

The Related Factors of Nurses' Participation and Perceived Benefits and Barriers in Health Policy Making

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ABSTRACT

Background: Nurses play a critical role in providing good health services.

Purpose: The aim of this study was to examine the factors related to the participation of nurses in the provision of health services and the perceived benefits and barriers to their participation in health policy making.

Methods: A cross-sectional descriptive study was conducted in several hospitals affiliated with the Iran University of Medical Sciences during the first half of 2018 on a sample size of 220 people. A standard, self-management questionnaire was used to collect the data, and SPSS 21.0 software was used for data analysis. None of the demographic characteristics were found to be significantly associated with nurse participation in or the perceived barriers and benefits to health policy making.

Results: The results of this study show that the participants were involved only moderately in health policy making. "Providing written reports on problems or receiving consultation from a related official" was the performance item most frequently cited by the participants in terms of involvement, whereas "Disappointment in work procedures" was the most frequently cited barrier item affecting involvement.

Conclusions/Implications for Practice: Despite the importance of the nursing role in health policies, this study indicates that nurses participate at only a moderate level in health policy-making activities. Providing more information to nurses regarding health policies, enhancing nurses' image of their job and their perceptions about the importance of their participation in the health policy, increasing partnerships with nurses at the upper levels of health services management, and supporting nursing professional organizations in the field of health policy are potential strategies for encouraging greater nursing participation in health policy making.

KEY WORDS:

nurse, health policy, participation, barriers, benefits.

The mission of a healthcare system is to ensure societal health, which is only fulfilled through the favorable provision of services. The only way to achieve this is to make provisions for the constituent elements of service delivery. As a critical component of health service delivery in all countries, nurses contribute to public health policies as key actors (Clarke, Swider, & Bigley, 2013). Nurses are the largest group of healthcare workers involved in healthcare service delivery (Lewinski & Simmons, 2018). Moreover, the more than 35 million people estimated to work as nurses worldwide make nurses the largest workforce in the health system (Shariff, 2014). Given the rapid development and transformation of healthcare systems, it is incumbent upon nurses to advance in line with these changes. To this end, nurses must be involved in formulating health policies rather than merely implementing these policies (Shariff, 2015).

Health policies are basically policies that are directly associated with the governmental health sector in any country (Shariff, 2014). These policies involve areas such as healthcare services, costs, and healthcare quality and access. Quality provision, accessibility, and cost-effectiveness improve the quality of life and welfare of society (Heydari et al., 2013). The participation of nurses in the development of health policies ensures safe, effective, accessible, and low-cost services (Jivraj Shariff, 2015). Health policies affect the nursing profession and healthcare (Shariff, 2015).

Discussions about health policies and health-policy reforms have focused increasingly on the need for greater participation by nurses and midwives. This need was first identified formally in 2000 and gained a significantly higher

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Introduction

Historically, healthcare systems invest most heavily on illness-related care. This emphasis on illness instead of health has given rise to the notion of medical priority and produces substandard economic and health outcomes (Peters, 2002).

profile through its inclusion in the 2002 World Health Organization (WHO) Report. Political participation includes involvement in political development processes, including identification of policy areas and policy formulation, implementation, evaluation, and modification (AbuAlRub & Foudeh, 2017).

