The Role of Nursing Education & Practice in Assuring

Quality Health Care in Low-Resource Countries

A case study of Kenya

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A&P, nursing skills,
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Dedication

For Shirwil, Winnie and Mariane- My most excellent daughters who have often asked wonderful whys, and why nots. 'You are a special enterprise on the part of God'

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Acknowledgement

First I want to acknowledge and thank all the nurses and everyone else whom I have contacted since the idea of writing this book came to be several years ago. You have been sincere, passionate and for all the right reasons want to see a change in the current situation in health care in Kenya.

I am proud to have lived and worked with all of you. The circumstances encounteredby hundreds of our patients and nurses provided insights needed to understand and describe the The role of nursing and nursing education in Assuring quality health care in low-resource countries health system. I would like to thank all the people in Kenya who shared their time ideas and information that went into this book. It takes a great team of skilled and dedicated people to see a concept and then turn it into reality tthe kind of team I worked with in this project. Their commitment to has made this journey possible.

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I wish state that my insight was sharpened during my PhD Thesis in Medical Education at Moi University entitled: *BSc Nursing Curricula Reorientation to Universal Health Coverage (UHC) Basis: A Primer Model for Kenya*. In that case I wish to extend my unreserved gratitude to Prof Simon Kang'ethe, Head of Deapartment, my supervisors Dr Anne Ng'eno, Dr Franklin Boibanda and Dr. Joseph Choge. The background into nursing leadership in health systems stem from my Masters coursework at The University of Colorado Denver (USA). Thanks to Dr. Colleen Goode, Dr. Joyce Verran, Dr. Gayle Preheim, Dr. Betty Geer, Dr. Swathy Sundaram, Dr. Angela Richards. Dr. Sue Hagedorn, Dr. Roger Reeves, and Dr. Mustafa Ozkaynak. I am grateful for their perspectives and technical expertise. Dr. Amy Barton my academic advisor at MSN level, Lilian Hoffecker, Health Sciences Librarian for facilitating my research. Special thanks to Dr. Gene Marsh, Emeritus Professor of Nursing Moi University, School of Nursing for walking with me and facilitating my studies in a very big way.

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Preface

The proposals concerning *The Role of Nursing Education & Practice in Assuring Quality Health Care in Low-Resource Countries* in this book are not complicated. The buzz worldwide is universal health coverage. We all need to do something to ensure that quality health care becomes a reality everywhere. One of the pillars of the Kenya Jubilee government Four Agendas is universal health care. The other pillars were affordable housing, food security and manufacturing. What is it that nursing and nursing education could do to contribute to this noble agendas? This book is one such attempt. in Chapter 3. For a quick glimple see **Appendix I** to **VI**.

This compilation is borne partly of my exposure to quality issues as an internal quality auditor, my diaries and jurnaling. Some of these have been painstakingly compiled and put together in first person accounts as textboxes. The bulk of these were my experiences in over 27 years and voices from the field of many others serving Kenyans and frankly from common sense. Some formed part of my studies: Masters in Nursing Leadership and Health Systems Administration at University of Colorado Denver and preliminary sections of my Doctoral in Medical Educationat Moi University (See Chapter 3 and 9).

A a student of nursing leadership and health systems I believe I found my niche. I will hardly scratch the surface though I have endeavoured to explain the phenomenon that is quality health care provision in as far as its limit permit. As a nurse educator 'I ensured instructors and the instructed did their bit, and rewarded them appropriately' (modified from the words of from Prof Lukoye Atwoli -my Dean at the School of Medicine, Moi University). I too aspire to have better health professionals.

With some of these insider information I would be one of the health system's perfect positive critics. Hopefully by being high on ideals as well as substance I may not necessarily be an advocate for a particular interest group or point of view – indeed; some of my views elicit vigorous disagreement from health policy, medical education and nursing fraternities. See industrial action crisis in health covered in Chapter 2.

Hopefully, this position was not unique to this author; there is always an option of putting forward our ideas through sharing reflective notes we took along the way, a great deal borne out of disappointment. For many more who served in this caring industry the story is still being written. For the few fortunate ones it is read as they write. *"There are things you perceive as self-evident, they are not always self-evident to everybody…you think there is evidence, you flog yourself to do them…you wonder why people are not seeing this… on a day to day basis there are too many initiatives which are pretty good that do not see the light of day…you record them in your memo and hope that someday someone will see them"*, Prof. Anyang' Nyong'o, during an interview at Harvard School of Public Health on Feb 12, 2014, when he was asked to describe the lessons he learnt as a Kenya's Minister of Medical Services (2008-2013). later served as the 1st Senator and the and Governor of Kisumu County. Kisumu was among the 4 pioneer counties selected for Universal Health Coverage piloting in 2018.

It is easy to get discouraged, be negative, look for who or what to blame or make excuses for not doing our noble duty of serving those who seek our services. In line with these challenges, this book aims to nurture reflective practice, possibly suggest a cultural shift in each one of us even as we endeavour to offer the best service possible to our clients in

the area of our calling. This is because quality health care in resource limited settings has remained more of an aspiration than an accomplished outcome.

In the face of all these majority of nurses were by nature, an unbelievably committed group, driven mostly by a strong sense of personal reward derived from helping sick people. For a good number of them this meant spending every working day in an inherently dangerous and unpredictable environment.

From the outset it is good to state that the ideals stated here may not get us out of the hole we are in as nurses in practice, education, policy etc., but just like a number of others may be a stop gap measure. But, having seen the powerful effect that information has in changing the lives of Kenyans, there was need to share it. In the process however it was unfortunate that social media had assumed the jury and regulator how health system operated. All the more reason why we need to check what's trending on health.

The author introduces new concepts of the care giver, referred to here as *The Compleat Nursing Care Provider* and the *Carelee*: who want to make their life count, make a difference, look forward to a better day, see possibilities, improvise and are innovative. Constantly searching for ways to do either this or that, with the interest of the patient at heart. One who is an expert at workaround: a method for overcoming a problem or limitation in a program or system. Looks around and says - there is always something to use and does not want to look for excuses. Who envisions that there was a greater reward for their efforts and felt that they had value and a destiny. Had a 'Yes We Can' attitude and were fundamentally optimists. Believed in doing their best.

I believe that change is everywhere … but opportunity is here. It is good to add that things are the way they are, not how you would like them to be, unless one makes deliberate effort to change. Use evidence to practice. See Chapters 4, 5, 6, 7. 8.

Mahatma Gandhi once said, "You must be the change you wish to see in the world" and Nelson Mandela's 'The time for change is upon us'. President Obama of US (and in his own words *"He was the first Kenyan - American to become The President of United* States said this concerning change, change will not come if you wait for some other person or some other time, we are the person that we have been waiting for. Hon. Musalia Mudavadi said *'ebindo bichenjanga'* paraphrased from Kiluhya 'never stand in the way of change, it changes'.

On the other hand Dr Geoffrey Griffins (1933-2005), Kenya's renowned educationist and founder of Starehe Boys' Centre said this, "*This world is full of people who do their duty half-heartedly, grudgingly and poorly. Don't be like them. Whatever is your duty, do it as fully and perfectly as you possibly can…*"

For me at this juncture in my career I am more interested in connecting my story with with those of other Kenyans who have ever dread the day they would find themselves in a hospital because a friend, a loved one, or someone they don't know suffered or even died while seeking help.

The perspective adopted in this book is from the vantage point of the largest component of the health care workforce and a critical element of our health care system – the nurses. At some point using every day dialect and paraphrasing where necessary. Anecdotal evidence showed that literally many treatments in hospitals were administered by the nurses who were clearly in control of the milieu.

Every metric on which hospitals (and healthcare for that matter) were evaluated – from quality outcomes; to safety; to patient satisfaction; to staffing efficiency; to medical staff confidence – were dependent upon having a staff of nurses who feel valued on the job. Why, because caring is a value-based concept in the nursing field.

Theoretically, patient satisfaction was connected with nursing care, nurses, and the organisational environment. Quality health care requires a nursing workforce appropriate in size and expertise and unconstrained in its ability to provide patient care safely. Therefore the text focuses on advancing their work in a complex system through leadership and vision.

Given the various stakeholder's concern about nursing care and nursing education in Kenya, the book concentrates on the accomplishments and failures of the system. Though I spent less time on successful features since they needed less attention. A good example the industrial unrests in human resources for health in Chapter 2 and the storm in nursing education in Chapter 9. Nurse workload, nursing politics and outmigration are covered inside this book. Seeing these shortfalls and gaps that exist was easy for most people, but putting this into context was another thing altogether.

According to Oxford Health Systems Collaboration (OHSCAR) – NDM 'inadequate health systems make many existing and potential future health interventions impotent. Nowhere are such effects more apparent than in Africa which continues to post the worst health indicators globally'. Nuffield Department of Medicine (NDM) had helped support an initiative that was working towards strengthening Health Systems Research in Kenya.

It is by recognizing the difficulties in nursing that we can begin to fix its problems. The goal of this book is to help nurses understand the health system so that we can work better in the system and change what needs to be changed. It includes a review of The Institute of Medicine, 2011 report *Future of Nursing* and its application to the local context.

In exploring the many controversial issues facing the health sector, my opinion as the author inevitably colour and shade the words used and the conclusions reached. Some are based on the most fundamental values and perspectives I hold dear to my heart. This is because I believe everyone should stand to benefit from a system in which health care for all is accessible, affordable, and appropriate in its resource utilisation and of high quality.

Any inaccuracies in the book are entirely my responsibility. Any disclosures in this book do not refer to any one particular institution or persons, in any such may be misconstrued as such has been done, I believe with their best interests at heart.

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It is my hope that this book will serve as a guide that inspires change and inFluence nursing policy development process within the context of where it exists by providing uncomplicated direction for the complicated system called nursing care, nursing education and by extension human resources for health. most of the issues explored would also apply to understanding health systems in other low resource countries.

The views expressed in this book are those of the author and do not represent those of their affiliated institutions or organizations or any other organization (s) for that matter.

smk

Simon Macharia Kamau

Nairobi, Kenya

2019

List of Acronyms

AHRQ- Agency for Healthcare Research and Quality

BCAOFR-CS - Best Care Anywhere Organizing Framework for Resource-Constrained Settings

CDF-Constituency Development Fund

CHAK-Church Health Association of Kenya

COBES-Community Based Education & Service

CMNLP-Comprehensive Nursing Practice Model for Rural Hispanics

CS - Cabinet Secretary

EBP-Evidence Based practice

GIZ-Deutsche Gesellschaft fuer Internationale Zusammenarbeit (GIZ) (formerly GTZ)

ICU/HDU- Intensive Care Unit/High Dependence Unit

IOM-Institute of Medicine

ISO-International Organization of Standards

JASEML- Journal of African Studies in Educational Management and Leadership KAEAM- Kenya Association of Educational Administration and Management

KEPH-Kenya Essential Package for Health

KHPF-Kenya Health Policy Framework KQM-Kenya quality Model

KQMH-Kenya Quality Model for Health Kshs-Kenya Shillings, also KES

MOH-Ministry of Health

MDG- Millennium Development Goals NTV-Nation Television

PDCA-Plan, Do, Check, Act PFP-Private for Profit

PNFP-Private Not for Profit

SDG- Sustainable Development Goals

TQM-Total Quality Management

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CHAPTER 1

The General Outlook and Future of Nursing In Kenya

Overview

The role of nursing educaion and practice in quality and access to quality health care can never be overstated. During each patient encounter, the nurse is focused on confirming that treatments are successfully delivered, assessments accurately documented, and medications administered correctly. The quality and impact of patient care depend on safe and effective care delivery as well as quality of training.

The *Future of Nursing: Leading Change, Advancing Health, the IOM* (2011) identified issues and made recommendations related to the scope of nursing practice; preparing nurses for leadership roles in system transformation; development of nurse residency programs; and ensuring nurses engage in life-long learning. The report identified the close link between the future of nursing and the success of healthcare reform. The report looked at the future of nursing in these respects. Sources from American Association of Colleges of Nursing (AACN) indicated that Registered Nurses comprised one of the largest segments of the U.S. workforce as a whole and were among the highest paying large occupations.

According to the U.S. Bureau of Labour Statistics, Registered Nursing was/is the top occupation in terms of the largest job growth projections from 2008 – 2018. Nearly 58% of RNs worked in general medical and surgical hospitals, where RN salaries averaged $66,700 per year.According to International Council of Nurses, in the *area of policy makers*, nursing's aim should be simple – to be a part of this group, to be able to articulate and demonstrate the value of the contribution nursing can make, and be seen as a credible and integral part of the process.

Many times the phrase "healthcare reform" is mentioned but it is exactly what it is by how it affects your nursing practice. There is no escaping this reality. Nursing education and leadership are critical areas that must be developed and sustained for us to be able to surmount these challenges. Nursing has a long and proud history of influencing the development of new policies in order to enhance the health of the people we serve. Hospitals were going to be paid for the value their services produce, not the volume of services performed. This was already happening elsewhere.

From Florence Nightingale to Lillian Wald, to Loretta C. Ford to Ramey Johnson nurses have been active in directing the policies that shaped their practice and their patients. Nurses today are no exception. That is why it is important for us, as emerging leaders, to understand the importance of policy, advocacy and gain some insight into the strategies that can be used to advance a policy initiative. When she was nearing the end of her life, Florence Nightingale said: "May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done."[68]

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[68] Nightingale F. Sick nursing and health nursing. In: Billings JS, Hurd HM, eds. *Hospitals, Dispensaries, and Nursing: Papers and Discussions in the International Congress of Charities, Correction, and Philanthropy*. SectionIII, Chicago, June 12-17, 1893. Baltimore, MD: The Johns Hopkins Press, 1894.

Fig above: The Fast Changing Patient Care Environment (Courtesy of Google images)
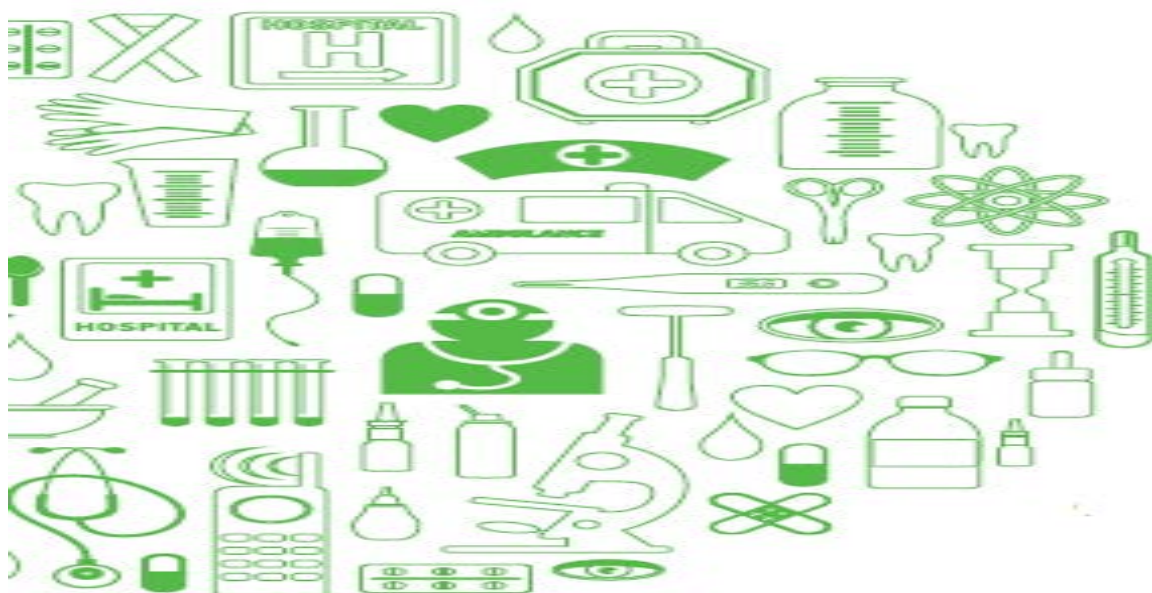(Used with permission)

Fig: Writing a *Future-Now* **healthcare that incorporates nursing education and practice**
[Courtesy of the clip developer]

1.1 Harnessing the Nurses' Voice

In Kenya, registered nurses RNs comprised the largest segment of professionals working in the healthcare industry Nurses make up the largest cadre (over 55%) of the health workforce. They are the initial point of contact for the communities with health care services. Nurses played an important and significant role in promoting positive patient outcomes. Because of this direct effect on patients, nurses must have a constant awareness and a diligent effort to identify and correct problem-prone processes.

But for all the hard work, dedication, and compassion a nurse shows to others, they also need someone looking out for them. In order to help them face the challenges they face, they need representatives in Senate, in parliament, in the counties to help address such challenges from a legislative perspective. The growing focus on ensuring and measuring quality and efficiency of healthcare outcomes necessitates markedly transformed graduate-level nursing education.

According to the Robert Wood Johnson Foundation, nurses are the largest group of healthcare industry workers with the most face-to-face interaction with patients. The Robert Wood Johnson Foundation (RWJF) has made significant and ongoing contributions to ensure that nursing professionals are provided the knowledge and tools needed to deliver high-quality, safe, effective, and patient-centered care. Some of these include Quality and Safety Education in Nursing; knowledge, skills, and attitudes (KSAs) that nurses must possess to deliver safe, effective care; preparing future nurses to continuously improve the quality and safety of the healthcare systems within which they work.

This presents an opportunity for nurses to take a leading role in shaping and improving the patient care experience. One of the challenges the health care system faces in delivering a consistent and positive patient experience is ensuring that employees are on board with established goals and desired performance outcomes. For example, many providers understand the importance of creating emotional connections with patients.

A strong patient-provider connection engages the patient and develops patient relationships that are enduring, promote healing and encourage an optimal patient experience. It has been shown that 84% of healthcare leaders place the patient experience among their top priority. No other health care cadre would deliver on this aspect better than the nurses.

The challenges on the nurse are many and will continue to rise, including emerging technologies and inter-professional rivalries, pressure to give evidence-based care among others. However, other cadres of staff felt the same. Mbindyo *et al.,* (2013) interviewed Clinical Officers (COs) and made the following observation, 'the notion of being 'sandwiched' refers to COs feeling that they were positioned between doctors who had hierarchical authority and nurses who have numerical authority'. Sources indicated that by mid 2017 out of 20,000 registered clinical officers in the country only 5000 worked in the public sector.

Cadres competed against each other, and well they might since not much was being done to address this anomaly. Each new graduate was easily inducted to become part and parcel of the bad game, hence the hegemony each held against the other seemed to get perpetuated somehow. Many a hospital administration usually adopted a laisez` faire` stance on such matters, letting such issues take a natural course. This was a recipe for chaos with each cadre pitting the other, pulling in different directions to the detriment of the entire structure, instead of being driven by a common vision and purpose for the good of all.
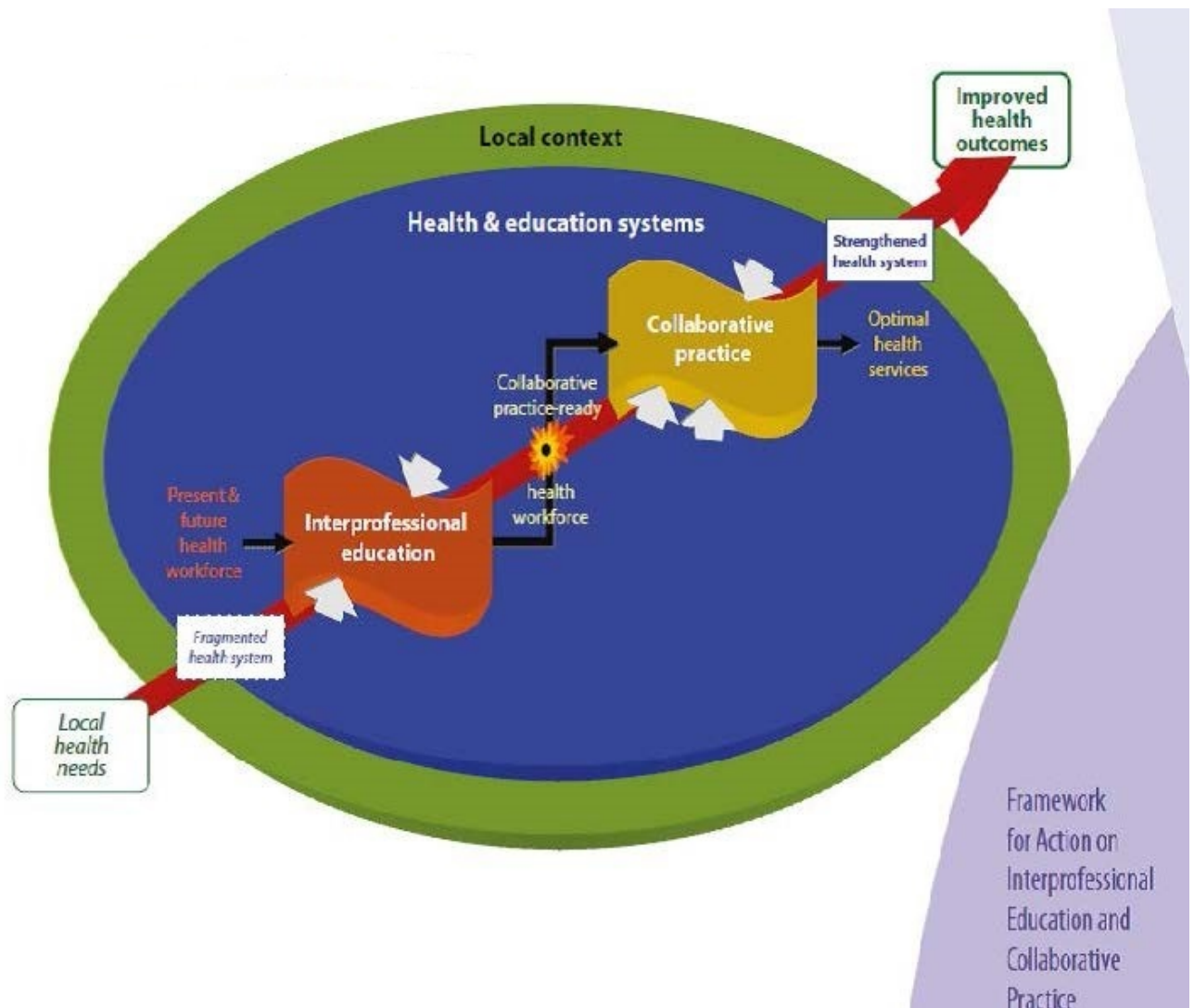
Fig: Bridging the gap in interprofessional education and practice
[Courtesy of WHO 2000]

This author had a discussion with two veterans, a Q officer, and an R officer. They shared some of what they thought were some of the reasons that brought about the differences. There was a lot of unfair competition; the type that some people said *made the sea red*.

Battles of supremacy were gruelling, in one sick bay belonging to a university R was a degree holder actually a job group higher than Q who held a basic diploma. Yet Q was recognized as the section head by virtue of being a Q. In one multi-chain midlevel medical college (s) the glass ceiling was real.

Apparently, there seemed to be an orchestrated effort to ensure that R's did not ascend to level of Principal and that Q's would by default become principals. Despite them commanding a critical mass in terms of faculty and programs, R's usually settled for deputy principals and mark timed there. The trend had been that a paltry number of R's and a few other professionals sometimes would be allowed to become principals whenever new branches were opening but once these centres were up and going they would have to take a backseat or exit. Q's would be the facility heads - period. Their training was usually shorter than R's, it was also common knowledge that Q's were rarely pedagogical scholars or managers by preparation but that did not matter, at least in poorly resouced settings..

A less tedious example but still a source of bitterness was shared one: During their time Q's and R's officers used to do 7 nights duty but while the Q's officers took two weeks off after nights, R's took only one week. Why was this so? The R officer said because *R's liked to oppress each other.* The Q officer, on the other hand, answered *who is this who was going to scrutinize how many offs one got? This arrangement was something that R's were unable to do. Therefore they cannot blame anyone but them.* The Same employer rewards equal work differently, should this be a matter for inter-professional conflict or do we just allow it? In whose interest? Or is it that R's are naïve, fixated in their ways or were plainly a cowardice lot. May be Q's were right and that is how it ought to be for everybody.

During the perennial industrial unrest that faced the health sector in the period between 2013 and 2017, it became difficult to pinpoint exactly where the smoking gun was. What came out as a running theme however were: discrepancies in pay, some called it unjustifiable pay, others discriminatory among different disciplines of staff in the health sector.

An example was cited by one Peterson Wachira, Chair Kenya Clinical Officers Union (KUCO) '… how is it a degree holder (intern) in one cadre could earn 130 per cent over and above a qualified degree holder in another cadre. How?' (6th September 2017 in *The Daily Nation*).

The health disciplines lost a golden chance by failing to iron out once and for all these contentious issues in the passing of The Health Bill Act 2014 which got the president's assent in mid 2017. Much as it was taken back and forth, gaps and even more room for conflicts were created in the bill. May be we need yet another bill?

Infact, the nursing profession has not been able to actualize their collective power. Nursing has not developed into a cohesive, increasingly powerful professional force that could be a partial counterweight to the dominance of medicine in the policy arena, as a formidable power base that is largely untapped in the day-to-day world of the politics and legislation. Nurses sometimes forget that as the largest group of health care providers, they could generate enough power to successfully reform the health care system based on numbers alone.

Abood, (2007) postulated that numbers was one among several bases of power nurses could choose to exercise in advocacy. Powerless behaviors decrease when nurses support other nurses. It would be good to recall that "Coming together is a beginning, staying together is progress, and Working together is success – Henry Ford (1863-1947). http://www.brainyquote.com/quotes/authors/h/henry_ford.html

According to Artz, (2006) involvement of only a fraction of US's 2.9 million registered nurses in even the smallest way could become a force for change for the nursing profession and for the health care system and the patients it serves. Nurses need to be a strong voice actively advocating for positive change.

Nurses cannot afford to remain in the background or added as an after-thought to policy and legislative arenas. Within such a climate the nursing profession must draw on its expert knowledge and experience to improve health care by helping shape effective health policy.

Nurses can strengthen their power base when they network with nursing colleagues and other supporters to build consensus on important issues. Just like one cannot imagine doing research without the internet today so must other matters of professional work life. However, nurses in many parts of sub-Saharan Africa (including Kenya) rarely feel that adequate (International Council of Nurses, 2005).

Nursing can make a major contribution to shaping health policy. Nurses by the nature of their work closely interact with health care consumers in a wide variety of settings. This gives them a broad appreciation of health needs, how factors in the environment affect the health situation for clients and their families, and how people respond to different strategies and services.

Nurses need to occupy front row seats at the point where healthcare policy impacts on patients to protect the health, interest, and safety of the many patients who place their trust in them. Those that are directly affected by a problem should build a capacity to solve the problem.

Not everybody has tested their abilities at advocacy, nor is it everyone who has the facts. We can work together as a unit, where one is certain that what *(not no matter what)* the chairman or secretary general said was an informed collective decision and not their own, that way members can stand their nurse leaders with a conscience.

Advocacy and health policy are a fundamental part of the mission of professional nursing organizations like National Nurses Association of Kenya (NNAK). Kenya Professional Nurses Association (KEPNA), the Kenya Union of Nurses (KNUN) etc. which utilize think-tanks and not the idea of one or two self-styled oligarchs and cartels. Their focus is on the collective interests, values, and status of the profession.

All the more reason why nurses must belong and support these organizations as they facilitate the collective efforts of the individual(s).They require contributive participants (both in substance and ideas) in order to forge ahead, free riding is not an option whereby an individual can benefit from an interest group's efforts without being a member, or at least without being heavily involved. One must make a stand and be ready to support it by any *(not all)* means possible, at least with some decorum and moderation. Remember it's a matter of timing; no force can stop an idea whose time has come.

According to Allen Hays *(n.d)* in an abstract *Democracy papers: The role of special interest groups*, the reasons for effectiveness lie in how a group employs its chief political resources: membership (and more so significant critical mass of actual/potential supporters

and key persons towards a cause), cohesion/intensity, money, and information at its disposal.

Information is the most powerful resource an interest group can have (Hays, *n.d*). They need contacts, insiders; they need to know who the actors are and what the best timing is. For example only a handful of Kenyans are aware or even contribute during public submissions before a crucial bill/budget is tabled to parliament, so even a hundred letters, a flood of phone calls all with the same message can seem like a lot of input (albeit from members of an interest group or from the public orchestrated by it).

If these can have as much genuine grass-root support so much the better. Armed with information it is possible to dramatize a problem. (Hays, *nd*) the link is available in the references.

Carrying everyone along takes time. One has to play by the rules or change the way they play. In the case of nursing issues many stake holders must be accommodated from time to time. These might include market players, investors in health care, insurance companies, professional bodies, unions, training institutions, the central government and the council of governors etc. Advocacy cannot be one directional. You need to ask - who do you need to talk to on this and that issue? Their goodwill in the outset was as good as the outcome.

How you pick up in case of failure of uptake? How do you determine the vibrancy of the uptake? How to disquiet the conflicting voices? Breaking down the complexities become easier since you already have more people who understood the concept. The value of outcome was a derivative of the value in terms of effort.

It was rare that an idea became a hit when very little ground work went into it. It was a process - weaving, soft launching, rolling out and finally controlling the case. Unfortunately, it was often a matter of wanting to jump the gun for many a well-intentioned activists or advocacy groups. They want the results instantly!

A very useful online resource is Community Tool Box had lots of stuff on 'Conducting a Direct Action Campaign' available: http://ctb.ku.edu. Here we are some excerpts from the resource. An interest group needs to learn: that being as organized as possible is key to legislative advocacy, being proactive with reliable ways of deciding on an action, communicating on the action to all those who need to know, being able to mobilize when it needs to be done, carrying out the action in a systematic and effective way.

It is not about a group agreeing on some large issue and then trying to react to (any and all) threats to what they believe in, this would be like harnessing the nurses' voice (knowingly or unknowingly) for the wrong purpose. Hassmiller (2010) a Senior Advisor for Nursing at the Robert Wood Johnson Foundation (USA) asks nurses to:

'Always say "yes" when asked to be at the table. If you believe you're ready but haven't been asked, then ask to be involved in a board or committee of interest'. I have not heard anyone talk about 'Be at the Table". A nurse getting a "seat at the table" has been a long-standing issue for the profession. It became necessary sometimes to fight for space, elbow others in the process. Know how to leverage positions and platforms to demand for their rights. That was why in 2010, a nursing professional practice model (PPM) by American Nurse Association was designed to provide a united voice and a framework for how nursing practices, communicates, and collaborates to provide the highest quality of care.

Serving on boards was a key component for any nurse trying to elevate their career and the profession as a whole, enabling them to make decisions and have a lasting and profound impact on issues affecting nurse safety, patient care and outcomes, and the culture of nursing as a whole

(A Statement by American Nurses Association - ANA Leadership on 13th April, 2017).

Rhonda Anderson, RN, DNSc, CEO of Cardon Children's Medical Center in Mesa, Arizona, "When you are participating as a trustee on a board, wear your RN credential with pride. Your knowledge about patients, your ability to translate patient care systems into financial language, and your ability to focus on how to design future patient-centered systems of care will be [a] significant contribution to that board! Stand up and be proud that you represent the most trusted profession in the country".

A few colleagues shared the following assorted sentiments:

> When I began my career as a nurse (it had been over 30 years down the line), nurses were never asked nor expected to be involved in policy-making. I have been around to see many changes, albeit –I innately think I did not deserve some things to be handed to me rather to actually work to be part of decision/policy making but that did not happen). I can tell you the most successful areas I worked were when nurses stepped up to the table.

People are not going to come to us and ask us information and insight and professional advice and to be involved. *Yes, we can*, *we have to sit at the table!* Nurses need to seek opportunities to serve on a Committee or Board or project of some sort.

Nurses should insist on better stakeholder representation early on though, I do believe we have to eliminate some of the rolls out surprises that we had to wait for fixes on. We can't sit back and be a supporter; we should sit at the table with all the other higher ups or whoever and converse.

"Nursing is a business and it is in the profession's best interest to craft our arguments in a business-like manner" (John Welton Ph.D., RN) as he proposed on *Paying for Nursing Care in Hospitals.* He has done a lot of work nursing care costs, nursing billing, and reimbursement. In his argument, prospective payment system must more accurately represent nursing care. One way was by utilizing nursing intensity billing (Welton, 2006).

When the engineers did the cardiac unit but no patients' toilets, no showers, no changing room. The engineers reasoned, "Because patients don't get out of bed" In one such scenario the cardiac did not have a sluice room, when they were confronted they wished it away they could not find the space. At last, space was found, an odd one though since it was next to the sterilization room, we had to make do with that.

The units were supposed to be opened without air conditioners, the nurses stayed put, they were not moving in without air-cons, period! There had been state-of-art operating theatres that didn't have changing rooms. These are very noticeable errors to someone who works in the area every day (like a bedside nurse). Not any nurse - and especially not the nurse decision makers are very far removed from current unit workflows and practices.

If nurses are not willing to step up and decide what needs to be done, others will. Currently, there are multiple examples of other professionals making rules or passing resolutions to control practice nursing. Moving forward in health care, nurses must be sure they have a seat at the important decision-making tables at all levels to shape policy in national, county government, as well as the workplace and the community (Leavitt, 2009). The policy is a slow process and change doesn't happen that often, so you have to be dedicated to stick with an issue.

At times the most tormenting so-called hospital policies are not even policies at all. Just for instance relooking at turbulence in nursing, was it a written down policy that nurses be surcharged when a patient absconds, again why only nurses?

What of the requirement to record a statement with the police no matter what time day or night it was? What of nurses being deployed to working in the procurement department? Whose interest would they be serving or rather whose interests do they defend and represent? Whose role were they usurping? How would that ensure that the procurement process would be above board?

The public procurement and disposal Act required for public participation, fairness, competitiveness and cost effectiveness among others. It ought also to be clear on who the supplies staff were. Would this not likely lead to the nurse being used to cover up scandals and laxity in the stores? What image were nurses portraying when they did that? How far can they go into other peoples' business, spans of control? Or maybe it is well intentioned as Khoury *et al.,* (2011) Gallup study observed that to improve process efficiencies (some departments; *emphasis mine*) require nurses to provide direction and leadership (see **junks and jewels** below).

Junks or jewels

In one hospital a nurse supervisor admitted that they lacked so many supplies yet the store was full of things! It even had some 3 large containers of goods *which nobody knows what they are;* some have been there for years. Expiry date notwithstanding, in business, you could call them dead stock. Oftentimes their inventory was non-existent. These had come either as donations or perhaps someone ordered them without consulting the users, others the bureaucracy involved in getting them to the user was prohibitive, might have been a syndicate of *white elephant* etc. Whatever it was that caused the phenomena, the fact remains they cost money. One needed to be creative for example - the other day she unearthed model female pelvis, an invaluable teaching aid but only after manually digging through stuff. Some items were good, some just needed batteries others needed repair then they could be issued out.

Apart from the above, there was need for the nursing fraternity especially in Africa to be in a position to make intellectual contribution as leaders. Idea catalysts, thinkers and doers, change-makers, problem- solvers already hard at work. People who can create an atmosphere for curiosity creativity and discovery.

Those unique perspectives by those who can chart Africa's own path to modernity. 'Ideas emerging from Africa have the potential to create a transformative impact not just here on the continent, but worldwide' (TEDGlobal, Arusha August 2017 TED.com). This statement is not a moment too soon. Africa had lately been listed as an exponentially dynamically developing continent, and all eyes were focussed on it

An advert seeking nurses' agenda towards e.g. Sustainable Development Goals should be in a position to receive adequate responses in terms of quality as well as content. Something much simpler - what would they say in an opinion poll that sought their input about future aspirations of nursing?

What of those unbelievable opportunities for nurses that one says - if money was not a problem? Those six million dollar jackpot questions? What of the revered phrase paradigm shift that nurses are fond of alluding to, ever paused to ask what they mean? What has shifted, where is the evidence, what will do so next, can we create that future and how?

These would require transformative leaders in the profession as well as their followers who were nolonger reluctant to invest in personal and professional development. Several investors would be interested to confirm that we have a critical mass (sometimes referred to as think tank) of forward looking resourceful, informed nurses who will make the much needed intellectual contribution. Nurses require an understanding of political context and process to effectively influence policy because content knowledge is not enough.

Back home as long as request for memorandum by legislature continue to receive abysmal

response from the nursing fraternity we cannot make or sustain positive momentum that will take the profession to new heights. How do we keep something ready just in case there was a constitutional moment, a crisis, a disaster, a vacuum somewhere, a breakthrough moment, anything including life in another planet etc. Should we stagger the exceptional potentials we have or explode them?

The reality was that nurses spent an excessive amount of time fixing problems caused by broken and inefficient processes and systems. This was accentuated by the need to interact with so many different departments and services.

While this essentially should allow nurses to spend more time on providing more direction and knowledge while performing leadership functions, this multiple role was unappreciated or did not always pay off as we shall see below. But what with hospitals keeping the nurses' wages low? As one nurse confessed confesed concerning her family domestic budget, '…there were times when I wasn't sure how we would keep the lights on'.

One TV show (date withheld) discussed the crisis at Pumwani Maternity, the Chief Officer Health, Nairobi County and a Member of the County Assembly (MCA)/representative from The County Committee on Health, Nairobi County assumed to know so much about nursing issues that the one member (a nurse) of the panel appeared cornered: while the news anchor/interviewer was after the sensational part, the other two panellists went for a 'blame the victim' onslaught. With all due respect, this nurse panellist tried, and that was commendable. Apparently, there seemed to be much coming his way that he was not expecting or was least prepared.

We should be seeing less of this kind of representation with time as we grow to become more focused and strategic. It is either that nursing gets proper and adequate representation or we reschedule such interviews until an appropriate time.

Of late impromptu press conferences and crisis interviews (some called by 'fire spitting', 'life-threatening', "Bully Pulpit", "flapping in the air" officials) could have derided the image of the profession more than enhance it. This could result in a low trust ranking of information coming from the unions and associations concerning health policies issues.

> I believe there was less one could achieve as a leader by 'cutting off the ears' of those representing the employer, statutory bodies or institutions set by the constitution. Even to those who do not believe in your way, there was need to find a way of passing the same message with less aggression and in a less condescending manner. Be ready and selective as you respond to an opposing argument or controversy in gracious manner was key, do some mental screening process.

> Arguments may not always be won on the basis of what was said, but people watch the how, the manner one responds to those who they disagree with including those who are rude to them without going overboard. They will respect or thank you for expressing yourself in a thoughtful manner. As a result they too were likely to support your effort and increase your reach anyhow without questioning your ability to lead.

There was need for deliberate efforts to uplift the nursing profession rather than add to the hordes of negative stereotypes. Help to deconstruct some of the social order that held nurses down especially in resource limited settings.

There had been concerns regarding the availability of effective leaders physically, symbolically and functionally at the operational, clinical, organizational and national levels that could effectively influence health policy. Moreso union leaders who were willing to listen to and accommodate dissenting views.

The revolutionaries needed to transform their ideas into programs offering solutions after making objective assessments on issues. As one KNUN member posted 'a union is not a cult as to be followed and believed unquestioningly'.

Nursing leadership must be seen to lead the way, must be the indefatigable, hardworking team, an enviable team which is ever energized. Why because they have a lot of nurses looking up to them, some facing very basic challenges in order to deliver care. Some of that care could be injurious to them as well to their patients. Leaders need to keep their part of their bargain.

A professional association or a trade union would likely go down if/when its leaders engage in propaganda, positioning and jostling for positions, horse-trading and politics at the expense of the main focus. It was alleged that some professional bodies were known to be misuse students' leaders by co-opting them into their forums, paying them a 'handsome' stipend, never bothering to know when or if ever they go to class or not. This was not good for the nursing fraternity either. It was unimaginable the kind of feuds and cliques that sometimes run these bodies some in the recent past.

Court injunctions after another almost denied the fraternity of leadership at the nursing council and directorate of nursing levels. Regular services like indexing of nursing students at times took more than a year. It was thought delaying of The Nurses Amendment Bill 2017 was due to prolonged wrangles and vested interests within the NCK.

The nursing council seemingly was not soliciting the views of members before implementing several far reaching decisions. For example on 29th August 2017, NCK issued a circular concerning its online services that would require nurses to pay Ksh 2000 annual licensure fee. Previously it used to be Ksh 2000 renewable every 3 years. Verification fee went up from Ksh 5000 to Ksh 12,000. Such drastic changes needed lots of sensitivity and soul searching as opposed to imposing them on members. How could this happen?

The Registrar NCK sits at the governing council of the nurses association (NNAK) and the chair of the nurses' association sits in the board of NCK. R.D. K on nurses' social media platform *Hiyo sioni nikirenew, wacha niendage Kirinyaga Road*, from Swahili-English I am nolonger going to require renew my license if at all, If need be I can get a counterfeit one it from downtown Kirinyaga Road.

> It was unfortunate that many Kenyans (nurses included) hardly appreciated that the key mandate of boards or council was to protect the consumers and in this case it should be assumed that NCK's function first is to protect the Kenyan public not he nurse, and that is the bitter truth. This was unlike the professional association or union. Nurses should not be offended to see that the three do not always agree to agree, though they all are stakeholders in the interest of self-regulation of the profession. As they say in business the customer is always right, so if forced to choose between the nurse and the patient's safety, the results become obvious. However in poorly resourced settings the consumer was not that empowered, but this was likely to be a thing of the past.

By July 2017, it was alleged that nurses in public service were yet to undergo the SRC-initiated job evaluation. Among the reasons being a court case *Petition No. 51 of 2015* KNUN versus Chair SRC and others (2016) *eKLR*. The ruling was that job evaluation was not to be tied to the conclusion of the CBA. During the over 100 days' nurses' strike of 2017, the open disagreement between the secretary general and the chair of KNUN almost robbed the nurses of proper placement in the job evaluation by SRC.

It was alleged that as a result SRC had deprofessionalized nursing to become graded as semiskilled discretionary nonprofessional's Band 'B' who neither made neither decisions nor contributed much towards decision making. Nothing could be worse than relegating nurses in

Kenya to the margin in terms of recognition and remuneration. However there was a state of contradictory positions concerning the issue. This was not until there was a renewed effort to get a job re-evaluation in September 2017. Hopeful this would elevate them to skilled professional specialist 'B' and 'C' or so.

SRC denied it was not the source of the document in SG's possession. The KNUN chair disowned the document too insisting that a re-evaluation was concluded on 8th September 2017. This coincided with the ongoing industrial action day 98th. While one faction insisted the industrial action was premature and ill-advised since there was no negotiated CBA, the other insisted NO calling off the strike until the concluded CBA was signed, registered in court and implemented as a return to work formula (RTWF). The media had a field day seeking counter sentiments from each faction. As usual they disagreed on virtually everything. On 27th July 2017 in a meeting with the CoG, the factions were requested to leave the venue and agree between themselves first.

About a decade ago the *Kenya Nursing Journal*, probably the only one then in Kenya went out of circulation for a couple of editions. When that was not the case this it was alleged that the journal became the preserve of some of the said leaders 'insatiable appetite to publish on every other page.

One way around this used to be to co-opt one or more of them as 'co-authors'. Side-lining others' contributions could easily have denied the journal its due credit. No explainable excuse whatsoever could justify such an omission on the part of nursing leadership.

The members of public and stakeholders (policy makers included) would be forced to look elsewhere. Perceptions of the NNAK's and KNUN role in the nursing profession may be unclear when one acts like the other. It marginalizes nurses when the only national leadership voice is coming out of unions.

How should nursing in Kenya position itself - more as a profession or as a union? Which one brings food on the table, or it was a matter of survival? – did I hear that? In the view of this author, while KNUN survives (to fight even more battles), NNAK inevitably will become irrelevant. Survival or natural selection/preservation might explain:

> In the **theory of natural selection alias preservation:** *while the strong survived to tell the tale with scars as evidence of the same, the weak perished without a sin attached to their bodies, innocence still running in their veins.*

> *[Darwin & Russel, 1859]*

In any case, nurses ought to on top of things, in control and not be dragged into every other press interview. This was often a catch 22 situation. If other people want to discuss nursing issues they can go ahead and do so, we can always make a rejoinder or rebuttal a negative rhetoric. Though "you can't unscramble scrambled eggs" the price of 'damage control' is something we must be ready to bear, its part of the business in media advocacy.

Knowing how to respond to both the message and its credibility as well as pre-empting and counter argument requires preparation (Staples, A. (2009). Weaving a narrative that was believable was important, but being present in a multidisciplinary panel that ended up belittling the profession was worse (in this writer's opinion).

'Learn as much as you can about the issue you are agitating about, have all the statistics available, both at the fingertips and at the tip of your tongue. If there is a science or political philosophy or history involved you should know it well enough to explain it in an understandable

way to the average person'.

Kingdon (2003) model approach in policy development states that health care advocates must lie in wait for a window of opportunity if they are to be successful in getting their proposed initiatives translated into health care policy. An important problem must be recognized, a viable solution proposed and the problem must have political support. *The research adds a much-needed support for the evidence about the issue. Putting the act together i.e. coalescing the four ingredients then timing* (italics mine), this can be challenge and we may not be that patient. Some bit of testing the waters must be done before *going for the jugular!* There are no shortages of lessons to be learned when this was not done.

The most well-intentioned ideas failed because one or the other may be lacking. Florence Nightingale used coxcomb pie charts during her days and did influence policy in a big way. How would we expect to do better in our days by going for/and with less?

A window of opportunity existed to promote the one year higher diploma programs for both registered nurses and BSNs. It has not been said often enough but it is true that we lack a policy paper that outlines whether or not the diploma will be referred to as Post under-Graduate Diploma (PuGD) for the degree holders and Higher Diploma for holders of basic diploma.

But again they will be in the same class, so? Or can a PG be granted only by a certain institution or does it become one when one had a previous degree? I recall with nostalgia that for a long time, only nurses got an (another) diploma at a post basic level, it seemed the title of a higher diploma was something they neither liked nor deserved. May be the Kenya National Qualifications Framework (Act) 2018, Legal Notice No. 118 was going to streamline these discrepancies once it was effected.

Seemingly only nurses could not finish an ordinary diploma in three years but have to go an extra six months. Why indeed? Out there a Diploma is a diploma. Some take 3 to six months, a year, others two. Few diplomas take longer than 2 years. Apparently, this did not matter to many employers (even when institutions of higher learning were the employing authority). The proposed Act stipulated that a Diploma would be taking 3 years.

This had created anarchy as was alluded to by no less than the Education Cabinet Secretary Dr. F. Matiang'i in May 2017 when he oversaw the drafting of Kenya Qualifications Framework one of the many *Matang'i reforms* in the education sector. He promised this was going to be effected from January 2018. This was going to be a one stop accreditation, teaching, training, testing, assessment and evaluation services for qualifications and accreditations.

It was a disturbing discovery that some health sciences programs have to go for long holidays in order to fit in a 4-year undergraduate program or else because they lack content. One such admitted 'we can crush this in 2 years!' (See **Nurse Practitioner** in below).

The utility value of Higher Diploma and Post Graduate Diploma is not in dispute but we have continued to refer to them as horizontal education. The employers have got the most out of these specializations without commensurate emolument. The nursing fraternity was caught flatfooted with less than the adequate number of specialized nurses in critical care and renal nursing when the government went for starting critical care units and dialysis centres in all the counties, it was all systems go.

In 2013, public hospitals had a capacity about of 88 dialysis per day while by 2017 this had increased to 900 per day. During the same period the number of ICUs increased from 2 to more than 11. (Also see The Role of Nursing Education and Collaborative forum for trainers and clinicians here below).

What about the nursing preparation with leadership and management of health systems. Our institutions continue to be run by nurses and doctors who have little or no idea on how to do it. How have we prepared for these positions coming up in the counties?

With all due respect, it could be understood if we let some of these leadership matters rest but this book is about interrogating health systems in resource constrained settings and issues of surrounding nursing leadership matter a lot.

It was not intended that the interrogation would be in a controlled environment but on things as they were. It would not serve posterity or the purpose of writing this book when we choose to engage in selective amnesia on what had gone wrong in the past and fail to learn valuable lessons from it.

1.1.2 Nursing excellence is possible

There is a need for support towards raising the level of performance for nurses in Kenya. "Identify the best person for the role on a deeper level, and that's the person who's going to truly care and make every patient's experience a memorable one." Theresa Mazzaro, supervisor of nurse recruitment and workforce planning consultant at in Fiercehealth *ebook* (2014).

"What we're looking for and what most of my colleagues are also looking for is the right fit - individuals who understand that working in healthcare is not just about money or prestige or title, but whether or not you are truly committed to what we value. When you do find people with the right behaviors, they tended to be high performers, they tend to be open to change, and they tend to be people who really care about the patient," Burnes Bolton in Fiercehealth *ebook (2014)*.

A large section of this chapter has been devoted to the role of nursing education in quality health care delivery. It ends with **Confessions of a hospital administrator** about nursing the reader cannot afford to miss. Professor Gayle Preheim (who was once my teacher) wrote this in one of her bios 'Nursing leadership, practice and education continue to undergo unprecedented change, it's exhausting and exhilarating!' By networking one can learn a lot and get some tips like MAIDET below:

MAIDET

With some networking, one can learn a lot and get some tips. One of my classmates at MSN shared that in their hospital they have MAIDET which stands for **M**anage up, **A**cknowledge, **I**ntroduce yourself, Duration for how long they will stay, Expectations on what will happen during their stay, and **T**hank you for choosing our hospital.

She emphasized "M" for "Manage Up" meant, in essence, to speak highly of the other members of staff, particularly the one to whom the care of the patient is transferred at the end of the shift. ("This is Susan, who will be looking after you now. She is very experienced and will give you excellent care!"). She added, 'I always tried to connect with my patients but find this is quite a successful tool for me. We also are using the 5 feet - 10 feet rule: *At 10 feet away, you smile, and 5 feet you say something'.*

On 9th Aug 2016 J.S. posted this on KNUN wall ….*making a serious face to avoid questions from clients does not make you any serious. Relax, smile, help people where you can and refer or consult where you can't...*

1.2 The Impact of Emerging Technology on Nursing Care

While myriad challenges and forces are changing the face of contemporary healthcare, one could argue that nothing will change the way nursing care is practiced more than advances in technology. Due to this, some issues are not as clear as they used to be.

Indeed, technology was changing the world at an invincible speed and nowhere is this more evident than in healthcare settings (Houston, 2013). Some likely matters that may already be familiar include Email, social media networking, the internet, cellular technology, text messaging, video conferencing, smart phones, telehealth, and telemedicine. According to e.mozilla.org online life is now a combination of desktop, mobile connected device, cloud services, big data and social interactions.

If we consider social media alone, it is said in academia 'publish or perish' like the proverbial "Ivory Tower" this tower might be getting taller and more out-of-touch than ever. Apart from being scientific, it does not seem right for medical academia to shy away from everyday communication: mass media, social media, and observations. As the world is moving in terms of communication so should those who write. I submit that as far as technology is concerned, the nurses, as well as other health care providers, have to "adopt-adapt-or-perish". There is a seemingly accelerated adoption of social media by health care institutions.

More than 94 percent of the 3,371 hospitals in the US in a study featured in *FierceHealth* December 2014, had Facebook pages and 50 percent had a Twitter account. The study reviewed hospital-related activity on four social media platforms*: Facebook, Twitter, Yelp and Foursquare* (Ilene, 2014; Kamau *et al.,* 2016). Social media platforms give hospitals the ability to respond to patients and collect data in real time, using new portals like Instagram, Pinterest, Digg, StumbleUpon, Snapchat and many that are evolving every day.

There is a likelihood that through the information superhighway consumers will continue to interact with hospitals through social media to exponential levels. From the study just alluded to, most hospital postings on social media provided generic observations or employee-related issues and achievements, which defeated the purpose of the platforms. This author adds that some employees, as well as some disgruntled elements, can pose and post as 'patients' which is most unfortunate. These are matters for weighing and considerations by the nurse now and into the future.

Several emerging human technology interface matters will change the practice of nursing; skills that nurses currently have will need to develop to acquire, use, and integrate these emerging technologies;   nurse leaders will need to integrate this new technology. Some of these technologies include Genetics and Genomics, less invasive and more accurate tools for diagnostics and treatment, Robotics, Biometric signatures, Electronic Healthcare Records (EHR), Computerized Physician/Provider Order; Entry (CPOE) and Clinical Decision Support (Houston, 2013; Ministry of Medical Services, 2014).

This calls for specialization in fields such as MS Nursing informatics. This and every other specialty training that meets the demands of the emerging technologies do not exist currently in

the country. According to NNAK agenda 2015 'Nursing specialization is the best vehicle in terms of identity and to be in tandem with the current specialized care, we shall lobby for increased nursing specialties and posting of nurses according to their specialization to guarantee developments of mentors, consultants'.

Pic: The focus is not on the computer directly, but rather how it helps nurses to enter, organize, or retrieve information.(Courtesy of clip developer)

Growth in robotics, for example, is expected due to workforce shortages, a growing elderly population, and a call for higher quality care not subject to human limitations. It is ironical that even with the serious shortage of nurses in our hospitals, anecdotal evidence showed that currently more than 7000 nurses in Kenya are not in service and plans to absorb them remain unclear.

On January 9th, 2015 the first batch of 170 out of a possible 700 health care providers (drawn mainly from newly graduated and jobless professionals) were airlifted to Liberia where they will work under the African Union Support to Ebola in West Africa (ASEOWA)-volunteer program for 9 months in an ongoing government pledge to help fight Ebola Virus disease (EBV). Ebola had killed about 8000 people in 6 months in Liberia, Sierra Leone, and Guinea. It is also worth noting that Kenya donated Kshs 90 million to these needy countries towards the same.

Pic: A poster by the African Union Support to Ebola in West Africa (ASEOWA)

It is against this backdrop that the likelihood that the use of robots as direct service providers could supplement or perhaps replace nursing in the future might appear far-fetched. Genetic advances are likely to eliminate the need for organ transplants since new organs will be able to be grown from a patient's own tissues.

Pic: Nursebotics (Courtesy of Robotics)

Clinical Decision Support Systems will likely be commonplace in the near future. Nurses then will need to have the knowledge, information acquisition and distribution skills (Houston, 2013). These will be competencies that employers will be looking for. These included ability to meet patients' care needs across the generational divide as will be seen below:

The younger generation consisted the largest cohort demographically. Whenever they became patients it was important for nurses to see them for who they were, that they were more discerning. The best evidence so far accessed by this author was explained in the Clinic 20XX report (Eagle, 2017). This US based study: Designing for an Ever Changing Present reported in Health Facilities Magazine as *designing hospitals for the millennial generation*. Millennial required a different hospital design.

There was need to be change ready and future proof while designing health care for an ever changing present and for the future. A need to adapt to and plan for what was going to happen. In a nutshell a clinic today needed to: well branded, have a Wi-Fi, video capabilities, users portals, mobile phone charging outlets, hospitality elements etc. They would like to switch from workstation, to entertainment, to education with ease even when in the hospital.

In the 20XX report, 62% of millennials wanted to have their health needs met as well as have a good experience as they do so. 54% described their phones as their lifelines as opposed to simply tools of communication, and that they would like to use them to access health care services.

Quality of waiting time was important to them and so was connectivity (both virtually and personal) to both technology and other people including friends and family. They preferred either walk in appointments with less than 30 minutes waiting time or same day appointments.

Nanda Upali Ph.D. observed that 'millenials just want more…love higher standards, so we give them clean, efficient, enhanced experience that exceeds expectations'. For example they preferred a care giver who displayed on the computer, reviewed and discussed health information together with them. Their positive experience included having a family doing a hospital stay with them for as long as possible. This meant providing for family needs in the patient's room.

1.3 Leading Change, Advancing Health: IOM report

The IOM report urged nursing leaders to reconceptualize the role of nurses across the care continuum and design new delivery systems enabling them to practice to the full extent of their education and training.

Nursing represents the largest sector of the health professions. Nurses made up the largest cadre comprising over 55% of the Kenya health workforce (Source: WHO Kenya Country Health System Fact Sheet' 2010). They were generally the initial point of contact for the communities with health care services. In the words of Peggi Winter (2015) in her doctoral thesis University of San Francisco, …nurses work across the continuum of care - from labour and delivery for those welcoming new life to hospice care for those coping with end-of-life decisions. Nurses provide prevention and wellness programs for children and healthy adults and care management for seniors with chronic conditions. Nurses are also found in *most* areas of the organization.

According to the Robert Wood Johnson Foundation -RWJF, (2011), nurses are the largest group of healthcare industry workers with the most face-to-face interaction with patients. This presents an opportunity for nurses to take a leading role in shaping and improving the patient care experience. Healthcare reforms taking place in Kenya from 2014 onwards have not been witnessed before on such a large scale. They give nurses new opportunities to deliver care and play an integral role in leading change.

According to the IOM report (2011), nurses have become partners and leaders in improving the delivery of care and the health care system as a whole. Accessible, high-quality care cannot be achieved without exceptional nursing care and leadership. Although it was difficult to prove causation, an emerging body of the literature suggested that quality of care depended to a large degree on nurses. One such assertion by Institute of Medicine (2011) was that to improve quality and access to patient-centred care it would be important to allow nurses to make more care decisions at the point of care.

Many of the quality measures used over the past few years addressed how well nurses were able to do their jobs such as the prevalence of pressure ulcers and falls among other nursing-sensitive care interventions (Kurtzman and Buerhaus, 2008). National Database of Nursing Quality Indicators which had more than 25 percent of hospitals in the US participating documented more than 21 measures of hospital performance linked to the availability and quality of nursing services.

Participating facilities were able to obtain unit-level comparative data, including patient and staffing outcomes, to use for quality improvement purposes. Comparison data were publicly reported, which provided an incentive to improve the quality of care on a continuous basis (Kurtzman and Buerhaus, 2008).

1.3.1 Teamwork
Teamwork and collaboration are critical to seamless high-quality care. The process begins with understanding the roles and responsibilities of each healthcare disciplines. The understanding and the trust it fosters must start when one joins nursing and medical school programs, and continue as a cultural norm in practice settings.

Healthcare's complexities make it difficult to provide comprehensive solutions across all

disciplines. Managers know that collaboration is a key element in handling intricate and ongoing issues and operations in any organization. An expert panel at the Institute of Medicine (IOM) identified working in interdisciplinary teams as one of the five core competencies for all health professionals (IOM, 2003). These growing complexities make it necessary for more interdependence among healthcare professionals.

An interdisciplinary approach enables persons from different disciplines to share unique perspectives to achieve common goals. Thus, it's important to gain a better understanding of factors contributing to interdisciplinary collaborations. It's also important that factors contributing to successful inter-professional collaboration be understood as disciplines work together to achieve common goals. Literature suggests that stronger collaborative relationships across healthcare disciplines are associated with improved patient safety, quality of care, and outcomes (Lumague *et al.,* 2006).

The manager must also understand the impact that inter-professional collaboration has on job satisfaction and team cohesiveness. Healthcare organizations benefit from effective inter-professional collaboration in terms of more efficient work processes, more satisfied healthcare providers, reduced healthcare cost, and greater responsiveness to healthcare needs, which improves the quality of healthcare and patient management outcomes (Lumague et al 2006).

Sharing accurate patient information, medical records, test results, and care plans among others between healthcare professionals are fundamental to coordinated care. Advantages attributed to inter-professional collaboration include collective responsibility or appreciation for the expertise of other team members, improved communication, cultivation and sustainable collegial relationships between partners, and formation of an effective healthcare team (Peterson, 2014).

To be effective in potentially catastrophic situations that saving lives is, multidisciplinary health professionals depend on their mastery of standardized routines and on complexity communication – spirit of collective mindfulness at its best.

Porter-O'Grady & Malloch (2015, p334) described collective mindfulness as the capacity of groups and individuals to be keenly aware of significant details, notice errors in the making, and have a shared expertise and freedom to act on what they notice. They listen intently and with full presence, question for clarification and intervene as a finely tuned unit. The lack of concerted effort and teamwork could be detrimental to the health of the nation including fighting cholera.

Team work skills

Patient safety experts agree that communication and other team work skills are essential for providing quality health care and for preventing and mitigating medical errors (AHRQ http://teamstepps.ahrq.gov/). The nurse must function effectively within nursing and inter-professional teams fostering open communication, mutual respect and shared decision-making to achieve quality patient care. This testimony was shared by a nurse concerning team work.

According to AHRQ, both nurse and physician change champions are important. However, this author observes that in resource-limited settings without physician support the effort is less likely to succeed, they are clearly in control of the milieu since they are the leaders and control resources in health care system.

The following notes were gleaned from Quality and Safety Education in Nursing (QSEN):

Function competently within the scope of practice; Solicit input from team members to enhance own and team performance; empower others to contribute towards betterment of the team performance; Support evidence contributed by others.

Offer leadership and guidance as necessary in collaborative care; Initiate and sustain partnership; Manage overlaps in roles played smoothly; Appreciate different communication styles and differing views; Assert own perspective as necessary as patient's advocate; Acknowledge own strengths and weaknesses, contributions to effective or ineffective team functioning;

Respect the unique attributes that members bring to a team, including variations in professional orientations, competencies; Implement care as agreed upon by the team. Identify barriers to teamwork e.g. by discouraging hands-off approach to patient care if observed among the team or not showing respect to the centrality of patient/family as core members of the health care team.

Communication is a vital part of teamwork. The SBAR is a powerful tool that is used to improve the effectiveness of communication between individuals and teams. SBAR stands for Situation, Background, Assessment, and Recommendation (Response is). The Institute for Healthcare Improvement (IHI) contains useful tool kits on SBAR. http://www.ihi.org/resources/Pages/Tools/sbartoolkit.aspx.

IHI graciously had made them available for free and focusing on the greater good which is patient safety. These are great for resource-constrained settings. SBAR promotes quality and patient safety, primarily because it helps individuals communicate with each other with a shared set of expectations.

Staff and physicians use SBAR to share patient information in a clear, complete, concise and structured format; improving communication efficiency and accuracy. It is easy to use and can help your staff learn the key components needed to send a complete message! Here is how SBAR works:

• *First*, quickly organize the briefing information in your mind or on paper using the four elements (Situation, Background, Assessment and Recommendation) in sequence. Only the most relevant data is included, and everything irrelevant or of secondary importance is excluded.

• *Second*, present your briefing. Since team members can immediately recognize and understand the familiar, predictable SBAR format, you help them more efficiently and effectively address a situation or solve a problem.

• *Third*, they may confirm, clarify or enhance what you've said, then work with you to take the required action.

SBAR increases overall operational excellence, creates an environment in which a team can work together more effectively and, most important, improves the safety of the patients they serve. One of the ways SBAR does this is by creating a shared mental model that ensures members are on the same page. SBAR also requires you to speak frankly and openly with others, regardless of their position in the organization. SBAR has been found very useful daily on inter-shift/transition handover.

 Team redefined: In their book, *The Wisdom of Teams*, Jon R. Katzenbach & Douglas K. Smith define a real team as a small number of people with complementary skillls who are equally committed to a common purpose, goals and working approach for which they hold themselves accountable.

Here are two examples illustrating the components of SBAR: **SBAR Example 1**

The following is an example (using fake names) of admitting nurse call to the primary doctor using SBAR:

> *'This is Muthoni Daisy, ICU nurse Cardiac Care Centre, I am calling from Compleat Healthcare Hospital about your patient Josphat Kiplagat.'*

Situation: Clearly and *briefly* define the situation. For example,

> *'Mr. Kiplagat a readmission had multiple prescriptions of Warfarin, Heparin, and Clexane at various points during his last admission. I am not clear as to which ones he is supposed to take now.'*

Background: Provide clear, relevant background information that relates to the situation. In the example above, you should consider including the patient's diagnosis, the prescribing physicians, and the dates and dosages of the medications.

Assessment: A statement of your professional conclusion.

Recommendation: What do you need from this individual? For example, 'Please clarify which is the correct dose of Coumadin for Mr. Kiplagat to take and how we should carry on managing his anticoagulant therapy?'

SBARR 2
In order to make sure what is meant, said, heard and understood is all the same message use a structured communication such as SBARR. In addition to the SBAR discussed above, there are 2 R's last R stands for Response. SBARR is a structured communication process that delivers key information in a format that catches the listener's attention. It communicates the current situation or status, relevant background information; current assessment of what you think is happening, and your recommendation for resolution or action. The listener is expected or requested to respond

The following is an example of a nurse call to the primary doctor using SBARR:

> *"Dr. Mutai, this is Joan Maina Orthopaedic nurse, I am calling from Compleat Healthcare Hospital about your patient Josephine Awuor."*

Situation

> *"Here's the situation: Mrs Awuor is having increasing dyspnoea and is complaining of chest pain."*

Background

> *"The supporting background information is that she had a total hip replacement two days ago. About two and half hours ago she began complaining of chest pain. Her pulse now is 124 and her blood pressure is 130 over 55. She is restless and short of breath."*

Assessment: *"My assessment of the situation is that she may be having a cardiac event or thrown an embolism."*

Recommendation

"I recommend that you see her immediately and that we start her on O_2 stat. Do you agree?"

The response is:*I need you here right now. When can I expect you?*
   [I also found ISBARR shared below very useful. Shared with permission]

ISBARR

with Cate Mimi 11:36am Jul 11, 2018

G M has suggested that I share this with us [THE KENYAN NURSES FORUM]. Okay then, if you have additional information, please do feel free to comment here so that we update each other.

It's about referrals. There is this general discontent at how we handle them. Both from referring facilities and also receiving facilities.

Now, there's this small little thing called ISBAR. It originated from SBAR used by NAVY SEALS of Uncle Sam.

Saasa, this tool was used to communicate critical information about ships and the storms and all that stuff to their headquarters. Or the guys who control ships. Kitu Kama hicho.

We, the medics, adopted it so that we are able to transmit information from one person to another, very briefly and concretely.

Let's stick to **ISBAR**

I. Identity.

------>identify yourself please and where you're calling from. BTW Ebu stop that kathing of, "this is W hospital calling... "There's nothing like that.

It's always, "This is Nurse Cate calling from W hospital... " Sawa wapenzi? Asante.

S. Situation

---->Why ate you calling. It's like starting to eat with dessert instead of starter. Ok, that's complicated, ignore it. It simply means I am calling to refer a 60 year old old DM patient with Acute Kidney Injury (AKI) "

B... Background

---->Brief relevant history.

Let's try... "Patient was newly diagnosed with DM type 2 .Admitted last evening with severe abdominal pains. The urea is 30mmol/l, Creatinine 1000umol /l. The potassium was 6mmol/l but we have already

donebinding..... Plus anything else you feel is relevant to that case. Just the essentials please.

----)This means hata Kama umeitwa from leave upeleke referral, please insist on knowing that patient well.

At least the basic. Sindio my frens? Sande yesu.

A... Assessment.

---->What is your take?

Patient has been diagnosed with AKI

Or APH or whatever else that you've dagnosed.

R... Recommendation.

--->in short, what do you want to happen? Or what's your idea on what should Happen? ...therefore, we

are referring him for hemodialysis.

Isn't that simple? Then don't hang up. Please let the receiving nurse ask anything they want to get

clarification upon. Kindly receive any further instructions. Implement it you can. If you can't let them know

you can't.

In all that, you've helped that patient.

Happy Referring and Receiving Experience to you, and me.

[Shared with permission from Cate Mimi]

The US Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) dedicates a full website offering free tools to enhance team performance in healthcare. Here is another powerful solution to improve patient safety within the organization. It is an evidence-based teamwork system to improve communication and teamwork skills among health care professionals: http://teamstepps.ahrq.gov/. TeamSTEPPS is the result of over 25 years of research and development, with core components of leadership, communication, mutual support, and situation monitoring. TeamSTEPPS provides higher quality, safer patient care by:

- D Producing highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients.

- D Increasing team awareness and clarifying team roles and responsibilities.

- D Resolving conflicts and improving information sharing.

- D Eliminating barriers to quality and safety.

This author recommends to the readers to familiarize themselves by first getting a quick, then a comprehensive overview of TeamSTEPPS (it has been mentioned in various contexts in this book). If you have interest and time permits, take a look at the *Tools and Resources and also Implementation Stories*. This will give you ideas for relevant to your professional work setting, role, and communication goals.

It is also good to state here that even within nursing fraternity we are still talking about a team. The great thing about nursing is that you are an individual within a team, as a nurse you still very well be successful and influential member of your team and also collaboratively.

Though often working collaboratively, nursing does not "assist" medicine or other fields. Nursing operates independent of, not auxiliary to, medicine and other disciplines. Sometimes one wonders if the word collaboration exists in other disciplines as much as it does in nursing.

For instance, a chief medical officer interviewed in (Khoury et al., 2011 Gallup study) had done a literature search of the term ''collaboration.'' He asserted that all such references were in the nursing literature and none in the physician literature. Could this be the problem, so that collaboration is not emphasized in other disciplines? This might be creating a lot of barriers for those trying to reach out.

Nurses' roles ranged from direct patient care and case management to establishing nursing practice standards, developing quality assurance procedures, and directing complex nursing care systems (American Association of Colleges of Nursing- Fact Sheet).

May be that is what Boyle (2011) had in mind when she stated, "As a clinical nurse specialist, I poignantly and repeatedly counter any depiction of my practice as being an extension of a physician or a mid-level anything. I am a nurse with a distinct set of skills and a hard-won, highly specialized graduate degree, and proud of it. Don't ever call me anything but a nurse".

A vital part of leadership role in the new age of health care involves working through the differences between professionals and building mutuality as a basis for preventing unnecessary conflict and resolving unavoidable conflict when it arises. Team based and continuum driven approaches to service place a great deal of emphasis on who people are rather than simply what they do (Caspers & Pickard, 2013). In times of rapid change, stress levels escalate, conflicts rise, and people's ability to collaborate breaks down.

That's bad news for quality patient care, safety, and satisfaction, and it could be bad news for an organization's very survival. Right now we need employees to be fully engaged and zeroed in on

SBAR should be used when giving patient information between primary caregivers regardless of discipline.

The pertinent information that can be included will fit in the four elements of the S-B-A-R.
Situation is a brief description of the most recent clinical updates of the patient status, for example, a most recent procedure or test done, current condition of patient, the most recent medication given prior to transfer.
Background is any information regarding familial or medical history of the patient that is pertinent to current care and patient condition.
Assessment is the information on the latest findings that reflect the most recent clinical status of the patient, that is, vital signs, blood test levels, devices, appliances, equipment that is being used, current mental state etc. The staff that is taking care of the patient must review the information with the other staff that will continue giving the care.
Recommendation is the information for future activities, assessment or monitoring of the patient, for example, the frequency of vital signs, any monitoring to be done or discharge plan.
The use of S-B-A-R is convenient and systematic. It is clear and simple. It should be used in all situations and all aspects of patient care.
(Source: AMREF RN- Bsc.Nursing upgrading Notes, Unit 6 on *Fundamentals of Nursing*) authored by Jostine Mutinda
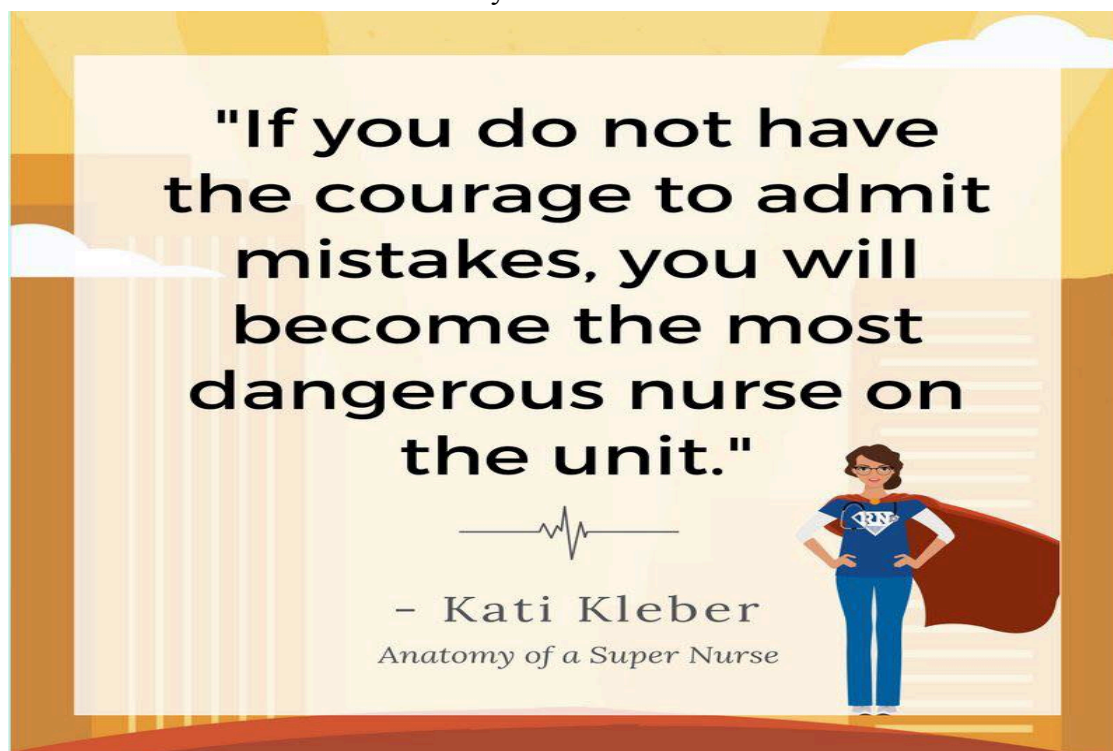
Mural -*Anatomy of the super nurse-* Courtesy of Kati Kleber

working together to get patients well and keep them happy. We simply can't afford a culture of conflict. But disputes are bound to happen. Throw in stress and the high stakes nature of healthcare and you can guarantee that conflicts will arise. The good news is that we can learn the skills to resolve conflicts and strengthen our organizations while we do it!

A variety of resources were available on conflict resolution. It may not be as simple as ABC of crucial conversations where:

   • <u>Agree</u>. Agree when you share views;

   • <u>Build</u>. If others leave something out, agree where you share views, then build;

   • <u>Compare</u>. When you do differ significantly, don't suggest others are wrong.

Compare your two views. Some work specific to health care has been done. The Exchange Strategy for Managing Conflict in Healthcare was done by Steven Dinkin, Barbara Filner, Lisa Maxwell (2012). Here are five tips for managing conflict from The Exchange Strategy:

   1- <u>Respond,don'treact</u>. Put a pause between action and reaction, especially an emotional reaction!

   2 –<u>Choose the right leader</u>. Make sure the parties aren't 'infantilized' by a leader who's too far above them.

   3 – <u>Listen</u>. Ask an open-ended question, and then stop. It can be as simple as, 'So, tell me, what's going on?' You'll know it's time to insert yourself again when the discussion turns negative.

   4 –<u>Use and encourage positive language</u>. Think before you speak. Use positive, easy-to- understand language. And remember, it's a conversation, not a trial!

   5 – <u>Build trust</u>. Trust can't be demanded. Be sure to ask how each party is affected by the conflict, and, secondly, what each person really needs.

1.3 What roles can nursing assume? Some begging questions

   D   What roles can nursing assume to address;

   D   The increasing demand for safe, high-quality, and effective health care services?

   D   Nursing challenges existing in the management of chronic conditions, primary care (including care coordination and transitional care), prevention and wellness, and the prevention of adverse events (such as hospital-acquired infections)?

   D   The increasing demand on nursing for better provision of mental health services, school health services, long-term care, and palliative care including end-of-life care? (Institute of Medicine, 2011).

   D   Much of health care comes down to what value nurses represent relative to other players in the system. As a profession, we need to get in the game and be better at validating all the incredible work we do. We need to be sure the quality data shows our collective value to patient outcomes. Nursing is a service and nurses are vital revenue generators. Economic invisibility of nurses will not do any more.

   D   Nursing was generally considered a "cost" rather than revenue in a hospital context, which makes nursing a constant target for cost reductions.

Conventionally nursing services fixed salaries provide poor incentives to exert effort. Hourly rates could be better but may be, only may be. At best care is billed together with the room and hospital services (much like an expense) rather than a specific care provider fee based on nursing intensity (plus direct and indirect nursing service).

The payment system must more accurately represent nursing care. This would serve as an incentive to the nurses to give better care. Institutions would see the need to hire more to sustain the same or better care (Welton, 2006). John Welton contributing to policies and politics in health care forum proposed how this could be done an article - *Paying for Nursing Care in Hospitals.*

D There are already measures used to rate the provider's performance used elsewhere in the world and nurse could stand to gain a lot if it were to be implemented. This ought to be cost effective either way. Nurses ought to bill and be reimbursed for the service they provided. Today, in response to variations in the quality of health care and rising health care costs, many policy makers and purchasers of health care services are exploring and promoting pay-for-performance (P4P) or value-based purchasing (VBP) systems. The American Nurses Association (ANA) had guidelines on the same.

A mural depicting the invaluable role of nursing (Courtesy of Scrubmag.com)

Nursing brings to the future a steadfast commitment to patient care, improved safety and quality, and better outcomes. Nursing inherently has traditional and current strengths of the profession in such areas as care coordination, health promotion, and quality improvement. Health care reforms provide opportunities for the profession to meet the demand for safe, high-quality, patient-centred, and equitable health care services.

IOM believed that nurses have key roles to play as team members and leaders for a reformed and better-integrated, patient-centred health care system. It assumed that nursing could fill new and expanded roles in a redesigned health care system (Institute of Medicine, 2011).

According to Hassmiller (2010), there were nine challenges that individual nurses and the nursing profession must address if we are to help lead a healthcare system that was more equitable and provided a higher quality of care. This chapter has in a fairly loose manner tried to address some of these challenges (See **flowchart** below):

To take advantage of these opportunities, however, nurses must be allowed to practice in accordance with their professional training, and the education they receive must better prepare them to deliver patient-centred, equitable, safe, high-quality health care services. Additionally, they must engage with other health care professionals through positive partnership to deliver efficient and effective care and assume leadership roles in the redesign of the health care system.

As nurses become more expensive to hire and maintain employers will need to rethink how they use their nurses; working conditions and approaches to increase nurses' productivity. They will need to use them in higher skilled tasks and delegate certain housekeeping and other tasks currently performed by nurses to less trained personnel. Higher wages and new roles would make nursing a more attractive profession (Feldstein, 2011; pp327).

Flowchart on Nurse's role in reforming healthcare

(Adapted from Hassmiller, S. (2010). Nurses role in healthcare reform. *American Nurse Today*. *5*(9): 68-69   www.AmericanNurseToday.com).

This sort of awareness would require changes in nursing scopes of practice, advances in the education of nurses across all levels, improvements in the practice of nursing across the continuum of care, transformation in the utilization of nurses across settings, and leadership at all levels so nurses can be deployed effectively and appropriately as partners in the health care team.

In addition, ensure that the nursing workforce has the necessary capacity, in terms of numbers, skills, and competence, to meet the present and future health care needs of the

public. These were recommendations for an action-oriented blueprint for the future of nursing, including changes in public and institutional policies at the national, state, and local levels (Institute of Medicine, 2011).

Charging for nursing care (Courtesy of the clip developer)

According to AHRQ available at (http://teamstepps.ahrq.gov/), change may involve giving people freedom and discretion, encouraging risk taking and speaking up, giving permission to find team-driven solutions.

The United States passed Legislation in March 2010 which would provide insurance coverage for more Americans. The 'Obama Care' Affordable Care Act 2010 officially called the Patient Protection and Affordable Care Act (PPACA) is a US law that reformed both the healthcare and health insurance industries in America. It mandated that everyone who could afford to must obtain health insurance by 2014 or get an exemption, or pay a penalty.

The law increased the quality, availability, and affordability of private and public health insurance to over 44 million uninsured Americans through its many provisions which included new regulations, taxes, mandates, and subsidies. Such laws had the opportunity of transforming the (US) health care system to provide seamless, affordable, quality care that was accessible to all, patient centred, evidence based and led to improved health outcomes. Achieving this transformation required remodelling many aspects of the health care system; this was especially true for the nursing profession.

Delegation

To help nurses it would be important to think outside the box in the area of delegation. Applying some of the principles of delegation or even outsourcing strategies that were rarely mentioned by most sources include: why should the nurse delegate? When delegating tasks to others goes from being helpful to beingnecessary.

As a nurse, start to think about the things that you don't have to do yourself. If possible, start with the things you least enjoy doing. I believe there is a whole list that nurses could come up with. Kamau (2014) conclusion in an inventory study into the nurse manager's job description '…offered an even wider scope with seemingly never-ending expectations on the nurse manager. This ironically left the nurse manager with 'no job' description so to speak'. May be this was because their job was difficult to describe.

Start to think about things you could potentially delegate. If it potentially will take somebody else less time, save you from headaches and the stress than if you did it - delegate it. Ultimately, if it will cost you less to delegate than doing all the work yourself - take the plunge, delegate it! Do not be surprised if you discover later on that this was one of the best decisions you ever made. The best fit of a delegate

would be to get one who was a clone of self which was not practical. Nevertheless, a best case scenario could be the satisfaction one got when they did not have to do the task all over again after delegating. The more specific the directives and the more empowered your team to function independently, so much the better.

It is not true that someone else cannot be trusted or become experienced in some perceived routine, mundane 'nursing and non-nursing' tasks that essentially drains the nurse's energy and time leaving less and less time for professional therapeutic nursing care. Nurses had taken it as a badge of honour to be jack of all trades 'you know the nurse is blah blah… the backbone of the health system'. Remember they too have a back that tends to ache terribly as a result. To keep your sanity and livelihood, setting boundaries and restraints is a must. Why should the nurse do unnecessary work, so many hours a week when they could work less and be just as productive, if not more?

Nurse as fulcrum is covered elsewhere in this chapter.

The IOM report 2011 offered recommendations that would collectively serve as a blueprint to a possibility of strengthening the largest component of the health care workforce - nurses by:

(1) Ensuring that nurses could practice to the full extent of their education and training,
 (2) Improving nursing education,
(3) providing opportunities for nurses to assume leadership positions and to serve as full partners in health care redesign and improvement efforts, and
 (4) Improving data collection for workforce planning and policy making.

Donna Algase (2013) an editor for Research and Theory for Nursing Practice: An International Journal shared her experience being nursed herself, '... in my nursing heart of hearts, I know it could be even more spectacular and effective if the nurses actually were "all that they could be."' She also alluded to the Institute of Medicine (IOM) report on the future of nursing that advocated that nurses be prepared to take more of a leadership role in designing and delivering health care in an inter-professional model.

According to Dickson & Flynn (2010), the nursing profession could influence policy development because it had (a) the capacity of science to produce evidence (b) the political savvy to use the evidence, and (c) the numbers to ensure that their perspective was heard. Nurses were the biggest factor in providing better care, this was according to FierceHealth *eBook* (2014) entitled 'How Hiring Right (Or Wrong) Has a Direct Impact on Clinical Outcomes'.

The *e*Book examines top nurse staffing challenges and how to overcome them. It also noted that when experienced nurses leave, hospitals must hire less experienced or temporary contract nurses, leading to poor patient outcomes. Nursing staffing issues have been covered elsewhere.

So far it is my hope that nothing exceeds the passion for ensuring that the individual care provider (in this case the nurse) does not fall through the cracks as we expand on the views. The individual care provider one moving target managers of health care in Kenya must keep an eye on. That is why I would propose that our health care systems adopt strengths-based approach in management. In a nutshell 'The Basics of a Strengths-Based Management Approach' according to Burger, Hoogerhuis and Standish (2014) include:

- Understanding and appreciating each employee's unique talents. Appreciation is the expected currency for doing a job well. To build an engaged and optimized team, managers first need to discover each person's talents, style, goals, needs, and motivations.

- Identifying the tasks and activities that each person does best. With an understanding of <u>what each employee does best</u>, managers can use individual contributions to building a stronger team. Emphasis is going into an outcome-

based health care system. It is more of effectiveness and not just efficiency (see **Campus siege** below).

Help employees understand, appreciate and invest in their unique talents. The better the managers do these the more they can help employees apply their dominant talents, and the greater each person's and the team's potential will be to consistently act with confidence, direction, and excellence.

According to Gallup Report entitled '*Managing for strengths'*: Employees who used their strengths every day were six times more likely to be engaged in their jobs (early, continually and throughout) and their engagement level affects how they care for patients. Employees unite as a team, everyone has their talent and their focus area, and all employees know how they contribute to the team to meet a clear and compelling performance goal.

There is this utopian thinking that crossed my mind as I internalized the managing for strengths concept: - There is no better way to find good staff than networking. Therefore it is possible to say then there be no better and more concrete networks than the networks that are built through collaborations. I know companies that bring together such talents, bringing in independent contributions to joint efforts. They are hubs of success. There are people who come together to create empires. How about making this a culture in everyday life in the workplace?

Employees have a better understanding of one another, are more collaborative and intentionally structure tasks and responsibilities to maximize the team's talents, utilizing paths of least resistance. Leaders and employees identify by the "the end of the game" who could manoeuvre what best (Burger *et al.,* 2014). When one gets involved in something that they feel they can make a difference it can mean so much to them as well as to those they serve. "We go out of our way to spotlight people who go above and beyond their job description and really call out the truly amazing caregivers that we have," Theresa Mazzaro in Fiercehealth *ebook* (2014).

Clearly, among the factors that helped providers to be optimally productive, clear performance expectations set forth in an accurate and up-to-date job description are important starting points. Daniel Ndambuki alias *Churchill* one of the most inspiring personalities and comedian in Kenya today pointed this out '… keep on doing what you are good at and with time everything will take care of itself…. Do it and go home saying there is no job like it?' Celebrities were useful in running voice overs in *jua-jijue-jipange* Maisha (paraphrase from Swahili for: get information, know your status, plan your life) HIV/AIDS campaign.

Considering how emotional elements affected patient experience, this finding by the *Gallup Consultants* was uniquely significant to leaders in healthcare. Jeff Burger, a Managing Consultant at *Gallup* asserted that managers who made strengths the backbone of their management approach could tap into employees' innate power and potential, helping them improve speed and productivity, resilience and growth, longevity and attendance, and innovation and precision.

Working from their strengths also could help increase employees' passion for their work. Across all departments and roles, strengths-based management helped build teams that performed optimally and contributed to better patient experiences.

I want to add here that it is not just about talent but people with a great attitude and were hard workers. Even in the music industry, many admit that talent accounted for 15% or less in terms of success. Stephen King might have observed this when he said, "Talent is cheaper than table salt. What separates the talented individual from the successful one is a lot of hard work."

Porter O'Grady and Malloch (2015) added that what is needed in health care is time for reflection and contemplation of ideas and issues. Experts agree that pay is not the chief motivator for productivity, but in general, employees desire to do meaningful work most of all, next they desire opportunities for collaboration through group decision making, then they want equitable pay. All human beings have a need to express their uniqueness and their talents in the work they do and be recognized for their contributions.

Oprah Winfrey was quoted saying that *"the way to make people happy is to find out what they want by asking them ..."* She added. It would be unfortunate to assume that you know what people want and how they want it without asking them to give you specifications. *"Feel the power that comes from focusing on what excites them."* Oprah is an influential book critic, an Academy Award-nominated actress, and a magazine publisher. She was ranked for 3 straight years the most philanthropic African American of all time. Here is one last quote from Oprah: "Doing the best at this moment puts you in the best place for the next moment." Don't waste those moments.

According to Standards of Nursing and Practice for Nurses in Kenya (NCK, 2012), the nursing profession (education and practice) in Kenya is geared towards Constitution of Kenya 2011, the nurses (Amendment) Act 2011 that have impact on health care delivery; An enlightened clientele with ever increasing demand, technological and scientific advancement in quality nursing care; Expanding roles of the nurse globally; aspirations to meet the Kenya Vision 2030, Sustainable Development Goals(SDG's), Agenda Africa 2063; and local, regional and global development blueprints. Health care also continues to shift beyond the hospital to more community-based primary care and other outpatient sites.

Campus Siege

A group of 4 gunmen members of Al-Shabab terrorists attacked Garissa University College on 2nd of April, 2015 and senselessly killed 147people (142 students and 5 members of the disciplined forces), 104 injured (91 of them critically). The gunmen had engaged policemen and Kenya Defence Force (KDF) in a standoff for more than 9 hours. Although KDF responded swiftly they were clueless on how to handle the situation as the wanton killings continued inside the campus.

It took the Recce Squad commandos less than 17 minutes in a sting operation to neutralize and end the siege. The combined effort rescued over 500 students. It was alleged that the Recce Squad came by road for the 6 hours journey that would have taken 45 minutes by air. All this time 4 helicopters were neatly packed at Garissa Airstrip, some from 10 am (2 belonging to local politicians, one had come with the Cabinet Secretary and the other one with the Inspector of Police. It took several hours for a chartered plane to come from Nairobi to evacuate the critically injured for further medical treatment.

It was alleged in Parliament in a debate that followed that the designated plane was not at hand to ferry them although they had set out at dawn for the offensive. Only 4 out of 11 Police Air wing planes were operational. Ironically, the Cabinet Secretary Internal Security and Inspector General of Police had been flown in several hours earlier. Each of the Recce Commandos was paid Ksh500 as Lunch Allowance. The tragedy attracted a lot of reactions worldwide and trending on social media overflow in response to how the situation was handled.

