (Rubin & Rubin, 2005).

Thirdly, to ensure trustworthiness of findings, the researcher used member checking in tandem with Bogdan and Biklen (2003). In this regard, all the participants were provided with an opportunity to review transcripts from their interview session and comment on the conclusions reached by the researcher. This also allowed both the researcher and the participants an opportunity to seek clarification and revision of the transcribed interviews before the final research document was written.

To this end, the quality of data was limited to the researcher's recording, reporting and interpretation of the interviews and observations. Furthermore, honesty and openness of the participants have a bearing on the quality of the study. As such, a more exhaustive, extensive and rigorous study can be done to remedy the above mentioned problems.

3.10 Challenges encountered in conducting fieldwork

The fieldwork did not go as originally planned mainly due to numerous challenges encountered by the researcher. Chief among these challenges are the following:

- The researcher experienced some delays in getting permission to carry out the research at hospitals in Harare. The hospital management had to get clearance from the MoHCC and this resulted in some unsuccessful visits to the hospitals even though the researcher explained that the research is purely for academic purposes and availed the introductory letter from the university to them.
- Some prospective participants were reluctant to be interviewed because they attached political connotations to the study. Thus the researcher had to spend additional time explaining the purpose of the research and rescheduling some interviews to accommodate new entrants to the study.
- Furthermore, some documents at ZINA were only availed to the researcher on condition that the researcher used them whilst in the officials' offices. Therefore, the researcher could not make any photocopies of these documents and thus making it difficult to cite them in this study.

3.10 Summary

This chapter dealt with the research methodology, describing and justifying the methods and procedures used in conducting the study. In addition, the research approach, the research design, the description of the study population and the

sampling procedures used, in addition to the methods of data collection and the data collection instrument that were used in the study were dealt with. Finally, challenges encountered during data collection were presented.

CHAPTER IV: DATA PRESENTATION, FINDINGS AND ANALYSIS

4.0 Introduction

This chapter presents and analyses the findings of the study. The primary objective of this research was to explore and understand the knowledge and policymaking competences that affect nurses' ability to influence public health policy development. In addition, the study was guided by the assumption that, nurses are expected to play a role in the development of health policies. Secondly, the study assumed that, nurses' participation in policymaking will make the achievement of significant improvements in the health policy feasible.

4.1 Research methodology of the study revisited

In this study, a self designed key informant interview guide with open ended questions was used as a research instrument in data collection. Interviews were used to gather data from selected participants. To recruit participants for the research study, purposive and convenience sampling techniques were used and this involved selecting research participants according to the needs of the study. In other words, participants who gave a richness of information that was suitable for the research study were considered for the study. The key informants interviewed were drawn from ZINA, ZMHB and hospitals in Harare. In order to ascertain whether the research objectives were achieved and the assumptions confirmed the presentation and analysis of findings is done against the set research objectives and assumptions.

4.2 Knowledge and policymaking competences (KPMCs)

According to Warner (2003), policymaking competences are requisite to intervene in the broad socio-economic and environmental determinants of health, intervene effectively in a culturally diverse society, partner in development of a humane health care system and bring nursing's values to policy discussions. Against this background the researcher sought to know from the participants, the available knowledge possessed by nurses in Zimbabwe. From what the participants said, the researcher found that nurses exhibit knowledge and policymaking competences even though they are not explicitly unleashing them to affect outcomes of health policy decision processes.

The researcher was made aware of the availability in Zimbabwe, of nurses experienced in policy related issues, with knowledge of government structures and policymaking processes. For instance, the researcher found that nurses collect, summarise and interpret information relevant to policy related issues. In addition, the researcher learnt of the availability within ZINA of skilled political analysts, who can communicate, collaborate and network with other stakeholders in the health sector. For example, the researcher was informed that ZINA engages in health policy dialogues at national, regional, or international levels. Again to demonstrate the nurses and ZINA's ability to work with other stakeholders in the health profession, the researcher was informed of situations in which nurses formed coalitions, and collaborated with other associations and partners within the health industry to present issues for the agenda of government.

4.4.1 Management and leadership

During interviews with participants one of the major points that received prominence was the fact that ZINA is manned by people who have years of experience both in politics. At the helm of the institution, is a former political consultant who has also been working in government institutions for more than five years. In addition, nurses within the senior management ranks are experienced medical practitioners who have been involved in government primary health care programmes for many years. Some of these people have worked as trade unionists within the health industry. These people have knowledge and policymaking competences which can be used to influence health policy decision outcomes.

4.4.2 Perceptions of nursing professionals

During the interview the researcher found that nurses believe that they are trusted and known for ethics and honesty, and this trust is closely related to power. For instance, participants revealed that nurses are involvement in the organisation and coordination of health centre committees (HCC) in which they play a leadership role. Furthermore, participants indicated that nurses exhibit knowledge of government policy processes and this makes them have a credible voice in health related issues that often contributes to the shaping of health policies. For example, one key informant interviewed indicated that, nurses play a leadership role that is influential in mobilising groups to access resources and reform the health policy. This shows that nurses are politically active in communities they operate from to the extent that they influence allocation of resources and the health policy.