Despite receiving encouragement to participate, nurses are notably absent from health policy reforms in comparison with other health-affiliated professions and groups (Ditlopo, Blaauw, Penn-Kekana, & Rispel, 2014). The central role of nurses in health service delivery helps explain their commitment to change policies from ethical and professional standpoints (Sayers & DiGiacomo, 2010; Shariff, 2014; Whitehead, 2003). The presence of nurses alongside patients during major life events such as births, illnesses, and recovery has indeed put them in an optimal position to provide health policy information (AbuAlRub & Foudeh, 2017). With their knowledge and experience acquired in the work environment, nurses enjoy a unique position in the health team that allows them to contribute to health policies by enabling effective strategies (Etowa et al., 2016). These characteristics increase the need for greater nursing involvement (AbuAlRub & Foudeh, 2017). Studies point to limited nursing participation in health policy development activities (Shariff, 2015). This may be attributed to the unheard voice of this hardworking group (Cheraghi, Ghiyasvandian, & Aarabi, 2015); the lack of nursing involvement at the higher levels of the healthcare system (Shariff, 2014); the lack of a proper understanding of the reasons or benefits of participation (AbuAlRub & Foudeh, 2017); the lack of knowledge, skill, support, time, negative perceptions of the nursing profession in society; and the lack of authority and available structural resources (Shariff, 2014). Many nurses attempt to play a political role that allows them to influence the activities of health policies directly (Whitehead, 2003). To exert influence in the world of politics, nursing leaders need to have certain characteristics that enable them to develop health policies effectively (Jivraj Shariff, 2015). In Iran, nurses engage in health policy activities through governmental and nongovernmental organizations. Governmental organizations include the Deputy of Nursing in the Ministry of Health and the national Board of Nursing. Nongovernmental organizations include the Iranian Nursing Organization, Iranian Nursing Association, Iranian Nursing Scientific Association, and Iranian Cardiac Nursing Association (Esmaeili, Dehghan-Nayeri, & Negarandeh, 2013). Unfortunately, despite the struggle over the past three decades by Iranian nurses to increase their participation in the policy-making process, their position in this process remains unclear (Cheraghi et al., 2015). All of the studies addressing the participation of Iranian nurses in health policy activities have been qualitative, with no related quantitative studies published. This study was conducted in 2018 with the aim of examining the involvement of Iranian nurses in health policy activities and studying the involvement-related benefits, barriers, and health outcomes. The questions asked in this study included: (a) What is the level of involvement of Iranian nurses

in health policy activities? (b) What are the perceived benefits of involvement in health policy activities? (c) What are the perceived barriers to participation in health policy activities?

Methods

Design

This was a descriptive cross-sectional study conducted in several hospitals affiliated to Iran University of Medical Sciences during the first half of 2018.

Statistical Population

The statistical population consisted of 530 nurses working in six hospitals, including Shohadaye Haftome Tir, Lolagar, Shohadaye Yaftabad, Shahid Fahmideh, Hazrat Fatemeh (in Robat Karim), and Imam Sajjad. Two hundred twenty nurses were selected from the statistical population using the Krejcie and Morgan table and enrolled as participants. Cluster and stratified sampling was used, with hospitals used as clusters and hospital units used as stratum. The six hospitals were selected randomly from among the hospitals in the Iran University of Medical Sciences hospital network, and samples were identified in each of the selected hospitals based on the population of each. The inclusion criteria included having at least a bachelor's degree in nursing and 2 years of work experience.

Data Collection Instrument

Data were collected using a standard self-management questionnaire that was developed in 2000 by Eden et al. (as cited in Juma, Edwards, & Spitzer, 2014), modified by Salvador (Lewinski & Simmons, 2018) in 2010, and used by AbuAlRub in 2016 (AbuAlRub & Foudeh, 2017). This questionnaire comprises four sections, as follows: (a) Demographic information; (b) Participation in health policies, which refers to any activity the purpose or impact of which involves governmental activities that influence the formulation or implementation of public health policies or are indirectly linked to related policy decision-makers. This section includes a 17-item checklist that is scored on a 5-point Likert scale ranging from 1 = *no involvement* to 5 = *strong involvement*; (c) Perceived barriers by nurses, which involves factors that personally prevent activities, with positive outcomes measured using a 19-item checklist scored on a nominal scale of 1 = *yes* and 0 = *no*; (4) Perceived benefits by participants that deals with the perceived positive outcomes from the result of activities and includes 17 items on a nominal scale of 1 = *yes* and 0 = *no*. Participation by participants was assessed as low level of involvement (1–2), moderate level of involvement (3), and high level of involvement (4–5). The total score for participation was based on the mean of the answers to the questions, whereas the total scores of the perceived barriers and benefits were based on the sum of positive answers (Salvador, 2010).