In an interview, later on, the Principal of the College said that although they had been on high alert for some time and requested for something to be done about university security, nuances on a possible terrorist attack that day were treated as April 1st 'Fool's Day' pranks by many.

As to why the attack happened despite clear warnings (which were treated with a dismissive attitude) remains a begging question. Since then, public servants including teachers and health care providers have fled the region, aggravating an already resource-constrained health care setting.

Source: [Motion For Adjournment Under S.O. 33(1) Garissa University College Terrorist Attack. Kenya Parliament Proceedings, Debate 14th April 2015, *The Hansard*, Electronic Version, Supplemented by *"Children of a Lesser God."*]

Kenya was generally an early adopter of different policies, and interventions meant to improve health services. As a result, many highly effective interventions have been introduced, affecting health outcomes (Kenya - Situation Analysis, 2012). However, the achievement of health outcomes on the level of health impact is significantly affected by a number of contextual factors such as high population annual growth rate of 2.4%.

The population of 39.4 million people (2010 census, KDHS, 2010), half of them below 15years of age, inequitable distribution of resources with a wide gap between the rich and the poor, women empowerment and generally gender disparities still continue to be an issue, literacy levels disparities whereby Nairobi was 78% while Marsabit 4%, security concerns with areas in the North being worst hit by inter-clan rivalries, cattle rustling, and the sporadic terrorist attacks.

These will mean that health care will continue to shift beyond the hospital to more community- based primary care and other outpatient sites. All these do have a bearing on nursing as a career with difficult personal and overarching choices to be made.

According to a presentation by the Chief Nursing Officer in Ministry of Health Kenya, Mr Chris Rakuom (2014) to a Moi Teaching & Referral Hospital's nursing workshop on the nursing process, nursing is a service and as a service: People seek it and nurses provide it.

It must be available, accessible, qualitative, and acceptable. He outlined The Vision of Nursing in Kenya to: Achieve high-quality nursing and midwifery services which are accessible and acceptable to populations and are being delivered by empowered nurses. Everything we do is intended to:

- D Improve the quality of nursing care/services.

- D Improve client/patient acceptability of our work.

- D Increase clients/patients responsiveness – the demand for services.

- D Improve the health status of our people.

- D Contribute to improvement of citizens' quality of life (QoL).

(Source: Chief Nursing Officer Ministry of Health, 2014)

Nursing had continued functioning as a department in the various organograms. Sometimes as the thinnest of the thinnest directorates portfolio-wise and in terms of authority. Main examples included the Ministry of Health headquarters and subsequently at county levels.

A classical case in point used to be in one level six Hospital (name withheld). In the later algorithm, the Hospital Chief Nurse docket fell under the Assistant Deputy Director of Clinical Services (ADDCS). This in effect meant that nursing was somewhere on the 4th or 5th rung from the top in terms of policy and decision making (Kamau 2012). Nursing needs a louder voice.

Nursing, therefore, cannot be just a department like any other, world over this anomaly has been rectified. This apparently meant that the nurse was not empowered enough nor was he/she well represented in decision-making at policy making level.

I highly doubt or rather cannot be too sure the situation has changed much. In a lot of organizations that have maintained the status quo, it's hard to justify to them, but once you look at patient management outcomes, patient satisfaction and quality outcomes and the trend the world over, you can see it pays off.

Patient satisfaction has a reciprocal effect, meaning it can be used to improve nursing care that will in turn increase satisfaction. Therefore it's an important indicator of quality nursing care. But then, did it also imply that that being patient with patients who were not patient meant the nurse was expected to be on the receiving end and to put up with everything?

The approved Revised Scheme of Service for Nurses, 2014 provides for establishing a Directorate of Nursing Services in the Ministry of Health organogram but is yet to be realized as opposition to this move in favour of the status quo remains at an all-time high.

The scheme of service, for example, would have addressed stagnation, promotion and re-designation challenges. The following is an excerpt from the chair NNAK Agenda 2015 'The year gone-by might have shown grim state of affairs within the nursing profession with stories of leadership wrangles, failure to absorb the economic stimulus program (ESPs) nurses, failure to implement the scheme of service, failure to finalize the Collective Bargaining Agreement, unproductive strikes never ceasing to seize the headlines'.

According to the scheme "Nursing" means nursing and midwifery practices. Nursing functions entail both operational and administrative/ leadership functions. It defined a nurse manager as one who performs the duties of management and administration of nursing or health services and has been trained in management or leadership.

The Nurse Manager is given the responsibility to accomplish specified goals for the organization they work for. The manager must communicate a strong belief in the nursing team's contributions towards the goals of the organization, a belief that with a strong will they can soar great heights.

Nurse leaders need management and leadership skills to guide nursing through the current and future tumult of health care challenges and achieve desired goals. The nurse manager had many varied formal and informal roles, which involve team building, decision-making, communication, negotiation, delegation, and mentorship among others (Jones, 2007).

There was need for nursing leadership to find (discover) people who are driving change in their local setting and the health sector but more so within the nursing fraternity; support them, benchmark, pick on best practices and encourage others to be proactive in bringing change to the society. My take - hospital leaders (including nurse leaders) do not need to fix such nurses; they need to get out of their way. Such nurses were inherently self-motivated, highly intelligent, and networked, life-long leaders. In Khoury *et al.,* (2011) Gallup study interviewed respondents argued that if nurses were to become leaders, they should be recruited for their leadership potential, not simply traditional nursing skills. They concluded:

Many nurses were not prepared to assume and thrive in leadership positions because of a lack of formal management training. Nurses needed to develop basic management and problem-solving skills. Leadership skills must be learned and mastered over time.

Potential leaders must be recruited, identified, and developed. Nursing training and education programs must be developed to address skill and knowledge needs of management disciplines.

Experts believe that Emotional intelligence (EI) is the job skill of the future. EI ought to be the in thing for nursing leadership (Porter O'Grady & Malloch, 2015). At the most basic level, EI is about "people skills or interpersonal skills". At more fully developed levels, EI is a determinant of effective and ineffective leadership. EI is about abilities to deal with our emotions and emotions of others.

"The most important single ingredient in the formula of success is knowing how to get along with people."

– Theodore Roosevelt, 26th President of the United States.
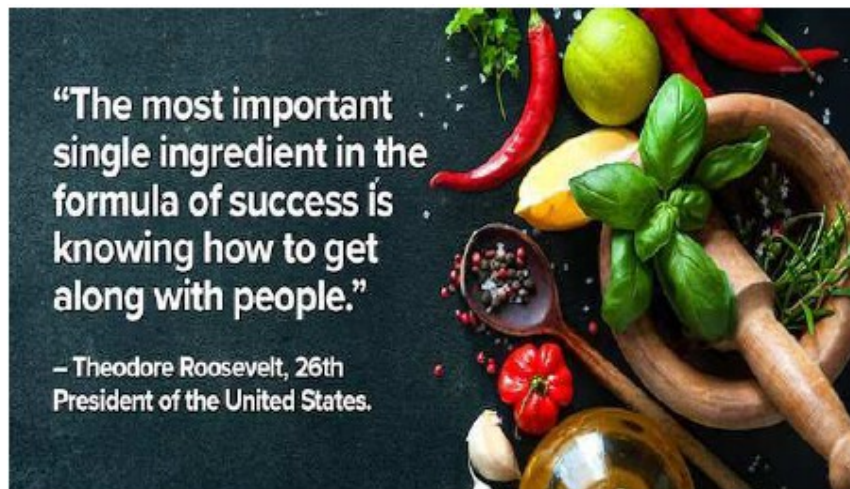
In doing so, our perceptions help guide our thoughts, actions, and decisions. As Porter-O'Grady & Malloch point out, gaining competency in EI takes time, effort, and practice. EI elements are tied to higher levels of leadership performance, and indicate a strong preference for:

• Participatory management

• Collegial and respectful interactions that put people at ease, encourage, motivate, and recognize

• Ability to self-assess, being aware of one's own strengths and weaknesses to increase consistency

• Illusion of control, steadfastness during crisis, maintaining optimism

• Relationship-building skills, genuinely caring about individuals

• Self-directedness, ability to stay the course, be focused, persistent

• Action-orientation, decisiveness

Selfcare

• Accountability, assertiveness, and directness in confronting problems, fairness

Leadership is about aligning individuals, influencing mutual goal setting and creating

possibilities through facilitation of key strategies. Leadership is change mastery. There is growing evidence in the literature and in success stories that EI is increasingly recognized as significant (Dainton & Zelly, 2015). Organizations that seek to improve a culture of safety, provide patient-centred care, and demonstrate the forces of Magnetism recognize the power of EI. These leaders in these organizations emphasize the bullets above.

The Human Resource for Health Strategic Plan (HRH) for Kenya 2009-2012 pointed out that Leadership and Management training was "missing" from the health sector available.

There appeared to be some concerted efforts borne out of some unknown fear from some quarters that nurses must not be allowed to rise above a certain limit. They must not be allowed to shine, that they must not run the show, a kind of premeditated moratorium. The rivalry has not helped to ease things up for the nurses because medical doctors have by default been the managers of Kenya's health care systems. May be they are afraid that nurses might become "sage on the stage", rather than the "guide on the side".

The Health Bill 2015 (now Health Act) (got the president's assent in mid 2017) is an act of Parliament to establish a unified health system, to coordinate the inter-relationship between the national government and county government health systems, to provide for regulation of health care service and health care service providers, health products, and health technologies and for connected purposes.

The entire devolved health sector required a restructuring process. However, National Nurses association of Kenya (NNAK) took issue with several clauses in the Health Bill. The association alleged that the act had failed to recognize nursing as a profession. It therefore sought to have a stay in its execution by petitioning some of some of its constitutional interpretation and referencing.

Yes, We Can!
Can a nurse become the Cabinet Secretary Health? YES.
Can a nurse become the Surgeon General? YES
Can a nurse become the Medical Superintendent? YES
Can a nurse become the Director of a national hospital? YES
County Chief Officer of Health? YES
Nurses deserved more space in decision making.

There was no denying that the MBChB was perhaps one of the longest, most rigorous course in the world but that did not mean that it had the entitlement to own the entire health system.

Historically, in Kenya, doctors have been in management and leadership positions, resulting in tension with nurses, clinical officers, and pharmacists who typically are not promoted into these positions.

Yet the Health Bill, 2014 (which got the president's assent in mid 2017) once again put MBChB (a basic medicine and surgery degree) as the qualifications of a county director of health (CDH). One Dr. SK, a Public health specialist commented on the matter:

> *I take issue with comment on the minimum requirements for county director of health. My take is we go for the best and broad knowledge base similar to the qualifications of a director of medical services. The county government deserve the highest qualification and deviating from basic degree of MBChB dilutes the noble role of CDH. MPH should be mandatory qualification and be registered public health specialist* (Online comment to CIC website Monday, 27 October 2014). CIC a c r o n y m stood for now defunct Commission on Implementation of the Constitution.

In a rejoinder GY on Monday, 13 October 2014 15:13Hrs wrote:

> *I have issues with the minimum qualifications requirement for County Director of Health. You do not need to have a medical degree to manage County Health systems. This requirement locks out good managers who have necessary skills to contribute towards development of health sector at the County level. In my opinion, Article 19 '(2) should read as follows: A person appointed a County Director of health shall-(a) be registered by the Medical Practitioners and Dentists Board; Nursing Council, or ... (b) be at least a holder of a Master's degree in public health, medicine or any other health-related discipline; and (c) have at least five (5) years' experience in management of health services.*

KM on Monday, 29 September 2014 20:48 reiterated

> *'I have disagreed with… the attempt to lock managerial positions of health facilities to some particular health professional … in the 1ˢᵗ Schedule. In my opinion, we should leave the qualifications of the in-charges open. The best option is to allow the facility management teams to propose names for appointment to the Cabinet secretary. The insinuation that nurses, clinical officers and pharmacists, lab technologists, medical biochemists, radiographers and the like have no managerial capacity is insulting.*

Several authors have expressed the same similar sentiments, one is that nurses should be the ones to define and explain their role and focus to the public and that medicine (really healthcare delivery) is strongly represented by a powerful group - doctors. An element of a power struggle has to be acknowledged.

I agree that nursing is a separate profession from medicine, but there is certainly a wide overlap. At the risk of being labelled 'double speak,' I feel nurses need to have support from the doctors and vice versa by providing added value to each other in a non-threatening

way.

The Task Sharing Guidelines, 2017 launched by the Ministry of Health forbid nongraduate clinicians from performing surgeries e.g. caesarean sections, hernias, amputations, post-mortems etc. This apparently is an extension of infighting that has been.

Doctors had been opposed to degrees in clinical medicine and surgery and insisted it is referred to as bachelor of clinical medicine. Historically there was a resistance of doctors to clinical officers and nurses having private practice as documented by historian John Iliffe (1998).

The confrontation has been tried and it has not been the perfect solution so far. My best guess is that there ought to be a middle ground somewhere that nurses can fit and offer focused leadership. The great thing about nursing is that you are an individual within a team.

Though your leader may lack great managerial skills (and this has happened in several instances) as a nurse you can still very well be successful and influential within a team by stepping in. But this is not enough. Wherever nurses have been allowed to lead, they did it well, so no need to fear. In the workplace, the way to go about it ought not to be by minimizing their own role while exaggerating the role of others.

It was commonplace to find a newly qualified Medical Officer; hardly 2 years in the service become the boss of the district health care services or a Sub/County Hospital. What incentives would such an officer need to donate that power and authority vested in them? Transitioning from medical school to being the decision maker was itself an overwhelming and confusing experience as some admitted.

The position of medical superintendent or district medical officer of health (DMOH) and by extension hierarchies in the hospital management team were powerful. Previously (before advent of devolution) there was a fair amount of hospital autonomy with reduced direct government control over public hospitals in the day-to-day decision making.

There was need to deconstruct the social order that elevated the AIE holder as one with largesse at his disposal (held *the yam and the knife* as Nobel laureate the late Chinua Achebe used to say). What with the bonuses, authority to incur expenditure (AIE) that came with the perk. An AIE holder of a public office in Kenya typically had the sensation of a 'lucrative' position since one was in control of finance, procurement, allocation of resources and audit.

In other words the autonomy allowed flexibility for hospitals to use user fee revenues in line with their submitted budgets. It was unfortunate that with devolution this deconstruction in the case of hospital autonomy was overdiluted to the extent that few individuals were interested in becoming medical superintendents. One county hospital in Kilifi had this position vacant for over 2 years although it kept on being advertised (Barasa *et al.,* 2017).

I submit here that there was more required in managing health care services than any basic qualification a health care provider might have. Mark Sanborn a recognized speaker on leadership was quoted saying, 'Being a leader does not require a Title and having a Title does not make you one'.

There is a philosophy that all professionals are "leaders" regardless of where they might fit into the organizational chart, this was emphasized by Steve Adubato in http://www.stand-deliver.com, an executive leadership coach theme in a seminar 'Why the Status Quo Just Isn't Good Enough: Leading Change in Challenging Times'. On 9th March 2015, MK posted **Yes We Can**! On KNUN wall, in that it was preferable to have naivety about 'we can' rather than lots of

intellect about how it could not be done.

These are administrative/management positions in charge of a system and not a cadre of staff. It has little to do with whether one is a medical doctor or not. Some countries have recognized the critical role and the difference a nurse occupying such a position can make. If the military can recognize that, against the stereotype of titles, ranks and even gender, then it is about time Kenya thought the same way. Crossing ranks is normal, it is not a new discovery nor will anyone be doing them a favour.

Health care professionals need to understand the law making process, which does not end when a bill is passed into law. Amendments should be thought out on day one after passage of the bill into law. It is critical that measures are put into practice in such a way that issues are addressed when needed before mere inconveniences become insurmountable obstacles.

(The following textbox amplifies that it takes not just a transparent system but the need to recognize people for who they are and not what they are, See **Just do it!** below)

> **Just do it!**
>
> Lt. Gen. Patricia D. Horoho, was the first nurse and the first woman appointed, became the Army's 43rd Surgeon General Dec. 7, 2011, in a ceremony at Joint Base Myer-Henderson Hall. Please see link http://www.army.mil/article/70556/.
>
> As Army Surgeon General, she directs the third-largest healthcare system in the United States, behind the Department of Veterans Affairs and the Hospital Corporation of America. Further development, the Trump administration removed Vivek Murthy, MD, on April 21, 2017, from his position as surgeon general in the middle of his 4-year term. His replacement was Sylvia Trent-Adams, RN, Ph.D., formerly the deputy surgeon general.
>
> The Surgeon General operates an annual budget of $13.5 billion (an equivalent of Ksh 1.23 Trillion, NB.One of the largest budget Kenya read was the 2014/15 of 1.7Trillion. The health sector was allocated Ksh47.4 billion out of which Ksh2.4billion would pay health worker's salaries). In the 2015/16 FY 2 Trillion budget, the Health sector in Kenya would receive Sh60.8 billion. Some Sh31.4 billion towards development which includes rehabilitation of hospitals across the country. An allocation of Sh500 million to buy more cancer equipment at the Kenyatta National Hospital and Moi Teaching and Referral Hospital has been provided for.
>
> The US Surgeon General manages more than 480 facilities and 29 executive agencies, many of which lead ground breaking research efforts. She oversees 140,000 military and civilian employees, and more than 3.5 million beneficiaries, globally. Yes, We Can!.

Who you are does make a difference

It was amazing how the contribution of an individual can make a big difference in matters of a nation, or an area where they have influence. Ms. Inhensiko, an enrolled midwife working in a rural, hard to reach health centre in Uganda, where she was the only health worker at the facility handling both clinical and administrative work for the past three years.

Despite being a midwife and having successfully established reproductive health services at the

health centre, she handled all other medical services at the facility (immunization and treating common cases like Malaria) and offered outreach services in the community, where she was assisted by community volunteers.

Since working in the health centre, immunization coverage in the area was reported to have improved from 60% to 90%; the number of mothers attending antenatal care and/or delivering babies by a trained health worker had improved significantly in the villages served. Her community outreach services, which were conducted every Friday, involved health education have considerably increased community awareness on a number of health issues. (*Damali Inhensiko, Midwife, Inhula Health Centre II, Luuka District Uganda was the winner of* 2016 International Health Workforce Awards *Community Health Care Category*). More available: http://www.who.int/entity/workforcealliance/media/news/2016/who_hw_awards2016/en/index.html

Some more on nurses who have made it:
http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Federal/Nurses-in-Congress

The following interview from the local setting perhaps might address some of these stereotypes. In an end of year interview [69] Newsmakers 2014, the then Cabinet Secretary (CS) Ministry of Health Dr. James Macharia said the following:

…his' was the most devolved ministry. About his appointment being a non-medic, he said that the President made it clear to all and sundry that he was not looking for a medical doctor but looking up to someone who could sort out the management issues within the ministry, someone who can achieve results. The CS said he was enthusiastic about his assignment.

He had settled in the job and people were no longer concerned that he is not a doctor; "now some people think I am a doctor" he quipped. His vision for the year 2015 was to work hard to finish the flagship projects: Free maternity services and installing IT system in all public hospitals and health centres. He saw his legacy would be one who left a-happy-healthy-medical sector.

Who you are does make a difference; this is a true saying when you consider the following: "There are many people doing great things in the world. They are great, and I want to be a great kid too." These were the last words of 11-year-old Liang before his death. The young boy from China had faced much pain and suffering in his last two years had donated his organs to give life to others after his death. Even doctors bowed in reverence to his body.

17.4 Dissatisfaction among Nurses in Kenya

According to Syallow (2010), the result showed that there was a lot of dissatisfaction among nurses in all the five categories of hospitals selected in the study of Rift Valley Province of Kenya. The study highlighted schemes of service and terms of services. It recommended that (nurse) managers when designing jobs should not focus on content alone but on flexibility of working hours. Since rigid and inflexible working hours caused a lot of stress in nursing.

Finances for non-financial nursing education

The changes that I have seen over the last 10 years in nursing focus heavily on economics. As a bedside nurse in the early 2000s, it was rare for me to hear about cost containment, reimbursement, insurance issues, bottoms lines, etc... I feel like every initiative that I now have to present to my staff is rooted in finances. From patient satisfaction to quality and safety initiatives, everything seems to have a reimbursement tag attached to it. Nurses now understand the cost of supplies, how much waste management and health insurance costs the organization, and even whether a patient can pay for their stay or not. In today's hospital setting, I feel like the focus has shifted, and the financial well-being of the hospital has become the "why" in why we do things.

I don't think that we have taken the focus off of patient care; we have simply tied finances to it. The concepts that I have come to learn through my work over time (healthcare policy, insurance, legal issues, etc...) are all things that I wish I had known from class. I wish there was more to the undergrad programs regarding many of these topics. There isn't room to tech nurses everything in health care unless we stop teaching other subjects, but there is no question about what to add to nursing education. [Shared from a US perspective]

The dissatisfaction of the nurse definitely affected the quality of services that ought to be delivered. Maina and Karani (2004) had studied challenges encountered by middle-level nurse managers in ensuring quality nursing care in Kenyatta National Hospital and documented similar findings

According to International Center for Human Resource in Nursing report 2010, Kenya had a great shortage of nurses; whereby the ratio was one (1) nurse to1345 population compared to the ideal standard ratio of 1 nurse to 250 population with barely over a thousand nursing degree holders then in the market (International Council of Nurses, 2010).

Kenya Union of Nurses (KNUN, 2013) sources put the current number of nurses in the public service at 13,000 and a further 8,000 under the Economic Stimulus Package (ESP), the union further demanded that the country of 42 million Kenyans needs 172,000 more nurses in order to improve the quality of healthcare provision in government health facilities. Vihiga county was among the smallest of the 47 counties with a population (2012) of 608,879, population density of 1500 people per Km^2 40 nurses per 100,000.

A Ugandan physician reported that only 12 of his 100 medical school classmates still live and work in Africa. None of them were in direct practice and none worked in the public sector. Possible reasoning was - a perceived lack of a career path in that– they felt they had no future in public service. [Case study cited courtesy of HRH]

According to Kenya Nursing Workforce Report 2012, nurses provided the bulk of direct patient care at all levels of health services delivery. With a shortage of nurses, especially in rural areas, it would have made a lot of sense if we helped the existing ones to be as productive as possible and to perform up to standard. This becomes especially important; notably having them spend more time on direct patient care.

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[69]Citizen News *Newsmakers 2014:* 26th Dec 2014, 1-2 pm.

1.4 Outmigration of Kenyan Nurses

Health workers in developing countries are often overworked, poorly paid, and not provided with the necessary equipment and supplies to do their jobs. Their work performance can also suffer due to a lack of adequate supervision and feedback.

A range of gender-related issues, such as inequitable recruitment, hiring, compensation, promotion, and training opportunities as well as sexual harassment and violence in the workplace, may also affect their job satisfaction, retention, and productivity.

Making matters worse, working conditions are deteriorating as demand to incorporate new and labour-intensive services, such as provision of antiretroviral therapy (ART) to persons living with HIV/AIDS, are added to their duties (human resource for health HRH website).

Imagine that you are working in a governmental or non-governmental organization in a developing country and have observed the following:

-Once trained and experienced, clinical health workers routinely leave their rural posts for better opportunities in the cities or abroad.

-Nurses are often overloaded with work, spending their time performing basic tasks that others could be doing.

-Workers sometimes go without pay raises or other recognition for years at a time.

Complex and interconnected set of issues with no simple solutions were related to the health workforce migration and outmigration. Evidence showed that workers often leave because of low compensation, lack of educational or other opportunities, poor working and living environments, and inadequate social amenities. These poor conditions ***push*** workers away from areas where they are most needed.

Simultaneously, better conditions ***pull*** them toward better work opportunities and a better life, resulting in the migration of health workers, both internally (e.g., rural to urban) and internationally.

Factors that affect retention and accelerate migration included:

- Payment and compensation
- Benefits and social security
- Job and professional satisfaction
- Work setting and conditions

Compounding the situation, those health workers who stay on the job face an increased workload and often intolerable and dangerous conditions with little hope of advancement. These factors may lead them to abandon the strong personal commitment that they had to help the people of their own countries or home areas.

Africa had 24% of the global burden of disease and only 3% of the global health workforce. At 2.3 health workers per 1,000 population, Africa had the world's lowest density of health workers. Kenya is an example of a country, where it sometimes took up to 18 months to fill a single

position (HRH, Global Health Workforce Alliance www.globalhealthlearning.org).

In 2016, sources from NHS Trust of the UK indicated that 40,000 nurses quit their job that year while Netherlands indicated that there were 200,000 nurse shortages by August 2017. Sources from US Bureau of Statistics by mid-2017 predicted that there would be 100,000 vacant registered nurses jobs by the year 2022.

Maybe (and I am speaking as a Kenyan here), it was about time US states' nursing boards and regulatory bodies relooked into the rather tough NCLEX exams. Whether there was need to retake NCLEX by those who had previously passed and were re-entering the profession.

In mid 2017 Nursing and Midwifery Council of the UK (NMC-UK) indicated that more nurses were leaving the national register than those joining it. Some experts thought that men joining nursing might be the solution to this crisis (nursesarena.com). Experts were also fronting a proposal for apprentice model to deliver more trained nurses. Indeed to jumpstart recruitment, UK's Health Secretary Jeremy Hunt announced opening 14,500 places for apprentices to become RNs by 2019.

By end of September 2017 NMC-UK removed the mandatory requirement for test of English for nurses originating from English speaking countries. The nurses' arena floated a survey on what the proposed NMC-IELTS changes meant for foreign nurses. It would be interesting to follow up on this study.

It was around this time that Abu Dhabi in the Emirates indicted that 2000 nurses were urgently needed. In the US the new USCIS form launched around that same time would ensure a seamless process to obtain work authorization documents and security number simultaneously.

Earlier on in 2008 a web site hosted by *majimbokenya.com* had made these projections; 20,000 nurses were needed in the UK, mostly from Africa…'because they are cheaper'. The pay for a new registered nurse (RN) in the US rates was around $27 per hour [approximate equivalent Kshs 2,700 per hour] while UK £ 22,128 per annum [Kshs 1,637,280 per annum] in 2017.

According to Feldstein (2011; pp320), the long run supply of nurses in the US was determined by those who decide to enter nursing school. But due to lack of capacity and shortage of faculty, only 42% of applicants were admitted. The immigration of foreign-trained nurses and getting a greater number of men enter nursing are the next option (Feldstein, 2011; pp. 212). In the short term, part-time RNs increase their hours of work and trained RNs re-enter the workforce. Unlike Kenya, in the developed countries a good number of nurses comprised of those who had entered into nursing after having worked in other jobs or careers. Some in their middle age or above. For example *The unlikely RN* from a brick maker to RN was reported by CNN.com and ♯BeTheNurse.

In the 2000s older nurses re-entered nursing in the US due to economic recession. The increased demand led to strong financial incentives for foreign trained nurses to immigrate. In the US they had increased opportunities for much higher pay (allowing them to remit funds home *from the diaspora* to assist their families), better working conditions and greater prospects for learning and practice.

A closer look at visa application process to the US in recent times had an item in the checklist *Nurse in a shortage area*. Being a nurse thus gave the applicant an almost express privilege to being granted a US visa, and subsequently a work permit.

The U.S. population is aging at a rapid rate; health care reforms (e.g. ObamaCare) were expected to bring millions of more patients into the system, and there are anticipated shortages in numbers of trained health care professionals to care for these patients. It was for these reasons that Work-Force Planning Model (WPM) tool was developed in 2013 by the American Hospital Association, American Organization of Nurse Executives (AONE) and American Society for Healthcare Human Resources Administration (ASSHRA).

The purpose was to help organizations better define their needs as well as find new ways to improve their recruiting, sourcing, retention, retirement, success planning and onboarding strategies. This is a great tool to check out for leaders in health systems and human resources in health. WPM can be accessed through any of these reputable organizations' websites http://www.aone.org, http://www.aha.org, http://www.asshra.org

The Philippines, former Yugoslavia and of late Ethiopia train nurses for export, this author does not see why Kenya cannot realistically develop a similar policy and stand to benefit from diaspora remittances (Kenyans abroad in 2017 remitted Ksh 1 billion becoming the leading source of foreign exchange). With all the mushrooming colleges and universities offering nursing, it is not possible we can absorb those graduates locally despite the nursing shortage we continue to experience as a country.

Nursing programs apparently were a favourite and easily made it into the charts of the 'new' institutions. Nursing in Kenya must remain committed to her ideals. But until we put money into creating jobs for these people rather than just creating supply we need to be more open in the future to a deliberate export route to solve the oversupply problem.

The "new" institutions were actually middle-level technical establishments that have been converted into universities. Mostly the political class aimed for each county to have 'its own' university. These mostly offered programs in business; education; arts and the humanities.

These were relatively cheap to teach but are not really in demand in the labour market, so the institutions probably were not going to do much in addressing Kenya's 40% graduate (and the general 22%) unemployment rate.

The population of youth in Kenya was expected to increase to 16 million by 2012, with as many as 40,000 youth entering the Kenyan employment market that had only created 150,000 new formal sector jobs in six years (USAID -2009).

Students' performance (academic achievement) played an important role in producing the best quality graduates who will become great leaders and provide manpower for this country. That aside, nurse educators are challenged to produce as many graduates as possible to meet the changing needs of the society both locally and the world at large. We really needed some propensity towards a university education that inculcates the graduates to become entrepreneurs or as a minimum opt for informal employment.

The increasing rate of unemployment in the country and the consequent careful selection of degree programs by prospective students should arouse universities to swing into action. They needed to embark on restructuring, rationalization, and harmonization of their academic departments, faculties, schools, institutes, and centers.

Fresh curriculums that have components of transcultural nursing, EBP, relational communication, human technology interface among other niches could become new selling points. Graduates needed to face in the job market confidently. In today's world, the skill to handle information and communication technology had become a necessity in any job place.

Faculty must maintain standards to graduate those who demonstrate after completion of the required coursework eligibility to terminal program competencies. These included like being able to pass Nursing Council of Kenya licensure examination as well others e.g. National Council Licensure Examination (NCLEX-RN) and Commission on Graduates of Foreign Nursing Schools CGFNS). These regulatory bodies' role needed to meet both the demand and supply of nurses.

Even though we here in Kenya might want to overlook the fact that our programs core need to base on the scarcity of nursing professionals in developed countries sooner or later we might. This drive in responsive to market demands has already been happening elsewhere.

For-profit brokerage agents were executing bonds and preparing our Kenyan nurses on behalf of hospitals abroad and were doing big (and at times exploitative) business. There was need to do much more than just take fees from immigrant nurses. What would be wrong with having our institutions accredited as NCLEX/CGFN centres per excellence? Identify responsive contacts, build excellent facilities and staff to offer more competitive standards required by our country and also the recruiters.

This country's nursing old guards must drop their matriarch tendencies and open up. We cannot continue to bank on the glory of the good name Kenyan nurses built before while 'daring abroad'. The standards of training have since fallen; we are producing more with less and for less, perhaps a reaction to economic recession. The challenges on the ground as well as off the ground are different.

Our graduates might get a harder time getting absorbed into the system. This ought to get us soul searching. We have for a long time been working with an elementary theory based on - who is being processed to outmigration? Or rather waiting for those who are interested to come forward. We need to start asking more quality related questions but more importantly: What calibre of nurses are needed, what are we exporting, what are their credentials in as far as competence and professionalism is concerned?

What shall we be doing with all these nursing graduates whom we cannot gainfully employ? We must stop expecting the new powerhouses and their agents to come fishing for them on their own terms. We need to build new networks for actively exporting nurses to burgeoning lucrative places on the globe based on more relevant policies. There was an obvious gap to fill by making nurses' outmigration a sustainable investment through policy reforms.

For the US, in particular, the population is growing and an increasing percentage of the population is becoming older; the baby boomers cohort (born in the 1950s) began retiring in 2011. The RN workforce was also aging; the average projected age for nurses in 2015 was 44.6 years). Medical advances and technology was increasing demand for hospital nurses (Feldstein, 2011; pp325).

But if anything technology was an enabler, it cannot replace the basic clinical or nursing skills. The incidence and prevalence of chronic illnesses was increasing. The demand for ambulatory outpatient services, home nursing and long-term care all point to increased need for nurses in all settings. Some states e.g. California had instituted minimum mandatory nurse to patient acuity ratios.

The number of Kenyan nurses intending to out-migrate for greener pastures continues to be on the rise mainly due to poor working conditions and pay at home, frozen employment by the government, active recruitment agencies, liberalized passport and expedited visa for professionals in some cases.

The cost of training one degree nurse is approximately Kshs. 1,200,000 per year for four years totalling to Kshs. 4.8million. Most of the degree nurses were trained through government sponsorship using tax payers' money. However, they were hardly accorded the opportunity to use their expertise in improving the quality of life for Kenyans.

Instead, a significant proportion of these nurses are poached by developed nations which have robust health systems that value such highly trained nurses. As such, Kenya remains a production unit for these countries in need of highly trained nurses whereas the Kenyan health care system continues to ail due to lack of the very highly trained nursing professionals.

WHO podcast on 09 July 2010 04:00 PM addressed this topic using strongly worded statements (see Improving health workforce migration below). That was some six years back today, yet in 2013 KNUN alleged that over 3000 nurses had out-migrated in the last two years. It would mean making judicial use of training resources to ensure that ongoing employment exercises always include positions for degree nurses with reasonable terms and also endeavour to retain the same within the public sector. The media was averse with this item sometimes ago[70].

Nurses seeking for verification of certificates from the Nursing Council of Kenya were 3,583 between the year 1999 and 2006. The intended host countries were mainly the USA and Britain. Kenya continues to loose highly trained manpower mainly because they lack incentives to work at home.

Incentives, in this case, can be looked at as the conditions within health care provider's work environment that facilitate, enable, encourage and motivate him/her to stay in their jobs, in their profession and to remain in their home countries. The Government freezing of automatic employment of nurses and cost-cutting measures initiated by health care facilities resulting in reduced staffing levels are some of the changes that have had impact on the nurse administrators.

According to Dr. James Kimani, then Director of Medical Services in the Ministry of Medical services, Kenya, Hospital Reforms Priorities 2010-2015 project that Ksh1.1Billion annually will be for recruitment of additional medical staff including nurses. Kshs 481 Million will be for implementing revised scheme of services for 5,900 staff to improve employee satisfaction and retention. A variety of incentives, both financial and non-financial, can be used to address the issue of retention.

Examples of incentives gleaned from HRHwebsite (Global Health Workforce Alliance) that can be introduced at the service delivery level range from providing extra monetary allowances for rural postings or providing houses, cars, or loans for these items to strengthening facility management practices and reducing on the job discrimination, such as that related to HIV status or gender.

In one study in Kenya, simple, low-cost interventions to improve work climate proved successful in retaining health workers. Over the period of one year, 10 rural facilities participated in a program in which the workers themselves identified the elements needed to improve their work environments.

These included more frequent team meetings, community outreach days, inexpensive renovation of facilities, more equitable staff shifts, the creation of staff lounges, and less littered yards, among other measures. Following the intervention, 90% of staff expressed high satisfaction with their work environments, up from 60% before the intervention (Global Health Workforce Alliance).

It is a reality that the developed countries also do face serious nurse shortages. The combination of fewer people going into nursing, the retirement of current nurses is expected to produce a shortfall of more than 1 million nurses in the US by 2020 (which is 4 years away today).

In an article published concerning the US, one participant in a focus group discussion (Araskar *et al.,* 2004) described the unrealistic expectation of assigning responsibility to one nurse for three or more patients receiving chemotherapy, which made it impossible to provide holistic care for patients who were desperately ill and often frightened. For her, this was a major ethical dilemma.

> **Improving health workforce migration**
>
> WHO podcast on 09 July 2010 04:00 PM addressed this topic using strongly worded statements: 'High-income countries are increasingly dependent on doctors and nurses who have been trained abroad. But the migration of health workers weakens the health systems in the countries of origin. WHO's Code of practice on the international recruitment of health personnel aims to achieve a balance between the interests of health workers, source countries, and destination countries'.
>
> From where this author sits, the exodus could be getting worse. The *Future of Nursing* (IOM, 2010) campaign of the US recommended recruitment and retention of a diverse nursing workforce as a major priority.

1.7 Nurses Must Be Given Space to Do Their Work

Allowing nurses to step outside of their traditional roles, and help them to grow. From a social–political lens, nursing has remained invisible and externally controlled, as nurses, we reach for meaningful expressions of our values, too often finding overwhelming constraint and resistance, sometimes within ourselves and sometimes imposed from without (National Nurses Association of Kenya-NNAK Agenda 2015). In spite of the scientific facts and evidence that nursing care and caring are crucial variables that make a positive difference in patients' (and nurses') outcomes of health and well-being.

The administrator's goal is to achieve the tasks of nursing as efficiently (i.e. quickly) and as economically as possible. They may not care about the interpersonal relationship that nurses value while giving care. They seek to control nursing actions, to limit caring time and to require concrete measurable outcomes to justify their actions, while nurses beg for time for caring tasks (e.g. listening to clients concerns) which do not have solid, quantifiable outcomes other than patient satisfaction (Morse *et al.,* 1990).

It was notable that patient satisfaction surveys had shortcomings in that some nurses (*Is America still facing nurse shortages?* Blog http://scrubsmag.com/) asked 'hotel style' questions which often gave poor results especially for bedside nursing care.

When the surveys were viewed in light of chronic staff shortages, being expected to work twice as hard with less (pay, utilities etc.) with sicker, sometimes older and heavier patients. The outcomes of the surveys was affected in some way by nurses feeling that they were being under-appreciated by administration and patients'/ families who were often sue happy. Often neither of these parameters considered that the nurses were short staffed.

It has also been shown elsewhere that good patient satisfaction scores may not be found in the same institution with good patient management outcomes, infact in some instances, it may be the opposite as was documented by Robbins (2015) who authored *The problem with satisfied patients.*

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[70] Amoni, P.K. 2006: *Exodus of Nurses*, Kenya Times, 9th November 2006, Kenya Times Media- Nairobi.

Being empowered might mean: Capitalizing on the new constitutional dispensation and devolvement of health care to the counties; nurses among other health care workers at all levels needed to become involved in lobbying, coalition building, and relationships with elected representatives.

Client power according to HSA, 2010 report by Luoma *et al.,* (2010) referred to the ability of citizens, citizen groups, and watchdog organizations to monitor and oversee the actions of health providers, ensuring that health services are made available, maintain high quality, and follow accepted norms.

According to Melynk and Fineout-Overholt (2011) being empowered means investing in lifelong skills: asking focused questions and learning to judiciously search the information rich environment efficiently. That is; formulating a searchable, answerable patient-specific question(s), incorporating good information seeking habits into a daily routine mainly through becoming friendly with and proficient at utilizing information technology and internet for what is relevant. Increased involvement must begin at an individual level (e.g., joining a professional organization/union).

Utilizing some aspects Quality Health Care Organizing Framework for Resource-Constrained Health Care Settings in Kenya (QHCOFR-LS) the following is what can be deduced: The devolved health care system, the commissioning of a new national hospital insurance service, free maternity care, increased funding from exchequer all show that this is a time of great opportunity in health care in Kenya for the nursing fraternity (See Appendix I to V). There are many windows of opportunity in this transition period, and Kenyan nurses can leverage these opportunities to institutionalize a culture of quality nursing care and offer leadership on aspects of improvement in things that will be set.

Taking a quick reminder on one of the nurse manager's report, when the participants were requested to describe their roles as nurse managers they felt that just like the giraffe was an indomitable figure in any health care setting. He/she bore the image of the hospital, going to great lengths/heights to ensure the smooth running of the institution amidst daunting challenges of a changing work environment.

The public image of nurse professionalism is important. Attributes of a professional nurse, such as caring, attentive, empathetic, efficient, knowledgeable, competent, and approachable, or lack thereof, can contribute positively or negatively to the patient experience. He/she must have a strong vision for nursing, its role in maximizing the patient centred experience and in meeting the organization's goals.

Uncertainty is a fact of life in many a local setting such that some of the tasks the nurse manager did involve making 'backstage disorganization look excellent onstage'. For example, when the rest of hospital management is gone off (After 5 PM, weekends, public holidays and all nights), the whole institution is in the Nurse Covering's hands and he/she knows all is not well.

He/she must struggle to remain on top of things even if there were no ready answers to the issue at hand. There seemed to be an apparent disharmony between the supporting structures available for him/her most of the time as well as the system she supports

According to Dr. Bruce Agins of HEALTHQUAL International, delivery of quality health care was a complex process with a lot of moving parts. There had to be someone who had ownership over the management of the work, someone who would make things happen on a daily basis. In Bruce's work, they had tried to find early adopters to buy in, start work, and get results to motivate others to join in (Technical Report, 2013).

From the foregoing of this book this far it would not be imperious to state that nursing offers such a person. But things have to change. It cannot be business as usual. We cannot keep thinking the same way and expect different results. It is stopping such excuse clauses like … *but you know as usual*.

Nurses should take up the relentless quest to advocate for evidence-based practice improvements by engaging in frequent assessment, evaluation, and questioning of current methods of care. It is not ever going to get any easier. *The Prince*, Machiavelli astutely noted some 500 years ago that there was "nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle than to initiate a new order of things".

In healthcare, we have one guarantee and that is, things will change. In order to get whatever it is we want for our health care system, all we have to do is to stop performing the actions that don't bring about the desired result and start performing the actions that do.

Learning how not to is very critical to learning how to. We cannot continue to do things 'the same good old bad old days' way (slavish, routine, ritual, rote, straight jacket of behaviour) and expect to get better results every time.

Prof Mutahi Ngunyi (of The Fort Hall School of Government), a political analyst who I regularly follow on social media said this in an interview:

'*if a banana tree gives you bananas today, gives you bananas tomorrow, gives you bananas the day after, why should you expect the banana tree to give you pineapples on the 4th day or oranges on the 5th day? Essentially you should only expect bananas, the results will be the same one way or the other.*

We know several ways that don't work or don't work well, 'Don't fall in love with your approach – improving care is the key'. The direction is more important than location, so if we do intend not to change direction, we may end up where we are heading because change continues regardless of our responses.

I was surprised when a student colleague from the US made the following comment about resource constrained settings and as to whether she thought we use EBP:

"I think you definitely could be practicing in a way that is evidenced based without knowing it. But evidence changes all the time and to keep up with the latest evidence, it is important to have that culture and desire to change the status quo. That way you can make sure that your changes are all in the right direction"

There is so much opportunity for change in the health care system. Ralph Waldo Emerson once said, *Do not go where the path leads, go instead where there is no path and leave a trail'* RW Emerson. It seems likely that in resource-constrained settings some are fond following any straight line in the hope that nothing gets their way. It's that serious so that we do not become the very people we are trying to run away from.

A realistic way of achieving better health results: conduct careful analysis to identify evidence- based opportunities for more efficient delivery of health care; whether prevention or treatment and then restructure the system to create incentives that encourage the appropriate delivery of efficient interventions (Cohen *et al.,* 2008).

But then according to Kurt Lewin …we must first understand why things have been done a certain way in the past and involve those doers in the solution. The new way needs to satisfy or meet the historical elements of the group's previous behaviour. I see this as a huge part of change buy in (Kaminski, 2000).

As much as we need to introduce new products and services it is important to review the current situation to identify non-value adding services. Some low-value services exist only to follow rigid protocols or justify billing.

No matter how long certain practices have been used, let us be willing to examine others. According to Porter O'Grady & Malloch (2015) in their masterpiece writing *Quantum Leadership*, if an organization provides 1000 services and only 25 make a difference, then the other 975 services must be considered for elimination.

Dialogue was needed to sort out which ones they are per institution or as a nationwide policy first by utilizing strategies such as *mapping resource utilization*. Individual care providers need to feel free get the word out; they need to be empowered to become agents of cost reduction whenever opportunities arise.

Many patients and their health care providers believed that despite limited evidence to support the use of certain healthcare services and products, their individual circumstances may be different, and therefore they may be more likely to benefit. But we need to choose wisely.

We need to bridge the gaps in assuring quality of care we provide. Michael Porter (2012) presented on 'Value Based Health Care' said that significant improvement in value will require fundamental restructuring of health care delivery, not incremental improvements. Noting that today's, 21st-century health care was often delivered to low income countries with 19th-century organization structures and management practices among others.

A nurse observed 'its like being in a hostage situation!' Once you are into these things, it tends to distance you from the patients, but we are helpless without it ... Patients also tend to regard technology as more superior than traditional clinical and nursing care. After all, a wise saying goes that, "there is nothing as inefficient as very efficiently doing things that should not be done at all".

Just like every other healthcare provider, in order to perform at their best nurses require recognition and support. The *Magnate* and *Planetree* accreditation in the US offers some of the best prototypes of what nurses are capable of. Magnet hospitals encourage greater nursing authority. Magnet hospitals are model patient care facilities typically employing a higher proportion of degree prepared nurses (59% BSN compared to 34% BSN in non-Magnet hospitals).

The magnet hospital standards is a program by the American Nurses Credentialing Center (ANCC) recognizing healthcare organizations that demonstrate nursing excellence (Houser and Oman, 2011;p14, 47,249, 251). Magnet recognition represents excellent patient care and clinical outcomes, a supportive and innovative workplace, and development dissemination and enculturation of EBP.

Therefore magnate hospitals must create an environment that uses evidence to preserve the development of nursing knowledge. It lays a lot of emphasis on transformational leadership, EBP, innovation, evolving technology, and evaluation of outcomes.

The foundation for the magnet nursing services program is the scope and standard for nurse administrators:

- It provides a framework to recognize excellence in nursing services management, philosophy, and practice

- Adherence to standards for improving the quality of care

- Leadership of the chief nurse executive and competence of nursing staff

- Attention to the cultural and ethnic diversity of patients, their significant others, and the care providers in the health care system

Although Magnate primarily focuses on nursing practice, it is important that leaders engage all disciplines in sustaining Magnate designation. This is valuable for achieving desired clinical outcomes for patients (Houser and Oman, 2011; p14, 47,249, 251).

1.8 Carelee: The carer of the carer

Nurses enter the field of nursing with the intent to help others and provide empathetic care for patients with diverse health needs. They provide essential psychological and emotional support to patients because they are the ones who spend the most time with them.

Nurses are in the best position to judge minute-to-minute changes in a patient's medical condition. Staffing shortages and falling within the essential job category forces many of them to work double shifts, nights, holidays and weekends. Routinely they were being asked to take in more patients than they could safely handle, a monumental task, given the kind of monitoring and medication needed by each or majority of patients.

Aging nurses, nurses suffering from chronic diseases, worsening shortages of staff all affected nursing workforce productivity. This loss of productivity substantially affected the availability and quality of health care.

Nurses have an important health advantage over the general population such as: being health literate; being educated; being employed; health seeking behaviour, access to personal health care and medical insurance; possessing skills and capacities for self checks e.g. self-breast examination, blood sugar monitoring, blood pressure measurements among others.

Being a nurse means that in many ways you are a role model for health and wellness (do-as-I-say do-as-I-do approach). But just like everyone else, they wish they had a support system guiding them. While this is true self-care can be difficult in today's pressure-packed workplace. It is challenging to focus on your own self-care.

A healthy nurse is certainly a healthy nation, but that statement usually does not get as far as it should. In 2017 the American Nurses Association (ANA) theme was focusing on *2017-The Year*

of the Healthy Nurse working towards "a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing."

ANA through Wiley publishers dedicated collections towards the healthy nurse campaign. These included cancer awareness, work-life balance, sleep-rest issues, combating stress, fitness, women's health, occupational health risks, best in books etc. The Journal of Advanced Nursing (JAN) run *Nurses' Health Virtual Issues.* These resources would be accessible freely between June and November 2017.

In class, nurses learn altruism, to be compassionate and provide care for patients unselfishly. Nurses oftentimes are overwhelmed by the needs of patients. They also interact with this fast-paced world; have families and financial concerns just like anyone else. They often experience a conflict between the moral imperatives of their jobs and the practicalities of their lives.

There has been an increasing awareness of the need to develop ways to "care for our carers". Firstly, it's an organizational responsibility to care for staff, secondly, an obligation amongst peers to support colleagues (peer-assist, peer-challenge), and thirdly, a personal responsibility to care for oneself (Huggard & Huggard, 2008).

'Think of it this way: if you are providing care to patients all day, then going home and taking care of family, only to turn around and come back into work to take care of more patients, you are going to start resenting the patients. You are going to start feeling drained by the people you are trying to help. You are going to feel irritable, tired, sad, angry and frustrated.' - Nursestogether on Tue, Jun 18, 2013

Peer-assist cuts through formal layers, with a motto 'it was not acceptable to refuse a request for help from a colleague nurse' although it acknowledges there are those who have either more expertize or willingness to help. Cognizant of the fact that no two people or issues are exactly the same. In *peer-challenge* peers not only review each other's goals and plans but also best performers are made in charge for improving the performance of worse off performers.

Peer-assist and peer-challenge were described in Bartlett and Ghoshal, (2002), lessons drawn from the British Petroleum (BP). This kind of expands the carelee concept to modified forms of peer-assist, peer-groups, peer-challenge, carelee proper and lastly *self* as a carer of self.

Each would supplement the other's efforts. These require creating processes and a supportive culture to link and leverage the will, forthrightness and expertize of individuals and embed it within the organization to give it a competitive advantage in the health care industry.

Caring in nursing is grounded in the basic empathic relationship between the nurse and the patient; as was explained by Jean Watson (2010). This theory of human caring advocates for relationship-based nursing (RBN). At the core of RBN is empathy and the communication of this empathy to the patient and the family.

It defines empathy as the ability to understand a patient's feelings, understand the situation from patient's perspective, and communicate this understanding to the patient. Over time, working in continuously emotionally charged situations with the suffering, this empathy can become overtaxed and exhausted, but who's caring for the nurse?

Self-awareness is core to stress management. A lot has been written on self-help, do-it-yourself (DIY) prevention and resilience strategies. The principle is that nurses need to take care of

themselves first in order to provide quality patient care. Structures for caring for the carer continue to challenge even health systems of developed countries notwithstanding resource constrained settings.

Some other aspect that the compleat nurse needs to realize in this self-help DIY is to learn to make the first move if and when they need help. *Don't ask "if" the carelee can help, tell them "how."* That's all it is! Don't ask them to figure out how your job is adversely affecting you; they probably understand your situation less than you. Instead, tell them "how." This way you might want to make someone want to truly listen to you and hear about you.

Might be this is someone you admire, an inspiration - someone who could motivate you to tackle a challenge in your career path. Finding, engaging and committing the right resources (including a carelee) to support you is a big discovery. Stop waiting for something to happen but take charge of your career, the odds may ever be in your favour.

In the absence of resources available in the workplace, then personal responsibility might be a fair attempt to address this matter. Non-availability to the nonexistence of such services and the absence of sufficient personnel to provide those services is a characteristic of resource-constrained settings.

The American Nurses Association (ANA) has such forums as *Navigate Nursing*. In one of its clarion calls run something like this *how many of us really can define what a healthy nurse looks like, know the status of our own health, and most importantly, how to improve our wellness? Join the movement, healthy nurse healthy nation!* On a different note, Kenyans might relate with sending to a short code the words: *simama usikike* Swahili for 'stand up and be heard' or *sema usikike* - speak and be heard.

ANA defines a healthy nurse as one who actively focuses on creating and maintaining a balance and synergy of physical, intellectual, emotional, social, spiritual, personal and professional wellbeing. A healthy nurse lives life to the fullest capacity, across the wellness/illness continuum, as they become stronger role models, advocates, and educators, personally, for their families, their communities, and work environments, and ultimately for their patients.

A regular Health Risk Appraisal helps nurses care for themselves by identifying certain risks and providing resources to assist with better health habits.

The nurse's relationship with self is a core concept in managing compassion fatigue. The personal relationship defines how you see yourself as a complete person (Durham& Durham, 2005).

It is essential to understand how you are wired and how you relate with or how this influences your outward expression. Even a relationship with self is not stagnant, it is ever changing. One needs to understand the dynamics. Nurses need to be assertive, to express personal needs and values, and to view work-life balance as an achievable outcome (Koloroutis, 2007).

According to Dorothea Orem who came up with Self-care Theory described self-care as comprising those activities performed independently by an individual to promote and maintain personal well-being throughout life.

The assumption being that the carer in resource-constrained setting will be equipped with this knowhow. This calls for engaging in practices of self-investigation, diagnosis, or treatment on the part of the carer themselves which may not always be possible without help.

Fortunately or unfortunately this leads to self-reliance even where outside help would have been indicated. So there is need to teach them to note the opportunity to seek help.

That is why it is vital to have a mentor (or at the minimum a surrogate) who can give you insight into the areas you do not have experience or which you need improvement. This it needs not be the same person all the time and in all areas (Durham and Durham, 2005; pg. 17).

To learn about attitude choose one who has a good attitude and so on. The type of nurse you want to work with. For example, to gain skills when dealing with your emotions choose someone who believes in you and your success, and could help you see where you are going. One who will celebrate your success and not be jittery about it.

Interestingly, Durham (2005) stated that this was often the easiest person to find! Let's take up this challenge, and ask if it was that easy why do most of us fail to - just tap? Why was this information not available, friendlier and easy to use by nurses?

Inherent in the caring profession will be a mixture of reactions: One nurse shared this 'one minute you are celebrating with a family who has gotten healed, in splits of seconds you are grieving with another after losing a loved one. You are the same person, you feel unprepared, as in, it seems no one taught you these things in school'.

It is times like that you need someone to resound your thoughts, your frustrations and all. This was especially critical when one started getting the feeling that things were going very well for everyone else except themselves.

> **Self-care is…**
>
> body: exercise, grooming, massages, breathing, yoga, conscious eating
>
> mind: quiet contemplation, meditation, focusing on the moment, healing music, laughter
>
> spirit: meditation and prayer, reading spiritual literature, listing positive things in your life, random acts of kindness
>
> -American HolisticNurses Association 2016

It had been shown that caring for others has often times led to compassion fatigue, burnout and other forms of psychosomatic ailments. It could be described as "Compassion Fatigue: Nothing Left to Give?" (July 2010; letters to the editor. *Nursing Management*).

Once depletion has occurred, too bad - the nurse is personally experiencing the pain of their patients and families in the process of providing empathic support. Burnout onset is more progressive and may cause indifference, disengagement, and withdrawal from patients and the work environment.

Burnout could precipitate compassion fatigue. Compassion fatigue, on the other hand, can be more acute in onset and may precipitate over involvement in patient care. The affected carer gives themselves fully to their patients, finding it difficult to maintain a healthy balance of empathy and objectivity manifesting itself as physical, emotional and spiritual exhaustion (Anewalt, 2009). '…nobody needs a smile so much as those who have none left to give!' remarked an advert *The Value of a Smile at Christmas* in recognition of the pressures its sales clerks were under during the Christmas rush. It added, '… and if in the last-minute rush of
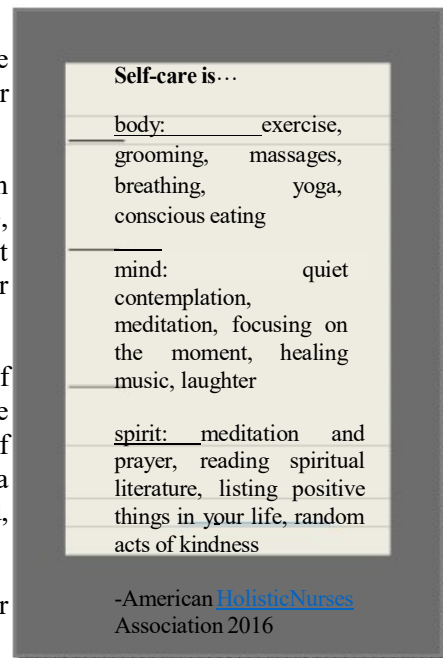
Christmas buying some of our salespeople should be too tired to give you a smile, may we ask you to leave one of yours?'

Compassion fatigue affects not only the nurse in terms of job satisfaction, emotional and physical health but also the workplace environment by decreasing productivity and increasing turnover (Lombardo & Eyre, 2011). One nurse lamented that 'no matter how much or how well they sleep, they still awaken exhausted'.

Burnout and compassion fatigue were being cited as some of the reasons why there was a need to address nurses' retention. It affects both new and old nurses, no one is immune. One nurse leader asked 'how do we retain seasoned nurses who have the experience to give good-quality patient care, those nurses who pride themselves as professional nurses? What about recruiting and retaining the nursing workforce for the future generation?'

Music to sing by

Since time immemorial music has been found to be relaxing to the soul, as such it was therapeutic. *Tazama Africa* is a musical band that had made it their business on voluntary basis to check on patients at Mater Hospital, Nairobi. They did it daily by giving them hope through music. They sang and played their instruments tirelessly, consoling the patients, singing away their waiting time and pain. In the outpatient department this contributed to perceived short waiting time. As evidenced by patients and occasionally nurses tapping their feet and nodding the head to the rhythm. The efforts by these unsung heroes ought to be replicated elsewhere.

Some of the nurses going through compassion fatigue were not even in the best shape to perform. Present-eeism is most commonly conceptualized as attending work despite illness. This contrasts with sickness absence, which involves staying home when ill.

Caring professions appeared to experience a greater prevalence of presenteeism. The consequences of presenteeism were not limited to productivity loss; the behaviour was linked with negative short and long term health problems (Fiorini *et al.,* 2016). In this study, they elicited four factors that predicted nurses' choices between presenteeism, absenteeism, and the consequence of these choices. These included: illness perceptions; work attitudes; organizational factors; and personal factors.

On the other hand, some carried work home, some excess of it. Nowadays keeping in touch with workplace through technology is possible. Telecommuting is a work arrangement that allows employees to work in their homes full time, maintaining their connection to the office through phone, fax, and computer.

Code Compassion on the other hand was studied among nurses in South Western part of the US (Lesley *et al.,* 2017). A unit could call upon the mobile Code Compassion cart containing refreshments, relaxation tips, and awareness messages about compassion fatigue, DVDs with do-it-yourself messages, asking nurses to pause, be mindful, reflect and, address potential burnout.

Whenever that distress signal was received, acknowledging the call, triaging was done. The code was activated together with chaplaincy if need be. Actions included: debriefing and, dialogue among others. Working with nurse leadership issues of time frame, follow-up on nurse's emotional wellbeing, keeping a log on the frequency and type of event and ongoing rounding for continuous awareness.

Awareness of recognizing potentially high burnout situations was highlighted in these institutions: multiple patients' deaths; traumatic/stressful events; prolonged/extreme staff shortages; highly acute cases etc. (Resources available http://dailynurse.com/).

According to American Association of Critical Care Nurses' Standards for Establishing a Healthy Work Environment, there were components that needed to be present to mitigate compassion fatigue. These included: True collaboration; effective decision making; appropriate staffing; skilled communication; meaningful recognition, and authentic leadership. Increased managerial support and feeling of being meaningful recognition experienced a lower compassion fatigue a high compassion satisfaction.

In the study area for Code Compassion they established The DAISY Award, a peer award to nurses who demonstrated lower compassion fatigue with positive attitudes, appreciation of significant moments and, excellence in patient care (Lesley *et al.,* 2017).

This section introduces the *carelee* - a carer of the carer. Carelee is a new concept that stands for *carer of the carer* in this case the nurse taking care of another nurse or nurses, a role that can be assumed by one who is approved by experience, reflective enough to feel and comprehend the constant changes across time through inquiry, caring, and practice of this walk that we call nursing.

One who will also help you identify among others: personal health, safety, and wellness risks, as well as create a plan to mitigate or eliminate them. Therefore carelee was not some form of neurogism – trying to create a new word. Nursing theorists had a history of creating such concepts, a tendency unique for each profession.

Caring is at the heart of effective leadership, therefore, carelee is a broader concept going beyond compassion fatigue and burnout to mentoring on the beauty of caring and what might be causing disillusion among nurses especially in Kenya (and perhaps other resource-limited settings). Some experienced nurses explained 'the work of nursing was like an iceberg, what you see on the surface is nothing compared to what was hidden below the water or behind the scenes'.

Attempting to delineate each context with a kind of mix and match approach. This author believes this approach would work for readers in these settings, who might not have had that luxury of a formal system that acknowledges that carers need care in the first place.

Much as caring for the caregiver as a concept is not new, carelee is - a paradigm of looking at nursing care. According to Sharma (1997), a paradigm is simply a way of looking at a circumstance or at life in general. Some people see the glass of life as half full or half empty. The optimists see it as half full.

They interpret the same circumstance differently because they have adopted a different paradigm. A paradigm is basically the lens through which you see the events of your life, both external and internal.

For example, a carelee is not necessarily the caressing – tender - loving care type but one who knows you, your values, your personality, your passion, and your purpose. Such that in any case even if they happened to be outside your situation, they are never that far, they would be willing to become an accountability partner, bring to your attention any inconsistencies. The relationship is reciprocal too if both of you are to get the best out of it.

For example do not respond negatively or defensively when the carelee brings something up. Be approachable, be open, and be forever thankful for their investment and support. 'Please do not underestimate the power of trustful outside eyes and a firm, but reassuring, voice' (Brittney & Katti 2017) while referring to the role of an accountability partner.

But it could be one of those 'supportive nurse managers who bend over backwards to accommodate our personal lives and who recognize us for all we do'. Nothing wrong with that. It is one who will tell you the truth, tell it as it was, make you come to terms with the complexity of care, build you up to face tomorrow and the realities of care with courage.

This was unlike the conventional role of the role of mentor, preceptor, and counsellor. Perhaps a controversial one for that matter. The mentee who wants to be like their mentor the carer is herself and grows their own brand more or less independent of the carelee.

Pic: Carelee, modeling and role-modeling (Courtesy of clip developer)

Caring is the reverse of possessing, manipulating, or dominating. In any actual instance of caring, there must be someone or something specific that is cared for. Caring cannot occur in a nonrepresentational or in an abstract manner, nor can it occur by sheer habit.

An essential ingredient of caring is communication: a dynamic, developmental process of transmitting perceptions, thoughts, and ideas in verbal, non-verbal, and written (direct or indirect) interactions. Within an intentional caring process, messages are effectively conveyed by persons or through technology.

Other essential ingredients of the caring process are knowledge, self-awareness, patience, honesty, trust, humility, hope, and courage. The nursing interventions need to have cultural and ethnic relevance for the client and are carried out within the ethical and legal domains of practice. To promote a safe, effective quality care environment.

The carelee will walk with you up the flights as a nudging, prodding reminder that there is a flight of stairs up, a landing ahead and that the way down will be easier perhaps, more dangerous at times. Note we are using:of the carer notfor the carer in that the responsibility of care would not be essentially be transferred to the carelee. This is someone whose judgment you trust; someone who will be honest with you and not just tell you what you want to hear. David Bush & Donni Alvarenga does a great job in *Health Coaching* for nurses @http:// nurseshealthcoaching.com. Check it out! More or less what we are talking about here.

Hopefully, if we had more carelees we would reduce the drifting of our nurses, give them a reason to believe in themselves and perhaps retain many more in the profession of caring. One can allocate him or herself the role of *carelee* of the carer. Nursing nurses promote stress resilience (Figley & Abendroth, 2011) in *Caring for the Caregiver*.

It's essential for the carelee to develop a one-on-one relationship with the individual nurse in order to provide support and guidance. Those who may be in need of referral counselling should be spotted early. Seeking out a mentor, supervisor, experienced nurse, or a charge nurse who understands the norms and expectations of one's unit may assist in identifying strategies that would help cope with the current work situation (Lombardo & Eyre, 2011).

Due to rapid changes in health care sector in general, nursing had become not only more competent-based but more evidence- based-knowledge intensive. Quality was the BUZZ word; it had become a basic in the globalized world.

Pic: Carelee one-on-one relationship with the individual nurse

It would be good to appreciate that in this world, whatever course in life you decide to take some people somewhere will tell you, you are wrong, how wrong, what is wrong. Infact there will be one or two who will tell you what is wrong with you.

Sometimes you need some pushing in order to realize your potential, one who sees who you are for what you are, who can give that push. One who will say 'this is not the end of the world, give your hand and we are going'. In other words, one who believes in you.

Carelee relationship can start off on an informal basis but ultimately this ought to be recognized, formalized and compensated for effort. 'Using mature or older nurses to mold and guide new graduates in the right direction needs to be the main focus in all hospitals' (Lee & Anstead 2010).

Those with the ability to listen deeply, offer caring and innovative options based on their own experiences. Talking about one's concerns and feelings with an appropriate person can give support and hope to the caregiver and assist with the development of an action plan. consider the following quote:

An organization's success was determined by having the right teams at the right places. *'Wrong people in the wrong place creates regression, right people in the wrong place create frustration, wrong pleaple in the right place create stagnation, while right people in the right place create progression'.* Dr John Kithaka, Captains of Industry, profiles of Kenya's leadings. *The Standard* June 10, 2015.
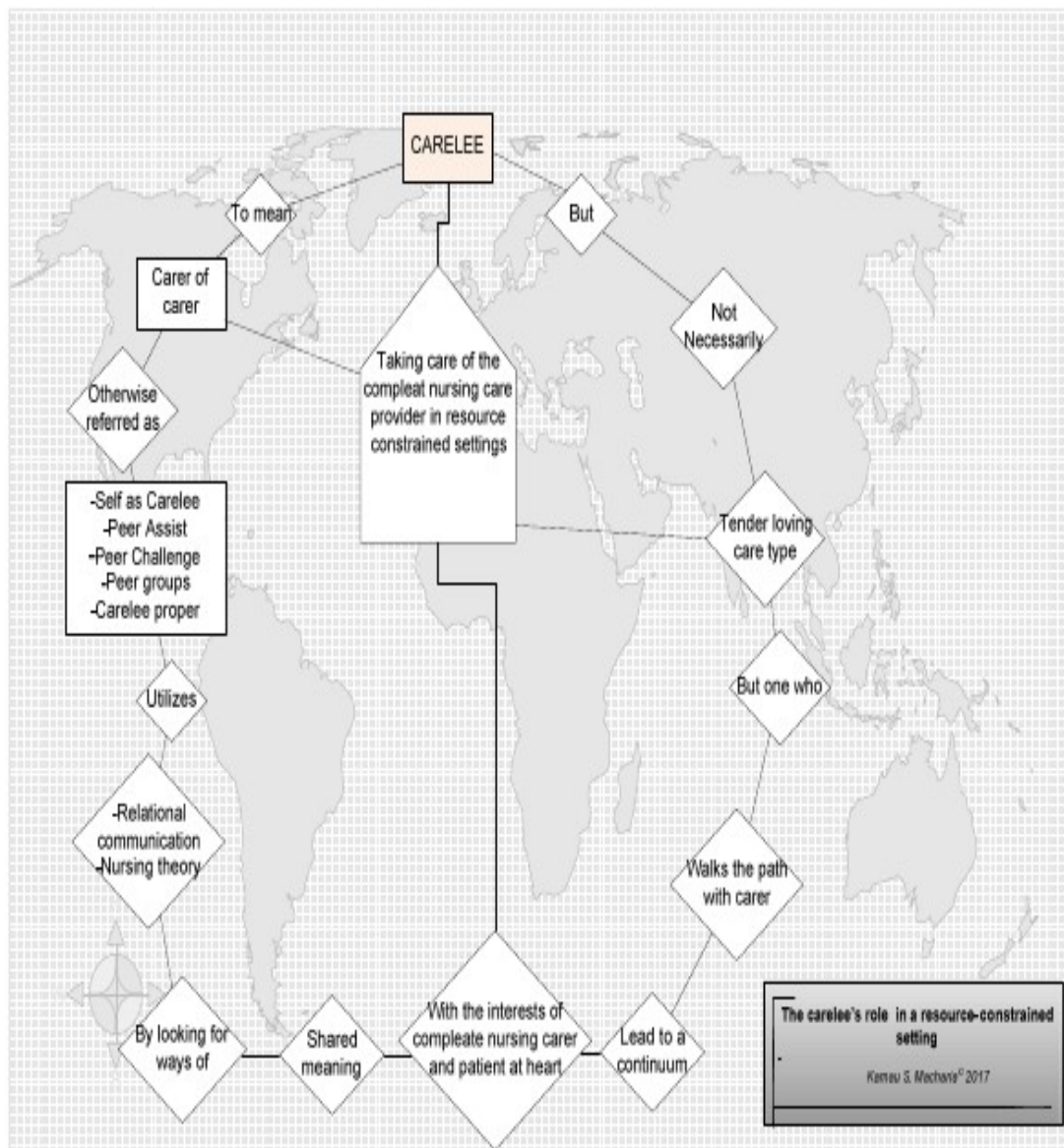
Fig: The carelee's role of taking care of compleat nursing care provider

Also see Carelee on Nurses Wikipedia (user draft)
https://en.wikipedia.org/wiki/User_talk%3ASymomash?oldid=736733792.

Lastly, we could even extend the mentoring to the diaspora; pair our nurses to some program partners on expectations, as global citizens to make them employable. May be create resource centers where they could connect with diaspora. A centre where they could engage in basic life skills, information and opportunities. However since this notion was still developing it will require another forum.

I was not going to tell nurses (of whatever age) how to find work-life balance. His or her values, desires and view of the world might be so much different from mine. Even their idea of balance will look differently from mine. BFigure out what works for you and your life. This is an ever evolving area anyone could share what works for them for the

benefit of others. There are researchers dedicated to this very topic for the rest of their lives.

1.8.1 Moving parts
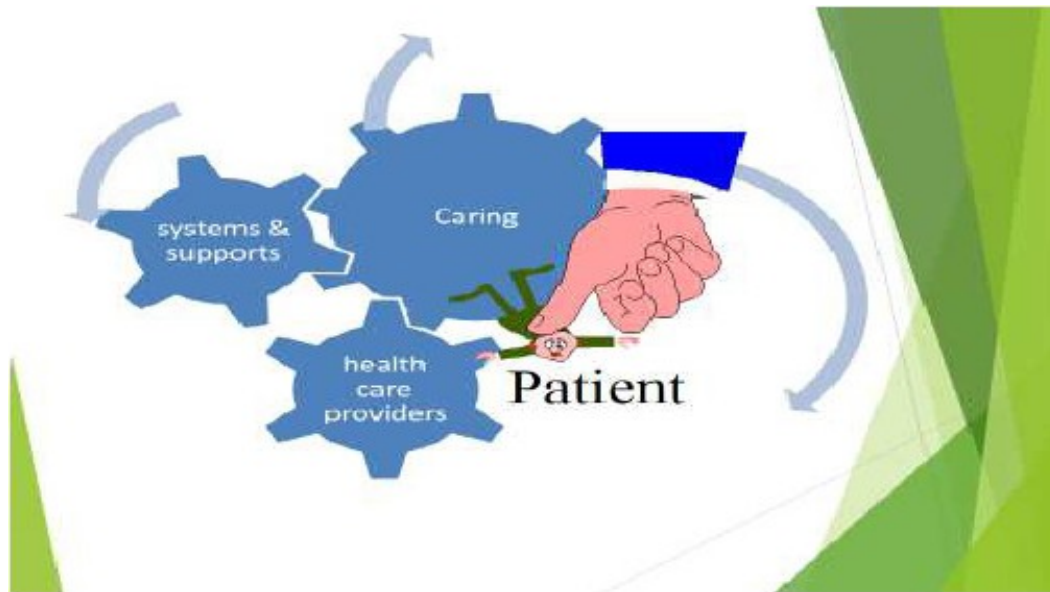
Fig: **The   moving   parts   &   cracks   of   the   health   system**

There was a cost of lost opportunities, failure etc. when either part tried to extricate itself from the

committment to being held mutually accountable. 'Caring is more than a cog wheel - it is a vital

fulcrum. Sometimes the carer might be crushed leading to pulling in different directions; the patient

might fall through the cracks'. [*Caption developed by Kamau, S. Macharia, 2018*©].

Every moving part in the health system is important. By default others recognize that nursing is more than a cog in the wheel in the system; in that that nurses can provide that vital fulcrum/ convener for the moving parts which in essence was caring. It is not anything nurses had chosen to be, it is by design that caring is the heart of health system and so is nursing. Alongside this let us consider the following sentiments however skewed.

The fulcrum describing this phenomena was borrowed in part from Nigerian poet Dike Chukwumenje who narrated how "Things have fallen apart and the centre cannot hold". The health system must have faith in the fulcrum; reforms need to be transformative beginning with the nurse.

The nurse-patient/family relationship is the cornerstone of nursing practice and leverages the powerful role relationships play in creating a caring and healing environment. According to the nursing professional practice model (PPM) by American Nurse Association 2010, the six nursing values embedded in the practice and underscoring their work were professionalism, patient and family centred, compassion, teamwork, excellence, and integrity (Winter, 2015).

Holding back this benefit due to them (and by extension the patient) will largely weaken the cog wheels. It is not a liberty that nurses themselves even needed to (but have to) fight for, the rest of the parts need to accord them that due. Trying a no-nonsense supervisor (in Swahili *nyapara* type) on them the way some of the county governments had started going about it would be the last straw that broke the camel's back and emancipate the production of everyone else.

> *Mimi nashangaa maana only nurses among the 20 cadres are on strike…ati wanfunga hos… where the others. Imagine 1/20 stronger than 19/20…* Paraphrased from Swahili English 'Sheng'. Imagine only nurses out of the 20 or so cadres of medical staff were on strike, yet some hospitals were but closed. Where were the others? Do we then take it that
> 1/20 (nurses) was stronger than 19/20 (the rest)? [On 7th August 2017, a subscriber A.M.
>
> posted on Face book wall *Enlightening Nurses*. This was as the national nurses' strike had entered the 65th day].
>
> Someone observed that a good number of the other cadres 'smartly' liked to ride on the others' strike with they themselves threatening to strike, ever postponing it, feigning some united front with the cadre on strike. With some getting CBAs signed without ever needing to go on strike while others were still on strike. The employers using docile group as a bait or may be using them to prove a point. All the while each one of them *prayed, preyed or scaveged* on what the hunter got.

Going back to the concept of moving parts, it was unfortunate that in some resource-constrained settings the moving parts often times appear to have one common agenda: - to crush the fulcrum. Everyone then pulls in a different direction, and the patient might fall through the cracks.

Abraham Lincoln once began a letter saying: "Everybody likes a compliment." Professor William James also said: "The deepest principle in human nature is the craving to be appreciated." Few health care providers realize the effects of even little courtesies in oiling the cogs of the (sometimes) monotonous grind of everyday caring - and, incidentally were the hallmark of functional health care teams.

(Courtesy of clip developer)

But even within nursing the same could be said. It was unfortunate a lot of court processes (between 2014- 2018) instituted by a section of Kenyan nurses against other nurses or nursing bodies had wreaked the very pillars that would have made the fulcrum strong .

These included cases e.g. blocking the implementation of the *Nurses Scheme of Service*, blocking the implementation of the Health Bill 2015 (now Health Act); blocking the appointed Director of Nursing Services from assuming office; blocking KNUN elections from taking place; blocking and degazzetting of elected representatives to the Nursing Council of Kenya from assuming office; blocking the job evaluation by Salaries Review & Remuneration Commission (SRC) etc. Different factions fought each other in public and more fiercely on social media platforms.

Figures:Why do nurses do other people's work? (Courtesy of Nurseslecture room), Question: 'I can't even handle one IV pump, how do you deal with 10 or more IV pump at one time and what *sic*… is wrong with this patient ?'(Courtesy of JustNurses.com)

Whenever the productivity in the health care organizations became less than pleasant from time to time and even on a day to day basis, nurses and by extension patients had borne the blunt of it. Though this might have been caused by new changes: anything from cost cutting to lack of basic necessities for care delivery et cetera, it could more likely be an element of employees' behaviour.

Patterson *et al.,* (2012, p11-14) in their research on organizational productivity and performance documented in the book *Crucial Conversations* concluded that some of the real problems why organizations failed were that the real problems were related to employee behaviour. Not the nonhuman processes, systems, and structures.

There were shocking deficiencies on concepts on human relations and communication in our educational system. They suggested that the solution was in holding one another accountable to the process. In their findings - '… in the best companies, everyone held everyone else accountable regardless of level or position'. Getting people to do that was a necessary skill (tools for crucial conversations).

We need to be cognizant of the fact that "In healthcare, you can't be an 'I' person; you have to be a 'we' person," observed Elizabeth Wykpisz, Chief Nursing Officer at Saint Peter's University Hospital, New Jersey USA (Fiercehealth *ebook,* 2014).

'If we could cultivate good communication skills and employ a 'never ending improvement' KAIZEN strategy you should be able to say like the Toyota that 'the car ahead is always a Toyota' and less like one its long time competitor 'unspoiled by improvement' and almost running itself into oblivion in the 21st century cutthroat competition', remarked one motivational speaker.

Today world over (perhaps with exception of some resource-constrained settings) nurses, in general, had the tenacity to be heard and state their own opinions. In today's world, we are told to open our minds, get into (the) trouble of thinking for ourselves and our mouths to be heard.

The opinionated, well-spoken individuals were becoming the new norm, no more any less the patients we care for. We should tend to find a middle ground on issues but rarely if ever should we solemnly agree on something in its original context. "Going along to get along" brought us to where we used to, wanting to appease everyone except ourselves, and we stagnated there for a long time.

For example, anecdotal evidence showed that nurses' autonomy could be an elusive if not strange phenomenon. From this author's experience, the mention of the word autonomy did not elicit much in terms of achievement or expectation by a section of nurses from one teaching hospital in western Kenya.

1.8.2 Disenchantment among carers

The following section is not a cure to the phenomena called di**ss**atisfaction or disappointment with/about caring and the nursing career. It is not anywhere near to therapy either; it is just a way to get started.

One of the main causes of frustration in nursing arose from inter-professional tensions. Health care had an inherent hierarchal structure with power distances between individuals and that was a cause for a lot of friction (picture the cogwheel again).

For example tensions between nurses and physicians arose because of overlapping roles, nurses' desire for collegiality, and changing role relationships as nurses achieve increased levels of education.

Consider this: the concerned nurses were interdicted while the neurosurgeon'ss admission rights were withdrawn for operating on the wrong patient. Investigations and blame game went on, and going on.

Tell-tale signs of compassion fatigue

Blaming, Chronic lateness,

Depression, Diminished sense of personal accomplishment,

Exhaustion (physical or emotional),

Frequent headaches, Gastrointestinal complaints, Hypertension,

High self-expectations, Hopelessness,

Inability to maintain balance of empathy and objectivity,

Increased irritability,

Abusing - drugs, alcohol or food,

When Venning *et al.,* (2000) did a random control trial comparing nurses and physicians, the research showed that nurse practitioners could do some of what doctors did, usually to the greater satisfaction of patients.

Career counsellors tended to agree - *that there is no best and worst career, degree or diploma programme. Life is all about what you make out of what you have. No degree course guarantees you success or failure in life.* I sought to get a clarification on this general observation.

According to Robert Kahiga, a career advisor based at Centre for Career Development, Kenyatta University described several factors to consider for choosing a course/career:

1. Passion/interest

2. Ability to do the subjects

3. Personality –physical

-social -psychological-
          stress levels

4. Opportunities

5. Levels of progression

6. Money

7. Entrepreneurship

8. Networking

Points to Ponder
'It is not who is right but what is right that matters' and "There is no limit to what you can accomplish if you don't care who gets the credit."
Moreover "The patient may not remember your name (or titles after or before it) but they would not forget the care you gave them".
The days of the lone scholar are waning fast, it's about networking, collaborations, making references not necessarily how much one knows.

On the other hand, this author felt that based on the above parameters a nurse ought to be fascinated by the immensity of possibilities available in nursing both locally and globally.

Knowledge actually increases when it is shared, so there is need to distribute value to each member of the team. All individuals in the collaborative team ought to contribute competently since they were all working towards the same goal and deserved the right to define the critical elements of their roles, challenges, and expectations. Even by not hiding critical information including errors.

One approach that had been found to work and is recommended goes like: 'Do Not Say That You Nearly Asked, Ask!' Never be reluctant to ask even the most basic of questions. Questions are the most effective method of eliciting knowledge. This resets and synchronizes collaborative roles of every team member.

Everyone in the team should generally appreciate constructive, timely, and sensitively delivered feedback that could be put into practical use. Gone by were the days when one would be asked: Who are you? Who do you think you are? What can a mere … mere that?

What makes you think that you can? One of the biggest disappointment in the caring profession as summed up by one nurse 'was the politics involved with healthcare and the disrespect of the different levels health care providers …We all could be great together if we respected each other.'

It would be professional elitism for any one professional to over-evaluate their own significance, think for everyone else, expecting them to defer to him or her. Same with expecting others to

twist themselves into shapes to please him or her. In a 'Don't talk to us until we talk to you culture' a cartoonist depicted a laughable 'when we need your opinion we will give it to you'.

> 'We need to dissolve the lie that some people have a right to think of others as theirproperty.
> And we need at last to form a circle that includes us all, in which all of us are seen as equal'
> – Barbara Deming

We needed to encourage others to challenge us, to take their ideas and suggestions seriously, their ability to take initiative, to believe in them in turn as we expect them to believe in us. We should never lose a momentum in the name of egoism.

There is no existence without co-existence. Attacks must be set aside in recognition of the fact that we are all in this together. Focusing on the patient is the common reason why each of us is here in the first place. Each individual needed to confront the ways their own behaviour actually drives this goal or otherwise.

Nevertheless, some of the reasons as to why a section of medical staff preyed on others were what I would call 'unpaid bills' by e.g., the nurses. Meaning that some harassment came because some of the nurse(s) just as could happen with any other health care provider(s) had not done their job properly, lacked training/information needed, lacked interest in what they were doing, did not believe in themselves, lacked in academic upkeep for level of performance required or just incompetence.

Incompetence to this author means lacking sound doctrine why one was doing what they do or are doing. While Porter-O'Grady and Malloch (2015) described that, 'Competence is not simply what people know. Competence is what people do with what they know and how well that makes a difference for others'.

The International Council of Nurses (ICN) had called for competency-based curriculum, defining competencies as characteristics that graduating students should demonstrate which

indicate they were prepared to perform and function independently in professional practice. This meant that we must ensure newly qualified nurses were better prepared for the realities of nursing practice. That they had the skills-set that were applicable to the marketplace. That they had what it takes

The bottom line is you can only give what you have. You cannot convince anyone you can 'pay the bills' when you are bloke, and they can see it. Nursing is not for the faint-hearted, it is for those who will work hard to thrive in the business that nursing is. Run your nursing career like a business/a consultancy though not entirely so but rather with a touch of a labour of love and compassion. Compassion and daily acts of kindness make life far richer (Sharma, 1997).

A touch of labour of love and compassion could mean contributing by giving your time and energy (your two most valuable resources) in a kinder and gentler way) in order to bring meaning to someone's life. It's about judging people by the size of their commitment to others. Unfortunately, this could often lead to inadequate self-care behaviours and increased self-sacrifice in the helper's role.

One needs to be constantly looking for ways to create new energy for self and the workplace. In nursing this might mean being able to rise above monotony, making pleasant routine nursing tasks among other things.

It was becoming likely that the only new knowledge that some care providers got was from the hints and facts thrown about during the clinical rounds without taking the bother to find out more, confirm the facts. Even a simple fact check online would do for figures thrown around.

Unfortunately, especially in public hospitals for whatever reason, it had become increasingly common for a scheduled clinical ward round to begin, continue or end without a nurse attending (at best a BSN intern or student nurse attends albeit without wishing to have their presence felt). Even the far between Continuous Professional Development (CPDs) staff attended needed to be timely, evidence-based, relevant and applicable to the work environment. There was no shortcut to knowledge, one must find out.

Some of the means some healthcare providers had resorted to like *faceworks* cannot work all the time and in fact can be a disgrace to the profession. Faceworks in relational communication refers to specific messages or behaviours that thwart or minimize the threat/damage such as: avoiding certain topics, changing the subject, or pretending not to notice, in other words, similar to an interesting cartoon found on social media entitled: *the face I make when I am clueless during clinicals*. JM on February 6th, 2015 posted on Kenya National Union of Nurses (KNUN) wall the following:

'…our level of engagement in discussion is too low we cannot speak our minds in the care of the patient. We have reduced ourselves to followers of instructions and not partners in the health care team as it should be ... giving only tentative or unsure feedback as if what they have done is inappropriate'.

After many years this author served in the hospital as a nurse he shares this conclusion. Do not be yoked to people whose aim is to bring you down, or rather do not allow people to put you down. This is *a stone and a hard place* dilemma considering what I am going to say next. Most of the time people don't mean anything bad with their questions.

Don't take questions too personal. Even if the tone and attitude of whoever is asking to seem aggressive. Even if it seems they make you look silly. Stay cool and be polite. Above all be professional. Endeavour to shape the events of your life rather than being shaped by them.

 'Remember no one can make you feel inferior without your consent'. –Eleanor Roosevelt.

Do not be too curious about who and why you, may be some bit of what of the issue, but no more. Keep it simple, don't overanalyse or overcomplicate things. Do not be the one to start cat fights, especially in public. William James said: "the essence of genius is knowing what to overlook."

You cannot make those critical patient care decisions when you are angry. You need to ensure that you are free to focus your attention on what matters most to patients. Conserve your energies by not allowing others to spoil your day. Stories have been told of people who walked out of the ward and out of nursing in the heat of the moment.

One did so because of their hospital's rigid policy on intangible things which not the least were the white dress, apron and cape. This is uncalled for and unnecessary. If it is getting out of hand report the incident to someone senior. You can even take leave of absence if need be. Consider the following incident that was shared on Forbes.

"… I am going to quit my job today". "Sensing the hesitation and insecurity in my voice …do not quit. Ask for the time off." I thought she was crazy. "Ask for the time off?" I replied.

I … walked into my boss' office (with no intention of asking for the time off), and blurted out "I need some time off." He replied, "How much time?" and I said, "Six to nine months." My boss sat quietly for a moment then said, "Okay." I was in disbelief. Had this just happened? The moral - it can't hurt to ask

It was during such breaks that some people found in unconventional ways jobs they came to love. Steve Jobs of Apple Macintosh would attest to that. His career path was one about loss, recovery but little to regret about.

Campaign for Action (2015) Assessing Progress on Implementing the Recommendations of the Institute of Medicine Report (IOM) 2010 *The Future of Nursing* report included: nursing should broaden its coalition to include more diverse stakeholders. The Campaign should build on its successes and work with other health professions groups, policy makers, and the community to build common ground around removing scope-of-practice restrictions, increasing interprofessional collaboration, and addressing other issues to improve health care practice in the interest of patients.

Often the care team was quite dysfunctional because of basic cross wiring in the command and control of the team. One Dr.Kevin insinuated that listening to nurses is a key to being a good doctor. I couldn't agree more. Posing this question, 'who knows more about the patient and how they were responding (or not) to your treatment… the doctor or the nurse?' He observed that apart from the military the medical profession was the other caree that involved giving and receiving orders in team communication.

Almost exclusively the doctor ordered other members of the team; obviously, the nurses received the blunt of it. Often times they were curt, dismissive, in a rush did not listen to input from other members of the team or else flat failed to ask!

Dr. Drummond MD posted on April 16th, 2017 'Doctors and nurses need to order less, listen more' in *LeadNurseAfrica* wall on Facebook. He recommended that doctors needed to ask more questions, listen to more, value what they were hearing and act on it. Even listen between the

lines where possible. More important it was good courtesy to want to know how the nurse or the doctor for that matter was doing with a 'how are you doing'.

Quoting from Dr. Oscar London MD in *'Kill as few patients as possible*':

'Working with a good nurse is one of the great joys of being a doctor. I cannot understand physicians who adopt an adversarial relationship with nurse. They were depriving themselves of an education in hospital wisdom'.

To ensure quality of health care provision in resource-constrained settings it might become necessary to use a form of assertive language. It was important that when necessary, health care providers politely assert themselves to support patient safety. An effective assertion is pleasant, persistent, timely and clear in offering solutions to presenting problems (Lo, 2015).

There was need to have an environment in which the nurse could raise concerns on behalf of their patients without fear of recrimination, and where such concerns would be properly and thoroughly investigated. In 'The two-challenge rule', a concern is stated at least two times to ensure it has been heard. There is a common nurses' saying - *practice with a questioning attitude.* The saying would reign especially true in such scenarios. Trust your nurse gut if you start to get a bad feeling about an issue.

This is also referred to as **Escalation of Concern** with such statements as seen below:

The escalation of concern consists of such statements/call outs as:

"This is unsafe,"

'I'm CONCERNED

"I'm scared"

'I'm uncomfortable,

Or

to mean

"This is a potential serious problem. Stop and listen to me."