4.4.3 Engagement in policy related dialogues

The researcher found that nurses and ZINA have on several occasions been involved in policy related dialogues with policymakers. For instance, participants concurred that, nurses were very instrumental in influencing the formulation of policies that saw the establishment of retention incentives in the health sector and the formation of the Health Services Board (HSB). These contributions by nurses to health policy processes are discussed below, when dealing with issues pertaining to the extent to which nurses have influenced the outcomes of policy decision processes. To this end, several situations in which nurses were engaged in policy related dialogues were presented to the researcher by the participants. In addition, it was revealed during the interviews that nurses engaged ZINA to push government to implement policy reforms related to improved conditions of service of nurses. The improved conditions of service include the introduction of retention incentives, rural and call allowances.

4.4.4 Partnerships and team building capabilities

Nurses in Zimbabwe are very good at working with other stakeholders in the health industry in articulating health policy related issues through building coalitions, collaboration, team build and networking. For instance, it is documented by Quimby and Mantz (2000) that nurses (ZINA) partnered with the American College of Nurse-Midwives (ACNM) and the Independent Clinics Organisation (ICO) to provide training and other support for 109 midwives in Zimbabwe.

Similarly, the researcher found that, ZINA with the backing of nurses combined efforts with other health professional associations and heavily criticised government for using strategies which were not complemented by health policies. This led to the establishment of the Health Services Board (HSB) which finally took over technical policy implementation duties from the Ministry of Health and Child Care (MoHCC).

4.3 Role of ZINA in health policy making processes

To understand the role played by ZINA in health policy development process, the researcher asked participants, to identify these roles. In this regard, four succinct roles of ZINA came out from the participants' responses. Firstly, ZINA represents the interest of its members in the health profession. In this regard, participants revealed that ZINA represents the interests of the nursing profession by serving as the nurses' voice at both the national and international levels. Secondly, ZINA provides guiding terms and conditions of service to the health profession. For example, participants underscored the fact that the association protects the profession through the provision of guiding terms and conditions of employment. In this regard, participants contended that ZINA ensures that the public receives the highest possible standards of care through the maintenance and enforcement of training and practice standards, as well as ethical approaches to professional practice. Thirdly, ZINA influences the outcomes of policy decision processes. To this end, participants emphasised that ZINA influences national and local health policy development to improve health care standards and ensure equitable access to quality, cost effective services. The fourth role of ZINA that was clearly spelt out in the participants' responses is that of acting as a labour or trade union. In this regard, participants held

that, when necessary ZINA acts like a labour or trade union for health care workers particularly when nurses elect to conduct collective bargaining or push their employer, the PSC to consider necessary reforms in the workers' conditions of service.

However, when the researcher enquired from the participants whether nurses are effective or not in affecting health policymaking decisions, mixed responses came out from the participants. For instance, while some participants agreed that to some extent nurses have been effective in affecting public health policy decision outcomes, other participants found it difficult to commend. In fact, the problem in establishing whether nurses in the civil service are effective or not effective in affecting policy decision outcomes is mainly caused by the fact that their professional association, ZINA rarely articulates a health issue by itself. For instance, most of the participants agreed that it is difficult to distinctively delineate ZINA's contribution to health policymaking processes because in articulating health issues, the association combines its efforts with other stakeholders in the health industry. Hence, the nurses' efforts in affecting health policies are diluted and blurred by the presence of other stakeholders.

On the contrary, other participants blamed the economic meltdown as the main reason why the effectiveness of nurses and their associations in articulating policy issues is significantly invisible. Z2 had this to say:

If you ask our members about our effectiveness, what they expect to see is us engaging in war with the government, forcing government to improve the working conditions of nursing professionals. However, we have chosen to do it in a way that shows that we understand the position the country is in economically. The government's resources are over stretched and hence even where we really think there is need for us as an association to intervene and pressure government, we cannot do it.

However, other participants portrayed and painted the current behaviour of ZINA and other associations in a negative way. These participants indicated that currently these associations are only concerned about their survival strategies and not really willing to oppose or exert too much pressure on government to have policy reforms necessary to have an enabling working environment for their members. Against this background, the researcher went on to enquire from the participants, what could be done to improve nurses' influence in national public health policymaking process.

Participants could not clearly come out and propose ways and strategies that can be used by nurses to strengthen their position and be more influential in the policy making process. For instance, one participant admitted that it is difficult for nurses to play a more influential role because of ZINA's lack of effective organisational structures in various parts of the country. In fact, in terms of size of membership and visibility on the policy arena, ZINA has not grown to be a very recognisable organisation that can have a very significant impact on public health policy.

ZINA has one office in the country based in Harare and its officials in other parts of the country do not have offices where they can conduct the business of the association from. In relation to this issue, participants pointed out that ZINA officials move around in health centre facilities to meet with members. To this end, participants indicated that there is need for ZINA to establish branches country wide and put in place personnel who can both market the organisation to the people out there and deliver on its mandate to the people it represents.