The WHO guidelines were used for the translation and cultural adaptation of the questionnaire into Persian (WHO, n.d.). This process included the following four steps: (1) Forward translation: In this step, the English version was translated into Persian by a translator who was completely familiar with the nursing field, concepts, and terminology and whose mother language was Persian. (2) Expert panel: The translation was reviewed by an expert committee, including a translator and a research team. This committee examined the translation thoroughly based on criteria such as grammar, use of proper equivalents, proper placement of parts of speech, precision, comprehensibility, and lack of ambiguous terms. The result of this process produced a complete translated version of the questionnaire. (3) Back translation: Using the same approach as outlined in Step 1, the Persian questionnaire was translated back into English by an independent translator whose mother tongue is English and who had no prior knowledge of the questionnaire. The back-translated English questionnaire was then compared and discussed with the original version in terms of conceptual equivalence in two sessions that were attended by the translators and the research team to verify its equivalence. (4) Pretesting and cognitive interviews: The Persian version was distributed to 30 participants as a pilot test to determine clarity and accuracy of meaning. These participants provided their feedback. After conducting the test, all of the findings were reexamined by the committee, and the Persian questionnaire was modified and finalized. A Cronbach's alpha of .77 was obtained for the questionnaire at this stage. The validity and reliability of the questionnaire were evaluated using content validity and Cronbach's alpha, respectively. After development, the questionnaire was sent to a group of nursing and health management professors to seek their opinions regarding content validity. Five of the six professors verified that the questionnaire provided good validity. The content validity ratio and the final Cronbach's alpha of the questionnaire were .83 and 85%, respectively.

Data Collection Method

At the beginning of the research implementation, the researcher in charge of data collection visited the hospital administrators and matrons of the selected hospitals to make the necessary arrangements. The process was followed by holding a brief briefing session with the managers of the nursing departments on the research subject. The opinions of the participating nurses were then collected via the questionnaires. Data collection lasted for a period of 3 weeks. The person in charge of the data collection distributed and collected the questionnaires.

Data Analysis

Descriptive statistics were used to analyze the descriptive data. Because the data were not normal, nonparametric Mann–Whitney and Kruskal–Wallis tests were used to examine the associations between the demographic characteristics

and participation and the perceived barriers and benefits. Data were analyzed using SPSS Version 21.0 (IBM, Inc., Armonk, NY, USA).

Ethical Considerations

The following fundamental principles were taken into account as ethical considerations in this research. The study was verified by the ethics committee of Islamic Azad University, Tehran Medical Branch (code: IR.IAU.TMU.REC.1396.05); letters of introduction were offered upon visiting different hospitals and departments; the aim of the study and method by which the findings would be used were clearly explained to the participants during the data collection process; participation in the study and responding to the questionnaire items were completely voluntary; participants could stop cooperating with the researcher at any stage of the research; the questionnaires were distributed to all of the participants in a completely anonymous manner in order to observe ethical principles, maintain the dignity of the personnel, and observe information confidentiality; reports were not presented on an individual or case-by-case basis; and findings were analyzed in a completely anonymous and cumulative manner.

Results

Two hundred twenty nurses participated in this study, with 166 (76.1%) women and 52 (23.9%) men. Mean age and work experience were 33.54 ± 4.60 and 8.93 ± 3.53 years, respectively. Most participants were married (52.7%), held a bachelor's degree (92.2%), and worked rotating shift works (83.2%).

The nursing performance in health policy-making participation is shown in Table 1. "Providing written reports of the problems or receiving consultation from a related official" and "Verifying or studying related legal affairs to health policies" were, respectively, the performance items most and least frequently cited by the participants.

The perceived barriers to participation in health policy making by nurses is shown in Table 2. "Disappointment with work procedures" and "Lack of any barriers" were, respectively, the barrier items most and least frequently cited by the participants.

The perceived benefits of participation in health policy making by nurses is shown in Table 3. "Resolution of nursing challenges by nurses" and "Helping those incapable of creating changes" were, respectively, the benefit items most and least frequently cited by the participants.

The associations between the demographic characteristics and participation and perceived barriers and benefits are shown in Table 4. No significant association was identified between any of the demographic characteristics and participation, perceived barriers, or perceived benefits.