Kamau S Macharia, (2018)
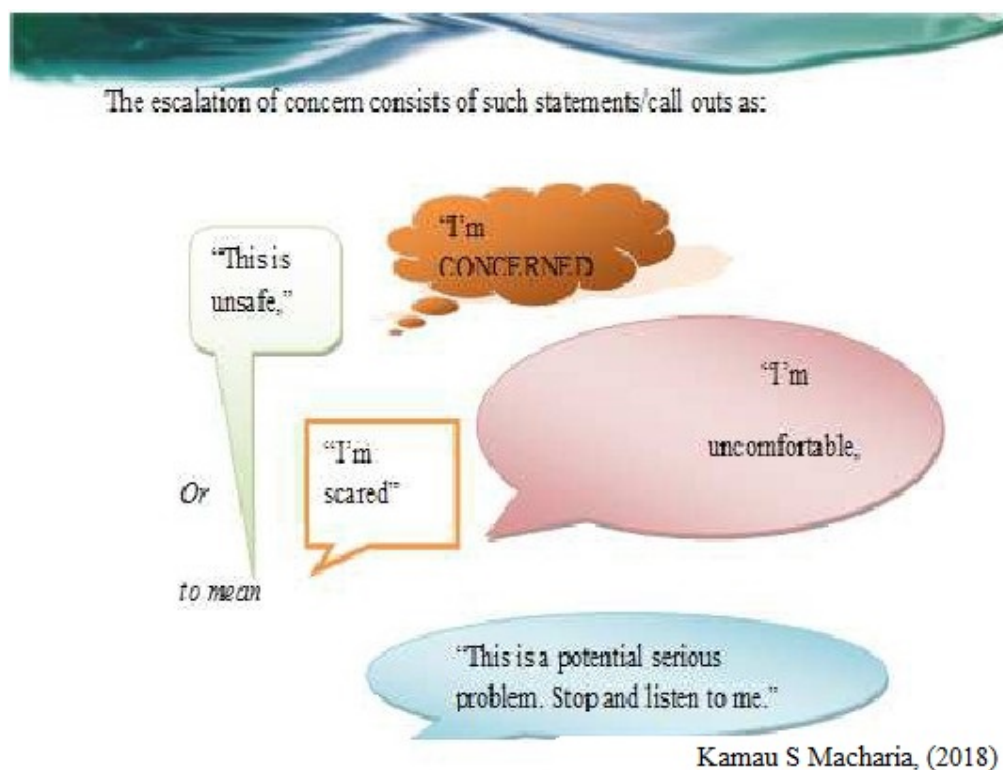
It would be good to urge each one of us to measure up, detest mediocrity and move to the next level. It is absurd to be entrusted with the care of a patient whose condition you half-understand and whose management appears outlandish without bothering to find out. It is neither witty nor relevant to be a member of such a team.

One cannot be the centre of attack in which everyone aims their heretics unless you choose to be one. I do not mean being challenged, everyone ought to get a dose of it now and then and I believe it is healthy; nuances will always be in every profession. It does no one any good to fret and brood over trivial matters like the comment of a co-worker that sounded like ill-will. Say No to the habit of processing and interpreting negatives. It is not healthy to spend most of your day fretting over past events that you have no power to change.

Do not get to the point where you do not see a way out. If and when you start to view nursing as dull, menial and hard work and see no reward to it or rather the fact that you see it that way means that there is a better way of looking at it. It is unlikely that you are *The First, The Only or Chosen To Be Different.*

You are not necessarily being asked to break records but you could. But then you ask, 'how can you care for others if you cannot even care for yourself? How can you do good if you don't even feel good? It's almost instinctive that nurses take care of others before taking care of themselves. No longer! Ever heard what they say in the airlines? *Put the oxygen mask on yourself before you place it on your child.* Support yourself, help yourself, and take care of yourself, so that you can better serve your patients and clients.

It is not good enough living day in day out with mismatched expectations in [work-lifebalance](). So much self-help and career advice were geared toward helping people pursue happiness, but there is need to add a voice in the case for nurses. The reason why you joined nursing in the first place might be the place to start. I like the way St Luke's University in Japan; School of Nursing put it concerning those intending to join nursing. They must be:

Someone who is concerned about others and sensitive to their needs; Someone who considers inter-human relations precious; Someone who can share in others' pain and suffering; Someone with scientific curiosity; Someone with a keen interest in global health.

Positivity and self-awareness are at the core of being able to sustain your life in healthcare. These are two of the seemingly easier ideas but it takes self-awareness to remain positive. A lot of guided patience is needed by nurses experiencing role conflict (described as inconsistent job obligations). They need a carelee.

This is because nurses experiencing role ambiguity were reported to be less satisfied with their jobs which in turn negatively influenced their job performance and also lowered their organizational commitment (Wu *et al.,* 2006). Might be this was what Durham (2005) otherwise called, 'the goal is to keep a 'good' job rather than to perform exceptionally'. It is no way to work even if you happened to 'Be Your Own Boss' (BYOB) (See **Point to ponder** below).

For many nurses (at least those I know) in Kenya, this was their first job; it would be good to give it everything you got. Be passionate about what you do and most likely, you will like it. Challenges will not seem like challenges at all, and somehow one can leap a seed of an equivalent benefit from any setback.

One nurse on holiday put it this way:

 'Will I ever develop the ability to leave my nursing identity behind on vacations? I don't think so. Nursing is what I do and a huge part of whom I am. I don't know about you, but I just can't help myself'.

I discovered that it was far easier to be instantly transported from vacation mode to nurse mode than vice versa. All I could think about was the boy. A patient…er…a passenger

fall? Where was the incident report? Follow-up? Then I thought, "Should I follow the

staff's advice, stop being such a nurse, and just enjoy myself?" David Foley (2017). *American Nurse Today*;12(4)

In all fairness, you might simply feel or it's actually so that you don't fit well with the profession or the team you are working with. It may or may not seem like a conscious decision you've made or not made but you got to where you are by some of your own decisions. The reality is that every minute you spend doing one thing you are making a conscious choice not to do another.

One nurse commented, 'Nursing is hard work that weeds out many of those who are not happy or fulfilled'. Most veteran nurses confess that the 1st year of nursing was the hardest (nursingguide.ph) but it could vary from one individual to another.

Mural courtesy of the clip developer

Where did the rain start beating you? If such moments are not addressed, it can be dangerous for organization's and your health. It is not good to be too hard on yourself either. Let's face it - not everyone does an outstanding job all the time. Those few times we need someone to tell us the hard truth.

Unfortunately, most bosses point out the bad and assume the good. You need to admit it whenever possible and move on. But it is a choice you have to deliberately make in order to enable the team to move on.

The morale of a team can be infected by (you or someone else) being the intentional "odd person out." If we could rule out that you are not the cause of some of the burn out then we might figure out something else; consider these in yourself. Could it be that you got some of these 8 characteristics below?

Being resistant to every change. Whenever a new idea is presented, always being the first to say it won't work. You don't have to have a reason. Just oppose it.

> **Point to ponder**
>
> *William James said: "I have no doubt whatsoever that most people live, whether physically, intellectually, or morally, in a very restricted circle of their potential being. They make use of a very small portion of their possible consciousness... much like a man who, out of his whole body..., should get into the habit of using and moving only his little finger... We all have reservoirs of life to draw upon, of which we do not dream."*

Always being negative - about everything. Seeing the glass half-empty. Always. There's nothing good about this place - leader – idea - day - the patients - life. This is not advocating always agreeing with a team and we have covered that in Groupthink.

It's OK to have different opinions, challenge the system - and even the leader. Differing viewpoints help make us all better. The key is to do so in a spirit of cooperation, not a spirit of disruption. You don't have to be the odd person out - even if you're different from everyone else. In fact, don't be.

Always having an excuse. That it's not your fault. It's someone else's fault. Always.

Never having the solution. It's your job to point out problems, not to help solve them. In fact, you don't care to build - you're here to tear down, cut the pillars that support the system, *and*, you intend to do that part of your job well.

Holding opinions/suggestions until after something isn't working well. Making sure everyone knows you were opposed to the idea from the start. You can clearly see how things should have been done. And, you make sure everyone knows how it could have been preempted then but wasn't. Neither does the advancing an aloof attitude commonly referred to as 'Just helping a fellow brewer with an answer… not telling him to do it'.

Talking behind people's back, rather than going to the source - it stirs more drama if you talk about someone rather than to someone. Of course, you talk behind the leader's back too, though you're usually extremely pleasant in their presence.

Refuse to participate in any team social activities. Who needs who, them, right? Why would you want to hang out with people you work with anyway? You might get to know them - and they might get to know you.

Don't buy into the vision. And, actually, this translates into working against the vision. You may even have a vision of your own. Sort of being one who *have a problem for every solution*.

You may have been injured in some way previously. It could have been on the job or in your personal life. You may have been passed over for a promotion or you began to feel taken advantage of in some way, feeling inferior, humiliated, or are just plain negative person and this is percolating into your professional life.

(Caveat - these are all written with a hint of sarcasm). Modified from *Ron on* churchleaders)

Taking responsibility, being knowledgeable, genuineness (or the sound of it) and authentic communication on your part will cut through much of these. ("To thy own self be true." - Polonius, *Hamlet, a Greek philosopher).* Do the right things. Act in a way that is congruent with your true character. Act with integrity. Be guided by your heart.

The rest will take care of itself. While attempting to be one way at work, while your "true" personality and character emerges outside of work do not be shocked or confused when your colleagues don't trust you, don't like you, and can't really wait to do without you. Abraham Lincoln put it this way 'Believe in yourself and everybody else will believe in you'. Kevin Kruse covered some of these points on *Being Authentic.*

Being proactive is a habit formed by everyone who takes on responsibility - one who needs to be 'response-able'. According to Stephen Covey - a leading American author/an authority in leadership; Proactive people recognize that they are response-able. They don't blame genetics, circumstances, conditions or conditioning for their behaviour. They know their behaviour is a product of their choices. Reactive people, on the other hand, are often affected by their physical environment. They instead find external sources to blame for their behaviour.

The blame mentality, if correct, should declare that nothing good or bad is ever our own fault. But Winston Churchill said that 'responsibility is the price for greatness'.

Covey further grouped the challenges/problems/opportunities of everyday life into two: Circle of Concern and Circle of Influence. Proactive people focus their energy and time on things they can control (their circle of influence) Things they can do something about: health, problems at work etc. The Reactive people focus their efforts on things which they have little or no control over (circle of concern) e.g. the national debt, terrorism, the weather etc.

A lack of congruence between personal and professional values creates a reality gap that is obvious to team members. Porter-O'Grady & Malloch (2015) linked authenticity to leadership: That the success of the leader is more closely linked to personal authenticity than to a particular leadership style.

Discovering your life purpose in your work is important. The career we choose ideally ought to be best possible medium to share our life's purpose with the world, but it is also true that for many people, a career change is about the most important learning experience in life. Though it was a leap of faith mostly, it should also make financial and logistical sense. This was what Amanda Carrado said on The Muse *Career story* on April 5th, 2017. She changed from being a financial analyst with JP Morgan Chase to become a recruitment consultant specializing in talent acquisition.

Real talk

According to Bishop Allan Kiuna who runs a column 'Real Talk'-:'The future truly makes all of us, regardless of current or past status, we are subject to the hope and mercy of tomorrow. He added Life will always be difficult if you are always trying to start all over instead of confronting obstructions and oppositions on your one resolved journey. On your single straight and narrow path towards a single destiny. Legacy has an irreducible minimum: never operate on your second calling! Your primary call is your lifeline and your source of life'.[*Real Talk' The Nairobian*]. I believe the bishop to some extent because one thing remains constant about every career and that is – human nature. Wanting to excel, being valued, going beyond the limits of oneself if that is what he meant.

As I concur with the above, I believe we all have points in our careers that don't go as planned, yet we would like to feel better about where we are going. Do you ever wonder if "this is it"? Yearn for greater meaning in your work? Getting too busy (or too bored) wishing life was more exciting. Every you speak, all that people heard was nagging and whining. Actually begging their attention. Albert Einstein once said the thinking that got us to where we are is not the thinking that will get us where we want to be.

For many people, the turning point was when something terrible happened in their lives, their career and so on. You think you will never be happy when you are in a rut. It is when you are there at your darkest that you need to grip down and try your hardest. If you do not see any of these possibilities but keep seeing progression of the end, not even a fair compromise to overcoming your limitations, even one step at a time, then it would be about time to do what we call in Kiswahili *'jiite kamkutano'* or self-evaluation or rather REFLECTION +ACTION=CHANGE. May be all you actually have to do – LISTEN – to yourself. Really getting down and really thinking about it. There is nothing as great as that moment, 'I came to a moment of pure realisation one night, at about 2am'.

The simple decision that this was no longer what or who you wanted to be. Or otherwise woo-ing your chosen career path back and see how it would bloom - just because of a change in your attitude. Give it the time and affection and attention it deserves. You realise that you miss the best years of your career can but you only see this now. Do not be surprised if you begin glowing with happiness..

Stephen Covey, recognized as one of Time Magazine's 25 most influential Americans and an acclaimed world top leadership authorities wrote in '7 habits of highly effective people' that there were 3 constants in life: change, choices, and principles. Some who followed these had something to share, 'I was giving to myself the advice I needed', 'See the causes of my frustration', 'Once I knew these causes I could act upon them' (in the words gleaned from Julio Peironcely Ph.D).

Covey continues, 'take a moment to think about your life now. Are you right-now - who you want to be, what you dreamed you'd be, doing what you always wanted to do? Be honest'. Sharma (1997) cautions that there is always the apparent risk that came with self-examination and soul searching. Some people even quit jobs that had stifled their progress the moment they discover the true purpose of their existence. But let's put another way - is there a risk in discovering yourself and the mission of your life?

Making a concrete decision from the very core of your heart that your life is more than the sum of your present circumstances and becoming the very best you can be is life's most noble pursuit. "The purpose of life is a life of purpose." Robert Byrne. Stephen Covey, on the other hand, wrote that *if your ladder is not leaning against the right wall, every step you take gets you to the wrong place faster.*

As long as you do not lose focus on where you want to go, expect change to happen and look for it. At times trust your basic instincts to sense and make sense of when a change was going to occur and be ready to adapt to it. It can mean more than one process of going around, under, over or through the challenge in order to adapt.

One can even believe in something illogical if need because 'imagination works and walks'. What was your moment? It may have been an offshoot of something you were doing as part of your career or off work. If only to encourage ourselves, it's advisable to leave the status quo. Better that than the fear, the empty feeling of resisting change.

Consider some words drawn from Robert Frost's (1874-1963) poem ***The Housekeeper***:

> *Strange what set you off*
> *To come to his house when he's gone to yours.*
> *You can't have passed each other…*
> *Though what good you can be, or*
> *anyone -*
> *Its gone so far…*
> *Been there for hawks since chicken-time.*

Our mind is capable of imagining things, the likely ones being irrational worries and fears – even scaring oneself to death. The opposite is true our mind can imagine exploits, surprising everyone
- even astonishing oneself. Therefore, move along! Let go and trust what lay ahead. 'Chances are
there, What if you make it? So I look at the - what if?'- Caleb Karuga in *Young Rich*. It may do you some good, God knows you need it. 'Do what you would do if you weren't afraid?'(Quote from *Who Moved MyCheese?* By John Spencer).

Let us start becoming what we are meant to be by developing our potentials and living purposeful life within our profession and beyond. "It is not a profession that makes a man; it is a man that makes a profession." Show some leadership wherever you are instead of complaining.

> "Competent nurses who refuse to play roles in processes that produce nursing leaders are more dangerous to the profession than incompetent nurses who emerge as leaders but lead poorly."

This was gleaned from *leadnurseafrica* wall on Facebook by Collins Ogbolu posting on 17th September 2016. Adding that it was more profitable for nurses to FOCUS on how they could contribute to the growth of nursing individually and collectively.

You might begin to realize that the 'sterile' world of nursing that you had grown accustomed to had: dulled your creativity made a hardened sceptic out of you; limited your vision; felt more exhausted than empowered or more cynical than self- renewed.

Ask yourself: what dream of your life is waiting for you or was it more of the same pain? It could not all be about frustration tolerance which is usually as a result of the fact that some

people went into nursing expecting one thing and become disenchanted when they receive something else.

Being cynical with an 'I can't' attitude hinders many things in terms of progress. The minute you believe something is not possible then it's not. Patience is a virtue in career life. The saying goes that 'Rome was not built in a day'. We could also put it another way – 'Rome was not built with stones but it was built day by day with vision'. While there might be things we could do to accelerate our tomorrow's growth today, we need to do our own growing one day at a time in most aspects of life.

Philosophical insight is a distinction that drives purpose in the profession. Thinking through the philosophy and historical backgrounds of nursing or in general the caring professions helped many people to form an informed choice that has kept them focused independent from prejudices. They were likely to be more autonomous in their judgement.

One therefore ceases to be 'a mere' nurse (if you allow me to use it), but means it. It was not that waves of doubt can't reach them but their habit of mind makes them better nurses. They were also given to theorizing about certain experiences in nursing. They are likely to initiate constructive discussion, explain what they meant.

Seek to know the truth, try to make sense of certain issues, reading widely for pleasure and self improvement, look for evidence etc. They take networking, even by correspondence seriously. These are some of the values that have seen nursing grow to become what it is.

Every other professional trying to make a difference somewhere will tell you they faced frustrations, 'Frustration is always there somewhere …'- General D. Opande, Commander UN peace keeping mission to Liberia (UNMIL)[71]. It was commendable that even having gone through that his team managed to disarm over 40,000 rebels in less than 1 year. Normalcy returned and for years to come Liberia moved from a failed state in 2003 to what it is today.

Those who enter health care profession(s) for love of the profession often found that the money followed their choice naturally. This was exemplified by Stacey Ryan MSN, RN. Quoted in *Five reasons to consider a career as a home care nurse*' appeared on June 15, 2017 in *Nursing Notes* a platform sponsored by Johnsons & Johnsons: '…they were destined for that profession …. they were nurses through and through … they wore it like an identity.'

As a nurse, it was important to identify early enough what was important to you. Might be you identify with a specific area of nursing in which you had always wanted to work. Maybe you want to be just a little more adventurous, move to another country, meet new people and explore new things. What of those projects that you've fantasized about doing "when I have time"? Maybe you just want to go on some holiday.

What of spiritual reconnection with a being bigger than yourself? It can be quite reassuring. Investing in yourself is the best investment you will ever make. It will not only improve your life, it will improve the lives of all those around you. It is not however advisable to make any major life decisions like quitting your job until you've recovered from compassion fatigue (physically, emotionally and spiritually).

Wait until you can see things more clearly. In our settings having an up and going plan 'B' as a nurse is never a bad idea especially if you are on employment, what you would do if you found yourself jobless tomorrow. C, D, E, F if you can for softer landing just in case. However, that is no excuse to do your employed job without the gist and energy you used to have. [71]*The Untold Story,* KTN News, 26th August 2017.

As a nurse, you would be imbalanced if you are unaware of all the wonderful avenues available to nurses. One nurse commented 'you can do whatever you want with it: be it – bedside, teach, conduct research, manage programs, write books, blogs, work with health care organizations, insurance, non-governmental organizations, school health, work for the central government, county government, pharmaceutical and non-pharmaceutical med products representative, or open an agency/consultancy/private practice etc.'

The world of work is full of tangible advice, people who have moved on in life, some after serious setbacks. Each of these ought to be treated as a learning experience, 'You should never be afraid of the learning curve, you will do some mistakes but learn from them and move on' - Caleb Karuga in *Mkulima Young: Champion of the week*.

Think BIG, start small, Start NOW! You can work full-time, part-time, float/pool, contract etc. Hands-on direct patient care, otherwise known as bedside nursing is the core of caring work. It has some unique characteristics: - it is more available, is a key driver in the healthcare industry, had variety, specializations, often times paid better and was more flexible.

This was where the majority of nurses worked and chose to remain. It is also the best place to begin no matter what other avenues one aspires to move into. It is not only a great launching pad; it provides a receptive fallback position. All great nurses put aside some mandatory direct patient care time, 'to remain in touch and in shape'. It is the recommended nurses' lifestyle. Many statutory nurses' bodies in different countries insist on this component for one to be retained in their register.

Stay in touch with what is happening in the region (and the world) around you; it is safer to be aware of real choices. The following examples might help. The first one was an extract from a recommendation note:

> 'He was instrumental in conception, getting the grant to implement two programs - Higher Diploma Critical Care Nursing and Higher Diploma in Nephrology Nursing in 2010. Today the two are in high demand after most of the county referral hospitals opened ICUs and renal units without adequately trained staff.

> As the only training facility in Western Kenya, the classes are always overbooked and have a long waiting list. These have become some of the most innovative income generating projects for the hospital. For these we always remember him, we feel honoured to be associated with such a hardworking inspirational nurse educator that he is'.

Apart from teaching other opportunities abound for nurses who wished to cast their nets wide. When you have the courage and the urge to move on up, you might endeavour to dare abroad. An example of a Kenya nurse who had outmigrated might suffice:

> A nurse friend of mine decided to venture abroad in the US; he was an ICU/renal nurse even before leaving the country. The pay check was not bad but soon he got disillusioned. He was not entirely feeling fulfilled, he wanted to find his niche. He finally got it by training as an anaesthetic nurse specializing in spinal and blocks.

There was need to refine their nursing practice to international standards. 'You either go world class or you don't go at all', these were the words of Barasa Mwabe the founder of *Mawanume ni*

Effort interviewed on The Entrepreneur KTN 18.30Hrs, 20th October 2016.

Furthermore quote of the week *Africa Leadership Dialogues:* "There is no such thing as African excellence. There is one definition of excellence, which is, world class" by Yaw Nsarkoh on Pan African TV *AfricaLD show* on Nov 3, 2013. This means we have to endeavour to raise and maintain standards in what we do.

In the new role of carelee, the onus is upon them to address why in his/her opinion (informed by contextual, environment, character factors etc.) the carer could be as satisfied or disappointed about nursing. Many including the carelee could admit having passed through this phase more times than they would wish to confess.

My testimony

For this author it took so long before coming up with the brands carelee and compleat nurse. For him, it has been 26 years in nursing (21 of these at the operational level or what we call bedside nursing), and the struggle never really goes away but you just learn how to handle it. After transitioning from one aspect of nursing to another over the years I know better. I still do 16 hours of clinical work per week but mainly as I mentor the undergraduate nursing students.

I worked mostly in public health facilities with only a short stint in some private hospital and a glimpse at the US as a student. I have had the opportunity and privilege to see health issues from a variety of perspectives.

Many times I struggled with meaning and burnout just like many other nurses I know did. In those 20plus years I have seen and worked in shortages both at the bedside and in management positions. The longest time in my career was as a backroom staff: I delivered babies for hundreds of women, took directions and orders at the bedside etc. In the years as a nurse manager, I implemented policies and protocols, worked on and implemented hospital based nursing courses. But my main concern was always taking care of 'my' nurses and having their interests at heart. I tried to ensure that essential resources and support were made available to them. I helped create support groups among staff. We held frequent come togethers and debriefing sessions. The most critical period was the nurse manager phase, they were my best years as a nurse. There were so many challenges but looking back I see I had some great times, like this was what I was made for, though I did not realise it then…

But like many a nurse knows, a life long career at the bedside is a thing of the past in today's healthcare environment. In resource-constrained settings especially, it can suck the life right out of a person (My 2 cents). This does not mean that this author advocates that nurses leave the bedside. Not at all, on the contrary the bedside is the backbone of nursing, but it also breaks a few bones. One needs to know how to balance - when to hang on, when to take a rest from it or when to leave all together. Do not just walk out, not yet! Whatever choice you make remember that once a nurse always a nurse.

Having got my MSN from University of Colorado Denver, US I believe that I have the best of both worlds. Nonetheless, as a student of health systems and health policy, I believe I finally found my niche.. Many of my opinions are still forming and I soon found that the one way of going around these was by asking questions. It has taken time, long enough to be relevant and hopefully make a contribution. My focus now endeavours to unravel and explain this phenomenon in as far as its limit permit. Perhaps suggest solutions whenever I can. My background as a clinical nurse, leader, educator, researcher, compleat_nurse] provided a lot of fodder for my projects. I am all eyes and ears everywhere I go. It gives me so much energy that I have something to look forward to every time. I push myself to look into what else, where else, whys and why not's. The motivation? - I realized that once I made a clear decision to blog, focus on this winding path, opportunities seemed to appear from out of the blues.' [http//:www.compleathealthsystems.com]   [smk]

For nurses who saw these changes coming, it was an opportunity like no other. It presented many real choices. It is important to be open-minded enough to learn something new, act differently and adapt in time in order to succeed as a compleat nursing care provider and collectively as an organization.

Napoleon Hill wrote in his book *Think and Grow Rich* that he believed: 'whatever the mind of man can conceive and believe, it can achieve'. In other words what you are looking for could be looking for you. As such it was important to be prepared for good luck by: connecting dots, have the needed openness by constantly learning the needed skills-sets for the marketplace.

Unfortunately, the nurse must overcome the victim mentality, the following from *leadnurseafrica* posted on its wall Facebook on 17 September 2016 stated in part: The common experience an outsider *might* have after interacting with an average African nurse is the litany of problems in Nursing, those behind the problems and how all of them have worked together to "Frustrate him/her" Echoing Florence Nightingale who said; "I attribute my success to this: – I never gave or took excuses. "The biggest enemy of progress among AfricanNurses today is habit of giving excuses over personal and professional setbacks".

What about the family? The best gift you could ever give your children is your love. Few things are as meaningful as being a part of your children's childhood. Get to know them again. Take the time to watch them grow and flourish. Show them that they are far more important to you than the fleeting rewards of your professional career. Don't miss the forest for the trees. Sharma (1997) asked – 'What is the point of climbing the steps of success if you have missed the first steps of your own kids?' Live your children's childhood.

The rituals you do together mean a lot more than the overtime cheque at work. The money, as usual, you will never get enough of it, but the honoured rituals' together with family memory are invaluable, remain forever.The memory of having the skill to know when to call family in to say their goodbyes with just enough time to spare.... Parenthood slips away fast, because sooner than you realize children will be all grown up, up and about looking out for themselves. A nurse never ever forgets the gift of family. It is a choice one has to make. Make the decision to spend more time with those who make your life meaningful.

No matter what your dream for your life is at this down moment, memorize it. Write it down. Share it. Embrace it. Do research on it. Plan it. Rehearse it. And make it happen! That means as a professional you are getting somewhere. Oprah Winfrey, the highly successful talk host said "(N)o matter what challenges or setbacks or disappointments you may encounter along the way, you will find true success and happiness if you have the only goal, there really is only one, and that is: to fulfil the highest most truthful expression of yourself as a human being."

Going back to my pet subject - the compleat nursing care provider that we envisioned earlier. This is a future-now and not a yester-today person who: even when they see a challenge bigger than they can handle, they see it is not bigger than they can manage.

One who is an expert at workaround: a method for overcoming a problem or limitation in a program or system. Reminded me of Steven Spielberg's movie *Back to the future.* In resource-constrained setting no matter how hard things get or how badly the 'compleat' nurse is pushed to give up, they look up, look forward and keep going. Look around and say - there is always something to use and do not want to look for excuses.

They have goals that energize their lives. Believe what has to happen in their career life has not yet happened while enjoying the special moments that every day offers because - today, this day is all you have.

Living in the fullness of each day and hope for what will appear in your future is what gets them out of bed in the morning and what keeps them inspired through their days. Knowing they might trip over stuff they weren't even looking for, which surprisingly becomes more than they expected, it could even be worth everything they have been looking for.

It has been said that you can change your life with a single idea - if it is the right one and as long as you take action now. Start off small, but start now. Every day, take some action to advance in the direction of your goal.

The evolving trend in management had sort of replaced hierarchy with networking, demanding that bureaucratic systems be more flexible, replaced control based management with relationship building, featuring empowerment and coaching (Bartlett & Ghoshal, 2002). Relationship dimensions: Internal (personal), horizontal (interpersonal), vertical (leadership).

The Carelee thus believes in networking, reaching out to people for ideas, perspectives and different forms of support. Those who will selflessly serve others, wake up the aspirations of everyone else, including those who are tired of the status quo and clients/patients who have no voice. Fortunately for some of it might include embracing a global perspective.

The orientation in nursing needed to work for them by refraining from viewing new expectations on nursing with old lenses. The longstanding deeply embedded 'matronly, big sister/brother, mother superior' culture was the accepted way of doing business in nursing.

They tended to be more task oriented than people oriented whose functional goal was about allocation and effective utilization of staff nurses. We need to see our staff as a work in progress by creating value in them with a sense of purpose, embracing positive appraising and constructive criticism. Inject meaning into individual effort.

Help them to explore newer, less typical, less traditional approaches to doing things. Literally, bring out vitality in them. Help them reconnect with each other and with the goals of the organization.

A panel of student nurses' perceived intolerance and intimidating behaviours by some qualified staff who must be avoided (Porter O'Grady & Malloch, 2015). This report had analyzed various findings noting that there was need for nurses to care for each other just as they did for their patients. Unfortunately, it has been said that 'nurses eat their young' and indeed in nursing the nurses (staff nurses and nurse managers) and not non-nurse co-workers have the greatest impact on nurses' stress. In this regard, nurses could be/were their own worst enemies and consequently the solution to many of their problems maybe lay within nursing rather than outside it.

"Breaking from the status quo means taking action, and when we take action, we take responsibility, thus opening ourselves to criticism and to regret." A choice quote from J. Hammond, R. Keeney, H. Raiffa in *hidden traps in decision making* (Harvard Business Review, 2011), a PDF may be available online. Another one that I might recommend for those interested in going a step further into self-discovery and making smart choices.(see **we are now leaving status quo** below):

(Mural courtesy of Harvard Business School)

A short African verbiose illustrating how a lacuna that perpetuates the status quo was upheld. Told of a mother (*sic*) who was conversing with her daughter (*sic*) went like this:-

> *Daughter I: Why do you always cut the tail of fish before cooking it?*
>
> *Mother I: Because my mother always did so*
>
> *The daughter I: Why?*
>
> *Mother I: I don't know, may be we need to ask her*
>
> *Daughter II (alias mother I): Why do you always cut the tail of fish before cooking it?*
>
> *Mother II: Because my mother always did so*
>
> *Daughter II: Why?*
>
> *Mother II: I don't know, may be we need to ask her*
>
> *Daughter III (alias Mother II): Why do you always cut the tail of fish before cooking*
>
> *it? Mother III: Because I had a small cooking pot.*

According to Dr. John Kithaka[72], the founder, Chief Executive Officer of Fountain Enterprises Program (FEP), whom I recognize as a mentor in many things, "My dream for Kenya is for people to identify their purpose and utilize their talents and gifts to exploit that purpose… people strain to make money and work in jobs they don't enjoy, yet it would be much easier and enjoyable to do so in the area of their calling". Dr. Kithaka is a motivational speaker on entrepreneurship and empowerment,

Fred Machoka, a renowned Kenyan media personality was interviewed in the program *Jeff Koinange Live*[73] christened *The Living Legend,* 40 *years later* added "enjoy what you do because
if you don't you will have a long day… Do what you enjoy doing, and get paid for
it."

The secret of happiness is simple: find out what you truly love to do and then direct all of your energy towards doing it. … then find someone who will pay you to do it. Once you do this, abundance flows into your life and all your desires are filled with ease and grace.

If you study the happiest, healthiest, most satisfied people…, you will see that each and every one of them has found their passion in life, and then spent their days pursuing it. This calling is almost always one that, in some way, serves others (Sharma, 1997).

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[72]Parents issue, No 335 June 2014: Inspiring Lives. www.parentsafrica.com

[73]KTN Jeff Koinange Live, 22 Hrs, Thurs 19th March 2015

'To do what nobody else will do, in a way that nobody else can do, in spite of all we go through... that is what it is to be a nurse' ~Rawsi Williams Tweet

> **Career Burnout** *'This is important especially if you realize that you have turned into a hard, mean, unapproachable nurse who only had moments of light-heartedness. Feeling angry and exhausted at the short staffed unit, sick of hearing No all the time from management, and for years you took hit after hit and never repaired the damage'* (these were comments I found valuable, made by a nurse I was networking with online in response to the importance of understanding burnout among nurses). She added *'It was at this moment I made my career change from the adult world to the children's arena and have never looked back. I have had to work to regain the love I had in nursing and get rid of my negativity toward healthcare. It took a long time of self-reflection to learn where I had lost my way and what I needed to do to regain it'*.

In whatever capacity that position may bestow unto us, it is only human to appreciate that it is indeed a privilege being there doing the needful for the patients during their time of need, so it would be best to serve them with humility, honour, and dignity.

A compleat health care provider by looking for new ways creating energy for themselves and their workplace will want to leave behind an enduring legacy, a system that outlives them. If indeed it's a true saying 'we have not inherited this land from our ancestors but we have borrowed it for our children'. This outlook does affect the quality of health care delivery a great deal.

The carelee is an advocate for the nurse's cause. It is about time we dignified the lives of our nurses in Kenya. We do not have time to waste time. A better life for our nurses is better health for our health care sector; no more no less.

The managers are there to ask if there's anything the nurses need to do their jobs. It is not being self-grandiose or anything, but if we took the largest health profession in the country and raised up their capability of providing excellent care through education, welfare, and other niceties you would most likely get better outcomes (Burnes Bolton in FierceHealth *eBook*, (2014).

Even if those needs were as simple as replacing a broken glucometer, providing sustained support from management and leadership is crucial. This might mean having managers who will conduct routine rounding on staff, sometimes on entire departments. Unfortunately, this has not always been the case, there has been marginal managerial attention focusing on problems of employee's capability and motivation (Bartlett & Ghoshal, 2002).

It was not good enough that some positive change was witnessed when you have a great and supportive manager one who had the ability to get things done. Only that such change rarely outlived them, it was unfortunate that for many resource constrained settings it was more to do with management capabilities of persons vested with responsibilities to manage and not having any superior systems in place.

Individuals, networks could fatigue but institutions did not. Therefore it was better to fight to have strong institutions, systems, frameworks, models etc. Strengthening them included funding them deliberatively and affirmatively to enable them to do what they were mandated to do. Strengthening bodies and persons meant supporting their mandate, giving them power, instruments, space and trust.

'Hospital administrators need to take the time to listen to nurses - the core of hospital bedside care and not just look at everything on a spread sheet in order to handle the economic downfall'

(Lee & Anstead, 2010). Sometimes managers and administrators get caught up in the numbers that they forget the basics and how important nursing is to the overall bottom-line.

"No one is sitting in an office, evaluating data and telling nurses what to do," said Mike Swanicke, a management engineer on the Performance Excellence Team. "We're working together to solve problems." *Run your Nursing Department Like a Business* University of Utah Hospital.

Patterson *et al.,* (2012, p11-14) described tools for talking when the stakes were high in what was referred to as holding crucial conversations. Crucial conversations were characterized by high stakes, strong emotions, and opposing opinions. How we each handle those moments matter a lot towards our joy and fulfilment in the workplace, ultimately the productivity of the organization.

Unfortunately for many such situations 'when it matters the most, we do our worst'. Or else employees fell silent when crucial moment's occasion. In their research they were able to document that in organizations where employees voiced their concerns their endeavours were less than half as likely to fail. These means that there are serious performance indicators that could be linked to relational communication in the workplace.

When fighting for others rights, those others must be seen to be behind you also. Unity across the ranks in nursing was paramount. Lately, the unity has held, brought some gains and also some not so good results. This author's observations were that caring in Kenya has not suffered such volatile and uncertain moments as now.

Out of the hard times a number of no-nonsense personalities who could handle anything emerged; a crop of nurse activists and advocacy leaders who after marginal success were known to regroup and return, since as they said it 'they were not asking for a favour' its until they got what they wanted. Words came easily for a number of them.

They often intimated that they were running for something and not against anyone. Anything accrued to them in the process was with the interests of the nurses (and by extension patients) at heart, so they said.

Hospitals in the Kenya need to address nurses' concerns early before strikes seriously undermine patient care. Apparently, somehow it was becoming more of a reality in Kenya especially that some compromises and gains could not have been achieved without the threat work stoppage or a strike. Why had this become necessary in our settings?

The Kenyan case fortunately or unfortunately demonstrated to a significant extent the need for long-term efforts to support nurses (albeit through resilient union campaigns - a not uncontroversial partner), to overcome the political sclerosis typical of so many African legislatures. Or could it be as the late Chinua Achebe wrote – paraphrased from *Things fall apart, 'As* a man dances so the drums are beaten, Mr. Smith danced a furious step, so the drums went wild'.

The tempo had been upbeat with the advent of the county health system. The county bosses or the health care providers were not in sync. The Salaries Remuneration Commission (SRC) governors were complaining rather loudly for healthcare providers' comfort about what was a perceived right e.g. disparate pay perks, 'hefty allowances medics earn', study leaves etc. These were perceptions the medical fraternity were not taking lying down. This was regrettable and

spending was mainly driven by historical trends and less ideally on strategic plans. Counties claimed that they were using less allocation on development and more on salaries for the 'bloated' workforce they inherited from the national government. (Counties retained all health workers employed before devolution in March 2013 at their former salaries and benefits packages). Yet several counties were not hesitant to use half or more of the little development resources on constructions, it hardly mattered whether they would get completed, equipped and manned.

Bad blood it seemed was a matter of interpretation, who was doing it and conveniently so. According to the Institute of Economic Affairs (IEA) in the 2012/2013 FY counties were probably given Kshs 55.1b. Further it is to be underscored that counties make their own choices about health allocations, so they may spend more or less than the national government on health. Did the counties really spend that amount on health? Or maybe the national treasury did not actually transfer that amount on its totality. The IEA is a public policy think tank.

Since 2013, there was some continued bad blood between County Governors and the central government over allocation of resources, the Governors demanding more while the central government demanded for accountability of what had already been released. Previously, there was even a call in support for a fresh referendum with 'Pesa mashinani' campaign which translated from Swahili means 'money to the grassroots' among other contentious issues. This had been gaining momentum and it would be a matter of time before Kenya goes through another YES/NO referendum on this and other matters.

County governments were pushing for a 45 per cent of national revenue devolved to counties. But by early 2015 the national treasury threatened to deny them increased allocation to devolved units that had apparently mismanaged previously allocated funds.

By conceptualization it had been expected that in 3 years of devolution counties would gradually build capacities, have functions such as costing unbundled meticulously. Health was a shared function as per the constitution. It was expected that counties should first have taken over preventive, promotive care which included primary health care activities, health centres and dispensaries. These were to be piloted before taking on larger facilities. Instead of this, things happened so fast.

Governors wanted a lot of work and the national government let go against the recommendations of Commission of Transitional Authority, 2012. One disappointed observer noted, 'it was not supposed to have been taking over from where the other one left, but from where they were and carry on'. She added, 'it was like dropping a 'ball pap!''

Problem holder's nolonger existed unlike before. It was believed that there were previously unappreciated and unexplained attributes of the national government that used to cushion and adsorb many things such as staff unrest. Devolution of health was a great idea that had not been well implemented.

This author could not help feeling like our government needed to work smarter to improve the provisions under the devolved plan that we now had, instead of constantly locking horns over its existence. Disbursement of funds from the national treasury was done on a monthly basis over the 12 month period.

For example 2014/2015 one such county received Ksh 340million from the national treasury that month. Ksh 150 million from this went to payment of salaries; 30million

most unfortunate considering that the most affected would mainly be the vulnerable and needy members of the society. Consider the following examples.

Barbara Schutt (then editor of the American Journal of Nursing) wrote concerning industrial action. This was soon after delegates to the American Nurses Association (ANA) in 1968 did away with *No-strike policy*, '… few nurses will use strike weapon easily, and if they do, they will use it responsibly - with adequate notice and plans to provide emergency care'.

This observation was becoming a remote reality, especially in Kenya. Strikes had changed from the rare exception to become the common norm in recent years. No need to explain that here, since activism was never the primary intent of this book but rather factors that would allow us to interrogate the quality of health care provision in our settings (see ♯**HealthcrisisKE Diaries** in Chapter 2).

Article 41 of the Kenya Constitution and labour relations laws spelt that: workers could express their rights to go on strike as one of the avenues when their rights to better terms and conditions of employment are violated by employers. Further, during an industrial action striking workers take directives from bonafide officials of the union only… Could these legitimate expressions have been overused of late (2012-2017)?

May be there was need to safeguard against strikes and lockouts by health care workers. On 60th and 129th day of the nurses' strike the Federation of Women Lawyers of Kenya (FIDA).

On 1st August 2017 FIDA went to court asked the attorney general's (AG) office in 90 days to file a bill to come up with a law that would mitigate the effects of industrial action affecting essential services workers.

In its submission filed under certificate of urgency it demonstrated that the respondents had allowed the strike to prolong with no hope of calling it off. It agitated for an order to compel them to sign the CBA to be signed and filed in court in 7 days. On 11th October:

> A Case filed by FIDA asking the Industrial Court to compel KNUN, COG, MOH and SRC to complete Nurse's CBA by signing and registering the CBA in court, was heard by Judge Nduma Nderi... COG, SRC and AG representing the Government gave their submissions and determination of the case will be on 8th December 2017...

> In another case filed by KNUN at Nyeri Court: Meru, Kirinyaga, Mandera and Lamu counties have been ordered NOT to hire to replace striking nurses until the case is heard and determined as indicated below:
> Cause No.384 of 2017. ORDERS :
> 1.   Application Certified Urgent.
> 2.   Services upon respondents by close of business tomorrow 12.10.2017.
> 3.   Inter-parte hearing on 18.10.2017.
> 4.   Pending the inter-partes hearing of the application, the Respondents herein are RESTRAINED from proceeding with RECRUITMENTS, SELECTION and APPOINTMENT of ANY Persons towards replacing the Claimant's members in the respective employments and more particularly as a consequence of the job advertisements by the 1st, 2nd and 3rd Respondents respectively.
> 5.   Cost in the cause...

This was not the first time such a petition was coming concerning essential services if one remembers the Petition70of2014 by bigwig activist Okiya Omtatah Okoiti. It sought among others ...*there is need for the state to enact a legal and policy framework to secure the rights of workers in essential services, and to ensure the amicable resolution of Labour disputes without disrupting service delivery*.The petition was dismissed by Justice Nduma on 8th day of December 2015.

Nevertheless, *The User Guide on Employee Relations for the Health Sector in Kenya 2016* said in part- no one should take part in a strike if engaged in essential services as health. This policy yet to be enforced exhorts workers to draw a line between self interest, politics and professionalism at all times.

Pic: A recent demonstrations by nurses on day 125 of the longest strike that lasted five months (Photo courtesy of *Precision Nurses* wall on social media)

The Bill of Right is entrenched in The Constitution Article 41 (2) (d). The bill of rights provides for industrial action among other things.

However the Labour Relations Act 2007, section"81": Essential services
(1) In this Part "essential services" means a service the interruption of which
would probably endanger the life of a person or health of the population or any
part of the population.
(2) The Minister, after consultation with the Board—
(a) shall from time to time, amend the list of essential services
contained in the Fourth Schedule; and
(b) may declare any other service an "essential service" for the purpose
of this section if a strike or lock-out is so prolonged as to endanger
the life, person or health of the population or any part of the

population.

(3) There shall be no strike or lock-out in an essential service.

(4) Any trade dispute in a service that is listed as or is declared to be an essential service may be adjudicated upon by the Industrial Court.

(5) A collective agreement may provide that any service may be deemed as essential service"

A bill had been tabled in the 12th Parliament in October seeking to secure essential services against the ravages brought by constant strikes and lockouts. It sort of cements want is actually in the labour relations act above but adds tough clauses to deter nonconforming parties.

Just like Petition 70 of 2014 the same argument might be advanced in the pushing of this bill. In as far as Section 81(3) and 78 (1) (f) purports to nullify the right to go on strike provided under Article 41 (2) (d) of The Constitution.

Whereas Article 2 (4) of the Constitution provides that; *"any law, including customary law, which is inconsistent with this Constitution is void to the extent of the inconsistency, and any act or omission in contravention of this Constitution is invalid."*

Fida observed that CBA's in the health sector appeared to be losing their value. There was a need to balance upholding the freedom of workers to go on strike while protecting the citizens' right to life which should supersede the strike.

The gains made by free maternity program, Campaign against malaria, HIV, TB would come to naught if we failed to properly organize manpower. Its manpower that implemented projects and programs. But then when we consider the following posting by A W on Face book wall enlightening Nurses commenting on a (then) ongoing industrial action by nurses that lasted 100days plus '… this opportunity of striking will never come again because I heard the government want to amend laws'

Could nurses cross the picket line to help handle emergencies, with the full approval of the union? The general observation was that many health facilities had literally been closing down during strikes.

However there were a few exemptions, around February 2017, over 300 nurses from the AIC Kijabe Mission Hospital downed their tools, demanding a 36.7 per cent pay rise. The caregivers, who were members of the Kenya National Union of Nurses, also alleged mistreatment by the hospital management.

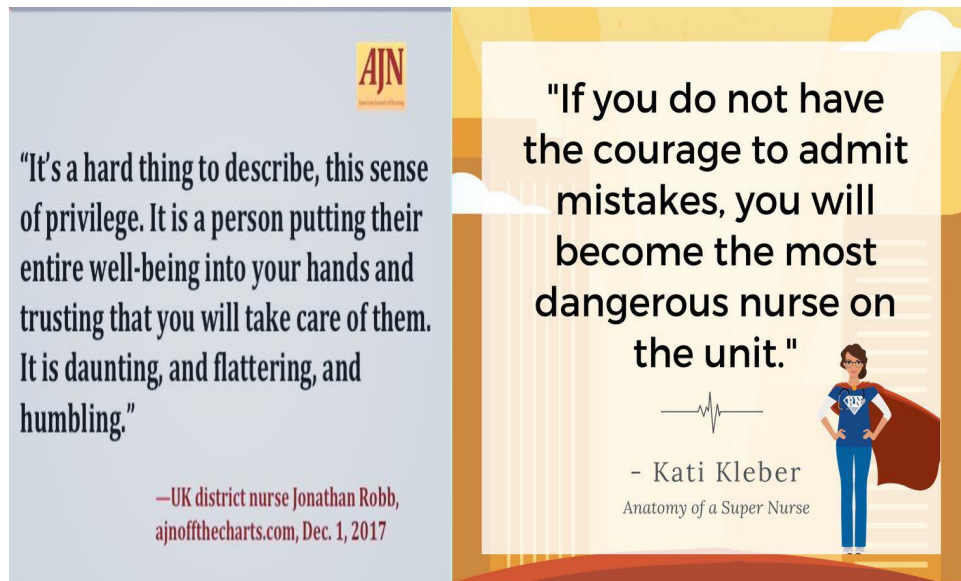They had taken the necessary measure to prevent loss of lives at the facility "We don't take chances with our patient's lives. We had agreed that HDU, ICU, maternity, nursery, the emergency ward and all the critical areas were working normally," The AIC Kijabe Mission Hospital had in its intents and purposes worked more as a 'tertiary' hospital of its own kind, receiving referrals and performing class super-specialty surgeries.

Many sub-Saharan African countries did not have a
A strong lead agency for health care workforce (might be comparable to Teachers Service Commission of Kenya). Rather, responsibility for staffing, personnel emolument, equity, promotions, and welfare was divided between numerous governments' bodies. For Kenya, these include the recently constituted Salaries & Remuneration Commission, directories in the Ministry of Health, Public Service Commission, and Counties' Public Service Boards. Piecemeal efforts and communication between these different commissions, departments, and agencies often were poor. Perhaps this did not have to be the case if the much touted *Health Service Commission of Kenya* was effected.

Point to ponder
The following was what President Paul Kagame of Rwanda said in a National Prayer Breakfast:

"Do not be afraid to face our challenges head on. If you don't work hard and fight hard to be at the table, you become the menu ..., you must fight to be at the high table. We have been items on the menu for too long ... No one owes us our livelihood and we do not owe anyone our livelihood. Working towards the achievements we deserve should not be a one-time event and a way of life. ".

"It's a hard thing to describe, this sense of privilege. It is a person putting their entire well-being into your hands and trusting that you will take care of them. It is daunting, and flattering, and humbling."

—UK district nurse Jonathan Robb, ajnoffthecharts.com, Dec. 1, 2017

"If you do not have the courage to admit mistakes, you will become the most dangerous nurse on the unit."

- Kati Kleber
Anatomy of a Super Nurse

Some wise observations above (Courtesy of Robb and Kleber)

'Success is liking yourself, liking what you do and liking how you do it'- Maya Angelou (1928-2013). Maya was an accomplished American poet, memoirist, civil rights activist, author (7 Biographies), and dancer. But she was more than all that (http://successstory.com).
She wrote this concerning her mission: *'My mission in life is not merely to survive, but to thrive, and to do so with some passion, some compassion, some humour and some style'.* *'Pursue the things you love doing , and then do them so well that people can't take their eyes off you'.* Some of her works include:- 10 rules of success, Live the life of your dreams, have the courage to begin, loving life and daring to live it.

Often times official statistics showed huge inconsistencies - and in some cases appeared like 'copy-and-paste' from the previous year(s). Figures concerning patients' workload, pay checks, leverage increased funding for staff were not always be accurate.

Data from staff unions and the official position often showed astronomical discrepancies. Lack of data could be used as a reason (or excuse) for inaction. This meant that there should be someone to question the data behind decision making in many cases, to question if errors in some of the data came as a result of incompetence or wilful manipulation for whatever reasons.

Without accurate data, it was impossible to develop effective interventions, and it was impossible to evaluate the effectiveness of those interventions that are in place. Even researchers were at times hesitant to rely on the secondary data available from some government sources to accurately quantify some of the problems.

The Nursing Council of Kenya should be commended for leading the way in terms of possessing an updated *e*-database of nurses in Kenya, but more needed to be done.

Literally speaking, everything matters to the carelee. Why, because the carelee belief was that nurses do and can enjoy doing what they did. It was a commitment not only articulated in clear human terms but also reflected in the daily actions and decisions of the carelee as a nurse leader. They were passionate about the need to help, literally searching out the afflicted nurses.

That means that we need to advocate that employers should invest in their employees (in this context nurses) because apart from the patients, they're the second to none reason for the existence of every hospital.

Taking note of this observation from one public hospital - A hospital's first priority was to treat the injured and the sick as they present; *while it was acceptable for a clinician to see five patients in a day - and spend 3 minutes on each, why doesn't it seem odd that a nurse must attend to more and spend more time with each?*

This argument was based on solid evidence, emphasis made by Burnes Bolton in FierceHealth *eBook*, (2014). Nothing could be truer about nursing in Kenya than the above comment.

The fact that Kenyan nurses were still standing was borne out of their resilience, they are not yet where they are going but things are not as they used to be. They were a good example of the saying that *persistence eventually wears out resistance. That together united we stand* but *those who fail to stand together in unity fall together in disunity*.

Pic: Together in unity (Courtesy of anonymous photographer)

Evidence showed that the world over many treatments in hospitals was administered by the nurses who were clearly in control of the milieu. Forget the rotten apples; nurses were the heroes of health care. Every metric on which hospitals (and healthcare for that matter) were evaluated - from quality outcomes; to safety; to patient satisfaction; to staffing efficiency; to medical staff confidence - were dependent upon having a staff of nurses who felt valued on the job (Mitchel 2009) (see Box 1 below).

Nursing was not the only indicator of patient satisfaction but it was indisputably one hospital service having a direct and strong relationship with overall patient satisfaction. Quality health care requires a nursing workforce appropriate in size and expertise and unconstrained in its ability to provide patient care safely. This observation was made by John Mitchell. Mitchell received the. "Top Leadership Team in Healthcare for Mid-Sized Hospitals" (*HealthLeaders* magazine in 2009) also (see **Informal leaders** below).

The carelee role will never be something any outsider can help us do, it is a relationship that needs to be nurtured. The carelee will need to understand the changing times. Taking on the role of a carelee of the carer ought to be something many will be willing to take on in order to absorb the disappointments, frustrations, disillusionment and breakdowns that some nurse somewhere could be going through.

The compleat nursing care provider can call up, shout out to, beckon, get a referral, look up and there will be someone to walk by them upstairs and rest with them on the basement, remind them that the way down is quicker but not necessarily easier.

Enjoy the cool breeze of the balcony together but remind them we cannot be there long. Help with picking the cane that fell off. Once in a while be with you down there as you recollect yourself and pick from where we left. If only we could react proactively rather than proactively to diffuse the adverse effects of caring o the carer.

Informal leaders

Nursing center *eNews* April 2014 advice to nurses:

'...be a nurse leader, no matter your role or setting, leadership qualities are important for us all to demonstrate'. Leadership is based on individual characteristics, approaches to situations, and ability to handle change. It is up to nurse leaders to adjust, adapt, and look for ways to highlight the talents and traits from each of the generations.

Nurses who feel valued can have a profound effect on the environment in which they work as well as their feelings toward the organization in which they work. While administrative leaders are needed, so are informal and formal leaders at every level and department and these need to be recognized'. Nurse leaders are in the best position to advocate for the types of system and payment changes that capitalize on the contributions of nurses. According to The Francis Report 2013 '...we must stop underestimating the importance of kindness and compassion, the fundamentals of good patient care that cannot be budgeted for.'

Why, because there will always be ups and downs of the caring profession. We have not yet discovered another way to it, but so is every decision to be someone's keeper, carer, and carelee. We feel, we react, we sense, we respond, not always the way we would have liked it but it does have a meaning in our heart of hearts - the heart of caring or otherwise *the hurt of caring*.

Cumulatively we often do take it in and not out, and this is where the problem is. Consequently, could be you notice or it had been brought to your attention that you are becoming more prone to a certain tendency to respond with a certain behaviour. We need a carelee in our career's lives. It

is a collegial role that we only can escalate.

We have to give back, dialogue – sharing/growing/filling pools of meaning (Patterson *et al.,* 2012) with those who have been there and seen it all, those in there and those approaching there. The carelee leaves clues and hints - some on purpose, other times maybe not even aware they were doing so. But he knows that he had left a trail for others, in this case, the carer and that carer could find his way if he could just read the writing on the wall.

Mentorship, preceptorship, counselling, reflection have tried but there seemed to be a middle ground in all these, the carelee. We can make it safe for them to open up, share with us what it is that was that was making them uneasy. Never again should nurses 'eat their young'.

They will be mindful to know that there could be someone watching, someone they could come and complain to. I LOVE NURSING wall on Face book, *Tag your mentor* was a great initiative asking members to recognize those nurses who made an impact in their early career life, with a caption '…protect my baby nurse from the rough life of healthcare'. It had more than 1500 (and counting) *comments* and even more *likes* in first 12 hours.

Carelee was not possibly a role with any monetary perks but nevertheless an invaluable one that could be formalized in organizations. Whether one thinks they can or can't, it was a choice that had to be made of becoming a carelee of the carer(s). Giving more of yourself to those around you, whether this meant your time or your energy - your two most valuable resources. The attitude you inculcate might be carried throughout the career life of the beneficiary.

It is a concept that was still evolving and being worked on elsewhere. It is the hope of this author had played the carelee role albeit in a small way through the section we have just covered. Carelee was not always something I spent my time thinking about, infact I started by figuring out the compleat nursing care provider. Blogged about it a bit, including slotting it in nurses' Wikipedia.

But with time I figured out that an effective compleat nurse needed lots of support. Looking at what was it that was missing from the all other supports I realized *carer of the carer* had hardly been touched. Though a bit on the care of carers information was available on lay care (usually the unpaid, volunteer family members to the sick) providers. It seemed like that there was more on them than on *nurses as carers who needed care too.*

The author also felt that the architects of the concept of Magnate® recognition were carelees. They exerted themselves not by looking for an easy way out but one that gave nursing a chance to foot stamp its authority.

Magnet accreditation was one of the most distinguished profiles any hospital could aspire to in the US. It had been proved that when nurses were given proper recognition, everything else fell into place. 'If you look at any Magnet®-recognized hospital system, you'll find that nurse satisfaction reflects on patient care. Happy nurses are happy at work, and therefore their positive outlook shows in the patient care they deliver along with outcomes', Suzanne Lee & Anstead Pamela (2010) had written several articles on self-care on the part of nurses.

To a lesser extent, carelee could be accorded as an honorary that could also be extended to those who had shown exceptional consideration and acts of kindness to nurses. Consider the *Confessions of a hospital administrator* that have been mentioned in later. I believe there

could be thousands of others out there if we were to believe in the genuiness of concerned people who responded to the nurses' petitioning the public and media for respect in the campaign dubbed:

#showyourstethoscope, #JustANurse, #NursesUnite hashtag[s] on Twitter and Instagram in November 2017.

Sharma (1997) summed up it this way, 'By elevating the lives of others, your life reaches its highest dimensions'. Nursing provides one such an opportunity (a higher purpose) that might be lacking in most other careers. It is part of what we do every day. You hardly need to try - just be a little kinder and gentler and have masterly ability to spot a carer who is not handling their patch well, who is about to burn out.

May be this way we can turn many around into a compleat nursing care providers. But each one of us needs to have the right outlook, the new paradigm. In the market place, not every utility car needs to be a Probox®, every motorbike a Boxer® and every jacket (popularly referred to as 'jeket') leather brown.

We too can change our outlook. The outlook could in turn influence policymakers at any level. Consider the following example:

"… My involvement with people with spinal injuries was the beginning of my real life. Before, I lived in a cocoon where I thought that all there was to life was waking up, going to work and going back home." Bright Oywaya, a member of the board of the National Transport Safety Authority (NTSA).

A former banker got paralyzed in a road crash. She has been a leading advocate for legislation to lower speed limits around schools and had taken the road safety message to the global stage. January 2014 she was among the advocacy panel that spoke on a panel at UN Headquarters on the need to include a road safety target in the Sustainable Development Goals. Today we have a specific road safety target to halve road deaths by 2020 in the Health Goal.

The reader will by now have realized that this author had some special liking for 'fables about fulfilling your dreams and reaching your destiny' based on the SagesofSivana' by Robin S. Sharma (1997). This is one self-help literally work that I might recommend.

Also, try www.whitedovebooks.co.uk they are some of the internet's leading website for self-improvement and personal development. While at: www.alt.binaries.e-book sample some of Dale Carnegie's work e.g. *How to Win Friends and Influence People.* It aided me enormously, might I recommend it too highly!? The beauty of it is that these are open source (free) *e*-books. Remember readers are leaders and you will be a true leader once you get into the habit reading, good stuff on personal development, evidence-based practice etc.

1.9.2 Changing nursing care models: Are we there yet?

With all these changes happening in our health care system, the reality of the matter might be just as Abraham Lincoln (1809-1865) had observed, 'It is not "can any of us imagine better?" but "can we all do better?" The dogmas of the quiet past will not work in the turbulent future. The occasion is piled high with difficulties, and we must rise to the occasion. As our cause is new, so must we think and act anew'. What is at stake is now worth more than what it used to be.

There is a mark-up in terms of value in everything we do. The service we have always given will no longer be just work, it is now referred to as a business. Patients are now called customers/clients. Administrators are now called managers.

Staff are now teams. Performance contracting can only be expected to be weighted more, targets escalated and cascaded further down. The age of accountable care has caught up with us. There is no future for healthcare decisions and actions for which there is no functional relationship

between what is done and what resulted or cannot be demonstrated (Porter-O'Grady & Malloch, 2015). Health care leaders will need to get staff engaged and motivated to change and grow in a context demanding a different way of delivering health care. The leader's role modeling in adjustment to change will encourage staff to adapt to change too.

Institutional models of practice, hospital stays and long-term patient relationships will no longer define nursing care. Continuously shortening hospital stays and less need for hospitalization for an increasing number of medical conditions will continue (Porter-O'Grady & Malloch, 2015).

There is now more than ever the need to encourage patients to be active in their care, create some independence, in fact doing everything for the patients is no longer the best way to render the needed assistance. There are many tasks that will continue to be placed in the hands of the patient for his own good. This will call for a change in attitudes, beliefs, and practices because this goes against the traditional "doing for" in the definition of nursing and caring.

Replacing the expectation of "being taken care of" in the dependency model of "doing for" with the expectation of "doing with". In the dependency model, the patients used to surrender responsibility, accountability, and control of the health care provider.

In the new approach, providers must focus on teaching and empowering patients to do more, involve the family members and significant others in the delivery of services for their loved ones in need of assistance. Follow up now means making sure patients can gain access to needed resources, information, home care, social support, network with others of similar challenge(s). Generally, these are not to be found within the health care system as has always been known.

Quality and customer feedback has never been so much a concern as now. The service charters that have oftentimes been taken as a formality will become a daily mark of the quality of service delivered. Indemnity insurance will become a requirement to practice.

Devolution had set off as an accelerated process of political decentralisation more than anything else. The bosses would no longer be on the 4th floor or there about at Afya House Nairobi, but a block away from the operational level/point of service.

It has not been said often enough but it's true that one of the very difficult choice every CEO the world over had to make or failed to execute was - 'to fire the people they should' or rather keeping the wrong person for too long or hiring the wrong person with regrettable consequences. Many human resource specialists agree that one sure way to avoid performance problems is to take the time to hire well.

There was a lot of fear about delivering results among some staff. This might not always be so going into the future. In short, we might need to admit that the good old days were not really all that good, not even as good as today or as good as the future could be. The following incident could be a sign of things to come:

'I will not allow one or two people to paint a negative image of other hardworking officers and to shortchange wananchi, who are hungry for speedy development and quality services," A.M., Governor Machakos County said. He had suspended a medical officer and 3 others in one of his county hospitals. KMPDU secretary general Dr. Ouma Oluga retaliated that the governor "can only ignore the matter at his cost". "It is okay, he can ignore those issues if he so wishes but we will withdraw our doctors if he doesn't apologize within seven days,"[74]

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[74] *The Star* Wed, 20th July 2016 'I won't say sorry for kicking out lazy officers', Mutua says
https://www.tuko.co.ke/227331-a-passionate-letter-a-doctor-this-a-killer-government.html

The governor had asserted 'I won't say sorry for kicking out lazy officers'. In a letter to the governor, the union faulted the governor for ignoring the laid down disciplinary procedures, while dealing with health workers due to what they termed a "venomous style of handling doctors".

They actually did strike and the story took many nasty twists at one point the medics failed to turn up for the meeting to conclude an agreement between the parties concerned. They accused county governments of becoming increasingly intransigent, disrespectful of medical doctors, political interference with their work, unfavorable working environment among others.

By the time of submitting this book for publication, the industrial dispute wasn't as settled as such. See also countrywide 100-days doctors strike (late 2016 to early 2017) that nearly brought the health sector to its knees. The reader might be interested in sampling the 'A Passionate letter from a doctor…'[75]

Ability to communicate effectively in complex and diverse professional situations into the future will include: being in a position to communicate across multiple cultures, generations, and professions; reframing conflict as a diversity of preference, beliefs and values; relationships between differing personal perspectives and the dynamics of power positions Dainton & Zelly (2015).

'As healthcare providers, specifically nurses, we tend to have an innate caring sense. If you come from a place of caring you will find that nursing is universal. No matter the culture you will find a way. I have found that expression has been my best tool.

Having the ability to express and implement quality compassion care has worked well for me.'(This was a comment I found valuable, made by a nurse I was networking with online in response to the importance of understanding cross-cultural communication).

Josephine Campinha-Bacote did a lot of work on cultural competence in the delivery of healthcare services. She developed a mnemonic; "ASKED" that helps people assess their cultural desire, awareness, knowledge, skill, and encounters. It is as follows (Camphina-Bacote, 2003):

Awareness: Am I aware of my biases and prejudices towards other cultural groups, as well as racism and other "isms" in healthcare?

Skill: Do I have the skill of conducting a cultural assessment in a sensitive manner?

Knowledge: Am I knowledgeable about the worldviews of different cultural and ethnic groups, as well as knowledge in the field of bio-cultural ecology?

Encounters: Do I seek out face-to-face and other types of interactions with individuals who are different from myself?

Desire: Do I really "want to" become culturally competent?

As one looks back at their career as a health care provider and evaluates themselves on how far they have come in knowledge, attitudes, and skills. They might also find that they were still

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[75] https://www.tuko.co.ke/227331-a-passionate-letter-a-doctor-this-a-killer-government.html
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lacking somewhat in actually seeing out different cultural encounters in order to provide cultural sensitive holistic quality health care.

Self-knowledge of your culture as a care provider is important. When individuals know that you care enough to 'ASKED' about their personal cultural background, it definitely helps to relate to them (Camphina-Bacote, 2003).

Outsourcing of agency float/pool staff will cover for the gaps in staffing. It is no longer cost effective for every organization to hire all the people it needs, and there are seasonal fluctuations too when the demand goes high or up. Through the syndication model, agency nursing is soon becoming a reality in Kenya. A colleague veteran nurse runs such an agency in Nairobi. More established outfits include Kenya onlinepharmacy.

Pic: Nurses often lacked tools of work. Above - a junk yard of out-of-order items lie in the open over prolonged periods due to fraud, waste, and abuse or else some of them could have been near obsolete donations that often came without spares or technical backup.

(Picture used with permission: Community Eye Health *Update 6*)

Job security will cease to be the main consideration in taking up an appointment. Nursing in Kenya would also go the way of other countries where they have one of the lowest retention rates of all healthcare staff. Porter-O'Grady and Malloch (2015) put it this way about today's workers, '…unlike previous generations of workers, they are not faithful to the workplace.

Instead, they are faithful to the work, moving anywhere the opportunity to do it appears'. There are just about four generations in the conventional workplace. This explains intergenerational conflicts namely based on each generations Date of Birth: *Veterans = (1922-1945); Baby Boomers = (1946-1964); Generation X= (1965-1980); Generation Y or Millennial's = (1980-2000).*

There are certain generational characteristics and potential age-based variations that have been studied; this was brought out in a meta-analysis of hundreds of research articles, a sample size of 1.4 million people done by Twenge and Campbell (2008)[76].

Generational management was about understanding the meaning of work for individuals of different generations. The challenges of each upcoming generation are different, and so the best strategy is to create new pathways bridging the generations rather than to expect later generations to conform to the values of the earlier ones (Porter O'Grady & Malloch, 2015).

> **Point to ponder**
>
> 'America thrived in the 20th century because we made high school free, sent a generation of … to college, (and) trained the best workforce in the world. We were ahead of the curve. But other countries caught on. And in a 21st-century economy that rewards knowledge like never before, we need to up our game. We need to do more'. — President Barack Obama.

One nurse shared that she has been in and out of one of the big hospitals in Kenya as an employee; she had her 4th personal file number (PF No.) from that institution but one from all the other institutions she served in the interludes. It has become possible to glean past records of an employee e.g. the recruiting team gathers feedback from a candidate's past employers via an online tool called a skill survey (Fiercehealth *eBook*, 2014).

The *HealthcareSource Quality Talent Suite*® software helps healthcare organizations acquire, develop and retain the best workforce possible in order to improve the patient and resident experience. The company's cloud-based talent management solutions include applicant tracking, behavioural assessments, reference checking, employee performance, compensation, competency etc. This means in effect that the dynamics of the workplace are changing.

Chris Hart, a renowned Kenyan newspaper columnist in relationship posted this on his wall on Facebook in the month of December 2014. He said that careers work differently nowadays, no one belongs to an organization for life anymore. There was a need for personal branding, repackaging, re-strategizing making reference to your vision.

Developing and marketing new skills, things you are passionate about (and get paid for it) or just volunteer to do some work that enables you to gain some life-skills or to enable you to meet some new people. The building blocks for 21st century include critical thinking, complex communication, creativity, flexibility and adaptability, collaboration, production and accountability (Source: Iowa core universal constructs). The 2015 State of the Union address focused on topics such as 21st-century skills:

The routine jobs of yesterday are being replaced by technology and/or shipped off-shore. In their place, job categories that require knowledge management, abstract reasoning, and personal services seem to be growing.

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[76] Generationaldifferencesinpsychologicaltraitsandtheir... Twenge and Campbell - 2008
    www-personal.umich.edu/.../Redman_Sept29_**TwengeCampbell2008**.pdf

The modern workplace requires workers to have broad cognitive and affective skills. Often referred to as "21st century skills," these skills include being able to solve complex problems, to think critically about tasks, to effectively communicate with people from a variety of different cultures and using a variety of different techniques, to work in collaboration with others, to adapt to rapidly changing environments and conditions for performing tasks, to effectively manage one's work, and to acquire new skills and information on one's own (Koenig, 2011).

Work on a series of projects and you will never lack work to do or fail to get noticed. A colleague of mine did conflict mediation and today was one sought after personality in the country. Another one did Information Communication Technology for Health Researchers and was flying all over.

Volunteer as a guest editor or reviewer for a journal or better still starts one, volunteer to man a call centre, volunteer as an administrator to a professional website or blog. Or write like this author does, relating your observations to other issues linking them up and communicating them in your own style, it is only the publisher when he tells you it is time to do the typesetting that will stop you from adding further ideas into the manuscript.

Is a generation issue or something else?

… I also find some frightening issues with young nurses when I am in the hospital setting for either a loved one or myself. Twice within the last year, I observed young nurses breaking sterile technique with IV tubing with one nurse disconnecting IV tubing from the patient and "plugging" or looping the end of the tubing into an unsterile port on the tubing.

The second case involved the nurse dropping the IV line as she was ready to start the antibiotics onto the floor; the tubing was not capped and consequently, the sterile end of the tubing became contaminated when coming into contact with the floor. The nurse plugged the tubing into the patient's saline lock and began the antibiotic infusion without blinking an eye.

What happened to the mindfulness of maintaining sterile technique and the ethics of causing no harm to our patients? Do these nurses feel that antibiotics will take care of their breaks in sterile techniques? I wonder where all of the training and ethics went in these two situations. I wonder if it falls on deaf ears because the students do not see these issues on their Nursing Council exams. *(Shared by Anne P. online)*

One sure way is to start a reflective journal, keep a pen and notepad next to you, then look-write; listen-write; read-write; and write-write. These are just a few tips that this author is familiar with and there could be thousands more out there. These can be done on top of primary roles as nurses. There may not be any monetary value attached to most of them, but they spice up life and give you something to look forward to.

Even with this in mind, it is important to know that 80% of today's jobs are found through networking(recruitingblogs.com), career fairs and recruitment agents which potentially stimulate productive collaborations/increase awareness of positions. Through the online recruiter platform like Relode marketplace and referral platform one could leverage their professional network to become a parttime recruiter of healthcare jobs connecting colleagues to potential hiring institutions and earn some 'agency' fee in a professional way (www.relode.com/).

According to *NerdyNurse* Brittney Wilson, working from home on a side hustle basis as an independent nurse recruiter was a reality. Other possibilities included becoming a blogger, a nurse content writer, a home care nurse, a case manager, a nurse coder, a nurse researcher, a nurse advocate, an online nurse faculty etc. Locally, I may not be certain of or aware of similar

outfits above, nevertheless it is was good to borrow ideas from elsewhere go ahead: join them but even more important start some.

Organized volunteering bodies in Kenya similar to International Peace Corps would be a great avenue to explore. I would like to quote one volunteer 'www.MedicalMissions.org has been a valuable resource for us, I highly recommend *MedicalMissions.org* to any Medical professional who is seeking to serve on a Medical Mission', these was the testimonial by Dr. Paul Whisnant concerning medical volunteering. *"There are numerous physicians, nurses and other medical specialists who are in the healthcare industry to truly care for others. Let's help them help others."* Rick Jackson, Chairman, and CEO, Jackson Healthcare. This author was a beneficiary of International Peace Corps' $4000 scholarship award in 2012.

Therefore we will need to identify potential in everyone and see a treasure wherever our posting takes us, but first and foremost in our call for duty, we must not allow what we don't have to stop us from using what we have.

The future of nursing begins with you and I....

Be part of the change you wish to see in Nursing *(adapted from Mahatma Gandhi 1869-1948)*

This chapter was not intended to further the interests of one group over any other. It was meant to frame (*as opposed to flame*) a debate - The future of nursing. It was not the intention of the author to further inflame the rhetoric (some divisive) that have been offered by some leaders of the health professions but rather to contribute to thoughtful solutions. This self-censorship is a prime message that users in a confession by one who this author felt deserved a *carelee* at large (see Box 1 below):

Box 1: 'Confessions of a Hospital Administrator'

'Confessions of a Hospital Administrator'

Posted by L.O on KNUN wall on Facebook on January 2nd, 2014

Gallup announced the results of its annual "Honesty & Ethics in Profession" recently. I was so pleased to see nurses ranked number one in the survey because they certainly deserve the honour. With the exception of grade school teachers, who ranked third, nurses were the embodiment of what it means to have a calling of dedication, grace, and love.

I worked in hospitals most of my career with much success (and a few times when I was not successful, but that's a story for another day). I started as a manager for what is called an "ancillary service", or nonclinical service. These include such areas as housekeeping, food services, engineering, IT and accounting. My specialty was public relations and marketing. I finished my career in hospitals 28 years later as a CEO responsible for an approximately $80 million in net revenue and payroll for up to 700 employees, mostly nurses. I even won a few awards, including being named nationally, with my executive team, as "Top Leadership Team in Healthcare for Mid-Sized Hospitals" by HealthLeaders magazine in 2009.

I was compensated well; on average about four times that of the average nurse's salary. Something I learned, as my career progressed, however, was that even with recognition and high compensation there were days I was barely worthy to serve nurses. The truth is I neither had the brains nor the courage to be a nurse. But I finally did figure out how I could serve as a useful hospital administrator to nurses as they went about the sacred task of laying hands on patients every day. Serving nurses is also a good way for an administrator to run a successful hospital.

Every metric on which hospitals are evaluated – from quality outcomes to safety to patient satisfaction to staffing efficiency to medical staff confidence – is dependent upon having a staff of nurses who feel valued on the job. It's also the right way to be in charge of a hospital. Here are four things a hospital CEO can do to serve nurses and manage a hospital well.

1 - Get Out of Your Office

If a CEO ever wants to be anything more than the latest suit in the front office, go to where the work of the hospital is done – at the bedside. I learned this important leadership tip from one of my two mentors. It wasn't always easy and there were many a day when I didn't think I had time given the work and people lined up in my office. But without exception, once I made it to the floors to where nurses (as well as physicians and other therapists) worked I understood it was the most important part of my day. Invariably I would find inspiration that made me work happier when I did get back to my office. And when nurses see an administrator every day, they begin to open up. The administrator hears what they need to hear, not what staffs think the administrator wants to hear.

For example, one day while making rounds I noticed the nurses seemed aggravated. When I asked why I discovered that they were running up the stairwell to another floor to get ice for patients. The machine on their floor had been broken on and off for weeks. Do you know how much ice nurses use? When I got back to my office I called the Director of Engineering and he told me they kept fixing the machine, but it was old and needed to be replaced. When I asked why the machine was not replaced with a new one, the Director said he tried, but the Chief Financial Officer (CFO) told him that a new machine was not on the capital list. Now, this hospital was doing well and had discretionary capital money. And the CFO, in his mind, was doing his job by controlling expenses while the Director of engineering was focused on the matter of the equipment's readiness and not the effect its downtime was having on staff and patients. But if I had not been up on the floor every day I would have never noticed that something was amiss with the nurses.

Needless to say, a new ice machine was ordered and installed within a week. Not only was the action of the Engineering Director and CFO insensitive and a bit clueless about the work of nurses (which I addressed), but the frequent trip to the next floor to get ice was terrible for productivity and patient satisfaction.

Getting out of the office also includes coming in a few times a month to make the rounds to visit nurses on the third shift as well as on weekends and holidays.

2 – If You Want to Solve a Problem in A Hospital, Ask the Nurses Nurses are really smart – they have to be to get through nursing school. If an administrator comes up with a bad process to address a problem without asking nurses what they think, it won't work. Because nurses are the queens and kings of work around and they do not suffer fools gladly.

When we were having a persistent problem with falls and the magnetic door signs my Chief Nursing Officer and I had decided would fix the problem didn't, we finally put together a committee of nurses to figure things out. It didn't take long. Their solution included; nonslip socks; beds with built-in alarms for high-risk patients (and a built-in scale, which also reduced back injuries among nurses); more frequent bathroom visits for patients at high risk; and family and patient education. And guess what? Our fall rate decreased to a fraction of the national average.

3 – Protect Your Nurses

There is a lot of power and money in healthcare. When these two things get mixed in with human nature, the politics can be rude and nasty. In hospitals, nurses are often on the frontline of this dysfunction. I am a collaborative leader, but I have had to stand up to doctors who thought they could bully - and even sexually harass – nurses. This included forcing three physicians to resign from the medical staff or have their privileges involuntarily revoked. I have added armed guards in hospitals to protect third shift nurses from intruders and mentally ill, combative patients.

I have had to argue against corporate drones that wanted to reduce nursing staffing ratios per patient to levels lower than safe national averages. And while patient feedback is usually valid, there are times I've had to listen politely while an unreasonable family or patient member made unfair accusations against nurses of the most outrageous nature, often in an attempt to get their hospital bill waived.

It wasn't always easy or popular for me to take these positions. The medical staff doesn't like it when an administrator takes a stand against their colleagues. Patients and family members write letters to editors and post their venom on social media. Even my own senior managers have pushed back when I insisted they set a good example. But that is the job of an inspirational leader: to live the Mission, Vision, and Values of an organization all the time, not just when it is easy. And it is worth noting; an inspirational, servant leader still holds others accountable. The difference is staff has a say in the metrics, which fosters ownership.

4 – Remember –What Happens in a Hospital is Not About You

I heard Al Stubblefield, the founder of the most successful servant leadership hospital system in the world, Baptist HealthCare System in Pensacola, Florida, talk about his transformation from a command and control leader to an inspirational leader. "We used to come to work early and spend all day and eat two meals in the executive suites and then go home. And we thought that was a good day." There is a real temptation to think the endless meetings that administrators sit in are the business of the hospital. I once had a CFO joke to me: "John, I feel like we're an advertising agency that does healthcare", so I was not immune to this mindset. And certainly what a good leader contributes to a hospital is important.

But that's exactly what it is – a contribution, not the end all. I have seen first hand that even when hospital administrators are embroiled in whatever political fight of the week may be, patients still get taken care of day in and day out by the nurses on the floor. They are quite capable of doing so with a total lack of nonclinical leadership.

And finally, remember this; there is a reason administrators (business executive) ranked far down the list at 22 percent approval compared to nurses number one ranking at 82 percent: hospitals are a nurses' domain, not the CEO's. The fact is that we are all going to be a patient someday. Nurses will be the ones who comfort our fear, ease our pain and make us want to go on, not the CEO. But a hospital CEO can help care for patients by making hospitals a good place for nurses to work.

[Original article by John Mitchell, CEO Grays Harbor Community Hospital, US].

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Chapter 2

♯HealthCrisisKE Diaries

This chapter is an exerpt from my journaling, as an interested party and also experiential. My employment sector at higher education had 3 industrial actions in 2017 alone and 78 days' in 2018. But nothing could be compared to the ravages strikes had on the health sector. This author tagged all of them and prepared some sort of diary: ♯ Healthcrisiskenya diaries. Dr Stephen Dr. Muhudhia from Nairobi Hospital a paediatrician and medical ethicist had tagged the two doctors strikes in 2012. I will be borrowing a bit from his wisdom shared during *2nd University of Kabianga International Conference in May 9-10, 2018*.

As we ushered in 2017 the health system in Kenya was like a floating bubble, there were more than enough stakeholders with needles to prick it. There was a crisis in the public health system in the country, a spill over from the previous years. Only that this time labour unrests in the country had come full circle.

Doctors, nurses and others went on strike:- at different times; sometimes together or concurrently; while some suspended, others continued; some got a deal while others resumed strike … on and on. The prominence given to either of the happenings in some way indicated the intensity.

More than 5,000 doctors from more than 2,000 public hospitals had managed to sustain a 100 days plus strike which began on 1st December, 2016. Apart from a 300% payrise and additional non-monetary benefits, the CBA ostensibly spelt out demands for equipping and 'restoration of the dilapidated public health facilities', scaling up of the health budget, ensuring continuous training of and hiring of doctors to address a huge shortage of doctors.The chapter juxtaposes the doctors' and nurses' strikes for expedience purposes.

Unofficial figures[34] indicated that by the 70th day of the strike over 300 lives had been lost, 20 of these within the first 20 days of the strike. Cancer patients bore the blunt of the stalemate. Patients previously treated at KNH had to seek treatment elsewhere. It wasreported[35] that Texas Cancer Center for example received 500 patients up from its usual 200 during that period.

There was need for clarification on the full process of realizing a CBA and more importantly on who should be held responsible at each and every stage. Relying on goodwill from employers will always result to situations like the one below:

During the negotiations, Kenyans had witnessed protracted infighting, turf wars within the health ministry and perceived lack of goodwill from the parties involved. According to the affected unions CBA processes mainly stalled secondary to politically inclined ideologies harboured by Governors.

Deadlock after deadlock, one court extension after another, negotiations were witnessed despite court sanctioned mediation from The Senate, Central Organization of Trade

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[34]*Real Victims*, KTN Prime , 1st Feb., 2017; 21Hrs
[35]The Standard, Tuesday, 18th April 2017. *The silent victims of the 100 days doctors' strike*

Unions (COTU), Law Society of Kenya (LSK), Kenya National Human Rights Commission (KNHRC), Inter-religious Council of Kenya (IRCK) among others.

With each party slowly exhausting its option, key representatives of each party (the union, the government, council of governors) skipped some meetings, walked out of the talks often. Some mediators gave up as others offered to step in but largely it was the grandstanding and brinkmanship that prevailed.

There was an obvious generation gap with the younger doctors taking an active role in the industrial action. Bloggers and proponents of moral uprightness had a field day posting and reposting what was perceived by the union as 'propaganda'. The private health sector was accused of benefitting from the impasse to make business but that aside the hospitals were far apart and their services were beyond the reach of a majority of Kenyans. On the other hand they were handling more patients than usual, but they could neither stepdown to public facilities, nor offload the credit risk clients, nor refer complicated cases as usual.

There were other angles to this, what might be called a 'catch 22 situation' in more ways than one including **Bringing the CBA upto speed 3 months later** as seen below:

Economically: - Most hospitals generated some of their funds through cost sharing. This in part sustained their wage bill as well as paid suppliers. Undisclosed sources indicated that KNH used to generate Kshs 4 million per day, but it could barely get Kshs200, 000 during the strike. Yet another unnamed one used to generate at least Kshs 25 million per month for the 3 months, it hardly collected Kshs 1 million per month.

Suppliers and informal sectors surrounding health care had suffered great losses. Reports indicated that Webuye Referral Hospital lost Ksh 6m due to unpaid bills as a result of patients leaving due to the resumed nurses' strike from June 2017. As the nurses' strike entered its 4th month it was estimated that Ksh 3b had been lost in terms of revenue for the hospitals.

According to the Institute of Economic Affairs the government of Kenya was grappling with an ever burgeoning public sector wage bill. The unsustainable wage bill was paid to less than 2% of the population (650,000: public servants, state officers and elected leaders). The 2 percent got over 50% of the national budget. This was at the expense of development and economic growth. The president himself alluded to this in a state of the nation address on 15th March, 2017, 'it was bringing the country to its knees'. The regime had experienced numerous pay rise related industrial disputes. Coincidentally this was a day after the doctors' strike was called off.

Delloitte an audit firm had done a report termed 'wind of change' in 2014 which had sought for ways to control the rising public wage bill. The survey had discovered that in some instances remunerative allowances accounted for 70% of the gross pay. In part it recommended that allowances should not exceed 30% of basic salary. It was reported elsewhere that that this was equivalent to each Kenyan paying Ksh540 per month to meet the bill.

Bringing the CBA upto speed 3 months later

On the 80th day, a former Permanent Secretary (PS) Heath before the select parliamentary committee on health and labour was alleged to have signed the Collective Bargaining Agreement (CBA) with the doctors' union Secretary General three months after he he had ceased being the PS three months after he had ceased being the PS Ministry of Public Health & Sanitation or rather 3 months after that ministry had ceased into being.

Alternatively this was *3 months* after health services had been devolved to be under the county governments as stipulated by the constitution 2010. The CBA was not ratified by the Salaries and Remuneration Commission (SRC), was not registered in a court of law and a recognition agreement was not signed with the Council of Governors (CoG).

Surprisingly the former PS called it a template and not the final document. One politician called this blackmail. There was a need to come up with a new CBA that could withstand a legal scrutiny. What became clear was that the document had brought the country this state of affairs. In terms of governance, no disciplinary measures had been taken against this former PS four years down the line. Was he perhaps instructed to 'tidy up' before handing over?

May be this was a *hot* matter they would rather let it cool down. Maybe fight when they were ready some other time *this year-next-year sometimes-never!* But not then. One would only pray that after this doctors' strike the health sector would have to settle now and for all. Hopefully never again would it become necessary to bring it to a standstill. "We would not wish the country to experience this again" KMPPDU secretary general upon calling off the 100 day old strike.

In Bomet, Lamu and Tana River counties the strike apparently did not happen. They continued to receive high numbers of patients from neighbouring counties and beyond. In one of the counties the health care workers had already signed a CBA that had seen their salaries and allowances increased, job group entry point enhanced, drugs and materials provided etc.

The governor and the head of state gave personal donations (Ksh1.5 and 0.5M respectively to be shared among the workers) as a token of appreciation for continuing to render services while others striked. In other words they were pampered. Hopefully this would address the system issues that cut across all counties. What lessons could be learnt? Or was this some window dressing, shoe string approach? Worse still, was it for political mileage? Did the end of the nationwide strike achieve more or less of the same thing? Was it worth the *trouble*?

Much as there were new dynamics and conversations brought about by devolution there was need to 'devolve' the mindset as it were. Unions were unwilling to discuss at county level. They unions insisted that health was a shared function and it was the role of the government to set labour standards and remuneration.

Counties wanted to do matters with a national face, 'the national council of governors (CoG) said this or that'. Each of these proposed outfits were great but they were informal as had not been envisioned in the constitution or the law as it is.

The opposite was also true. The Tharaka Nthi Governor H.E Muthomi expressed his frustration ' …we cannot control people who answer to a national union and it's the individual counties paying them'. Let us also consider West Pokot governor's wish list: why not devolve the unions to the counties? Why? No matter how well individual counties felt they had performed in the health sector, the national union sort of dragged their staff out of work by calling for a nationwide strike. In effect the governors felt helpless on matters to do with labour disputes. SRC's advisory role was mandatory and binding in all matters remuneration of public officers though it was the government's role to look through its fiscal policy in relation to

those recommendations and then implement what seems fit. SRC decisively endeavoured to cap allowances and issued circulars to that effect. It had also carried out a job evaluation of all civil servants (though some sectors declined to be evaluated) and made recommendations of new salary scales. Every union (in its wisdom) wanted to beat that date by clearing any pending issues. This was expected to take effect sometimes in July 2017.

Earnest & Young and *PriceWaterHouse Coopers* contracted by SRC to do the JE using Paterson model for job evaluation the job holder described job and explained the duties and responsibilities on which time was spent. In a systematic way determined the value/worth of a job in relation to the other jobs in the organization. Somehow the tool assessed the performance or appropriateness of the current incumbent for the role using the principle of 'fair pay for fair play'.

The outcome would help the human resource department or an authority like Salaries & Remuneration Commission (SRC) to develop a detailed, updated job description of the role and pay structure. This way it would be possible to evaluate the job in future. Generally Paterson grading model banded decision making. Downloadable PDFPM 6 form.

Without belabouring the point, increasing wages without decisively dealing with the rising cost of living and the unregulated spending of public resource was like shooting on a moving target. If that indeed was the position by law, it was then the national government's role to negotiate CBA's, and then the county governments would have to comply with the recommendations. As such it was necessary to get an interpretation of the constitution on several matters labour.

It was notable that around the same time of the doctors' strike, public university lecturers called off the 54-day strike after the government awarded them a 17.5-percent salary increase following intensive negotiations. Kenyan university lecturers on January 19th 2017 had downed tools citing the government's failure to honor an agreement on salary increase and better working conditions.

Their 54-days strike paralyzed learning in 33 public universities while putting cutting-edge research programs in jeopardy. Health sciences disciplines students and interns could not access the needed experiences for the 100 plus days and they were not in class either. It appreared that the boycotts were demoralising and radicalizing traineees too as some issued solidarity statements through their students' associations..

However, dons through the university academic staff union (UASU) and Kenya university staff union (KUSU) resumed the strike from 1st July 2017 unless the government honoured the Ksh 10b deal they had reached in March of the same year (the government instead released 48% of the figure promising to pay the rest at a later date).

The dons were not amused and insisted on getting the full amount, meanwhile the strike continued. The strike was called off on day 18th with a written commitment undertaking to release the remaining Ksh 5.2b. This was not honoured and therefore on 1st November 2017 the dons resumed the strike. This was their 3rd strike that year. This author served as a faculty member in one of the public universities during that period.

On the same note, nurses and clinical officers on the other hand threatened to reenter the strike they had called off a month or so earlier. In Nyeri County, the 1000 nurses' workforce went on strike in May 2017 citing lack of promotions and non-recruitment of more nurses since 2013, yet more than 400 nurses had since left the service. They alleged that a ratio of one nurse to 40 patients was putting too much pressure on them. On 30th

June nurses from Moi Teaching & Referral Hospital downed their tools citing failure of the hospital management to implement the CBA that had been negotiated 4 years earlier.

Around the same time KNUN governing council issued that the 25,000 unionised nurses resumed from June 6th 2017 the nationwide strike they had suspended 5 months earlier unless the Council of Governors signed, registered in court a negotiated CBA, and resumption of the Nurses' Allowance which had only been paid once with the January 2017 salary. However, in one level 5 hospital the strike was more of a continuation since its nurses hardly resumed from the December 2016 one.

This was a long-drawn-out work boycott by all standards, by the time it went into the 5th month it was apparent that it might not be ending any time soon given the continued antagonistic positions by the parties. As a result of the prolonged industrial action, every other department in that hospital was in effect immobilized.