4.6 Factors that influence NPs' participation in health PMPs

During interviews with participants, the researcher noticed that the major factors that influence participation of nurses in health policymaking processes are coalition building, collaboration, education, resource constraints and ZINA's organisational structure.

4.6.1 Ability to build coalitions

NPs through their professional association, ZINA, engage in coalition building, lobbying and advocacy to influence access to quality and cost-effective health services. In this regard, the researcher found that ZINA's successes in altering policies and systems related to quality of care, task shifting, health worker mobility and deployment, retention working condition incentives and staffing norms, are heavily dependent on its ability to lobby, build coalition and engage in advocacy work. For instance, participants held that ZINA is involved in building strong

coalitions that have the potential to foster consistent commitment to quality health care nationally and across various levels of health workers. This is in tandem with the Capacity Project (2007) which indicates that successful coalitions broaden the base of support for a particular position. For instance, coalitions are an effective platform from which to advocate for changes in national policies that affect the practice of health professionals and quality of care (ICN, 200).

Additionally, an example of one successful coalition building intervention by ZINA is a study tour by 24 midwives to Uganda and Senegal to encourage the exchange of ideas and experiences, sharing of lessons learnt and establishment of networking among associations. To this date, midwifery associations connected through this initiative are communicating with each other through newsletters and e-mails. For instance, H4 said:

I am one of the people who benefited from coalition building programmes organised by ZINA and other associations. Through this coalition, members of our nursing group are able to identify key audiences, influence policy agendas and have our voices heard.

Similarly, Quimby and Mantz (2000) argue that through successful coalitions, the Midwifery Association Partnerships for Sustainability (MAPS) program in Zimbabwe overcame restrictive legislation that prohibited licensed private midwives from purchasing and dispensing contraceptives and medications.

4.6.2 Ability to collaborate with other stakeholders

Participants indicated that patients are benefiting from the existing continuous collaboration among health care workers, ZINA and other associations. For example, ZINA and other nursing associations have united nurses in building collaborative efforts between health and other sectors to advance the overall development and quality of nursing. In this regard, participants noted that tremendous achievements have been made including the establishment of nursing standards, hospital and community protocols. In fact through collaboration, nurses have managed to prepare and disseminate a code of ethics, effectively implemented nursing processes in health institutions and contributed to curricula development in schools of nursing. This evidence of effective collaboration shows that NPs are dedicated to their work and have comprehensive knowledge of legislative processes regarding health policy in Zimbabwe.

4.6.3 Engagement in human capacity development

The researcher found that ZINA continuously offers education that gives female health workers more professional independence through providing training in business as well as clinical skills. In this regard, participants indicated that ZINA is involved in empowering the female dominated health profession by providing women with a mechanism to take on leadership roles that might otherwise be unavailable to them. In addition, participants particularly those drawn from ZINA, contented that the association has its members at heart, such that it has been very instrumental in assisting them to access programmes on scholarships and advanced

training to enhance the nurses' capacity in discharging their services and understanding of policy related issues.

However, participants pointed out that education in the area of policy development is not available in nursing academic programs such that nurse training programs do not assist nurses in valuing and identifying their political involvement. In fact, it is a challenge for nurse educators to teach students how to translate policy because limited time in clinical experiences prevents immersion experiences in policy development (Leavitt, 1989).

On the contrary, participants particularly those drawn from ZIMB highlighted the need to take due care and consideration in carrying out programmes meant to capacitate nurses. According to these participants, the interests of professional bodies can clash with national priorities, such that there is need for continuous policy dialogues among stakeholders with different agendas. Along these same lines of argument, The Project Capacity (2007) posits that, doctors can oppose the delegation of certain responsibilities to nurses, who may in turn collectively oppose task-shifting to community health workers.

4.6.4 Gender disparity

The researcher also noted that, nursing continues to be a female-dominated profession, and nurses are reluctant to enter into politics. Indeed, due to cultural beliefs and traditional norms, women have always been excluded in leadership and

decision making positions. To this end, women have also been made to believe that leadership positions are a men's jurisdiction and it is a situation that is still acceptable in our culture. In the same vein, participants pointed to the fact that, since independence, no woman has held the post of Minister of Health in Zimbabwe.

4.6.5 Legislative constraints

NPs are civil servants who are governed by rules and regulations established by the state and their employer the PSC. In this regard, civil servants are not allowed to be politically active while at work. In addition, nurses sign the Official Secrecy Act, which prohibits them from disclosing information that is of a confidential nature. For instance, H7 said, "We fear disclosing the confidentiality of the nurse-patient relationship in open discussions". Hence, nurses cannot publicly discuss pertinent health related issues in meetings that involve people from all walks of life

4.6.6 Resource constraints

According to Dye (2002), the relative influence of a group in policymaking processes is dependent on the size of its membership, wealth, organisational strength, leadership, access to decision makers and internal cohesion. Similarly, some participants in the study echoed the same sentiments, reiterating the fact that ZINA still commands a relatively small number of nurses as compared with other associations such as the ZCN. Consequently, its pool of financial resources is very small and prohibitive, such that it is not able to carry out some of the programmes that it is mandated to do as a professional association. For instance, these participants lamented the lack of financial resources as the major contributory factor to the failure

by ZINA to establish effective organisational structures in various parts of the country. In addition, due to financial resources constraints, nurses' advocacy work is very limited to a few targeted places, mainly in Harare and because of the size of such events very little press or media coverage has been received during these events.