Discussion

The results of this study show that the most frequent health policy activities that the participants were involved was "Providing written reports of the problems or receiving

TABLE 1.
Nursing Participation in Health Policy Making

No.	Activity Type	Mean	SD
1.	Objection to or disagreement with a health policy-related issue	2.50	1.02
2.	Providing written reports of the problems or receiving consultation from a related official	3.29	1.16
3.	Presenting a plan on the health policy law to higher authorities	2.05	1.09
4.	Contributing to the selection of most competent individuals for related positions	2.44	1.12
5.	Membership in nursing associations and nursing political organizations	2.19	1.09
6.	Communicating information on health policies to applicants or other professions	2.14	0.89
7.	Offering and publishing critiques on health policies in academic conferences	2.30	1.24
8.	Participating in various elections of the nursing system	3.14	1.16
9.	Establishing contact with a related official to health policies	2.75	1.02
10.	Verifying or studying related legal affairs to health policies	1.79	0.92
11.	Campaign advertising in health-related issues for candidates	2.09	1.11
12.	Giving speeches on health policy-related issues in nursing conferences	2.53	1.14
13.	Running for a health policy-related position	2.30	1.06
14.	Using mass media to shed light on health policies	2.94	1.21
15.	Other activities (e.g. discussing certain health policy-making issues in daily reports, sending e-mails to the Ministry of Health and Medical Education with regard to health policy making, and discussing health policy making in nursing associations)	2.82	1.05
16.	Cooperating with a committee or group to develop health policies	2.78	1.05
17.	Investing in a health-related electoral campaign or policy making	2.06	1.29
18.	Participation	2.75	0.94

consultation from a related official.” This finding is at odds with previous studies of Jordanian and U.S. nurses, which found voting for a candidate and making health policy proposals to be the most frequent health policy activities in which nurses were involved (AbuAlRub & Foudeh, 2017; Vandenhouten, Malakar, Kubsch, Block, & Gallagher-Lepak, 2011).

Furthermore, the results of this study indicate that Iranian nurses are only moderately involved in health policy making. This differs from the results of AbuAlRub and Foudeh (2017), who found that Jordanian nurses had a low level of involvement in health policy. In another study conducted on South African nurses, the results found a suboptimal level of involvement among the vast majority of nurses, which supports the findings of this study (Ditlopo et al., 2014). Similar to many other countries, the role of Iranian nurses in developing political processes is limited to the implementation of approved policies (Shariff, 2015). Given that an adequate understanding of health issues, laws, and policies is a prerequisite for being involved in health policy activities, another reason for limited nursing participation may be a lack of sufficient understanding of this issue (AbuAlRub & Foudeh, 2017). The primarily unheard voice of the nursing community is yet another factor that may account the persistently low level of nursing participation in health policy making (Cheraghi et al., 2015).

The results of this study show that the most frequently perceived benefits to nurses being involved in health policies

were “Resolution of nursing challenges by nurses,” followed by “Nursing independence” and “Personal satisfaction of feeling of service” (building self-confidence in nurses). These findings differ from those of Oden, Price, Alteneider, Boardley, and Ubokudom, (2000), who reported “Improving the health of the public” and “Making a difference in others' lives” as the most frequently cited perceived benefits (Oden et al., 2000). Nursing involvement may also be supported by educational programs, standing as candidates for political and administrative positions and finding sponsors for other candidates (AbuAlRub & Foudeh, 2017). Based on the findings of previous studies, the involvement of nurses in the health policy development process is positively associated with gaining experience and participating in political development, having a model to follow, receiving training and acquiring knowledge about health systems and political development processes, having a political orientation, conducting research, providing support through professional organizations, and developing managerial skills (Shariff, 2014). International nursing associations have proposed coordinating nursing activities, maintaining union with the profession, and developing a powerful leadership as ways of increasing nursing involvement and have thus made related investments in academic structures to expand the effective involvement of nurses in the development of global health policies (Gimbel, Kohler, Mitchell, & Emami, 2017). The Institute of Medicine

TABLE 2.
Perceived Barriers to Participation in Health Policy Making by Nurses

No.	Activity Type	Frequency	Percentage
1.	Disappointment in the work procedure	111	50.45
2.	Lack of external support	107	48.64
3.	Lack of time	103	46.82
4.	Lack of access to key figures	103	46.82
5.	Diverging values or attitudes of policy makers	99	45.00
6.	limitations in adopting individual viewpoints	88	40.00
7.	lack of financial support or other resources	78	35.45
8.	Other barriers (nursing shortage, workload, or resistance to the implementation of certain policies)	76	34.55
9.	Lack of political knowledge	71	32.27
10.	Lack of any change with my participation	59	26.82
11.	Unclear path to gaining necessary information in this regard	59	26.82
12.	Unclear nature of the efficacy of political activity	54	24.55
13.	Individual opposition to contradictory viewpoints	53	24.09
14.	Disagreement by others	49	22.27
15.	Lack of change through political activity	35	15.91
16.	Personal priorities	32	14.55
17.	Lack of relevance to the field of nursing	21	9.55
18.	Lack of proper understanding of creating changes	16	7.27
19.	Lack of any barriers	13	5.91