Every other union seemed to make good their threat and the strikes took place. Preemptive measures apparently did not to work each time. Seemingly, there was an apparent lack of goodwill to resolve the crisis or may be there were no solutions after all. Parties would snub appointments and meetings that had been agreed on just the previous day.

What resulted was a crisis meeting after crisis meeting. It was during a press conference called to deliberate on the ongoing nurses' strike (Day 2 of the resumed strike) that at one point, Kisii County Governor Ongwae speaking on behalf of the Council of Governors (CoG) asked that governors be given a break. A break from what? Looking at it from another perspective, it seemed they were looking at nurses' grievances as something perky, not deserving of a break from their busy re-election bid campaign trail.

On the other hand SRC argued that a valid CBA must be backed by a letter of no objection from them, as each commitment must be in tandem with the ability to pay. This was not always the case. Parties had negotiated CBA's without considering where the money would come from in the short and long term. Issues kept on coming up that had not been considered in the earlier negotiations.

Some negotiators were not sincere in that some of the things they had agreed on were not implementable. Some parties had not brought on board the SRC on time, while at the same time they accused it of misinterpreting its role and pronouncing itself on matters beyond its core mandate.

The disputed figures per nurse per month were going to be: *Ksh 25,400 Nurses Allowance; Ksh 15,400 Health Risk Allowance; Ksh 5,000 Extraneous Allowance; 5,000 Responsibility Allowance and, Ksh 50,000 Uniform Allowance annually*. Parties released conflicting information e.g. the CoG was talking of Ksh 40.3b in the four years if the CBA were to be implemented as it was, nurses talked of Ksh 7.5b annually. Why the disparity? Let's look at the following example.

But then was it money that was essentially lacking. Reports from National Treasury as on 14th August 2017 about Ksh 33.3b of county idle funds (unspent) was at Central Bank of Kenya (CBK). This was some 4.7% of Ksh 698.8b of cumulative transfers to the counties as at July 8th 2016.

The governors generally blamed the Integrated Financial Management Information System (IFMIS) for the slow absorption of funds. This was despite constant disruption of service delivery especially in the health sector. If indeed this was so, unspent funds could be due to undelivered service or mismanagement.

It was apparent that SRC had not been part of the negotiated deal all along. Nevertheless, on 9th June it gave guidance to CoG (and especially) the nurses' union to reconsider their position. All this while the Acting Secretary General (SG) swore never to sit in a meeting to renegotiate the CBA. This grandstanding went on, in the over 60 days not more than 2 substantive meetings between the parties had taken place.

When a new CBA was likely to happen? Though SG pointed out that there was light at the end of the tunnel now and again (possibly referring to the new CBA) he equally stated, 'the strike was now reloaded, nothing has changed until we say so!'

With all due respect let us contrast the above chest thumping approach with what CM posting on social media on 5th October 2017, '…*the SG… was astitute, cool and above all, pragmatic. He ably articulated members' grievances without issuing threats, ultimatums and was not frothing in the mouth and gesticulating wildly in the presence of his employers.* This particular RTWF was signed on day 18 of their strike (by then nurses doing 122nd of their strike).

The dilemma on how to resolve the perpetual industrial actions was real in a country where citizens did not want to be taxed more, with rising inflation as reflected by rising prices of consumer goods (by mid-2017, 2 Kg Unga or maize flour Kenyans' staple food was retailing at Ksh 160 and a Kg of Sugar at Ksh 200), prolonged dry weather and famine. May be the battle seemed in many ways about food security after all, someone felt.
Seemingly, some politicians wanted to capitalize on the situation and make a kill. Unfortunately in the process, real patients also died for lack of care. By day 8 of the resumed nurses' strike, ten deaths had been reported and there was fear that the strike was getting out of hand and likely to become a runaway situation like the doctors' strike that had just ended some 2 months earlier.

This was compounded by the upcoming closely contested general election with some ifs about the repeat presidential election of 26th October 2017. It seemed we had to hold the election somehow.

According to an SRC blog by Sarah Serem (chairperson SRC) the current industrial unrest could hurt Kenya's investment plan. It could ruin the country's reputation as an investment destination.

SRC was established under *Article: 230* of Kenya's Constitution with the objective of bringing sanity and order in the management of the burgeoning public wage. The wage bill in 2016/17 fiscal year was Ksh 627 billion (about 52% of the total revenue of Ksh1.3 Trillion) for the 650,000 public workers making it the government's largest expenditure. In effect making us a consuming rather than a productive economy (short of going The Greece way) where less than 1% of the population consuming 52% of the revenue. SRC targeted to progressively reduce this to 35%.

The emotional component: - Salary is an emotive issue which can be quite volatile. It is difficult to ensure a health industrial relationship as prescribed by the law. Strikes whenever they happened one has be ready for the emotional journey. When things are down as they could get during an industrial action collegial social support was critical. It gave strength to keep walking, converge for purpose of demonstrating and keep the focus.

It was emotionally draining when parties waited to act when pushed by strikes. Unfortunately it seemed strikes had evolved into a mode of communication. It was bad enough to negotiate a give and take with perceived insincere partners during a strike. When one was under pressure it was possible to make an irrational decision for instance:

On the 71st day the 7 officials of Kenya Medical Practitioners, Pharmacists and Dentists Union (KMPPDU) started a 30-days jail sentence (previously suspended for a month) for contempt of court for failing to call off the strike as required by the industrial court.

The Council of Governors had filed the case, the industrial court declared the strike illegal and ordered the officials to call it off failure to which they would face a custodial sentence. The bone of contention being the failure of the government to honor a negotiated 2013 Collective Bargaining Agreement (CBA) [36]

The private practitioners in solidarity with the jailed union officials christened 'CBA 7' withdrew their services for 48 hours essentially paralyzing the health sector countrywide. They were released 48 hours later after a successful appeal. In several ways, jailing their leaders infuriated the doctors, cemented their resolve to soldier on and could have played a role in prolonging the strike.

Much as it was apparent that a lot of people would have liked to see the problem solved amicably many were experiencing emotional fatigue. No less than the secretary general of KMPPDU admitted to this in a letter to colleagues entitled *we shall heal* on March 8, 2017 wrote: '...public have grown weary and stretched by unending stalemate…' With accusation and counter accusation, and perhaps the public being advised by misinformation.

Parties were reading blackmail, frustration, anger among others. The cabinet secretary Ministry of health noted 'It is regrettable that it took so long and we cannot begin to fathom the extent of the pain that Kenyans have suffered. Those 100 days will remain black days in the history of medicine in this country and that is not a record we want to keep'.

Betrayal was a common perception. The doctors clearly admitted that their work was hampered by the nurses' strike and vice versa. It was no great time for nurses on contract, interns, casuals and those in management who were deemed to be 'somehow' working while the rest were on strike.

The Chairman of KNUN was opposed to the resumption of the nurses' strike citing that the negotiations were progressing well and expected to be fruitful. Suspicions that union officials could have been compromised were common in such developments. The major

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[36] www.kmpdu.org/documents

fallout among union officials played out live on national television on day 12 of the nurses' strike as each faction wanted to address the press conference at Nairobi's Railway Club.

The unfortunate incident of 'battle of egos' was not just embarrassing for the profession but also caused panic among the nurses. This was also apparent going by the various factions pulling in different directions, each with its own social media platform, lots of mudslinging and vitriol posted against each other.

In some counties it was reported that nurses had reported back to work by the second week. On day 23 some striking nurses were teargased by riot police outside MTRH Eldoret while picketing to eject some of their colleagues who were on duty. It was reported that the hospital had hired about 51 nurses during the crisis.

Nothing could be more disheartening than being ignored over such a weighty matter as an industrial action. While the political class continued with the 2017 election campaign, the striking nurses continued to hold demonstrations all over the country but it no longer made headlines. The matter was being treated with remarkable nonchalance. A news anchor somehow captured this contradiction 'mgomo wa wauguzi unaendelea kwa sikuya 38, ukiendelea ukisahaulika' in colloquial Swahili - even as the nurses' strike entered its 38th day, it was apparent that it had slowly been downgraded into a none issue.

Day 38th also happened to be 28 days to the general election of August 8th. While everyone saw that it would not be long before the strike was resolved little did anyone imagine would drag past the general election day, but it did, One Kenyan nurse observed: 'Nursing was becoming invisible in Kenya. The government seemingly did not prioritize nursing as a profession in our country. The political class were not willing to articulate the nurses' voice and experiences in revealing the health care systems' current predicaments and possibilities. Sort of they felt embarrassed by the strike'.

Seemingly the public had become increasingly disenchanted with strikes. Various interested parties observed that after the general election there was need to face the reality, need for a strategic retreat, may be call off the strike and re-strategize. But that did not happen.

The political class kept on the campaign tempo as if the strike had become a non-issue. The strike was relegated to backstage because of political campaigns which had given it a blackout. It had become apparent that election campaigns made state officials lose focus on issues affecting Kenyans, until after elections. Worse still, most politicians only mentioned the ongoing nurse's strike in passing.

May be the timing was not that good after all as some came to realize but then the acting SG had to somehow come to terms with the circumstances, 'governors focused on the voter not us, blame them for the strike not us', he admitted to one of the dailies and as released to nursesarena.com on 6th August 2017. 'They turned up at the negotiating table without a meaningful agenda', he added. But then CoG chair of Health Committee put it as it was when he said, 'we had other engagements that we needed to attend to'. If indeed this was so, was KNUN expecting too much on their part to surmount the intricacies of negotiating with transitioning parties?

The authorities could not afford to be at war with their own professionals. They needed to raise the confidence health care workers had in their work. More critical for the professionals was what became of thousands of Kenyans in dire need of healthcare?

It had been observed that the strikes affected the health seeking behaviours and patterns of Kenyans. For one, immediately the strike starts the numbers of patients drop stat! Expectant women stop coming for deliveries, perhaps opting for traditional birth attendants (TBAs). Emergency rooms are deserted 'one wonders where the casualties were taken'. Lots of non-adherence issues arise for patients on chronic medications including ARVs, TB among others.

Seeing 'sick' patients being forced to vacate hospitals was an extreme no health care provider wished to go, many too poor to afford to go elsewhere. Some of them were not even able to clear the public hospital bills they had accumulated so far.

Patients on skeletal traction were especially vulnerable, they were forsaken, and a number of them were reported to have remained in the deserted wards throughout the strike. For a good number of patients though, home was no good and they would rather have stayed in the hospital.
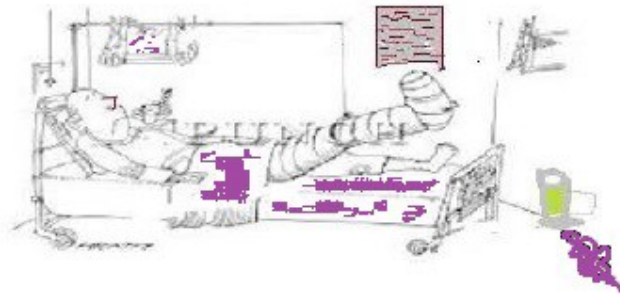
Pic: Patient abandoned on skeletal traction (Courtesy of clip developer)

The role of caretaking was left in the hands of ill prepared significant others, lay care providers. The emptiness characterizing hospitals during strikes was a ghostly site. Abandoned equipment and supplies would often get vandalized or stolen in several such facilities. It was a common observation that many would not be returning to a better place.

Mental health units were worst hit by the industrial action with media reports showing incidences. The few remaining ones still operating being overloaded. The facility at MTRH in Eldoret, which serves about 80 patients - double the capacity - was overwhelmed. It was reported that some patients relapsed on failing to get medication and treatment at county hospitals.

For some unfortunate union members just like the doctor's 'CBA 7', the nurses' strike turned personal. Services at Port Reitz - the second largest mental health institution in Kenya after Mathari Mental Hospital in Nairobi - ground to a halt or doing with minimal care and treatment. Three nurses from Mathari Mental National Hospital were arraigned in court allegedly for 'recklessly and negligently allowing mentally sick patients to escape by unlocking the gate'.

Politically: - Whereas the political class in Kenya paid themselves outrageous amounts, and raided the public pulse often, health care workers were required to make concessions on their demands. For example members of parliament (MPs) forced through a raft of allowances against the capped SRC recommendations. They somehow managed to manipulate SRC against capping the maximum allowance they could earn.

Two days after the doctors' strike was over MPs allocated themselves an additional Ksh 6.5 billion send-off package as a compensation for the reduced term (from 5 to 4 and half years). They wanted this factored in the 2017/18 financial year budget which was to be unveiled in 2 weeks' time (read on 30th March, 2017, was read earlier than usual due to the general election). They, in one voice firmly pushed for an award of a severance pay to cover the eight-month reduction of the usual five - year (*read* severance pay for work not done).

Each MP in Kenya earned on average Ksh 1million and enjoyed tax exempt on their earnings. The debate continues as to whether the elected leaders should pay taxes on their earnings. Their perks were by and large 'untouchable' going by their displeasure over SRC's recommendations to reduce the earnings of the (incoming) 12th parliament among other state officers. These were big demotivators towards expecting others' willingness make concessions.

Lawyers representing the doctors apparently needed *political mileage* out of the cases since this was an election year! One of the said lawyers had declared interest in the presidency of the country. Getting a win-win solution was difficult without soberness and rational thinking. For both sides, it was necessary to abandon the hard stance and go back to the drawing board for the way out. It became obvious with time that no intermediary could ably solve this, perhaps *unless divinely*.

Being an election year: the opposition blamed the government, the government blamed the doctors and said the opposition was politicising the crisis. Union official said: "For us, the strike is still on until we get what we wanted ... this government has shown is it lacks empathy for poor people". The government on the other hand accused doctors of "using the lives of Kenyans as a bargaining chip".

One of the opposition pointmen even proposed health services even though it was a shared function be partially removed from the counties but not totally reverted to the national government. Further, health system must be reorganised and workers hired and managed by the central body (national health commission), similar to Teachers Service Commission. He said this as he addressed thousands of energised doctors and medical soon after the release of the KMPDU officials.

On the 93rd day the Inter-Religious Council of Kenya reported to the appellate court that on the basis of concessions both sides had agreed on 95% of the issues. But then, the government seemed to be willing to give no more than a 50 percent payrise offer equivalent Ksh14.5billion (or else take or leave it).

Emerging from the 4th annual devolution conference mini-summit was some seeminglyunpalatable news. The executive together with the council of governors issued a joint statement which seemingly watered down the said 'gains' as it were by withdrawing the enhanced Ksh 600m incentive in terms of additional backdated riskallowances effective from January 2017.

Everyone was concerned about what was going on on the health sector and their stake. For intance, The 2nd HeSMA Leadership Congress, Kisumu in May 2018 discussed on proposed Scheme of Service for health leaders, credentialing guidelines, proposed health and leadership guidelines.

Among others the press statement spelt out the doctors to: resume work immediately, recall of the registrar doctors on study leave back to respective stations, doctor interns to resume their clinical attachment forthwith, reconsider review of registration and certification of doctors by Kenya Medical Practitioners and Dentists Board (KMPDB) and revert the role to the Ministry of Health. Consequently there was a new tune, the mediator and the union were pleading - 'come let us reason together … this one last time'.

Looking at it from another angle, it seemed some employers somewhere had been disappointed all along. Consider the following: According to one such governor [37] the county had 35 doctors in 2013 but only 17 were available to render services, the rest were on study leave, 'some study leaves apparently extended beyond the Governors' term in office, yet they were on the county's payroll. These were some of the anomalies we have to rectify'.

In yet another occasion during the doctors strike, no less than the country's chief executive complained (*paraphrased*) '… we (*ad-lib* are offering to) pay them so much but they work for … hours a day in public hospital and then run to their private practice,… this is blackmail and we are not going to accept!' However, the president's intervention (goodwill) had been very consequential on the outcomes of the strike. Doctors had many things to thank him for the interference.

But when it later came to the nurses' strike (in its 50 plus days on 29th July 2017, it was a matter for the CoG's since the national government had already paid out their staff (may be he forgot MTRH nurses were under the national government were also on strike). The KNH nurses threatened to join their colleagues in solidarity.

Not withstanding KNH was a 'sickly' hospital and this was variously reported in the media [38] a sad state of affairs on 3rd August 2017. Most striking it was - *a dozen or so mothers sitting on a bench alleged waiting for emergency C/s for over 24 hours in a filthy labour ward*. The country's health systems were getting more unpredictable, the processes were becoming unclear, and the outcome equally so. Considering for example the gains made by the free maternity care, the Beyond Zero, Managed Equipment Services Project etc. were being eroded further with each day of the strike.

Out of about 260 doctors in KNH 60 of them had participated in the strike, the hospital went ahead and fired 12 of them in the wake of the stalemate. It took the hospital a week to have the return to work signed after the strike had been called off.

The counties put the striking doctors on notice preferring disciplinary action to those who would not have resumed duties by certain date. The Ministry of Health and the counties

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[37]Focus on Busia County, K24, 6th Feb., 2017; 08.00Hrs; interview with H.E. Sospeter Ojamong

[38]Citizen TV, Thursday 3rd August 2017, 21Hrs, *Sickly KNH.*

however chose the longer bureaucratic disciplinary guidelines. The council of governors (CoG) said as much that they were gearing to start engaging expatriate doctors from Tanzania and Cuba among others 'who were cheaper'. This was assuming issues like culture shock, prejudice and legal hurdles they would have to face. In the aftermath it was reported that Kenya had started importing Tanzanian doctors with the first batch of 500 expected later on.

However, an injunction was filed in court barring them on the ground that the law was clear that for a foreigner to be recruited then there could not be found a local with the similar qualification. There were about 1400 doctors who had cleared medical school, who would be joining the workforce the later in the year. Apart from this there were a number of unemployed doctors in the country. This was not to say that we were anywhere close to getting the ideal number of doctors in the country. KNH for example had 264 doctors but its ideal was about 2000.

Picture: Kenyatta National Hospital main entrance and tower block

(Photo courtesy of the BBC News photographer)

Concerning the nurses' strike that coincided with the active election campaign (started on June 5th 2017 which was 65 days to the general election date of August 8th). The onus was on the government to ensure the nurses' strike did not go past the election date; unfortunately this became a reality with every passing day, badly bruising the nurses' ego. Moments of crisis were moments of opportunity also.

Crisis turned into circus and the way out for everyone was to blame politics for everything including the strike. The opposition used it as a pointer to the sitting government failure to offer basic health care to its citizens by addressing workers' issues.

After the election as expected there would be the settling downtime especially for new members of the council of governors and possibly a whole lineup of a new government. In other words a new set of players. Then, there was the Supreme Court order for a re-run of the presidential elections in 60 days (and a foreseeable possible postponement of the same).

Experts including SRC agreed that disparate pay (and not necessarily inadequate pay) was responsible for most industrial disputes in the country. When one health profession was (over-)pampered at the expense of others it would come as no wonder that it fuels conflicts and further labour unrest. Some counties apparently did their bit.

In county Zendi, a medical officer just after internship was recruited at job group 'P' as opposed to 'L' in 2 grades above majority of counties. A nurse on temporary contract was appointed at Ksh 32,000 which was like double what other counties paid. Unfortunately contracts were renewed on yearly basis. Some cadres it was done half yearly. This category of staff continued to offer services during the national health workers strikes of 2017/17.

While the rest of the country had health crisis no strike was reported in Zendi County. While for some of the counties the strikes threw their systems into a tail spin where facilities were literally closed. How was it that other medical cadres could not continue without those on strike? Time to learn from Zendi County - what systems were in place? How sustainable were they? Would the same survive the goodwill of the incoming governor (as became the case)?

2.3.0.1 Over and Out?

The doctors union called off its 100-day strike after reaching a deal with the national and county governments. "The signing of the return to work formula (RTWF) ends all the remaining contentious issues between the parties" in part read the statement Inter-religious Council on the 100th day. RTWF removed all the pending disciplinary measures and victimization on the doctors.

On the other hand the secretary general KMPPDU said "We are happy that the doctors union have finally put an end the strike. While the strike is over, the dispute may not be…" Among others a collective bargaining agreement which was signed in 2013 would be renegotiated within following 60 days while doctor's services resumed.

There was need to bank on the remaining goodwill to close in on the pending issues. The CBA would cover doctor salaries, welfare programs but improved health facilities. If only the public could then see that the fight was about them (a stable health sector).

As if to point towards what was expected, counties were not willing to pay for the months the doctors were on strike 'not working' and there was renewed call into action some weeks after. Isolated softer demonstrations and go slows were not unusual across the country since several counties had *struck off* the doctors from their payroll for March 2017. No other than the president himself intervened directing that they be paid. Counties insisted they would *not pay for work not done* or else did not have the money all together, seemingly the funds tranche had been spent?

Ironically, some counties asked the government to provide the money for January to March, 2017 to enable them pay the doctors. Where had the money gone? Being an election year county bosses were engrossed in election campaigns to pay attention and resolve the matter once and for all.

By 1ˢᵗ May 2017 (Labour day), KMPDU issued a warning <u>pay doctors to avert strike.</u>
It was indeed, disappointing to let the matter drift towards the resumption of the total shutdown that was experienced in public hospitals countrywide. By the middle of that month the CS Ministry of Health indicated that Ksh1.5b and 1.6b had been released to the counties for doctors and other health care staffs respectively even though most counties said they had not received the said disbursements. Along the ongoing twists and turns, two doctors on 19ᵗʰ May 2017 filed a case in the industrial court to compel the Ministry of Health and Council of Governors to pay the doctors.

Unfortunately quite a number of doctors said they have had enough of it. Sources from the union indicated that about 10 % of the total 3900 doctors in the county had left in the immediate follow up of the industrial action.

Undisclosed sources had indicated that a handful of them were waiting on the wings; to take the factored accumulated arrears in one hand and resign from public sector with the other, 'shake it proper'. If this would happen, what a *slap in the face* if they made good such a threat. Only time would tell.

It was not surprising then that the Secretary General KNUN at some point hinted what appeared to be an ultimate way out, 'layoff everyone, pay pension, readvertize, whoever wants to work for counties can go ahead and apply'[39]. May be may be not, but then this suggestion might create a critical mass of county government employees who might be easier to manage.

This author would not be surprised that some governor somewhere wished *if only there were funds enough to pay off the damn terminal dues; we could do away with this nagging lot and start afresh with some of our own*.

Seemingly there was some disproportionate negative energy among the striking unionisable comrades in relation to the gains accrued. To this extent some pundits felt that after 100 days the doctors finally settled for (more or less) what the government had offered them on Day 2 of the strike. It would not be surprising if and when the nurses follow suit and took the risk allowance and uniform allowances and RTWF they had been offered on 5ᵗʰ June (or rather Day 1 of the resumed strike). But then it was not all about the money, it was about a better health system.

The medics needed to come to terms with a humbling reality, the fact that ttheir *new* bosses were the governors, county chief officers, members of county assemblies and a myriad of others including policies from the ministry of health. That is how it was meant to be in the first place with devolution.

The ghost was not being put to rest any time soon. In the words of the KMPDU secretary general on interview[40], 'The strike is off, no one is talking about patients suffering, but each day we are seeing patients suffering'. Or rather, 'we are not yet there, we may not have got all we set out to do, but we are well on our journey there'. On 27ᵗʰ May while issuing a further 'final' two weeks within which to have the CBA signed the

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[39]Daily Nation, *Healthy Nation* 15ᵗʰ August 2017 by Vera Okeyo; [40]*KTN Friday briefings*, 7ᵗʰ April 2017, 21:00Hrs; B. Kyalo Interview with Dr Ouma Oluga, as a guest anchor

Secretary General KMPPDU said, 'In the period we have been negotiating with 9 to 11 different teams over the same ISSUE. The pace has been painfully slow'.

The doctors' CBA was eventually signed on 30th June 2017 with the Ministry of Health and salaries Review Commission (SRC). Finally with Council of Governors (CoG) on 6th July 2017. Eventually it was filed in a court of law on 18th September 2017.

It indeed promised good tidings for the union members going by the contents available on: www.docdroid.net. The officials in a press conference indicated that this was a milestone not just for the members but for the country's health system. But then the journey had just began; that of implementation and consultations etc. *[P.S It was not all rosy for them or anyone for that matter, by end of March 2018 Treasury was reported to have backed off on the Ksh 11b deal with the doctors likely to ignite another season of labour unrest]*

Something else accrued from the experience: mediation & negotiation skills, concerning which they felt confident that they could make a difference if called upon. On 18th September KMPDU had their CBA finally filed in court of law, this was 287 days after it was signed, which was 200 days since the 100 days strike began.

The KMPDU SG extended to help out any parties that were having challenges in terms of negotiating, signing and filing of a CBA. This was certainly a welcome gesture since KMPDU apparently was leading the way in this case. Hopefully other unions would take the cue. May be referring to the nurses' strike which by then had entered its 106th day then.

But then, with all due respect it would not be fair to use the doctor's strike as a bench mark to resolving the nurses' strike or any other for that matter due to the unique requirements of each. The timings were different with nurses' strike standling over a transition between 2 governments. Moreover the two were not being handled with equal importance.

A.M. on *KNUN Official Forum* Facebook wall posted on 15th August 2017 while responding to J.M's *Law of diminishing* returns '… even if doctors took 100 days, at least they were talking, are we even covered by media comprehensively? No'. On the other hand by the time the nurses' strike clocked the 'revered 100th day' (as one faction insinuated) on 12th September that year, it was apparent to a good number of them that there was not much to show for it.

Politics of the day had overshadowed the nurses' strike. There so much to say concerning the state of the nation and less on the nation's state of health. There were hardly more than 2 mentions per week concerning the strike from the 2nd week of July upto late August 2017. Again, reporters were looking for content and in the words of one of those interviewed '…there was not much to report' #BehindTheHeadlines, a half hour feature based on the nurses' strike on 23rd September on *KTN News*. On the other hand the doctors' strike happened at a time when it was possible to have it in the headlines on a day-to-day basis.

Why the hurry when you can wait yet another day? On 81st day of the nurses' strike the Kenya's president elect himself while launching a new cancer treatment plant (cancer therapy and digital radiotherapy simulator) at KNH lauded the hospital's nurses for continuing to offer services even though their counterparts in the public service were on

strike. Way forward – 'let's give these governors some few weeks to settle then we will look into their (nurses') issues, meanwhile resume work.

KNUN did not call off the strike there and then, but by and large many nurses had resumed duty. Indeed on 86th day, the newly elected Nakuru governor instituted a task force to report on the nurses' industrial issues in 30 days. Nyandarua, Tharaka Nthi counties also saw the need to give dialogue a chance. Seemingly the stick (threats, intimidation) had failed miserably and it was time to try the carrot (dialogue).

But then either side should be given the benefit of doubt. The striking staff continued receiving their full pay despite being out of work for 100 days or so. Only one or two counties had stopped paying and even then they still paid some in what had come to be referred to as 'a divide and rule basis', some form of intimidation.

One health services manager put it squarely '…as long as salary has not been stopped some do not see why the strike should end'. Another one added, 'I know three of them who were seriously into business 'now earning double''.

On 31st August 2017 (88th day of nurses' strike), the Council of Governors consisting of about 30 present out of 47, together with representatives from the Public Service Board and SRC among others, having received the report of the previous 3-days negotiations with KNUN officials including allegations that that nurses had reneged on call allowance among other demands.

The CoG declared the strike illegal, that the CBA could not be implemented in the form it was. They went ahead to issue a 7-day ultimatum for nurses on strike to report to work by 8th September 2017 or face the sack. Upon expiry of these notice, some CoGs went ahead to advertise for vacancies in terms of 1-year renewable contracts for those who would be replacing the ones on strike.

The CS health went ahead on 120th day to direct that the nurses be sacked, and that the government was going to take administrative and legal implication on the individual nurses who will not resume duty as ordered by the industrial court. He said this during the opening of Annual Catholic Health Conference. He ruled out any further talks about the CBA until the nurses were back to work.

Things were complicated by Supreme Court of Kenya ruling on 1st September nullifying the presidential election, ordering a fresh one in 60 days. The same day the industrial court declared the nurses' strike illegal and ordered the KNUN national governing council to call it off in 7 days.

This implied that the nurses' strike was unprotected by law. Failure to which they would be jailed for contempt of court. The response from the Union was 'strike reloaded, reenergized'. It had been demonstrated in many an industrial action that a CBA was impossible to achieve without ceasefire and good will on both sides. Would it follow the road of the doctors' 'CBA 7'?

Would the national nurses' strike straddle 2 general elections? Was another 97 days too long to wait?

Or longer had we gone to January 18th as some of the sentiments of 'No election26th October until and unless the *minimum irreducible minimums* were met' on the presidential elections front were realized.

Around 5th September clinical officers- Kenya Union of Clinical officers (KUCO) issued strike notice. KUCO made good their threat and started the strike on 15th September. Their borne of contention this time: SRC (report yet to be made public) job evaluation had demeaned them from professional to semiskilled, a grade discretional Band B'3'.

Laboratory scientific officers, pharmaceutical technologists and radiographers issued a notice and some held demonstrations, the main issue - rejecting 'insulting grading structures by SRC' of their profession. Sources indicated that radiographers were also on the wings raring to join in. Various quarters suspected that these banding was meant to give the CoG a reason not to honour a CBA with 'semiskilled' workers after all.

According to Dr. Abdi Mohamed, chair Association of Private hospitals (*The Nairobian* October 20th 2017 pg. 15), the health sector took a nosedive when the health function was devolved … Devolving services soon eroded the gains made on public healthcare dogged by doctors' and nurses' strikes.

On 2nd November 2017, day 151st of the nurses' strike a deal had been negotiated that would see the strike that started on 5th June 2017 being called off. The return to work formula included nurses on strike being required to report back to work in 48 hours; there would be no victimization for taking part in the strike, withdrawal of all show cause letters for taking part in the strike.

Photo above showing agitated members of the nurses' union in the recent strike

[Photo Courtesy of Kenyannews.co.ke]

The CBA would be signed within 30 days. Grading issues would be sorted out pending a court case. Further, payments would be staggered in 3 phases for Nursing Allowance of Ksh10, 000 per month, Uniform Allowance of 15,000 in the next financial year.

The resumption of work was not without its share of challenges: some counties (e.g. Murang'a) had already 'replaced' the striking nurses with others. Garissa County was mostly serviced by non – indigenous staff and there would be logistical challenges for them to be expected to resume duty immediately. Most of the nurses were not on pay and the next pay was expected by end of November 2017. A section of them wondered, 'how do you report to work with no money?'

Apparently some counties also had their own pending domestic grievances with their nurses. A case in point was TransNzoia County branch union's officials warned that …turudi halafu tupeane notice. Swahili for *even though we are to resume but we will be issuing our notice (? another industrial dispute) soon*.

The conclusion of the matter was: The need for better affordable healthcare remains and that the health workers' strikes in the tail end of 2016 and three quarters of 2017 were seen by proponents as a means to advance a better healthcare system for the country.

Picture: An obviously distressed patient waiting outside a deserted consultation room during the height of industrial action by doctors. [Courtesy of the photographer]

The post script

When all is said and done concerning Kenya's healthcare crisis: My two cents - there is more to consider than the need to call for an industrial action most critical being –Timing! The social economic political circumstances played out louder than the ongoing industrial unrest.

On 10th July SRC released new guidelines for allowances, job grading and salary structures, remunerations of state officers and public servants (2017-2022) that would in effect see some earn less than before.

These were in line with job review and just concluded job evaluation. It would ensure among others fairness and harmony in remunerations of benefits. It took account of job performance, the economy and earnings adjusted to the cost of living. This hopefully captures the aspirations and hopes of Kenyans in the constitution to reduce the public wage bill. It would be unfortunate if the SRC decision was going to throw the country into another quagmire of further industrial unrests, but it did.

These drastic measures would save the country Ksh 8 billion in the first year. But then, was this a saving in a true sense since the budget was a projection of the fiscal year? We know saving = money earned but not spent. The already striking nurses (as expressed on day 38) wanted the saved Ksh 8b to be allocated to them.

What an uplifting thing that would be? But then did it matter that some of the money was going to be subtracted from them too? Every key monetary gain accrued from the industrial action and the abeyance thereof must be factored in the financial year budget.

The Chair CoG during a governor's retreat in September 2017 reiterated '…the resources are not sufficient to increase the wage bill. Nurses should be patient until the economy improves'. He added that the precedent set by the striking health workers posed a major threat to other sectors of

 the economy. In this respect it would be farfetched to imagine that parliament could be recalled from recess to pass a supplementary budget to benefit health care in this country!

There was uncertainty over the transition effect in the period towards and after the 2017 general election, the myriad election petitions (339 was the highest in Kenya's history so far), majorly the repeat presidential election ravaged the country's economy in a very negative way. Kenya's election was slated as one of the most expensive in the world. The electoral body alone used more than Kshs 52b [~5.2m US$] for the two elections which were only - 97days apart. The by-elections were likely to cost more since they would be spread out on a case by case basis.

The government had to review economic growth projections downwards owing to the prolonged electioneering period, cut down on unnecessary expenditure like out of the country travels by public officers. The harsh economic conditions had made the National Treasury remissions to the counties even on critical services a struggle. In any case any hoped for monetary award if at all could only be spread out, but to take effect from a date into the future. But then why was it that the state was able to honour the doctors CBA which required Ksh 8.2b for 4000 members and finding it difficult to honour nurses' 7.8b for 26,000 members?

There was very little money in circulation, stock exchange almost flopping or literally closing business more than once. Lots of consumption, little income generation, few goods and services, few to no foreign investors coming, reduced number of tourists, no payments being made to suppliers and service providers.

Safaricom® for example was reported to have made a Ksh 400m loss on the few days of the election in its Mpesa platform because agents were reluctant to transact. It was going to get worse with the ensuing economic boycott of its products and services sanctioned by the opposition leaders. According to Kenya Private Sector Alliance they lost Ksh700b in 6 months preceding the two elections of 2017. While Nairobi Stock Exchange lost Ksh 90m in the same period.

This author remembers how this became an excuse for shelving and even postponing major events, commitments and decisions. Some of these were communicated in the following format *… as you are aware we are in an unprecedented political situation that requires our response. A time to exercise our civic duty. In this respect we have decided to postpone by one month… we regret any inconvenience caused*.

Kenyans were sharply divided along political lines, this percolated lines of defence in union matters. This momentous opportunity also meant that Kenyans were more polarized than any other period. There was potential volatility in traditionally hotspot regions whichever way the election went. Lastly, there was perception of an 'evil eye' around the months of August/September as disaster prone. There was little to no service in some public offices some of it due to workers' strikes, breaks and public holidays.

There was a vicious cycle of having to rebuild the nation every 5 years which had become a reality, almost a tradition. Demographic health statistics usually took a nose dive as several gains were lost. These were not facts a union leader could afford to assume.

International Labour organization (ILO) *Convention number 98* on right to organise and collective bargaining has been domesticated to form part of Labour laws in Kenya. The two industrial actions involving KMPDU and KNUN had resulted in Kenya being indicted at ILO, summoned to appear before the health services sector tripartite committee to unravel the causes of prolonged industrial unrests within the health sector. It was a privilege being part of reforming the labour sector in Kenya.

The timing of an industrial action around such a time whether it might have been anticipated or not needs to take into account the above modifiers. In future this ought to form a critical basis for trade unionists as to whether to call for a strike at such a season but more opportune was when to change strategy if they found themselves in such a crisis. Very pessimistic huh! Well, these are all issues

for our weighting and considerations because our circumstances were unique.

Then, there was the repeat presidential election boycott followed by a post-election economic boycott by the opposition, including the secession talk and swearing in of a parallel presidency later in the year. The economic boycott for example was timed to 'escalate until the regime goes down'. The timing of strikes around elections season was awry either way in the view of this author.

[Post was shared in blog which is run by this author, See another blog post below]

Over and Out With the Kenya Nurses' Strike November 6, 2017 by CompleatNurse

The nurses' strike is over after 151 days. *Lisilo budi hubidi* paraphrased from Swahili – it was futile to resist the inevitable, and that was calling off the strike. Whether or not it had achieved the set out goal was no longer the issue. Hopefully this ends all the remaining contentious issues between the parties. The reality may be the strike is over, while the dispute may not be.

In the opinion of a good number of the striking nurses and other stakeholders, it was a matter of time before the strike dissipated. The steam had gone out of the members and the greater proportion comprised those who had resumed duty. Out of a possible 500 nurses in one particular county only 47 remained on strike.

They were coming back a battered army with bitter lessons. There were many begging question:

-How do we face betrayal, those who chickened in early, the timid who filed in at the earliest opportunity?

-How to relate with a new crop of those who had capitalized on the strike to get themselves a job?

-How to model for the new generation of nurses joining the profession?

-How to relate to every other health discipline who counted it too risky for them to be on strikeThe nurses' union still had a full in-tray. There was need to bank on the remaining goodwill to close in on the pending issues. The unfinished business included delivering the Collective Bargaining Agreement (CBA) within 30 days. Some nurses had not been on pay for the last couple of months, yet they were expected to deliver optimal care upon resuming duty. The union was expected to facilitate payments of pending salaries by 30th November 2017. Some union branches continued to ring bells of industrial action even as they resume, promising battles with their respective counties. Other counties insisted they would not pay for work not don or else did not have the money. A few had allegedly replaced the striking nurses with new ones e.g. Murang'a's 492 nurses..

Borrowing from the doctor's strike, it was not until 18th September that KMPDU had their CBA finally filed in court of law, this was 287 days after it was signed (which was 200 days since the 100 days strike began or rather 100 days after the strike was called off). The nurses' CBA if it saw the light of day, and it should was likely to deliver in staggered doses, titrated towards the next financial year. This meant time and patience with lots of give and take.

The public confidence

Even though the nurses' strike was over, many Kenyans also know that signing the CBA was one thing. Getting it implemented could be the beginning of another round of industrial action. It was unfortunate that this seemed to be the language employers understood. The current public universities lecturers' strike which resumed for the 3rd time this year was about an already concluded signed and filed in court CBA.

What about the patient? Certainly the patient had fallen through the cracks as they say. There were several gains were lost.

It will be disappointing for the public if the concerned parties were to let the matter drift towards the resumption of the total shutdown again. Instead the public should remain hopeful that a milestone had been achieved not just for the nurses but for the country's health system as well.

What had changed?

Above: Picture of an empty ward characterized most public hospitals during the nurses' strike

[Photo courtesy of citizentv]

After calling off the strike, will the nurses be going back to a more conducive working environment? Back to normal for many meant to the old improvisation, shortage of staff and stuff. More likely it was back to the same beaten infrastructure, some which had been vandalized in their absence. Problems and trials would continue.

They would be meeting a new governor in some places, and a new lot of chief officers. The counties outfit would be experimenting on several things including human resources. Trying a no-nonsense supervisor (in Swahili *nyapara* type) on nurses the way some of the county governments had started going about it would be the last straw that broke the camel's back. This would in effect emancipate the production of everyone else.
See the other posting on nurse as fulcrum.

What we could expect in the weeks ahead?

An influx of patients and clients seeking their services was obvious. The system would be strained beyond limit once again. See Health digest http://riftvalleyhealth.blogspot.co.ke/2017/11/patient-influx-overwhelm-hospital-as.html

The ripple effect of the strikes in the health sector would continue to be felt in the short and long term, in the years to come.

The promise
The promised deal that brokered the calling off the nurses' strike included:

-uniform allowance of KSh15,000, which will be increased by Sh5,000 each financial year. This allowance has been increased from the KSh10,000 they had been receiving.-a risk allowance of between KSh20,000 and Sh25,000, depending on job group, in the next financial year.

-risk allowances will be increased to KSh30,000 in the 2020/2021 financial year. A nursing allowance of between KSh15,000 and KSh20,000, to be implemented in two tranches, 60 per cent beginning January and the rest from July 2018.

The union

The nurses' union should be commended for the achievement of a return to work formula (RTWF). Nevertheless there were some prickly observations that perhaps cost the union dearly.

This is the era of emotional intelligence. I believe there was less one could achieve as a leader by 'cutting off the ears' of those representing the employer, statutory bodies or institutions set by the constitution for that matter.

Arguments may not always be won on the basis of what was said, but people watch the how, the manner one responds to those who they disagree with without going overboard. They will respect or thank you for expressing yourself in a thoughtful manner. As a result they too were likely to support your effort and increase your reach without questioning your ability to lead.

'Fire spitting', "flapping in the air" and infighting officials could have derided the image of the profession more than enhanced it. This could result in a low trust ranking of information coming from the union and association concerning health policy issues in the future.

Unionist posturing in politics would continue to hurt it for some time. But then the leaders had no one but ourselves to blame, that's the nature of Kenyans. Political proofing of union issues was going to be a big task going forward. Playing victim would not work. Union issues are political issues some argue, nevertheless it makes sense to run with the government in power at any given time. After all it is the employer. They say in nursing school the instructor and the textbook are always right. Even when they disagree.It was upon the student to know which one of them was right there (when).Rebuilding the nurses' union would be necessary, perhaps usher in a new crop of visionaries. Those who could create some optimism in order to command the same or a better following next time. Certainly there would be a next time some short distance away.

Take a rest

After calling off the strike, it was realistic to expect the nurses to take a rest from social media. Not throwing in whatever post and comment as had been witnessed during the strike. Voices of reason were likely to persist or take over in a more sober manner. Hopefully they would make it their priority to heal the divisions within the nursing fraternity using a methodological and deliberate approach. Try and put this ghost to rest sometime soon.

It was expected that there would be a push and pull favouring out-migration especially among the younger, specialized nurses. Undisclosed sources had indicated that a handful of them were waiting on the wings; to take the factored accumulated arrears (if it ever came) in one hand and resign from public sector with the other.

Lessons learnt

There were numerous lessons learnt from the just called off strike. Seemingly there was some disproportionate negative energy among the striking unionisable comrades in relation to the gains accrued from the strike.

To this extent some pundits felt that after 100 days the doctors finally settled for (more or less) what the government had offered them on Day 2 of the strike. It would not be surprising if the nurses had followed suit and took the risk allowance and uniform allowances and RTWF they had been offered on 5th June (or rather Day 1 of the resumed strike). But then it was not all about the money, it was about a better health system.

The other reality was that there was a lot of work in progress with devolved health care with no low hanging fruits for county public service board employees (including nurses). It makes sense to also see the harsh economic and political realities the country was going through.

The timing of the last industrial action whether it might have been anticipated or not was a fodder for drawing some lessons. In future this ought to form a critical basis for trade unionists as to whether to call for a strike at such a season. But more opportune was when to change strategy if they found themselves in such a crisis. Calling for 'a mother of all strikes' in the health sector many will agree was not tenable in future although it cannot be ruled out.

What do you see in the times ahead? Do you feel it is over and out as far with the nurses' strike?
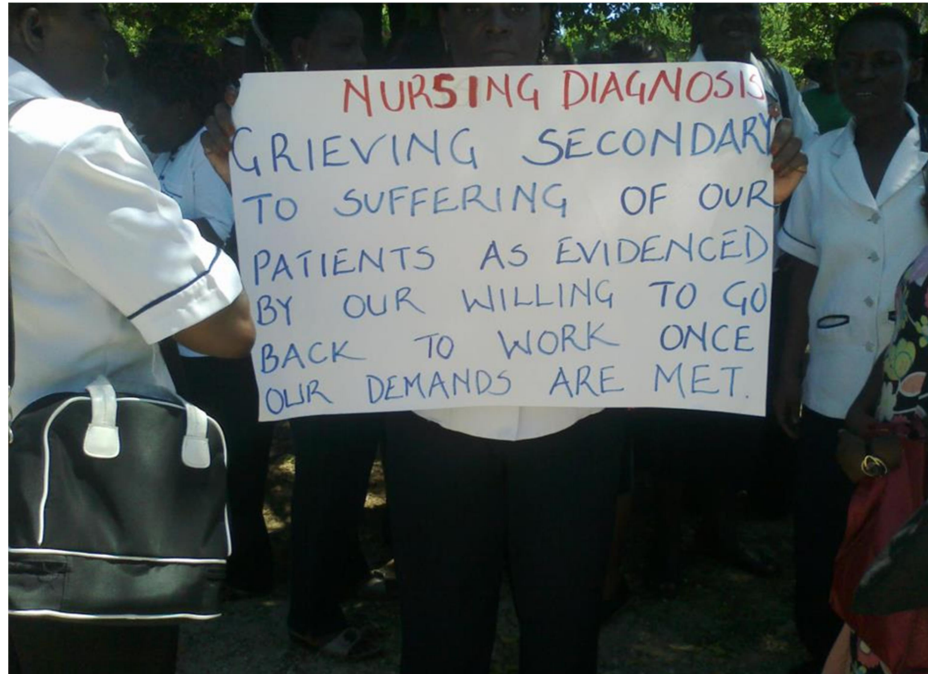
Pic: Some of the innuendos during the industrial action by health care providers Courtesy of the Nurses website

The chapter so ar on ♯HealthCrisisKE Diaries was an exerpt from this author's diary that followed up innuendos there about the happenings during the doctors' and laterthe nurses' strike of 2017, with just a bit on the universities' lecturer's strike. The video below in a way summarize the current status of health sector in Kenya.

 Please copy and paste links to your browser:
https://www.youtube.com/watch?v=FDBQGJ j2fY g

KNH the tower of hope amidst challenges

Kenyatta National Hospital (KNH) has been associated with milestones and ills in the same breath. Stories of medical firsts like the separation of conjoined twins are juxtaposed with allegations of negligence, insecurity, overcrowding, long treatment waiting lists and broken down equipment.

'There are inadequate public health facilities in Nairobi and its environs so we end up providing primary and secondary level of care instead of concentrating on our mandate of providing specialised healthcare on referral basis. The referral system is broken. Hospitals at lower levels should act as a filter, but they don't, so we end up treating patients who do not meet the referral criteria and who should otherwise have been treated at the lower levels. his overstretches us.

Patients in critical condition are also brought in without following protocol. The referring hospital is supposed to call to confirm whether the facilities needed for treatment of the referred patient are available. Sometimes that doesn't happen, putting KNH in a very precarious position' 'There has to be corresponding improvement in lower level health facilities so that they can take up their responsibilities and leave KNH to concentrate on specialised services'. Lily Koros CEO talking to Healthy Nation's Merab Elizabeth on 20th Feb 2018 [KNH boss talks about the problems bedevilling the national referral hospital](#) See also: https://www.nation.co.ke/news/KNH-nurses-blame-lack-of-tagging-for-surgery-mix-up/1056-4342244-gc4qmxz/index.html

But then KNH itself needed to improve on its systems to avoid errors. Consider the following: "That night we had 61 patients against two nurses," MN not the real name added, responding to Parliamentary Committee on Health which was probing the brain surgery mix-up. The mistake was however not noticed even after the surgeons in the theatre called the ward twice upon realising that the patient on the table was not AN, but the nurses there confirmed the identity of the patient as being right. Based on a medical scale (Glasgow Coma Scale) used to measure coherence of patients, at the time of preparing the patient for surgery, he was not coherent, scored a 13 out of 15. It became apparent that KNH then did not have appropriate mechanisms for labelling patients. The two patients had since been discharged and were recuperating well.

Pic: Which way Kenya's public health system? (Courtesy of the clip developer)

Kenyatta National Hospital (KNH) one of the national two national referral hospitals in the country was the microcosm of the ailing public health system. Anyone remembers the callous #KNHrot on Twitter in early 2018? It touched mainly on patient safety (including allegations of rape of post natal mothers living in the mother's hostel who had to go every two hours to breast feed their neonates two floors down at the new born unit). Other issues that arose included a public perception of an insensitive hospital leadership among others. It was hard to know where truth lay in this saga, victims were unwilling to volunteer information, while social media was prosecuting the matter based on generalities and conjecture. However Investigations were ongoing by the time of publishing this manuscript.

One thing was for sure - the country's health system was at cross roads, sinking lower and lower in the period 2017-18. Which way Kenya's public health system? There were no ready answers, by gleaning the comments on mainstream media and social media perhaps one might come across some good suggestions. One O.C.O on Jan 18, 2018 tweeted on the trend #KNHrot '…we need to shock the system and retain Kenyans who will serve and policy leaders who will not steal'. A great pointer to the way forward though it fell short of showing how to do that. We must embrace international patient safety goals.

Pic: Patient safety is paramount, was an important pointer to the quality of health care. (Courtesy of clip developer)

In the immediate period following the brain surgery patient's mix-up of early March 2018 due to possible mislabelling, many Kenyans felt something needed to be done to address the KNH crisis. It was felt that just like one media house posed the question: 'What is the worst that must happen to KNH before something drastic is done?' "

"*/Kp"\j ku'ecug'\y q"Wpnpqy p"Ch kccp"O crg"Cf wnu"-(?may be had names y kj "r quukdkrkx{ "qh'c "5t f "qpg+"cnin coma following head injury. One of them was diagnosed with an intracerebral haematoma was due for surgery to evacuate the clot. It was only after like 4 hours of looking for the pathology, calling in 2nd 3rd aon call that it was concluded that this was the wrong patient on the table. So they reversed he pateint as we say theatre. Meanwhile the right patient's general condition was deteriorating and had to be taken to ICU. A third patient (perhaps a confounder) succumbed to head injury after missing the opportunity for surgery. The incident missed basic but vital procedures before and during the operation, which resulted in one of the worst cases of medical malpractice. This led to a cascade of events, a wake up call as will be seen here below."*

The situation was made worse when over 700 doctors (mainly registrars and interns) downed their tools in solidarity to their suspended colleague in the neurosurgery mix-up and the suspended KNH CEO. Specialist consultants numbering 300 threatened to join in adding their voice to working in an unsafe working environment. They cited the mix-up as a tip of the iceberg of the system failures that bedevilled the public health system especially KNH.

In a press conference with one of the media houses on 6th March, 2018 the specialist consultants alleged that KNH had only one working CT scan machine serving the over 2400 patients. The MRI had broken down for sometime and a good number of essential equipment was lacking. The question of patient identification they indicated was somthing that could be sorted out with barcoding as an add in to digitization of electronic health information, and it would cost perhaps Ksh 100m. Compared to Ksh34b (leasing) medical equipment program. They lamented that KNH had not benefitted from the medical equipment program which had targeted the county hospitals.

It was notable that this was also during a time that vpkxgtuk{ "lecturers servicing the medical schools had downed their tools due to a pending CBA, The university teaching staff had just began another strike (one in a series of industrial actions from the previous year 2017).

Other cadres of health workers at KNH had also threatened to follow suit. Nurses especially felt that they were being victimized for system failures. Come to think of it - how many near misses could likely have ended up like the mix-up above? A fail-safe system failure was evident even though doctors tried to absolve themeslves of any wrong doing and placed the whole blame on one ward nurse. Bridging these gaps is about assuring access to quality care 'Best Care Anywhere'. The government has since contracted an audit firm to look into the systematic quality assurance failures facing KNH.

The battle had just began. This book cannot fathom what was about to happen to Kenya's public health system. One thing was for sure- the stem will need a beat and a heart to survive this one. It was the prediction of this author that Kenya's oldest referral hospital would get a new lease of life but at an enormous cost in terms of patients' suffering.This is what many had been saying all along - upgrade the former 8 provincial hospitals to be equal in status to KNH or MTRH, this will in effect decongest the two. In March 2018, Nyali MP Mohammed Ali presented a bill in Parliament that sought to compel national government to establish referral hospitals across all the 47 conuties in the country.

The main concern for Kenyans ought to be: can the next door proximity to the incident or accident health facility diagnose and treat a health problem you might have? That is - irrespective of who the patient was or happenned to be. To do all these we need evidence: to practice using evidence, to gauge our practice against existing and emerging evidence.

CHAPTER 3

Nursing Curricula Reorientation to Universal Health Coverage

(UHC) Basis: A Primer Model for Kenya

Overview

This chapter's insight was sharpened during my PhD Thesis in Medical Education at Moi University going by the above title. Proposes reorienting the BSc Nursing curricula to meet the needs of universal health coverage challenge in Kenya. Realizing UHC will require nurses who are prepared well in advance with the know-how right from school and on-the-ground. Evidence from across most settings globally and locally shows the need to reorient training to the UHC agenda.

Research question: How can the BSc Nursing curricula be reoriented to address concerns about emerging roles placed upon nurses by universal health coverage (UHC)?

Purpose: To reorient the BSc Nursing curricula to universal health coverage (UHC) basis.

*Objectives:*i)To align the requirements of BSN curricula to UHC, ii)To identify emerging nurses' roles for universal health coverage (UHC), iii) To determine the nurses' perception of working environment in relation to UHC, iv) To determine the nurses' perceptions of challenges in UHC.

Method. Mixed study: The procedure will involve administration of a questionnaire to respective Bachelor of Science degree nurses together with in-depth interviews with key informants. There will be a Delphi technique surveying on experts' view on BSN curricula as regards UHC. Ethics issues will be adhered to –privacy, written consent, approval and, confidentiality.

Data Analysis: The Quantitative data analysis will be done using both descriptive and inferential statistics. Deductions - interpretations – based on the objectives. Qualitative data will utilize interpretive methods into categories themes and representative quotes. Results will be presented as graphs, tables, percentages, fractions, % and, statements

Findings expected: Will uphold the theoretical assumptions that there was an implementers' gap that could be bridged by reorienting the nursing curricula. These will attempt to offer practical suggestions on how the nursing curricula can be improved by including universal health coverage (UHC).

Expected application and recommendations: Nurses' learning needs and concerns towards universal health coverage (UHC). It will recommend UHC content input into the BSc Nursing curricula.

Pic: Road to UniversalHealth Coverage
[Picture courtesy of Rwanda UHC]

3.0 Introduction

Chapter 3 entails: the background of the proposed study 'BSc Nursing Curricula Reorientation to Universal Health Coverage (UHC) Basis in Kenya', statement of the problem, Study justification, objectives, research questions, Hypothesis, Scope and limitation of the study and definition of operational terms in the study.

3.1 Background of the study

The BUZZ internationally is 'Universal Health Care Coverage, it has taken a momentum like never before; a quote captured from Rachel Thompson (Rachel is a *Research Associate* Centre on Global Health Security).We now have an action plan in Kenya to make UHC for all households by the year 2022.

Nevertheless universal health coverage is not a new thing if we look at it from a global perspective. For Kenya which is beginning to actively engage in UHC some of the things have been there but there will be additional roles for implementers (Okech, T., Lelegwe, S, 2016); (Koon, A. et al, 2016); (Kazungu, 2017); (Kamau S. , 2018) ; (Obare, V., Brolan, C., Hill, P, 2014). Some of the studies I just referred to were between 1 and 4 years old by now. They all attempted to describe Universal Health Coverage in Kenya.

The nurse is an important partner and player in the implementation of UHC and is the subject of this study (Thompson, 2017).Nurses in poorly sourced settings might be eager to travel these paths namely execution of flagship project by properly positioning themselves. However they were conscious that there were unique contextual factors that were present in these settings that hindered them. These included lack of preparedness on some of the policy changes and additional roles demanded on them by the policy changes (Atieno, J., Edwards, N., Spitzer, D., 2014); (Gorry, 2013).

Realizing this ambitious goal would not only require political goodwill but also know-how among care providers on-the-ground among other requirements. The proposed study attempts to determine the additional roles of the nurse and propose reorienting the nursing curriculum to meet universal health coverage challenge.

Government decrees assume an existing knowledge and readiness of systems. Implementers might feel alienated, need to know any new roles for partnership and seamless implementation. To leverage (influence or optimize) on implementers of Universal Health Coverage (UHC), hence there was need to integrate local evidence on policy development (Atieno, J., Edwards, N., Spitzer, D., 2014).Nurses need to influence the formulation of health policies rather than just implementation of them (Arabi, A. et al, 2014).

Universities' role in demystifying government and internationally ratified agendas such as UHC. A government's agenda becomes an agenda for higher education in most developing countries and almost all parts of the world (Mizikaci, 2006).

Nurses in poorly sourced settings might be eager to travel these paths; however they were conscious that there were unique contextual factors that were present in these settings that hindered them. These included lack of preparedness on some of the policy

changes including Universal health coverage (Atieno, J., Edwards, N., Spitzer, D., 2014); (Arabi, A. et al, 2014).

Just like every other healthcare provider, in order to perform at their best nurses require graduate nurses require adequate knowledge which should be from their undergraduate training supplemented with on-job training and regular updates.Updating the nursing school was important priorities that are overlooked in many countries (Sobel, H., Huntington, D., Temmerma, M, 2016); (Health workforce development: I-TECH's approach to building the capacity of pre-service educational institutions, 2011).

During the 6th Global conference on nursing & midwifery in 2014 the theme was -*At the Heart of It All: Nurses and Midwives for Universal Health Coverage".*One of the conclusions was that:

> *'…health-care services were changing from acute care services to more community services and continual care services. Nurses' curricula don't have competencies for work in community and nurses are not prepared to work independently at the same time'.*

This will be a mixed study will attempt to describe pertinent elements of BSc Nursing curricula for capacity building for nurses on the basis of UHC. The approach will be concurrent nested strategy: Survey + interview + Delphi technique and interpretive policy analysis (Creswell, 2009); (Schwartz-Shea, P., Yanow, D, 2012) aim being to triangulate findings, maximize on the strengths of each as follows:

Quantitative aspect: cross sectional survey design (measuring exposure and outcome at the same time with questionnaire closed ended questions)

Delphi technique – will assist to determine the additional roles of the nurse as per UHC. It will incorporate views from experts in UHC in Ministry of Health as well as those teaching from BSc Nursing Curriculum and Nursing Council of Kenya with regard to what they feel was missing or should be addressed in the BSN curricula concerning UHC.

Qualitatively will be phenomenon evolving emergent design, utilizing semi-structured in-depth interviews; namely interpretive policy analysis (Schwartz-Shea, P., Yanow, D, 2012) with key informants about what they felt were the nurses' learning needs, perceived benefits, working environment and coping strategies with regard to UHC. Purposive recruitment of participants will be up to saturation about their roles, perspectives on UHC, perceived learning needs and concerns on UHC. Target population will be nurses working in selected public hospitals Central, Nyanza regions Kenya.
Ethics issues will be adhered to –privacy, written consent, approval, confidentiality.

The Quantitative data analysis will be done using both descriptive and inferential statistics. Deductions - interpretations – based on results of specific, observed, measurable, attainable, and realistic and time bound (SOMART) objectives.

Qualitative data will utilize interpretive methods into categories themes and representative quotes. Results will be presented as graphs, tables, percentages, fractions, % and, statements.

3.2 Definition of some of the concepts (abstractions) on the topic

• *Universal Health Coverage (UHC)*-theoretically means that all people will have access to needed health services and that 'quality' 'does not expose the user to financial hardship. Aims to provide financial protection so that the costs of using health services do not create financial hardship for those who need to use them. It could also mean 'health for all'. (World Health Report 2010). There is more of the literature review.

.*Reorient:* change the focus or direction of. Reorient BSc Nursing curricula- find its bearings or focus in relation to Universal Health Coverage.
Universal Health Care - Universal health care means that everyone in the country has access. While some of them may have to pay cash, others may have private insurance and whereas some people's coverage is subsidized through government programs. But generally speaking, universal health care is mandated by the government - that everybody's has got to have it look for a way of having one (Overbeck, 2018). There is more of the literature review.

• *Curriculum* noun (plural *curricula* or *curriculums*) the subjects comprising a course of study in a school or college (Concise Oxford English Dictionary). In the matter of this study it refers mainly to the Bachelors of Science in Nursing BSc Nursing otherwise referred to as BSN. Undergraduate nursing program that takes 4 years, followed with 1 year internship and licensure by Nursing Council of Kenya (NCK). Graduates of these programs are popularly referred to as BSNs or degree nurses.

• *Resource-Constrained Settings*-resource limited, resource poor settings, low income settings. Usually the first impression for this study refers to some health care facilities in some parts of Kenya or elsewhere, some of which are run by the Ministry of Health or faith based organizations.

• *Reorient nursing curricula*: to redirect nurse education from being disease-orientated towards UHC (e.g. proactive advocacy, social and health policy, a health promotion ideology etc.)

• *Quality in health care* is the degree to which processes and results meet or exceed the needs and desires of the people it serves. Those needs and desires include safety (The Joint Commission International for Accreditation, JCIA 2015). Patient's safety thus emerges as a central aim of quality.

• *Health system*s are defined by the World Health Organisation (WHO) as "all organisations, people and actions whose primary intent is to promote, restore or maintain health" (WHO e. , 2007)

• *Learning organizations*-system level continuous improvement through the collection, analysis of this data, creating new knowledge, and the application of the new knowledge to influence practice (evidence based practice) (Porter-O'Grady, 2015). The organization creates enabling infrastructure and engages care providers in these pursuits. Continuous learning includes continuous professional education (CPDs) synonymous with Continuous medical education. Nurses need a certain minimum number of CPD hours for retention. This study will presume that the nurses will be working in learning organizations.

• *Caring* a therapeutic intervention. In most cases nurses understood the contribution they make in this aspect (Draper et al, 2008). They were willing to look at ways to

maximize resources and processes to improve value for patients, payers, communities they served, and the organization as a whole.

- *Experts*: people are regarded as expert in a given field if and when it is clear that they hear and see more than the rest do. They also know more about the history and background of the matter. They can appraise and interpret on the matter based on what they have been able to experience and in the process helping others to see what they might not have seen before (Kramer, 2015) quoting Elliot Eisner.

- *Value judgment***:** Assessing phenomena in relation to a set of value-based criteria. It is from these values that the individual is guided towards social selection of behaviour.

- *Hypothesis:* Are not statements of "truth", but their validity will be tested. This test will be done indirectly via formulating questions and planning interventions, whose effects will then analysed and serve to either confirm or modify the original hypothesis

- *Primer:* From the **Oxford Dictionary** primer is a noun that means providing a basic introduction to a subject or used for teaching reading. Original words related to these were primarium (manuale) 'primary (manual)'. In this case the subject being reorienting BSc Nursing curricula to universal health coverage is perhaps a first of its kind for Kenya (and perhaps elsewhere). Envisions that I will come up with a learning model to demystify UHC and show how it could become as much one of the courses in BSc Nursing just like gender now is a common course in most curriculums.

- *Model and framework* are used interchangeably. A version, a product. The nursing profession needed to educate more nurses with new models of care and expanded scopes of practice. Come up with education models focused on patient-centered/family-centered care in a variety of clinical and community settings (Honig, J., Dohrn, J., Doyle-Lindrud, S., Kelly, A, 2015).

3.3 Justification

➢ Initial data gathering: need to improve understanding of UHC among nurses

➢ Assumption (from literature, preliminary document review of BSc Nursing curriculums, peer educators and nurse practitioners) is that a learning need exists among the nurses on their role in UHC

➢ As an emerging area in health care delivery in Kenya – need for leadership and policy direction on UHC

➢ UHC had become a standing theme for nursing and allied professionals' conferences in Kenya and elsewhere for the last one year. This could mean it was perplexing to health care providers.

➢ Baseline necessary, there is generally 'no one-size-fits-all' approach UHC (Yazbeck, A. et al, 2018); (Aknif, E. et al, 2018).

➢ HCW including nurses might protest changes in policy if they were not properly engaged from the beginning (Koon, A. et al, 2016); (Atieno, J., Edwards, N., Spitzer, D., 2014).

3.4 Statements of the problem

Even universal health coverage is not a new concept globally, the frequency of the discussion in Kenya shows it is now a big agenda. But for the implementers including nurses the action plan apparently has not connected with them. There seemed to be a general feeling of 'things are moving too fast' or unpreparedness. A few studies globally

and locally demonstrated the need for learning within the organizations for UHC for nurses in service. No study looked explicitly at the undergraduate nursing curriculums or how it could contribute to achieving universal health coverage.

Thus the proposed research seeks to reorient the nursing curricula to UHC basis. The variables will not be manipulated since this is a cross-sectional study i.e. a one-time study where the exposure and the outcome are measured at the same time.

3.4.1 The variables

The variables are derived from the title which guides the research question, objectives and the rest of the study. The title of the proposed study: *BSc Nursing Curricula Reorientation to Universal Health Coverage (UHC) Basis: a Primer Model for Kenya* also strives to meet the criteria for optimization on search engines (SEO). This will make the research more visible online (Ogoma, 2018). The main independent variable will be Universal Health Coverage while the main dependent variable will be BSc nursing curriculum. The intervening variables(caused by the independent *variable*, and is itself a cause of the dependent *variable*) include nurses' role in UHC, nurses' perceptions, nurse' perceived benefits of UHC, nurses concerns, working environment, hospitals, counties, age, gender, level of seniority, years of experience, where trained, other demographics.

3.4.2 Purpose of the proposed study:

To reorient the BSc Nursing curricula to universal health coverage (UHC) basis.

3.5 General Objective

To reorient the BSc Nursing curricula to the emerging issues in practice of Universal Health Coverage (UHC)

3.5.1 Specific Objectives of the Study:

i)To align the requirements of BSN curricula to UHC,

ii)To identify emerging nurses' roles for universal health coverage (UHC),

iii) To determine the nurses' perception of working environment in relation to UHC,

iv)To determine the nurses' perceptions of challenges in UHC

3.6 The research question

How can the BSc Nursing curricula be reoriented to address concerns about emerging roles placed upon nurses by universal health coverage (UHC)?

3.6.1 Proposed hypotheses

The null hypothesis will be correlational for qualitative aspect of the study by making predictions that will be tested empirically (at some point within the study) about how phenomena will behave in the real world *if the assumptions are true*: Quantitatively these will be tested as follows:

i) The objective to align the requirements of BSN curricula to UHC. This will be done qualitatively hence not sound to have a hypothesis. However the research question will be: to what extent can the BSc Nursing curricula be oriented itself to Universal Health Coverage (UHC) basis in Kenya?

ii)To identify emerging nurses' roles for universal health coverage (UHC),

H0: μA=μB =μC;   HA: μA ≠μB≠μC will test following hypothesis 'Null hypothesis **[H0]**will state that there will be no difference between the population means of implications of emerging nurses' roles for UHC in 6 different hospitals, it will be the same for all groups, and that the alternative (research) hypothesis **[HA]** will predict inequality of means. Assuming analysis of variance ANOVA (*p=0.05*)'.

iii) To determine the nurses' perception of working environment in relation to UHC
H0: μA=μB =μC ;   HA: μA ≠μB≠μC will test following hypothesis 'The null hypothesis **[H$_0$]** will state that there will be no difference between the population means for nurses' perception of working environment for UHC in 6 different hospitals, it will be the same for all groups, and that the alternative (research) hypothesis **[HA]** will predict inequality of means. Assuming analysis of variance ANOVA (*p=0.05*)'.

iv) To determine the nurses' perceptions of challenges in UHC

H0: μA=μB =μC ;   HA: μA ≠μB≠μC will test following hypothesis 'The null hypothesis **[H$_0$]** will state that there will be no difference between the population means for nurses' perception of the challenges in for UHC in 6 different hospitals, it will be the same for all groups, and that the alternative (research) hypothesis **[HA]** will predict inequality of means. Assuming analysis of variance ANOVA (*p=0.05*)'.

3.7 Theoretical Framework

The mixed study approach will utilize both qualitative and quantitative methods in more or less equal measure is informed by the pragmatic philosophical and lately constructivist world view that I as the researcher holds (Creswell, 2009). Neither qualitative nor quantitative will be sufficient to adequately inform the need to reorient BSN curriculum or inform the graduate nurses that they were prepared to achieve UHC goals. Pragmatist philosophers will do all what and how approaches it will take to understand the research problem. The aim therefore will be to triangulate findings and maximize on the strengths of each. This was supported by (Creswell, 2009).

Qualitative (inquiry) somehow yield the full picture, the nuances, subtleties of how and why reorient BSN curricula to UHC? These rich experiences, data and observations from) when triangulated with quantitative data (validation), hopefully will help to refine the nurses' understanding of UHC and generate theoretical inputs (Polit & Beck, 2012); (Heppner P., 1992).

Why BSNs and not all nurses. A study that this researcher has adapted by (Nurses' knowledge of universal health coverage for inclusive and sustainable elderly care services, 2016) in Hong Kong concluded that nurses with higher academic qualifications, placed a higher degree of importance the need to develop and strengthen policies to improve the quality of nursing education. Moreover, the resources and time for this research are limited if we were to reach all the nurses.

For a population 43 millionaccording to the *Kenya Healthcare Workforce Report*, the ratio of practising nurses to the population was 8.3 per 10,000, compared with the World Health Organisation recommendation of 25 nurses per 10,000. Of the 51,649 nurses

below 60 years who had been ever registered, only 31,896 were active in hospitals, 22,000 nurses employed in the public service (MOH 2. , 2012).

A survey has been found as the best way to get information and feedback to use in planning and program improvement. (2010, University of Wisconsin System Board) like would be the BSc Nursing curricula and UHC strategy for that matter. Questionnaires will an in-person administered survey –number of question and multiple steps, sections (Field, 2005).

This researcher has adapted a format of questionnaire development previously used by (Tung, F. et al, 2016) and one that was used in a multi- country study where he was a co-investigator (Preposi, P., …, Kamau, S. et al, 2018) though theirs were self-administered while this study proposes an interviewer assisted questionnaire.

The qualitative technique will employ multiple approaches: nursing conceptual thought, priori, Delphi techniques, and interpretive policy analysis approach.

To begin with this being a nursing related study will of necessity acknowledge that nursing theory is guided by a conceptual thought. Generally there were 4 main concepts that generally comprise the core of nursing conceptual thought: *The Person, the Environment, Nursing, and Health*. These will act as theoretical basis for the proposed research. The concept of person will be implicit in the nurse, nurses' nurse lecturers, and, beneficiaries (Fawcett, J., Desanto-Madeya, S., 2012). The others are explicit shown in the specific objectives above and model below.

Figure: Conceptual framework for BSc Nursing curricula reorientation to universal health coverage basisin Kenya
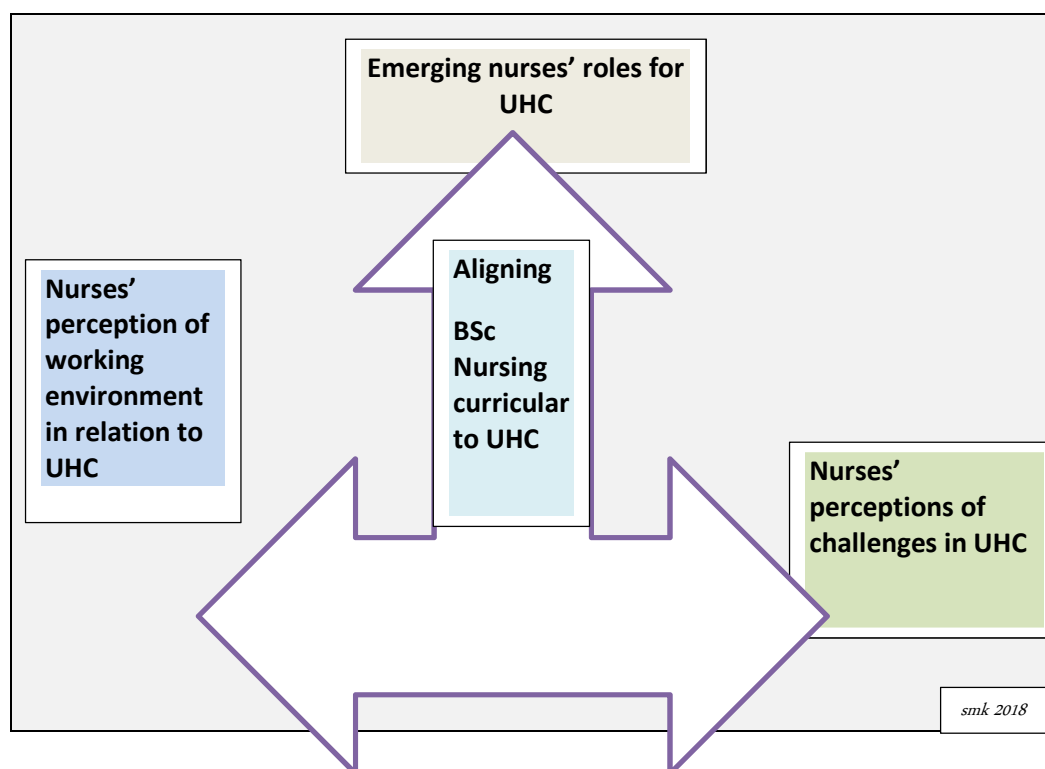
Figure: Theoretical underpinnings hinged on an assumption that an Implementers' gap exists in UHC most likely can be bridged by reorienting nursing curriculum

[Courtesy of clip developer]

Priori – on purposive recruitment of key informants (a nurse in leadership or management position) and nursing experts in UHC as well as those in BSc Nursing curricula for the Delphi survey.

Experts: will include - UHC experts in (1) MOH education department under the Director of Nursing Services and NCK and particularly those who have experience through the exchange program with Cuba. I will try to reach out to the Cuban family physician based in Nyeri and Kisumu Counties.

I will try a face to face interview with each of the panelists for round one as this might gain some trust and influence rate of subsequent rounds which I hope to do using Zoom™ video conferencing with screen sharing. An email and phone call will be used to supplement the two.

In the Delphi survey experts will input in three main thematic areas of the nursing curriculum: general nursing, reproductive health, community health.

I will come up with a list from literature and document review of BSN curricula and frame the following statement – 'this is what I think are the nursing roles and activities regarding UHC, do you think there is something I have added or omitted?' Possibly delete what was not necessary.

Roles and activities that are prescribed in the curriculum must remain. The list will be circulated. I will categorize theme as the role and activities as sub-themes in each role. Then I will combine opinions of each round (multi-stage) into group consensus up to point of decision making (Hasson, F, 2000).

 I will make summaries on what were common, mentioned many times in the feedback from the experts and recirculate up to point of idea saturation based on degree of convergence or what would be the 'law of diminishing returns', with likely tie breaking by the 3rd round (Hasson, F, 2000).The data from the Delphi would be qualitative and will be analysed using content analysis techniques by subjecting it to NVivo software.

Interpretive policy adopts a constructivist epistemological approach. Making this assumption that there could be a distinction sandwiched between the natural and social worlds and, that nurses will allocate meaning to actions and events as experienced. This therefore means that they will perpetually be engaged in construction of reality to make sense of complex phenomena like UHC policy, it's politics and how it affects their daily lifeThis construction was dynamic in that it could change, get reconstructed, and be subject to various legitimate interpretations (Schwartz-Shea, P., Yanow, D, 2012)

I will relate from time to time with the study by making constructions representing his understanding of various aspects of UHC from evidence gathered. Schemas using concept, argument and mind maps will be developed. This approach is supported by (Rycroft-Malone, J., Bucknall, T., 2010).

3.8 Scope and limitation of the study

3.8.1 Inclusion exclusion criteria
There were about 2000 BSNs licensed to practice in Kenya so far. Figures of BSNs employed in the public sector were not readily accessible but unofficial figures indicate that they tended to be were fewer in public service due to limited absorption. However the number of BSN interns was high in the public sector though these would not be included in the study due to their inadequate exposure to the health system (Nderitu, 2016).

All nurses who were not holders of a Bachelor's degree in nursing will be excluded attempts will be made to confirm from the nursing services managers' records.

Student nurses will be excluded due to their inadequate exposure to health systems and they were not yet through with their curricula.

Nurses from other counties other than Kisumu and Nyeri will be excluded, either because the level of UHC in their counties was less developed or were not part of the national piloting of UHC.

All those unwilling to participate or choose to drop out will be allowed to do so without any consequences on their part. Attempt to oversample will be made to cover such incidences.

The targeted curriculum here is the BSc Nursing. Therefore all nurses who are not graduates of a BSN program will be excluded. The challenge will be in trying to exclude those trained outside Kenya as it might not be necessary. An item will be included to them in the demographic data. Nurses with a Master's degree and above will be assumed

to have had a Bachelor's degree in nursing though this was not always the case. These were likely to become confounders.

3.8.2 Limitations of the study

As could happen with some mixed studies – there is a possibility of divergent results. This is overcome by declaring such a possibility from the outset. If this does happen these will be reported as such and where possible the incongruences might be reconciled by going back to the respondents to clarify (Tonkin-Crine, E., et al., 2016).

The study discussed the consequences of data agreeing (convergence), complementing each other (complementarity) or contradicting each other (dissonance) in a mixed study. They indicated that dissonance does not indicate a failure in the study but can be considered constructive if it leads to a richer understanding of the phenomena.

Interpretive research design is kind of an open field; the value judgments can go in any way as both I and my respondents, we were all trying to make sense of the phenomena – Universal Health Coverage policy. A similar limitation was acknowledged by (Koon, A. et al, 2016).This Reflexivity on the part of a peer researchercan crowd the interpretations (Polit, D., Beck, C, 2012). This will be overcome through use of an independent interviewer in certain cases (like where there could be familiarity between researcher and a respondent), avoiding leading questions and the use of multiple qualitative approaches.

Interviewer-administered 'questionnaire' *alias* interview schedule schedules will generally filled out by myself as the researcher or my trained enumerator, who can interpret questions when necessary. However this does increase the chance of bias sneaking in via the interviewer but at the same time will have the advantage of having the interviewer available to explain the questions.

In some circumstances schedules may be handed over to respondents and enumerators may help them in recording their answers to various questions in the said schedules (Kothari, 2004), I foresee that this will be a likely event. This will however depend on particular respondents, who will find it easier in my judgement as a researcher.

It will not be possible to look at all the BSN curriculums in Kenya due to time constrains and inaccessibility. However the Nursing Council of Kenya (2009) prescribed curriculum, *Training file* and *Scope of Practice* will be scrutinized for content, roles and activities.

UHC was being rolled out by multiple actors: the national government, county governments, international bodies, non-governmental agencies among others. Seemingly each acting from their corner and there was a need for concerted effort. Nevertheless even WHO (2017) admitted that there was no one size fits all in matters UHC.Each country and county is unique but best practices were global and comparable across borders. There will be need for timing and liaison at every stage of the research, these being preliminary lessons from the pace setter counties.

The purposive selection of panellists in the Delphi technique means the sample was not likely to be representative enough. Delphi technique is structured around consensus multi-stage transformative decision making process. This may not be always be achievable because some panellists may not respond to all rounds or may be unavailable to answer to the survey (Hasson, F, 2000). Efforts will be made to keep in touch with them to keep the tempo of the response rate.

Even though UHC has been around the global arena for over half a decade, it was still new in our settings and we may not have adequate experienced hands and minds around it. The 'expert statuses may therefore be untenable.

Much as it might appear like so, this study not speculative because since 2013 researchers have attempted to explain UHC in Kenya one way or the other (Okech, T., Lelegwe, S, 2016); (Koon, A. et al, 2016); (Kazungu, 2017); (Kamau S. , 2018) ; (Obare, V., Brolan, C., Hill, P, 2014). Results released by an opinion polls company *Infotrack* on December 20th 2018 showed that nearly 50 percent of the people they interviewed were aware of the Government of Kenya's 'Big Four agenda'. The action plans included Universal Health Coverage.

Further, after going through one of the core textbooks guiding this study *Designing and conducting Health Systems Research*, the writers seemed to support my approach in terms of topic selection and timing. Module 3 'identifying and prioritising research topics in health systems research' among other considerations in health systems research was political acceptability. Political here should be taken to mean high level policymakers. Universal health coverage is today without a doubt one of the health concerns globally and in Kenya (Varkevisser, C., Pathmanathan, I., Brownlee, A, 2003).

Moreover, every other county in Kenya had one form of the UHC initiative or the other alongside the rolled out national program (The 'Big Four' Implementation Plan Universal Health Coverage Delivery Plan Framework, 2018).

I acknowledge that the small sample of BSN nurses would hardly represent the experiences of Kenyan nurses on Universal Health Coverage. The target population in a way was only those primed into UHC via national government piloting but not where this had taken place through other initiatives including that of the individual county governments.

Lastly, it was not easy to get literature on the topic. There was plenty on universal health coverage but none of the studies I accessed was explicitly dedicated to any of the health professionals' curriculum even though the matter was mentioned inside the studies. The next section will look into some of them.

3.9 Literature Review

This section will cover literature reviewed for the purpose of justifying and supporting the proposed study. It will have the following subsections: Literature connected to Universal Health Coverage; Literature connected to Universal Health Care; Literature connected to curriculum in response to the changes brought about by UHC on nurses; Literature connected to the enhanced core and complementary competencies of the nurse to meet Universal Health Coverage.

3.9.1 Why require the BSN curricula alignment to Universal Health Coverage?

This subsection is connected to the general objective - why universal health coverage (UHC) in the first place? This will guide the rest of the study as to what extent the BSc Nursing curriculum can be oriented to universal health coverage (UHC).

The World Health assembly in the 2012 resolution recognized the role of health as a catalyst to attaining universal development goals (WHO 6. , 2012). Universal Health Coverage was well-defined in the World Health Report (2010) as:

'All people with access to needed health services', 'quality', 'does not expose the user to financial hardship'.

 In other words the primary goal of universal health coverage is to provide all people with access to health services they need, namely "utilization relative to need".

This means that the use of health services is driven or determined by health needs, rather than other factors such as capacity to pay or geographical location (World Health Report, 2010).

Often the following questions are asked: If a person goes into a ('any') hospital anywhere and that person had no health insurance, can he be denied health treatment? If he gets the treatment, who pays for it? Why was pricing of drugs based on how much the consumer was willing to pay or what the market could bear, why can't we have a control for it?

The health sector operates within policy frameworks which include among others the National Health Sector Strategic Plan 2013-2017, Vision 2030 Sector Plan for Health, the proposed Kenya Health Policy of 2014-2030 etc. Each of them substantially addresses the need for universal health coverage. Systems approach to UHC was what was needed (GOK 3. , 2012).

Healthcare is a public good that should be available for all Kenyans and in fact the main obstacle we have to overcome as health system in Kenya is not the lack of demand but the demand for quality and affordable healthcare.

It is along this that the Jubilee government of Kenya set out to fulfil 'universal health coverage for all households by the year 2022' as one of its' Big 4 Agendas flagship. Others include: affordable housing, food security and manufacturing. By consolidating the health of Kenyans by making it more equitable, this becomes a key strategy into fighting poverty and fostering development.

Health was regarded as outcome and indicator of the other dimensions of SDG (UN, Assembly UG. Transforming the World: The 2030 Agenda for Sustainable Development,

2015). The following goals touch on health (access, affordability, quality etc.) and adult learning (in the case of nurses). They will in some way be addressed in this study:

> • Goal No. 1: End poverty in all its form;

> • Goal No. 3: Ensure healthy lives and promote wellbeing for all ages. This will include universal health coverage (UHC) by the year 2030. SDG No.3.8 focuses on achieving UHC, which includes financial risk protection. It requires that all will have access to quality essential healthcare services, vaccines and medicines.

> • Goal No.10: Reduce inequality within the country

> • Goal No. 16… promotes inclusive societies for sustainable development.

In Africa, few countries (if at all) have realised universal health coverage for their citizens. UHC was formally enshrined in African Union Agenda 2063 slogan christened - *The Africa we want*. Aspiration 1:

> *A prosperous Africa based on inclusive growth and sustainable development in that - African people will have a high standard of living, and quality of life, sound health and well-being* (AU, 2015)

At independence in 1963 the Kenyan government pledged to fight 3 enemies: poverty, ignorance AND disease. These have remained an aspiration this far. Kenya's Vision 2030 aims at "Creating *a globally competitive and prosperous country with a high quality of life for its citizens by the year 2030*". It states that Kenyans shall have affordable and quality healthcare for healthy and productive citizens (GOK 3. , 2012).

 Health care is a sound investment on human capital for any country (GOK 2. , 2007).Universal health coverage aims to provide financial protection so that the costs of using health services do not create financial hardship for those who need to use them. Expenses incurred by people towards the cost of utilizing health services (e.g. medicines) should not negatively affect on their living standards (WHO virtual campus (WHO b. , n.d). The said WHO Virtual campus online course was undertaken by this researcher in part of 2017.

This means that the use of health services is driven or determined by health needs, rather than other factors such as capacity to pay or geographical location...

The idea of Universal Health Coverage (UHC) loses its meaning, if it is not accompanied by quality health care. However universal health coverage should not be confused with universal health care which means that everyone in the country has access. While some of them in universal health care may have to pay cash, others may have private insurance and whereas some people's coverage is subsidized through government programs. But generally speaking, universal health care is mandated by the government - that everybody has got to have it (Overbeck, 2018).

Therefore Universal Health Coverage (UHC) means that all individuals and communities receive the health services they need without suffering financial hardship (Universal Health Coverage -UHC, 2017).

In other words universal health coverage takes into considerations all components of the health system: health service delivery systems, health facilities and communications

networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation. But more importantly health care financing, a skilled and motivated adequately supported health workforce. Therefore quality UHC required investing in the workforce, and a supportive leadership culture (Crisp, S., Brownie, S., Refsum, C, 2018).

World Bank report 13th Dec 2017 indicated that nearly 100m people annually were pushed to poverty by health care costs all over the world but mainly these were from developing countries (EAHPTH, 2018); (Tracking Universal Health Coverage: 2017 Global Monitoring Report).

This therefore means creating access and providing effective coverage for the all the citizens("breadth"), for all needed care ("depth"), offering particular benefits to address the disparity needs of the least well-off ("height") at affordable costs and under conditions that are not oppressive as well. See figure below. (Source: World Health Organization´s (WHO) Knowledge Network on Health Systems report for the Commission on Social Determinants of Health).
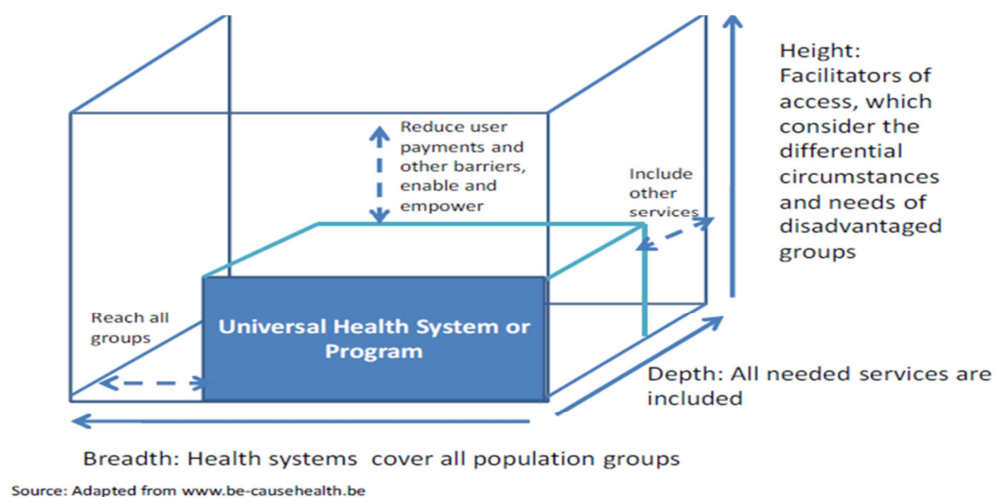
Figure: The UHC cubicle

[Source: World Health Organization´s (WHO) Knowledge Network on Health Systems report for the Commission on Social Determinants of Health].

Generally, governments moving their health systems towards UHC seek to ration care on the basis of "need," for example by covering cost-effective treatments, and providing greater entitlements to people with lower-incomes. In resource constrained settings like Kenya, there is not enough finances to deliver the health services to all to those who need them.

For Kenya sources from the Ministry of Health indicate that it will cost the government Ksh 40b annually to run the UHC program. The piloting phase in Kisumu, Nyeri, Isiolo and Machakos counties was going to cost Ksh3.9b to cover 3.2 million people (GOK 4. , 2018). It was for this reason that Nyeri and Kisumu will form the setting for this study.

The four counties were chosen for the pilot phase on need basis.

Machakos County was chosen after research indicated that it was the county most prone to road accidents in Kenya.

Nyeri, Isiolo and Kisumu got nominated according to the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2018 which came to the conclusion that the county of Nyeri had a high prevalence for non-communicable diseases diabetes, cancer and hypertension among others.

Isiolo on the other hand was among the 15 counties with high maternal mortality rates but also had a fairly low population density. Kisumu was selected on the base of high prevalence rates of communicable diseases which included malaria and HIV. Machakos was prone to road traffic accidents and injuries being on the major highway from Nairobi to Mombasa.

UHC enables everyone to access the services that address the most important causes of disease and death. It includes the full range of <u>essential, quality health services</u>. The spectrum ranges from health promotion to prevention, treatment, rehabilitation, and palliative care. With UHC coming in the nurse's role as promoters of health becomes more complex, since it has embraced a more multi-disciplinary approach.

There were examples of such primary care multi- disciplinary teams in the LEAP (Learning from effective ambulatory practices) model of the US. The nurses do patient follow-up through home visits, preventing need for readmissions to hospital. Learning from effective ambulatory practices (Flinter, M. et al, 2017).

UHC ensures that the quality of those services is good enough to improve the health of the people who receive them and also ensures they are protected from the financial consequences of paying for health services out of their own pockets thus reducing the risk that people will be pushed into poverty because unexpected illness.

UHC helps nations to make progress towards the other health-related targets and beyond since a healthy citizenry is more productive 'allows children to learn and adults to earn'. It's an investment in human capital.