In addition, some participants indicated that, spending money on events that increase the visibility of ZINA may portray a bad picture to its members, or may be wrongly interpreted as wasteful usage of resources. For instance, Z3 said:

Our members would like to see us doing things that translate into immediate benefits for them, and that is why the association, now and then, engage partners in development projects that immediately benefit them instead of wasting scarce resources on awareness campaign materials such as posters and t-shirts. I am not saying, these things are not important, but what I am saying is after the campaign will the member benefit anything in the short run.

4.6.7 Organisational strength of ZINA

The researcher found that ZINA has offices at 47 Livingstone Street in the Avenues area of Harare. There is a small number of officers mainly holding managerial posts in the association. These are the only offices in the entire country for the association and in all other towns, representatives of the association do not have established

offices where members can go and see them. The management team is composed of a chief executive officer who is at the helm of the association and other four members in managerial positions, a secretary who doubles as the receptionist. To the researcher, this organisational structure is too thin to run the affairs of an association representing the interests of the population of nurses in the country that are members.

4.6.8 Knowledge of legislative processes

During discussions with key participants, the researcher learnt that ZINA is run by people who have a lot of knowledge of legislative processes in Zimbabwe. For instance, the chief executive officer, a holder of a master's degree in political sciences, is very experienced in policymaking as he has once worked as a member of a team of political analysts, advisors or consultants. Other officials in the managerial rankings are former medical practitioners who have held senior posts in government institutions and in other trade unions in the health profession. As such they are aware of government structures and are also privy to the demands of the health profession.

However, this knowledge and political competence is not being directed accurately to its correct use to make a meaningful impact on policy decisions and to put the nursing profession highly visible on the policy map. In this regard, many participants pointed out that these people are more involved in administrative work of the organisation, meetings with other associations and stakeholders in the health industry instead of attending to the needs of the nurses which have implications on public health policy.

4.4 The extent to which nurses influence the shaping of public health policy.

In order to understand the knowledge and policymaking competences of nurses, the researcher sought to know from the participants, the extent to which nurses influence public health policymaking. In this regard, five key questions were asked to the participants. To start with, the participants were asked to tell the researcher about situations in which nurses took the initiative to influence public health policy and successfully affected policy decision outcomes in relation to the issues at hand. In response to this question, participants managed to identify several situations and the researcher picked common understandings that surfaced from the responses of the spectrum of participants.

4.7.1 Retention incentives

Generally, all participants pointed out that nurses and ZINA were very instrumental in influencing government to put in place retention incentives as a way of improving nurses' conditions of service and reducing on the staff turnovers in the public health sector. For instance, participants from ZINA, and ZIMB pointed out that the reassignment by government of municipalities and local authorities to provide more primary care services in urban areas was a nurses' initiative. This was meant to release workers from central hospitals for redeployment in district health facilities manned by local authorities where the conditions of service are much better. In addition, participants concurred that the improved conditions of service of nurses that

are prevailing in rural areas, such as better housing, rural allowance, communication and other infrastructure, that are needed to influence workers to stay there were initiated by nurses' in partnership with other stakeholders in the health sector. In this regard, Z2 said:

We had noted during interviews with health workers that lack of such incentives pushed health workers away from rural areas and out of the public sector so we influenced government to put those incentives in place. Currently, there is the much applauded Primary Care Nurses (PCN) trained for rural deployment, an initiative which was borne out of nurses, ZINA and other health professionals associations' initiative to increase the number of health workers in rural health facilities.

Indeed, participants particularly from the ZIMHB, highlighted that ZINA, NAMAS, ZNC and ZACH helped government to identify solutions to health professional's attrition and retention of key medical staff members in rural areas where most educated and most qualified medical staff do not want to go and stay. The participants held that the institutions made government realize that for doctors and nurses to be retained in the public sector, the government has to invest in incentives to make the public sector more competitive than the private sector. Furthermore, participants noted that as a result of the incentives put in place, Ministry of Health officials have recorded increases in enquiries to rejoin the public sector by doctors and nurses who had left for private practice. In this regard, Z1 had this to say:

The Zimbabwean government introduced numerous policies and strategies to ensure the retention of skilled health personnel in the public sector after various successive consultative meetings with nursing associations including ZINA. These policies include the provision of housing and transport allowances, call and stand-by allowances, performance management system based salary reviews, fellowship and scholarship programmes, advanced training programmes and bonding of newly trained graduates. These measures were adopted in an effort to retain skilled health professions after realising that service delivery was being compromised by the migration of health professionals.