TABLE 3.
Perceived Benefits of Participation in Health Policy Making by Nurses

No.	Activity Type	Frequency	Percentage
1.	Resolution of nursing challenges by nurses	124	56.36
2.	Nursing independence	115	52.27
3.	Personal satisfaction of feeling of service (building self-confidence in nurses)	109	49.55
4.	Developing the capacity for participation in political activity across all nursing specialties	103	46.82
5.	Sense of fulfilling professional obligations	88	40.00
6.	Realizing individual potentials for initiative	84	36.18
7.	Professional progress	75	34.09
8.	Progress in the job or health policy making issues	74	33.64
9.	Public health promotion in society	72	32.73
10.	Other benefits (e.g., enhanced healthcare quality, safety, risk prevention, and nursing empowerment)	66	30.00
11.	Creating opportunity for new skill building	65	29.55
12.	Communicating with others	59	26.82
13.	Ability to impact the health of numerous people	45	20.45
14.	Lack of any benefit	43	20.55
15.	Contributing to the implementation of individual work plans	30	13.64
16.	Creating changes in people's lives	25	11.36
17.	Helping those incapable of creating changes	23	10.45

TABLE 4.
Associations Between Demographic Characteristics and Participation and Perceived Barriers and Benefits

Variable	Participation (<i>M</i> ± <i>SD</i>)	Perceived Barriers (<i>M</i> ± <i>SD</i>)	Perceived Benefits (<i>M</i> ± <i>SD</i>)
Marital status			
Single	2.70 ± 0.91	5.62 ± 4.52	5.62 ± 5.05
Married	2.82 ± 0.95	5.56 ± 4.09	5.32 ± 4.56
Mann–Whitney test	4117	5845	5970
Z	−1.079	−0.278	−0.009
p	.28	.78	.99
Gender			
Male	2.84 ± 0.72	5.30 ± 4.79	5.73 ± 5.15
Female	2.73 ± 1.00	5.70 ± 4.13	5.40 ± 4.69
Mann–Whitney test	3036.5	3859	4222
Z	−0.773	−1.160	−0.242
p	.44	.24	.80
Work shift			
Fixed	2.85 ± 1.00	6.02 ± 4.69	5.38 ± 4.76
Rotating	2.73 ± 0.93	5.04 ± 4.20	5.37 ± 4.79
Mann–Whitney test	2391	3191	3206
Z	−0.807	−0.554	−0.519
p	.42	.58	.60
Education			
Bachelor’s degrees	2.78 ± 0.95	5.54 ± 4.29	5.41 ± 4.75
Master’s and PhD degrees	2.67 ± 0.54	5.37 ± 4.09	5.06 ± 4.71
Mann–Whitney test	4117	5845	5970
Z	−1.079	−0.278	−0.993
p	.67	.94	.88
Age group (years)			
< 30	2.63 ± 0.90	5.08 ± 3.81	4.63 ± 4.23
30–40	2.77 ± 0.93	5.83 ± 4.45	5.81 ± 4.88
> 40	3.32 ± 1.12	5.64 ± 4.82	5.58 ± 4.28
χ^2	5.045	0.844	2.947
df	2	2	2
p	.80	.65	.22
Work experience (years)			
≤ 5	2.61 ± 0.96	5.76 ± 4.98	4.69 ± 4.55
6–10	2.76 ± 0.92	5.53 ± 3.93	5.59 ± 4.63
11–20	2.85 ± 0.97	5.53 ± 4.50	5.27 ± 5.24
χ^2	2.408	0.192	1.665
df	2	2	2
p	.30	.90	.43

underlined the need for health policy education in health specialization programs in its 2003 report (Heiman, Smith, McKool, Mitchell, & Roth, 2015).