"To pretend that health is somehow separate from people's social conditions is madness. No patient should be denied access to care, regardless of health status or insurance. That is the passionate message I believe and fight for every day of my professional career." - Ruth Lubic, Nurse Midwife who co-founded the National Association of Childbearing Centres (ICN, Nurses' role in achieving Sustainabel Development Goals: International Nurse' Day resources and evidence, 2017).

Corruption thrives well when there is a new process without prior tested and proved road-map. There was fear among some leaders in the health care professions that some people might take advantage of the initiative.

If money got misappropriated in the name of UHC then the support and fanfare behind the campaign will fade away; resentful nurses may not then have the motivation to buy-in. Scandals involving NHIF had become an ever evolving affair with more money being lost (Did NHIF trade in money meant to save mothers?, 2018) the more recent one cited here being the Kshs 6b *Linda Mama* fund also referred to as Free maternity program.

Already so much was being spent in hosting meetings to discuss UHC. This was a concern by KMPDU during the last county governor's conference discussing UHC at Makueni in April 2018 (GOK 4. , 2018).A second conference was held between 11th to 13th September 2018 in Nyeri County. This time the theme was "*Universal Health Coverage for Sustainable Development*"

For Kenya the 2017 budget allocated 3.9% of the national budget to health, This was less than a quarter of what was needed and a far cry from the Abuja Declaration (Uneca, 2001). African heads of states then committed to allocate at least 15 per cent of their national budgets to health but generally Kenya has continued to allocate between 3 to 6% to health. Out of FY 2018/19 Kshs 3.1Tn Budget, with Kshs 44.6Bn went towards UHC, seemingly, the UHC got the highest allocation of the four agendas (The National Treasury and Planning, 2018).

'Kenya has been falling short of this goal, even getting outperformed by some neighbouring states like Uganda (8%)' Siddarth Chatterjee- UN resident coordinator commenting on the 2014/15 budget. Kenya generally allocated 3 to 6% to health (The National Treasury and Planning, 2018). County governments on the other hand were on average setting about 25% of their budget towards health.

UHC is no easy feat to design and for a country at any income level. However even low-income countries across Africa were working towards or improving UHC (International Bank for Reconstruction and Development, 2016). This may soon become a reality for their citizens. We need to accelerate this momentum, translate experiences and expertise into actionable policies and practices (Rozita, H., Amanda, F., Nagpal, S, 2017).

Nurses were concerned about their new roles in UHC since they tended to spend more time with patients than any other clinicians. Their role in the new dispensation was therefore crucial. Nurses' had the numerical advantage as the largest job classification and sub-classification in the health sector (certificate, diploma, degree, MS, doctorate, designations, specialization, and postings from community to critical care).

According to (Schveitzer, M., Zoboli, E., Vieira, E, 2016)the challenges nurses faced as far as universal health coverage were related to education and training, how to assure better working conditions for themselves and lack of clear definition of nursing roles in primary health care.

The systematic review showed a need for setting nursing goals based on humanization of care that integrates the physical, social, psychological and spiritual perspectives with: more time to care, fewer people to attend, better physical space, more resources to attend to the client's wellbeing and quality of life. However, the study discovered depersonalization of care.

Various studies described scenarios of ever-emerging expectations on the nurse with none being taken away, with less and less time to give direct care (Schveitzer, M., Zoboli, E., Vieira, E, 2016). There was need for humanizing practices to be taught and emphasized at undergraduate level.

The special role of the nurse in engendering UHC could not be overlooked while addressing equity and the role of women. Women generally encountered more barriers in accessing healthcare for themselves and their children (Atieno, J., Edwards, N., Spitzer, D., 2014) (Atkins, 2018).

Notably nursing had been predominantly a female profession. Sources indicated that between 2003 and 2012 a quarter of all nurses trained were male (MOH 2. , 2012); (MOH 1. , 2014). Conservative figures from the two reports were a 1/5 to a 1/3 of nurses being male. It was not possible to ascertain how many of those BSNs were.

An empowered nurse in UHC would in a big way address this gap what is popularly referred to as *ensuring "G" in UHC* (WHO d. , 2017); (ICN, 2017); (Atieno, J., Edwards, N., Spitzer, D., 2014). The Atieno et al (2014) study referred to earlier also found that gender context was itself a barrier in nurses' participation in policy in Kenya. This was also a discussion point (WHO 1. , 2014) whose theme was *At the Heart of It All: Nurses and Midwives for Universal Health Coverage".*

Even though in Africa, primary health care was mainly nurse-driven as evidence in this article (OECD, WHO, World Bank, 2018) they were not always involved in policy making.

There was interplay between competing values among the actors on the ground, whose professional lives were going to be shaped by broader UHC movement (Walker, L., Gilson, L, 2004). The study investigated what it was nurses wanted to know about UHC and how it would affect them. They recommended a need to come up with that evidence practice and that policy change ought to be viewed through the lens of the implementers not the bureaucrats.

The Constitution of Kenya Article 43 provides for The Bill of Rights. In it is Kenyans' right to the highest attainable standard of health. This includes the right to reproductive health services. The standards of health envisaged include progressive access to curative as well as promotive, preventive and rehabilitative services. Kenya had tended to invest more on curative whereas; curativecare often would never have been needed if people had very good preventive and primary care.

With increasing interconnectivity, mobile phone coverage and a vibrant press media Kenyans were more aware of health issues than ever before. According to Communication Authority of Kenya the uptake of mobile services hit 88% by mid-2017.

In Vision 2030's Social Pillar, the government obligates to improve the quality of life for all citizens through ensuring an equitable, affordable and quality healthcare of the highest standard.

Medical insurance cover determines whether people can afford to use health services whenever they require them. According to (World Health Report, 2010) report on financing of universal health coverage. More than half the global population lacked any type of formal social protection. This was according to the International Labour Organization (ILO) and that about 5–10% of people were covered in sub-Saharan Africa and southern Asia. On the other hand middle-income countries, coverage rates ranged between 20% to 60% (WHO 5. , 2010).

The Poverty Reduction Strategy Paper for the Period 2001-2004 (Republic of Kenya, 2000)defined poverty as the inability to feed self and family, lack of proper housing, poor health and inability to educate children and pay medical bills.

According to (World Bank, 2018) about one million Kenyans fell into poverty annually due to health related expenditure. Almost (36%) of the Kenya's population lived below the poverty line in 2015/16 (in 2017meant living on less than US$ 1.90, a day in terms of purchasing price parity) (World Bank, 2018). According to a (GOK 1. , 2007) 44% of Kenyans who fell sick did not seek health services due to lack of finances.

Even as Kenya aspires to compete in a world market with countries that have a real national health plan. There is not enough funding to deliver the health services promised

to those who need them. Therefore governments moving their health systems towards UHC seek to ration care on the basis of "need," for example by covering cost-effective treatments, and providing greater entitlements to people with lower-incomes.

UHC is as much a global target as it is a reality, it is a lifetime opportunity Tedros Ghebreyesus, the Director General WHO, during World Health Day 17th April 2018 said:

'UHC is not a dream for the future. It is a reality now'; 'All roads should lead to universal health coverage'. This WHO's 70th anniversary 2018 theme focused on UHC movement:

> '… That all people (everyone everywhere) can get quality affordable health services. ... without the prospect of financial hardship…that indeed the dream was affordable and achievable using domestic resources'.

As a candidate for the helm of WHO in 2017, Dr Tedros had campaigned on the promise that he would make UHC his number one priority, He had a track record of expanding health systems and access to health in Ethiopia which borders Kenya to the north.

Ethiopia happened to be one of the few countries in sub-Saharan Africa that managed to meet the millennium development goals MDGs targets by 2015 (Venessa, 2017). Having worked as minister of health before (2005-2012), might be in a position to appraise some of the contextual issues of low resource settings. It would be interesting to know how he involved stakeholders and especially nurses in Ethiopia. This researcher will be doing a query letter for personal communication from Dr Tedros.

> '…the numbers of persons requiring service, the quality of the service provided as well as the cost of the service need to be addressed urgently from the customers' perspective for us to improve on the healthcare coverage in Kenya', Dr Gitahi Githinji of AMREF contribution to a panel discussion Sub-theme Universal Health Coverage (NACOTSI, 2018).

In many parts of the world payers (including Insurance companies) insist on paying only for quality health care. Medicare (US) beginning 2009 were reluctant on footing bills for medical complications which were clearly due to poor clinical practice, such as pressure ulcers and infections associated with catheter usage (Mitchell, 2009); (Böhmig, 2010).

Charlesworth, M. a past Director of the World Health Organization, 1993 said:

> *"Everywhere, it appears, health care workers consider that the 'best' health care is one where everything known to medicine is applied to every individual by the highest trained medical scientist in the most specialized institutions"*

Charlesworth's assumption perhaps was that health care providers will have this interest at heart - an ultimate aspiration of a universal health care for the patients (as well as for themselves).

In many ways UHC is politics: According to Agnes Soucat, WHO's Director of Health Systems, Governance & Financing:

> *UHC was a political matter, for it to be given priority when it came to the public purse, to have it implemented would require pool funding through*

collective taxation. To sustain it from domestic funding was a priority. She observed that even though UHC appeared ambitious it was an achievable goal. But this was not going to be cheap as it would require significant public as well as private funding. Public financing would enable the poor and disadvantaged to get efficient health care services. [Interview 13th Nov, 2017 by Devex in New York] (Soucat, 2017).

The best time for countries to prioritize health coverage for all of its population is before it becomes richer or achieves high-income status said Takao Toda (The vice –president of global health at JICA):"…we are still poor so we are not able to do what Japan does. But that is wrong. In 1961, we (Japan) were poor, but we covered all people "Japan supports the UHC cause worldwide (Ravelo., 2015).

This makes the economics of UHC complex and not just dependent on the wealth of a nation. For instance the US allocated almost 20 percent of its gross domestic product GDP to health on an annual basis, and yet thirty two million US citizens had no health coverage at all (Missoni, 2010).

The US has been struggling for decades with universal health care for its citizens inspite of its economic muscle. They passed legislation in March 2010 which would provide insurance coverage for more Americans which was known as The 'Obama Care'. In his inauguration speech on 28th November 2017, President Uhuru Kenyatta pledged 100% Universal Health Coverage for all households in Kenya within the next 5 years.

Dr. Mesack Ndirangu, The Country Director of AMREF- Kenya in anAmref.org blog post entitled *Crusade critical in achieving universal health cover*. He noted that the health insurance coverage in the country was around 20%. Majority of these were mainly the National Hospital Insurance Fund (NHIF, 2018) holders which hadseven million principal members or rather a total of over 25 million Kenyans). The rest had other private medical insurance.

This corresponded with World Bank report that about one million Kenyans fell into poverty annually due to health related expenditure. It could be that the same poor people (a good number uninsured or having the bare minimum NHIF were also seeking for health care in the private sector); (Shroff, Z. et al , 2018).

Moreover, (Marek, T. et al 2005)in an Africa wide World Bank study was able to document that 47 percent of the poorest quintile of Kenyans used a private facility once in a while like when a child is sick. Moreover almost 70% of NHIF payouts went to private facilities ((Universal Health Coverage Piloting kick off, 2018). Therefore UHC will have to take into consideration the public private partnership (Shroff, Z. et al , 2018); (GOK 4. , 2018).

According to (Kurth, A., Jacob, S., Squires, A., et al, 2016) in order to effectively meet the requirements of universal health coverage, it will mean that all cadres of nurses, nurse practitioners, and midwives undergo training and be allowed to practice to their fullest scope. This will include developing opportunities to include clinical nursing (Vanhook,P. et al, 2018).

Experts have placed a premium on the need for a practice-ready health workforce competency-based education as becoming more important now than ever before because of UHC (Kurth, A., Jacob, S., Squires, A., et al, 2016); (Koon, A., Mayhew, S, 2013)

(Keck, C., , Reed, G, 2012). Make nursing curricula more applicable to different settings in terms of priority diseases and conditions of the individual country.

The challenges of rolling out of universal health coverage may be compounded by the inability to orient the minds of nurses to the new system as evidenced partly by the crisis that has continued to face the human resources for health in the recent past.

Sustainable Development Goal (SDG Goal No.3.8) called for member states of the United Nations to achieve universal health coverage (UHC) by the year 2030. Realizing this ambitious goal would not only require political goodwill but also know-how among care providers on-the-ground among other requirements. The Jubilee government of Kenya on its part has set out to fulfill universal health care for all households by the year 2022 as one of its' *Agenda 4* flagship: affordable housing, universal healthcare, food security and manufacturing.

However, the world over nurses were leading the battlefront in terms of their institutions using models such as *Magnate* and *Planetree* models in the US offers some of the best prototypes of what nurses could learn and the difference it had made. This encourages greater nursing authority (Houser & Oman, 2011; p14, 47,249, 251) as guided by evidence based practice.

The regulatory body Nursing Council of Kenya acknowledges that this will be the expected normal going forward.

> *'As the nation's hospitals face increasing demands to participate in a wide range of quality improvement activities, the role and influence of nurses in these efforts is also increasing'* (Draper D., 2008).

> *'Nurses are committed to UHC and we are aware of the trends in healthcare, the costs and the added demands on the daily practice of nursing work'* (ICN, Nurses' role in achieving Sustainabel Development Goals: International Nurse' Day resources and evidence, 2017).

The Federation of Kenya Employers (FKE) recently released what was referred to as The 2018 Skills Mismatch Report which showed that a good number graduates from our universities were not market-ready. There was need for institutions to teach courses that encourage out of the box thinking, that promote government policy and economic growth. Generally, courses which aligned themselves with the government agenda (FKE, 2018). For the education of health professionals it might seem like they would have referred to universal health coverage.

With the changing opportunities in the labour market and the health sector, nursing as a profession in Kenya must know where to lay the most emphasis. Without a doubt UHC provides a good sounding board if it is to remain an effective career. This needs to start with the curriculum.

The world over nurses were leading the battlefront in terms of their institutions using models such as Magnate®, Planetree® (ANCC Magnet Recognition Program, 2018); ISO 9001:2008 quality management systemsand regulatory bodies such as the Nursing Council of Kenya. The Magnate and Planetree models in the US offers some of the best prototypes of what nurses could learn and the difference it had made. Magnet hospitals as learning organizations encourage greater nursing authority (Houser & Oman, 2011; p14, 47,249, 251) as guided by evidence based practice (Aknif, E. et al, 2018).

I too believe UHC was a possible, it is also one of the *Agenda Four* of the Jubilee government of Kenya, the others being housing, manufacturing and food security. Kenya's government, through the Ministry of Health has a target of attaining universal healthcare in the next four years. What is it that nursing could do to contribute to this noble agenda? "Healthcare is a public good that should be available for all…," noted Ms. Beatrice Kinyanjui (Director, Private Sector Innovation Programme for Health-PSP4H) during an informative learning session dubbed 'Accelerating Affordable healthcare in Kenya using Innovative Models'.

'Universal Health Coverage for all by 2022' is one of the Big Four Agendas. Piloting roll out Kisumu, Isiolo, Nyeri, and Machakos Counties. Stellar efforts: Makueni, Kakamega, Laikipia, Kitui counties among others. Each country and county is unique 'no one size fits all' (WHO, 2017) but also global and comparable across borders (GOK 4. , 2018); (Aknif, 2018).

The 1st official International Universal Health Coverage Day was cerebrated on 12th December 2018 just a day before the official kick off of UHC in Kisumu led by Kenya's President Uhuru Kenyatta. Also present were dignitaries from World Health Organization (WHO) including the Director General Tedros Ghebreyesus.The theme for 2018 was: "Unite for Universal Health Coverage: Now is the Time for Collective Action."

Theoretically, patient satisfaction in most cases was connected with nursing care, nurses, and the organisational environment. Literally every metric on which hospitals (and healthcare for that matter) were evaluated – from quality outcomes; to safety; to patient satisfaction; to staffing efficiency; to medical staff confidence – were dependent upon having a staff of nurses who feel valued on the job. Why, because caring is a value-based concept in the nursing field (The future of nursing: Leading change, advancing health, 2010); (Mitchell, 2009); (Health workforce development: I-TECH's approach to building the capacity of pre-service educational institutions, 2011).

In 2010, The Rockefeller Foundation (http://www.jointlearningnetwork.org/) established the Joint *Learning Network* (JLN). This is purposely a sharing platform and community of practice for those actively involved in-country to reform their national health systems to achieve the UHC agenda. The input from such effort was on a wider scale focusing on collaborative learning around six technical areas: Primary health care access, quality health care, provider payment, population coverage, information technology, health financing.

Speaking on the need for disruption in the health sector, Prof. Bitange Ndemo advised that much as it was important for Kenya to benchmark with other countries who have attained universal healthcare, it was more important that innovations are geared towards addressing the healthcare problems in Kenya. As such we needed to customize our approach.

Apparently there appears to be a public as well as implementers' concern on health sector (recent media reports, crisis after crisis) about the modalities of implementing Universal Health Coverage (Onyango, 2018); (Njue, 2018). Njue in the cited article wrote that 'the two priorities of health human resources were training and skills development' She added:

> *'...the approach to capacity building is unstructured and coupled with challenges, rendering its purpose ineffective and intentions unachieved...most of the capacity building in Kenya is donor-supported and -driven; serving programmatic needs to deliver specified health indicators; hence, lacking the right mix in diversity to suit all healthcare workers. The training needs to be structured, holistic responsive and targeted...'* Njue is a capacity building manager at Mission for Essential Drugs (Meds).

In a personal communication, Annette Eichhorn-Wiegand, a Quality Health Management Systems Advisor with Christian Health Association of Kenya (CHAK)[1] There were conflicting requirements of donors and government managers in some cases:

> *- The confusion in Kenya is far too large as every donor brings in its own quality system and as people have very little background of quality management and how the different models and systems are linked and married, it is often difficult for them and confusing.*

To try and remove confusion the following subsection will be discussing on universal health care and why it is not the same as universal health coverage. Even though some use the two concepts inter-changeably, or in one sentence as in universal health care coverage. This researcher admits however that this is a slippery slope argument which looked at either way does not change the intent which is: universality, health and cost.

Universal health care does not mean coverage for everyone for all the care they need. Universal health care can be looked at from three angles: who are those covered, what services are they being covered for, and how much of that cost is covered (WHO 3. , 2010).

In the words of Amadeo Kimberley in his article 'Universal Health Care in Different Countries, Pros and Cons of Each: Why America Is the Only Rich Country Without Universal Health Care' essence universal health care forces healthy people to pay for others' medical care (Amadeo, 2017).

Universal health care in a way forces the same standard of service at a low cost on hospitals and health care providers. The government will try to control the cost of medication and health services through negotiation and regulation.

As the state focuses on providing basic and emergency health care it limits payments in order to keep the costs low. The government may limit services with a low probability of success to cut on costs For instance it may decline to cover drugs for rare conditions (Praveenghanta, 2009)

Universal health care could assume one or ether or a combination of the following models:

> 1) Insurance mandate states and nations decree that all the people buy medical insurance,

> 2) In a single payer system the state taxes its citizens in order to provide medical insurance for all the people and meets all medical expenses (e.g. UK, here the government owns the health services, pays the health care providers - that is socialized

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[1] Personal communication between author and Annette Eichhorn-Wiegand in 2013

medicine. In some single payer systems there may be some out-of-pocket and co-payments

       3) Tier system: here universal health care does not mean state-only health care; the system continues to have both public and private insurance and public and private health care providers. While the state ensures it meets its mandate on catastrophic or minimum insurance coverage for its entire population. However this system allows one to top up on voluntary insurance or fee-for service care when desired.

In universal health coverage the government offers health care to all households regardless of their ability to pay.

I will conclude this subsection with the following observations. In the case of the BSc Nursing curricula, it might by necessity be required to adapt to the changing market demands, global conventions, emerging diseases, the constitution of Kenya, devolution of health services, the constitution, curtailed funding from central government and changes in education policies such as the crossover from 8-4-4 to 2-6-3-3-3 competency-based curriculum education system.

Moreover, to remain competitive among and between higher education institutions training nurses there would be no better way than to produce nurse graduates who were well grounded in the enhanced and new roles of the nurse in universal health coverage. A transcript that indicates the number of units specific to UHC might put one graduate a shoulder and a head above the rest.

I envision coming up with a primer learning model to demystify UHC and show how it could become as much one of the courses in BSc Nursing just like gender now is a common course in most curriculums in Kenya.

3.9.2 Emerging nurses' roles for universal health coverage (UHC)

This section will look at how the nursing curriculum was likely to respond or has responded on the basis of universal health coverage. Systematic interventions in nursing education and practice were needed to facilitate graduate nurses in their enhanced roles to meet the demands of universal health coverage.

Nurses competencies differed in part on the basis of their training, ability to lead, do research and, implementation of evidence-based professional practice (Osotsi, F., Mutema, A.Kangethe, S., et al, 2014).

Both the International Council of Nursing (ICN) and WHO have provided some policy direction for core elements in the education of nurse and midwives in order to build their capacity to contribute to universal health coverage.

Not all countries in Africa have taken this up. This was vividly captured in (ICN, Reforming primary health care: A nursing perspective, 2012) and World Health Organization (WHO 8. , 2013) (Atieno, J., Edwards, N., Spitzer, D., 2014).

In order to reach more people with quality health services there was need to strength the capacity of nurses and midwives (the largest cadre of the health workforce in many countries) (Koon, A., Mayhew, S, 2013); (Atieno, J., Edwards, N., Spitzer, D., 2014).

UHC was not new. It has been around for more than 50 years. Infact Japan celebrated its UHC 50th anniversary in 2011 while South Korea had its 40th anniversary around the same time (Ravelo., 2015).

Many Scandinavian countries have had UHC long enough. Japan is one of the big proponents of universal health coverage. This meant that UHC has always been the right way to go in terms of equity and access to health care. This means that it ought to have been a relevant input into nursing curriculum earlier than now.

Kenya's Jubilee Government in August 2017 decreed an action plan 'UHC for all households by the year 2022'. Government decrees assumed an existing knowledge and readiness of systems for UHC. This might have left implementers including nurses feeling alienated.

There was need to know any new roles for partnership and seamless implementation. There was need to leverage on implementers of Universal Health Coverage (UHC), need to integrate global agendas such as UHC to local evidence on policy development. Universities' role as a minimum - demystify agenda.

Initiatives towards Universal Health Coverage have brought about The Joint Learning Network (JLN). These were adequate proof that there was a lot Kenyan universities could benefit. This might necessitate adjusting curricula to meet the demands of UHC.

JLN does this through a combination of in-person meetings, webinars and discussion boards, members exchanging tacit knowledge, expertise and experiences around specific challenges of UHC. JLN has been able to produce new knowledge, guidelines and self-assessment tools on UHC (JLN)

Medical schools in Indonesia provided some initial training on UHC which would prepare their graduating health workers. Indonesia started its journey towards UHC in 2014. As UHC (otherwise known there as Jaminan Kesehatan Nasional (KN) expands, the report recommended that more intensive and nationally standardized training to continually adjust the standards of competencies (Marzoeki, P., Tandon, A., Xiaolu, B, et al, 2014); (Wiseman, V. , et al, 2018).

WHO (2013) came up with a set of education guidelines for transforming and scaling up health care providers' education and training. This transformation and scaling up health professionals' education and training stressed on the importance of embracing competency-based-curriculum which could prepare nurses for the skills-mix role.

El-Saharty and Sparkes p25in a World Bank commissioned study in Bangladesh called them skills-mix innovations (The Path to Universal Health Coverage in Bangladesh: Bridging the Gap of Human Resources for Health, 2015). This was also underscored in the (WHO 1. , 2014).

According to Whitehead's work entitled *Health promotion and health education viewed as symbiotic paradigms: bridging the theory and practice gap between them*, there should be no disconnect between what they learn and what they will do (Whitehead, 2003). In Bangladesh there was alreadytension regarding UHC between policy makers,

academicians, civil society on the future needs of education for health professionals (Talukder, M., Rahman, M., Nuruzzaman, M, 2015).

The guidelines provide evidence-based guidance in the area of pre-service education. It also contains recommendations on how to incorporate continuing professional development (CPD). (WHO 8. , 2013).

Subjective evidence shows that many nurses just like other health care workers might have a challenge understanding the complexities of health care systems as a starting point (Porter-O'Grady, 2015).

The IOM report (Institute of Medicine, 2001) on the future of nursing emphasized the need for:

> "…a profound change in the education of nurses both before and after they receive their licenses", report continued "creating an expectation and culture of lifelong learning for nurses is therefore essential". "Having enough nurses with the right kinds of skills will contribute to the overall safety and quality of a transformed health care system."

The proposed WHO (2013) nursing curricula based on UHC would prepare nurses for clinical care competencies. These included: health assessment, disease management, case finding, case management, observation and treatment according to delegated responsibility etc.

Complementary competencies would include: cultural sensitivity, participatory research, leadership, development of tools and guidelines for data collection and analysis, and experiential learning through action.

It also emphasized computer based e-learning, inter-professional training to enhance collaboration among others (WHO 8. , 2013).

An interesting recommendation though from WHO's *a framework for community health nursing education* was the need of training nurses within the community they come from as happens in Thailand in a project called "nurses of the community".

It was believed that they would be willing to work in that community and that they understood the contexts of health care in the community (WHO 3. , 2010); (Chan, W., Fang, I., Chan, E, 2017) (Missoni, 2010). In yet another report this approach was referred to as teaching of local needs-based skills (WHO f. , 2017).

I foresee that such an approach in Kenya might be construed as 'being tribal' it made sense a lot of sense when one considers training in primary health care and family nursing. Nevertheless, 'closeness-to-community', 'to closely resemble the communities they serve' (The curious case of Cuba., 2012). For instance the family doctor nurse program teams live in within the community they served, some for most of their working life.

Incorporate primary care, public health, and social determinants into the Cuban and Thailand's nursing curricula and familiarity with local health problems were likely going to be key lessons being considered from a nurses' training and practice perspectives to UHC basis for many countries including Kenya.

Also included was in nursing curricula based on UHC especially in the areas covering family health nursing were: using evidence-based knowledge, advocacy training, health promotion through patient education and representation, negotiation skills and how to influence and action policy, (WHO a. , 2000)report noted that:

> 'Although advocacy was taught as part of the nursing curriculum in many nursing schools, it still needs to be further emphasized in training and practice, particularly in many developing country contexts'.

Basically much of primary health care action will be expected to be in informal settlements of urban areas or in the rural areas. By adapting UHC, Kenyans will in essence be ready to experience primary health care than we have been used to. The doctor's role as we are used to will increasingly be task-shared to the nurse (care managers or nurse practitioners as they are known elsewhere). This was the perspective in the US's Center of Excellence in Primary Care (Rethinking the primary care workforce: an expanded role for nurses, 2016); (Vanhook,P. et al, 2018).

Therefore UHC will work well if it meets the needs and aspirations of the people, with their participation because it's them that matter. For this to happen the people will need to be empowered (WHO 9. , 2017).

Concerning health promotion the UHC approach will demand a more multi-disciplinary approach. Practicing nurses will need to have a theoretical basis of health promotion, a wide range competencies and understanding of socio-economic-cultural diversity (Kemppainev, V., Tossavainen, K., Turunen, H., 2012).

The role of alternative medicine has been discussed variously in terms of disease prevention, promotion and care. In Guatemala for instance the role of alternative healing has been recognized to the extent of incorporating Maya medicine into their nursing curricula. (WHO 4. , 2007); (Missoni, 2010).What would it be like in the era of UHC in terms of intercultural relevance? Would Kenya support such an approach, at least in some regions?

On the other hand, Bafana Msibi, Executive Manager for Compliance Inspections at South Africa's Office of Health Standards Compliance (WHO g. , 2018) had the following to say:

> *"In any health system, nursing is the backbone of the system," "In our country especially, and in other countries in Africa, primary health care is nurse-driven."*

From Swaziland, another South African nation, Baleta in 2008 came to a similar conclusion: that the nurse was the backbone of their health system (Swaziland nurses the well being of its health workforce., 2008).

The Cuban nursing and medical curricula was oriented on social accountability - addressing priority health needs with a fairly detailed focus on the underserved (Keck, C., , Reed, G, 2012); (Morales, I., Fernández, J., Durán., F, 1988) ready to practice in resource limited and often rural settings.

Furthermore, according to (WHO f. , 2017)there was an essential and urgent need to scale up educational programmes, inter-connected research as well as teaching activities

in order to produce multidisciplinary health service delivery teams who were capable of,. This would require that they be taught multidisciplinary competencies in school.

> *'The best way nurses support the development of the profession, is by creating a climate of cooperation, worthy and challenging workplaces, with interdisciplinary and ethical thinking'* - Dr. Idolise G. Infante (ICN, Nurses' role in achieving Sustainabel Development Goals: International Nurse' Day resources and evidence, 2017).

Dr.Infante was Cuba's Director of Nursing, who believed that nurses were responsible for much of the success of Cuba's healthcare system in UHC. The Cuban government was very supportive of nurses' training and practice. The approach that worked for them was first to raise the profile for the Cuba's nursing profession (Gorry, 2013); (Swanson, 1988); (Morales, I., Fernández, J., Durán., F, 1988).

Here is the Cuban, of undisputed UHC: the elusive health for all has been achieved in a third world country comparable if not higher than most developed countries (Hadad, 2009). They put policy into practice! See what happens - from all over the world people were flocking to Cuba to learn how of all places Cuba had achieved this. Cuban health care providers were in great demand worldwide, which is a great motivation to do better on their part (Lamrani, 2014); (Agencia Cubana de Noticias, 2014).

The following facts speak a lot about the standard of health care in Cuba:

> *'... life expectancy at 78 years, infant mortality at 4.5 per 1000 live births, and 5% low birth weight infants, as well as early achievement of most of the UN's Millennium Development Goals(MDGs), including eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and reducing child mortality...'* WHO validated the elimination of mother-to-child transmission of HIV and Syphilis in Cuba. WHO 2015 and WHO 2016; (Gorry, 2013); (WHO 7. , 2012).

Kenya has since started an exchange program with Cuba along these lines. But as usual as would be expected from a belated policy point of view, we started with the doctors not the nurse (or doctors together with the nurses). It is a development that we shall be following closely.

The initiative referred to the duo/dyads of *Family Doctor-and-Nurse Program* started way back in 1984 became the bedrock of Cuba's success story in UHC. Nonetheless, the stability and continuum of care for families and their neighbourhoods in Cuba could be credited to the family nurse practitioner. Of essence this could mean that the training of family nurse practitioners (FNP) will become an added approach in nursing curricula (Hadad, 2009); (Vanhook,P. et al, 2018).

There was anecdotal evidence that Nursing Council of Kenya and KMTC were looking into this. The component of family nursing in the BSc Nursing curriculum needed to be stressed and where it was lacking it needed to be embedded. This would also call for faculty preparation on the same (Maaitah, R., AbuAlRub, R, 2017).

The family doctor nurse program teams were accountable for the health wellbeing of residents of geographically defined area of about 375 families (or 1500 people). They were coordinated by local polyclinic (each polyclinic serving 40-60 family doctor nurse offices or 20,000-60,000 residents). Their main roles were to implement a strategy of

integrated, community- based care that stressed on prevention, health promotion, patient responsibilities and public participation (Gorry, 2013).

Cuba's nursing curricula incorporates learning outcomes in primary care, public health, and social determinants with such seriousness that there was a lot that Kenya could learn from. China and Thailand had made great strides in UHC and each of them had developed a comprehensive community-based approach of training its' nurses (WHO f. , 2017); (Morales, I., Fernández, J., Durán., F, 1988); (Hadad, 2009).

The above report emphasized concrete steps needed to be taken to protect, motivate, increase and retain adequate numbers of skilled, well-educated and trained health workers in order not to undermine the goal of achieving UHC.

The Pan American Health Organization (PAHO) conference met in Hamilton, CA between April 15-17th 2015. It recommended that for UHC to be achieved there was need to conduct an education and health care needs assessment across countries regarding resources and goals for nursing education programs to meet health care needs focussing on curriculum that matches the health care needs of the country. It stressed on the need to develop competency-based curriculum for nurses.

In response to the United Nations' call for increased human resources who could help achieve Universal Health Coverage (UHC) the Hamilton conference advocated for a model curriculum to train Advance Practice Nurses (APNs) that fit into the context of the individual country but could be applicable to other regions of the world (Honig, J., Dohrn, J., Doyle-Lindrud, S., Kelly, A, 2015); (Missoni, 2010).

I did a follow up meeting on Zoom™ on 5th Dec 2018 5.30Pm EST and 14th Dec 2018 5.00pm EST with Dr Judy Honig the principal investigator in the cited study above. She clarified that the US uses primary care and primary health care interchangeably to mean the same thing.

She added that for UHC to work it had more to do with the community and not the hospital or what was referred to as primary health care where people live and work. For them to get competences in the extra roles in UHC the BSN student needed for more outpatient experiences during training. This would be by optimizing education to enable the BSN nurse become more sophisticated in Universal health (Honig, 2018).

Primary health care which essentially is the focus of UHC has broadened the horizon of health care workers a great deal (Varkevisser, C., Pathmanathan, I., Brownlee, A, 2003). According to Dr Dominick Karanja while discussing the proposed Food and Drugs Bill, if we want to reduce the demands on health care it would be by making sure people are well most of the time. This ought to be the focus of universal health coverage (Karanja, 2018).

Many BSN programs elsewhere and even here in Kenya were more hospital oriented thus leaving the graduates unprepared for primary health care. Bodenheimer in (Bodeiheimer, T., Bauer, L, 2016) advocated reorienting the nursing curriculum to meet these demands therapeutic long term relationship with patients and their families for disease prevention and management.

For Kenya an equivalent to what the APNs do would be what the Private Nurses Practitioners do in private practice. However for purposes of removing confusion, APNs generally referred to nurses with a Master's of Science in Nursing (MSN) degree, but

those in private practice needed a Masters and of late a Doctorate in Nursing Practice (DNP) (American Academy of Nursing Primary Care Expert Panel, 2018).

The nursing profession needed to educate more nurses with new models of care and expanded scopes of practice in primary care (Honig, J., Dohrn, J., Doyle-Lindrud, S., Kelly, A, 2015).

On the other hand (Tung, F. et al, 2016) explicitly recommended that:

> *'…there was need for nurses to be more attuned to healthcare policy. The educational curriculum for nurses should be strengthened to include studies in public policy and advocacy in order for them to make a difference through their participation in the development and implementation of UHC in healthcare services.'*

In order to effectively achieve UHC as a human right which it is, additional requirements might include ethical, analytical, critical and reflexive thinking and political competencies .The nursing education should prepare them for these roles in order to effectively deliver community-centred care (Cassiani, S., Bassalobre-Garcia, A., Reveiz, L, 2015); (The Right to Health: A case of Kisumu County, 2017).So nurses' competencies in advocacy forthwith will need to be given considerable weight in the BSN curricula.

Why advocacy? UHC has broad scopes and targets beyond health even though the efficiency of the health sector will be more scrutinized (WHO d. , 2017). There will be need for nurses to engage in evidence-based advocacy (Missoni, 2010).

There will be high chances that UHC will be realized progressively in resource constrained settings. Starting with those who are worse off, we will need available evidence and local tools to craft those packages. There may be myths concerning what UHC is and what it was not (Universal Health Coverage -UHC, 2017).

The international Council of Nurses (the world governing body of nurses) in a policy guideline in 2015 showed the need to review of nursing curricula to ensure it include content related to the value and cost effectiveness of nursing (ICN, 2015).

Universities will need to come up with education models focused on patient-centered/family-centered care focussing on bio-psychosocial approach to health and wellbeing, as well as diversity of clinical and community situations (Gorry, 2013).

These will include competencies of nurses in socioeconomic diversity, cultural competencies in a primary care setting. Others include human resources education in nursing, nurse strained to become leaders of change and nursing knowledge production towards health policy development (Cassiani, S., Bassalobre-Garcia, A., Reveiz, L, 2015); (Arabi, A. et al, 2014).

Koon in (Koon, A. et al, 2016)investigated qualitatively how Kenyan nurses understood concepts related to UHC and whether they were in a position to make value-based judgement on how to respond to UHC demands. UHC was not widely understood by nurses then (about 3 years ago today), the respondents related it to the free maternity care. Through interpretive policy analysis they came up with recommendations that the need for nurses to collectively learn how to interpret and influence domestic policy reform measures.

Since 2013 researchers have tried to explain UHC in Kenya one way or the other (Okech, T., Lelegwe, S, 2016); (Koon, A. et al, 2016); (Kazungu, 2017); (Kamau S. , 2018); (Obare, V., Brolan, C., Hill, P, 2014); (Crisp, S., Brownie, S., Refsum, C, 2018). Every other county has one form of the initiative or the other. (The 'Big Four' Implementation Plan Universal Health Coverage Delivery Plan Framework, 2018) Indicates the national government led pilot phase (4 counties) will run up to October 2019, and then the final rollout to the 43 counties ('Meeting Kenya's Universal Health Care Challenge', 2018).

This study therefore is well grounded and timelier since we now have a more deliberate action plan, however approaching explicitly from a curriculum perspective globally was dawning to this researcher as unusual. Nevertheless almost each of them without exception has underscored the need for well-trained and inspired health care providers as key in achieving universal coverage.

No curriculum could be said to be perfect. Recognizing the 'hidden curriculum' thus becomes necessary (WHO g. , 2018). Nevertheless, it was noted that there was little preparation of nurses on policy making. Nurses were yet to demonstrate a clear and obvious political role in health system and governance (Atieno, J., Edwards, N., Spitzer, D., 2014); (Arabi, A. et al, 2014).

No curriculum will ever be perfect and we need to recognize the forever "hidden curriculum" that arises from the fallibility any human designed systems (WHO g. , 2018).

Policy related content it seems was either missing or inadequately covered in traditional nursing education (Atieno, J., Edwards, N., Spitzer, D., 2014). This was coupled with inadequate to learning system in many health care organizations. Or rather a good number of them could not be described as learning organizations (JLN); (Aknif, E. et al, 2018).

> 'If there is one universal recommendation to countries wanting to make progress towards Universal Health Coverage (UHC), it is to develop the learning capacities…' (Aknif, E. et al, 2018).

On the other hand (Yazbeck, A. et al, 2018) advocated for learning about UHC from doing it. This was a six African countries review and commentary about a broad viewpoint on learning operational lessons from others and from doing. I believe this was a good approach too, but it could not be the only way. Reorienting curriculum to this global momentum for Kenya would be a greater thing as it prepares the incoming generation of nurses on what to expect concerning UHC, thus this study becomes a primer model for Kenya.

Nurses were constrained by practice regulations from contributing effectively to primary health care delivery. It was imperative for nursing governing bodies in the country to expand the scope of nursing practices since nurses and midwives had the necessary skills and knowledge to address some of the emerging issues, due to its hands-on procedures but were mandated to refer to doctors and clinical officers (Kurth, A., Jacob, S., Squires, A., et al, 2016).

It had become necessary to enhance nurses' workforce performance through multi-disciplinary, inter-disciplinary and trans-disciplinary participatory action research. That is research to support decision making and operations in context. On the minimum this

will be the demand placed by health system research, observed by various experts writers who included: (Varkevisser, C., Pathmanathan, I., Brownlee, A, 2003); (Alonso-Garbayo, 2016) and (Missoni, 2010).

Many African countries continued to depend on the limited numbers of doctors thus ended up failing to meet the demand for treatment by the population.This was also acknowledged by Ms. Nargis Kaka, the Officer in-charge of Discipline, Standards and Ethics at the Nursing Council of Kenya on November 1, 2018 while addressing an open forum at the JKUAT's School of Nursing.

Some of the treatment nurses had administered was nothing short of heroic and life-saving often in very difficult circumstances yet they were not legally covered to do them. Yet many reports and studies had indicated that building the capacity of nurses had been found to be a more economical way to bring health care to the population in many settings as compared to physician-based care (WHO 6. , 2012) (Institute of Medicine, 2001) and (Kurth, A., Jacob, S., Squires, A., et al, 2016).

After conducting a Gap Analysis, the United Nations Population Fund (UNFPA), AMREF and NCK, there were plans to look into the nursing curriculum for pre-service entry Midwifery intake in Kenya. Moi University was gearing to mount the first such a program in the country (UNFPA, 2018). While UHC may not necessarily have driven this course the role of the midwife in achieving UHC was underscored by the 3 organizations. UNFPA, AMREF, NCK.

From a practical point of view the model of task sharing nurses have unofficially done other people's work but there will be need to structure this right from training, it must not remain in the 'hidden curriculum' because it was not safe practice. They needed to know what to expect, what some of these tasks involved. Step number 2 in curriculum development after needs assessment is referred to as task analysis. This was according to Harden and Crosby, two renowned in scholars medical education from Dundee University.

Ms Agnes Waudo a former Chief Nursing Officer Ministry of Health, now talking on behalf of the Emory University/MOH/CDC collaborative program on task-sharing/shifting noted that task-sharing would be used to scale-up UHC using available human resources. However it was regrettable that at times unskilled professionals were given tasks they did not know, this infringed on patient safety. Issues of nurses taking on this extra work were discussed (GOK 4. , 2018).

According to Missoni the editor of (Attaining Universal Health Coverage: A research initiative to support evidence-based advocacy and policy-making, 2010) concerning task shifting:

> *'...Task-shifting, for example from doctors to nurses and from health professionals to lay providers, offers opportunities for expanding coverage and addressing human resource shortfall...'*

The reasoning task sharing according to (Brownie, 2018); (Crisp, S., Brownie, S., Refsum, C, 2018) was that there is an enormous potential for nurses to expand their scope of practice through task-sharing with doctors. Why, because one there were more nurses than doctors and nurses would be more accessible, be more willing to work in

rural areas than doctors. This would free up some of the doctor's time to attend to those needing more intensive care (Harrocks, S., Anderson , E., Salisbury, C, 2002).

The Harrocks' systematic study was on whether nurse practitioners working in primary care could provide equivalent care to doctors. Some of the studies indicated that the nurse could take up to 70% of the doctor's workload, with an added advantage of higher patient satisfaction and treatment adherence scores. Same with simultaneous disease prevention and health promotion scores. This pointed to a higher UHC access and impact by incorporating a wider scope of nursing practice and task sharing.

WHO endorsed task sharing to ensure universal health coverage in the areas of HIV/AIDS and maternal-neonatal child health. Task sharing and expanded training were fundamental outcomes in order to meet universal health coverage needs (ICN, Reforming primary health care: A nursing perspective, 2012). This will require reorienting the nursing education (Ford, N., Schneider, H., 2010).

The lessons learnt concerning task sharing in managing the HIV/AIDS pandemic in resource constrained countries can be escalated if the approach could begin from the pre-service training angle. This gains even more relevance with the expansion of health care delivery model through the universal health coverage. Educational curricula of nurses need to incorporate inter-professional competencies (Frenk, J. et al, 2010); (Crisp, S., Brownie, S., Refsum, C, 2018).

According (Maaitah, R., AbuAlRub, R, 2017) nursing curricular should be designed to incorporate early and continuous inter-professional collaboration. This could be through holding a number of joint classroom and clinical training opportunities.

By strengthening inter-professional partnerships this will optimize dialogue about UHC and what would be the contribution of different professionals. The key emphasis from these two studies was for the nursing curricular to produce an inter-professional and policy ready nurses. This was supported by (WHO 1. , 2014).

The BSc Nursing curriculum will need to support safer and real issues in task sharing by taking into account the emerging more flexible professional practice boundaries, team - based care, multidisciplinary and multi-sectoral teams (inter-sectorality) including that of being a tactical nurse (Crisp, S., Brownie, S., Refsum, C, 2018).

Interdependencies will become critical in order to generate evidence that could be used to guide change. The tactical nurse sort of coordinates the primary care team (Missoni, 2010); (RN Role Reimagined:How empowering registered nurses can improve primary care, 2015).

These were the expanded harmonising roles for the BSN nurse in UHC. This is besides the need prepare and fortify nurses to articulate issues at policy development level (ICN, Reforming primary health care: A nursing perspective, 2012); (Gorry, 2013); (Atieno, J., Edwards, N., Spitzer, D., 2014).

Seemingly, curriculum development, training content, problem-based learning and *e-*learning were much needed expertise to strengthen human resources for health in Kenya. This was one of the findings of a commissioned market study report (KHF, 2016)

3.9.3 Nurses' perception of working environment in relation to UHC

In addition to the literature covered above on nursing curriculum orientation to UHC basis the following section will highlight some of the perceptions of nursing towards their working environment in relation to UHC.

According to the UN's World Health Organization (WHO), Cuba's health care system is an example for all countries of the world for its excellence and its efficiency in universal health coverage. Despite the challenge's experienced in term of resources Cuba had managed to guarantee access to care for all segments of the population and obtain results similar to those of the most developed nations (Lamrani, 2014); (Agencia Cubana de Noticias, 2014).

It was not that Cuba had the best state of art technology, nor did it pay its nurses a lot of money, but they were well prepared for the context of working environment which was very supportive and the team work was exceptional. It laid a lot of emphasis on primary health care team led the nurse (Lamrani, 2014).

Nurses as members of primary health care team have a big and expanded role in UHC. Some experts have even called for revolutionizing primary health care (UN, Assembly UG. Transforming the World: The 2030 Agenda for Sustainable Development., 2015).

Sustainable Development Goal 3.8 includes 'a target to achieve universal health coverage by 2030, which includes financial risk protection'. It requires that all will have access to quality essential healthcare services, vaccines and medicines. This is a tall order for Kenya's the nurses' working environment as it will mean more workload. This was cited in many studies including (Böhmig, 2010); (Bodeiheimer, T., Bauer, L, 2016); (Crisp, S., Brownie, S., Refsum, C, 2018) among others.

According to (WHO 3. , 2010):

> '… core clinical care competencies for nurses for UHC include health assessment, disease management, case finding, case management, observation and treatment according to delegated responsibility etc.'

Nurses will need to ensure a working environment that was culturally sensitive. They will require to have tools to enable them get involved in participatory research (making available tools and guidelines for data collection and analysis). The working environment for UHC will emphasize more on inter-professional competencies, leadership, doing a lot of competency mapping (Missoni, 2010).

The management will need to ensure there was adequate investment in health workforce who were key in rolling out UHC especially in the nurses' working environment (Koon, A., Mayhew, S, 2013); (Crisp, S., Brownie, S., Refsum, C, 2018).

For nurses especially, this was a prerequisite for ensuring universal health coverage as was emphasised by (Kurth, A., Jacob, S., Squires, A., et al, 2016)who posited that:

> '…when developing, adjusting, or sustaining universal health coverage in a country, a failure to invest in the nursing and midwifery workforce as a key

cadre will undermine universal health care coverage and result in poorer patient outcomes and increased health system costs'.

For UHC to work properly, an effective and properly functioning primary health care (PHC) system will be necessary. The target of realizing UHC could be diluted if real desire was not there to motivate, guard, retain and increase the numbers of skilled, well-educated and trained nurses (WHO f. , 2017).

Primary health care (PHC) was defined as the first place residents went when they fell sick, and where diseases are detected and diagnosed. It necessitates that providers know and understand the people they serve and serve them in a timely way. They needed to ensure the sustainable availability, training and retention of health care workers and a workforce with the right mix, distribution and composition (Politzer, 2017); (Koon, A., Mayhew, S, 2013).

Need to train nurses to take on expanded practice roles including triaging, physical examinations, management of common disease presentations, and pharmacologic management for priority lifestyle diseases such as diabetes and cardiovascular diseases, long-term holistic care of the elderly (Kurth, A., Jacob, S., Squires, A., et al, 2016); (Couper, I., et al., 2018).

Some nurses will need to take up the role of health coaches, a fast emerging discipline that can be taken up by nurses even on part time basis. A health coach is a person employed to help people attain their goals in health (Concise Oxford Dictionary), in this case health goals especially to keep healthy, or in the case of those with illness how to cope, self-manage, avoid complications, optimize on social support, how to transition from hospital to home and how to stay out of hospital for as long as practically possible (Bodeiheimer, T., Bauer, L, 2016).

Studies indicate that our East African neighbour Rwanda is not far from achieving universal health coverage (Nyandekwe, M. et al, 2014); (Morgan, H., Mihara, N, 2017). From as far back as the year 2008 it has made steady progress (Logie, D.; Rowson, M.; Ndagije, F, 2008).

But in order for this to happen it Rwandan nursing and midwifery project built the nursing capacity by involving a consortium of North American universities. The UHC program also involved nursing faculty. It became necessary to address the gap in quality nursing education and elevate the role of the practicing nurse (Kurth, A., Jacob, S., Squires, A., et al, 2016); (WHO 1. , 2014).

This was supported by (Whitehead, 2003) who recommended partnering between nursing faculty and the clinical nurse educator (CNE)as this was thought would bridge the gap between education and practice

According to (Morales, I., Fernández, J., Durán., F, 1988); (Keck, C., , Reed, G, 2012); (Hadad, 2009) the Cuban model nursing curricular oriented to UHC basis emphasized:

> *'...increased proportion of epidemiological and public health sciences (including social communication), emphasize service learning in the community, introduction of problem-based and other active learning methods, introduction of clinical skills early in training with the basic medical sciences.'*

Bafana Msibi, who heads Compliance Inspections at South Africa's Office of Health Standards Compliance (WHO g. , 2018) emphasized that nurses needed to be trained in leadership, and added that:

> *"The nursing profession needs to produce leaders for the health care system. They must be developed through the system, know it inside out, and they must also understand the processes of policy development within it."*

Certainly we cannot take in everything from elsewhere but we can learn from them as we tailor our own to meet the demands of universal health coverage. The comment by Judy Nyakawa, from National Treasury during the (GOK 4. , 2018) sort of summarizes what this study is about:

> *'We need to inculcate UHC into our education system because we spend so much money treating ailments when we should be preventing through education, a case in point when dealing with lifestyle diseases'.*

This was a likely outcome of this research but we will need to see how this phenomenon will emerge.

Let me end this section with the words of Florence Nightingale, the founder of modern nursing.

> "May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done." (Notes on Nursing. What it is, and What it is not.)

Nurse philosophers and theorists like Nightingale left us this inspiration: Not to be satisfied with the way things are. We should strive to pioneer a new path that improves health care for both the patients and the nurses.

3.9.4 Nurses' perceptions of challenges in UHC

The theme of the 6th global forum for government chief nurses and midwives in 2014 was 'nursing and midwifery workforce and universal health coverage (UHC)' (WHO 1. , 2014). It emphasized on a positive working environment for nurses in order to achieve UHC. It was apparent Kenya was not represented going by the list I went through of participating countries from the African region.

Generally, governments moving their health systems towards UHC seek to ration care on the basis of "need," for example by covering cost-effective treatments, and providing greater entitlements to people with lower-incomes (Frenk, J., Chen, L, 2010). This will call for nurses to take up the role of advocacy on behalf of their patients who for one reason or the other might feel left out.

In resource constrained settings, there is not enough funding to deliver the health services promised to those who need them. Nurses saw this as a challenge especially going by their experiences after devolution of health services from the central government to

counties. The nurses had at times worked without minimum medical supplies and equipment, staffing and even irregular pays (Intrahealth, 2015).

Various studies that Schveithzer and colleagues came across in their systematic review entitled 'Nursing challenges for universal health coverage' described scenarios of ever-emerging expectations on the nurse with none being taken away, with less and less time to give direct care (Schveitzer, M., Zoboli, E., Vieira, E, 2016). The conclusions from most of these studies were that:

> '...nursing challenges for universal health coverage are related to education and training, to better working conditions and clear definition of nursing role in primary health care'. There was need to '...invest in multidisciplinary teamwork, community empowerment, professional-patient bond, user embracement, soft technologies, to promote quality of life, holistic care and universal health coverage'.

Just like every other healthcare provider, in order to perform at their best, nurses require recognition and support. Evidence shows that many health care providers had a challenge understanding the complexities of health systems as a starting point (Emil, S., et al, 2014).

The government of Kenya by endorsing UHC from as an international commitment and being the main actor and employer of nurses has a duty to follow through on these commitments especially on human resources for health. The international bodies will on their part ensure that this happens. They will need to know what concerns the nurse to ensure delivery of quality care in line with universal health coverage (van de Pas, R., et al, 2017).

If the industrial crisis were anything to go by then something was not right with the nurses in Kenya. Prof. Sharon Brownie, Dean University of Agha Khan Nairobi recently wrote *To achieve universal healthcare, Kenya must invest more in its nurses* (Brownie, 2018)this was an appendage to her work in (Crisp, S., Brownie, S., Refsum, C, 2018).Her article revolved around the need to pre-empt public health crises caused by nurses' strike.

Nyikuri in (Nyikuri, M. et al, 2015) on the other hand observed that dramatic changes to service delivery placed a lot of pressure on frontline health workers including nurses. Health care industrial unrests had become common. For instance in 2017, 300 man-days of healthcare provision were lost due to the doctors' strikes and nurses' strike with a hash tag (♯HealthcrisisKE Diaries); (Kenyatta Hospital nurses go on strike, 2017).

The national nurses' union had already issued a strike notice slated for mid-January 2019 agitating for among other things challenges in the nurses' of working environment such as staff shortage, inadequate tools and supplies for nurses' work.

Quality of care delivered in UHC was a concern for the nurse. Initial data gathering by this researcher indicate that the nurses were concerned if indeed universal health coverage would translate into quality health care for all. In the words of one nurse, 'the ultimate aspiration ought to be *universal health care* for the all patients (as well as for care providers themselves) and not just *universal health cover*'.

There could be an algorithm that needed to be discovered as to why nurses saw UHC as fragmented concepts aspiring 'what is to be achieved but little about how to get there' (Schveitzer, M., Zoboli, E., Vieira, E, 2016).

Generally, health cover was about getting value for money. UHC should ideally mean high quality of health care. Medical insurance companies were reluctant on footing medical bills which were clearly due to poor clinical practice, such as pressure ulcers and infections associated with catheter usage (Mitchell, 2009).

A lot of what will be used to gauge quality of care delivered was in the nurse' domain. John Mitchell, a former CEO Grays Harbor Community Hospital, US wrote 'A lot of these depended on nursing care'. Furthermore, he continued

> '...every metric on which hospitals are evaluated – from quality outcomes to safety, to patient satisfaction to staffing efficiency to medical staff confidence – is dependent upon having a staff of nurses who feel valued on the job. It's also the right way to be in charge of a hospital' (Mitchell, 2009).

The important role of the nurse in UHC was underscored by no other than Prof Khama Rogo, World Bank/IFC Global Health Specialist while delivering key note address as the chief guest in a conference in April 2018 whose theme was: *Meeting Kenya's Universal Health Care Challenge*:

> '…The nurse must be brought back to become in charge again …we have perfected the art of inefficiency to a point of no return…'

The later part of the above comment apparently referring to others who had been vested with leadership in health system in Kenya (GOK 4. , 2018).

It was of great concern that Health Act 2017 was drafted in such a manner that it curtails the leadership potential for nurses in the health system. Empowering nurses to reach their full potential in service delivery and practice would have been the right thing to do if the act was in cognizant with the additional demands of UHC on the nurse (Brownie, 2018).

Infact the challenge facing our health care system is not the lack of demand but the demand of quality and affordable healthcare. We need to accelerate the UHC momentum, translate nurses' experiences and expertise into actionable practices (Hussein, R., Folsom, A., Nagpal, S, 2017). There was need to find out what challenges nurses perceived concerning UHC implementation.

Quality care must be placed at the centre for effective universal health coverage (UHC) .Kenyans were going to expect better care as a result of UHC. Quality improvement is a societal expectation as it is the one that benefits from the improvements.

Therefore, a nurse *has two jobs whenever they come to work every day: to do their work and to improve it* (Batalden, B., & Davidoff, F., 2007). The need for improvement in healthcare has been documented throughout the years (IOM, 2001). Enabling nurses to function with greater effectiveness will therefore contribute to better quality care and outcomes.

There was a general call for development of trustworthy ideas for better implementation and outcome of Continuous Quality Improvement (CQI) activities proposed in Kenya Quality Model for Health – KQMH (MOH 3. , 2011). Indeed section *3.2.3.4* of the

KQMH document encouraged staff to generate a great number of improvement suggestions and show how these improvements could be implemented.

KQMH cautioned that there was need to guard against diminishing the involvement of health care workers in the UHC agenda in all stages. Especially their view in tackling common barriers to UHC in service delivery -primary health care, quality of care etc.

It was interesting that a caveat was found to be in order when beginning implementation of KQMH p14such that its developers cautioned in *section 3.1.2.1.1 Preparatory Phase, Step 5*, 'DO NOT start with sections or departments that are facing lots of problems as it will take a long time to solve the problems and build a "showcase" (MOH 3. , 2011). I believe that government piloting of UHC in the four counties was meant to show case.

The UHC ambitious agenda will be up scaled to the next level from the registering of households to the program. The next phase must include strengthening health infrastructure as well as personnel (Nduati, R., 2018). Indeed nurses as stakeholders require being involved in decisions that affect them as key implementers of universal health careactivities so as to have the greatest influence and impact (Arabi, A. et al, 2014). Whereas nurses were expected to work overdrive to make sure UHC works anecdotal evidence showed that many were anxious about the extra workload and roles as a result of UHC.

Table 1: New and enhanced nurses' roles in universal health coverage

Role	Enhanced	New	Expectations
Advocacy	X		Put more emphasis during training
Action research	X		Put more emphasis during training
Participatory research	X		Put more emphasis during training
Multi-disciplinary	X		Put more emphasis during training
Multi sectoral		X	Initiate into program
Family Nursing		X	Initiate into program
Policy	X		Put more emphasis during training
Cultural diversity		X	Initiate into program
Task shifting		X	Initiate into program
Task Sharing	X		Put more emphasis during training
Home visit	X		Put more emphasis during training
Health coaching		X	Initiate into program
Human resource education		X	Initiate into program
Alternative healing		X	Initiate into program
Long term relationship with patient and family		X	Initiate into program
Value and effectiveness of nursing care		X	Initiate into program
Disease Prevention	X		Put more emphasis during training
Health promotion	X		Put more emphasis during training
Geriatrics and people with special needs	X		Put more emphasis during training
Case management		X	Initiate into program
Problem based learning	X		Put more emphasis during training
Tactical nursing		X	Initiate into program
Cultural diversity		X	Initiate into program

3.9.6 RESEARCH METHODS

This section will cover the research methods proposed for this study. It will have the following subsections: study design; study setting and study participants; sampling; study framework; ethics considerations; proposed analysis and reporting of findings; work plan and the budget.

3.9.1 Study Design

A mixed study - concurrent nested strategy: Survey + interview + Dephi technique and interpretive policy analysis (Creswell, 2009); (Schwartz-Shea, P., Yanow, D, 2012)aimed at quality improvement (Batalden, B., & Davidoff, F., 2007). The mixed aim being to triangulate findings, maximize on the strengths of each as follows:

■ Quantitative aspect : cross sectional research design (measuring exposure and outcome at the same time with questionnaire closed ended questions)

■ Delphi technique – with nursing experts in UHC and BSc Nursing Curricula regarding what they feel was missing or should be addressed in the BSN curricula concerning UHC.

■ Qualitatively will be phenomenon evolving emergent design, semi-structured in-depth interviews; namely interpretive policy analysis (Schwatz-Shea and Yanow, 2012) with key informants on what they felt were the learning needs of the nurses concerning UHC. Purposive recruitment up to saturation about their roles, perspectives on UHC, perceived learning needs and concerns on UHC.

3.9.6.2 Study Setting and Study Participants

Target Nurses working in selected public hospitals Central, Nyanza regions KenyaAccessible population: 1) Nurses in Kisumu and Nyeri County, 2) experts in UHC and the BSc Nursing curricula in selected Kenyan universities and the ministry of Health.

For each of the two Counties Nyeri and Kisumu: 1 sub-county, 1 County referral, 1 level V Hospital. Total 6 hospitals; Time, funding, homogeneous likely supplement with qualitative study. Target population SCH 40x2, CH 65x2, LVH 150x2 = approximately 510, BSNs (graduate nurses) would be like a 1/5 of that = 110 for a homogeneous population 30% = a basic minimum of 36 to a max 87($\pm$10) to cater for drop outs just in case (Yamane's).

Nyeri has been a fairly stable county in terms of human resources for health. Kisumu represents a fairer cosmopolitan region compared to Nyeri.

Kisumu as well as Nyeri counties were endowed in terms of expertise, infrastructure, health workforce, supply chain management as well as networking and collaboration. Both counties have expansive Level 5 hospital at formerly Provincial General Hospital (PGH); equally large county referral hospitals, and 14 or so other level 4 hospitals.

The reality is that there are worse off settings than Level 5 hospitals run by faith based and the Ministry of Health among others but they do in most aspects.It was interesting

that a caveat was found to be in order when beginning implementation of KQMH p14such that its developers cautioned in *section 3.1.2.1.1 Preparatory Phase, Step 5*, 'DO NOT start with sections or departments that are facing lots of problems as it will take a long time to solve the problems and build a "showcase"' (MOH 3. , 2011).

It may be tempting to think that such a recommendation meant we could wait for things to improve before we bring in such efforts.However with up-scaling of the study at a later date, more diverse sites will be captured.

A salient consideration or assumption made for study sites would be *supportive leadership and a philosophy of quality* such that they generally would be more given to quality improvement efforts (Porter-O'Grady, 2015). Continuous professional development (CPD) for practicing nurses is supported by Sustainable Development Goal ((SDG) No. 4: … promote life-long learning for all, supported Knowles' andragogy of adult learning and principles of adult learning- andragogy (Kearsley, 2010).

Figure: Map of Nyeri County

[Courtesy of Maphill]
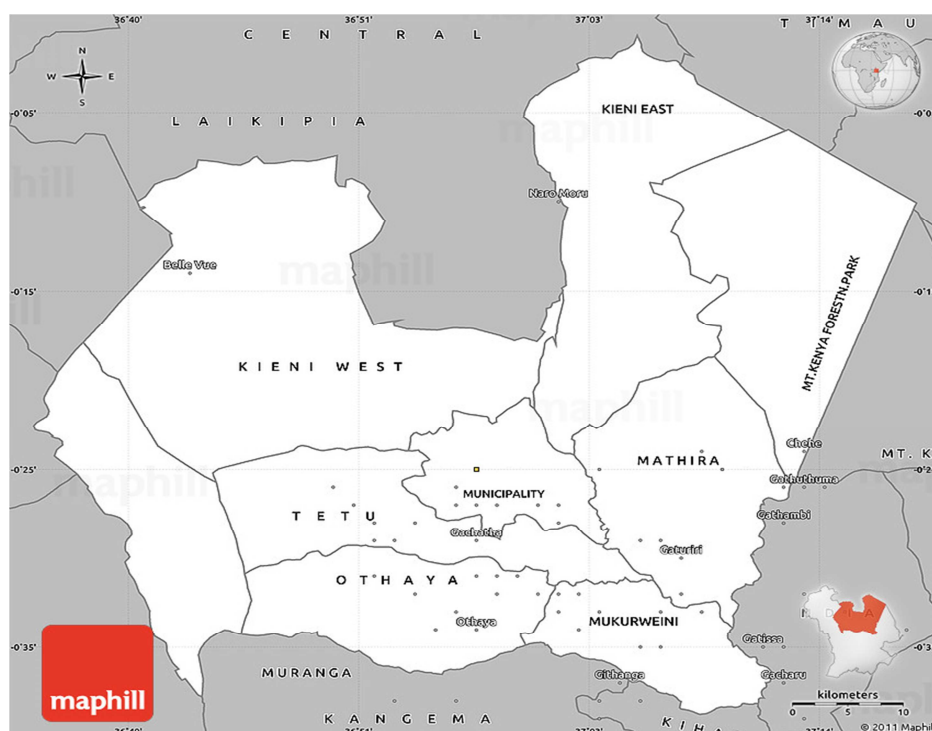
Figure: Map of Kisumu County

Kisumu Municipality
(Main Areas and Sublocations)

(c) Moumié Maoulidi, MCI, Columbia University

3.9.6.3 Sampling

A stratified random sampling will be applies to cater for gender, male nurses generally comprised 10-20% of entire population nursing fraternity (Institute of Medicine IOM, 2012; Nursing council of Kenya records)

Then random every kth element from 4th (limitation - internal validity issues). Minimum acceptable norming sample size is 30 for correlational studies (Kothari, 2004).

3.9.6.4 Sampling formula:

Yamane's formula (Israel, 1992); (Creswell, 2009):

The size of the population must be known or estimated (*N*). By dividing *N* by 1 then add *n* multiply by the square root of estimated margin of error *(e^2)*, the sampling interval width (*k*) is established for every (*kth*) item to be recruited into the study.

Conventionally written as follows:

$$n=N/1+N (e)^2$$

n= Sample Size

N =the size of the population

e-the error of 5%

Why a random k^{th} (3rd) element? – to cater for randomness and cost-benefit considerations.

A pilot study on quantitative data will be used to test for reliability of the interview schedule; it's consistency in terms of: removing ambiguities, length, structure, wording (Mwituria wa Maina, 2012)and also incorporate input from experts.

Validity of measurement tools: Pearson coeff reliability/ stability from piloting which will be done in Kericho county– similarity in sample homogeneity - to have the final outcome of interest in my study, only that the county's level of involvement with UHC was not to the same scale as Kisumu and Nyeri, it will also be easily accessible. Data entry into dummy tables and MS Excel worksheets, analysis methods I plan to use will be descriptive and correlational.

Deductions - interpretations – based on results of SOMART objectives. Present as graphs, tables, %, and statements

Study Framework

This subsection will cover data collection, data analysis and output

Table 2: Study Analytical Framework

Objective	Variables/tool	Statistics Analysis	Statistical output
1. Reorienting nursing curricula to universal health coverage (UHC) basis	Qualitative therefore the research question: How can the BSc Nursing curriculum be reoriented to address concerns about emerging roles placed upon nurses by universal health coverage (UHC)? How the nurses describe UHC.	–Interpretive policy analysis (Schwatz-Shea and Yanow, 2012),	–matrices of categories, themes patterns
		–Delphi technique with UHC & BSN Experts	–summaries
		NVivo software –Frameworks /Quasi statistics –Organize data into frames and frames into themes	–Original statements in italics
2. To determine the nurses' perception of working environment in relation to UHC,	Quantitative; Dependent variable – UHC Independent variable- BSc Nursing Curriculum Intervening variables- Nurses' working environment for UHC Intervening variables - both continuous and categorical: Nurses' working environment, nurses' perceptions of working environment, Different hospitals, age, gender, level of seniority, other demographics Measurements – Questionnaire items. Likert-like scale rating 0 to 5 and 1 to 5	SPSS –Chi square,	–Predict associations, Contingency tables
		Parametric ANOVA –Binary logic regression Non parametric equivalent student t test	–correlational: relationship quantifiers: Odds ratio, p-value , average rank R^2
		–Mann Whitney U test.	–u value, z value, p value

3. To identify emerging nurses' roles for universal health coverage (UHC),	Mixed Quali -/Quantitative Independent variable – UHC Dependent variable- BSc Nursing Curricula Intervening variables-both continuous and categorical Intervening variables: Nurses' emerging roles in UHC, Nurses' understanding of UHC in relation to their work,Different hospitals, age, gender, level of seniority, other demographics Measurements- Questionnaire items. Likert-like scale rating 0 to 5 and 1 to 5	Quantitative: SPSS – Chi square	-Predict associations, Contingency tables
		SPSS (Analyze Correlate Bivariate) -Binary logic regression -Pearson Correlation coefficient r2 to predict, validate, verify relationships	-Relationship quantifiers: Odds ratio, p-value, R2 -Correlation's magnitude of r2 variability (zero, ,+), Observed p value (alpha)). -Test reliability/ stability of questionnaire -Scatter plots, histograms
		Qualitative: NVivo: -Frameworks /Quasi statistics: -Organize data into frames and frames into themes	-Original statements indented italics
4. To determine the nurses' perceptions of challenges in UHC	Mixed Quali -/Quantitative Variables : Independent variable – UHC Dependent variable- BSc Nursing Curriculum Intervening variables: mainly categorical, Nurses' perceptions on challenges in UHC, coping strategies for UHC, Different hospitals, age, gender, level of seniority, other demographics Measurements- Questionnaire items. Likert-like scale rating 0 to 5 and 1 to 5	Quantitative: SPSS -Chi square Univariate	-Predict associations, Contingency tables -Descriptive cross-tabulation tables
		Qualitative: NVivo: -Frameworks /Quasi statistics: -Organize data into frames and frames into themes	Original statements indented italics

3.9.6.6 Ethical considerations

Confidentiality will be maintained and respondents' names will not be identified in documentation related to the study. No direct harm to the respondents is anticipated, the benefits as foreseen will be many. Approval from Institutional Ethics Committee (IREC) will be sought. Letter of authorization to proceed at every stage will be sought from institutions'

Quality Improvement Team (QIT) and individual respondents through informed consent. Informed consent means that a person knowingly, voluntarily and intelligently, and in a

clear and manifest way, gives his consent (Armiger, 1997). Privacy of respondents will be upheld. Traceable personal identifiers will be removed from the data to ensure anonymity.

Levine in (Levine, 1976) advocated that confidentiality was intended that individuals were at liberty to give and suppressor disclose as much information as they wish to whomever they choose, as such covert information or otherwise shared by respondents will be held in confidence. The respondents can choose to with draw from the study at any stage.

Collected from nurses selected health care organizations, centres from those willing to participate in the study. Generally, interview schedules usually expensive in nature as opposed to questionnaires. They require personal involvement in terms of the enumerator(s) engagement with the respondents. Where resources are put at the disposal of this researcher, the study area can be public hospitals at least level 5 in 5 counties.

Why level 5 hospitals? These were likely to be learning organizations as teaching hospitals, already implementing some form of regular CPDs. There was also opportunity of getting a variety of nurse cadres, nurse to patient ratios are just fairer than those at lower levels, and hence they might be easier to engage in the study. Creating a learning environment that was relevant and supportive of the next generation of nurses is critical to the professional practice of nursing (Kurth, A., Jacob, S., Squires, A., et al, 2016); (Böhmig, 2010).

If for a very good reason I was under pressure to drop out any study site I would not drop the county and level 5 hospitals, otherwise I might risk not get adequate numbers of BSNs. Minimum acceptable norming sample size is 30 for correlational studies (Kothari, 2004).

Apart from the fact that Kisumu and Nyeri counties will be actively running the UHC program, level five hospitals will be the capstone sites due to the fact that there was a higher likelihood of getting more BSN nurses working there than lower level facilities. This had been the generally observed distribution in the country.

At this stage my involvement in data collection method will be as an interviewer in administering the questionnaire and recording results on paper or directly onto a handheld computer.

I will gather qualitative data on selected key informants using unstructured moderator interview, nonverbal observations, field notes and voice recording. The strength of key informant interview is that it capitalizes on the fact that it is an in-depth interaction between me as the researcher and the key informant. I can be able to clarify points on the spot and seek new knowledge based on what is being said, thereby potentially leading to deeper expressions of opinion (Polit, D., Beck, C, 2012).

3.9.6.7 Proposed Analysis and Reporting of Findings
Cleaning of data will be done to identify e.g. check that the data are arrange in the formats ready for analysis, sufficient discrimination in the questions, removeambiguous items, missing items etc. Coding of extracted data will be into MS Excel worksheets as sections and categories.

Demographic data will be presented through the used frequencies and percentages. Using descriptive statistics, I will report on to what extent and the utility value of the nursing curriculum in preparing the graduates for the demands of universal health coverage in nursing care provision by the sampled population as a whole and by other criteria such as age, gender, location etc.

For quantitative primary data collected on interview schedule, analysis tool will utilize SPSS version 23.

I will attempt to determine if there will be is a linear correlation between age, gender, location etc. and other factors by utilizing SAS statistical software get the rate of their use through the use of nonparametric data and multiple regressionsince data collected from the interview schedules responses will be described as scores but not real measurements. These will be presented in scatter plots, factor analysis, and path analysis among others

Bivariate Pearson's "r" used to test the direction of association, and Independent t-test (*2 tail*) will be used to predict the significance of the strength of association

Qualitative data analysis will be done using atheory building packageNVivo and *CmapTools* softwares. These will permit researchers to examine relationships between concepts, concept mapping, find patterns in data explore hunches, develop hierarchies, coding scheme for themes.

I will also elicit a few insightful views from key informants among others. Reporting will include clusters, categories (data will be placed in the same category if they can be related to one another) and representative quotes.

3.9.6.8 Findings expected
Findings are expected to uphold the theoretical assumptions that there was an implementers' gap that could be bridged by reorienting the nursing curriculum. These will attempt to offer practical suggestions on how the nursing curriculum can be improved by including universal health coverage (UHC).

3.9.6.9 Expected application and recommendations
Based on the initial lessons from the two counties, I expect this research to be generative: that participant will be in a position to share their learning needs and concerns towards universal health coverage (UHC). They will suggest on how they could become better as implementers and support my view that BSc Nursing curriculum will need to incorporate UHC content.

Further research would highlight how to incorporate UHC content into BSN curriculum. Other counties would be incorporated as the program rolls out nationally to the rest 43 counties. I hope from the motivation of this research to be in a position to propose a model of training on UHC for BSN nurses.

3.9.6.10 Summary
Universal Health Coverage is such a momentous opportunity for nursing in Kenya. UHC will demand nursing coverage across the continuum of care from the hospital to the community, across a lifespan, across socioeconomic diversities etc. It will be a plus for UHC if Kenya could see to that. It would make a big difference in the health of our

people.With the changing opportunities in the health sector, nursing as a profession will need to know where to lay the most emphasis. This must start somewhere. A good place to start would be by reorienting the BSN curriculum to UHC basis. This will be what the proposed study will be about.

***This proposal was for a doctoral thesis in Medical Education at Moi University by this author. Full study expected in 2 years time from the date of this publicatons.

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Chapter 4
Evidence Based Practice

Why is this so important? Studies have shown that two out of three clinical encounters generate a question, yet only 40 percent of those questions are answered. If they were all addressed, it could change up to eight management decisions each day a clinically significant impact. This is a call for evidence. For a long time, scientific research was left to academics but that can no longer work in healthcare, every health care provider is accountable for determining the value of their interventions. Why EBP? Every patient deserves care that is based on the best scientific knowledge and that ensures high-quality, cost-effective care.

However, the following was one nurse's response o why EBP: *I have an entirely different way of addressing clinical questions. I'm starting to ask questions about how I can improve the care I give to patients and how I can be involved in my workplace's efforts to improve care for the patients it serves. I have discovered by purposeful reading in my practice area that research reports and research summaries contain many implications that apply to practice in the critical care unit (Jill Webbs in Vignette).*

The first part of this chapter is an excerpt of a modified essay that was submitted to Global Research Nurses competition whose theme was- *"with reference to a research study that you have worked on, describe how nurses contribute to clinical research and discuss what support is needed to enable greater involvement for nurses in clinical research".* The essay related to small efforts that when followed brought among others; a tracheostomy study, infection prevention practices and control (IPPC) study and a walkthrough survey, self and accidental poisoning study, applying theory into practice (Newman and Nightingale theories among others covered elsewhere in this book.

The advent of Evidence-Based Practice became one of the benchmarks to interrogating the provision of quality health care if it made a real difference. An overview is presented of one practice model, the Iowa Model of Evidence-Based Practice to Promote Quality Care since I felt that it was one of the easier models to understand. The model was initially meant as a practice model but has had varied applications by teams, units, and organizations in research, academia, grant proposals, publications, knowledge attitude & practice (KAP) studies regarding research and EBP.

Another factor that has been proven to edify the quality of health care provision accepted in EBP is embracing theory into practice. There is need to let the reader be in a position to relate with how all these might occur in practice. Slightly adapted Advanced Theory in Nursing and State of Science 1: Evidence-Based Practice coursework materials were used. Valuable updated relevant readings and links have been provided (in text and in the references section) together with a template for staff training on electronic library searching.

Traditionally, knowledge was viewed as something that can be possessed. Today, however, it is viewed as a utility-something not possessed, but access. People who want to use knowledge should know how to access it, how to apply it, and when to let it go (Porter-O'Grady & Malloch, 2015).

According to Houser and Oman (2011; p14, 47,249, 251), EBP is not a *cookbook medicine*, handing down edicts to the health care provider to practice in a single way. Infact, evidence alone is never sufficient to make a specific clinical decision about a specific patient. The clinician needs evidence plus good judgment, clinical skill, and knowledge of the patient's unique needs to apply evidence specific to the patient situation. Evidence (basing practice on what has been explored, tested, and found to serve the health needs of patients) is one of the triads in EBP.

Improvements, accomplishment, and progress in nursing (and science in general) result from carefully building up on the research findings of those who have come before us. The results that they shared, published and how that has been understood by others. The key to this is the useful feed-back they received.

Evidence-based practice (EBP) is the conscientious and judicious use of current best evidence in conjunction with clinical nursing knowledge and patient values to guide healthcare decisions. The process begins with a question, followed by an extensive review of the literature to evaluate what answers and discussion already exist. In this context then, the term evidence-based practice (EBP) is hard to avoid in contemporary health care even in resource-constrained settings.

Even if an organization were to pretend that it is not motivated to rely on interventions that have been shown to be effective a host of external powers would push them towards quality. These include statutory regulators, quality management systems (QMS), and accrediting organizations among others. They not only expect it they will be appraising them from time to time.

A US report indicatd that less than 40% of hospital care was based on research evidence supporting its efficacy (IOM Roundtable on Evidence-Based Medicine, 2007) The report lamented that, "Care that is important was often not delivered. Care that was delivered was often not important". There was a l s o an often cited 17-year latency between bench (translatable research) and bedside (Morris *et al.,* 2011). Health systems research was especially in demand, why because many countries including developed countries faced underutilization of necessary care, the overutilization of inappropriate care, rising costs, disparities in access to care, patient safety concerns, and outdated public health infrastructures among others.

EBP, in this case, referred to as evidence-based management is the utilization of various types of research evidence by managerial leaders to support decision making to improve processes and outcomes. EBM provides managers with the resources they need to create positive change. A gap existed in healthcare leaders' understanding of how to utilize appropriate evidence to improve inefficiencies in healthcare delivery.

It is critical for healthcare professionals to understand and apply strong evidence to every aspect of healthcare. System-level research leading to innovations was needed to address what are increasingly recognized as system-level problems through what has come to be referred as learning organizations. Learning, in this case, refers to the capability for continuous improvement through the collection and analysis of data, creating new knowledge, and the application of the new knowledge to influence practice.

A learning organization should acquire the ability to continuously, routinely, and efficiently study and improve itself. It ought to create an enabling infrastructure and engage care providers and connect them in peer learning communities, develop analytic tools to interpret and manage data among others. The validated information allows care providers as well as their leaders to perform their jobs with higher standards and better outcomes.

The other two are clinical experience (expert panels, consensus statements etc. not sacred cows) and patient preference (satisfaction, patient-centred, cognizant of cultural values, quality of life, treatment burden, co-morbidities etc.). Therefore EBP is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. It is also a process of finding, appraising and applying scientific evidence to the treatment and management of health care. It involves using the best research-proven assessments and treatment in our day to day client care and service delivery. Nursing research provides the foundation for evidence-based nursing practice.

4.1 How Nurses Contributed Towards Generating and Utilizing Evidence

According to International Council of Nurses (ICN, 2012), nurses were excellent at giving care and at solving immediate problems, often with few resources. They interacted with consumers of health care in a wide variety of settings. This gave nurses a broad understanding of health needs of how factors in the environment might affect the health situation for clients and families, and of how people might respond to different strategies and services. Yet, nursing has difficulty getting this message out to policy-makers. They proposed that national nurses' associations were best positioned to influence policy by bridging the bedside to boardroom divide.

The feeling of this author is that we must start by utilizing EBP from where we are. First and foremost there is need to focus on changing competences and attitudes towards translating evidence to practice for better health outcomes.

This is what happened in a couple of years back in one level six hospital in western Kenya. The critical care nurses had noted with concern that after CCU patients with tracheotomies were transferred to the wards, many suffered poorer outcomes than expected. After conducting a retrospective chart review of all these cases to document the problem. It was alarming to find out that 78% died within 72 hours to 60 days following their transfer from Critical Care Unit (CCU).

A team of nine CCU nurses then conducted a survey of acute rooms in the hospital. Some other key findings included that there were inadequate resuscitation facilities: suction machines and oxygen were not in every ward, emergency drugs were not well stocked, and acute rooms did not always have a nurse. No protocols existed on resuscitation or tracheostomy care.

The study recommended the creation of a step down high dependence unit (HDU); placement of a nurse in every acute room; stocking each ward with a minimum of one suction machine, an oxygen administration set and pulse oximetry.

Of all the projects this unit implemented, the tracheostomy study stood out. They wanted to: (1) assess the current state of tracheostomy care in primary and tertiary healthcare facilities, and (2) assess the knowledge, attitudes, practices and skills of ward nurses in tracheostomy care. Utilizing a descriptive cross-sectional survey of knowledge, attitude, and practice of tracheostomy care among ward nurses.

Although these critical care nurses had little to no background in research, the team leader sought the commitment from all of the nurses to form a team and each began a small research study. The team leader continued to mentor them, structure how they would work through the process of proposal writing, and helped them expedite proposals through human subjects review.

With the assistance of visiting nurse researchers who lent access to US university databases, they conducted a literature review that revealed adverse outcomes were related to tracheal occlusion in patients discharged from CCU to the wards. Occlusion of tracheostomy occurred in the absence of proper nursing care which might be due to lack of education and existing protocols.

Another finding was that nurses felt tracheostomy care was the doctor's responsibility, while doctors felt it was a nursing responsibility. The study recommended that protocols for tracheostomy care and education were needed in order to inform nursing practice throughout Kenya.

Going forward, since then tracheostomy care workshops were held. The intention was to follow up with a post-training questionnaire on the same sample and analyze the comparisons. Anecdotal evidence already showed improved patient outcomes. The expanded project would include a primary level facility with the intention of comparing with the level 5 facility. These would be replicated throughout the Rift Valley Province. It was hoped that with some assistance (have since applied for a grant) it would be possible to publish these experiences and existing knowledge base in the form of a manual.

Many other small projects emerged, such as a study of 'buffer' shifts (4 to 6.30pm) that demonstrated the shifts were actually detrimental to patient care. In another study, three nurses conducted an assessment of infection prevention practices and policies which resulted in a practice change (Gichuhi, *et al.,* 2015). These nurses presented their study at several conferences nationally.

Some other CCU nurses conducted an audit of poisoning cases admitted to CCU in the preceding four years. It was assumed that all patients were suffering from one kind of poisoning and treatment protocols did not exist. After a literature review, they were able to develop an assessment tool to distinguish the type of poisoning and appropriate treatment. The rate of mortality of patients with poisoning dropped to a clinically significant level (Kamau, Chebor & Mwangi, 2014). These were but a few examples of studies conducted by CCU staff after creating positive expectations and creating an environment of collaboration and support.

In the past, nurses in that institution were rarely involved in developing concept papers, proposals, and budgets. Nurses often were recruited as data collectors after a study was underway. This was a significant step forward for nurses now that they were the instigators of searching for evidence and if there was none: observed and identified questions related to patient care, designed and carried out the study, and then used the findings to make necessary changes in patient care. The importance in this change of roles for nursing could not be underestimated because it meant that questions that had to do with the welfare of patients could be addressed directly and that nurses in other units saw the benefit and reward of this activity and followed suit.

4.2   Support needed to enable greater involvement of nurses in research

According to Chipps *et al.,* (2017) acute care hospital environments provided excellent settings for clinical nurses to conduct research that aimed at improving quality and patient safety. In the US, Magnet[®] recognition was one approach frequently used to develop a culture that promotes robust scientific inquiry among nurses.

In low-resource countries, such as Kenya, there are other strategies that would stimulate nurses' increased participation in research and use of research, for example waiving the reviewers' and publication fees, providing access to scholarships for graduate education, access to high-speed internet, computers and databases, to provide staff time out to do research and funding for studies. Most of these were recognized more than a decade ago by the classic works of Haynes (1998) and Rogers (1983).

Such an effort jointly by Shearwater Foundation/International Peace corps and Moi University duly recognized that this author benefited from had its own parameters. The statement announcing the scholarship read in part as follows: - *Two scholarships each approximately $4,000 USD to pursue Master's Degree studies in Nursing will be awarded in the year... The purposes of these scholarships are to:*

   D *Provide future educators and mentors for practicing nurses and nursing students especially within MTRH and Moi University School of Nursing.*

   D *Provide critical thinkers, researchers, advanced practice nurses, nurse managers, and political advocates for social justice in health care who can influence positive health care outcomes in Kenya*

   D *Provide nurse experts for the further educational development of Kenyan nursing at the local level.*

Indeed, as health care providers we really are a part of a global community! We all have such rich experience to share. A lively participation in an online discussions forum is so enriching. As I sat at my desk in Kenya I realized we too could contribute in some way in developing innovative solutions to big global issues of our time – extreme poverty, inequality, and climate change. Why not? Some of my networks were sitting at their desks or whatever it was in Nigeria, in India, in Afghanistan, in Myanmar and in dozens of other countries. We were all discussing modules on *Leadership and Management in Health* (LMIH) course hosted by University of Washington.

Having opportunities to attend the conferences were such valuable experiences allowing nurses to hear the work of others, to network with and share experience with others from countries where nursing research had evolved or was in the process of evolving. Global Research Nurses Network offers such a forum. From time to time they do run competitions for nurses from resource-constrained settings; winners get full sponsorship to attend international a conference wherever it will be held next.

Global Research Nurses Network principally promotes clinical research. But there were other schools of thought concerning nursing research. For example, Jacqueline Fawcett Ph.D. considered a theory expert and internationally recognized as an authority in models of nursing wrote that nursing research is all about either generating a new theory or testing one which is already there. This was a masterpiece she co-authored *Contemporary Knowledge in Nursing Practice* (Fawcett and Desanto-Madeya, 2012) that connects research and theory. She was honored with Betty Neuman Award during the *Nurses Research Day* on 18th October 2015 for her distinguished role in promoting nursing research.

As we consider stepping up the quality of healthcare provision, whether we are at Research Utilization or Evidence Based Practice there will be tools available to choose from. An example is Iowa Model of Evidence-Based Practice that recognizes triggers in practice as the catalysts that prompt the need to seek knowledge.

The University of Iowa Hospitals and Clinics' (UIHC) Department of Nursing was known for its work on the use of research to improve patient care. This reputation was attributable to staff members who continued to question "how can we improve practice?" or "what does the latest evidence tell us about this patient problem?" and to administrators who support, value, and reward EBP.

According to Basow (2013), studies have found that two out of three clinical encounters generate

a question, yet only 40 percent of those questions are answered. If they were all addressed, it could change up to eight management decisions each day - a clinically significant impact. Fineout-Overholt and colleagues (2005) described four components to forming an appropriate clinical practice question "PICOT". One of the most challenging issues in using EBP in the clinical setting is learning how to adequately frame a clinical question so that an appropriate literature review can be performed utilizing a "**PICOT**" model acronym:

The PICOT question format is a consistent "formula" for developing answerable, researchable questions (Melnyk & Fineout-Overholt 2011). When you write a good one, it makes the rest of the process of finding and evaluating evidence much more straightforward.

P: Population/patient - age, gender, ethnicity, individuals with a certain disorder

I: Intervention/indicator (Variable of Interest) - exposure to a disease, risk behavior, prognostic factor

C: Comparison/control - could be a placebo or "business as usual" as in no disease, absence of risk factor, Prognostic factor B

O: Outcome - risk of disease, accuracy of a diagnosis, rate of occurrence of adverse outcome

T: Time - the time it takes for the intervention to achieve an outcome or how long participants are observed

Note: Not every question will have an intervention (as in a meaning question) or time (when it is implied in another part of the question) component.

Additional letters (PICOT**TS**)
T: Type of study
S: Setting
More resources https://guides.nyu.edu/c.php?g=276561&p=1847897

The nurse practitioner needs to consider each of these components when developing a focused question. Once the PICOT question has been formed, a literature search is performed. Successful search and critique of the literature is a critical component for nurses to master when implementing change driven by EBP. According to Fineout-Overholt *et al.,* (2005), correct literature appraisal assists how the evidence will be used to answer the PICOT question or implement a practice change.

We might have observed from day to day work that a relationship is found between the number of antenatal care visits and delivering at a health facility. That is, if the quality of ANC is good (quality means that mother receives all services such as iron supplements, BP, urine tests, education on health facility delivery etc.), they are able to understand the importance of HF delivery.

Building the model
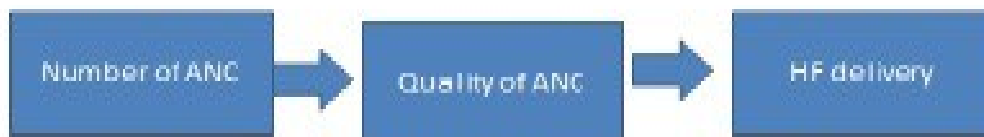
Begin by defining the variables:

Dependent Variable: - Delivering at the health facility (HF);

Independent Variable: - No. of ANC visits;

Moderating variable: - Quality of ANC.