However, some participants had mixed feelings about the degree to which nurses affect public health policy decision outcomes. For instance, despite that NPs were engaged on several occasions in discussions pertaining to retention incentives and other conditions of service by ZINA and have noticed positive changes to that effect, the participants still think ZINA is working flat out to recruit, retain and increase their membership. Actually, the researcher deduced that some nurses believe that ZINA is trying to boost its financial position by increasing the flow of subscriptions to the association. For instance, H1 said, “This is where their money comes from, so we believe they want to be seen to be doing something for us”.

In addition, some participants did not seem to agree that nurses and ZINA are very instrumental in initiating health policy changes. For instance, participants pointed out that salary reviews were introduced to match the cost of living in an environment of hyperinflation. Similarly, participants argued that call allowances were introduced

to allow the professionals to work extra hours due to staff shortage. To these participants, these changes were inevitable and did not need the initiative of nurses, ZINA and other stakeholders in health profession to push government to implement.

Furthermore, some participants lamented lack of consultation by ZINA to solicit nurses' views and ideas on issues of concern to the health professionals. Accordingly, ZINA has on several occasions sidelined nurses from making meaningful contributions to the planning and implementation of developmental activities at their work places. For instance, participants argued that ZINA has not made any concerted efforts to try and retain health staff posted at clinics and strongly believe that only the government has made lasting efforts to retain skilled health staff there.

Lastly, most nurses interviewed indicated that measures that have been put in place by government after consultation with nurses through ZINA are yielding mixed results. These participants stated that bonding is effective in retaining staff and salary restructuring has reduced the turnover of workers from the public health sector. However, while call allowances have helped retain staff, numerous complaints have arisen and health professionals have threatened to go on strike over unpaid allowances. From the way these participants criticised these measures, the researcher found that nurses strongly believe that implementation of policies aimed at retaining staff will not achieve the desirable results as long as the question of low remuneration remains unresolved.

4.7.2 Establishment of a health services board

Apart from being instrumental in initiating the introduction of retention incentives, participants pointed out that in 2005, nurses influenced ZINA and other health professional associations to criticise government for using strategies which were not complementary with health policies. This led to the establishment of the Health Services Board (HSB). For instance, before the establishment of HSB, different strategies used to retain staff in the public sector by the Ministry of Health and Child Care (MoHCC) and the Public Services Commission (PSC) had mixed impact on the distribution of health workers and lacked complementary policies (The Capacity Project, 2007). According to participants problems resulted because the PSC, the ultimate employer of civil servants including health workers, managed and controlled human resources policies while MoHCC implemented and monitored technical health care delivery policies.

4.7.3 Formation of coalitions

The researcher also asked participants how nurses get their ideas and recommendations considered by policy makers during health policy development processes. In this regard, participants highlighted that the nurses and ZINA do not present policy issues as standalone individuals to government but speak with one voice with Zimbabwe Medical Association (ZIMA), Zimbabwe Association of Church related Hospitals (ZACH) and National Association of Medical Aid Societies (NAMAS). This is in line with Quimby and Mantz (2000) who argue that a by-

product of stronger associations is that individuals gain courage and strength by working together in groups towards a common cause.

In addition, the participants said issues are presented to government after prior meetings have been held to come up with a common understanding on policy issues.

In this regard, Z2 had this to say:

Yes, I admit it involves a lot of give and take as well as compromise because as different individuals we do not share the same vision at times and we also have different backgrounds and aspirations. Sometimes we rope in donors which government institutions find difficult to resist because of the financial connotations donors' involvement implies.

On the contrary, one participant regardless of being a subscribing member, portrayed ignorance of ZINA's operations, especially on how the association interacts with policy makers and argued that government only consults nurses and ZINA because it represents many government employees.

4.7.4 Scheduled meetings on calendar

Asked by the researcher, how often nurses meet with ZINA to discuss new developments or give feedback on public health policy related issues, participants from the association pointed out that there are scheduled quarterly and annual meetings where ZINA gives feedback to members and informs them of any new developments. In addition, participants said meetings to discuss urgent issues of

concern can be held whenever it is necessary. As an example, participants mentioned that, when junior doctors and nurses were planning to go for an industrial action in city hospitals in 2013, ZINA met with them before meeting MoHCC authorities. The nurses' concerns were discussed and presented to PSC which moved in to rectify the situation. However, ZINA officials admitted that, it has been very difficult to meet with members as planned because of financial constraints regardless of the fact that ZINA has an obligation to meet and report back to members on a regular basis.

4.9 Organisational structures

The researcher also sought to know from the participants, the procedures and structures put in place by ZINA that can be used by nurses to communicate their problems and influence the policymaking process. The responses given by the participants showed that ZINA still has a long way to go for it to be effective in communication and hence in influencing health policymaking processes. For instance, participants highlighted that ZINA has one office in Harare, and officers scattered around the country. These officers are the ones always in touch with members in various health facilities in the country and normally operate as focal people for the association at the various constituencies. In addition, most of these officers do not have offices to operate from but visit and meet with members at the members' work places.