On the other hand, the most frequently perceived barriers to involvement by Iranian nurses found in this study were “Disappointment in work procedures,” followed by “Lack of external support” and “Lack of time.” These findings are consistent with the results of AbuAIRub and Foudeh (2017) and Oden et al. (2000). In another study, understanding the existing clinical concerns and responsibilities;

inadequate time to formulate, implement, or modify policies; lack of a proper understanding of the reasons for and benefits of involvement; and an incorrect understanding of professional boundaries that excludes political development were identified as the most important barriers to the involvement of nurses and midwives in political development (Etowa et al., 2016). Furthermore, other studies have identified lack of supportive organizational structures, inadequate political and policy development skills, insufficient time, lack of resources, and insufficient involvement in policy

formulation committees as key barriers to involvement (Akunja, Kaseje, Obago, & Ochieng, 2012; Cramer, 2002; Kunaviktikul et al., 2010; Richter et al., 2013). Proper management, political authority, and education have also been determined as important factors contributing to the positive resolution of barriers to nursing involvement in the design of health policy making (AbuAIRub & Foudeh, 2017). In Iran, nurses are more involved in caring for patients, and in recent years, the process of hospital accreditation has been increasingly long and burdensome on all hospital employees. This has further contributed to nurses in Iran having little time available for involvement in health policy activities.

The results of this study indicate no significant association between any of the demographic characteristics and nurses' participation, perceived barriers, and perceived benefits. AbuAIRub and Foudeh (2017) found that holding the position of staff nurse was associated with a lower level of participation in health policy. In addition, Vandenhouten and colleagues found that psychological engagement, resources, and recruitment networks explained 55% of the variance in the political participation of nurses (Vandenhouten et al., 2011).

The researchers emphasize the use of research as valid documents for understanding the political trend of nurses, despite evidence indicating that they lack adequate support for producing documents. In low- and average-income countries, nurses tend not to receive sufficient training and lack access to the instructors and resources necessary to undertake research. Thus, there is a great need to increase the research capacity of nurses to enhance their skills in understanding, developing, and utilizing politically beneficial knowledge (Juma et al., 2014). Limitations to political involvement in low- and average-income countries arise from the perceived sociocultural issues involved in the nursing profession (Etowa et al., 2016). Moreover, academic cooperation with national, regional, and international nursing and nonnursing organizations has been shown to be an effective way of promoting nursing commitment to global health research and policies (Gimbel et al., 2017).

Conclusions

Nurses are in a position to significantly assist policy makers and improve the policy-making process. They should play an important role in health policy activities, particularly in light of their large representation on hospital staff rosters. Despite the importance of the nursing role, this study found only moderate involvement by the participants in health policy making. Several strategies are thus proposed to increase nursing involvement. These strategies include defining and promoting a specific career path for nurses as health policy experts, identifying nurses' positions in health and health policy, providing more information to nurses regarding health policies and related laws, promoting a positive perception of the nursing profession among nurses, creating an understanding of the significance of nursing participation in

health policy making among nurses, increasing nursing involvement through the appointment of nurses to high levels of health service management, supporting nursing professional organizations such as the Nursing Organization of the Islamic Republic of Iran to increase the involvement of nurses in health policy making, increasing nursing knowledge and skills by holding retraining workshops with the aim of teaching health policy-making knowledge and skills, and developing incentives for nurses to provide constructive and insightful health policy-making suggestions.

Acknowledgment

This article was derived from a medical-surgical nursing master's thesis written at Islamic Azad University, Tehran Medical Branch. The researchers express their gratitude to all colleagues and individuals who helped with this research.

Author Contributions

Study conception and design: MB, KA
 Data collection: MBS
 Data analysis and interpretation: MBS
 Drafting of the article: MB, MBS
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Accepted for publication: August 2, 2019

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 The authors declare no conflicts of interest.

Cite this article as:

Barzegar safari, M., Bahadori, M., & Alimohammadzadeh, Kh. (2020). The related factors of nurses' participation and perceived benefits and barriers in health policy making. *The Journal of Nursing Research*, 28(4), e103. <https://doi.org/10.1097/jnr.0000000000000385>

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