"PICOTTS" model

Population women visiting ANC (who also delivered at HF, or visited ANC but did not deliver at HF). It excludes all those who either did not visit ANC but delivered at HF or those whom we do not have proper records to ascertain this status.
Intervention -ANC care

Comparison - No of visits (few less than 4) and more (at least 4 or more), or late 1st attendance of ANC versus early/regular attendance. Could also be the quality of ANC but this would have its ethical implications since no justification whatsoever that a woman can be deliberately denied quality care. But circumstances might arise when supplies were lacking this period can be compared with another one where there was plenty.
Outcome is health facility (HF) delivery
Time – when ANC care, schedules etc. **T** -type of study, **S** -setting

If we do not know something, we can research on it - that was why we went to school. Literature searching techniques are beyond the scope of this book and the reader is directed to further reading in the references below, a rubric utilizing medical heading (MH) or Medical Subheading [MeSH] on HINARI PubMed and CINAHL databases has been highlighted in the Research Brief and Annotated Bibliography. HINARI PubMed is available free to all developing countries. Individuals and Institutions can subscribe. Electronic library searching is an indispensable skill to muster in today's world.

Though you could do that, do not (impulsively) search Google or Yahoo for your literature, there is a better way. Endeavour to do things differently, save time and reduce unnecessary hits. Start a notch higher this time. Time for change is upon us. Due to the importance of this activity, a proposal to train staff on electronic library skills a template for you to adopt is available as an addendum below. Ask your Librarian for assistance, a System/Research Librarian near you would be willing to give you some tuition on the electronic literature search.

If you have access to more institutional databases I would recommend going straight to systematic reviews which save you the trouble of doing the summaries yourself. A credible literature search will have been done for you by dedicated staff. In terms of the hierarchy at the bottom of evidence-based practice are opinions from experts, and yet these have been what many have relied on for decades during ward rounds and such like forums. Of course, there continue to be clinical practice questions for which there is relatively little research information and experts can be helpful here (Level VII) see table below.
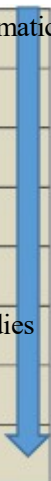
According to Porter-O'Grady, T. & Malloch, K. (2015) in their masterpiece: *Quantum Leadership: Building Better Partnerships for Sustainable Health* "It is nearly impossible for a single person to know more than 10% of what there is to know about a particular topic." It's a great reminder that we can't possibly "know it all", "Lone geniuses are out. Collaboration is in," and that we can all learn from one another/co-laboratories (emails, video conferencing, shared whiteboards, databases) This way we will not only learn other ways on *how to do* but also concerning what we do, *how to do better*. (Also see Table below).

Nevertheless, many nurses do not know how to access research evidence, do not possess the skills to critically evaluate research findings and even those who do may not know how to effectively incorporate research evidence into clinical decision making. We need to move from Level VII and that is the way to go. But the searching skill even for these constrained databases will still be necessary for you.

EBP is considered a major shift in health care education and practice. In the EBP environment, a skilful health care provider can no longer rely on a repository of memorized information, but rather must be adept in accessing, evaluating, and using new evidence that emerges in systematic research (Polit & Beck, 2012). The Agency for Healthcare Research and Quality (AHRQ) produced a "knowledge transfer framework," This is a recommended resource for those who would like to further their interests in these areas.

Table: Evidence hierarchy: levels of evidence regarding the effectiveness of an Intervention

Level I: Systematic review of Random Controlled Trials (RCTs) or Systematic review of RCTs
Level II: Single RCT or Single non-randomized trial
Level III: Systematic review of correlational/observational studies
Level IV: Single correlational or observational study
Level V: Systematic review of descriptive or qualitative or physiologic studies
Level VI: Single descriptive or qualitative or physiologic study
Level VII: Opinions of authorities, expert committees

When it came to expert opinion (see **table on evidence hierarchy** above) it was important to appreciate what we have. A case in point was that of Mr Francis Amakoye, an Occupational Therapist with over 35 years' experience based at Alupe Kenya Medical Research Institute (KEMRI). He had distinguished himself an expert at diagnosing and treatment of leprosy. The institute hosted the only leprosy centre in the country. Leprosy and especially in children was a challenging area among the emerging and re-emerging diseases which was hardly taught in conventional medical schools even in tropical Africa. He received hundreds of students every year who look forward to picking his brains, and he never disappointed.

May be as a result he made this comments during one such educational visit 'don't Google anything as long as I am still alive, Google my head'. [This author had been part of such at delegation 4 times in 15 years].

4.3   Demystifying Research

The research tradition includes six rules that encompass all phases of an investigation following some rules:

1. The first rule identifies the precise nature of the problem to be studied, the purposes to be fulfilled by the investigation "a way of seeing one's subject matter on a concrete (making real) level, thereby allowing puzzle solving to take place". There will always be empirical work (usually meaning experimental) needed to generate and test theories, conceptual 'models, frameworks', fill gaps in other research or come up with something new or angle. There was an evolution of concept analysis methods in nursing, redefining concept - based research methods. The frameworks proposed in this book inform a developing concept about interrogating health systems in resource-constrained environments.

2. The second rule identifies the phenomena that are to be studied. Meaningful research ought to provide answers to the most pressing problems encountered, it rends itself making a significant contribution to the body of knowledge/discipline; or could quite possibly be the major accomplishment of the decade. Imagine if one was to do a research that identifies why there is a trend of an emerging jiggers menace in Kenya.

Refinement of key words for library search by serving as a focus-"ruling some things in as relevant, and ruling others out due to their lesser importance", literature review

3. The third rule identifies the research techniques that are to be employed and the research tools that are to be used.

4. The fourth rule identifies the settings in which data are to be gathered and the subjects who are to provide the data.

5. The fifth rule identifies the methods to be employed in reducing and analyzing the

data.

6. The sixth rule identifies the nature of contributions that the research will make to the advancement of knowledge and recommend what more work is needed to identify other puzzles and to develop methods for their solutions. Dissemination of findings is critical.

Numerous evidence-based models are available to assist practitioners in using evidence in their practice According to Titler, (2007), they all share certain steps:
Select a topic (for example, diabetes self-care management).

1. Find and critique the evidence. Notice where there are significant differences of opinion among researchers and give your opinion based on what you see as the differences, ascertain the areas in which little or nothing is known, the gaps that exist in the body of knowledge
2. Adapt the evidence for use in a specific practice environment.
3. Implement the BP.
4. Evaluate the effect on patient care processes and outcomes.

The Iowa Model of Evidence-Based Practice to Promote Quality Care (discussed below) to clarify the steps needed to put research into practice, with the goal of improving the quality of care.

4.4 The Iowa Model of Evidence –Based Practice

4.4.1 Model Overview

The Iowa model highlights the importance of considering the entire healthcare system from the provider to the patient, to the infrastructure, using research within these contexts to guide practice decisions. A number of steps have been identified in the Iowa model to facilitate practitioner's engagement in problem identification and solution development as it relates to incorporating evidence findings into practice.

The first step in the Iowa Model of EBP is to identify either a problem-focused trigger or a knowledge-focused trigger that will initiate the need for change. A problem-focused trigger could be a clinical problem, or a risk management issue; knowledge triggers might be new research findings or a new practice guideline.

The first version of Iowa model (often called the 1994 version) was developed at the University of Iowa Hospitals and Clinics (UIHC), mainly to guide what was then referred to as research utilization (Titler, et al., 1994). The model has been in place for over 20 years at UIHC, during which time it was revised and updated in line with quality improvement and EBP literature (Titler et al., 2001).

The Iowa model is a practice model with the primary purpose of guiding practitioners (including physicians, nurses, allied health) in the use of evidence to improve outcomes (Rycroft –Malone & Bucknall, 2010; p138, figure 6.1). It is based on planned action process and incorporates conduct of research, use of research evidence, and other types of evidence e.g. expert opinion and consultancies.

Knowledge-focused and problem-focused "trigger(s)" lead staff members to question current health care practices and whether patient care can be improved through the use of research findings. Priority should be given to topic/project which is a high priority for the organization. A team is formed that assembles relevant research and related literature, critiques & synthesizes research for use in practice. If it is found that there is not a sufficient number of scientifically sound studies to use as a base for practice, consideration is given to conducting a study. Other types of evidence e.g. case reports, expert opinion may also be incorporated where need be.

If a practice change is warranted, changes are implemented using the process of planned change, piloting the change with small groups of patients and evaluating it and refining it to see if the change is appropriate for adoption in practice to additional population(s). 8.4.2 Assumptions:

(a) Working as a group/team is an important part of applying evidence in practice;
(b) Evaluation is essential part of the process of EBP;
(c) EBP is a process, not an event that requires multiple steps to align clinician behaviour and system support for delivery of evidence-based health care;
(d) The model is applicable for various health care disciplines, not just nurses and that improvement in processes and outcomes of health care are often interdisciplinary in nature.

Pic: Dynamics of change (courtesy of the clip developer)

4.4.3 Intended Users and Utility

Intended users for the Iowa model are practitioners. The give and take of ideas as the basis of developing a good project. Although originally designed for practice the model has been adopted by some academic settings and used to integrate EBP content into curricula.

Since the original publication in 1994, the authors have received over 1200 requests (including this one) to use the Iowa model for publications, presentations, grant proposals, graduate and undergraduate courses, clinical research and EBP programs. It has been cited over 90 times in nursing journals articles. Multiple publications from staff at the University of Iowa illustrate the application of the model and include evaluative data regarding the impact of changes in practice.

The Iowa model was also used as the framework for the Advanced Practice Institute: Promoting Adoption of evidence Based Practice 3-day train–of trainer program (TOT) at UIHC under the author Marita Titler (Rycroft –Malone & Bucknall, 2010). It has also been used to guide EBP Internship program. Evaluation data and details from these programs are used to improve on the model.

4.4.4 Theoretical underpinnings

Theoretical underpinnings of the Iowa model come from quality and performance improvement and organization systems literature. For example, the decision point regarding "is this topic a priority for the organization?" illustrates the importance of organizational support for implementing EBP. The evaluation component, dissemination of evaluative findings, and the feedback loops illustrate theoretical underpinnings of quality and performance improvement in the model. The model differentiates between the conduct of research and the process of EBP.

4.4.5 Hypothesis generation

Although the Iowa Model is a practice model rather than a research model, it has generated research hypothesis and been used in 19 grant proposals. It has also been used to guide assessment of knowledge, skills, and attitudes regarding research and EBP with subsequent educational programming for staff to improve the use of evidence in practice

(Witzke et al., 2008).The model has been tested and evaluated in acute care settings through numerous EBP projects on various topics: the return of bowel sounds following abdominal surgery in adults, preventing aspiration with enteral feedings in adult critically ill patients (Bowman et al., 2005) among others.

4.4.7

Strengths

D It starts with a small pilot of the evidence, is the evidence and changes important to the organization? (Priority is given to topic/project which is a high priority for the organization – does it fit the context and its' vision, mission, and goals?). It guides the user through implementation and evaluation of implementing changes.

D An excerpt from the Catriona M. Doody and Owen Doody (*n.d*) article entitled Introducing evidence into nursing practice: using the Iowa model states, "To develop an evidence-based practice at the unit level, the team should draw up written policies, procedures, and guidelines that are evidence-based. Interaction should take place between the organization's direct care providers and management such as nurse managers, to support these changes".

D The team work is emphasized. The Doody's article highlighted the importance of team composition and a bottom-up approach to implementing evidence-based practice. This is essential as change is more successful when initiated by frontline practitioners, rather than imposed by management.

D It is intuitive for practitioners and decision points in the model assist in driving the process forward. The model seems more user-friendly so practitioners without experience in this field can use it more easily step by step.

D It is multidisciplinary and multi-institutional.

 4.4.8   Weakness

A major limitation of the Iowa model was on using teams of clinicians to address EBP issues, rather than individual practitioners. Patient's preferences apparently were missing or rather visual reminders in the model graphic would have been very valuable. It puts patient and family so far towards the end of the process. Its focus was much more from the view of the organization and steps of preparation. It might have been better if it had the patient at the centre, kind of orients everyone to why we are doing what we are doing.

Although the model had been tested and evaluated in acute care settings e.g. through numerous EBP projects, it had not been revised since 2001 (Geissler & Kirst, 2009). A consortium of Iowa University Hospital and College of Nursing employees was working to revise the model but was yet to release their results by the date of publishing this book.

Seven steps of the Iowa Model (below), modified from Doody & Doody (n.d) 1*: Selection of topic 2:Forming a team 3:Evidence retrieval 4: grading the eviene 5:Developing an EBP standard 6:Implement the EBP 7:evaluation*

The Iowa Model of
Evidence-Based Practice to Promote Quality Care

Problem-Focused Triggers
1. Risk Management Data
2. Process Improvement Data
3. Internal/External Benchmarking Data
4. Financial Data
5. Identification of Clinical Problem

Knowledge-Focused Triggers
1. New Research or Other Literature
2. National Agencies or Organizational Standards and Guidelines
3. Philosophies of Care
4. Questions from Institutional Standards Committee

Is this Topic a Priority for the Organization?

No → Consider Other Triggers

Yes

form a Team

Assemble Relevant Research and Related Literature

Critique and Synthesize Research for Use in Practice

Is There a Sufficient Research Base?

Yes →

Pilot the Change in Practice
1. Select Outcomes to be Achieved
2. Collect Baseline Data
3. Design Evidence-Based Practice Guidelines
4. Implement Evidence-Based Practice on Pilot Units
5. Evaluate Process and Outcomes
6. Modify the Practice Guidelines

No →

Base Practice on Other Types of Evidence:
1. Case Reports
2. Expert Opinion
3. Scientific Principles
4. Theory

Conduct Research

Is Change Appropriate for Adoption in Practice?

No → Continue to Evaluate Quality of Care and New Knowledge

Yes → Institute the Change in Practice

Monitor and Analyze Structure, Process, and Outcome Data
- Environment
- Staff
- Cost
- Patient and Family

Disseminate Results

◯ = a decision point

Reference
Titler, M. C., Kleiber, C., Steelman, V., Rakel, B., Budreau, G., Everett, L. C., et al. (2001). The Iowa Model of evidence-based practice to promote quality care. *Critical Care Nursing Clinics of North America, 13*(4), 497-509.

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The steps to the Iowa Model include (a) problem identification, (b) forming a team, (c) a critique of the relevant literature, (d) implementing practice change, and (e) dissemination of findings (Titler et al., 2001).

4.4.9 Discussion

It's been well documented that patients who receive research-based nursing care have better outcomes compared to those receiving "routine care" or care based on tradition (Melnyk et al., 2004).When the argument is improved patient outcomes, it is difficult to ignore. Bringing the evidence to the table gives your argument strength.

This was certainly something health care providers in Kenya can endeavour to do. One of the advantages to EBP and the use of a model such as the Iowa Model is that you gather the evidence and support to convince others why the change is necessary and appropriate for the organization.

There is this saying that the reader might have heard… "Show me the evidence"? Or "Let the evidence speak for itself". Some people do not want to change but will if you show them the evidence. The Iowa model supports the need to gather the evidence and show it to the group you are working with to get support for the change in practice.

4.5 A Synopsis of application of the Iowa Model of Behaviour Change

(Adapted from essay turf.com)   http://essayturf.com/blog/application-of-the-iowa-model-of-behavior-change/))

The purpose of this synopsis is to review the application of the *Iowa model of behavior change* to the implementation plan, discussing ways to reduce falls in the elderly with cognitive impairment in the long term facilities. Falls among elderly people might be viewed as a normal consequence of the aging process. The frequency of falls varies depending on the clinical setting. In US fall incidences in acute care range from 2.3 to 7 falls in every 1000 patient days.

However, the highest incidence of fall occurs in long-term-care institutions, like nursing homes, about 50-73% of about 1.62million of nursing home patients experience a fall each year. Falls contribute a considerable percentage of unintentional injury in elderly; can be related somehow to a considerable number of deaths. Therefore, it is important to find a way to reduce these falls (Gosney & Harper, 2012).

The Iowa model of Evidence encourages nurses to identify a problem and identify questions triggered by practice questions. This model helps nurses promote quality healthcare by making decisions that are central to patient care outcomes. This model thus is quite useful for nurses to find ways of reducing fall in elderly people. Once a facility views the elderly health as a priority in the organization it will form a team focused on developing, implementing and evaluating the practical change.

The team, in this case, would ideally consist staff nurses who came up with the practice question, advanced practice nurses and unit managers. Due to the fact that this evidence-based model enables nurses to use research evidence for better patient management outcomes and therapeutic nurse-patient interactions. This would assist in providing the best care possible to these patients. This was because; in the practice setting there was a challenge for nurses to provide their patients with the high-quality measurable care. Nurses, therefore, needed to be aware of the introduction,

development, and evaluation of evidence-based practice. The Iowa model is a good starting point for this. The Iowa model consists of seven steps.

Step 1: Selection of a topic

Here, the magnitude of a problem and its priority has to be considered, and how it applies to every area of practice. In addition, how will healthcare improve with knowledge of this problem? Other factors to consider are the availability of evidence and data in solving the problem and how much the staff is committed to solving it. In the case of fall reduction, nurses have to understand that the falls are unexpected and occur without the patient's expectation.

The factors that increase the risk of fall include the use of high-risk medications, intrinsic risks of vision, balance impairment or cognitive impairments. In addition, falls can be caused by extrinsic factors such as wearing of inappropriate footwear, poor lighting, and slippery and uneven places. Causes of fall include arrhythmia, focal muscular weakness, hypoglycaemia, medication, orthostatic hypotension, and syncope.

Step 2:Forming a team

In this stage, a team that is responsible for developing, implementing and evaluating the plan. The team should include all interested shareholders such as staff nurses and unit managers in this case. Specialist personnel in the fall will be useful at this stage to provide input and support and give their views on the viability of a certain plan for counteracting the identified problem. Evidence-based approach is best when initiated by the staff nurses themselves rather than the management. Senior nurses should help junior nurses to effect the desired change. The team draws policies, guidelines, and procedures that are written and evidence based.

Step 3: Evidence retrieval

Here, a brainstorming session is held to identify the resources that are available, and key terms that guide the evidence search. In the case of fall, the evidence can be sought from electronic databases such as PubMed, Medline, and Web of Science. Other sources include consultations with Quality Improvement and Innovation Partnership to provide guidelines for care standards that are relevant to caring for fall patients.

Step 4: Grading the evidence

In determining the evidence related falls, the selected team will need to classify collected research as either quantitative or qualitative. Qualitative data will help in the understanding of the problem whereby the focus is on describing and understanding of the problem. The theoretical development ought to be based on real experiences as experienced by the participants involved such as staff nurses and the fall patients.

Step5: Developing an evidence-based practice (EBP) standard

The team needs to set recommendations for practice based on the consistency of replicated studies. The chosen practice should centre on the patient. In the case of fall, the practice should ensure that the risk of fall is reduced in these patients.

Step 6: Implementing EBP

The hospital management and the direct care providers such as nurses should directly interact to support the changes in the evidence-based plan.

Step 7: Evaluation

This stage is important because it reviews the contribution and value of evidence to the reduction of falls. There is a need for comparison of data prior to the evidence (as a baseline) to the data after using the evidence (outcome). This will show the contribution of evidence to patient care.

Some organizations in Kenya have in place Quality Management Systems [ISO 9001:2008 ISO 9001:2015 etc.] or are aspiring towards this. It is a requirement then that they must have a vision, mission, mission statement, core objectives, goals, service charters etc. There will be projects commissioned by the top management, regulatory bodies, institutional standards, internal/external benchmarking data, grant proposals, quality improvement initiatives sanctioned from the top.

Some of the flagship projects in Vision 2030 involve building a body of knowledge in research to enhance industrialization. Performance contracting indicators have some considerable weights on ongoing and completed research projects. A few organizations in Kenya put aside funds for research; the bottleneck comes to access them due to the high level of expectation in terms of proposal writing. Some of these unutilized funds are returned to the treasury at the end of the financial year, while individual researchers continue to conduct research using their own funds.

There will be those who wish to 'go it alone, after all!!' In a rejoinder to this, our Professor, Colleen Goode of the University of Colorado Denver gave us this advice, "*It is unusual to do an EBP project by yourself. I have never done one by myself. If you are trying to change practice in an organization it takes a village"*. Dr. Goode who was one of my course instructors at CU Denver is one of the architects of the Iowa Model, a great legacy.

At one point the multidisciplinary is strength and then it is mentioned as a limitation by the authors. May be if they all have different agendas or cannot all be researchers then this becomes a roadblock to further steps in the flow diagram of the Iowa model as they would have to be trained on research.

On the other hand, Rycroft & Bucknall (2010, p.143) referred to, "the need for at least one individual or governance group (e.g., the Research Committee) to have primary responsibility for guiding users through the EBP process." You need a mentor who knows the process and steps of the Iowa model, who is knowledgeable in the area of implementation and EBP.

Change champions will come in handy at some point, they have positive working relationships with other health professionals, encourage peers to adopt the innovation, arrange demonstrations, and orient staff to the innovation (Rogers, 1983). Rogers wrote the masterpiece Diffusion of Innovation. From more than 4,000 studies on innovation adoption, Rogers developed the diffusion of innovation framework.

This framework was used as the basis for developing and testing a translation research model in which diffusion of an innovation (such as an EBP) is influenced by the characteristics of the innovation and the manner in which it's communicated to users (such as nurses or interdisciplinary teams) in a social system (such as a health care organization).

Just like the Iowa model it emphasized on intended users across disciplines and a team approach apart from the need for organizational support. This model approaches EBP from a systems or organization perspective rather than from the perspective of an individual provider. Bringing people to read the same page might be a challenge (Eastbrooks *et al.,* 2006). We shall explore this in a bit through groupthink in a short while in this chapter.

3.6 Why choose Iowa model over other models

By and large, this is what I would say is unique about Iowa model of evidence, and why as a leader I would choose it over other models:

1) Its intuitive design, very logical flow, easily understood by nurses with varying degrees of experience.2) It includes knowledge and problem "triggers" that prompt user to evaluate current clinical and administrative practices.
3) Promotes nursing research when evidence is lacking.
4) It has wide application

EBP needs to be taught to all hospital employees and in the nursing syllabus in order to gain institutional buy-in and compliance to its concepts and methods of application within the practice environment. There is continuing debates about how to allocate scarce resources to EBP and research among competing needs generate lots of heat but all-too-little light.

In a nutshell, the Iowa model of evidence does sensitize us to be triggered in practice and to act as catalysts for knowledge seeking. It relies on the health care provider to pull research into practice when a trigger is encountered and traditional knowledge cannot be used to solve a problem. Although the Iowa model does not explicitly allude to this, another factor that has been proved to edify the quality of health care is embracing theory into practice as seen below.

4.7.0 *GroupThink*

Janis Irving developed an influential theory of group decision making designed to explain and predict how bad decisions are made by groups. Sometimes groupthink has come out as one dysfunctional group decision making. Multidisciplinary teams for the sake of it can be defeating. In the name of being representatives from minority departments (luckily nursing is not one) an officer moves from one meeting to another all in one week in the name of inclusion - to make teams appear representative, or with a more parochial view for goodies such as sitting allowance, lunches, per diems etc. What might be going through the mind of such an officer as they engage in this 'shuttle diplomacy'?

I guess the least of concern would be seriousness about whatever the business is all about and end up as a 'rubber stamp'. The rigorous nature of the kind of burden in the committees' terms of reference is not for such. Take for example aspects evidence-based practice (EBP) e.g. searching for evidence, critiquing it, knowledge translation etc.

Along with not fully analyzing the problem another disservice with groupthink is the inability to think beyond what is being decided. The groupthink mentality might also come to play when groups go along to get along. It's 'easier to get along to get along' but regardless of whichever opinion one might have there will be those who will not like it. The end result of the decision-making process is likely to be less effective than if group members questioned the information at hand, being careful to look at the problem from a variety of perspectives.

Albert Einstein (1875-1955), the world renowned mathematician said this, 'if I had one hour to save the world, I would spend 55 minutes analyzing the problem and 5 minutes finding the solution'. Bruce Lee, the legendary karate kick-boxer also said, 'I am not afraid of a man who practices 1000 kicks but rather one who practices one kick 1000 times'.

The group in a dysfunctional decision-making process at times make unanimous decisions that may not have fully analyzed the problem (Janis, 1982). Few people are willing to rock the boat yet this might necessary in order to arrive at the better option or best possible decisions. Self-censorship by keeping the mouth shut when experiencing doubts. Individual health care

providers who are group members might suppress critical thinking, feeling that a consensus has been reached when it has, not wanting to be the odd one out. Silence is interpreted as consent. People also find it difficult to make decisions that would proof their previous decisions were wrong.

There is a tendency of making decisions that justify the previous decision. The tendency of some decision makers to escalate commitment to a previously selected course of action when objective evidence suggests that staying the course is unwise, an individual chooses to invest further in spite of this.

Calling in others is a way of actively seeking information that confirms the validity of their decisions and they would prefer no dissenting voice of reason pointed out the irrationality or evidence to the contrary. Anyone known to have a consistent presence of mind to scrutinize facts is rarely admitted to such forums. If at all, the absence of significant criticism by *frienemies* rather than enthusiastic support of the sycophants is usually taken to mean that a proposal had astounding support.

There a gender component to this, customarily many an African woman will not speak during meetings (though this is changing) but will discuss all that happened after the meeting. In the constitution, the rule says no more than 2/3 of any gender should sit in a meeting in a public office, again affirmative action should not only require their representation but their contribution when and where it matters most, one of which is access to quality health care Their concern is not just in maternal and child health but are equal partners with men in every other aspect of health.

These might be realities our Kenyan health care managers will need to come to terms with. A number of them are sort of insulated from the issues on the ground. An old colleague used to call this *mkubwa kusimamia kazi mpka kazi inasimama*, a Kiswahili paraphrased akin to a controlling management style that leads to workers becoming less and less productive with an ultimate likelihood for a standstill.

One notorious executive who dragged on and on had a habit of introducing each line with – 'And again… That again… But then…But again… In as much as…' Statements full of excuses discussed enablers of the problem but less on solutions. Other times one wondered whether the words had been spoken in a different language before being translated into the bad English that itself needed to be translated. Did not even pause to ask for inputs. It was hard sitting long enough through the session.

Many such a leaders have a personal stake in the matter at hand and so the outcome was already clear on forehand. Some CEOs state a preference up front and so many such meeting were never meant for decision making. Participants are left wondering why they were called in the first place.

Some shrewd leaders will have ordered for a buffet meal and drinks (even music) which take up much of the time, the rest of the time is taken up by the leader's speech, the clarion call is that 'this meeting has been called to discuss and come up with a way forward'. Very valid points that health care providers had sequester because there was no forum to air them. Participants need to know how they were involved, how they participated, their comments- what it is they said, see how their input got incorporated.

The opposite is preferable. This is whereby there were those who might be referred to as entrepreneurs, according to Kingdon (1995), "lie in wait in and around *the boss* with their solutions [already] in hand, waiting for problems to float by to which they can attach their solutions, waiting for a development in the *organization's* stream *of thought* they can use to their

advantage" (emphasis in italics mine). This Kingdon strategy works well in policy development process but can be otherwise misused as seen in *GroupThink.*

Too much homogeneity was a likely cause of groupthink. Group members who have are very similar background, exposures, values or beliefs are less likely to challenge the leader or each other's ideas. They tended to be engrossed in an 'echo-chamber' mentality- speaking to themselves about themselves and, rarely ventilating for those outside looking in felt. Many people mistake uniformity for unity; sameness for oneness, but differences should be seen as strengths, not weaknesses. There was need to interact together genuinely, being open to each other's influence, begin to gain new insight exponentially because of differences.

Patronage and sycophancy have an (a usurping) role in many health care meeting setups in Kenya. Issues with far reaching implications (on many things including health) are often pushed through at such opportune moments or hour as a plotted absence of perceived opponents when there is too much pressure on the members to make a decision (Dainton and Zelley, 2015).

Whereas democratic principles state that 'the minority have their say but the majority have their way', it has not always been possible to achieve even that skewed objective in many instances. If the 'tyranny of numbers' is anything to go by this is squarely where it matters, whereby members try to justify a decision by talking themselves into it, coming up with a litany of reasons why a decision is good and why anyone opposed to it is bad. Or else too much pressure (including but not limited to buying them) is put on dissenting members to change their stand. As a resulting trust is put at stake.

Inattention to results is a serious sign of a dysfunctional team due to the absence of trust among its members. This was described by Patrick Lencioni in his book called *The Five Dysfunctions of a Team.* Distrust makes it very difficult to build a strong foundation for a functioning team.

In this type of team, people are guarded; people do not respond to questions or share opinions freely and they speak carefully. When team members are truly comfortable with one another- and when they respect each other and what the other members bring to the team- they can focus their energy completely on the job at hand without worrying about the need to protect themselves.

How often we allow a member of our team to go without being an active participant as long as they are on our side. Do such workers strengthen us or weaken us? You are only as strong as your weakest link, not to mention the negative effect it would have on the other members of the team.

How often have decisions been passed within the shortest time (minutes even) and after this we spend days or months on end discussing them? Should we discuss them before we pass them or discuss them after we pass them? Which is which?

How often are meeting after meetings held to plan or discuss how the job got done than actually getting it done? Getting engrossed with what was done other than talking of best practices or most effective practices. This pre-occupation with past achievements was characterized by rambling, over-explaining or just plain boring stuff that does not add value. When looking for comments on a job done, most profitable would be opinions and views of the other people who see how it has been done, not the original person who did the job. He ought to allow people to mingle and discuss. He could choose to respond to a few of the comments thoughtfully and only when valuable.

The same reason perhaps why Fred Allen said a meeting … *is a group of important people who singly can do nothing, but together decide that nothing can be done.* This might be what happened at some point during the constitution making process pertaining to several issues e.g.

devolution of health care services.The Bomas Draft had a provision for a Constitutional Health Services Commission (Section 251 of the Draft). The Health Services Commission was unlikely to survive a political onslaught. Sort of majoring on minor things as some people commented then, the medical fraternity including Kenya Medical Association (KMA) took to agitation for the legalization of abortion at the expense of among others, the Health Service Commission and merger for all laws on health into one chapter. Instead the public saw us in bad light, sort of outlandish with some of the matters we were fronting. We forgot to assert further for the retention of the Health Services Commission in the draft. Opportunity lost.The mutilated Bomas draft many Kenyans today wish was passed died with the aspirations of health care professionals. What followed was more debate from the health care providers after passing Constitution 2010 than before. This stillbirth has had more collective impact on the quality of health care provision in Kenya than any other issue before.

Although processes must never overtake the significance of desired outcomes (Porter O'Grady & Malloch, 2015), one way of overcoming groupthink is to develop and follow an organization-wide decision making policy (Dainton & Zelly, 2015). Adaptive Structuration Theory provides an example of such a process - Decision Making 'Complex Cyclic Path': when groups cycle through the same actions every time to solve a problem.

This path will provide a structured, expected and consistent path to follow to think through and understand presented problems and the solutions arrived at. Organizational culture must encourage questioning, especially of decision-makers' assumptions & propositions. Seven decision making steps along the cyclic path were shared by a school health nurse (see seven decision making steps along the cyclic path below).

One last point about meetings and emotional intelligence: Even when you do not get your way remember at the back of your mind -There will always be another meeting. Learn when to slow down. Don't win the race at the expense of your colleagues, friends and family.

4.7.1 Seven effective decision making steps along the cyclic path

1. Background to problem: Need to clarify our sick policy so that parents understand when to keep children home, and staffs understand the criteria to follow to properly educate parents and provide consistent care to caregivers

2. Problem Presented: Too many children are coming to school sick, inconsistent standards amongst staff

3. Solution: Create a clear, simple language illness policy that includes a parent handout, send handout out frequently during high illness times

4. Resources: Support through hospital epidemiology department and school health program, possibly adapting their illness policy

5. Timeline: Rolled out within 3 weeks

6. Who is Responsible for Success: Infection Control Nurse, Charge Nurses and Managers

7. How follow through will be conducted: Manager will follow through with compliance audits

(Courtesy of Prof Gayle, *Relational Communication NURS 6793* Spring 2015, University of Colorado Denver).

Such bottlenecks are likely to be at national policy such as parliament as much as in boardrooms e.g. District (County) health management teams (DHMT) and Hospital Management Teams (HMT), Unit/ward level, community health based organization meetings, village health committees.

It is my hope that the *Groupthink* theory has found its place and I believe there is a lot Kenyans have observed concerning this theory. We see these things all the time but situating them into a theory makes a lot of difference. This theory is easy to understand, it shows acuity. It became apparent that by applying Janis Irving's *GroupThink* theory it was easier to dissect this phenomenon that so easily beset us about bad decisions.

This brings to mind the saying, "that looks like it was designed by a committee" (not a compliment!). Essentially there is nothing wrong with a committee if we could add value to the terms of reference to include: gathering evidence, literature review, reviewing of data. The committee should acknowledge limitations/delimitations. Achievements to include what the committee did what it could not.

We can no longer assume that as long as good people are representing us in meetings they will make good decisions and so forth. They might be going to the meetings unprepared or casually. See **completely lost** below. I think to avoid the situation of *that looks like it was designed by a committee*, what we need is good facilitators/leadership and good team working skills.

Completely lost

I was appointed to this committee and another one to organize a conference. As one would imagine the later was asking for more, it required attending every Wednesday for those a year or five months and more frequently as the day grew nearer. I really looked forward to the ethics meeting, I loved looking at other people's proposals but it was difficult to give it my best, but it often happened on another day.

The venues for the two meetings was 40 Km away from my usual station making it mainly on public transport (motorcycles taxi or a probox commonly), using my own fare, no form of facilitation so to speak. I missed quite a number; I felt completely lost at times, went in casually often and was unprepared a few times. To say the least I might have been my station's best choice but I was not ably representing them one way or the other.

In a nutshell: An effective meeting should be more of a record of the way forward, not of deliberations-

- Increased operational efficiency may mean having more meetings or teleconferences. However, brief weekly meetings can be more efficient than holding on to all your questions and issues for a month or longer.

- Instead of not going to meetings. You should focus on making them better.

- Increase your benefit by making sure you attend all relevant meetings and asking insightful questions.

- Action generated against whom, what and when.

- Think though each action (identify sub-actions that cumulatively lead to achieving the main one).

D There should be no surprises (what do you expect?) what are the agreed deliverables? These are the basis of the engagement.

D An irresponsible and careless attitude in any meeting will bring disaster in the form of wasted time and resources

D Best Practices Quality Management Systems e.g. ISO 9001:2008

D Utilize templates, frameworks

D Special meetings are special and should have one core agenda and no AOBs Any Other Business (AOB's). In any case AOBs are not to be discussed in any meeting; they are fodder for members to think about, or to become substantive agendas for the next meeting.

I do not necessarily subscribe to his idea but one busy don colleague applied this principle: Try to skip meetings as much as you possible can - they are big time wasters. Ask in advance for the agenda. If there is none, look for and find an excuse. If you have to attend ask for when it ends and remind the chair that you have to leave the meeting earlier or at the stoppage time in case it prolongs.

Concerning matters arising either extreme would drain even resilient members. In one hand the chair might say *I think it's clear crystal* while on the other hand he dwells on *matters arising from matters that arose from …those previous (of previous) meetings*. Or rather, either brush out everything or sustain pending issues that kept on pending. How do we avoid all these? See below some lessons I picked from my meetings mentor:

4.7.2 My meetings mentor

One of this author's mentors was good at chairing meetings. Among other points the `following were some best practices I picked from her: At the beginning she was fond of saying, 'we want to make our agenda (or program) very straight forward… Can we agree these are the issues we are going to discuss?' Then she would ask members how long the meeting should last; proposers and a seconder on the same.

She could defer a matter if there were a number of issues that could not be answered, facts that could not be found etc. about it, she might say, 'If you say you don't have it, we should be very quick to defer, not waste time'. Then she would set deadlines, upon which the matter must be addressed, by who and report to who, by which date and eventually report during the next meeting. Most of her deadlines were astonishingly short but one had to deliver.

This was what she often said about other matters, 'let us pack it somewhere, we deal with it after this'. About emerging issues, she might say, 'we do not want to open a Pandora box, we have serious business to conduct before going that way'.

Sensing an emerging blame game she might say, 'we cannot talk about people who are not here in this meeting, the presenter has to take responsibility and follow it up himself'. Issues that appeared systemic were noted to be dealt with at a forum that could address systemic issues, which an ordinary meeting could not, that could include if need be the formation of a sub-committee.

Matters of policy were to be noted as such and dispensed off expeditiously. If there was a policy to handle this, it was not to be discussed. She might have said, 'do we have a policy about that or

we don't? That is what policies are there for so that we do not waste time dealing with every issue'. If the matter was weighty- investigate and report later against the stated policy. At one point she issued the following directive, 'we do not want stories and excuses we want an actionable report (I insist joint) on exactly what happened, leave the rest to us'.

Lastly before *Any Other Business* (AOB's) and there was still time she dealt with the packed issues during the meeting. Some of which by now may have gotten answers as the meeting proceeded. She tried to summarize, with little or no discussion. If it became clear that a discussion was necessary she would defer to the next meeting and as usual task some members to do some background check.

She liked saying, 'I want tables, my brain thinks more clearly when I see tables', and so we plotted tables on many issues. The secretariat knew what to do over breaktime whenever there was an issue being discussed, they inserted tables into what we had done and waoh! The results were better. We often took time out to allow for a table about what we were discussing. Collossal as tables were it did not take long before this values were passed on to others. The sense of ownership of the process was could I say fairer than without tables. So much for that.

I also found some odd things about my mentor. At the end of the meeting like she requested everybody to stand up to say *The Grace* (a common short final prayer) and if there was a meal she said a quick prayer, rarely did she ask someone else to pray. That aside, she appeared on top of things, was assertive but a good listener too. Apparently every other meeting she led used to be so very productive, at times it was a mystery how she managed to do that. It might be something to do with preparation and good leadership skills. 'At the end of the day, good leaders often do not do the work but they make you feel like they did' this was said by Jo Miller editor of Beleaderly and CEO Women's Leadership Inc. The few we could pick like the ones above were exceptional.

Leading by consensus will rally a team around a common goal, but according to Jennifer, that alone was not enough to be a leader and create change. 'Consensus was good but direction and decisiveness create action. Consensus must be guided'.

It would be good to mention what she said about why policy?: provides for a course of action; provides guidelines; establishes consistency; provides a standard that can be evaluated; provides at a minimum what must be done, how to resolve difficulties, omissions and commissions; provides steps; a framework to build upon in terms of areas of information, choices, training; provides for need for updates/revision from time to time to accommodate emerging issues and discard the no longer relevant; uses a common language understood by users; is made available/accessible at point of use.

Let us move a step further through a preview of a case analysis of 'The Challenger' (see **Groupthink challenger** below) borrowed from outside of healthcare. Then look through a preview of a case analysis of nursing theory to enhance the provision of quality health. For a start here is one nursing' theories link for you: http://currentnursing.com/nursing_theory/

4.8.0 Embracing theory to enhance provision of quality nursing care: A snapshot

Some nurses often times find theory intimidating, but working with theories is less daunting than many expect, the reality is that you have been working with theories of this or that all your life even if they hadn't been labelled as such.

Theories provide an abstract understanding, move beyond describing a single event by providing a means (a lens) by which all such events can be understood. For example, a theory of customer service can help you understand the poor service the customer or even you yourself (in our context the patient) received from the radiology department. The same theory can help you understand the good service you encountered last week at the mother and baby clinic sometimes ago. A theory like this one can assist the hospital in training and developing staff (Dainton and Zelley, 2015). We just looked at the Groupthink Theory in the paragraphs above. Everyday practices enriches theory and vice versa as both practice and theory are guided by values and beliefs. Theory helps to reframe our thinking about nursing and guides use of ideas and techniques.

Theory can close the gap between theory and research and envision potentialities. "The study and use of nursing theory in nursing practice must have roots in the everyday practice of nurses" (Alligood, 2014). It guides nursing practice and generates knowledge, it helps to describe or explain nursing, it enables nurses to know WHY they are doing WHAT they are doing (Gordon, Parker, and Jester, 2001) and enhance evidence-based nursing. Another example might be why health-supporting activities inside the hospital could be carried on outside the hospital (Halie, 2000).What evidence; best practices (including theories) are there that would support this?

An observation was made by Leah Curtin (1989), a former editor of Nursing Management, was that "Practicing nurses who despise theory are condemned to performing a series of tasks - either at the command of a physician or in response to routines and policies". Margaret Newman, on the other hand, showed the necessity of linking practice with theory by saying, "We have to embrace a new vision of health. Our caring must be linked with a concept of health that encompasses and goes beyond disease" (Parker & Smith, 2010).

GroupThink: The Challenger

 Shuttle Challenger on January 28, 1986. Shortly after launch, the Shuttle exploded destroying the vehicle and all crew members; These are excerpts from the analysis of the space shuttle disaster by Forrest Jeff entitled 'A failure in decision support system': http://dssresources.com/cases/spaceshuttlechallenger/h is a good example of the dangers that flawed group decision making can result to:

National Aeronautics and Space Administration (NASA) was made aware of the problem but it was "down-played" as a low-risk situation; the decision to delay a Shuttle launch had developed into an "unwanted" decision by the members of the Shuttle team; all members … felt that they should live up to the "norms" of the group; they soon changed their presentation of objections once threatened with the possibility of being expelled from the program; a NASA administrator who was "appalled" at a company that would make such a recommendation based on the data available; Thiokol became highly susceptible to "groupthink" when they requested a break from … At this point they became insulated, conducted private conversations under high stress and were afraid of losing potential future revenue should they disagree with NASA; all parties were afraid of public and political response to another launch cancellation (there had already been six cancellations that year).

Each party began to rationalize that past success equalled future success; Individuals who departed from the group norms were signalled out as unwelcome members; Conflict management was avoided by NASA's domination of the entire meeting. NASA, at times, became very assertive and intimidating. Considering NASA's attitude, no group member or individual was willing to be held accountable for any comment or decision;

At the end of the meeting NASA, very reluctantly, suggested that they would still cancel the launch if Thiokol insisted. No response from Thiokol was made and the NASA officials could not see the expression

of "self-censorship" that was being communicated on the face of each Thiokol engineer. The ability of each member to have voted anonymously was the key factor that would have maintained the integrity of the group decision support system (GDSS) and the quality of the decision… a decision to cancel the launch would have been made. Members of the group made a decision knowing that the decision was based on flawed information. A second concern is that the decision made put safety last and operational goals first.

Only one member expressed serious concern for the potential loss of life. Open and free communication before and during the meetings was discouraged through such group dynamics as mind guarding, direct pressure and self-censorship. Individuals, who know of a situation that, unless acted upon with integrity might cause social harm, have a responsibility to contact any authority that will manage and control that situation in the best interest of the public -"Whistleblowing" by Jeff Forrester).

4.8.1 Building a case for nursing theories

Kamau, Rotich & Mwembe (2014) published an article on *Applying Margaret Newman 'Theory of Health as an Expanding Consciousness' in Management of HIV AIDS in Kenya*. They noted that it would be good to recognize that patient-as-person involved an appreciation for the patient's self-perception and expression of an illness and the recognition that the patient's illness was a unique experience, one that was influenced by the patient's attitudes, knowledge, and current personal or social context (Mead & Bower, 2000).

Kamau *et al* (2015) did a review study on *application of Florence Nightingale's Model of Nursing and the Environment in the management of Multiple Drug Resistant Tuberculosis Infected Patients in the Kenyan Setting* (Detailed information has been presented elsewhere in this book)

Two patients could have varied responses to the same illness or chronic condition due to their personality, different life experiences, and circumstances. These were some of the reasons why nurses needed to use a nursing theory in patient care. According to Polit & Beck (2012); 'Theory is the ultimate aim of science: It transcends the specifics of a particular time, place, and group and aims to identify regularities in the relationships…'

A statement by College of Nursing of University of Colorado Denver, Guidelines for Evaluating Published Research Reports (NURS 6031) Themes or Rules-of-Thumb, Item number (11) stated that: 'Other things being equal, research related to theories is more important than non- theoretical research'.

Nurse Managers in charge of nursing units are encouraged to consider adopting on a minimum one relevant nursing theory/model (Papathanasiou, Kourkouta & Sklavou, 2013) as a step towards Evidence-Based Practice. At a minimum, it is not hard to think of an experience where a theory could have been applied (even if that was not so) after getting acquainted with one. Now, suppose it had actually been applied? The difference is obvious and quite fulfilling. More importantly how accessible (even in terms of understanding) is the theory to you as a practitioner?

4.8.2   **Proposal for staff training workshop on electronic library information**

4.8.1   **Background and justification of the workshop**

We intend to hold a workshop on capacity building on Electronic Library Information Technology for staff based in this institution/hospital/….. to be held on the digital platform. The…. week of ……….. is proposed as a convenient date.

The HINARI Programme was set up in 2002 by the World Health Organization (WHO) together with major publishers and it enables developing countries to gain access to one of the world's largest collections of biomedical and health literature. More than 8,000 information resources (in 30 different languages) are now available to health institutions in 105 countries, areas and territories benefiting many thousands of health workers and researchers, and in turn, contributing to improve world health.

Objectives:

1. To train hospital staff on Electronic Library Information Technology

2. To promote effective and efficient online and offline digital library usage among staff.

3. To promote literature review undertaking for appraising evidence, conducting and consuming research by taking advantage of information technology and digital resources available.

4.8.3 Anticipated Outputs:

Staff will have trained on Electronic Library Information Technology with a bias on medical library and health system which it is hoped will be multiplied and disseminated. The costs- benefits of this multiplication will be better understood by the number of staff accessing, effectively and efficiently utilizing HINARI and other data bases for research, evidence-based knowledge, consultancy and general learning.

4.8.4 Outcomes

More participation in research work and evidence-based practice (EBP). A multiplier effect of the same is expected from the trained staff (as change agents) towards their counterparts. Trained staff can act as channels for rapid adoption and continuous learning.

Diffusion of this innovation among staffs as consumers of knowledge will take place between and amongst themselves with increased online database availability and online search diversification. Staff will adopt informatics multiplication as a viable way forward since hard copy publications are expensive and inaccessible. Informatics generally is the use of ICT to communicate, manage knowledge, mitigate errors and support decision making. If you're still not convinced that an informatics infrastructure is essential to facilitate quality patient care, watch the video at the link below.

 Health Information Technology: Key to Quality Improvement. (Take help of tutorial on YouTube) http://www.youtube.com/watch?v=XbtTcT4Cl_k

While online publishing is now a reality, the world is slowly moving away from publishing hard copies to printing only on request thus there are not enough hard copies of journals and periodicals to go round in most libraries today. There was a transition from physical resources to electronic resources although at a slow pace.

 Additional Resources will be saved through this method in the long term. This sizeable surplus it is hoped will enable the institution/hospital… to subscribe to accredited referenced databases to increase access. It is envisioned that online library is clean and high yielding since it requires minimal investment in terms of space and paperwork.

Networking with top notch libraries worldwide would also make it possible to borrow materials at little or no fee from vendors of knowledge-based data sources. Telemedicine is a reality that makes learning interactive without the limitation of time, distance and space. Moving away from brick and mortar institutions into virtual space.

A sizeable number of staff have access to a personal computer or laptop. The emergence of smartphones and androids have also eased on portability and interfacing.

A follow up on the ability to critically appraise and apply current research knowledge for the participants will be the next step. We would wish to train a cohort of staffs from the different departments on the same in an upcoming proposal.

4.8.4 Request statement

The existence of internet opens up a world of possibilities for maximizing on what is published online and even real-time consultation. Existence alone may not yield much without its effective utilization. There is almost nil or marginal costs close to zero transmit data on the internet and on the other hand, is accessed at the lowest possible cost, easy to find. Conditions for its use is something most users hardly bother to know. The HINARI PubMed collaboration has now been made available free through the World Health Organization (WHO).

 In view of the above prevailing circumstances, the opportunity to have this workshop(s) will significantly make a difference in digital library use. Resource persons have been sourced from within … meaning that it will be possible to customize the service.

We therefore request for sponsorship in tune of Kshs … (In words….shillings only) from your organization. Please see the enclosures with …. budget breakdowns, programme, and list of participants.

For these, we will be forever grateful.

Thank you in advance

Facilitator's: … (Name, qualification, designation, affiliation, contact address, email)

4.8.6 Materials needed for two days workshop on electronic library information technology.

Requirements

(Y) 15 computers with the Internet, reliable bandwidth with HINARI access code and password

(Y)   LAN intranet access for multiple users to access

(Y) Overhead LCD, an electronic smart board monitor is preferred where available

(Y) Modems [3G and above -Telkom®, Safaricom®, Equitel®, Yu®, Airtel®, or smartphone with hotspot android® (personal)   promoting participants' BYOD (Bring Your Own Device).

D Earphone and speakers connected per computer/user (personal) promoting participants' BYOD (Bring Your Own Device)

Budget

S/No	Item	Unit Price	Total
1	CD duplication from master DV (Quality CD-R 700mb 52 x 80min) HINARI Measure DHS	20 x Kshs… 20 x Kshs…	…./= …./=
2	Flash disks 2GB per participant	20 x Kshs…	…/=
3	1 GB airtime data per participant	20 x Kshs…	…/=
4	**Writing materials** Notebooks Pens Pencils Rulers	 20 x…/= 20 x …. /= 20 x …. /= 20 x …/=	 …./= …/= …/= …/=
5	Graph books	20 x …/=	…/=
6	Spring Files	20 x …/=	…/=
7	**Refreshments** Lunch 10'oclock Tea 4'oclock tea	 20 x …/= x days 20 x …/= x days 20 x …/= x days	 …./= …/= …/=

8	**Honoraria for facilitators**		
	….. (chief resource person)	…./= x 2 days	…./=
	…..(IT support resource person)	…/= x 2 days	…./=
	One Computer Technician	…/=x 2days	…/=
	Secretarial services	…/=x 2days	…/=
	Contingency at 10% of subtotal		…/=
	TOTAL		**…./=**

3.8.7 Programme

Venue(s): Computer lab, exhibition stand. Refreshments/meals (where….) Date:

DD/MM/ YYYY

Day 1

Facilitator's   name:

Technical team lead by: ---

8am -9a.m: - Registration

           -Group norming

           -Setting   up

9am -10am: Introduction

10am –10.20am: Health Break

10.20am -10.50am: Hinari PubMed Module 1

10.50 am-11.20am: Hinari PubMed Module II 11.20am-

11.50am: Hinari PubMed Module III 11.50am -1pm

Quizzes + exercises Searches

        - Internet profile

1pm-1.15pm.A message from the sponsors: …., Visit to the exhibition stands at own pleasure.

1.15pm – 2pm   Lunch Break

 2pm – 2.30 pm- Hinari PubMed Module IV

2.30p.m -3pm- Hinari PubMed Module V 3p.m

- 4p.m - quizzes + exercises

                Internet services 4pm

- 4.20pm- Health Break. 4.20pm –

5pm -Group work

Day 2   DD/MM/ YYYY

Facilitator's   name:

Technical team lead by:

8.00am -9.00am -setting up

–recap on previous day's

9.00am - 10am   -group representation on topics and searches so far

    10.00am -10.20am - tea break

10.20am - 10.50am -introduction to reference management tools e.g. Mendeley, Zotero

10.50am -11.20am – Overview on Integrated DHS measure, Google Scholar, Open Data
    Kit   .

11.20am --11.50 am   quizzes + exercises

                    Internet   searches

11.50am - 1pm   Miscellaneous topics

                Library search skills (online)

1.00 pm-1.15pm - A message from the sponsors, Visit to the exhibition stands at own
    pleasure.

    1.15pm - 2pm   lunch

2 pm   -3 pm   Groups' refined topics

                Presentations Plenary

3.30pm - 4 pm   Closing and award of certificates of participation

                    Setting up of a peer research team
                    Prologue

4.9.8 List of participants

Name, designation, department, email address, phone

4.9.9 Closing remarks on EBP

To choose one model or theory from the other, look at what resources you have and what you intend to accomplish in the end and see which one looks like it will take you down the path of least resistance. Strategies to maintain consistent, reproducible employment of EBP in patient populations and practice areas throughout the network requires utilization of standardized EBP implementation tools such as the Iowa Model.

Nurses need to promote best-practice outcomes, as they are the experts who recognize, through experience, education, and clinical judgment, when a practice is inappropriate, outdated, or targeting the wrong patient population. How could EBP models/frameworks, nursing theories benefit our practice?

We must step up our practice, Think Big, Act Small, Start Now! Small efforts here and there and in this way questions that may not have immediate answers in resource-constrained settings can be thought through.

I have never forgotten what one John Kabanya, a pharmacist commented during a Funzo-Kenya workshop at KMTC Nakuru in November 2013:

"When you come up with a budget, the boss will ask you where the money will come from. Tell him this. 'I have partners who are going to assist me'. He will ask you whether you have talked to them, say Yes. He might say but you have not talked to me! Don't ask your boss to give you the money. Tell him that you want to assist him. Discuss the solutions you are proposing to a problem you have. Remember that you have to propose solutions, otherwise, you are wasting his time"...

My final thoughts on EBP and research bring us to the next vital component - helping health care providers' access evidence. Even within existing financial limitations, access to research data bases should not be seen as an afterthought or an add-on after everything else has been done. On the other hand, the data we generate should no longer remain unshared, unpublished and essentially wasted. It should be possible to create as a minimum a memory that captures the knowledge stored in peoples' heads. Our hospitals and higher education institutions must become learning organizations.

Evidence is available from databases through performing a literature search, appraising evidence and consuming research. I have a problem with the approach that the research is taught in many learning institutions (at least where I have been). Students are taught research methodology with the emphasis being to conduct research as though it was like 'picking low hanging fruits' which it is not while infact it means climbing up and taking on the riskier branches.

On the other hand learning how to consume research would be picking the low hanging fruits. Data created from research are valuable resources that can be used and reused for future scientific and educational purposes. Shared data facilitates new scientific inquiry, avoids duplicate data collection and provides rich real life resources for education and training.

This is an upside down approach in my view. If indeed research must be done then we are sure there is no tangible evidence to be found anywhere or at least the need for the rigorous

activity that research is necessary as the only way out and can be supported. Wouldn't it be better that our students first and foremost become skilled at literature searching, appraising research, becoming consumers of research?

Figure: The three aspects of appraising evidence

In other words, encourage readership of research work and where there is need conduct research. No wonder we are unable to implement even our own findings into practice because either they are not actionable or pragmatic enough or were derived from less than adequate evidence.

Worse still was the principle of ownership of the research. It may have been conceived by someone else or someone else did the research for and on our behalf (thanks to the proliferating academic writing business hubs. The largest concentration used to be housed along University Way, Nairobi among others). All some candidates needed was some coaching to enable them to defend 'their' research before a panel. The passion may be lacking. Al-Riyami (2008) wrote the following in an authoritative review article entitled *How to prepare a research proposal:*

Health research, medical education, and clinical practice form the three pillars of modern-day medical practice. As one authority rightly put it: 'Health research is not a luxury, but an essential need that no nation can afford to ignore'. Health research can and should be pursued by a broad range of people. Even if they do not conduct research themselves, they need to grasp the principles of the scientific method to understand the value and limitations of science and to be able to assess and evaluate results of research before applying them (Dr. Asya Al-Riyami was the Director of Research & Studies, Directorate of Research & Studies, Directorate General of Planning, Ministry of Health, Muscat, Oman).

Researchers were embracing social media even in their collaborations on primarily scientific forums. *Your Newsfeed on Mendeley is a great place to see what's trending*, both in your network and in the wider world of academic research. You'll be able to:

D   Discover and follow interesting people in your research field

D   Stay up-to-date with connections and see what's trending in your network

D   Keep in touch with colleagues and leading researchers.

Reputable science research journals had Facebook links as well as blogs e.g. *PLoS* has a blog to capture diverse perspectives on science and medicine. They call it Translational Global Health is an international blog focusing on key knowledge and implementation gaps in Global Health – from latest scientific evidence to policy and population health impact. Articles are both commissioned and *crowdsourced*.

Your scientific reputation is not only measured only in peer-reviewed publications. Your scientific blog posts, your tweets, your contributions in forums, all this will grow your reputation (Julio Peironcely, in the Next scientist blog).

Deriving a publishable paper from the research is another challenge. Few learning institutions subscribe to credible databases. A lot of students simply Google and come up with whatever stuff related to a topic. My take on this is that as long as the approach is to have the student conduct research without first inculcating the more important consumer value, then the essence of why research and evidence-based care will not take root.

At least for health care staff, the need to consume research is more important than conducting the research itself, but then they are not well grounded in these skills. I have attached here below a proposal that the reader can adapt on training a team on online literature searching.

Resource persons can be gotten from reputable libraries. Some staff who have advanced post-graduate education might be helpful too. I say - some staff because a reality check would likely find that even in some of the medical institutions of higher learning, a number of teaching staff (some teaching research) may be lacking in this vital component or are not researchers themselves in the first place.

When it happens that the only research (es) one ever did was *as partial fulfilment for the award of a degree* then that would not be good enough. We need to do much more as Kenyans scholars and health care providers if EBP will get us to where we ought to be as we strive for excellence in whatever we do. Draw upon the best evidence to provide the care most appropriate for each patient (Institute of Medicine, 2008). That way the quality of health care provision would move a higher notch.

Bedside nurses in a number of studies wished someone would collect and synthesize the evidence for them and convince them of its benefit before they will adopt new practices (Yoder *et al.,* 2014). Do we even have such persons in resource-constrained settings? Whichever the answer may be, as long as access to the library (including online library databases) was limited and even such exists staff do not use or consult them, EBP and innovations will take a back seat.

Mostly, staffs stuck to what they knew and what they did. Thus the importance attributed to the bedside leadership role cannot be overstated. I believe as part of nurses' professional growth and survival we need to grow more "in the trenches" leaders! The bedside is where the action is! It is the perfect vantage point to be a positive change agent for healthcare delivery.

Using library search engines is not easy either. It would be unrealistic to expect them to add these activities to their duties. Off course there would be little time to search during a shift and compensated time out would be needed with a lot of administrative input that creates a culture of EBP and research utilization. Nevertheless, my take on this is - if as Kenyans we have plenty of time to be on social media that is more than enough 'quality' time to skim through a standard research article.

According to Johns Hopkins Nursing Evidence - Based Practice Model and Guidelines (Sigma Theta Tau International, Indianapolis; 2007) - Evidence-based practice (EBP) is a problem-

solving approach to clinical decision making in a healthcare organization that integrates the best available scientific evidence with the best available experiential (patient and practitioner) evidence, considers internal and external influences on practice, and encourages critical thinking in the judicious application of such evidence to care for the individual patient, patient population, or system.

There are many models for EBP, but they all include 5 distinct steps: (1) asking important questions, (2) acquiring the evidence, (3) appraising the evidence, (4) applying the evidence to practice, and (5) assessing the results and adjusting the processes if needed[60].

The following background notes were gleaned from Quality and Safety Education in Nursing (QSEN). Evidence-based care integrates best current evidence with clinician expertise and patient/family preferences and values for delivery of optimum health care:

The nurse will identify efficient and effective search strategies to locate reliable sources of evidence. Learn to critically appraise original research and evidence summaries to an area of practice. Exhibit contemporary knowledge of best evidence related to practice. Initiate changes in approaches to care when new evidence warrants evaluation of other options for improving outcomes or decreasing adverse events.

Analyze how the strength of available evidence influences the provision of care. Develop guidelines for clinical decision making regarding departure from established protocols/standards of care. Value the need for continuous improvement in clinical practice based on new knowledge. The big question remains: So how can we get over the stigma of – it's a nice idea – to using evidence in our daily practice?

Educators in nursing and other health care disciplines must prepare them to appreciate the research and to participate in its design, implementation, and evaluation at the level of their preparation. Practicing nurses of all cadres and levels must actively seek to develop and adopt EBP protocols. Institutions must support this effort. Health care leaders must facilitate a conducive environment that fosters intellectual pursuits and supports research efforts.

Collaborative arrangements between hospitals and faculty must be developed for such activities as student projects, continuing education, coming up with clinical practice guidelines, protocols, and research endeavours. Consumers of healthcare need to be educated about the value of health care research. Policy makers want to be informed of pertinent findings so that results can be translated into health policy. The next few chapters concern utilizing theory and evidence based inpatient care.

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[60] Evidence-based behavioral-practice. Steps for evidence-based behavioral practice

http://www.ebbp.org/steps.html

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CHAPTER 5

Utilizing Theory and Evidence to Deliver Care 1:
Addressing Nurses' Workload by Utilizing Research Brief - Annotated Bibliography

Overview

This chapter is a modification from a much briefer document by the same title that was sent by this author to the concerned stakeholders from two capstone sites in Zendi County (fictitious name). Workload according to *Human Resources Norms and Standards, 2014* considered three factors: the effort (i.e., time) required for specific health staff to carry out particular activities; the category allowance factor, which is additional time spent on non-service activities (e.g., management or record keeping); and individual allowance factor, which is time spent on activities by specific individuals in a staff grouping (e.g., a matron's additional activities above other nursing staff).

It provided guidance on the levels and skills of health workers needed to deliver the Kenya Essential Package for Health (KEPH). These norms and standards were developed through the Workload Indicator of Staffing Needs (WISN) approach, an evidence-based method that considered the work actually performed by staff at a facility. Staffing norms and standards are usually – population based; facility based; disease pattern based. Acuity was a special consideration among other circumstances. Acuity in terms of severity, crisis of an illness.

More work, faster, with less, is hard for anybody and nursing is no exception. There is a direct relationship between nurse staffing and patient well-being. Nurses serve as an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients' conditions deteriorate. Substantial decreases in mortality rates (especially for patients who develop complications) could result from increasing RN staffing.

High quality and accessible health services cannot be delivered without sufficient numbers of well-skilled, well-distributed and well-managed health workers. This was according to Human Resource for Health (HRH) 2009-2012. In human resource, management-staffing is the process through which an organization ensures that it always has the proper number of employees, with appropriate skills, in the right jobs at the right time to achieve organization's objectives.

The erosion of Kenya's key health indicators – life expectancy, infant mortality and maternal mortality – during the last two decades can be traced at least in part to the deterioration of the health work force. The acute shortage, inequitable distribution and inadequate skills of health workers have contributed to this negative trend. Staff shortages

are particularly acute in hard-to-reach regions. Staff shortage will likely become more severe before it gets better. Annexed to this Chapter is a policy brief to The Cabinet Secretary, Ministry of Health, Kenya & Chairman, Council of Governors Kenya, entitled *The Nursing Situation in Kenya: Patients Deserve Better Care*.

Nursing is important in quality and safety of hospital care and in patients' perceptions of their care. There seems to be a close association between patient's safety, undergraduate nursing students' learning with nurse staffing levels in Kenya. The Ministry of Health, as well as the Ministry of Education, do not yet support changing nurse workforce standards for teaching medical institutions.

This research brief targeted sites were Kijani Level 4 and Zendi level 5 Hospitals (not their real names), both acting as teaching hospitals for School of Health Sciences, the University of Kue (not its real name), Kenya. The review focuses on nursing staffing as an issue, and the effect of workload on patient outcomes, students, and staff outcomes. Hospitals were going to be paid for good patient outcomes (value) and not paid for services related to bad outcomes derived from the processes of care (e.g. Hospital Acquired Conditions). This was already happening elsewhere hence need to transition from volume to value. This called for among others improvement in care coordination and quality of care while decreasing costs.

Given that nursing is the largest provider class in hospitals, the potential for nurses to improve outcomes is limitless. This brief sought to some extent establishes the relationship between nurse workload and nurse-sensitive patient safety and students' learning outcome indicators existing in research.

Scheduling around workload is now a critical method of staffing, so is contracting float/pool nursing for workload - bringing staff members on board based on an agreed workload and paying them for the workload rather than based on metrics of time. These methods give staff more control over their work-life and life outside of work. This has become a reality in some of the big towns in Kenya with some nurses by design or by choice remain without a permanent job for extended periods of doing 'locums'.

A search mode was developed. The online search spanned a period of between 2003 and 2014. A research brief and annotated bibliography were compiled from the relevant literature. The research brief is designed for the nurse manager and policymaker to provide information without requiring extensive reading. The reader can choose to dwell on the specific section(s), to start anywhere in the main text, or just the annotated bibliography.

There were a lot of staffing issues in research that could be applied in the two teaching hospitals. Kenyan nurses and nursing faculty might be interested in a staff-understandable review of what has been researched. Nurse managers ought to implement staffing processes that align staff skills and competencies with prioritized patient needs supported on a shift-to-shift basis.

A fair and balanced patient assignment increases nurse satisfaction in their daily work. A workplace culture of respect based on the belief that employees who feel successful, and

appreciated in the workplace truly leave their work, both physically and mentally fulfilled at the end of the day. They are thus able to better manage their time and maintain a healthy balance between work and personal life. Undergraduate BSc Nursing students would benefit more from optimum nurse to patient to student ratios.

Cases of retirement and retiring nurses

A graphical view of sampled hospitals in Nakuru County clearly showed why there was retirement of nurses now with even more retiring in the next few years in Kenya's public hospitals.

Wrote Francis Njenga (in Rift Valley Health Blog on Friday, 8th June 2018), 'Gilgil Sub-County Hospital, one of the major health facilities in the region held an annual farewell party for its retiring staff... seven nurses and one tailor, the very last of tailors in the institution'.

He went on to say, ' ...of the 71 nurses remaining and reported in the facility's latest Nurses Staff Returns, 54 of them (76%) were above 45 years old; with 26 of these nurses (36%) aged 55 – 60 years. Only 17 nurses (25%) are aged 25 – 44 years'.

Nakuru Level 5 Referral Hospital nursing staff returns by mid 2018 reflected a staffing of 338 nurses against a calculated staffing need of 600. Of these 235 nurses (69.5%) were above the age 45 years; 106 (31%) aged 55 – 60 years; 95(28%) aged 35 – 44 years old and a meagre 8 nurses (2.4%) were aged 25 to 34 years. [The mandatory retirement age for public servants was 60 years].

5.1 Introducing Concepts Used in this Research Brief

-Researchbrief presents policy-oriented summaries of individual published peer reviewed documents. Or presentation of original research on significant policy questions. A collection and analysis of relevant information to enable policy makers to make informed business decisions. There are several formats and templates of writing one. The following is a simplified one for the purpose of this book. It is presented in the first phase of this chapter with in-text numbering chronologically.

-Annotatedbibliography differs from a standard bibliography in that it is a list of citations to books and articles that gives a brief account of the research that has been done on a given topic. It gives a summary of each of the entries it provides a descriptive or evaluative comments (annotations). There are various templates available for making one.

This chapter is modified one (perhaps not a brief at all) for purpose of this book. It is presented (numbering refers to the in-text of the research brief above it, this is not always the tradition) in the later phase of this chapter. Concordia University Library website offers good resources on research brief and annotated bibliography (library.concordia.ca/help/howto/ann...)

-Healthworkforce refers to a human resource that is responsive, fair and efficient in order to achieve the best health outcomes possible, given available resources and circumstances. Need norms/standards that govern production of sufficient staff and ensure fair distribution (HRH must be competent, responsive and productive); HRH observatories are essential for facilitating HRH management

-Workload/assignment : meaning the number of patients that a staff member can care for and complete all care safely. Workload measurement systems quantify patients' requirements for nursing care as the sum of the times of the tasks required or as the amount of time required relative to standard patients.

-Safety: Avoiding injuries to patients from the care that is intended to help them. Minimize risk of harm to patients and providers through both system effectiveness and individual performance. Remember the kindergarten where everything was 3's, model. They had three rules the children must follow, "We keep ourselves safe, we keep our friends safe, and we keep our things safe." Pretty much everything fell into these three categories. It is not any different in healthcare. Add to this safety from pilfering for all the hospital equipment and you are almost done.

-Nursingstudent: a nurse in training indexed by Nursing Council of Kenya, a novice working under a qualified Registered Nurse. An example is BSc Nursing which is a four-year undergraduate nursing degree program.

-Clinicalareaenvironment: encompasses all that surrounds the student nurse, including the clinical settings, the patients, the equipment, the staff, the preceptor nurse, and the nurse faculty It is a complex social and cognitive experience for the nursing student. It offers situational learning where the student can participate in

real life and working situations. The basic premise is how do healthcare organizations produce nursing services? How do management structures contribute to the delivery of nursing services?

-Nursingfactor: According to FierceHealth *eBook* (2014) 'How Hiring Right (Or Wrong) Has a Direct Impact on Clinical Outcomes' nurses are the biggest factor in providing better care. It also states that when experienced nurses leave, hospitals must hire fewer experiences or temporary contract nurses, leading to poor patient outcomes. The eBook examines top nurse staffing challenges and how to overcome them.

-Thelawofsupplyanddemandfornursing. There are more people leaving the field because of retirement than there are people coming into the field, and demand is increasing (Richmond Times, March 11, 2007). Some are changing careers. The highest demand for health-care professionals can be found in nursing, worldwide hospitals are always looking for experienced nurses. We need to be able to recruit a lot of the students into nursing, see more nurses graduating and passing their exams.

-Nursesensitivemeasures: According to National Database of Nursing Quality Indicators Nursing (NDNQI) that are strongly influenced by the care that nurses provide or directly measure nursing as reflected by the *structure, process, and outcomes* of nursing care. *The structure* is indicated by the supply of nursing staff, the skill level, and their education/certification. *Process* indicators measure aspects of nursing care such as assessment, intervention and RN job satisfaction. *Patient outcomes* that are determined to be nursing-sensitive are those that improve if there is a greater quantity or quality of nursing care (e.g., pressure ulcers, falls, IV infiltrations etc.). Some patient outcomes are more highly related to other aspects of institutional care, such as medical decisions and institutional policies (e.g., frequency of Caesarean sections) and are not considered "nursing-sensitive(http://www.nursingquality.org).

-Nursingeducation: The courses of theoretical and practical instruction provided to undergraduate nursing students (in this context Bachelor of Science Nursing), with the purpose of preparing them for their duties as nursing care professionals.

-NursingCare: It is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of diseases, and advocacy in the care of individuals, families, communities, and populations.

-NursingProfession: Is a vocation founded upon specialized education, training, the purpose of which is to supply objective counsel and service to others to promote health, prevent disease and help patients cope with illness. Nurses are advocates and health educators for patients, families, and communities. When providing direct patient care, they observe, assess and record patient symptoms, reactions, and progress.

5.1.1 Introduction

Nursing is amongst the most challenging of professions, as nurses work long hours, night shifts, and with severely ill and sometimes dying patients. Nurses have great physical endurance. On 10th May 2015 RN posted this on KNUN wall:

> *'Nurses work on a rotation basis. They can work during the morning for a few days and revert to working in the evening for a week and then a few days of night shifts before they get a day off. The timing of their shifts is such that their sleep patterns are disturbed. When they finally get the hang of a particular shift, a new one starts…other nurses have to cover their shifts. they will have to replace it later…hold on till the passing of duty to the next shift, which by the way, rarely ends as scheduled. When you're done with one difficult shift, you know there will always be another.*

According to Meyer and O'Brien-Pallas (2010) who developed *The Nursing Services Delivery Theory (NSDT)* founded on Open System Theory (Katz and Kahn, 1978) describes relational structure for reconciling disparate streams of research related to nursing work, staffing, and work environments.

In NSDT, *Size* refers to the capacity of an organization to produce nursing services e.g. numbers of beds. *Roledesign* assigns responsibility for particular tasks to distinct job descriptions. *Staffingpractices* refer to the ways in which care activities and responsibilities are divided among nurses at the operational level based on care recipients e.g. nurse– patient ratios, *staff characteristics* e.g. experience levels, or management practices e.g. length and scheduling of shifts. *Nursingcaredeliverymodels* e.g. team, primary describe how nursing work is divided and coordinated at the work group level. *Coordination* entails mechanisms to standardize skills; *work processes* e.g. clinical pathways, or *communication methods* e.g. electronic health record.

According to International Centre for Human Resource in Nursing report 2010, Kenya has a great shortage of nurses; whereby the ratio is one (1) nurse to 1345 population compared to the ideal standard ratio of 1 nurse to 250 population with barely over a thousand nursing degree holders then in the market (International Council of Nurses, 2010). But then it was possible to say that in Kenya what we had was not a shortage of nurses but shortage of working nurses. Or rather shortage of employers that treat nurses with respect.

In response to this situation, the Kenya Ministry of Health (MOH) and Public Service Commission, supported by the Capacity Project through the US President's Emergency Plan for AIDS Relief (PEPFAR), put in place an emergency hiring plan to take advantage of these unemployed nurses, doctors, and other providers. The plan created a non-governmental outsourcing mechanism to quickly hire, orient, and deploy 830 providers in more than 200 high need, public sector health centres within one year.

These workers were hired under the same terms and conditions as those working in the MOH and public service but with an end-of-contract gratuity in lieu of a pension. This equity served to minimize drawing workers away from other sectors and facilitated their

smooth transition into MOH positions when their emergency contracts ended. The Clinton Foundation had provided funding to the Kenya MOH to recruit 1,000 additional health workers using a similar approach,

Kenya Union of Nurses (KNUN, 2013) sources put the current number of nurses in the public service at 13,000 and a further 8,000 under the Economic Stimulus Package (ESP), the union further demanded that the country of 42 million Kenyans needs 172,000 more nurses in order to improve the quality of healthcare provision in government health facilities. Fortunately, these workers are being formally transferred to the public service as full-time employees and their salaries have been included in government budgets

The nurses union had galvanized the Kenyan nurses in a way no one had anticipated. Though it started off as an outfit belonging to degree nurses and perceived junior nurses this was nolonger the case. Unlike the NNAK which apparently was patronized by the older generation, KNUN is a union with membership across the age and specialty spectrum, although the younger nurses have been the main drivers and communicate a lot albeit on social media. It was possible that with time there would be a loss of institutional memory in NNAK, perhaps it was losing its relevance.

'The debate over staff-patient ratios has raged for a number of years now – with no clear or universal consensus to emerge. It is not as easy as staffing nurses unit by unit. 'We'd bring in agency nurses only to find that we didn't need them. We'd staff up to meet a perceived need only to find that we had too many nurses for the tasks at hand. We'd send nurses home on one unit while hiring someone new on another. It didn't make sense'. These were the observations by *Run your nursing department like a business.* http://healthcare.utah.edu/nursinginnovation/2011/10ideas/one.php.

Even if you work in a public hospital the bottom line still applies and we must think about it "Everything we do is for our patients. But in order to do it, our hospital must stay viable." Even if public and not-for-profit hospitals may not subscribe to financial viability, they can make their hospital nationally known for the professional practice of nursing. Identify gaps in quality, efficiency, and patient satisfaction, and use them to drive our strategy for improvement.

The Institute for Healthcare Improvement (IHI) is also a great resource, bookmarking and registering as a user of this site is a desired add-on for every health care institution as it would help us to close the gap between what is and what could be in terms of health outcomes, offer tools to help us trouble shoot on the challenges we face on an ongoing basis. http://www.ihi.org/Pages/default.aspx IHI works with local partners and governments to build their capability to use and teach quality improvement methods from the outset, ensuring the sustainability of the methodology.

Across the board observation of literature showed that there was a clear link between staffing levels and quality outcomes. Generally, the nurse-patient ratio is 1:6. Every registered nurse is given 6 patients in the general medical wards. In acute & critical care units, emergency units, CCU's 1:1 ratio is maintained. The general policy by peri-operative grand round[6] for example recommended standard for nurse-to-patient ratio of 1:4 or 1:5 on medical-surgical units, 1:3 or 1:4 on intermediate units, and 1:2 in intensive

care units. It is difficult to imagine when this will be possible for the Kijani and Zendi County Hospitals.

According to Standards of Nursing and Practice for Nurses in Kenya (NCK, 2012), the established staff to student ratio for both classroom and clinical area should meet the following: A recommended lecturer to student ratio in class room teaching of 1:10.

Recommended ratio in the clinical placement for various settings is Intensive care/high dependency unit: 1 nurse to 2 students; General wards: 1 nurse to 4 students; Long term care, health centre and dispensary clinics: 1 nurse to 6 students; and Labour Ward: 1 nurse to 2 students. Such an ideal clinical learning environment should suffice to equip the students more appropriately with the required skills and competencies for the provision of the desired level of nursing care.

These ratios would help the nurses to provide comprehensive nursing care to the patients as much as student learning with maximum patient satisfaction. The clinical experience must adequately prepare nurses into the workforce. The student nurses cannot be included in the ratios since they are novice to the profession and may not be competent enough to provide holistic nursing care to the patients.

Qualitative interviews with lecturers and tutors identified several barriers to scaling up the production of the nursing workforce[14]. These could be described in terms of limitations in clinical capacity, tutor capacity, or physical capacity.

Tutors noted difficulty with clinical placements, as current facilities serve as clinical sites for multiple institutions and cadres of health students. Tutors identified the need for clinical mentors to oversee the student nurses. Nursing faculty for whatever reason were generally not able to accompany students during their clinical rotations yet the statutory bodies (read Nursing Council of Kenya) that regulate both nursing education and practice expect faculty shall be present for student supervision while students are assigned to clinical areas.

The faculty shall select, teach, guide, and evaluate all clinical learning experiences in the clinical facilities. Generally nursing faculty currently were understaffed. In a certain KMTC campus, the nursing faculty apparently had 700 students with 4 lecturers, one LCD projector no standby generator in case of power outages. They somehow relied on trainee BSc Nursing students on teaching practice attachment. This obviously interfered with flow of content. Additionally, tutors faced logistical challenges associated with clinical placements, including transportation and accommodation for students on away rotations.

Shortages of nurses in the public hospitals have been as a result of migration, a high rate of attrition and a long freeze on civil service employment. Public-sector hiring freeze began in 1994 resulting in a shrinking health workforce that limits the government's ability to respond to increased demand for health services. Since this freeze there has existed a large (yet undefined) population of unemployed healthcare providers, especially nurses, in the labour market in Kenya.

Despite increased levels of government health spending and the lifting of the civil service employment freeze, the total number of health workers in the public service continued to decline during the last five years (HRH 2009) as a result of high levels of attrition and in particular because of retirement related losses.

Even though the retirement age for civil service had been adjusted upward from 55 to 60 years, in February 2012 the Chief Nursing Officer Chris Rakuom hinted that 60 per cent of the estimated 22,000 *nurses* in the public sector (that was about 13,000 nurses) were just about to retire. *The public sector nursing workforce in Kenya: a county-level analysis (2012)* reported that Counties were hiring nurses who were about to retire, up to a 1/3 were 50 plus years old in 20 counties, only 4% of the nurses in the country were 30 years and below. (See **Retire at 60** below).

> **Retire at 60**
>
> In the Mental Health Unit of a Level 6, 6 out of 13 nurses retired after attaining the age of 60 since 2012, without replacement. 2 others would be leaving in the next 2 yearsld be retiring. Against an average patient population of 70, the nurses there worked 7.30 am to 6.30 pm shifts. Getting an off was a luxury since only one nurse can take an off in any given week. In yet another 'new development' by June 2018 in Rift Valley Provincial Hospital Nakuru about 60 nurses were expected to retire.
>
> 'If there was a time nurses were going to retire, it was in the next two to five years. Seemingly, of late every other nurse I met (in the public service) shared their own apprehension related to forthcoming retirement in the coming months', a year or so'. (Source: Shared covertly by a veteran nurse).

Murang'a Tana River, Kirinyaga, Kisumu and Mandera counties in that order, had the biggest number aged 60 and above. The study carried out among all the 18,625 nurses in the public sector found Meru, West Pokot, Tharaka Nthi, Narok, and Wajir, in that order, had the biggest number of younger nurses. A flurry to recruit younger nurses by other counties, the report warns, could cripple services in poorer and hardship countries (resource-limited settings), which have the biggest number of younger nurses aged 20 to 29.

The lean staff meant that patients often waited for long periods to get attention and quality of care suffers. Staff burnout has been a problem. Despite the freeze, training institutions continued to churn out graduates who now form a significant pool of unemployed Kenyans from which to recruit.

Despite a pool of unemployed (potentially available for hire) health staff available in Kenya, staffing levels at most facilities were only 50% (Adano, *HRH 2008*). The Kenya National Union of Nurses (KNUN) has said more than 3,000 nurses had fled the country for greener pastures in two years (2012-14) allegedly due to poor salaries and working conditions. Therefore then it was possible to say that in Kenya what we had was not a shortage of nurses but shortage of working nurses. Or rather shortage of employers that treat nurses with respect. Therefore then it was possible to say that in Kenya what we had was not a shortage of nurses but shortage of working nurses. Or rather shortage of employers that treat nurses with respect.

Emergency Hiring Program was designed as a fast-track hiring and deployment model in 2008 and later those hired under the Economic Stimulus Package (ESP), but many of the 8000 nurses were yet to be absorbed into the government payroll by the date of writing this. With a wage of Kshs 19,000 (USD$ 205) per month, in their own words, they felt underpaid and undervalued, were easy to lure away even though the country needed them most, a big loss to Kenya that had to train them but leap little in return. A good number disclosed and shared that they would readily walk out of the shabby ill-equipped outdated wards at home.

Onth30 March 2016, one AWW, a finalist BSN student filed a petition (No. 01 of 2016) to the National Assembly pursuant to Article 119 of the Constitution of Kenya and national assembly standing orders. Praying it to enact the direct absorption/employment of degree nurses by the Public Service Commission.

This was by proposing to introduce a comprehensive bill that incorporated all draft policies and proposals by various individuals and associations to produce one comprehensive hybrid draft for the direct absorption consideration. It appealed for expedition for absorption of a bare minimum of only fifteen degree nurses per county in every fiscal year starting with 2015/2016.

5.1.2 County and Sub-County Hospitals

Kijani is a Sub-County Hospital (formerly Level 4 hospital) in Zendi County. Operational wise it had 200 beds and 17 cots. Bed occupancy 88% -90% per month, daily admissions 40, and average Out-patient Departments attendance was 300 patients per day. On average 238-250 mothers delivered in the hospital per month, 35-40 of whom delivered via Caesarean section. The nursing levels by mid-2015 were 65 nurses for the whole hospital. Between 2013 and 2015, 12 nurses had retired, 26 transferred out, with no replacements (Source: Office of the Nursing Officer in Charge, Kijani Sub-County Hospital, 2015).

Services offered: Antiretroviral Therapy, Curative In-patient Services, Family Planning, HIV Counselling and Testing, Immunization, Eye Clinic, ENT, Psychiatry and Orthopaedics clinics. It was the teaching hospital for University of Kue School of Health Sciences about 4 Km away from the medical campus.

It also hosted Kijani Campus of the Kenya Medical Training College in its vicinity which offered Diploma in Kenya Registered Community Health Nursing and Diploma in Clinical Medicine. Diploma in Kenya Registered Community Health Nursing from Aarqu Medical Training College (fictitious name) also undertook their clinicals there. (Source: Office of the Nursing Officer in charge, Kijani District Hospital, 2013).

It had one of the best e-health information technology LAN networks in the country. Although revenue issues, rather than clinical needs, seemed to have driven the investment in IT, sort of agreeing with Bates (2002) who observed that billing systems were generally much better than the clinical systems.

Zendi County Hospital (formerly level 4 hospital) in Zendi County. Nursing levels 120 nurses to cover for both inpatient and outpatient nursing services (Source: Office of the Nursing Officer in charge, Zendi District Hospital, 2013). Operational wise its capacity included 250 Beds and 26 cots. Bed occupancy averaged 80% for medical and surgical wards while it was about 120% per month.

A number of deliveries per month ranged between 330-380 mothers, out of whom almost 150 delivered via caesarean section per month (Source: Office of the Nursing Officer in charge, Zendi District Hospital, 2013). Services offered include Antiretroviral Therapy it hosts a Comprehensive Care Center (CCC), *Amkeni nyote Intl* (not a real name) an NGO working deals with HIV/AIDS research, Curative In-patient Services, Family Planning,

HIV Counselling and Testing, Immunization among others in the region. It was the other teaching hospital for University of Kue School of Health Sciences which is 50 Km away.

5.1.3 Nurse to Patient Ratios in the Teaching Hospitals

The University of Kue (not its real name), an ISO 9001:2008 certified institution, was one of the 21 training facilities in Kenya duly recognized and approved by Nursing Council of Kenya to train in theory and in clinical practice nurses at Bachelor's level. The health sciences programs were offered at The Kijani Campus situated within a purpose built 120 beds hospital (though not yet operational). It had witnessed high enrolments since it opened its doors in August 2011 with the first batch of 40 students in BSc Nursing and 52 in Diploma Clinical Medicine. It was worth noting that according to Universities Act 2014, universities were to stop offering diploma programs from July 2017, since these courses were offered by midlevel colleges.

A population growth of about 750 students in three years. On the other hand, teachers (lecturers, Technicians and the clinical instructors/ preceptors) have had to struggle to cope with overenrolled classes. However, these were positive outcomes for Kenya whose youthful population is about 43% of the total population (KDHS, 2011). It also meant that the numbers was likely to rise as the demand for the courses offered in the health sciences campus exceeded the number of applicants. Further, there continued to be an unmet need for those seeking to upgrade from diploma to degree in nursing and clinical medicine.

Pic: Overcrowding, bed sharing, patients on the floor, 'lay care takers' were a common sight in many public health facilities in Kenya (Picture courtesy of *Prezo Nazlin Umar* post on Face book Jan 24, 2018)

When Kenyan women parliamentarians went for a fact finding tour of the Kenyatta National Hospital during the height of #KNHrot in early 2018 they were able to establish that one maternity ward meant for 19 mothers had 93 at the given time '…may be one reason why the mothers decide to take leave and get some fresh air' perhaps endangering themselves. (*KNH Rape Claims*… by Patrick Vidua *The Star* Jan 22, 2018). The whistle blowers and victims were however not coming out clearly on the details. Either way it was important to unveil the risks, threats and challenges in terms of patient safety.

Many ails of KNH could be said were a product of dumping of referrals, nonfunctioning peripheral health facilities of Nairobi and its environs which could not guarantee even basic essential obstetrics care (WHO definition), intravenous hydration for children with diarhoea and vomiting, stitching of assault cases etc. KNH was mandated to offer specialized and subspecialized care, research and teaching etc but was weighed down this other stuff (Points gleaned from G.A. Got post shared on social media 22nd Jan., 2018).

Pic: Overcrowding, bed sharing and 'lay care takers' are a common sight in many public health facilities in Kenya (Picture courtesy of NASCOP treatment consultative conference, Nov 2013)

5.2.1 Would Legislation really help?

All nurses have horror stories about when their ratio of nurse to patient got out of hand. Whether it was by flukily luck or by some other unknown design, a facility will usually get away with doing with as few nurses for as many patients as possible. How then can a system or even the law blame a nurse who was clearly overworked? Only if there was a law to that effect.

Rarely did we have in Kenyan public hospitals a matrix that informed how many nurses could be maintained on patients' raw numbers and acuity. It seemed that some institutions based theirs on whims and common sense. Stretching the nurses to as thin as possible was the norm. Often nurses being forced to take on a group of patients that were well beyond the abilities of any normal human to care for. In any case one could do their very best and still fall short due to understaffing. An average nurse is all too human not a superhero.

A nurse could get into trouble in such situations but it should be remembered that almost in all instances it's the patients who suffer due to understaffing. It became even tougher that the number of support staff who complements nurses' work usually was literally nil to bare minimum.

However, it's never as simple as 'How many nurses are needed to care for how many patients?' There are as many as 100 different factors that have to be factored in – and situations are never static. So no one formula can suit any one situation all of the time, that's why some countries have it and some don't. Some parts of the US have mandatory staff-patient ratios e.g. The State of California went ahead to legalize a mandatory nurse to patient ratios aimed at reducing job-related burnout and dissatisfaction, decrease nurse workloads and to improve overall patient safety.

Bill AB 394 of 1999 implemented in 2004, specified the minimum number of nurses that should be staffed for each hospital unit, given the current number of patients therein. "The bill itself is not about helping employees," one dialysis nurse said. "It's about workers coming together to make sure their patients are getting the quality of care they should be getting." Nurses simply did not have the time to complete their important work.
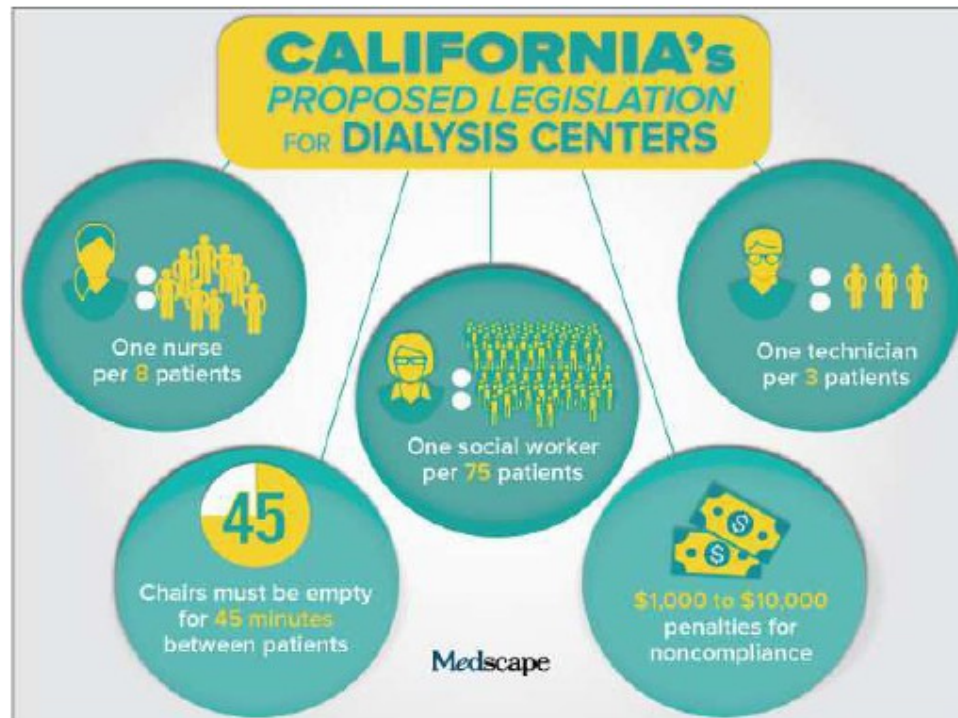
Fig: A sample of mandatory staff to patient ratios to be applied in dialysis centres in California, USA

[Courtesy of *Medscape* April 26th, 2017]

Lampert Lynda on 10th September 2013 on mightynurse.com, *Nurse Stories Series* listed 3 reasons why there was need for mandatory nurse ratios. *Protect the patient*, *protect the nurse*, *and keep facilities honest*. When someone asks, 'has the blood pressure of Mr X been taken, it was previously 180/90'. The honest answer you can give could be 'do I have a patient by that name?' What could we make of it?