However, some participants became emotional and temperamental when asked to discuss about the readiness and accessibility of ZINA to discuss health policy related issues. These participants were bitter that even though there are some ZINA officers on the ground in other towns apart from Harare, nurses who get in touch with them say very little about their operations in those areas except to recruit new members for the organisation. In fact, one participant who transferred to work in Harare from a health facility outside Mvurwi said that ZINA officers hardly call for meetings to discuss thorn issues. The same sentiments were echoed by H7 who had this to say:

ZINA neglected us nurses when it became difficult to find a common consensus between us and the PSC on issues relating to reviewing of salaries and other benefits. We wanted to take industrial action as a way of pressing government to bow down to our demands but ZINA disowned us, took sides with the government and called the industrial action illegal.

However another participant used politics as an escape goat in pointing out that the country's political environment does not allow for too much criticism of those who hold the power to make decisions especially relating to resources allocation. Specifically, H6 said, "You oppose government but not very openly, it is not safe".

4.5 Summary

This chapter presented and analysed the findings of the study. In this regard, the findings of the study were analysed with regard to the objectives and assumptions of the study. The following chapter presents the conclusions reached and the recommendations made by the study.

CHAPTER V: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This Chapter provides a summary of Chapters I to III and the conclusions that arose from the findings as discussed in Chapter IV. Thereafter, recommendations are synthesized and areas for further investigation to broaden the knowledge base around nurses' knowledge and policymaking competences are consequently discussed.

5.1 Summary

This qualitative research sought to understand the requisite knowledge and policymaking competences for nurses to participate in public health policy processes. Using semi-structured interviews, the research got relevant in-depth information from thirteen participants who had the necessary experience in nursing and knowledge on public health policy. Each of the thirteen participants was interviewed for at most one hour. Interviews were conducted on different days with a maximum of three interviews per day. To guide the interviews and remain focused on the subject matter, a self designed interview guide was used but with flexibility as determined by participants' responses. All the thirteen interviews were audio-recorded and later transcribed by the researcher, who then reviewed each transcription in its entirety, to come up with general themes.

In order to understand the knowledge and policymaking competences of nurses, questions in the interview guide and those that emerged during the study were developed and informed by the literature review in Chapter II. Also, to qualify to be a theme, a response was raised and discussed by at least four of the thirteen participants. Thereafter, common themes were grouped together to yield five overarching themes identified as: (1) knowledge and policymaking competences, (2) role of ZINA in the PMPs, (3) factors that influence participation of nurses in policy development processes, (4) the extent to which nurses influence the shaping of public health policy, (5) ineffective organisational structure. From these five main themes, research findings were generated.

5.2 Participants

Individuals who were experienced in nursing and had knowledge of public health policy were chosen to participate in this study. Three ZINA officials and three staff members from ZIMHB were interviewed at their offices in Harare, after each and every one of them had mutually agreed with the researcher that it was a comfortable environment for them to share the best of their experiences. The participating individuals for the in-depth interviews also included nurses from hospitals in Harare who were interviewed at their work places. Both men and women were purposefully interviewed to ensure gender representation. To this end, eight participants were women and the other five were men who were experienced in nursing and had knowledge of public health policy processes.

The pseudo names of the participants from ZINA are Z1, Z2, and Z3 while those from ZIMHB are B1, B2, and B3 and the seven participants from hospitals are H1, H2, H3, H4, H5, H6, and H7. A1, the chief executive officer of ZINA was a male aged 52 and a holder of a master's degree in political sciences who had been a policy analyst and political advisor to the former Minister of Health, Dr. Stamps. A2, the public relations officer for ZINA was a female aged 42, who had been a practicing nurse for 17 years. She was a holder of a general certificate in nursing. A3, the finance and administration officer at ZINA was a female aged 39 who had worked with the Ministry of Health as an administrator for ten years. She was a holder of a degree in public administration. B1, the human resources director at ZIMHB was a male 47 years of age, while B2, the public relation manager was a female 41 years old and B3, the personal assistant to the human resources director was a female aged 39. The researcher did not manage to get information pertaining to their academic qualifications because the participants considered it as confidential information.

Amongst the nurses interviewed, H1 to H4, three matrons were female while one matron was a male at the hospitals they were working. They were holders of degrees in medicine and general certificates of nursing. The other three nurses interviewed, H5 to H7 were holders of general certificates in nursing and sisters in charge of their sections in the hospital departments they work. All the nurses interviewed had been working as nurses for more than five years. They had all been involved in administering government health programmes both inside and outside their work places. Again the nurses refused to divulge their ages to the researcher. However, they all mentioned that they did not have any formal training in public policy.