Without trying to demean anyone what would be the answer to this question? Perhaps your guess is as good as mine. The best case scenario - the nurse consults the pile of files to find out about the patient, or dashes to the cubicles to call out whoever will happen to be the patient going by that name and then takes the BP pap! Why doesn't it bother the powers that be that this was one of the more common responses they had been getting for far too long? By the mere fact that there was some form of hesitation, straight way the next concern especially in acute care should be on patient's safety.

It was good to appreciate that a nurse will usually know as much as they have written down but more importantly based on their own assessment of the patient. What if they have not had a chance to settle down to countercheck all the reports they received from the outgoing shift? What if this was 4 hours or more since the nurse reported on shift?

It was not a question of how good the nurse was, remembering the particulars of tens of patients for one is not possible and it was perhaps it was not even 'safe' to pretend that one could do so. So how do the nurses manage? For the longest that this author remembers the above scenario had formed the Kenyan nurse's career life?

In any health care setting, the turnover of staff especially nursing staff can affect quality patient care due to the time is taken for the newly employed to accustom themselves to the hospital routines and policies. Turnover in health facilities had a negative impact on patient care as well as operation costs. Nationally, the US in 2014 nurse turnover stood at 20 percent, but nearly 40 percent of nurses were ready to leave their job after a single year. About 14 percent left the field altogether, and the 'working wounded' that remained were at best demoralized and at worst error-prone.

With six nurses for every physician, nursing was the heart of American health care. Nurses spend the most time with patients and are typically very dedicated. They entered their profession primarily to care for people. But nurses faced significant change and challenge in today's medical environment (Freudberg, 2015).

The nurse staffing ratio must be based on the following; the severity of illness, need for specialized equipment and technology, and the complexity of the clinical judgment needed to develop, implement, and evaluate the patient care plan, an ability of patients to provide self-care, and the licensure of the professional. Other states were not eager to emulate it and have been watching to see what happens to California, but generally different states had adopted different models, while others didn't have a model at all.

Numerous shortcomings had been noted for California such as lack of flexibility to patient acuity, skill mix and even increased nurse workload[9, 13]. Legislation is a most unlikely way to go for Zendi County any time soon[11].

5.2.2 Can student nurses be a quick fix to nursing shortage?

Nursing shortage creates demand for more nurses to be recruited, it also creates an environment that compromises on patient safety. The available nurses demand (or often get) better terms and conditions of working environment. More and more experienced nurses approach retirement age. It creates an urge for more people to want to join nursing. More nurses graduate than can be absorbed in spite of the nursing shortage. It's like a storm whichever way one looks at it. It seems to be the situation in most countries worldwide. In 2007, A La´Crosse, a health care administrator called it a "*perfect storm*" of a nursing shortage. It was also described by Talsma *et al.,* in 2008.

In Kenya, the Nursing Council of Kenya (NCK) set standards related to the education and practice of nurses. The NCK uses the Regulatory Human Resources Information System (RHRIS) to track nurses through the process of training, examination, and registration to practice nursing. As of mid-2013, the NCK had approved 83 nursing training institutions of which 53.0% were public, 32.5% faith-based and 14.5% private. Training institutions offered programs at the certificate, diploma and degree level and were located in 30 of Kenya's 47 counties.

Nurses trained at three levels, certificate (i.e. an enrolled nurse), diploma (i.e. a registered nurse) and degree (i.e. Bachelor of Science in Nursing (BScN) and off course at Masters level. From 2003-2012, 25,415 new students joined nurse training with the annual intake tripling between 2003 (1,545 new students) and 2012 (4,294). Over half of the nursing students (57.4%) got training from any of the 28 Kenya Medical Training Colleges (KMTCs), (Kenya Nursing workforce report, and the status of Nursing in Kenya-2012).

Nurse managers ought to implement staffing processes that align staff skills and competencies with prioritized patient needs supported on a shift-to-shift basis. A fair and balanced patient assignment increases nurse satisfaction in their daily work. One of the factors that can be part of the formulae can be staff preceptorship with students etc. That said, student nurses are not part of the formal staff rota in most cases. They are seconded to placements mostly in an 'observational' capacity – so cannot be included in the ratio themselves.

Implicit rationing of nursing care (whether in terms of time, the number of staff or skill mix) is the withholding of or failure to carry out all necessary nursing measures due to lack of resources especially nursing staff (Papastavrou *et al.,* 2014). They added that a permanent shortage of nurses was making rationing of care an increasingly prominent feature in health care.

Nevertheless, anecdotal evidence shows several counties and hospitals were willing to start MTCs most likely in order to deal with nursing shortages in what might be considered a 'working to learn model'. Examples were Pokot County and Nairobi Women's Hospital respectively. By mid 2017 Kenya had 64 MTCs up from 27 in 2013. Current intake of 27,000 students annually and 10,000 graduating annually.

This seemed a quick patch since apparently most diploma nursing curriculums in Kenya were approximately 30% classwork and 70% practicums e.g. a 44 months basic Diploma Kenya Registered Community Health Nursing (KRCHN) program consisting of 140 weeks clinicals and 36weeks classwork. Most critically student nurses did not get any stipend commensurate to the work they did. Most hospitals instead charged the students an attachment/affiliation fee.

It was increasingly becoming necessary for students to have a personal accident insurance or other insurance (including NHIF) before being allowed to undertake attachment, internship, field visits in various facilities. Some insurance companies like Corporate Insurance Company Ltd (CIC) offered students a 3 month's spell cover for as low as Ksh 350 (approximately US$3.2) premium, details available: www.https//:cic.co.ke.

The students were exposed to long stretches of clinical placements perhaps more than were beneficial to their learning with little or no supervision from faculty who appeared to have abdicated their responsibilities. The school sort of simply hand over the list of students to the hospital to do with/to them what it saw best; which included compulsory day and night duties, balancing the staffing ratios etc.

Most of these students were in their late teens and early twenties; they did not get as much of a chance to be students but were treated as if they 'were nurses already?' At least that was what their counterparts, the BSc Nursing students thought of them. BSc nursing students seemed to enjoy more freedom from being exploited by hospitals since they were more in class. A balance between the two extremes might need to be worked out concerning nursing curriculum and its implementation. The shift would be moving from educating nurses using a hospital and content-based curricula, transforming to

competence-based curricula, provide and equip technology-rich computer and simulation laboratories and support the development of learning materials.

A good question was to ask them whether they felt that learning was taking place, the answer had usually been an astounding - No! They were working. A tutor responded that we needed to appreciate that theory background does not need to be sufficient but adequate to function. A number of these rotations e.g. 8 weeks for mental health and 12 weeks in paediatrics among others did not have an immediate assessment component (or had none at all). These left the students with little motivation to learn but to hang around 'working'. One tutor commented on the issue as follows:

> '... they looked so lost, no clear objective as to why they are there,... after all, they know they will not be assessed, imagine a student on mental health rotation might be assigned gate key for 5 days! Maternity rotation alone was 36 weeks and 28 weeks community health?'

> 'Class work was always such a crush program, one wondered why the hurry? Where to? A lot of student's time seemed to be wasted in the wards.'

No wonder some of these hospitals had been known to suffer serious shortages of manpower in the months of August and Christmas season when most academic years ended or students took a break. A certain mission hospital was known to retain its graduating class from its training school for up to 6 months in what could be some form of 'internship' to offer free services. In yet another one the practice was hiring paying volunteer nurses in exchange of training experience (or rather the intern paid the hospital to do internship). While this was common practice among other careers it was catching up with nursing too.

The *XY* student's progress forms did not seem to meet their intended purpose any more. Some of these yellow forms (filled or blank except the student's name) could be found lying around somewhere in the ward drawers long after the students cleared the rotation or even graduated.

Far from being a trainee, student nurses were expected to be extremely responsible, with a litany of expectations from the staff which was mainly tedious and repetitive. Sometimes staff forgets that students are a willing but disorganized pair of hands. "You are expected to do a lot of work and are fully accountable for what happens on the wards.

If there was a huge problem, you might call your supervisor, but otherwise, you're there to work as a full member of staff" just as one student nurse was quoted in *thejournal.ie*, care should be taken while allotting patients to the nursing students for their learning experience by keeping the patient safety in mind. It would be presumptuous to expect a student to share or have an attitude of being ready to work as the staff. The priority of nursing care can better be analyzed by registered nurses than student nurses. Injuries to the patients can be avoided by close supervision of student nurses by their instructors who are assigned for clinical supervision.

A panel of student nurses' perceived intolerance and intimidating behaviours by some qualified staff who must be avoided (Porter O'Grady & Malloch, 2015). This report had analyzed various findings noting that there was a need for nurses to care for each other just as they did for their patients. Unfortunately, it has been said that 'nurses eat their young' and indeed in nursing the nurses (staff nurses and nurse managers) and not non-nurse co-workers have the greatest impact on nurses' stress. In this regard, nurses could

be are their own worst enemies and consequently, the solution to many of their problems may lie within nursing rather than outside it.

The hospitals should provide an environment where students are recognized as learners, while the students are expected to articulate their learning objectives to the staff nurses, but at the same time must be willing to be engaged and connect with patient care activities [14]

On the other hand before an RN delegates a nursing task the following criteria must be met: adequate training for the task, demonstrated learning of the task, safe performance of the task in the nursing situation, the patient's status is safe for the person (student nurse) to perform the task, appropriate supervision is available during the task implementation, and the task is in accordance with the published policy and procedure of the facility.

These were difficult to fulfil in resource-limited settings with some hospitals desperately resorting to using students to cover staff shortages. One veteran nurse observed *it was like maturing a teenage girl into a woman and a mother at the same time.*

The opposite could also be true. Some staff felt students were a bother. The nurse would have preferred that the student sat in one corner and not bother her. If there was any learning going to take place then the student could just watch.

By early November 2017 one particular KMTC had a total of 350 nursing students, comprising 7 different cohorts. This institution's teaching hospital had at some point 47 nursing students in a ward so small, one staff described it as 10 by 5 metres area-wise. When one considers that there were students from other disciplines, the congestion was unbearable for the patient and staff.

Pic: Meeting the expectations of all those seeking health care services in many public health facilities can a big challenge to an overwhelmed health care provider (Picture courtesy of Caroline Ryan)

This author happens to be a product of both the BSc Nursing and the Diploma Nursing programs and that in some way might inform some of the sentiments above. Should governance be an issue in terms of curriculum making and implementation? Stakeholders ought to make their inputs, especially alumni of the programs unlike what one cartoon satirically *when we need your opinion we will give it to you.*

5.3   Patient care at the operational level/point of service amidst nursing shortages

Balancing the acuity of the assignment evens the workload and reduces the risk of something being missed or medication errors of the nurse with a high acuity assignment. A study[3] was able to link nurse staffing, burnout, and health care-associated infections.

Nurses were at the forefront in preventing hospital-acquired infections (HAI), as these costs were not reimbursed by insurance (e.g. Medicare in the US) and were costly to a hospital. The moment a patient sets foot in a hospital, he becomes a guest whose experience will be based mainly on the good intentions of the caregiver (the host). It should then be natural that this caregiver gets properly compensated.

In their introduction, they thought that reducing burnout in registered nurses was a promising strategy to help control infections in acute care facilities since nurse staffing in the form of nurse-patient ratios and hours of nursing care per patient-day had been implicated in the spread of infection. A fatigued employed at the risk of burnout was not an engaged employee. Elizabeth Scala ably utilizes tagline "Nursing From Within" to write a blog elizabethscala.com about burnout.

RNs working in hospitals with the highest patient-to-nurse ratio are twice as likely to be dissatisfied with their position and experience job-related burnout as those working in hospitals with the lowest patient-to-nurse ratio[16]. By increasing RN staffing levels and thereby lowering the patient-to-nurse ratio, hospitals could reduce turnover rates by decreasing the job dissatisfaction and burnout that may lead to resignation.

Everyone remembers some burn out sometime? Imagine now how that could lead to more infections in your unit. Care at the bedside calls for a certain level of team relational communication as exemplified by bedside report as was shared an item on 'Teamwork' by a nurse friend in this author's network (see **Teamwork** below).

Teamwork

When we implemented bedside report, we did implement a checklist of "must haves" that included introductions to the patient, safety checks (double-checking medications, wristbands, etc.), and meeting the patient's immediate needs, and letting them know that the new RN would come back within a certain time frame. Additionally, if the family were in the room, they were invited to be part of identification/introductions. We found that the process of implementing bedside report (like many other things) is only truly effective if it is done consistently. Meaning that explanations about what the patient was going to see/hear/do during this time were consistent from shift to shift and regardless of who the nurse was. That is why the checklist became so important in our unit. Physician and nurse relationships must exude teamwork, understanding, and solidarity.

The results indeed found that there was a relationship between nurse staffing and patient infections acquired during hospital stays as follows: looking at it in a little detail, overall; 16 patients per 1,000 acquired some type of infection while hospitalized [3]. The most common infections were urinary tract infections (8.6 per 1,000) and surgical site infections (4.2 per 1,000), followed by gastrointestinal infections (2.5 per 1,000) and pneumonia (2.1 per 1,000).

It clearly indicated that differences in nurse workloads across hospitals were associated with the rate of patient infections. That increasing a nurse's workload by 1(one) patient

was associated with increases in both urinary tract and surgical site infections.According to a Southampton University (UK) study on 31 NHS Trusts reported in *The Telegraph* on 23rd August 2017, every extra patient on nurse's caseload increased death risks by 7%. Further, a 10% increase was associated with a 16% likelihood of death following common surgical procedures.

The study found that there were far higher death risks in understaffed hospitals Lack of caretaking time was found to be the 'missing link' that somehow determined the rates in different hospitals. Shortage of staff meant that crucial tasks - administering medications, detecting patients who were deteriorating went undone. 'Missed nursing care', or 'important care' that should have been delivered but was not, was widespread. The norm was 8 patients per nurse but it often went as high as 18. In a way the patient paid the highest price (life) when authorities economized on nurses or employed less qualified/less experienced ones.

The reader might agree that there are tensions involved in nurse staffing ratios and patient safety especially since RN staffing census has usually been low many times. Whenever RN ratios were adhered to, patients received safe, quality care. There was little doubt this was so when the patients were asked. Studies[6] had demonstrated that increases in the number of RNs caring for patients resulted in fewer complications, lower morbidity, fewer medication errors, and lower costs.

Duffield[5] did a great piece on nursing staffing, nursing workload, the work environment and patient outcomes as a 5(five) year longitudinal study. In their introduction, they observed that nursing staffing (fewer RNs), increased workload and unstable nursing unit environment were linked to negative patient outcomes' including falls and medication errors in medical surgical units.

A healthy work environment is one in which there is not only absence of harmful conditions but an abundance of health promoting condition (derived from WHO 1986 definition of Health). How do we to ensure a healthy work environment? Continuous assessment of risks to health; Appropriate provision of information and training on health issues; Availability of health promoting organizational support practices.

For the nurse a positive work environment might include: Work autonomy and clarity of roles and responsibilities; Sufficient resources; Recognition of work and achievement; Manageable workload and effective workload management; Supportive management and peer structures; Effective management of occupational health and safety risks including a safe and clean workplace; Effective employee representation and communication; Maternity/paternity leave; Enforced equal opportunity policy; Sustainable employment (security of tenure); Personal security.

Evidence on the positive effects of higher proportions of RNs on patient outcomes in CCU and surgery was strong and consistent[1]. Higher RN staffing was associated with less: hospital mortality, failure to rescue, cardiac arrest, hospital-acquired pneumonia, and fewer adverse events. Conversely, lower levels of RN staffing were associated with higher rates of urinary tract infections, pneumonia, shock, cardiac arrest, upper GI bleeding, failure to rescue and increased length of stay (ALOS).

Time dedicated to actual nursing care is astonishingly becoming less. One study measured sources of nursing inefficiency in the medical-surgical setting[7], and revealed that the majority of nursing practice time was accounted for by documentation (35%), medication administration (17%), and care coordination (21%), with only 19% of nursing

hours, on average, being consumed by actual patient care[2]. This being the case then the statement below might make us see the seriousness of the situation.

One result of increased workload[7] was that basic nursing interventions e.g. comforting, skin care, oral hygiene, documentation, teaching of families were left undone or delayed in the case of answering call bells, vital signs, pain medications, dressings, turning, measuring/documenting intake and output mobilization and dressings. Imagine core nursing undone [7].

There is, therefore, need to eliminate those tasks that do not add value to unit operations or care outcomes. They should not interfere with the delivery of high-quality nursing care. You might want to list some of them.

If we relate these comments to our situation, it is a sad fact that a nurse, even a compleat, outstanding nurse can only do one thing at a time. Clinical work is naturally chaotic, the nurse moves from task to task focusing on what is important, when a more important problem surfaces, she stops what she was doing to deal with it. When she's not running off to help someone else she is trying to "fit one more thing" into an already hectic routine? These results in perturbation; amount of time completion of a task is postponed.

It was ok to tell/ even write to the seniors that you are having a bad time. It's important that they should come to terms with the fact that the situation won't improve by just working harder. But then, how do we expect that the patients too will understand this to adapt? Would it be such a pipe dream to imagine a time when the patient can see what we are going through and vouch for us right there? That they do see that we were doing our best in the circumstances and that something needs to be done.

Even the best of effort is only a singular contribution to the journey for the greater good that we refer to as quality health care. For example, if six patients in a 42-bed Nyayo ward all press their bells at once and there was only one nurse on night duty as is sometimes the case for our teaching hospitals, five may not be answered.

"If a patient hits the call bell and no one is at the nurse's station, did it really make a sound?" - Unknown, RN

On 25th February 2015, DB posted on KNUN wall (see **All alone** below).

All alone

Day 4 of my night duty.... Feel so fatigued whereas hv got 3 more days to go... Am all alone in ward of 50+ patients… Am supposed to give Rx, document, order drugs, if an admission comes niachanishe trolley ya dawa so that I receive the patient, give nursing care... etc... Asubuhi I take all the obs, cardex n tally thm all... feel lyk quitting ths job. (Interpretation from Sheng- Swahili- English colloquial, Rx is for treatment or the task of doing a medications round). 'This is the fourth night I am on duty, already I feel so fatigued though 3 more nights to go. I am all alone in the ward which has over 50 patients. I am supposed to give treatment, order drugs, document etc. If a new admission gets here I have to stop what I was doing to attend to it. In the morning I do all the observations, write the cardex and enter them, I feel like quitting this job'.

When nursing demand/supply levels exceeded 80%, the number of negative outcomes increases not only for the patients but for nurses and hospitals[10]. Nurse overtime working hours were positively associated with increased negative outcomes not only for the

 patients but for nurses and hospitals. Mandatory overtime and night shift in a predominantly female profession raises significant issues, such as the difficulty of meeting both professional and family responsibilities. When the patient- nurse ratio exceeded 7:1 worse things can happen [16].

There was a direct relationship between nurse staffing and patient well-being. Nurses serve as an around-the-clock surveillance system in hospitals for early detection and prompt intervention when patients' conditions deteriorate. Substantial decreases in mortality rates (especially for patients who develop complications) could result from increasing RN staffing.

The results of the study implied that had Pennsylvania instituted a state-wide nurse-to-patient ratio of 1:4, possibly 4,000 of the 232,342 patients studied may have died within 30 days of being admitted; had it been 1:8, more than 5,000 may have died. A more recent study done in South Africa[4] concluded that it was by improving the practice environment, including patient to nurse ratios that held promise for retaining a qualified and committed nurse workforce that may benefit patients in terms of better quality care.

A study [12] comparing China and Europe found that substantial percentages of nurses described their work environment and the quality of care on their unit as poor or fair (61% and 29%, respectively) and graded their hospital low on patient safety (36%). These outcomes tended to be somewhat poorer in China than in Europe, though fewer nurses in China gave their hospitals poor safety grades. How would our teaching hospitals fare in this one?

Nursing is important in quality and safety of hospital care and in patients' perceptions of their care. Improving quality of hospital work environments and expanding the number of baccalaureate-prepared nurses held promise for improving hospital outcomes in China[12]. Degree nurses are barely 1000 in Kenyan hospitals but we want to believe that they would make that difference.

From the perspective of nursing education: if a nurse has too heavy an assignment he/she cannot effectively mentor a student[14]. Having a student to guide with an overly heavy workload creates additional stress and distraction to the nurse and may increase risks such as those mentioned above.

In 1996 and 1997, the Ministry of Health oversaw the direct absorption into public service of the pioneer groups of degree nurses. Currently, the public sector has a total number of 22,000 nurses overall against a population of approximately 43,000,000 Kenyans. But since 1999, successive regimes hardly advertise for these positions thus foregoing the potential benefits that come along with this cadre of professionals in the healthcare system.

Degree nurses are prized for their skills in critical thinking, leadership, case management, and health promotion, and for their ability to practice across a variety of inpatient and outpatient settings. Many organizations worldwide recognize the unique value that a degree prepared nurses bring to the practice setting. Ann Kutney Lee and colleagues (2013) was one of the many such studies which had come up with findings that showed how patients, employers, and the profession benefitted when nurses advanced their education.

5.4   It is a battle worth fighting

Nurses worldwide are fighting to create better health care settings and coping with a loss of stability and an increased workload. Nurses are well placed to advocate for quality professional practice environments in today's health care system [9].

Considering patient acuity can more accurately determine the workload. Six low acuity patients are much easier to manage and creates less work stress for the nurse than 6 (six) total care patients. A consensus statement on safe staffing levels by the Nursing Standard's Care Campaign[9] ran a captivating 'Eight patients per nurse is unsafe'. The alliance argued that if a nurse on a general medical or surgical ward were to be asked to care for more than eight patients on day duty, this should be reported as a clinical incident.

The alliance presented the case to ministers for safe minimum levels of nurses on hospital wards, backed by evidence-based methods. Nursing leadership is facing a great challenge in advocacy on this issue. Luckily, in the US they managed to recruit others into their course e.g. Institute of Medicine[8] and advocacy groups in the political class.

This approach will become important as we explore outcomes sensitive to nursing practice as relates to workload and scope of practice [15]. A political connection with someone who gets along with their peers is an advisor that can grease the wheels for you if you have issues during the course of your proposing and petitioning the national or county assembly.

'Creating a safe and effective environment for your patients can begin at the bedside but opening new pathways to improving patient care is advanced through advocacy', observed Kaitlyn Gregory *DNP* (2017). Calling on the nurses to rise to the occasion to lead change, give forward experience by highlighting the important role nurses play in advancing health care. Writing in today's version of *Nursing Notes* hosted by Johnsons & Johnsons (available: *www.DiscoverNursing.com*). Dr. Kaitlyn a clinical nurse specialist in Philadelphia US received an award for *Giving Excellence Meaning* (GEM) in 2016.

Advocacy and activism seem something nurses can do here in Kenya. For instance to draw attention to one of the biggest challenges facing the nursing profession today: unsafe nurse staffing. In advocacy it would be good to appreciate the not all issues have the same weight – *'some arguments you have to hold with a belt and a suspender, because one is no adequate on its own'* as Kenya's Senior Counsel Ahmednassir Abdulahi used to say.

The timing was ripe since health services have now been devolved (albeit with a lot of aggrieved parties involved) to county level with the 2010 constitution dispensation. We can access Zendi County Governor, Senator and Chief Officers of health with ease to lobby their support for nurse-to-patient ratios in hospitals, nursing homes, and the facilities that nurses worked in on a day-to-day basis. Much of the formal training even at Masters level in health-related programs apparently contained insufficient emphasis on policy-related competencies.

4.5   The gap and steps we can take

It is fascinating that this information might appear repetitive, but it helps to tell a story, but that story is only as good as the interventions we can take to make improvements. Unsafe staffing is an issue that affects everyone at some point. When there are not enough nurses to take care of the patients, it was unsafe for both patients and nurses. Mistakes are made, patients have more complications, and more patients die.

Nurses suffered more workplace injuries and feel harassed in the workplace. They become burned out and may exit the profession prematurely. The gap that needed to be addressed was that much of the data accessed was derived from USA, Europe, China and Taiwan and only a few from Africa. It was therefore important to look critically at which of those factors could apply to our situation.

Staffing patterns in these countries and ours may be different but I believe the number of patients assigned and how they are assigned and to whom they are assigned transcend geographic boundaries. It does also affect the students learning in the practical areas (wards, laboratories, and clinics etc.) since staff who are over-stretched are less likely to give much attention to teaching. In the hospital setting the nursing preceptors or mentors are vital for orienting students and new nursing staff. Ideals and values may not get much of a chance.

The nursing students will most likely have to improvise procedures and cover for the shortage of manpower at the expense of learning. This was the reality that even our students had been brought up in - that healthcare organizations need to work using less to achieve more. Appreciating that there was what was known and what was done in practice or some know-do gap. More often than not the ideal remained more of simulation/theoretical than a reality in practice. This was not the same as working smart.

We need to understand how to use this data towards evidence-based practice, by developing an intuitive grasp of situations and quick targeting of problem areas since nursing staffing shortages in Kenyan public hospitals is not likely to end any time soon[11]. Organizations need to recognize that working nights is a necessary evil and they need to make sure there are incentives in place that make people want to work the night shift and compensate for people's changes in their lives and for their families.

From this research brief, it is clear that there was adequate research on the subject. Based on these, we can generate more information to gradually implement a plan to change our work environment. Beginning with advocacy, making a case for ourselves, but we need to articulate these issues based on our data. Developing a factual base for your opinions ensures an informed dialogue with others, supports your views with hard data or factual evidence to increase your credibility.

The great thing was that medical related courses still hold the premise of being market driven ventures and continued to attract many school leavers. Pubic as well as private hospitals have been getting accreditation as medical training colleges training institutions for nurses, midwives and laboratory technicians. Through affiliations to universities their graduates could transition vertically to degree level. What remained it seemed was absorbing them, increasing the staff student ratios.

5.6   Begging Questions

Utilizing Quality Health Care Organizing Framework for Resource-Constrained health care settings in Kenya the following might need to be looked at critically:

(1) How can we make our work environment safe for our patients, students and for ourselves?

(2) Lay care providers (including relatives 'caretakers') whether they do assist with care or usurping, complementing or substituting nurses work, cover shortages; sort of lowering the cost of providing services by shifting tasks from health care providers to less specialized community members.

(3) The congestion in the wards, patients sharing beds overcrowding and what it means for staff; when can a nurse in a public hospital ever say the ward has a maximum number of patients and can admit no more?

(4) At what point can we say that a hospital can no longer absorb more students?

(5) How can we make the nursing curriculum more user-friendly to the two most important clients- the student and the patient?

There were a lot of staffing issues in research that could be applied in the two teaching hospitals and nurses might be interested in a staff-understandable review of what has been researched. Nurse managers ought to implement staffing processes that align staff skills and competencies with prioritized patient needs supported on a shift-to-shift basis. A fair and balanced patient assignment increases nurse satisfaction in their daily work.

Undergraduate BSc Nursing students would benefit more from optimum nurse to student to patient ratios. Interventions seeking to optimize the ratios of nurse to patients should be comprehensive, as increases in nursing students recruitment will only be feasible if the limitations in clinical placements, faculty capacity, and physical infrastructure were simultaneously addressed.

While addressing a group of nursing students on an education tour of the western region of Kenya during the height of one of the protracted industrial action in 2017 by medical staff. A county health official observed, *'hata nyinyi mtakuja tuta-strike na nyinyi,* when you will come out you will find out why, because health is not a priority to them especially the county government'. Paraphrased from colloquial Swahili- English (Sheng): when you students will have graduated to join the service, strikes will continue since as it is health sector was apparently less of a priority in as far as county authorities were concerned.

May be the reason why a nursing faculty was heard to often say to the students, 'this is theory we have just finished, pray it to your God that you will meet it somewhere else'. But then at the end of the day, we are also consumers of the products (graduates) that we produce and release into the health system. It was becoming increasingly common that in some fields (possibly including nursing) graduates needed to be retrained in order to become employable. Others needed some 'panel beating and spray painting' one employer quipped.

If we could help to form knowledgeable and well-rounded nurses of tomorrow. If we could find the compleat nurse who has a profound piece of mind, willing to teach and describe his/her thought process on how one gets to certain conclusions, we could be sure that our future nurses are in great hands. It's those amazing people that help make the world go-round!

No conventional work could be accessed with the phrase *compleat nurse*. However, some seminal work made mention of a compleat nurse. The earliest that this author found in part was *Aristotle's Compleat and Experienc'd Midwife* by W-S-, MD. alias William Salmon (1644-1713). In one quote he wrote. '...And yet if you don't meet with one altogether answering this description, he may be a good *Nurse* for all that; but the nearer to this, the better. But this is not at all...'

5.6.1 Any hope then?

According to 20^{10} IOM Future of Nursing Report "Strong leadership is required to realize the vision of a transformed health care system…"The nursing profession must produce leaders...from the bedside to the boardroom."— By increasing the number of nurses on hospital/health system, policy, and organization boards. Nurse leaders can provide a valuable perspective that balances the business needs of health care with clinical and patient outcomes.

Their role in decision-making can also have a direct impact on the quality and safety of care. One source that appealed to me was from the University of Utah Hospital that was entitled *Run your nursing department like a business* Improve efficiency—and quality— with smaller, more flexible units. Available: http://healthcare.utah.edu/ nursinginnovation/2011/10ideas/one.php:

This was what they said: We put our entire nursing department on a centralized staffing grid and made hospital-wide staffing decisions based on our census status to ensure an ideal nurse-to-patient ratio. With this one change, we were able to optimize our staffing 24 hours a day.

To further improve efficiency and staffing, we designed each of our new units with three smaller pods and three separate nursing stations. Now, if our census is low, we can simply shut down a pod—so we don't have to staff up on a unit that's not fully loaded. Our pods also allow us to co-locate patients based on their clinical needs, so we can assign specialized nurses to very specific areas.

What's more, the smaller pods keep nurses in closer proximity to their patients and create a quieter and less chaotic environment. "It's a great way to give more personalized care," "And it's incredibly cost effective." With centralized, global staffing and smaller, flexible nursing pods on each unit, University of Utah Hospital had a healthier financial outlook than ever before, taking care of 11% more patients with 4% less labour - a reduction in nursing labour costs of $100(Kshs 8,600) per patient day.

IOM Roundtable Report (2007) recommend that one of the means to ending nursing shortage could be if workflow was predicated on the principles of evidence.

This was the strategy they applied. *Improvement is a science*: They had developed each of their creative nursing ideas with a structured, systematic approach. Here's how they did it:

D   Analyze the data. Listen to staff concerns, examine financial performance data, and pinpoint any gaps in quality or patient safety.

D   Develop a pilot. Try out the new idea on one unit and measure results.

D   Expand the program. Bring the idea to other units after a pattern of success has been established with the pilot.

5.7 Detailed Search Strategy

An integrative review of literature to identify a maximum number of eligible articles from databases with key terminologies, networking and searching journal registries.

5.7.1 Limiters

-Years 2003 to 2013 (2 exemptions of 2001 from Institute of Medicine-IOM booklet and Hagedorn model on politics in care, 1995).
-English Language

5.7.2 Expanders: Applied related words

After using "Workload", "Quality of Health Care+", "Nurse-Patient Ratio", and "Patient Outcomes" as keywords, reports were initially excluded if workload was discussed in terms of integrating a new policy in the workplace or if patient care was not addressed. I was able to use CINAHL and PubMed databases primarily (as seen in the table below) and then expanded my search using "Find it" and recommendations from others in my workforce.

I also looked at endnotes of articles for further links, especially at the abstracts. I believe other data bases might have expanded this view and will be looking into them in future. By focusing the review, potentially relevant sources identified were reduced from 3982 to less than 20 reports. So far I have 15 as presented in annotated bibliography below. Further readings are also provided in Appendix below.

One author Aiken, L[4, 12] did more than two collaborative articles on the topic. Therefore based upon my search there does not seem to be many authors concentrating on this topic. Position statements from various professional bodies cited the works of authors now and then.

What was fascinating was that they seemed to be saying one and the same thing i.e. information might appear repetitive from the reports. This was a notable weakness on my search namely; no new issues coming up. Authors from far-east Asia also seemed to be making some impact in this area of workforce (interesting I had some difficulty citing their names). I did get two articles from Africa (one report from Kenya) which was rather disappointing. It would be interesting if we were to relate this environmental factor of nursing shortage to congestion in the wards; patients sharing beds; the role of lay care providers.

5.8   Annotated Bibliography

1. American Association of Critical-Care Nurses 2005, Web Site www.aacn.org

AACN is an authoritative professional body for nurses working in intensive care units in the US. They assert that negative, demoralizing and unsafe conditions in workplaces could not be allowed to continue. The creation of healthy work environments was imperative to ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial viability.

2. Birmingham, S. (2010). Evidence-based staffing, the next step. *Nurse Leader*. Mosby Inc.

This article by Birmingham, S. (2010) stated that there was strong evidence of the impact of nurse staffing on patient safety and quality. That there was the right nurse who may be assigned to right patient(s) for an equitable distribution of care hours and fairness in workload. That fair and balanced patient assignment increased nurse satisfaction in their daily work.

3. Cimioti, J. (2012). Nurse staffing, burnout, and health care-associated infection. *American Journal of Infection Control*. Elsevier: 40. 486-90

This study [3] was able to link nurse staffing, burnout, and health care-associated infection. In their introduction, they thought that reducing burnout in registered nurses was a promising strategy to help control infections in acute care facilities since nurse staffing in the form of nurse-patient ratios and hours of nursing care per patient-day had been implicated in the spread of infection.

For purposes of this review, it was notable in the Cimioti study that differences in nurse workloads across hospitals were associated with the rate of patient infections. That increasing a nurse's workload by 1 patient was associated with increases in both urinary tract and surgical site infections.

4. Cotzee, S., Klopper, H., Ellis, S., Aiken, L. (2013). A Tale of two systems-nurses practice environment, wellbeing, perceived quality of care and patient safety in private and public hospitals in South Africa: a questionnaire survey. *International Journal Nursing Studies*. 50(2):162-73.

Closer home this study[4] done in South Africa concluded that it was by improving the practice environment, including patient to nurse ratios that held promise for retaining a qualified and committed nurse workforce and may benefit patients in terms of better quality care.

5. Duffield, C, (2011). Nursing staffing, nursing workload, the work environment and patient outcomes. *Applied Nursing Research*.Elsevier. 24, 244-255.

This was a great piece on nursing staffing, nursing workload, the work environment and patient outcomes as a 5-year longitudinal study. In their introduction, they had observed that nursing staffing (fewer RNs), increased workload and unstable nursing unit

environment were linked to negative patient outcomes including falls and medication errors in medical surgical units.

6. Girard, N. (2013). Perioperative grand round, nurse staffing ratios. *AORN Journal. 97* (5): 604.

Girard outlined the general policy by peri-operative grand round; nurse staffing ratios. The recommended WHO standard for nurse-to-patient ratio of 1:4 or 1:5 on medical-surgical units, 1:3 or 1:4 on intermediate units, and 1:2 in intensive care units. Girard alluded that there were tensions involved in nurse staffing ratios and patient safety especially since RN staffing census was found to be low many times. When RN ratios were adhered to, patients received safe, quality care. Studies had demonstrated that increases in the number of RNs caring for patients resulted in fewer complications, lower morbidity, fewer medication errors, and lower costs.

7. Hendrich, A., Chow, M., Skierczynski, B., Lu, Z. (2008). 36-hospital time and motion study: How do medical-surgical nurses spend their time? *Permanente Journal.12* (3):25-34.

Hendrich measured sources of nursing inefficiency in the medical-surgical setting and revealed that the majority of nursing practice time was accounted for by documentation (35%) medication administration (17%), and care coordination (21%), with only 19% of nursing hours, on average, being consumed by actual patient care.

8. Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press. (2001). Available at: [http://www.nap.edu/books/0309072808/html/]

A key statement by the Institute of Medicine, 'Health care is not just another service industry. Its fundamental nature is characterized by people taking care of other people in times of need and stress. Stable, trusting relationships between a patient and the people providing care can be critical to healing or managing an illness'.

9. Kay, J. (2013). 'Eight patients per nurse is unsafe'. *Nursing Standard. 27*(37): 18 RCN Publishing Company.

I found Kay's a sound resource since it was a more recent, current double peer reviewed article containing a consensus statement on safe staffing levels by the Nursing Standard's Care Campaign. It ran a captivating 'Eight patients per nurse is unsafe'. The alliance presented the case to ministers for safe minimum levels of nurses on hospital wards, backed by evidence-based methods.

10. Li-Fang, L., Sheuan, L. (2012). Exploring the association between nurse workload and nurse-sensitive patient safety outcome indicators. *Journal of Nursing Research. 20* (4): 300-309.

The results from Taiwan concluded that nurse workforce and nurse-sensitive patient outcome indicators are positively correlated[10]. Nurse overtime working hours were positively associated with the following nurse-sensitive patient safety outcome indicators: patient falls, decubitus/pressure ulcers, near errors in medication, medication errors, unplanned extubation, hospital- acquired pneumonia, and hospital-acquired urinary tract

infections; risks of patient falls, decubitus/pressure ulcers, unplanned extubation, hospital-acquired pneumonia, and hospital-acquired urinary tract infections significantly increased when the patient- nurse ratio exceeded 7:1.

World Bank Group: Service Delivery Indicator Survey (SDI) July 2013. This survey released recently on frontline health care providers in Kenya underscored the reality about shortage of nurses in Kenya.

11. You, L., Aiken, L. (2013). Hospital nursing, care quality, and patient satisfaction: cross-sectional surveys of nurses and patients in hospitals in China and Europe. *International Journal of Nursing Studies*. 50(2): 154-161.

You and colleagues found that substantial percentages of nurses described their work environment and the quality of care on their unit as poor or fair (61% and 29%, respectively) and graded their hospital low on patient safety (36%). These outcomes tended to be somewhat poorer in China than in Europe, though fewer nurses in China gave their hospitals poor safety grades. Improving quality of hospital work environments and expanding the number of baccalaureate-prepared nurses hold promise for improving hospital outcomes in China.

12. Pamela, T. (2011). Mandatory nurse: patient ratios. *MedSurg Nursing*. 20(5):265-68.

This writer was giving the scenario on how the state of California went about instituting the mandatory nurse to patient ratio. There were several misgivings on the effectiveness of such a move.

13. Kenya's Health Workforce Training Capacity: A Situation Analysis. (2010). UNFPA.

To address the shortage of health care workers, Kenya has employed various strategies including emergency hiring program and online upgrading courses. Due to the shortage of nurses, staff nurses have limited time to teach student nurses. Retrieved; www.unfpa.org/sowmy/resources/docs/library/R200_KenyaHealthWorkForce_2010_Hea lthWorkforceTrainingCap

14. Hagedorn, S. (1995). The politics of caring: The role of activism in primary care. *Advances in Nursing Science*, 17(4), 1-11

Activism in primary caring promotes exposing, provoking, and unbalancing the social power that maintains people in a state of disease, while simultaneously nurturing caring. Activism provides the knowledge and means of redressing the social inequalities that maintain an environment of disease. Florence Nightingale wrote, "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle" (Notes on Hospitals).

15. Aiken, L., Clarke, S., Douglas, S., Julie, S., Silber, J. (2002). Fact Sheet 2003–
1. The Aiken Study: Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*, Vol. 288, No. 16, October 23–30

Clear Link Between Staffing Levels and Patient Success. The study found that for each additional patient over four in a nurse's workload, the risk of death increases by seven percent for surgical patients. Patients in hospitals with the highest patient-to-nurse ratio (eight patients per nurse) have a 31% greater risk of dying than those in hospitals with four patients per nurse. On a national scale, staffing differences of this magnitude may result in as many as 20,000 unnecessary deaths each year.

5.9 A Policy Brief: THE NURSING SITUATION IN KENYA: PATIENTS DESERVE BETTER CARE

According to International Council of Nurses (ICN, 2012), nurses were excellent at giving care and at solving immediate problems, often with few resources. They interacted with consumers of health care in a wide variety of settings. This gave nurses a broad understanding of health needs of how factors in the environment might affect the health situation for clients, families, and community.

They are conversant with how people might respond to different strategies and services. Yet, nursing had difficulty getting this message out to policy-makers. ICN proposed that national nurses' associations were best positioned to influence policy by bridging the bedside to boardroom divide. One way to do this is to develop policy briefings policy issues, lobby for more nursing input into health care decision-making.

Using EBP they can develop policy briefings that can make a case, present the key messages and identify the needed support. The following policy brief was written by this author and posted to (1) The Cabinet Secretary, Ministry of Health Kenya (2) The Chairman, Council of Governors Kenya

THE NURSING SITUATION IN KENYA: PATIENTS DESERVE BETTER CARE

A Policy Brief to (1) The Cabinet Secretary, Ministry of Health Kenya &

(2) The Chairman, Council of Governors Kenya

Introduction

Substantial decreases in mortality rates (especially for patients who develop complications) could result from increasing nursing staff. While increasing a nurse's workload by 1(one) patient was associated with increases in urinary tract & surgical site infections, patients' fall and failure to rescue[61].

-Kenya had the ratio of one (1)nurse to 1345 population (International Council of Nurses, 2010).

- World Health Organization recommends averageof 22.8 nurses per 10,000 people for optimal delivery of services

Implication

A consensus statement on safe staffing levels by the Nursing Standard's Care Campaign[2] stated *'Eight patients per nurse is unsafe'*. The alliance

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[61] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press. (2001

argued that if a nurse on a general medical or surgical ward were to be asked to care for more than eight patients, this should be reported as a clinical incident[2]. If six patients in a 42-bed Nyayo ward all needed help at once and there was only one nurse on (night) duty as is often the case in many public hospitals, five may not be answered. A health care-related mistake becomes more likely, while a just-in-time intervention is unlikely. High quality and accessible health services cannot be delivered without sufficient numbers of well-skilled, well-distributed and well-managed health workers (Human Resource for Health Kenya, 2009-2012).

One result of increased workload [62] was that basic nursing interventions e.g. comforting, skin care, oral hygiene, documentation, teaching of families were left undone or delayed in the case of answering call bells, vital signs, pain medications, dressings, turning, measuring, documenting intake and output, mobilization and dressings. Only 19% of nursing hours, on average were consumed by actual patient care[2].

A nurse at work in a general ward: Picture courtesy of WHO

Recommendations

Nursing ratios should be adhered to ensure safe, quality care. 172,000 more nurses needed from 21,000 (Kenya National Union of Nurses, 2013). By 2016, there were 45,018 nurses, midwives in Kenya a ratio of 13.8 nurses per 10,000 patients (WHO recommended 44.5 per 10,000) [Source, MOH, WHO]. Unless the nursing situation was addressed as a matter of urgency there is going to be a challenge in succession planning i.e. passing on the baton to the next generation:

*Require Kenyan hospitals to develop and implement minimum standards for nurse: patient ratios that take into account patient acuity,

[62] Kay, J. (2013). 'Eight patients per nurse is unsafe'. *Nursing Standard*. 27(37): 18 RCN Publishing Company

*Different counties should consider ordinances to ensure nursing staff norms at absolute levels, below which it's possible to raise the red flag,

 *Implement incentives to increase the nurse workforce in Kenya, including scholarships, tax incentives, etc.

*Implement incentives to retain and motivational mechanism the existing nursing workforce in Kenya, including paid internship and residency programs for all new graduates,

 *Funding the establishment of new nursing schools in Kenya,

*Both national and county governments must create an enabling environment to every Kenyan to access acceptable, high-quality healthcare.

Detailed Search Strategies

The table below was may not necessarily be part of the briefs but meant to add value to the reader's understanding on how part of the literature review was accessed.

-the research brief has been amplified in this chapter, therefore not a brief any more, while the policy brief above has remained as it was except for the photograph *A nurse at work in a general ward.*

Pic: Student nurses and staff sharing in a continuous professional development (CPD) session
(Courtesy of Community Eye Health Update)

Detailed search strategies that was used in research brief & annotated bibliography

CINAHL	(MH "Workload")OR (MH "Quality of Health Care+") AND	
	(MH "Nurse-Patient Ratio") OR (MH "Patient Outcomes")	
HINARI PubMed	This strategy is limited to "developing countries." I got o 13 citations and utilized one from South Africa. ("Developing Countries"[Mesh] OR "Africa"[Mesh] OR "Asia, Central"[Mesh] OR "Asia, Southeastern"[Mesh] OR "Asia, Western"[Mesh] OR "Developing Countries" OR "Africa" OR "Kenya" OR "East Africa" OR "South Afric OR "Tanzania" OR "Asia" OR "Central America" OR "South America")	
	AND	
	(("quality of health care" or "patient safety" or "burnout"))	
	OR "Quality of Health Care"[Mesh] OR "Patient Safety"[Mesh	

KEY: (MH) medical heading; [Mesh] medical sub-heading

Filters: Journals, English, year, author

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CHAPTER 6

Utilizing Theory and Evidence to Deliver Care II:

Applying Margaret Newman's Theory of Health as Expanding Consciousness *to Psychosocial Nursing Care of HIV-Infected Patients in Kenya*

Chapter co-authors: Simon Macharia Kamau, Rose Jelagat Rotich, David Juma Mwembe

Overview

Margaret Newman's Theory of Health as Expanding Consciousness is considered a grand nursing theory, she described a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world. Newman's theory proposed that: Health is not lack of illness, or a process to become healthy from being ill, but it instead of the expansion of consciousness as a result of choices made within the context of patterns of behaviour.

Nurses in Kenya have mostly used the psychosocial-medical model to nursing HIV-infected patients which fail to answer many of the nursing concerns and reduces their autonomy in carrying out nursing care. Indeed the pride of the nursing as a profession is anchored on its regulatory tools and the ability for self determination.

Methodology: This mini-review was an evolving emergent design. Slightly adapted *Advanced Theory in Nursing* coursework materials were used. The greatest resource was referrals to links and hints as offered by those who got interested in the study. A best case scenario is appended. Conclusion: Newman's Theory of Health as Expanding Consciousness is, therefore, a generic tool applicable to guide psychosocial nursing care of clients infected with HIV. It would be a great resource with a potential to evidence-based nursing care. It would provide a basis for several case studies. Nurses find more fulfilment in their work by utilizing a nursing theory.

6.2. Background

Anecdotal evidence shows that nurses involved in the care of HIV-infected patients in Kenya have mostly used the psychosocial-medical model whose primary focus is on the diagnosis and treatment of symptoms and disease. This fails to answer many of the nursing concerns and reduces their autonomy in carrying out nursing care.

For example, many HIV-infected persons have high levels of depressive symptomatology, as well as suicidal ideation and hopelessness being increasingly reported, usually upon knowing their seropositive status or precipitated by the progression of the illness [1]. How would the nurse best handle these concerns? A Theory (or a combination of theories) might come as a handy relief

6.3 Why Theory

Everyday practice enriches theory and vice versa as both practice and theory are guided by values and beliefs. Theory helps to reframe our thinking about nursing and guides use of ideas and techniques. Theory can close the gap between theory and research and envision potentialities. "The study and use of nursing theory in nursing practice must have roots in the everyday practice of nurses" [2]. It guides nursing practice and generates knowledge, it helps to describe or explain nursing, it enables nurses to know WHY they are doing WHAT they are doing [3] and enhance evidence-based nursing. Another example might be why health-supporting activities inside the hospital can be carried on outside the hospital [4].

What evidence, best practices (including theories) are there that would support this? "Practicing nurses who despise theory are condemned to performing a series of tasks - either at the command of a physician or in response to routines and policies", an observation made by Leah Curtin, a former editor of *Nursing Management* [5]. Newman, on the other hand, showed the necessity of linking practice with theory by saying, "We have to embrace a new vision of health. Our caring must be linked with a concept of health that encompasses and goes beyond disease". The theory of health as an expanding consciousness provides this link.

As we introduce this theory it's good to recognize that Patient-as-person involves an appreciation for the patient's self-perception and expression of an illness and the recognition that the patient's illness is a unique experience, one that is influenced by the patient's attitudes, knowledge, and current personal or social context [6]. Two patients can have varied responses to the same illness or chronic condition due to their personality, different life experiences, and circumstances. These are some of the reasons why nurses need to use a nursing theory in patient care.

According to Polit referred to in [7], 'Theory is the ultimate aim of science: It transcends the specifics of a particular time, place, and group and aims to identify regularities in the relationships…' A statement by *College of Nursing of University of Colorado Denver*, Guidelines for Evaluating Published Research Reports (NURS 6031) Themes or Rules-Of-Thumb, item number 11 states that: 'Other things being equal, research related to theories is more important than non-theoretical research'.

6.4. Theory of Health as Expanding Consciousness

Margaret Newman's Theory of Health as Expanding Consciousness (HEC) posits that "every person in every situation, no matter how disordered and hopeless it may seem,is part of the universal process of expanding consciousness – a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world" [8].

Newman wanted to move from the reductionist model of 'health is the absence of disease', and develop a model that would articulate the essence of nursing practice. Health within illness dichotomy may not be a readily accepted concept. This theory considers illness as an opportunity for awareness and growth. 1t also shifts the focus of health care from fighting the enemy of illness to learning about oneself through the illness experience.

The concept of consciousness as defined by Newman is the informational capacity of the system (in this case, the human being); that is, the ability of the system to interact with the environment. Consciousness includes not only the cognitive and affective awareness that is normally associated with consciousness but also the interconnectedness of the entire living system that includes physiochemical maintenance and growth processes as well as the immune system [8].

6.5. Assumptions

Newman held the view that *Health as an Expansion of Consciousness* (HEC) is based on five assumptions [9]:

1. Health encompasses conditions previously viewed as pathology,

2. "Pathology" can be a manifestation of the total pattern,

3. Pathology may exist as a manifestation of a pattern that exists prior to the manifestation of physical or structural changes (manifesting as pathology),

4. Removal of the pathology does not change the pathology, and

5. "Illness" maybe be the only way an individual's pattern can manifest, and as such that is health for that individual we

We wanted to add a sixth assumption that, 'The tension in illness can allow patterns of expanding consciousness to emerge'.

6.6 Concepts

Some of the concepts of this theory are; 'The theory of health as expanding consciousness (HEC) was stimulated by concern for those for whom health as the absence of disease or disability is not possible'. Nurses often relate to such people: people facing the uncertainty, debilitation, loss and eventual death associated with chronic illnesses.

The theory has progressed to include the health of all persons regardless of the presence or absence of disease --asserts that every person   in   every   situation,   no matter how disordered and hopeless it may seem, is part of the universal process of expanding consciousness – a process of becoming more of oneself, of finding greater meaning in life, and of reaching new dimensions of connectedness with other people and the world [10].

6.7 Propositions

The theory proposed that: Health is not lack of illness or a process to become healthy from being ill, but it instead is the expansion of consciousness as a result of choices made within the context of patterns of behaviour. Although this theory can be abstract and challenging to grasp, one of the main strengths of this model is that it addresses the patient and their choices, experiences, and state of health (and unhealthy) as a whole [11].

6.8 Application to Practice

Kenya has been battling with HIV/AIDS since it was recorded in 1984, HIV infection has spread very rapidly in the country and the magnitude and impact of HIV/AIDS is a major public health and development challenge. It was estimated that more than 1.5 million Kenyans were infected with HIV about 400,000 undiagnosed and that over 1.5 million Kenyans had died of AIDS and AIDS-related with some regions recording as high as 14% of their population as having the virus [12]. Estimates show that the undiagnosed figures could be higher.

A diagnosis of HIVAIDS can be devastating to persons and their families as they face a multitude of physical, emotional, spiritual and social stresses from the effects of treatment, changes in lifestyle, disruption of home and family roles, and fears of stigma. People infected with HIV are challenged by changes in their endurance and strength, reproductive capacity, sexuality, and self-image, as well as their own mortality. It is often asserted that AIDS is at the core of a "vicious circle", whereby the impacts of AIDS increase poverty and social deprivation, while poverty and social deprivation increase vulnerability to HIV infection. This is especially true for resource-constrained settings like Kenya.

For the newly diagnosed HIV-positive client just as Newman referenced in [13] they learn that "each day is precious and that the time of one's life is contained in the present." The adverse effects of stigma were all-encompassing in terms of feeling of health and wholeness. There was need to know that simply having a disease does not make a person unhealthy.

One of the persons living with HIVAIDS put it this way, 'we need to be free from stigma because that is all that kills'. One could experience health and wholeness in the midst of having a chronic and progressive disease, before and even after CD4+ T cells levels prognostic indicators signify need to initiate ARTs and opportunistic infections (OI's) medications.

We tended to relate this with Martha Rogers (Newman stated that *Roger's theory of Unitary Human Beings* was the main basis of the development of her theory) who had said earlier that health and illness may not be two separate realities, but rather as a unitary process. Rogers' Science of Unitary Human Beings puts the key thesis of the model as The individual is a unified whole in constant interaction with the environment; nursing helps individuals achieve maximum well-being within their potential… in that people can experience health even when they are physically or mentally ill.

Nursing must find ways to care creatively for patients. Holistically to encompass the whole person, not just a body part or system.   We need to emphasize this at every opportunity and during their appointments to the *Comprehensive Care Centres* (CCC). Indeed health is not the opposite of illness, but rather health and illness are both manifestations of a greater whole.

One can be very healthy in the midst of a terminal illness as long as they maintain a healthy mind-set,   positive self-image,   eat well,   involved in social support,   avoid

reinfection and adhere to treatment among others. We have a saying here in Kenya that, 'One is either infected or affected by HIV'.

It was to be assumed that at least every Kenyan knew someone who has it. In some regions of this country, people know entire households that have been wiped by the virus. Not long ago it was not possible for people to own up in public disclosures about their seropositive status.

We now have people living with HIV (PLWHA) for over 27 years and are apparently healthy. Discordant couples were still a big dilemma for us even as we endeavor to move towards elimination of mother to child transmission of HIV (*e*MTCT).in sub-Saharan Africa by December 2015[14].

Beyond Zero worked hand in hand with other organizations as the National Organization of Peer Educators (NOPE). NOPE worked by using rapid response initiatives whereby they link the newly diagnosed HIV-positive persons to the nearest health facility for management. NOPE targets 90.90.90 i.e. they had to test 90% of the population; link 90% new cases to the health facility and 90% were expected to have a low viral load within 3 months of treatment.

An important realization by Newman was that (orientation to - emphasis *ours*) time, movement, and space was in some way interrelated as parameters of health. Every remaining faculty must be appreciated especially during the times of diminishing health or terminal stages.

Some people have realized new strengths unknown to them before the diagnosis with terminal illnesses; one Asumpta Wagura had achieved exponential feats [15]. Her motto goes like 'Do not take life for granted. Celebrate it'. She has been a beacon of hope for people living with HIV/AIDS (PLWHA). She was the Executive Director of *Kenya network of women with AIDS* (KENWA). Many people look forward to Asumpta's *Diary* in Wednesday's edition of The *Daily Nation*, One of Kenya's leading national newspaper.

Time is a treasure for the HIV-infected persons, they can make a choice on how best to use it to gain maximum returns in terms of their future and that of their children by making realistic goals based on the life expectancy. Increased insight into the meaning of their experience and the meaning of health can be realized when the client and the carer(s) connect in their new roles in health during counselling and social support.

The theory applies to the nursing today because of the increasing emphasis on continued care outside of the hospital. Whereas health-supporting activities inside the hospital can be carried on outside the hospital, a lot of social support and empowerment is needed. *Home-based care* has been shown to reduce the workload of the health care providers and lowers the economic burden of rural/local health care centers to care for HIV/AIDS patients [4]. But home-based care as taught in nursing curriculum is a new concept in Kenya although it had always been practiced in the African traditional cultures.

The patient needs to be psychologically prepared for the recovery at home and to accept this as part of his/her medical/nursing history now. Helping them understand that this is not temporary but will be the norm will help them get the available resources they need to

function. While home nursing does not seem readily appealing to the nurses in Kenya, it would in a big way '…bring out the significant caring manner witnessed by the power of nursing presence in the patient's usual surroundings' as was proposed by Newman.

The patient needs to acknowledge the issue before anything can be done about it. Acknowledging and accepting it will lead to this new wonderful consciousness (expanding consciousness) where help can enter the patient's life. In this new consciousness, the nurse needs to involve the patient in the nursing care plan. Define what their goals are, whether they are new or still the same goals, and how to get there.

Newman talked about making deliberative observations about patients and reflecting what she observed back to the patient. This specific attention stimulates patients to respond by talking about what was meaningful in their unique circumstances and their subtle needs. From our experience(s) and as seen in the case study below, HIV-infected persons really appreciate this: they wish to connect with self, interpersonal and the community in a holistic sense to achieve a greater sense of health. The point is; if you can get a patient to identify their goals and then give them tools to achieve those goals, that patient can continue to help him/herself and transcend" their current state, adds Newman.

The meaning of the new seropositive status and illness will need to be understood within the context of the patient's entire life, not just his/her physical state (whether ill or just HIV positive). This way a path towards health becomes apparent to the patient. The eventuality (about full blown AIDS) can be postponed but it will catch up with time.

The patient will be prepared in advance on what to expect as CD4+ T cells counts start going down significantly and AIDS sets in '… and if becoming "ill" is the only way a person's pattern can be manifested, then be it! That is health for the person' adds Newman. This process of focusing on meaning in patients' lives to understand where the current health predicament fits in the whole of people's lives has endured as central to the Theory of Health as Expanding Consciousness.

We felt that the following Newman's quote, though a paradox in light of public health, holds some truth; "[t]he responsibility of the nurse is not to make people well, or to prevent their getting sick, but to assist people to recognize the power that is within them to move to higher levels of consciousness" [12].

There is an increasing interest in personal transformation during illness. Case studies from clinical practice illustrate the potential contribution of 'shared consciousness' or..... For Newman, a disease is a meaningful reflection of the whole and health is 'expanding consciousness' in assisting people to use the power within them. The two (illness and health) are thus seen as a continuum.

6.8.1 Case Study Mrs Y.

Utilizing   Margaret Newman's theory through   a case of a family experience of HIV/AIDS in Kenya "This is a case of Mrs Y, a 32-year-old female, a resident of the Kericho County in South Rift region of Kenya. She is a housewife and the husband is a small scale farmer. She has married a mother to eight (8) children; four boys and four girls, all alive.

She tested HIV positive in 2002 but the husband was HIV negative to date. She started using antiretroviral (ARV) drugs eight years ago when her CD4's were 250. The family had been enrolled with Walter *Reed Project* (WRP is an NGO Supporting HIV/AIDS patients- through, counselling, testing, medication and food supplements for free. The project is a partner with PEPFAR (Presidential Emergency Plan for AIDS Relief).

The rest of the children were negative apart from the last born who was seven months old and now sickly. All the 8 children were born in a hospital, 4 after they knew their status.

Mrs Y has been in and out of the hospital since 2006 with complaints of chest congestion, oedema, difficulty in breathing and fatigue. Most notably her health has been down with every subsequent pregnancy. On the other hand, Mr.Y has been undergoing a series of regular laboratory tests but remained HIV Negative. The couple verbalized appreciating their support for one another despite their status view life positively for the sake of their children who are unaware of the health status of either of their parents.

Furthermore, the health care team have been helping them especially when they are admitted. The nurse at the Comprehensive Care Centre utilized the components of Margaret Newman's theory of Health as Expanding Consciousness to assist Mrs Y in pattern recognition so she may understand new possibilities for action; that in illness, there is room for health. Expanding consciousness around her illness helped her see that within the confines of her disease, she could enjoy aspects of health. Illness was not something that "happened to her", but was a part of her life's pattern.

Nurses have had a wider role since they are the patient every other time which enabled them to win the couples' trust and confidence leading to a therapeutic nurse-patient- relationship over the years. Weekly visits by a home-care nurse includes- assessments of her weight, blood pressure, Vitamin B12 injections and reviewing medication adherence.

The home-care nurse also identified the potential for increased interaction with others and an increase in consciousness by triggering the understanding of new possibilities for action. To recognize past patterns of relating and how present circumstances have changed those patterns.

Something interesting the couple once said was '…the best medication for the patient with human immunodeficiency virus/acquired immune deficiency syndrome is acceptance of the status'. They added nutrition and adherence to antiretroviral medication regimens as very important.

They recognized psychosocial support as a means of coping among those with HIV/AIDS, Mrs Y. belongs to a peer group, she says '…it has proved to be thoroughly effective'. Here they emphasize on *get tested, start treatment early and have annual viral load tests apart from living positively*. Previously she had also felt that she did not want to 'feel like a burden' to anyone. However she adds that most of her long-time friends have since passed away, she says these were mainly those with the very little social exchange.

Mrs Y represented over 2.2 million people Kenya living with HIV/AIDS (PLWHA). Kenya's population was 40 million people by 2009 census. An early

step for the discordant couple in HIV preventive counselling on behavioural risk assessment was done to the couple as high-risk individuals.

Her health had taken a nosedive in the last few months. She had become debilitated and sick with side effects from ART therapy. She was unable to work, play with her children or keep up the chores around their home. Were it not for the help they got from the Walter *Reeds Program* all their financial resources were but exhausted, they were running low on all including groceries.

She said she was able to face her death with pride and dignity. She felt that she had continued to live and enjoy her children as much as possible. She had provided real hope and encouragement to others experiencing an HIV/AIDS diagnosis. She made the following comment close to her death, "I may be dying of AIDS, but I feel healthier than I have ever felt".

5.9 The Future

There were various writings on Margaret Newman's Theory of Health as Expanding Consciousness [10, 13, 17] posits that humans cannot be divided into parts, but are inextricably whole beings. Health was central to the theory "and is seen as a process of developing awareness of self and the environment". That "Consciousness is a manifestation of an evolving pattern of person-environment interaction" and that consciousness is an on-going process. This author felt that sometimes manifestation of a problem could be mistaken for the problem itself, therefore one needed to be careful.

The author also felt that the theory of Health as Expanding Consciousness (HEC) helps direct nursing in supporting patients of today and if integrated with current social media technologies like Web 2.0, will be one that will prove useful well into the future. For example, a social platform like "Patients Like Me" [16] was designed to help patients encourage others beginning the journey, find support with others who were dealing with similar conditions.

Taking *Health as Expanding Consciousness* literally these technologies really can support patients in "finding greater meaning in life and of reaching new dimensions of connectedness with other people and the world". Nursing can help patients navigate to such resources that will support them through their health experiences. Theories like Dr. Newman's will offer direction on how to find consistency in supporting patients in an ever changing landscape of knowledge and care.

6.10. Conclusion

Margaret Newman's Theory; expanding consciousness is a process wherein an individual becomes more of his/her real self, as he/she finds greater meaning in his/her life and the lives of those people around him/her. Self-awareness may eventually lead to acceptance of one's self and one's circumstances and limitations. Newman's theory of pattern recognition provides the basis for the process of nurse-client interaction. She suggested that the task in intervention is a pattern recognition accomplished by the health professional becoming aware of the pattern of the other person by becoming in touch with their own pattern.

Humans cannot be divided into parts, but are inextricably whole beings. Health is central to the theory "and is seen as a process of developing awareness of self and the environment" (Newman, 2010). Consciousness is a manifestation of an evolving pattern

of person-environment interaction" (Newman, 2013).This consciousness is an on-going process.

Therefore, we submit that Margaret Newman's Theory of Health as Expanding Consciousness (HEC) is a generic tool that would be applicable to psychosocial nursing care of clients with HIV in Kenya and elsewhere. It is, therefore, a great resource. Several case studies based on this model would be possible. Nurses would find more fulfilment in their work by utilizing a nursing theory. Hopefully, readers will be directed to seek further information, some of which are contained in the links below in order to fully appreciate the utility value of this approach to nursing care. A home page referred in [17] would be a great place to refer.

Nurse Managers in charge of nursing units (including CCC's) are encouraged to consider adopting on a minimum one relevant nursing theory/model [18, 19] as a step towards evidence-based practice. On a minimum, it is not hard to think of an experience where the theory could have been applied. More importantly how accessible (even in terms of understanding) HEC is to you? How can it benefit your practice?

Acknowledgment

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Chapter 7

Utilizing Theory and Evidence to Deliver Care III

Applying Florence Nightingale's Model of Nursing and the Environment *on Multiple Drug Resistant Tuberculosis Infected Patients in the Kenyan Setting*

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Fig: 'The Lady with the lamp' (Courtesy of clip developer)

7.0 Overview

Nursing has a long and valued history of using evidence to impact practice, beginning with the earliest pioneer, Florence Nightingale (Nightingale, 1859). Nurses in many resource-limited settings have mostly used the medical model which failed to answer many of their concerns in managing tuberculosis-infected patients.

Florence Nightingale's Model of Nursing and the Environment states that nurses manipulate and mediate the environment to put the patient in the best condition for nature to act upon. Nursing theory and models have been recognized as key components to evidence-based practice today. Every nursing unit in developed countries employs at least one. Kenyan nurses need to realize this and embrace this principle.

This chapter begins by expounding a commonly known, but not always well-understood model by the founder of modern nursing, Florence Nightingale. Methodology: The current study was a review and it applied Florence Nightingale's Model of Nursing and the Environment on drug-resistant tuberculosis-infected patients in Kenyan. The format of this review was completed by using the authors' adapted "Advanced Theory in Nursing" coursework materials.

Secondary sources and seminal works by the theorist were also scrutinized. A case scenario was embedded that was somehow typical to maximize what could be learned about this theory. Conclusion: Nightingale's model is a generic tool applicable to guide nursing care of clients infected with multiple/extremely drug resistant Tb with potential to improve nursing care and provide a basis for case studies.

7.1. Why Theory

Due to the changing and challenging nature of nursing, various theories and philosophies have been advanced to guide nursing practice, education, and research. It has been said that everyday practice enriches theory and vice versa as both practice and nursing theories

are guided by values and beliefs [1]. Theory helps to reframe our thinking about nursing and guides use of ideas and techniques. Theory can close the gap between practice and research and envision potentialities. While proposing her idea of practice theory, [1] provided the following concise description of a substantive theory:

"It is a theory that says; given this nursing goal (producing some desired change or effect in the patient's condition); these are the actions the nurse must take to meet the goal (produce the change)".

According to Heartland National Tuberculosis Center [2], nurses who happen to be new to Tuberculosis control and prevention face multiple challenges including a) learning the basics of tuberculosis infection and disease diagnosis and treatment and b) gaining problem-solving skills essential to Tb case management.

The general practice nurse is the first line of defense in Tb control worldwide, and this important role needs to be recognized and strengthened [3]; one way would be through nursing theory-guided practice. "Practicing nurses who despise theory are condemned to performing a series of tasks—either at the command of a physician or in response to routines and policies", Leah Curtin, a former editor of Nursing Management made this observation [4]).

It was evident from literature [4] [5] that there was a gap between nursing theories for practice as taught in the classroom and actual nursing practice. Many nurses especially in resource-limited settings like Kenya had little or no knowledge of nursing theories as a basis for practice and did not knowingly apply nursing theories to practice. The literature further suggested that some of the theories as taught were inappropriate for practice in the African context [5].

According to Owino [5], there was apparently no evidence of published studies on practice outcomes of Nursing theory utilization in Kenya then, and this seemed to hold true four years later today according to us (the authors of this article). These were observations by Owino et al., a Kenyan nurse who developed a grounded theory Owino's Theory: Nurse-Client Interaction for Childbirth Preparedness Analysis and Evaluation; just referred to as Owino's Theory [5].

7.2. The Theorist

Florence Nightingale (1820-1910) was bestowed with several honours: OM [(order of Merit (commonwealth)], RRC (Royal Red Cross), Honorary Freedom of the City of London. She came to prominence for her pioneering nursing work during the Crimean War where she tended to the wounded British soldiers. An Anglican herself, she believed that she was called to be a nurse. Though living in the 19th century she was endowed with premodern feelings and modern ideas, which remain quite relevant today.

She laid the foundation of modern nursing [6] [7]. Her work has influenced many other disciplines including mathematics, writing, public health, medical tourism, heath care legislation/ reforms, medicine, hospital architecture and the church.

She is one of the most celebrated, written about character through biographies (there are more than 300 Nightingale biographies and 16 volumes of her writings), art, theatre,

poetry, and museum [7]. Queen Victoria wished aloud that she had Nightingale in her cabinet. Nursing schools, babies, buildings, and streets were named after her [8].

7.2. Introduction to the Model of Nursing and the Environment

7.2.1 Analysis:

o Nightingale's concept model is overlapping with discrete concepts. o

Model is still applicable to practice today.

o Model is simple and easy to understand.

o The model requires the nurse to use knowledge in addition to "artistic"

oAllows intuition and personal caring to aid in patient health.
viewpoints.

Nightingale emphasized that the person had a key role in his/her own health and that health was a function of the interaction between person, nurse, and environment. The major assumption was that nurses concern was with the person in the environment and the person interacting. The laws of health as defined by Nightingale were those to do with keeping the person and the population healthy. She indicated that proper use of fresh air, light, warmth, cleanliness, quiet had the least expense in terms of vital power.

She believed in a "healthy house" in order to prevent illness and promote wellness. Two of the elements to a healthy house that were emphasized in her theory were fresh air and sunlight. *The health of houses*, as she prescribed, were the administration of each or all of these: ventilation of patients' rooms and the larger environment, light, cleanliness, punctuality, eating of food and interpersonal milieu.

The patient's capacity for self-healing was facilitated by the nurses' ability to create an environment conducive to health. Nurses, on the other hand, manipulate and mediate the environment to put the patient in the best condition for nature to act upon, concerning this she said, *"what nursing has to do… is to put the patient in the best condition for nature to act upon him"* [9]. Nurses must also be protected while they care for others [3].

5 essential elements to a "healthy house": clean air; clean water; proficient drainage; cleanliness; light.

7.2.2 Assumptions:

o Nurses should be educated and trained in the field and care of patients.

o Nurses should focus on environment and how to manipulate it to put patients in the best possible state to achieve health and healing.

o The environment is essential to the health of the patient.

o Nursing and medicine are separate.

o Nursing is a science and an art.

7.2.3 Strengths:

o Nightingale's Model of Nursing and the Environment is easily adaptable, as well as applicable, to all patient care settings.

o Model and theory's meaning and purpose are easily understood.

o Nightingale's writings are easy to read and understand regardless of the difference in time period and changes in terminology over the

years. **7.2.4 Limitations:**

o Nightingale's environmental theory does not directly discuss the effects of the environment on patients' psychological health.

o The theory is limited but it is still effective.

7.2.5 Controversies:

Among some of her beliefs, here are a few that we found interesting and though we felt some would not be a reality in today's healthcare:

1) Noise—she stated patients should never be waked intentionally or accidentally during the first part of sleep.

Counterargument: Today on night shift patients are woken up multiple times per night for vital signs, medications, labs etc. Patients are lucky to get two to three-hour stretches of sleep during the night.

2) Variety—she believed in varying colours from flowers to plants and even rotating paintings on a regular basis.

Counterargument: Hospital rooms are neutral colours and are lucky if they have a painting or a working wall clock on them. If there are flowers (or a card for that matter) in the room, they are from family, not provided by the hospital. There is actually very little "variety" in the hospital.

3) Nutrition and Food—she vowed that no business be done with patients while they are eating because that is a distraction.

Counterargument: In most cases, patients are on "hospital time" when they are in the hospital and we distract them often as they eat.

4) Her philosophy about nursing as a calling. Treating a patient was priceless. However, she may not have meant "calling" in a religious sense but having a kind

of feeling for one's work—an inner sense of what is right, which she termed "enthusiasm," from the Greek ethos, having a god within.

Counterargument1: some people do not agree that nursing is a calling with; fewer wanting to play some of the roles she modelled for women-the obedient wife, caring sister, modest daughter and her feminist ideals (emphasis ours). B.N. posted on *Enlightening Nurses* on social media on 15th September 2017, 'Love for your work should not blind you not to see what you deserve … Even a calling deserves logistics…' This was during the nurses' strike in Kenya which lasted over three months. Some nurses felt that it was therefore wishful thinking to assume it was a calling. It was more realistic to appreciate that nursing was a calling, a career or a mixer of both.

Counterargument2: If you would not do something without being paid, you should not do it just because you are paid. You should likely do nursing because it is your passion and by exploring it, help others. Any other reason, it will come off as inauthentic and you risk damaging your therapeutic nurse-relationships or employer employee relationship among others. In other words to me (this author) this would be an easy way to screen out misfits in any profession early enough.

Counterargument 3: Brittney & Kati (2017) described making money through blogging, that some nurses struggle with the guilt about making money writing about nursing. In the following quote I have replaced the word *content, blogging* with *care and nursing*. 'Many people are idealists and believe that nurses should provide free high-quality *care* out of the kindness and desires of their hearts. Financial gain from their *care* is an absurd thought to them.

It would be wonderful if we could all feed our families and pay our mortgages with kindness and good intent, but the world simply doesn't work that way, doing *nursing* out of the kindness of our hearts is impractical in the short run and damaging in the long run'. Adding, 'We all enjoy being nurses and taking care of patients, but it is a career; it is not a hobby. No one expects you to work a shift for free. We should be compensated appropriately for not only our time, but our expertise as well. Do not sell yourself short … realize that your expertise is valuable and needs to be considered well'.

Continuing Brttiney & Kati's line of argument, they observed that *there were so many talented online influencers that were either making no money, or barely enough to enable them to continue providing value*. Same with nursing care providers.

5) She was against a standardized nursing licensing exam and felt that an individual should be evaluated on their character and morals.

Counterargument: This would be rather odd today, no nurse can practice without first passing a board exam and get state or national body license. Continuing Professional Development (CPDs) for nurses in Kenya is a pre-requisite for renewal of the practicing certificate every 3 years. This is in recognition of the fact that knowledge and skills depreciate over time, and that new technology and public health issues are dynamic

7.2.5 Symbolism of *The Lady With The Lamp:*

The lamp is an international nurse symbol that is widely known to symbolize Florence Nightingale and her transforming work in the nursing profession. Her lamp became synonymous with goodwill, reliability, and compassion, which are all attributes that are highly desirable in the field of nursing today. During many pinning ceremonies, new nurses often hold up lamps and recite a nursing pledge, which is another nurse symbol that is associated with Florence Nightingale.

The pledge, which is adopted from the physician's Hippocratic Oath, is based Florence's ideologies and promises to be compassionate, uphold a certain code of ethics, and keep patient's information confidential. nerdy nurse *Nurse Symbols: The Origin and the History* Published: July 25, 2017.

Counterargument: Some people assumed that the head cap gear worn by nurses was synonymous with (or rather replaced) the lamp in the later days. A good number of nurses nolonger adorned the cap and pin or else did not allign themselves with much of the nurses' symbolism. The nurses' pledge, candle lighting and pinning are still administered today to nurse graduands though it be not with the same sentimental value. But Nigntingale left us much more than symbolism:

Fig: Florence Nightingale left symbolism in nursing
[Courtesy of the clip developer]

Nurse philosophers and theorists like Nightingale, Hildegard Peplau, Virginia Hendersen, Dorothy Johnson, among others left us this inspiration: Not to be satisfied with the way things are. We should strive to pioneer a new path that improves health care for both the patients and the nurses - Brittney Wilson, RN - The Nerdy Nurse blog *http://thenerdynurse.com accessed on 24th May 2018.*

7.3 Nursing and the Environment:

Adapted from [6] [10] focuses on the patient while manipulating the environment. Nursing and the environment referred to several things: the "health of houses"; prevention of illness; promotion of health; observation of sick; "healthy house"; attention to nutrition; attention to patients and their needs.

7.3.1 Concepts

o Ventilation and warming (clean air)—Should be the first and last thing that nursing should fix. Air that the patient breathes should be pure, fresh and warm.

o Clean water—water should be sanitary. Sewers should be kept separate from drinking water, and water should be purified to prevent illness

o Drainage—pipes and sewers should drain effectively. In Nightingale's time, this was a real issue.

o Cleanliness—Open windows, clean dust, dispose of waste properly, clean linens, carpets, and floors.

o Light—dark houses are unhealthy and poorly circulated. Sun and light were essential for proper healing of patients.

o Nursing aids in the ability of a person to maintain health and to heal, by managing the environment.

o Frequent observation and individualization per patient were necessary.

o Nursing encompasses observation and management; the environment encompasses ventilation and warming, and the health of houses.

o Nurses are to manipulate the environment and manage health. This directly affects all the concepts in Nightingales model.

7.4. Tuberculosis

Tuberculosis is a serious communicable disease. Tb control was challenged by the HIV epidemic, it had shown improvements, and with key indicators such as Case Notification, Case Detection, and Treatment Successes all showing improvement before HIV came into the scene. HIV and Tb formed a lethal combination with each speeding the other's progress. From then on tuberculosis was ranked second only to HIV/AIDS among the infectious agents with highest mortality rates worldwide, 8.6 million people fell ill with Tb and 1.3 million died from it. Over 95% of these deaths occurred in resource-constrained countries. Tb remains the leading killer of people living with HIV [11] [12].

7.4.1 Drug-Resistant Tuberculosis

The emergence of drug-resistant Tb since 2005, particularly among males, has been a key challenge. Extremely drug resistant tuberculosis (XDR-Tb) is a form of tuberculosis caused by a strain of Mycobacterium tuberculosis a gram positive bacterium that is resistant to isoniazid and rifampicin as well as any Fluoroquinolone and any of the

second-line injectable anti-Tb drugs. When new strains prove too clever for the two most powerful first-line drugs isoniazid (INH) and rifampicin (RIF), multiple resistant tuberculosis (MDR) emerges, these drugs that were once effective become worthless against this strain of tuberculosis.

Drug Resistant-Tb is confirmed through laboratory tests that show that the infecting isolates of Mycobacterium tuberculosis grow in vitro in the presence of one or more anti-tuberculous drugs. Two different categories of drug resistance have been established: Mono resistance is resistance to only one anti-Tb medication while Poly-resistance involves two/more drugs other than the combination of Isoniazid/Rifampcin (INH/RIF).

Access to quality second line drugs as well as laboratory capacity for second-line drug susceptibility testing presents a formidable challenge for programs in low resource settings in Resource-Constrained Settings. Quality second line drugs are expensive, less available take longer, even up to two years, with a high likelihood of drug toxicity, further resistance and defaulters [11] [12].

In 1993 the WHO declared Tb a global emergency. It was interesting that even though only 10% of those exposed to Tb became infected, one-third of the world's population were infected with the bacterium that causes Tuberculosis, meaning that one-third of the world's population had latent TB, which meant they have been infected with TB but aren't (at least not yet) ill with the disease. Out of 3.7% of new Tb diagnosed cases were multiple drug resistant (MDR-Tb) with a relapse rate of approximately 20%.

Former Soviet Union countries ranked the highest with cases of extremely drug resistant tuberculosis (XDR-Tb) worldwide. Kenya was ranked 13 in the list of 22 categories of "high Tb burden" countries worldwide. According to WHO, Kenya had an estimated 2300 cases of multiple drug resistant (MDR-Tb) in 2007. Current figures by National Tb and Leprosy Program, Kenya, there were 15 new multiple drug resistant (MDR-TB) cases are diagnosed monthly in Kenya.

This information was released during the world Tb day marked on March 24th, 2015. World Tb Day served to promote advocacy for prevention, screening, and treatment of tuberculosis. "TB has no borders, anyone can contract Tb. The healthy, the young, no one is immune" [13]. *Get tested; Get treated; Get cured* in the mulika & maliza spotlight on Tb campaign.

One in ten of all MDR-Tb cases is extensively drug resistant (XDR-Tb). Resistance often develops in areas with poor Tb control programs where: Tb treatment was poorly managed when patients do not complete their full course of treatment, when incorrect dosages were prescribed or when there was a break in drug supply [11] [12][14].

The African Region accounted for over 80% of the Tb cases among people living with HIV and since higher mortality from MDR-Tb and XDR-Tb had been documented in HIV-positive patients [11]. Some of HIV patients were co-infected with MDR, XDR Tb, therefore, collaborative activities were widely implemented [12] [15].

In Kenya, patients have free access to diagnosis and Tb treatment services from public health facilities under the National Tb and Leprosy Program (NTLP). Ordinarily, Tb treatment under directly observed treatments (DOTs) had two phases: an intensive

(initial) phase, which comprised the first 8 weeks for new cases and twelve weeks for retreatment cases, and a continuation phase of 4 - 6 months immediately following the intensive phase [12].

Involving community volunteers

Hospital co-works with Community Health Volunteers [CHVs] and Community Health Extension Workers [CHEWs]. Cough monitors were community health volunteers (CHVs) who have been trained how to identify those people who they come across who are coughing; where possible inquire the length of coughing and make early referrals to chest clinic for early diagnosis. They would also escort them and became contact persons in case of follow-up. Each worker was encouraged to build a deep personal connection with every person in their jurisdiction. Mark you these are not health professionals talking to the community members, they are community members.

They helped to demystify Tb diagnosis and treatment - that the regime had become more user-friendly, shorter. *Gene expert* test required one sputum specimen and was very accurate (higher sensitivity & specificity to Tb diagnosis and drug sensitivity testing than smear microscopy). Emphasize coughing hygiene, good ventilation, avoiding overcrowding and good nutrition. They were also useful in defaulter tracing. Refer for investigation cough of any onset.

In the National Tb and Leprosy program (NALEP), trained CHVs in Siaya were able to refer people suspected to be having early signs of leprosy. In the first one month after training at least 10 of those referred were positively diagnosed at the Alupe Leprosy Centre in Busia County. With patients eyes closed, by utilizing a very simple technique fine touch sensation over the lesion patches with *whiskers of a star grass*, contrasting the same with areas without patches. The patient would report *if he had been touched and where*. He reported not having been touched in the areas with the lesions! Leprosy is, early enough to treat before deformities and other complications caused by the disease had occurred. The leprosy bacterium spread the same way as the Tb, same factors in prevention and control. Leprosy, however, was a more neglected disease, but perhaps more common than previously thought.

Moi Teaching & Referral Hospital (MTRH) in Eldoret, Kenya had a standard model in the management of MDR-TB according to WHO Green Light Committee on management of MDR/XDR Tb [16]. WHO established the *Greenlight Committee* in the year 2000. This committee works with programs and pharmaceutical companies to secure the necessary drugs at 99% less than the open market price. It cost an average 1.2 Million Kenya Shillings (an equivalent of 10, 200 USD) to treat one patient with resistant Tb according to [17] [18] WHO 2014 estimates.

The Moi Teaching & Referral Hospital (MTRH) in Eldoret, the second largest hospital in the country in 2010 reported that 79% of notified Tb patients tested HIV positive and 37% of HIV positive Tb patients were accessing Highly Active Anti-Retroviral Therapy (HAART). By then the centre had 11 multiple drug resistant Tb cases (six of them on home care) and 1 extremely drug resistant Tb patient (the only case known in the country then) who was being managed in the isolation ward.

7.5 Application of Theory to Practice

The Isolation wards and the homes where drug-resistant Tb infected patients were managed need to meet the 5 essential elements to a "healthy house" namely: clean air; clean water; proficient drainage; cleanliness; light.

Nightingale talked about observation as a reliable means of obtaining and verifying knowledge. One of the key determinants of Tb management success involves high level of case detection which goes with keen observation.

Nightingale was frequently seen making rounds and documenting observations at night carrying an oil lamp thus she was fondly referred to as *"Lady with the Lamp"* [19]. Tb treatment is a strict six-month drug regimen provided to patients with support and supervision to ensure adherence through directly observed dose therapy (DOTS)—an observer watches the patient swallow the medicines for adherence and side effects management [3].

The growth in mobile phone penetration (estimated at 8 out of 10 Kenyans by mid-2017) had created new opportunities to reach and improve care to underserved, at-risk populations including those with tuberculosis (TB) or HIV/AIDS. Mobile phone penetration was estimated at 35.5 million by early 2017. Remote Mobile Direct Observation of Treatment (MDOT) for TB patients. The MDOT model combines Clinic with Community DOTS through the use of mobile phone video capture and transmission, alleviating the travel burden for patients and health professionals [37].

With MDR-Tb infected patients usually at 3rd to 4th month of treatment, sputum should have converted to negative. Conducting routine drug susceptibility testing for all TB cases allows early identification of drug resistance in the population at greatest risk. Utilizing a patient centred nursing process approach, case finding and patient holding as highlighted in the International Council of Nurses (ICN) manual in many ways recognized Nightingales emphasis on strict observation and documentation.

Nightingale did a lot of documentation of her thoughts; her memoirs form a solid part of the history of modern nursing (Florence Nightingale, Notes on Nursing 1860/1969) as well as influencing other fields such as advocacy, health care policy, statistics, and public health. Nothing can take the place of monitoring and evaluation in the management of Tb. Just like Nightingale did, keeping a journal, logging in and proper documentation of Tb issues by the nurse and to some extent (emphasis ours) through some training of the client are necessary competencies. She underscored the critical role of outcome documentation.

Monthly Tb reports have to be submitted on or before the 5th of each month upwards from 1st level (community) to facility level—Sub County—County-National Tb and Leprosy program (NTLP) to the global level [20]. Data is analyzed to give vital statistics. This way we can monitor the clients at risk of developing MDR/XDR Tb and pre-empt it where possible.

Nurses must constantly do evaluation and reassessment to ensure appropriate care at each stage to enhance the patient's adherence to Tb treatment protocols. Nightingale argued using statistics, to prove that decreasing mortality would cost less money… for patients to heal translating into what we would now consider as evidence-based practice [7].

She ably plotted a polar pie chart on the Crimean battle hospitals mortalities significant decline (from 42% to 2%) as result of her interventions (mainly by improved hygiene, and advocacy by calling upon the British Sanitary Commission). Charts continue to be a visual way of understanding data we still use to show prevalence rates, new cases, Tb progression to non-infective condition; sputum conversion from smear positive to smear negative.

In some parts of West Pokot County in northern Kenya, a whole village could be Tb infected: with 800 new TB cases diagnosed annually and a Tb prevalence rate of 223 per 100,000 and a Tb incidence of 85 per 100,000 (the projected County population in the year 2012 was 562,845 people) and 42 nurses per 100,000 persons [21]. Alupe Sub-County Hospital's Leprosy Centre in Busia and Tb "Manyattas" (some kind of isolation traditional dwellings within the villages of Sigor region of West Pokot County) have retained their utility value among the communities. Every year they receive thousands of medical tourists.

7.5.1 Applying Model of Nursing and the Environment in control and prevention of Tuberculosis

The anti-contagionism view which Nightingale apparently subscribed to postulated that some diseases were communicable and could spread by pollution of the air we breathe.

> Counterargument: Contagionists, on the other hand, believed diseases only spread through direct contact, something Nightingale opposed. She did say that sufficient levels of contaminants could induce endemic or epidemic ills. Tb is mainly transmitted by droplet airborne from person to person supporting the anti-contagionism viewpoint. Undetected cases continue to transmit since a person only needs to inhale a few of these organisms to become infected. This knowledge comes in handy when we consider cough etiquettes—avoiding risky behaviours like spitting, discouraging open coughing, use of disposable tissues, spitting into tight fitting sputum mug, proper sputum disposal (bio-hazards) by burying or burning. Observation of universal precautions, Infection Prevention Practices and Control Protocols (IPPC), hand washing, provision of additional antiseptics such as hand sanitizers [22].

In anti-contagionists' view; in order to prevent the spread of Tb to others, it was advisable to avoid overcrowding (e.g. church etc.) for Tb this would be until sputum conversion from +ve to −ve. To avoid contact time with other clients it is necessary to reduce waiting time through triage.

Some African cultures encourage relatives to stay in when their significant other has been hospitalized, however, it's discouraged for lay caretakers to stay overnight for an MDR/XDR Tb patient and in any case, *N95* masks must be worn by all attending to including visitors [22]. When there happened to be Tb in one of the adults, there was a likely risk of household exposure to children and other relatives. For children the effectiveness of vaccination against the disease was critical.