5.2 Findings

Basically, nurses in public health institutions had sound knowledge and policymaking competences. However, these nurses had not been able to fully unleash their knowledge and policymaking competences through participation in policymaking because of various reasons. Chief among these reasons were an ineffective organisational structure of ZINA, lack of educational materials on policymaking in the nursing training curricula, gender disparity in the health profession, restrictive legislature and resource constraints. In fact:

- i. ZINA had only one office in Harare where its operations were centralized making it difficult for nurses in various parts of the country to have effective communication and enough representation on issues of concern.
- ii. ZINA representatives were only mainly concerned with recruitment of new members into the association instead of educating members on how they could affect outcomes of policy processes.
- iii. ZINA heavily relied on other stakeholders in the health profession in affecting outcomes of policy decision processes such that its existence on the policy arena was blurred.
- iv. The public health profession was female dominated and because women are not as politically active as their male counterparts top leadership positions

were males' prerogative, hence the interest of the majority did not often prevail.

- v. The training curricula for nursing professionals did not include educational material on public policymaking processes or government procedures.
- vi. Nurses were civil servants who by default abide by the Officials Secrecy Act hence nurses could not publicly discuss confidential issues pertinent to policy reform.
- vii. Nurses were public servants and as such they were not allowed to participate in political discourses at work, and this deprived nurses the opportunity to effectively affect political decisions.
- viii. Nurses in public health facilities were employees of the PSC, a department in the Ministry of Public Service, Labour and Social Welfare and as such the nurses' bargaining powers were very limited.
- ix. Nurses did not have enough resources to be able to significantly affect policymaking decision outcomes.
- x. ZINA was not able to hold scheduled meetings with nurses due to lack of financial resources.
- xi. ZINA did not occasionally consult with nurses when making decisions on policy issues concerning the nurses.
- xii. Implementation of policies aimed at retaining staff did not achieve the desirable results because of low remuneration which remained unresolved.

5.3 Conclusion

In view of the foregoing findings, therefore, the conclusions deduced were as follows:

- i. An effective organisational structure that allows for meaningful participation of nurses in policymaking was not available in ZINA.
- ii. The absence of effective organisational structures deterred effective communication and involvement of nurses in policymaking.
- iii. ZINA's existence on the policy arena and impact on policy decision outcomes was heavily blurred by the involvement of other stakeholders in the health profession.
- iv. The female dominated nursing profession was found to be less politically active due to inherent cultural norms that downgrade women to lower decision making positions in society.
- v. The use of the available knowledge in nurses did not seem to attract scholarly and political discourses.
- vi. ZINA was not clearly articulating policy issues to fulfill its mandate to its members.
- vii. There were no nursing role models and leaders to advance learning in policy development.
- viii. ZINA was not consulting nurses on health related issues.
- viii. Legislative restrictions deterred the participation of nursing professionals in policy related issues

- ix. Resource constraints negatively affected nurses' involvement in policymaking.
- x. Low remuneration deterred the implementation of policies meant to retain nurses in the public service.

5.4 Recommendations

In view of the foregoing findings and conclusions, the study makes the following recommendations for practice and further research:

- i. ZINA should establish an effective organisational structure that would allow for the establishment of offices country wide to enhance its operations.
- ii. Nurses should openly articulate policy issues, get coverage from the media and produce publications of their work in policymaking to improve their visibility on the policy arena and the nurses' contribution and involvement in policymaking.
- iii. ZINA and nurses should engage development partners who can avail funds for infrastructural development, awareness campaigns and human capacity development programmes.
- iv. The nursing training curricula should include educational topics and materials on policy development processes.

- v. There should be capacity development programmes for the female dominated health profession that encourage women to take up leadership and decision making positions.
- vi. Government should review nurses' salaries to match with the changing cost of living.

5.5. For practice

In addition, recommendations for further academic inquiry were considered along the following lines:

- (a) The available knowledge and policymaking competences in nurses can be used to formulate evidence based public health policies.
- (b) There should be ways to expand the capacity of nurses to make meaningful impacts on public health policy decision outcomes in developing countries like Zimbabwe.
- (c) Amplified presentation of positive, empirically-based findings on the merits of nurses' involvement in policymaking should assist to allay real and imagined fears of allowing public servants to engage in political debates or policy development processes.
- (d) Expansion of qualitative and quantitative inquiry into knowledge and policymaking competences of nurses in health institutions should assist to broaden the knowledge base on the merits of nurses' involvement in public

policymaking.

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APPENDIX 1 INTERVIEW GUIDE QUESTIONS

Respondent's: Organisation _____

Sex _____

Position _____

Length of period of service _____years

*Section A: **The extent to which ZINA influence public health policymaking.***

- 1) Tell me about situations where nurses felt that they knew exactly what had to be done in relation to public health policy and they got policy makers to go along with it?
- 2) Tell me of a situation(s) when nurses, ZINA and other players in the health industry took the initiative to have an issue of concern addressed by policy makers?
- 3) What are the strategies used by nurses to have their ideas and recommendations considered by policy makers during health policy development?
- 4) How often do nurses and ZINA meet to discuss new developments or give feedback on public health policy related issues?
- 5) What are the procedures or structures put in place by ZINA that nursing professionals can use to influence the policymaking process?

*Section B. **The role played by ZINA in the public health policymaking process***

- 1) How often does ZINA organise meetings with nursing professionals to solicit information that can be used to affect public health policy in tandem with changes in the public health environment?

- 2) What are ZINA's obligations to the nursing professionals that affect the national public health policy?
- 3) How does ZINA relate with the Ministry of Health and Child Welfare and other relevant authorities in the health sector?
- 4) Do you think ZINA is effective or not effective in affecting the public health policymaking process and why do you say so?
- 5) What do you think can be done to improve ZINA's influence in national public health policymaking process?

*Section C. **Factors that influence nurses' participation in the policy making process.***

- 1) How significant is size of population of nurses in public hospitals?
- 2) What effect does this have on ZINA in affecting public health policymaking processes?
- 3) Which programmes or projects are carried out by nurses or which that have an impact on public health policy?
- 4) Which civil society groups does ZINA work with that can affect the public health policymaking process?
- 5) To what extent do you think ZINA is making use of civil society groups to affect public health?

*Section D. **Availability of policymaking competences within NPs***

1. How do NPs get support from other players in the policymaking process to make things happen the way that suits the nursing professionals?
2. What do you think are the reasons why nurses are or not capable of getting their agenda adopted even when their ideas are very good or not?
3. How prepared is ZINA to handle a burning issue that is affecting nursing professionals working environment?
4. How does ZINA prepare for a meeting where it wants its ideas or interests to be adopted on the agenda?
5. Suppose ZINA knows who is likely to resist its ideas and the possible reasons for that, how does it handle the issue prior and at the policymaking table?

APPENDIX 2 INFORMED CONSENT FORM

Introduction

My name is Patrick Chipindirwe, a final year (Masters in Public Policy and Governance) student from AU. I am carrying out *A qualitative study on knowledge and policymaking competences of nursing professionals*. I am kindly asking you to participate in this study by answering questions that I will ask you from my interview guide.

What you should know about the study:**Purpose of the study:**

The purpose of the study is to explore and understand through the obtaining of information from key participants, knowledge and policymaking competences of nursing professionals. You were selected for the study because you are a nurse in the public service and member or official of ZINA. As such you are expected to have relevant information required for this study. In addition, fourteen other people are participating in this study, some from ZINA and others from hospitals in Harare.

Procedures and duration

If you decide to participate, you will be interviewed by me. It is expected that this will take approximately an hour. Where necessary, a follow up interview to clarify some issues raised in the interview may be held and this will not last longer than half of an hour (30 mins)

Risks and discomforts

Some of the questions which will be asked to you may require you to tell me what you may consider as confidential information however, I would like to ensure you that all information obtained during the course of this study is going to be treated with the highest level of confidentiality. We will have a one-on-one interview. Your identity will not be mentioned in any of my reports or in any way that can reveal it. In addition, you may not be comfortable to give me answers to some of my

questions, in such circumstances, feel free to refuse to provide an answer to such questions. Finally, if it becomes inconvenient for you to continue with the interview, you are free to excuse yourself and withdraw from the interview.

Benefits and/or compensation

The study is solely for academic purpose and participants will not be given any benefits for their contribution in this study. However the recommendations of this study if considered will benefit the nursing professionals and will also add to the body of academic knowledge.

Confidentiality

Any information that is obtained in the study that can be identified with the participant will not be disclosed without their permission or used for any other purpose other than this study. In addition, names and any other identification will not be asked for in the interview. The respondent is assured that the highest standard of confidentiality will be maintained during and after the study.

Voluntary participation

Participation in this study is voluntary. If participants decide not to participate in this study, their decision will not affect their future relationship with ZINA or the Ministry of Health Child and Welfare. If they chose to participate, they are free to withdraw their consent and to discontinue participation without penalty whenever they feel they can no longer continue with the study.

Offer to answer questions

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

Authorisation

If you have decided to participate in this study please sign this form in the space provide below as an indication that you have read and understood the information provided above and have agreed to participate.

Name of Research Participant (please print)

Date

Signature of Research Participant or legally authorised representative

CONTACT DETAILS:

Name of researcher:

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APPENDIX 3 LETTERF ROM AFRICA UNIVERSITY



INSTITUTE OF PEACE LEADERSHIP AND GOVERNANCE

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14 March 2015

TO WHOM IT MAY CONCERN

Re: Permission to Undertake Research for Dissertation at Africa University

Patrick Chipindirwe student registration number **129694** is a student at Africa University. He is enrolled in a degree program in Public Policy and Governance and is currently conducting research for his project, which is required for completion of the program in June 2015. The research topic is **"A qualitative study of knowledge and policy-making competences of nursing professionals"**. Patrick is expected to undertake this research during the period March-May 2015 before the dissertation can be submitted to the Faculty in June 2015.

The student will share with you the results of this research after its approval by the Institute.

We thank you for your support and cooperation regarding this research.

Yours sincerely


Prof. P. Machakanja
Director