Those who are in close contact for sustained periods of time are most at risk and these are often the children of those with the disease. WHO reported that in 2013 about 53 million children under 15 were living with latent Tb infection, a condition that can develop into active Tb at any time [22]. Findings suggested that about 7.6 million children younger than 15 in 22 "high burden of Tb" countries became infected in 2010. Of these nearly 651,000 developed the disease [18] [23].

Fresh air and light as advocated by Nightingale play a key role in Tb care. Tb bacterium is sensitive to light and does very well in stuffy poorly lit rooms. As much as possible patient is to stay outdoors. The rooms must have wide openable windows. She emphasized importance of variety since the "nerves of the sick suffer from seeing the same walls, same ceilings same surroundings". The need for an outdoor, pleasant surroundings, sunlight, and fresh air perhaps meets this goal.

A good example that contravenes Nightingales principles were prisons in Kenya. They are extremely congested such that the holding grounds which were meant to have 500 inmates might have four times that number. Tb thus is high among inmates. Prisoners in cells shared the same poorly ventilated air for extended periods of time, and movement within the prison was limited to some limited perimeter. Prisoners found that it was a big privilege to be allowed some few minutes of sunlight per day, one politician claimed "some prisoners were locked in the cells for months without seeing the sun" Kenya National Assembly Official record [24].

One of the strategies used during Nightingale's time was quarantine. To keep the disease away from non-infected areas. The management of XDR Tb will remain a challenge as there is no effective treatment and isolation for indefinite period could raise human rights issues. Nevertheless, for MDR/XDR Tb we need to isolate those who meet stringent criteria such as non-adherence, refugee camps. Kenya is host to the largest refugee camps in the world of about 630,000 refugees in Dadaab and Kakuma. In May 2016 the Kenya government ordered the closure of Dadaab refugee camp in Garissa County for what it cited as security reasons.

Another common problem that might be mitigated by admitting patient into the isolation ward is that of long distances the patient has to cover to reach facility (on average most are 5 to 10 km away or further for nomadic communities). Even at home, a separate room for the patient is advisable during intensive phase of treatment [12] [20].

Kenyatta National Hospital (KNH) had closed the isolation ward for some years and it took some activism and media report to have it repossessed from the Nairobi Hospice in September 2014. This was significant in the wake of the Ebola threat that had seriously affected a number of West African countries of Liberia and Sierra Leone among others. Reports by *Save the Children International* [25] indicated that in Sierra Leone a "terrifying rate" 5 people were getting infected with Ebola virus disease every hour which overwhelmed the country's health care system.

The experience the staff had gained would be called upon in the wake of *Chikungunya* virus outbreak in Mandera County in June 2016. This is a mosquito-borne disease, the mosquitos biting usually during daytime, and could be prevented by wearing long-sleeved clothing and covering exposed parts, sleeping under long lasting insecticide-treated nets (LLITNs) and spraying the breeding sites.

Out of the 600 people, 10 of them were health care providers who got infected in their course of duty, it was further reported that by June 1st, 2016, 70% of the population of Mandera County was infected or hospitalized due to either cholera or *Chikungunya* virus. Several schools had closed. The situation was aggravated by lack of clean running water in health facilities and the town in general. There was also fear of a yellow fever outbreak in the region, spreading from neighbouring countries of Ethiopia and Somalia where some cases had been reported. A response team led by the Cabinet Secretary, Ministry of Health visited the area to assess the situation.

The Nightingale model advocated for proper diet selection and administration. Tb patients usually have poor appetite, some of the drugs they take also cause them nausea and vomiting as side effects. Therefore a collaborative food drug plan is necessary: eat pleasant healthy balanced diet, modified where necessary of affordable locally available food, drink only safe water. Just as Nightingale advised on monitoring of patient's expenditure of energy, regular

anthropometric measures monitoring like weight and body mass index are done as most Tb patients tended to waste away. Indeed weight gain was an important prognostic indicator for Tb.

Going back a little more on the concept of ventilation; ventilation of dwellings was a key concept in Nightingale's model [26]. She wrote, "I do think that the feeling of fresh air and warm sunlight on patient's face raises their spirit and has an effect on the psyche. The lack of which has also contributed to delirium in some hospitalized patients". Preferably we should have natural lighting and where possible fit UV lights into the room.

Tb patients experience night sweats and need pure fresh air which is circulating adequately, perhaps what Nightingale had in mind. In the rural areas and much of the informal (slums) settlements in resource-limited settings, the houses are overcrowded and many lack windows. The traditional African hut had one or two "peeping" holes, which acted as windows. The hut is commonplace wherever one goes into the rural Africa. Many people do not have separate room for fireplace. All these compromises on ventilation.

Successful tuberculosis treatment depends on more than chemotherapy and requires specific clinical and social frameworks based on an individual patient's circumstances [27]. Interpersonal milieu was referred to in the Nightingale model [28]; the role of the community in—psychosocial support to encourage patient to finish treatment, social support (i.e., assistance and emotional support from others); active case finding; cough monitors; management of contacts—tracing, follow up/visiting patients home every 3 months for 24 months to ascertain close contacts even the asymptomatic ones. In case of defaulter tracing, visit patient's home within 24 hours.

In the public/private sector mix, there are now stickers on public transport in Kenya commonly known as "matatus". One read: "Stop Tb, open windows for air circulation". The Preferred mode of transport for Tb patient is the "bodaboda" namely bicycle or motorcycle seat-taxis.

> A higher education institution with a health campus in Kenya for years had this middle aged driver of a 62-seater bus who had very poor coughing and spitting etiquette. He drove nursing, clinical medicine, environmental health students among others on a regular basis for clinical work and field work. It was later confirmed that he had defaulted Tb treatment twice. A section of the management was aware of his being unfit for the job long before this but did not take necessary precautions. The fate of the ?Tb contacts unknown as yet.

Some ideas for incentives to motivate the patient to adhere to treatment are known to be effective and enhance the patient/nurse relationship: support groups; award ceremonies on successful completion of treatment; reimbursement for travel, food, visits, and reminder alert reminder phone calls [3] [12].

7.5.2. Applying Model of Nursing and the Environment on advocacy

Nightingale left us the legacy of connecting caring with activism [9]. Florence Nightingale wrote, "It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm. It is quite necessary, nevertheless, to lay down such a principle" [29]. Activism in primary caring promotes

exposing, provoking, and unbalancing the social power that maintains people in a state of disease, while simultaneously nurturing caring [30].

> Counterargument: 'There is the right way and the wrong way to do things and there is a wrong way to do things. The processes and protocols and even how to go about being in advocacy was not all that clear' (*words of wisdom* by Weatherby F. RN, PhD, University of Oklahama). One needed to be careful even if the cause was noble lest one found themselves defenseless and on their own.

When she was nearing the end of her life, Florence Nightingale said: "May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done" [31]. Further "All the results of good nursing may be spoiled or utterly negatived by one defect, viz.: in petty management, or in other words, by not knowing how to manage that what you do when you are there, shall be done when you are not there." This excerpt from, "Notes on Nursing" by Florence Nightingale. This was possible if nursing leadership could get together and, rally nurses around an issue. She reiterated on the need for boldness "... how little can be done under the spirit of fear".

It is worth noting that just as MDR Tb is a relatively new threat to health it is an entirely man-made phenomenon resulting mainly from badly organized Tb-control efforts and poor therapeutic practices of the past. Activism provides the knowledge and means of redressing the social inequalities that maintain an environment of disease [30]. Activism and political reform in Tb care today can be seen in the following scenario:

In October 2011, an HIV-infected Nairobi woman was diagnosed with XDR-Tb while already receiving her treatment at the Kenyatta National Hospital for MDR-Tb. Treatment was provided by the hospital; however, she was prescribed three additional medicines that she had to buy herself, to supplement the regimen. Following a public outcry over the handling of the patient's case, the government stepped in to pay for all her medication [32] [33].

Mismanagement of Tb treatment is the primary cause of resistance therefore uninterrupted drug supply is a must. Pointing out the need for bold policy decisions urging the government to invest in country's Tb program: equipping to diagnose, treatment and care of XDR- patients in Kenya. Sometimes in mid-2016 anti-TB drugs were out of stock in public hospitals. Efforts to mop up rural health facilities for slow moving or idle stocks did not yield much.

The current anti-Tb regimes were likely to be dead stocks in private pharmacies hardly to be found in any of them. An original brand of *Rifampcin*, previously the drug used to treat Tb and also Brucellosis in human used to cost like Kshs 200 per tablet almost ten years back. What options did the patients have? NONE! Everything possible must be done to ensure effective case detection and treatment success by well-run control programs otherwise MDR-Tb will become a major public health problem worldwide [33].

High turnover of health care staff including those in central Tb units is one of the main challenges to Tb control. Nurses working with patients infected with MDR/XDR or even suspect Tb need to be educated about the occupational risk, best-practice recommended methods of protection as they take care of Tb infected patients and should have HIV tests regularly. Those found positive do not work there but opt to work in less risky environment. There is a high demand for training of health care

workers in this area [3]. The relatives often lacked the necessary knowledge and skills about how to support and care for sick at home. Women in Africa often share a disproportionate share of care giving than men.

If the reader happens to be coming from developed countries, it would be fair to state that there are disturbing "standard" third-world conditions where majority of our patients live. This is where the pavement ends. Uncertainty was a fact of life in many a patients' environments: for example, the fact that there is lack of hot, running water; that the toilets do not flush; that the mosquitoes are malaria-ridden. Even as they stand up for the rights of the patients, most nurses and families of health care providers in many African states were living in very basic conditions and could not access quality medical care for themselves.

If indeed fear of being ostracized for being Tb infected is real then the stigma for MDR/XDR Tb infected is worse. Serious health disparities with majority of the population not having any form of medical insurance. The professional or lay care giver often times learns how to thrive in these prohibitive contexts e.g. how to "perform care with nothing" which might mean anything from doing without some necessary protective gear to having to improvise on some basics. Nightingale worked in worse surroundings, so we can do better.

6.6. Case Study

Scenario—Mrs F. Chepkemoi (not her real name) is a 61 y/o female who has been admitted for acute confusion, dehydration, wasted, urinary tract infection, malnutrition, and wound care. The patient is widowed, mother of two grown up children lives on her own in single rented room at Langas Estate, Eldoret. Was brought to the Emergency Department after a neighbour checked on her and found her in that state.

Subjective—Patient complained of itching and of being thirsty, unable to eat. Has had fever and night sweats, weight loss, and productive cough.

Objective—Patient has poor hygiene and appears to be restless.

Significant past medical history—had a history of Pulmonary Tb, declared cured on Catt 1 (notes indicated she had 2 cultures and 2 smears consecutively negative converted). She was HIV negative.

Assessment—Vital signs are: B/P 90/60, HR 110, T 39.8°C, RR 34, SO2 87%, Patient alert and oriented to place and person only. Pale +, Skin tenting, mucous membranes dry. Red and raised rash to extremities, stage II pressure ulcer to coccyx. Lymphadenopathy axillary nodes, Weight 44 Kgs, Height 5'1". The patient is ambulatory, unsteady gait noted. Respiratory system: difficulty in breathing, reduced chest wall movement the right side with coarse crepitations. Chest X-ray showed bullous lesion, with right lower lobe consolidation. Sputum smear positive. Culture and sensitivity later showed resistance to INH and Rifampcin.

Suspect—MDR-TB.

Plan—Care for her in the isolation unit for the first 3 months and do observed dose therapy. Administer IV fluids and medications as ordered. Start Regimen Step 1 to 3 agents. Schedule nutritional consult with dietician.

Establish hygiene care routine. Social services evaluation for living conditions assessment. Routine skin assessment and wound care. Handle the issues of myths on the threat of MDR-TB that might lead to stigma such as "it is incurable", but nevertheless control the number of contacts. Turn off fluorescent lighting and use natural light and lamps for patient comfort. The isolation ward was a prototype in the manner of Nightingale's "healthy house": proficient drainage, clean air, no dust, adequate ventilation, natural light. After 3 weeks fever had subsided, patient had gained weight and anorexia had improved. The case was an ongoing concern by we were writing this chapter

7.7 Conclusion

The general practice nurse is the first line of defense in Tb control worldwide, since Tb (including MDR-Tb) is a treatable and curable disease. This important role must be recognized and strengthened [3]. One way is through nursing theory-guided practice. We therefore submit that Florence Nightingale's Model of Nursing and the Environment is a generic tool that would be applicable to nursing care of clients with MDR/XDR Tb in Kenya and other resource-constrained settings. It is, therefore, a great resource. Several case studies based on this model would be possible.

Hopefully, readers will be directed to seek further information, some of which are contained in the links below in order to fully appreciate the utility value of this approach to nursing care. A link like these ones [26] [34] [35] would be a great place, to begin with. Nurse managers in charge of nursing units (including Chest Clinics and Tb units) are encouraged to consider adopting on a minimum one relevant nursing theory/model as a step towards evidence-based practice. According to [38] 'nursing, nightingale and beyond is a picture of struggles, success, and potential solutions to the predicaments surrounding the nursing profession'. It was a virtue to keep Nightingale lamps ablaze.

Acknowledgements

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CHAPTER 8

Utilizing Theory and Evidence to Deliver Care IV

Nurse Managers' Perceptions Towards Their Roles in a Resource - Constrained Hospital Settings

Overview

This is an excerpt from a wider study on job description of nurse managers by this author. Aimed at describing the experiences and perceptions of nurse managers towards the various factors that affect their roles as nurse managers in the hospital. Being a nurse manager is a unique skill. It requires wearing two hats: that of a caregiver and that of a leader who can implement and adopt innovative ideas to improve patient outcomes or else 'Speaking out for nursing. Speaking out for health'.

Methods: This was a descriptive phenomenological peer research design, drawing lived experiences and perceptions of nurse managers. The study was done in February 2012 in a 600-bed public hospital in Kenya, purposively targeting all the 16 consenting nurse managers working in the institution: 13 took part in the mixed study, 6 in the focus group discussion and 2 in the face to face in-depth interview. Experiences and incidents collected became the unit of analysis into 5 key points.

They were subjected to secondary analysis resulting in this qualitative report. This phenomenon was subjected to a modified Abraham Maslow's theory of motivation.

Results:

Problem Recognition: Nurse as an employee, awareness of the demanding job, reflecting. Reflexivity on the part of the peer researcher. Some respondents disagreed that the job was satisfying to them. Some apprehension was obvious.

Commitment: Accepting the role, altruism, duplicating and reciprocating. All respondents agreed that they did work that someone else was supposed to do.

Exhaustion: High expectations, lowly appreciated, stagnating but not redundant, wearing out, frustration. Lack of recognition, supplies, and equipment came out strongly as limiting factors in the performance of their complex roles. The nurse managers felt generally overworked and were not paid in commensurate.

Discussions: There is great need to clearly outline the nurse managers' role in the hospital as their job description. Their roles were either complex, multidimensional or both. There is a need to equip the nurse managers with leadership skills.

8.0 Background

The nurse manager is responsible for development and supervision of nursing services in a division/department/unit managed by senior nursing officers. The nurse manager's job is key in facilitating patient care and in ensuring the quality of work life of the nursing fraternity. The nurse manager is given the responsibility to accomplish specified goals for the organization they work for [27]. The manager must communicate a strong belief in the nursing team's contributions towards the goals of the organization. Fennimore & Wolf, (2011) on *Leveraging the Evidence and System-Level Support* came to the observation that the nurse manager was the defining role, crucial to the achievement of workplace outcomes. This agreed with [1; 20; 24].

'Evidence links NM leadership to nurse satisfaction and retention, professional practice environments, employee engagement, use of research, and patient quality and safety' -Dr. Nora Warshawsky has extensively studied NM [21].

The American Organization of Nurse Executives (AONE) developed the *Nursing Workforce Model* to assist in understanding the complexity of the nursing workforce. The model is based on Systems Theory [28] originally defined by Peter Senge (1990).

The *delivery systems domain* of the Nursing Workforce Model recognized that:

-The best way to organize the delivery of care was still a dilemma

-There would be increasing demand for healthcare services and with increasing acuity

The *work environment domain* recognized:

-Rigid structures that lack the capacity to be flexible and innovative stifle the work environment and discourage nurses who see ample opportunities to improve care processes. Flexible work schedules were a common component of many family responsive human resource policies. This covered a number of flexible work arrangements such as allowing employees to adjust their time of reporting and leaving work within certain limits. Work schedules are flexible and may vary from week to week or day to day.

According to Nursing Workforce Model, the right setting for providing care as well as the appropriate staffing and differentiation of roles for that setting were increasingly important for nurse managers.

Further, AONE also came up with: The Nurse Manager Leadership Collaborative Learning Domain Framework (NMLC) outlining the three domains- the Art, the Science and the leader within (see figure below)

**Nurse Manager Leadership Collaborative
Learning Domain Framework**

**The Science:
Managing the Business**

- Financial Management
- Human Resource Management
- Performance Improvement
- Foundational Thinking Skills
- Technology
- Strategic Management
- Clinical Practice Knowledge

**The Leader Within:
Creating the Leader
in Yourself**

- Personal & Professional
  Accountability
- Career Planning
- Personal Journey Disciplines
- Optimizing the Leader Within

**The Art:
Leading the People**

- Human Resource Leadership Skills
- Relationship Management
  & Influencing Behaviors
- Diversity
- Shared Decision Making

THE NURSE MANAGER

© 2004 NMLC

Fig: The Nurse Manager Leadership Collaborative Learning Domain Framework

(Used with permission)

According to Prof. Anna Karani, a renowned Kenyan nurse researcher, educator, and writer; the shortage of nurses is acute in many countries, and there seems to be little hope of a quick change in this situation. It is therefore essential that this scarce resource is not only appropriately trained, but also creatively deployed. The first step in achieving these objectives she said would be to understand exactly what the demands are [2].

Hospitals in Kenya and indeed throughout the region are in the midst of significant and even dramatic changes including embracing the Quality Management Systems model (ISO 9001:2008). The impact of these changes on the role of the nurse manager is just beginning to be identified and` research in this area is limited [3].

Kleinman studied nurse managers and made this observation, "nurse managers are often less well prepared to manage the business activities than the clinical activities" [4]. While [5] commented this about nursing from the Kenyan setting that, '…studies have shown that nurses are management, preparing and monitoring budgets, managing upward to senior colleagues, and using technology in everyday practice burdened with non-nursing duties which take away time which could otherwise be used for the core functions of nursing'.

Nurses are often appointed into the position of managers based on their clinical expertise, but they often lack confidence in topics ranging from human resource. One peer social media [6] (www .nursetogether.com) by nurses pointed out this reality, 'Nurse manager is sometimes a role that is thrust upon a nurse because nobody else wants the job…'

According to Ginette Rodger, then Chief Nursing Executive of Ottawa Hospital, in a positional statement christened - *NursingLeadership 2002* in Canada, 'leadership is the most pressing issue for the profession to act on' [7]. The WHO Nursing and midwifery Strategy 2016-2020 show the need to empower the nurse manager as a global agenda. In September 2017 it held a meeting in Bosey Switzerland to address the missing link between the nurse manager and the nursing unions, the boardroom etc.

Globally, the International Council of Nurses supports leadership development through projects like the Leadership for Change action learning program, locally through National Nurses' Association of Kenya (NNAK) [8].

8.2 Justification
Motivation for this study came from the author's (a nurse manager himself) concern for his own roles, perspectives, and needs which may have had implications on his performance in general. This led to concern about other nurse managers.

On more than one occasion the Chief Nurse of the study site had asked the nurse managers to come up with a job description for themselves, only one out of the 16 nurse managers submitted hers'.

It was an official requirement by QMS ISO 9001:2008 in this study area that every nurse manager be issued with a job description. This was as far as it went; being issued with one. As to whether or not it was cognizant with the job demands of the nurse manager was another thing all together. The issued 'JD' as was popularly known fell short of defining the scope. Reports, literature, book reviews and policy reviews from the wider inventory study [9, 10] offered an even wider scope with seemingly never-ending expectations on the nurse manager. This ironically left the nurse manager with 'no job' description so to speak.

These others emerged as the study progressed and it came from the respondents themselves and I quote, 'You have reached a new milestone in your life -you've become a nurse manager. In your role, you now wear two hats - that of a nurse and caregiver and that of a nurse leader'. 'How do I become effective in my role?' 'Do I have what it takes to make important leadership decisions, to manage the litany of concerns that I may face in your nurse manager role on a day-to-day basis?'

8.3 Objectives
1. To describe the experiences and perceptions of nurse managers towards the various factors that affect their roles as nurse managers in the hospital

2. To conduct an inventory into the job description of nurse managers in resource-limited setting

Scope:
American Nurses Association (Nursing Administration) and Standards of Nursing Education and Practice in Kenya

8.4.1 Literature review
Online search: English language, MeSH- Key terms: nurse manager, nurse leadership, job description, resource-constrained setting, and nurse administrator. MeSH stands for Medical Sub-Headings.

- HINARI PubMed freely accessible in low-income countries

- CINAHL (Cumulative Index to Nursing and Allied Health Library)

- Modifiers: Boolean, wild card

- Google - tags

- Dissertations

- Conference papers

- Local library for hard copies of nursing journals

- Referrals

- Polit & Beck (2012) a resource for methodology

 section Materials were critiqued & synthesized for relevance

8.5 Methodology
Peer to peer (P2P) - a shared view between participants (nurse managers) and researcher added to the study's 'authenticity' and honesty (Polit & Beck, 2012, Conroy, 2003). The researcher was a former nurse manager. The reader is also directed to see http://www.shu.ac.uk/_assets/pdf/hccj-ResearchMethodology.pdf.

Potential advantages of *Peer to peer phenomenological* [11] design include - ease of access, ease of recruitment, and the ability to get particularly candid, in-depth data based on pre- established trust and rapport[11; 20].

Another potential advantage is the researcher's ability to detect subtle nuances that an outsider might miss or take months to uncover.

The phenomenological researcher asks: what is the *essence* of this phenomenon as experienced by these people and what does it *mean?* Its main focus is a person's perception of meaning rather than the event itself [23].

Focus groups discussion capitalizes on the fact that members react to what is being said by others, thereby potentially leading to deeper expressions of opinion. The team utilized unstructured moderator interview guide, nonverbal observations, field notes and voice recording through a 3-hour focus group discussion.

For quality control checks we shared field notes from the interview to enrich the context. It was necessary to confirm responses against some previous answers where appropriate to detect inadmissible responses. The researcher maintained a follow-on dated reflexive journal in an effort to bracket: interests, things that I took for granted, clarifying personal values, possible conflicts or lack of neutrality, remaining open and looking out for surprises.

The phenomenological researcher asks: what is the essence of this phenomenon as experienced by these people and what does it mean? [11]. Focus groups discussion capitalizes on the fact that members react to what is being said by others, thereby potentially leading to deeper expressions of opinion

The study made use of purposive sampling all the nurse managers working in the hospital. Target population was a purposively selected, fairly homogeneous group of all the 16 nurse managers (13 took part in the mixed study a few weeks earlier), 6 subjects (2 males and 4 females) were conveniently selected for the focus group discussion while conveniently 2 (1male, 1female) in the face to face in-depth interview with seasoned nurse managers

Data gathering was done in 2012. The setting: A venue of choice which was a familiar meeting point that acted as a conference room within the working environment during tea time (10 am) ending at 1 pm. The arrangement was informal, some sitting on easy relaxing chairs or across a table. We employed the use of unstructured moderator interview guide, nonverbal observations, field notes and voice recording through a 3-hour focus group discussion.

The panel consisted of moderator/note taker I (a BSN staff nurse), note taker II (a monitoring & evaluation officer who was also an experienced transcriber), observer/ non-verbal (a nurse counsellor). Recording of voice was allowed. Probing was done up to exhaustive exploration and completion of data (saturation).

A recorded formal face-to-face interview with two seasoned nurse managers (one male, one female) was done in turns in one of their offices. Why? It became necessary to obtain varied views, confirm and enrich understanding on some themes that had emerged from the focus group. They were seasoned in the sense that they had mentored most of us who earlier on worked under them as staff nurses.

A shared view between participants and researcher added to the study's 'authenticity' and honesty. For rigor in the methodology member checks on site were allowed on voice recorded and summaries made with critical feedbacks although it added little to the accuracy of the transcript.

Transcription was also taken as part of the analysis process. Each transcript was systematically checked for verbatim accuracy by listening to the audiotape while reading the notes that were taken in free hand, working with a peer reviewer. Sensitive information was marked, anonymized or expunged from the transcribed format where necessary.

Some modified Colaizzi's procedural in phenomenological data analysis steps referred in [12] involved going back and forth on the protocols and returning to participants to validate some of the findings (see figure below). It allows participants/clients to be exposed to the ongoing research as it develops. Two

participants were asked to review the study findings, and both agreed that the results captured their experiences.

The analysis was done thematically and in verbatim where necessary supplemented using ATLAS. *ti 5.0 scientific software*: Meaningful segments were identified, categorized, coded and portions of the text corresponding were subsequently retrieved. The final results have been presented in 5 key points. Some findings were triangulated with the quantitative results to from the wider study [9]. These were subjected to secondary analysis 2 years later by the same researcher to unearth some more hidden meanings as seen in figure below.

Figure   : Emergent staging of sampling, data collection, analysis & reporting framework.
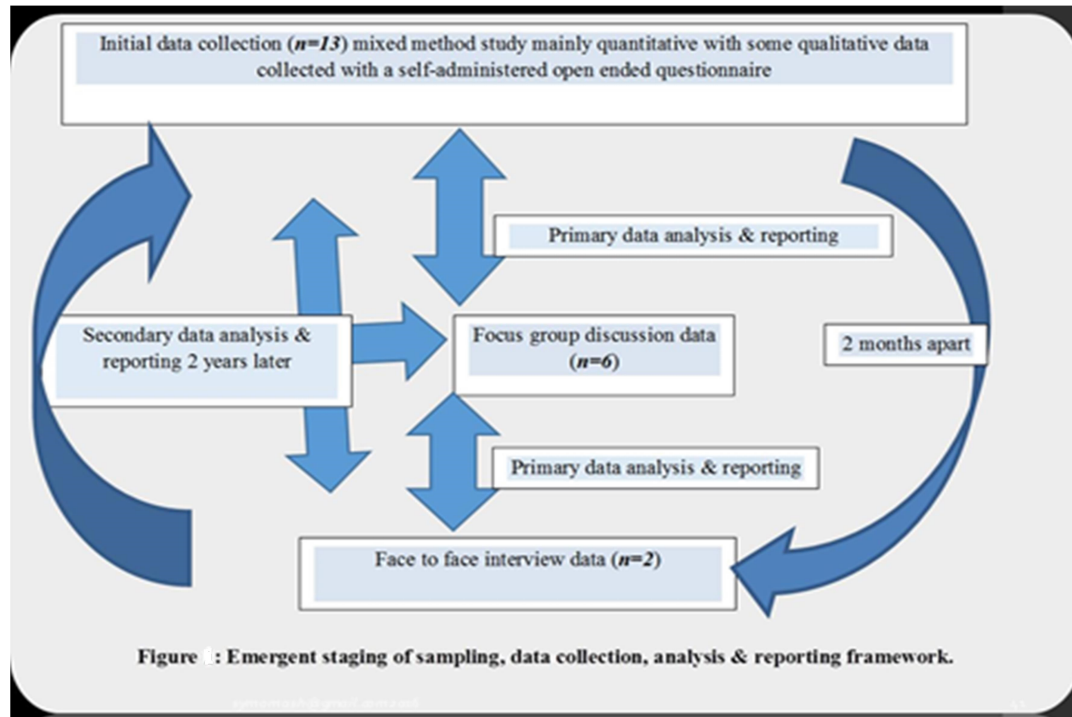
8.5.1 Data management Plan
To enable organization, durability and data sharing of this research; essential documentation
- about analyses or data manipulations, creating classifications for persons (e.g. interviewees), data sources (e.g. interviews) and coding was done. Classifications contained attributes such as the demographic characteristics of interviewees, pseudonyms used, and the date, time and place of interview.

Documentation files like the methodology description, conceptual framework, interview guidelines and consent form template were imported into the ATLAS *ti 5.0 scientific software* project file and stored in a 'documentation' folder in the Memos. All textual documentation in ATLAS *ti 5.0* was later exported either as textual files, a whole or groups of objects or summary extracts reports. As much as possible data was converted to standard, interchangeable and longer-lasting formats that hopefully most software would be capable of interpreting e.g. Rich Text Format (.rtf), Open Document format for textual and Free Lossless Audio Codec (FLAC) (.flac) for audio recordings. All with the necessary backups.

The study outcomes were shared through several avenues including (Macharia, 2012; Kamau, 2012; 2014) and repositories the University of Colorado http://hdl.handle.net/10217/78933 among others [29].

7.6 Delimitations
A potential limitation of peer research is the researcher's inability to be objective about group (or self) processes, which can result in unsuspected short-sightedness about important but sensitive issues. The Observer-as-participant in acting capacity was first described in the classic works of Goode and Hatt in mid-50's [13]. (Take help of tutorial on *YouTube*) https://youtu.be/ZAkrP9bFXzA.

The Observer-as-participant was used whereby the researcher participates in a one-time slot but then takes a back seat to any further activities but would un-obstructively take notes. This author found it necessary to recruit an independent moderator (a staff nurse) to steer the discussions in the focus group discussion. This prevented ''leading'' the discussion. This effort it was hoped would create a platform where the rest of my colleagues would discuss freely.

Prior to, during and after this discussion the researcher maintained a follow on dated reflexive journal in an effort to bracket: interests, things that I took for granted, clarifying personal values, possible conflicts or lack of neutrality, remaining open and looking out for surprises. Any biases as such were also overcome by employing qualitative and quantitative data collection methods at different times [9]. The entity of the study area as an employer to the respondents and researcher; meant that a few aspects of the study findings would only be covertly disclosed.

8.6 Ethical approval
Permission to expedite on the study was sought from the Institutional Research and Ethical Committee (IREC). Process consent was sought at each stage. The identifying features of the study site and subjects have been removed from this report, while most of the issues raised have since been addressed.

8.6.0 Results
Some of these findings were triangulated with the quantitative results from the wider study: The mean age of respondents was 40.9 years (38.9% of the nurses were between 31-40years) the rest were over 40 years with 70% being female. The majority were married (only 10% were single), 70% had a Bachelors of Science in Nursing (BSN) degree while the rest had both Higher Diploma and Diplomas. Duration of engagement in this hospital mean was 6.3 years and 9.3 years as nurses since graduating. All those who responded were confirmed as Nurse Managers and none was in acting capacity [9].

8.6.1 The Conceptual Framework

Final results have been presented as clusters and categories. These were described by Groenewold (2004) in illustrated phenomenological research design [20] and Leedy and Ormrod, (2001) in Stories rather than surveys

The American Nurses Association ANA had come up with *7 Things You Should Know to Be An Effective Nurse Manager*
http://lists.ana.org/img/lists/ana-leadership/16-207-ANA-roadmap080416%20FINAL.pdf.

Some of the following concepts were incorporated in here:
 i)   Know who your go-to people are;
 ii)   Meet with your team to set clear goals, visions, objectives, and expectations;
 iii)   Assess your team's strengths and weaknesses, along with areas for improvement;
 iv)   Take time to get adjusted to daily changes, situations, and open conflicts;
 v)   Maintaining composure and positivity for your staff is key;
 vi)   Get to know all the processes, data, and procedures that impact your team;
 vii)   Be a team player who is reliable and resourceful. Continued education and training help everyone stay on top of best practices.

The conceptual framework shown in figure below evolved as an emergent design reflecting on what was already learned [11] and not out of a prior theory. Therefore it captured the results as they came out. This will be discussed later on. The original conceptual framework on these underlying assumptions of the perceptions of nurse managers towards their roles in the hospital were first used in the inventory study on job descriptions of nurse managers [9].

CLUSTERS AND CATEGORIES

Problem Recognition
• Nurse as Employee
• Awareness
    of the
Demanding job
• Reflecting
.Reflexivity on peer researcher

Commitment
• Accepting the role
• Duplicating
    &
Reciprocating
• Altruism

Exhaustion
• High Expectations
• Lowly Appreciated
• Stagnating but not redundant
. Power dynamics
• Wearing out
• Frustrating

Figure   : Conceptual framework on underlying assumptions of the perceptions of nurse managers towards their roles in the hospital.

(Used with permission: Kamau, S. M. (2014)

8.6.2 Themes

There were many common themes and reconstructed voices expressed across the focus groups and interviews emphasizing the need to elicit authentic self-expression of the interviewee [14]. These were observed when reviewing the data. A summary of the findings is given in 5 key points below: -

Key point 1. Challenges of the nurse manager position: - Was the position interesting or just plain challenging? - Mixed reaction responses: Representative quotes: 'I think given an opportunity to make some alterations; being a nurse manager is challenging rather than interesting. Challenging in the sense that there are a lot of responsibilities that are bestowed in a nurse manager especially now that we are moving in a direction where you can't recognize the roles of a nurse manager'.

'I think in a functional system, I could say it is interesting to certain extents. It appears that those responsibilities that others are shunning end up being handled by the nurse manager. So you spend most of your time addressing non-nursing duties'.

Interesting Position, representative quotes: 'Ok, I would say that it is actually interesting to be a nurse manager because considering the different situations that you will find yourself in and realising that you are able to advise, to supervise and even get through the challenges as my colleague is saying'.

'Getting through the challenges as he has mentioned, it is interesting. When you come on duty in the morning and at the end of the day reflect back on the aspects of services you have offered to the client, they are very varied and I think that is where the aspect of the job is interesting comes in.

So, despite all the challenges that the nurse manager goes through, at the end of the day, I would say that it is an interesting role'.

Challenging position: Representative Quotes - 'It is more of a challenge than interesting because the issues handled are quite many, things that you may find that some are outside the nursing duties, one goes out to do administrative and even some involving the engineering sections because some of these items we use involve engineering. Those under the nurse manager expect him or her to know some of the issues revolving around engineering'. 'I also agree that it is more of a challenge than an interesting thing, because if what my colleagues have said. We all carry the burden of almost everything in the hospital'.

'The greatest challenge as a nurse manager has to be when you lack what you are supposed to have, for example, equipment. You could be having maybe two O_2flow meters in a big unit. So you don't have the equipment required for the people on the ground to use, it becomes a very big challenge because they are supposed to work using this equipment and supplies, so that is a challenge'.

'Decision making on its own is challenging because being a player, you may make certain decisions that the management may not agree with. Such occurrences' affect the managers negatively'.

'My issue is recognition, when you are holding that title 'Nurse Manager', some people may not recognize you, as the office expects you to play a big role when the doctors consider you just another nurse'.

'They have to come very early in the morning and the last people to leave in this hospital that is my observation'. 'In supplies department, there are   shortages of items, we get information, pass it to the relevant authorities and make orders, but the process takes quite some time for supplies to come, the authorities above derail the process yet all the blame goes the nurse manager. There should be a bridge to communicate between the management to provide these things in time. The blame on the nurse manager by the authorities above is wrong'.

The conclusion to Key point 1: Nurse managers tended to agree to disagree as to whether the job of the nurse manager was challenging or interesting. There appeared to be some apprehension about coping with challenges, perhaps they felt overwhelmed by some challenges and multiple roles. Sort of agreeing with Williams *et al.,* [30] who summarized it thus: As professionals, nurses are accountable for their own educational development, growth of their own practice, and execution of their own professional role.

As advocates, nurses provide direct and indirect care focused on the achievement of optimal health. As innovators, nurses act as agents of change in driving processes and policy and leveraging technology. As collaborative leaders, nurses lead within the professional practice setting with state-specific nurse practice acts, a defined scope of practice, and nurse-led initiatives.

Key point 2: Benefits that the position of a nurse manager offered (if any): What the nurse   managers   really   felt   about   the   benefits   of   this   position: Representative quotes: 'I don't think there are any added benefits to this particular position apart   from   the   fact   that   you   attend   meetings   at   some   level otherwise no added benefits'.

'Job satisfaction working as a nurse manager, when your unit is running well and challenges that were there are addressed. By the end of the day, you have that satisfaction'.

'So job satisfaction and self-motivation are the benefits considering that you could be earning less than the others. I am saying this because you might have some nurse managers who are at lower levels than their subordinate.'

Key point 3: Nurse Manager: - The Roles versus the Job: The nurse managers strongly believed   that duplication   of roles existed in the then work setup.

Representative quotes: 'As a nurse manager, I don't think that there should be duplication of roles in the unit. For example, client who has been given a bill which is erroneous and the person has a complaint, he/she will be told to go and see the nurse manager. As you try to go through that, you realize that you will be getting a challenge because of someone else's mistake but once the patient complains, they look up to the office of the nurse manager to solve such issues. It's a give and takes'.

'It comes down to what we have said earlier that the position of a nurse manager carries lots   of responsibilities carried from elsewhere,   since you   seem to understand the needs of a client, you tend to go an extra mile to make sure that certain requirements are supplied.   At the end of the day, you would have worked so hard and felt tired'.

Key point 4: There perception on what makes a good/outstanding nurse - Who an outstanding nurse was to the nurse managers: - The nurse managers thought basic but appropriate nursing knowledge and reasonable communication skills as traits that should be portrayed by an outstanding nurse

Representative quotes: 'I think it is that nurse who has knowledge about nursing and responds complete to nursing needs of the client. Responses which are appropriate based on the required knowledge'.

'If I can add to that, should be a nurse that is able to provide quality services to patients which entail prompt services to the patient, being able to report on the patient, s/he should be adequate in terms of documentation-so that everything was done is able to be reported'.

'Should be a person who is able to communicate with the patient, for everything that is done to the patient one should be able to get back and explain to the patient and let the patient understand and participate in terms of care'

Key point 5: There Perception on what should be the requirements for a nurse manager position. Special abilities that a nurse manager should have

Representative quotes: 'I would say that a nurse manager should have very many special abilities which I don't know whether it is possible to mention'.

'One thing, as a nurse manager you need to have very good human relations skills that are communication and interpersonal relationship, because as we have heard, you deal with a varied number of people from nurses to engineers, so you have to have the ability to communicate very well with this people for things to run.

At the same time, there is need for technical skills in nursing because when you supervise as a nurse manager you have to have the highest attainable skills for whatever area you are dealing with because you will be supervising the students, supervising the new nurses, even these other nurses. So it is really necessary that you have the highest skills as far as the technical doing of whatever is required. At the same time, the issue of organization, a nurse manager has to have good organization skills because as we have said, your day has so many activities and to all these activities you really need to know how to organize them'.

ˊThey have to have very high levels of decision making because they will be meeting with so many things that need immediate interventions. So as a nurse manager you have to have very high skills in decision making, so as to prioritize, so as to have whatever is to be done should be done carefully because it is something to do with the life of a patient'.

'Maybe I can add the issue of being observant so that you are able to capture all the things that are happening to the unit, whether it is problems or staff that are coming on time and those not coming on time, you know? Really having that extra eye'

'I also think that networking is a very important aspect here because as a nurse manager you are an actor between the people who require the service, management and those who provide resources. So for you to be able to adequately address the problems, you need to know the functions of relevant department in the hospital so

that you can link this others pieces together'.

'Education – degree or a doctorate , whatever it may be , but it should be utmost high'
'It should not be separated at the highest level and the practicability of the work, they should be considered in all spheres, the highest level attainable and also very practical best performing 'coz you could have the papers but you are not performing, so it should actually be the highest level as possible but also be a very good performer regarding the issues to be handled' 'Education and practice should also be the case'.

'Most of the time I see people being appointed because they are at N1s level'. (N1= designation nursing officer grade 1 conventional acronym is NO1).

'At times, it is possible to have somebody who has attained the highest but attitude may end up affecting the behavior of how somebody approaches responsibilities'. Other issues that might be important in appointing nurse manager

Representative quotes: 'I think experience is something that should be considered so that to be appointed to manager at a particular place then you should have had experience in that field for quite some time'.

'Concurring with what Number three is saying you should have at least rotated in all divisions. In the event that one is appointed in one division, the manager can be able to work well when there is changeover of staff. We also need to be gender sensitive, we have to mix females and males in different areas, so that when they have meetings they can interact and at least share ideas'.

'I tend to differ a bit in that, if you have the qualities of a nurse manager, as we have mentioned earlier, you can even be appointed as a nurse manager in a place you have not worked because basically, you have the general training and everything, you also have the good skills we have talked about, communication, decision making, organisation. So I think you can still be effective even in a totally new place which you have not worked provided you have the basic requirements as we have said'.

'Secondly, regarding the issue of gender, it is good to be in line with the other national policies on gender but at the same time that should not be the only reason; you should not be appointed because you are not common. Maybe they are not common for example; all the nurse managers might be women and so you want to bring a man, bring him because of the qualities. Gender should go hand in hand with the requirements. The position should not just be given out based on gender'.

What the nurse managers perceived as the next steps that would improve the position and improve output:

- Nurse Managers felt the need for the hospital management to review their remuneration and give substantive allowances and some sort of recognition.

- Nurse Managers felt that there was the great need to restructure the position. They felt that once the position was held for some time, preferably 2-3 years,
one should be allowed to move to other exciting positions for growth without

being viewed   by the   management in   a bad light.

• More results could be realized if nurse managers oversaw operations that were related to their particular nursing fields. This would not only ease operations but would also facilitate the spirit of ownership and job satisfaction.

• Nurse Managers need to be capacity built with much emphasis laid on leadership, administration and public relation issues. This would ensure that a nurse manager would be capable of handling the roles assigned to him or her and at the same time being able to correctly report and share with the rest of the hospital.

• Duplication of roles needed to be
  AVOIDED.

• Despite the fact that they did not have substantive allowances or recognition from other players in the hospital like doctors do, MOST of the nurse managers felt that they had experienced personal growth.

• There was a heated debate about the general progression and advancement of nurse managers. ALL the participants felt that the hospital management needed to come up with reasonable and clear criteria for progression and advancement for the position of the nurse manager. Suggestions for advancement included setting up intermediate positions between nurse managers and the hospital's Chief Nurse. They felt that creating such positions should be informed by the need, and would strengthen their progression.

8.9.2 Surprises

The biggest surprise that came out of the   study was the fact that the nurse managers held the opinion that, the Title NURSE   MANAGER in then setup of   the hospital was a nothing but a vague title. This attributed to the fact that they saw no end after being in this position. They strongly felt that there was need to re- structure the position. 'It is sad to say this but I think the hospital has used as a way of obtaining cheap labour. A way of getting maximum output with   minimum labour'   one participant   said this indignantly.

The second big surprise that came out of the study was the fact that the participants held varied opinions on how the nurse manager should hired- some felt that the position should be advertised and make it competitive while others   thought appointments should be made.

'This position would be more appropriate for it to be advertised so that those who have the interest can apply and that the appointing authority can have an opportunity to vet those who have applied when it comes to skills and experience we have discussed.'

'I   think   the   process of   appointment is   better,   considering this is an appointment that is happening after ones performance has been observed over time. Unlike if it was an advertisement because anybody else can apply. So how can we then verify this person who has come for an interview that s/he is effective as a nurse manager? I don't mind the appointment considering   that they   are appointing   you after observation'.

Summary on the Roles of a Nurse Manager

The participants reiterated that the following broad roles should be the core duties of a nurse manager: To oversee patient care and ward/Unit management. Responsible for hospital linkages between the other nursing personnel and other sections (including the hospital management) to oversee educational and supervision functions. Other administrative and personnel disciplinary functions strongly related to their jobs [25]. Core abilities necessary for nurses in administrative roles include:

- Abilities to use management skills that enhance collaborative relationships and team-based learning to advocate for patients and community partners

- To embrace change and innovation

- To manage resources effectively

- To negotiate and resolve conflict

- To communicate effectively using information technology

7.7 Discussion and Conclusion

As seen in figure above the findings could be allocated to the following clusters and categories:

Problem Recognition: Nurse as the employee- must support system, awareness of the demanding job, reflection on the part of the participants with sudden grasp of meanings vividly brought out. Some respondents disagreed that the job was satisfying to them. Some apprehension was obvious. Reflexivity (self-scrutiny) on the part of the peer researcher, a nurse manager himself.

Commitment: Accepting the role, altruism, duplicating and reciprocating. All respondents agreed that they did work that someone else was supposed to do.

Exhaustion: High expectations- getting less than needed support, lowly appreciated, stagnating but not redundant, wearing out, frustrations- some quite intense, power dynamics (inter and extraneous) between nurse-cadres and up against other health care disciplines. Lack of recognition, supplies, and equipment came out strongly as limiting factors in the performance of their complex roles. They felt generally overworked and not paid in commensurate.

These findings agreed with [15] who a studied a wider scope of nurses in the Rift Valley Province and also with [16; 27] case study of Kenya on Human Resources in Nursing (CHRIN) to International Council of Nurses. Both recommended that a number of studies needed to be carried out to shed more light on some critical areas in human resource dynamics in nursing and further that remuneration for health workers needed to be improved further to facilitate retention of nurses in the country.

There was great need to clearly outline the nurse managers' role in the hospital as their job description. Their roles were either complex, multidimensional or both. There was need to equip the nurse managers with leadership skills tended to agree with: International Council of Nurses (ICN) and Canadian Nurses Association (2005)

position statements and American Organization of Nurse Executives (AONE, 2004) that The best way to organize the delivery of care was still a dilemma, there would be increasing demand for healthcare services and with increasing acuity; The work environment domain recognized that: -Rigid structures that lack the capacity to be flexible and innovative stifle the work environment and discourage nurses who see ample opportunities to improve care processes.

8.8 Insightful view

Presenting an insightful view of the findings was described by Morse (2006), "and then I had an idea." While [18] 'using metaphors and changing words to represent things as they are through altering the … perception …of, 'data' as isolated bits of fact…'

No better way to tie all these together than the metaphor [22] scripted and shared by one of the two seasoned nurse managers during a follow-up interview which summarized contextual factors surrounding the respondents went like this;

> *'In Africa, we attempt to explain phenomena using analogies. A giraffe is one of the main attractions in sub-Saharan Africa. An elegant, stately animal. You should see it towering the heights of the Savannah, chewing very tiny leaves from among the acacia thorns. But you have not seen anything yet!   Wait until it takes to run, what a wonder.*
>
> *When it bends to drink from a pond, it looks so vulnerable. It appears to be something to do with its supporting structures or more likely the system it has to support. So is the nurse manager in the developing countries like Kenya'.*

Pic: The giraffe [Acknowledged metaphor scripted and shared by one of the two seasoned nurse managers during a follow-up interview. Photo courtesy of Encarta].

When requested to describe this more fully, it came out that the nurse manager, just like the giraffe is an indomitable figure in any health care setting. He/she bears the image of the hospital, going to great lengths/heights to ensure the smooth running of the institution amidst daunting challenges of a changing work environment. There seems to be an apparent disharmony between the supporting structures available for him/her most of the time as well as the health system she supports.

Apparently, this offered an insightful view of the findings. Morse a prominent nurse researcher posits qualitative researchers to be ready for insight and that they must have considerable knowledge about their data to be able to link them meaningfully[17].

Being a single site study of a small convenience sample, it may be risky to generalize the findings without replicating the study with another sample in other contexts. Perhaps some of the limitations mentioned in this study could be overcome by having organization(s) commission such studies through task forces as this may bring out salient issues. But then day-to-day management in an environment of resource constraints and uncertainty requires in-charges who were resilient, reflective, and continuously able to learn and adapt [31]. The study was done in 2012-2013, the immediate period after devolution of health services in Kenya highlighted the importance of leadership development including the building of critical soft skills such as relationship building. Health facility staff can be impacted upon by health sector reforms in unintended and sometimes damaging ways, it was hoped that decentralization would be able to achieve these.

8. 9 Utilizing Abraham Maslow's theory of motivation to explain the phenomena

Maslow in 1943 posited that human needs are organized into a hierarchy of relative potency. Maslow uses the terms like esteem needs to describe the general stages that human motivations move through.

- According to Maslow's theory, every human being has basic needs. People are motivated by the desire to satisfy these needs. As one need is satisfied, another appears and takes its place, and the individual is then motivated to satisfy the new need.

- Inherently, one cannot achieve self-actualization or self-drive unless all the lower level needs have been met.

- Self-actualization is the ultimate drive or motivation that comes from within an individual. It is an indicator of self-growth

- In regards to Maslow's theory, prestige is a factor of esteem; without it, one has lower esteem, and without esteem, one cannot achieve self-actualization. Today self-actualization has another level above it - self-transcendence that is as you actualize and even touch the lives of other people.

- A holistic, human and personal approach to the needs.

- Includes observations about people's innate curiosity and not just what

motivates them.

- Many nurses have used Maslow's theory of motivation and hierarchy of needs as a framework for planning patient care.

- Since Maslow's needs apply to all human beings the theory can be extended to nursing management as well. In this case, it will be employed in the investigation of the levels of motivation among nurse managers.

- The study revealed that most of the nurse managers in the study area in western Kenya were not enthusiastic as nurse managers as they saw it as a mere title.

- It seemed that nurse managers could certainly reach their social needs but would have difficult time succeeding with Esteem and Self-Actualization needs to give the constructs of the job. It has been ascertained that employees who had high levels of self-esteem, a positive self-concept were more productive.

- A new entry into the hierarchy Self-transcendence is said to supersede self-actualization is an area nurse managers have made some breakthrough as they touch the lives of others in caring.

- Individuals at work experience a variety of needs. Managers and/or supervisors should identify ways in which to meet group or individual needs to motivate them to work.

Please see the schema Maslow's theory of motivation to explain the phenomena *levels of motivation among nurse managers* below:
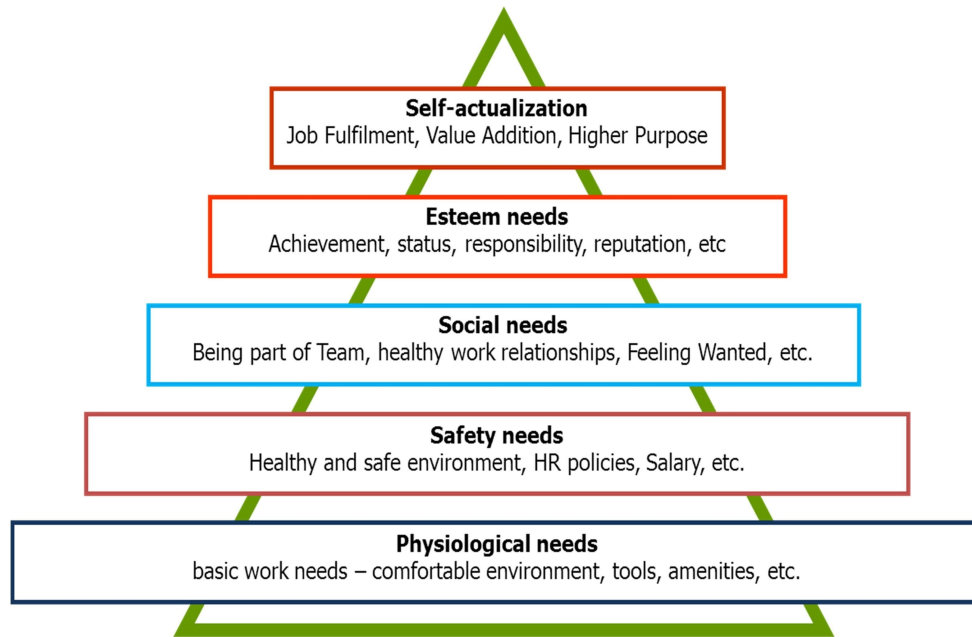
Fig: Maslow's theory of motivation to explain the phenomena levels of motivation

Levels of motivation among nurse managers (Modified from Vipin Ramdas, 2016)

http:// www.vipinramdas.com/maslowshierarchy/

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Chapter 9

The Role of Nursing Education in Quality Health Care in Resource-Constrained Settings

9.1 Introduction

That negative impact on quality of care could be related to anomalies in nursing education as well as poor structure of career progression is a fairly foregone conclusion. This was especially so in resource poor settings like Africa. In an ideal situation there would be need for perpetual learning in order for one to remain relevant, competitive or otherwise useful. The need for consulting empirical evidence was critical for the nursing profession to develop and command respect among equals in science as a caring professions.

Unfortunately promotions and deployment in public service had more to do with years of practice and less to do with advanced knowledge (once in a while both). Furthering nursing education was therefore more of a personal effort that did not conform to a laid down career progression structure. Stalling and stagnation did happen inspite of advancing knowledge.

The nurse workforce constituted the largest sector of health professionals in Kenya and included individuals with varying educational backgrounds and expertise. From Kenya Enrolled Nurse (KEN), Kenya Enrolled Community Nurse (KECN), Kenya Registered Community Nurse (KRCHN), Bachelor of Science of Nurse (BSN), Masters of Science of Nurse MSN, Doctor of Philosophy (Ph.D.) etc. Movement from one scope to the other advanced one depends on advancement of knowledge.

As the registered nursing population in the country shifts to becoming increasingly degree-prepared, unintended consequences (employment, earning power, skills, and roles and responsibilities) for those nurses who do not achieve higher education may occur. Like other health professions, nursing includes a large number of specialties and subspecialties.

8.2 Levels of entry

Policy makers and those in government simply get confused by all the cadres and levels of nurse training and see that as part of the nursing problem (Khoury *et al.,* 2011 *Gallup study*). At times nurses issues have been dismissed that way. An example was when AWW, a finalist BSN student petitioned the Eleventh Parliament (No. 01 of 2016) Second Session in conducting parliamentary initiative for enacting absorption of degree nurses.

Some legislators asked why degree nurses, why not all nurses or why not just say

nurses? Many were ready to use such excuses to evade real issues instead of drastic changes. This could be likened to putting Elastoplast to a wound and hope it will heal. Listening in, perhaps such ambiguity was what provided fodder for them to downplay the real issues, with *point of order Mr. Speaker Sir!*

Nurses must have lost numerous benefits just because these issues compounded or complicated their line of argument. An example was when there was a push to end enrolled nurse training, allowing the job category to dwindle as enrolled nurses retire over time. The then Minister of Health Hon. Charity Ngilu rejected the move. Shortage of staff to support various functions is a challenge if we are to base our argument on cadres.

By 2015 a number of MTC's admitted pre-training students for a certificate in Enrolled Community Nursing under the World Bank sponsorship - Beyond Zero Campaign initiative. In April 2017 admitted 400 students to KMTC's for KECHN.

KMTC scholarships were advertised in November 2017 targeting candidates from marginalised and vulnerable groups (VMGs) willing to serve their communities upon graduation under the program *Transforming Health Systems for Universal Coverage*.

According to HSA 2010 report by Luoma *et al.,* (2010), any given year finds well over nine thousand medical professionals in training in Kenya. How this impacts on the ratios of staff to patient has not been documented, but the Hivos study 2013 did something on absenteeism, while I would expect the effect on direct patient care to be the same in both cases. In-service training in Kenya has largely been opportunity-driven, rather than based on the skill-acquisition needs of the sector or preference of individual providers, how this impacts on the quality of health care provision was not accessed by this author.

According to HSA report by Luoma *et al.,* (2010), there was increasing need to strengthen pre-service training at various levels, to align skills with the requirements of the health sector. With an unprecedented growth in professional knowledge, rapid changes in health care system, changes in the nurse's role and the emergence of new diseases, it is imperative for nurses to pursue higher academic qualification to develop specialized skills to better manage health care.

Encouraging and even requiring higher education for nurses had driven many nurses in Kenya to seek RN-BSN upgrading. It has also been observed that more universities are opening up space for upgrading Registered Nurses from Diploma to BSN in Kenya offering upgrading programs with flexible modes of study to cater for the working students. The Nursing Council has a list of accredited institutions offering this program[77].

In Kenya, there exist clear and well-disseminated standards and guidelines for clinical care, nursing qualifications, and licensure, as well as accreditation of training institutions. Every three years, nurses are recertified based on documented criteria such as continuing education credits. These regulations are well spelled out in the nurses' codes of conduct and ethics for the various nurses' professional associations.

Kenya is also likely to go the way of other countries like Lesotho which planned to raise annual graduation of nurses by 42%, Ethiopia planned to introduce a 'flooding and retention' strategy and accelerated training to increase the number of nurses (Mullan F. in Bangdiwala 2010). This would lead to a deliberate policy to export the nurses,

something we in Kenya should emulate as a matter of urgency.

Seemingly we have more than adequate capacity to train nurses but an underperforming capacity to absorb them mainly for economic reasons. That is assuming that we have not undermined their quality and capacity to compete in a global economy. Plan for a global market. As my economist friend used to put it 'you must think as the market thinks'.

There was an urgent need now more than ever to shun mediocrity. Collins Ogbolu in Lead Nurse Africa blog observed that in Africa career growth in nursing without intellectual growth was a breeding pill for mediocrity. Promotions ought to be fair and transparent manner, the overriding factors should be competitiveness, meritocracy and absence of nepotism, tribalism, cronyism and political influence.

It was hoped that the Draft PSC Regulations (Validation) 2018, set to replace the PSC Regulations of 2005, once approved would require public servants to not only sit for an exam but that other competitive and objective methods of recruitment and selection will be applied. Aptitude or other competency tests where appropriate. (PSC - Public Service Commission of Kenya).

9.3   Need for more educated nurses

Within the field of nursing there are opportunities to work in different specialty areas. "A more educated nursing workforce has the highest potential for achieving the best possible patient outcomes," said Burnes Bolton, who also served as vice chair of the IOM committee. Hospitals that had implemented policies to raise the education level of their nursing staffs cited quantitative successes.

There is also data suggesting that more educated nurses were more satisfied with their careers, one study from the local setting was able to document this with some certainty (Chebor, 2014).

The issue is not just about having access to care; it's making sure that when you have access to care, you're receiving the best, the safest, the most efficient, the most effective care," she said. "We need our nursing workforce to be highly educated to be able to deliver on that demand." Winter (2015) added, 'It is now, more than ever, a necessity to have a well-trained, highly competent nursing workforce. Simply having the knowledge and the skill to do a job is insufficient; rather, it is implied that a competency has an action attached to it that verifies what is achieved by that action.

According to the National Database of Nursing Quality Indicators, the nurses themselves reported better satisfaction in their work environment, their contribution to quality, their collaboration with physicians and the support they received from hospital leadership.

Compared with hospitals in which only 30% of nurses had bachelor's degrees with nurse workload care of an average of eight patients, mortality would be almost 30% lower for patients at hospitals in which 60% of nurses had bachelor's degrees and nurses care for an average of six patients (Aiken *et al*., 2014).

This was according to American Association of Critical Care Nurses (AACN) study that confirms the strong link between nursing education and patient outcomes. The study findings interpretations were that; Nurse staffing cuts to save money might adversely affect patient outcomes.

An increased emphasis on bachelor's education (see BSN as a basic below) for nurses

could reduce preventable hospital deaths. With such a prospect, then it is an insult to the nursing profession in Kenya that some counties in the year 2014/15 could *afford* to 'secretly' hire some BSN nurses on contract for a paltry Ksh15, 000 (equivalent of 145USD) per month.

These counties deployed them mainly to run the county hospital ambulance(s). Moreover, who said this was the best job for them? Considering they were mostly trained with inpatient and some community focus and much less on emergency nursing?

To the best of this author's knowledge, such an ambulance regular or permanent deployment is best left a nursing team with Advanced Trauma Life Support (ATLS), Advanced Cardiac Life support (ACLS) and Emergency Obstetric Care (EmOC) certification. In our resource-constrained setting, a team of well-trained paramedics/technicians can do (See **BSN as basic** below).

It's been said elsewhere but I will emphasize again that a window of opportunity exists to promote the one year higher diploma programs for both registered nurses and BSNs for its utility value in terms of care delivery.

Yet we lack a concept paper that would outline whether or not the diploma will be referred to as post graduate (PG) diploma for the degree holders and Higher Diploma for holders of a basic diploma.

But again they will be in the same class, so? Or can a PG be granted only by a certain institution or does it become one when one had a previous degree? I recall with nostalgia that for a long time, only nurses got yet an (another) diploma at a post basic level. It seemed the titles of a Higher Diploma or Higher National Diploma was something they neither liked nor deserved.

Only nurses of all the other midlevel health care professionals being trained in Medical Training Colleges could not finish an ordinary diploma in three years but had to go an extra six months, a total of $3\frac{1}{2}$ years. Why indeed?

> **BSN as a basic**
>
> Although a BSN education is not a panacea for all that is expected of nurses in the future, it does, relative to other educational pathways, introduce students to a wider range of competencies in such arenas as health policy and healthcare financing, community and public health, leadership, quality improvement, and systems thinking. – *Institute of Medicine* (IOM), The Future of Nursing: Focus on Education

[77] RN to BScN through Distance Learning, Nursing Council of Kenya, Newsletter, Issue 6, Vo1, April 2010

Out there a Diploma is a diploma. Same job scale at entry level as those who finished in 3 years, that's ridiculous Some take a year, others two, even fewer take longer, it does not matter to many employers (even where an institution of higher learning is the employing authority).

Anecdotal evidence shows that some health sciences undergraduate programs and this could apply for many others have to go for long holidays in order to fit in a 4 years academic year calendar or rather they might be making up for a lack of content. One such a don admitted, 'we can crush this in 2 years!' This was as the undergraduate nursing program remained quite overloaded with no let-up in terms of time.

Guinness Book of World Records on 18th May 2011 rated BSN as the toughest undergraduate degree of all college degrees. In the 4 years (equivalent of 1000 working hours) with 64 university exams, 130 series exams, 174 assignments.

In another way this was a good thing in the era of fake degrees although this does not indicate that there cannot be any cheating in a BSN program. Makerere University in September recalled 65 Bachelor of Law (LLB) degrees that had been acquire in the last 10 years (an equivalent of 5 graduation sets).

The authenticity was in line with the university policy. A press statement dated 21st September signed by the Academic Registrar confirmed the matter that had been making rounds in the media for some weeks. As expected this was going to brew a crisis for the legal profession.

The utility value of Higher Diploma and Post Graduate Diploma is not in dispute but they continue to be referred as horizontal education. Many employers have continued to get the most out of these specializations without commensurate emolument.

The nursing fraternity was caught flatfooted with less than an adequate number of specialized nurses in critical care and renal nursing when the government went for starting critical care units and dialysis centres in all the counties. Now it's for all systems go.

Results from a study *Innovations in Health Workforce Development for The 21st Century* by Kasina (2016) indicated serious disparities. Some of the 47 counties had as few as two (2) nurses and as high as forty four (44) nurses in others with critical care and renal nursing specialties.

There were six (6) training institutions offering these nursing specialization in the country. Whereas there was inadequate infrastructure in these training centres, some were handling a capacity of 25-30 students each.

The study was to establish existing workforce in nursing specialization and explore the efficiency of nursing development infrastructure. It came out that lack or inadequate workforce with knowledge and skills to handle the machines and manage the patients who needed the specialized care was slowing the effort to have two dialysis units in every county and ten intensive care units beds.

What about the nursing preparation with leadership and management of health systems. Many of our institutions continue to be run by nurses and doctors who have little or no idea on how to do it. Have we prepared for these positions coming up in the counties? The Health Bill, 2014 (got the president's assent in mid 2017) made some flimsy attempt

to rectify this..

9.4 Role of nursing faculty in assuring quality health care

According to the Institute of Medicine's (IOM) reported on the Future of Nursing (2011), graduate nurses will be the future leaders in practice, administration, education, and research.

IOM reported that due to healthcare reforms, multiple changes in the delivery of care and the number of Americans with access to this care, the need for highly educated nurses will expand dramatically. Accordingly, there is what has come to be referred to as Graduate-Level QSEN Competencies Quality and Safety Education in Nursing (QSEN) is a consortium for Association of American Colleges of Nursing.

The overall goal of the Quality and Safety Education for Nurses (QSEN) project is to meet the challenge of preparing future nurses who will have the knowledge, skills, and attitudes (KSAs) necessary to continuously improve the quality and safety of the healthcare systems within which they work.

This author's opinion is that there is a disenchanted role of the nursing faculty in Kenya. The day our Kenyan graduate nursing programs will be taught by the nursing faculty will mark a major milestone in the quality of graduate nurses we get at the end of these programs and if they will be able to make a notable impact in their relevant areas.

The following situation is a fair representation of what could be happening. It was reported that there were situations where some institutions ran health related programs in undergraduate (and or post graduate) that no single member of teaching staff went through such a program themselves. Some of those interviewed admitted that they utilized the knowledge they received in their diploma and higher diploma. The rest of the staff by virtual of their 'relevant' graduate education gave inputs into these programs.

Many of our masters and Ph.D. nursing programs currently were generally taught by medical doctors and a lot of inputs continued to rely on non-nursing faculty, which put into question the content coverage. No less than the Cabinet Secretary (CS) of Education admitted that apparently, many Ph.D. supervisors were not well qualified themselves.

There were shortages in equipment and materials, poor compensation for researchers, the system lacked quality control and there was no clear mechanism for weeding out poor students. *One looks into how to survive in the program rather than finishing it*, as one recently Ph.D. grandaunt confessed.

It could be said that mostly our MSN (and entirely all PhDs) programs used to be research based with very little time on didactic coursework hours. Therefore, having fairly little in terms of content inputs that could be regarded as intriguing, critical stuff that engaged the students' minds on how to think. The kind of stuff needed to transform the landscape that was the Kenyan health system. The CS education and CUE impressed a new directive in ensuring that all graduate degrees had course content input.

The period from 2002 to 2018 could be said to have been lucrative for graduate nurses in Kenya up until CUE demanded that all public universities required to only have lecturers who at least have a Ph.D. degree by 2018. This was despite the Ph.D. degree enrolments for all programs being less than 10 percent of the total student population in the country.

The processing of students from the time of initial registration to graduation was too long. The majority of faculty members only had masters' degrees and therefore, technically did

not qualify to train post-graduate students.

New orders to get serious

But then, many students, world-over, simply paraphrase and lay claim to what has been stolen and the so-called plagiarism software cannot detect such sentences (*papaKenya* on social media, reacting to this news on The Standard). Paraphrasing and then citing your source in not plagiarism (*sufkim* added). There should be more. We need serious and capable scholars (*mts jumw* commented).

The best person to detect plagiarism is the supervisor and that is if s/he is well read (*musatsa5*). We having proposal writing joints and business in town - First work toward closing them as they are compromising quality of education… of projects even are done by …for a value (*mukiri*). That one is covered by the eleventh commandment: 'Thou shalt not be caught' (*mkenyamoja13*).

The University of Nairobi issued new regulations that in 2016/17 academic year a capping the number a supervisor could handle at a time to no more than 8 students (5 masters and 3 doctorates). It could only admit on a 'rolling on' basis. Prospective students were taken through lots of pre-matricualtion stuff and one was never sure of their admission status. Off course many gave up.

They also discontinued all Ph.D. by research by introducing mandatory coursework. Apart from introducing stringent anti-plagiarism guidelines for all research papers. As the only public university offering doctorate in nursing (only one other private one) in the country, this was going to present an uphill task in terms of access to graduate nursing education. For some time there had been a public debate on the quality of university education in Kenya.

For some time now the focus of our graduate nurse training apparently was to fill faculty positions. Most graduate programs had 3 students per class enrolling, and given at most 10 to 15 MSc Nurses graduate each in the whole country from all the five or so universities offering graduate programs, Kenya will continue to have a big shortage of these nurses in the coming years. They are ardently being sought for by the more than 21 institutions accredited by the Nursing Council of Kenya to offer undergraduate BSN programs.

Go-getter hiring institutions were booking them from the class before they graduate. Some are said to be willing to settle outstanding bonding terms from previous employers, primarily the hospitals. Many such are forced to re-advertise for positions or lower the 'irreducible' minimum requirements rubrics, if not give them appointments at a slightly higher entry level than would be usual with other disciplines. Purely nursing doctorates holders are fewer.

The problem in a big way lay in the remarkable cost of graduate nursing education and the numbing indebtedness of graduates. Nursing education at the graduate level apparently by some chance (or stroke of luck) is hardly regulated by the Nursing Council of Kenya but by the universities offering the degrees. This may or may not always be responsive to market demands for graduate nurses which are asking for innovative approaches including calls for increased interprofessional education.

Nurse Practitioners

NPs are trained at the graduate level and generally have a master's of nursing degree or a doctor of nursing practice degree, with a specialization in primary care, acute care or psychiatric/mental health nursing, sometimes with a focus on paediatrics, adult/gerontology or women's health. NPs must qualify as a registered nurse before they can complete a graduate-level nurse practitioner

program. Master's level training takes one to two years of full-time study and includes clinical rotations. Doctoral-trained NPs typically complete another year of postmaster's training and complete a higher level of clinical hours.

[Source: Research Brief No. 13, February 2013; National Institute for Health Care Reform Download Yee et al., 2013.pdf]

Would it be acceptable to come up with an innovative enterprising curriculum where students graduate in less time, cost and achieve the same outcomes as graduates from more traditional curriculums? Can't we be more innovative? Come up with tailor-made programs that serve our people, not our ego. Some accelerated graduate degree programs (15 months to 24 months) are needed in our systems.

It is about time we asked ourselves whether we get a favourable rate of return on investment for our graduate students in nursing when we charge them so much fees and make it so hard for them to graduate on time. Compare this (time wise) with starting a Masters through to completing a Doctorate of Nursing Practice (DNP) it can take a of 3 to 4 years in the US, coming back to Kenya as a Doctorate or Ph.D. if you like!

Funding for universities was becoming a real challenge. The Auditor General's report based on 2015 indicated that 11 public universities were technically insolvent and could not meet their financial obligations. Delayed salaries was becoming a norm. A good number could hardly submit statutory deductions (pension, Saccos etc.). Many staff medical schemes were stale and hospitals had started turning away lecturers. Multi-billion shillings' projects had stalled. With effect from January 2018, the ministry was rolling out even more stringent measures curtailing on further expansion of campuses and employment of non-teaching staff on permanent and pensionable basis.

He processing of students from the time of initial registration to graduation was too long. The majority of faculty members only have masters' degrees and therefore, technically do not qualify to train post-graduate students.

The next example on nurse educator opportunities had already been alluded to in the previous chapters, but from a different context, nevertheless there is a good reason to revisit it;

As alluded to earlier the period from 2012 to 2017 was lucrative for graduate nurses in Kenya. Why? It seemed that for some time, the focus of our graduate nurse training apparently was to fill faculty positions. Unfortunately these were very few. Most graduate programs had 3 students per class enrolling, and given at most 10 to 15 MSc Nurses graduated each year in the whole country from the five or so universities offering graduate nursing programs.

Kenya will continue to have a big shortage of these nurses in the coming years. If we consider that they were also needed as clinical nurse specialists etc. They were ardently being sought for by the more than 21 institutions accredited by the Nursing Council of Kenya to offer undergraduate BSN programs. Go-getter hiring institutions were booking them from the class before they graduate. Some were said to be willing to settle outstanding bonding terms from previous employers, primarily the hospitals.

Many universities were forced to re-advertise for positions or lower the minimum requirements rubrics (which obviously went against Commission of University Education - CUE directives), if not give them appointments at a slightly higher entry level than would be usual with other disciplines.

All the nursing faculty chairs wanted was: to fill vacant positions, reduce staff turnover, attract prospective students, push the students through the system (the university) by seeing to it that courses were taught, not having to defer them because of lack of teachers or part-timers, practicals were undertaken, exams/assessments administered and marks submitted on time.

The unwritten policy seemed was 'attract and retain partners'. Where possible snatch staff from competitors including where possible convincing promising external part-timers to leave their current employer. Programs had to meet some target of generating income for the university through the privately sponsored students and other income generating projects.

The private sponsored students program was expected to fund like ¾ of the budgetary arm of many institutions. Stringent measures by Kenya National Examination Council (KNEC) from 2016/2017 also made it difficult to have a sizeable number of students getting minimum C plus university entry criteria. Fortunately it was the same year that saw private universities been given a chance to admit government sponsored students program (GSSP).

All the students who scored C+ got a chance to be admitted under the GSSP. It was unfortunate that especially for health sciences programs the government did not send the commensurate capitation for these students which was generally above Ksh 220,000 per academic year. The students had to be turned away from the private universities or choose a different program there.

The question remained: was it CUE or professional bodies which should regulate professional degree courses in the universities. Right from 2011, turf wars between CUE (then, Commission for Higher Education - CHE) and these bodies have been witnessed, with courts pronouncing themselves one way or the other. Each had a quality assurance and accreditation mandate coupled with muscles to flex, weight to through around but most important 'teeth to bite'.

Regulatory bodies had suspended courses in some universities. Pitying the commission on one side versus 19 or so professional regulatory bodies. In February 2017 CUE was suspended from solely accrediting degree programs in an application filed by Kenya Medical Laboratory Technicians and Technology Board and Kenya Medical Practitioners & Dentists Board. By extension, what nursing faculty wanted or was struggling to achieve and what CUE wanted were two different sets of priorities.

The new CUE regulations decreed that a graduate studies supervisor shall not have more than 5 students (total masters and doctorate). For some time there was an ongoing public debate on the quality of university education in Kenya. Apparently, the lecturer job could no more let people in than it could keep them out. A number of universities had started laying off untenured tutorial fellows who could not meet the terms of the (2 years renewable once) contract within which to acquire a doctorate.

For a good number of those who went for further education especially the vertical mobility (RN-BSN. BSN-MSN, MSN-PhD) if you ask them why the answer they give is: *They want to teach*. How can we tap this urge to teach among our nurses in Kenya? Could it also mean that we have more nurses who are teachers and not nurses?

For those who are called into teaching, they will teach even if it pays less (and it does) than

clinical work. But for a good number they have not done their homework, so they believe there is a lot of money in teaching, period. (Please see **The expertize nursing education doesn't have and the experts it has chosen to ignore** below).

Unfortunately, some do not realize that money in nursing is in clinical work, which anyway is more available and has more slots. If indeed one was to compare a Nursing Officer II (two) in a teaching hospital like Kenyatta National Hospital or Moi Referral earns an equivalent of an Assistant Lecturer Grade '11' or a Tutorial Fellow in a publicuniversity. One did not need to be a degree holder to be a Nursing Officer II, just 3 years working experience from Nursing Officer III.

Apparently a new graduate with a BSN (after internship) entered the system as a Nursing Officer I (One) in these two hospitals, essentially earning more than the Graduate Assistant, Tutorial Fellow, clinical instructor, a senior technician who used to teach him or her a year or so earlier. Yet it required a minimum of a Master's degree to be an Assistant Lecturer/Tutorial Fellow with proof of Ph.D. progression.

A Tutorial Fellow (TF) was actually appointed on contract basis grade '11'. It would make sense to assume that the few nurses with Master's degree working in clinical practice or elsewhere would be willing to join academia for a 2 year untenured (renewable once) contract as Tutorial Fellows, earn much less (if we factor in the new nurses' CBA of 2017 with the ministry of health and county governments).

Even fewer could be expected to be pursuing a doctorate degree. There was little incentive to continue into a lengthy Ph.D. program monetary wise. May be, as a result, some nurses considered pursuing a doctorate as generally "worthless" except for those already working in a university.

A good number of Ph.D. candidates never finished at all. The platform for doing research was not well-supported. There was a scarcity of funding for doctoral studies. So far the funding burden naturally fell on the students leading to high drop-out rates.

CUE required that universities allocate a minimum of 2% of their recurrent expenditure to research activities; this was inadequate considering it also depended on what it was that the 2% was of. The long way to the professorship and the relatively low income of dons in Kenya made pursuing a Ph.D. a less attractive option.

Notwithstanding this, from 2012, CUE guidelines prescribed doctorate as the minimum entry into 'academia proper' in lecturer grade '12', a very humbling earning substantially. Yet the health industry as it were required only a nursing diploma (higher diploma) or at best an undergraduate degree and were much more lucrative than the academic jobs that needed graduate education.

Many of the diploma nurses admitted to the university for RN_BSN upgrading programs would essentially be earning better perks than a good number of their lecturers in public universities. A general nurse in Kenya who could garner enough energy to do a few overtime locums per week can make plenty of money (about Ksh 200 - 500 per hour), possibly much more if the time were to be an equivalent to current Ksh 1350 per credit hour in terms of part-time lecturers.

It would be realistic to know that nursing faculty operates in a highly competitive market

where nurses with graduate degrees can receive much higher salaries from the hospitals and the rest of the health systems (Feldstein, 2011; pp327). A significant factor in the shortage of nurse faculty in the US then was that faculty salaries were lower than market wage.

In Kenya the high demand for upgrading RN-BSN (though dwindling in some catchment areas) and the regular BSN degree, for universities nursing schools to increase tuition levels they should be able to attract the necessary resources to expand their capacity and admit a greater number of students.

A nurse who is at the level of Assistant Chief Nursing Officer (ACNO) and above needed not think much of many a university dons in terms of money. If the collective bargaining agreement (CBA) by the nurses' union got through (and there has been a lot of labour unrest along this path) then the difference will be exponential. Some critics felt that it was apparent that 'while the rest of the sectors (in Kenya) had moved on in terms of remuneration dons had been left with just titles'.

Certain university interview panels had not come to terms with these dynamics. Some got amazed by previous earnings of many nurses transitioning from the clinical area. One such a promising candidate was desperately needed by one university due to the much needed specialty in maternal & neonatal nursing was offered the position of an assistant lecturer with an enhanced salary going to be equivalent of a serving lecturer. Unfortunately, she did not think the offer was good enough since another university was offering her a full lecturer position with better perks. The begging questions then were:

- D For the same qualification, same experience the candidate would be hired at different positions by different public universities;

- D How can the universities attract more nurses to become teachers from catchment areas like the main referral hospitals? Zero option if we consider nurses income to be higher than they would get in most universities.

The referral hospitals had the highest concentration of degree nurses. So much for that, hopefully, this puts the case to rest. The Nurses (Amendment) Act 2011 and the Health Bill 2015 (now Health Act), if they were to be implemented to the letter, would provide for seamless opportunities for the Kenyan nurses and other healthcare workers like no other time before.

The Directorate of Nursing having kicked off, it was a matter of when not if any more, that there would be no need for Kenyan nurses to out-migrate for a good number of nurses (though the working conditions locally were still unacceptable). Money was also not forthcoming although there was willingness on the part of the employer to pay. The country's economy had not been doing that well in the 2015-2019 period.

The Cabinet Secretary, National Treasury in 2016/2017 financial year budget might have started showing some recognition of this fact when he proposed that the budget did not provide for any salary increment and had suspended promotions in all sectors except for health care workers.

A handful of Doctorate of Nursing Practice (DNP's) holders were trickling back after getting the further education outside the country (See **Nurse Practitioners** above). As usual few were taking up clinical work as clinical nurse specialists much as this is where they might have made the greatest impact. This in effect might mean we have a long way

before direct patient care can feel their impact.

Apparently, for some strange reasons, most of the faculty in Kenya isolate themselves from clinical areas. One nursing faculty shared that *the day I no longer see myself in the wards will be the Day*. With this attitude, it is no wonder that there could be a lot of malcontents making up the faculty. It was a fact that not every nurse would like to work with patients but there are much needed desired characteristics of a thriving partnership between faculty and staff nurses that must be cultivated.

While this may vary from one institution to another but generally student nurses' preceptorship/mentorship had been found to be wanting in Kenya. May be it's the proverbial *'People who love their work and hate their jobs'*.

A good number *run away into teaching* as one veteran instructor puts it. In a good number of such cases, armed with minimal exposure to direct patient care after BSN internship, candidates go for the MSN and that becomes the last time they would have anything to do with patients, except of course during students' clinical assessment week which might happen once a semester. Do we have this calibre in nursing faculty? Certainly, the answer is a colossal YES!

Would it be farfetched to insinuate that for some elements the health care system sort of rejected them? In other words for a good number, a nursing job might have ended up not being about what they thought it would be about. But then why should misfits teach, lead in nursing, one might ask? If they harboured less than good attitudes about nursing going by what they did or said, shall we not have invested in the wrong teachers?

What if by some chance these attitudes percolate to the students (and they will usually do), then the quality of patient care in future might suffer. We are interrogating the quality of health care provision in resource constrained settings and the quality of education and practice in nursing and allied health care really matters a lot.

Some nurse teachers however do not see patients as a necessary evil and value working with them, like this one who said 'I love direct patient care as I feel it's vital to stay 'in touch' at the bedside to be an effective healthcare leader and teacher'. Another one wrote 'I find myself pursuing an advanced nursing degree so that I may pass on to inspiring nurses the knowledge, caring, and compassion the Neonatal Intensive Care Unit (NICU) nurses demonstrated to my son and family in our moment of need'.

Many publications in the field of medical education show that health professionals fail and falter mainly in the area of clinical skills and communication skills competence. The "gaps" applied to nursing include:

D   Theory and practice gap - students reported teacher during skill lab was not helpful and effective;

D   Teaching and service gap;

D   Academic and service gap;

D   Academic and clinical gap.

D   Unstructured clinical teaching perhaps contributed towards less skilled, not competent and not confident graduates

The focus today thus should be in addressing the gap between academic and clinical education and training. Irrespective of the program one was pursuing it might be

considered reckless today not to have a business mind and a sense of purpose but above all being responsive to market demands.

'Universities should be producing what the sectors that create wealth need…,' recommends Prof Dr Maggie Kigozi, a Ugandan medical doctor, consultant, business icon, educator in an interview with *The Scoop* (Africa 24 Media, 17th July 2017) (See **A collaborative forum for trainers and clinicians** below).

Initially, nursing schools were part of the hospital with training being clinically based and task-oriented but today nursing education is in colleges and universities with so much simulation and competency based training. Outcome indicators of nursing education should include critical thinking, professionalism, leadership, embrace openness, integrity, broad based consultation and consensus building in decision making, innovativeness, and communication among others.

Most complaints by patients and by other consumers of health and health related services were about the practitioner's clinical competence and communication skills. To be more precise: they lack those skills. Those were the comments made by Dr. Marianne Darwinkel, VVOB (Flemish Development Association) project advisor while describing the skills lab methodology (Darwinkel, 2007).

Inadequate skills lab space and equipment contributes to students practicing on real patients resulting in increased patient's risk for medical and nursing errors, undue stress and dissatisfaction on patients. Given the risks inherent in learning new skills or advancing underdeveloped skills on actual patients, there was a need to explore innovative teaching methods for improving acquisition of competencies by learners.

Simulation is one of the innovative learning and teaching approaches in improving mastery of skills. It is highly interactive, allows multiple learning objectives in a realistic simulated environment whilst mirroring the clinical setting. Simulation improves patient safety and helps learners achieve competence while linking their theoretical knowledge with clinical practice. It enhanced patient's safety and quality of care as it contributed to safe and competent practitioners.

Simulation enables learning in a non-threatening environment, where they can make mistakes without endangering lives. There was a need to procure appropriate and cost-effective manikins, introduce new methods of students' assessments together with appreciation training on simulations for teaching staff.

Some universities were known to engage clinical instructors on the part-time (? voluntary) basis, mainly these were newly graduated BSNs post internship, every other one of them soon takes off once they secure better offers. Few ever get to see their appointment letters, (or could it be that they did not stay long enough?) as clinical instructors, even fewer got paid for it, and if they got the money it was after a long wait (a year or so).

The role of clinical nurse educator (CNE) has yet to be appreciated in many teaching hospitals in Kenya except Aga Khan University Hospital and Moi Teaching & Referral Hospital. Moi University, School of Nursing in collaboration with some visiting nurse faculty started engaging 'Clinical Nurse Educators' since 2013.

These are nurses already working at Moi Teaching & Referral Hospital. The initial terms were basically voluntary but ongoing negotiations might bring forth fruits in terms of commensurate pay. The impact these efforts have had are yet to be evaluated.

There were about 15 CNE's by mid-2015. There were about 8 institutions that sent their students to that sent their students for attachment to MTRH. One CNE confessed that there were 450 students from nursing alone in the hospital at any given time.

A collaborative forum for trainers and clinicians

It pains me that not even one tutor comes around to check on the welfare of the students in the clinical areas. No tutor comes to interrogate the nurse manager on how the students are doing. It demotivates the nurses to see that tutors are nowhere in the clinical area. We are a worried lot, are these the kind of nurses who are going to nurse us? We even don't know how much they know. If you are not seeing the instructor around whom are you going to believe -The student? The tutors miscommunicated through the students and not tutor-to-nurse, once in a while the student comes with a note from the tutor.

Signatures will not do, we remember that they are easy to forge up and not always possible to verify, what we need is student supervision. When nurses start to see students as colleagues and not as students it is not good for the students' learning.

It is good to make students busy, accountable for the time they are in the clinical area. Students spent a lot of time while in the wards on their phones doing stuff: chats and browsing… Nowadays students are monitoring vital signs using their cell phones instead of a second-hand watch, who is to blame. There ought to be a barometric clocking in/out system for the student. Bring out a nurse in the physique and psych of the student by empowering them.

At times students are given assignments which are beyond their capability. Some procedures have been abdicated by primary nurses to the students. Boredom, routine tasks act as demotivators to students. In some wards, vital signs monitoring was exclusively student's work even if it meant doing temperatures with only one thermometer for the whole ward.

It's the morning of the assessment and a tutor who has never been seen to come around to supervise the student appears and demands a co-assessor (ward nurse). You start running up and down looking for this and that on the material day. Most tutors do not adequately prepare the students for assessment. Sometimes there are overwraps of assessments from different institutions.

We are not working in a vacuum; we are working amidst other professions. As the nurse manager for my division, I sit in the interns vetting committee that conducts midterm and the final assessment on medical officers' interns. We assess how safe that Dr is to handle patients, everything from motor skills to availability to attitude. Even primary nurses have a say as to which intern can be released or needs more time to do the rotation. Why can't this happen for the nursing profession? Why must a nursing student transit from one rotation to another… to finish?

This was what some of our corroborative colleagues had observed about nursing in Kenya. That before introducing BSN, MSN, and Ph.D. that nursing care was better. The question is, what difference has it brought to the quality of nursing care in Kenya? May be maybe not, but suppose they were right? (As shared by participants in one collaborative forum).

The CNE role included:

Bridging the art and the science of nursing; bridging the gap between theory and practice, reducing medical errors; empowering the primary nurse to remove the tendency to relying on ungrounded opinions as a basis for decision making; doing a skills check, mentoring & preceptorship; supporting the nurse managers and nurse in charges;

Helping in doing root cause analysis; ensuring clinical supervision of students to help them meet their objectives by bringing up the students at their level of training; reducing conflicts between what is expected by the teachers and the hospital, conducting clinical nursing rounds and bedside teaching, handling the exchange programs students and fellows.

Small group clinical teaching increases both knowledge and attitude without significantly compromising other routine nursing care in the ward. The focus of ward nurses was mainly to finish their clinical assignment and but also supervise learning. This was becoming less and less a reality as the number of students to instructor or nurse ratios increase in our hospitals.

Caring relationships between faculty and students' generate caring moments. This author was a co-investigator in an international study carried out between February and August 2014 targeting 2nd year to 4th year students (McEnroe-Petitte *et al.,* 2016) which aimed to identify the level of students' and instructors' caring behaviours and if there was a correlation between instructors' and students' caring behaviours.

Respondents consisted of nursing students from identified schools and colleges of nursing in seven different countries, Kenya included. One of the data collection instrument is based on Jean Watson's (2010) *Theory of Interpersonal Caring* and was designed to measure nursing students' perceptions of instructor caring.

Some of the key areas included:

"Helps to Decrease Patient's Pain"

"Helps me to envision myself as a professional nurse"

"Demonstrates Professional Knowledge and Skills"

"Allows Patient to Express Feelings about his or her Disease and Treatment"

"Shows genuine interest in patients and their care"

"Cares about me as a person" etc.

Some of the reported findings were that instructor's caring behaviour affected nursing students' caring behaviour. Through positive faculty modeling and role modeling, nursing students could be professionally trained to develop the competence of caring. Moreover, when the climate of nursing education was perceived as caring, the student acquired a professional way of being and learned to care as a professional nurse.

If the instructor showed genuine interest in patients and their care, made the student feel that he/she could be successful, was attentive to the student when they communicated and allowed the patient to express feelings about his or her disease and treatment (*p < 0, 05*). If the instructor made the student to envision himself/herself as a professional nurse and inspired him/her to continue their knowledge and skill development, the student demonstrated professional knowledge and skills (*p < 0.05*).

The study has since been presented at several international conferences including *43rd Biennial Convention Conference Host: Sigma Theta Tau International, the Honor Society of Nursing. Las Vegas, Nevada,* USA. Added to Virginia Henderson International Nursing e-repository http://hdl.handle.net/10755/603121.

For resource constrained settings like Kenya, it is a luxury we cannot afford to have a separation of faculty and nursing practice like it happens. Just like in the medicine program where doctors who teach in Kenya are on top of things in the hospitals and have vibrant practices, there is no reason why nurse educators should be allowed to shun practice to that extreme. The fact that it does happen in other similar fields' means it is possible for nursing too.

We need a model that would see practicing nurses who are qualified to teach seconded to teach while on the other hand those already teaching take up compulsory paid hands-on shifts in the hospital working alongside other nurses (with or without their students). The later suggestion would be a bigger challenge compared to the former, mainly because the nursing faculty would like everyone to believe they are fully engaged elsewhere and have so much in their hands, this is not necessarily true.

It would make much sense when a nurse educator or one in practice and now teaching is able to relate with what they are teaching to the students. With the fast changing scenario in the medical, nursing knowledge and evidence-based practice being the in thing this would really help (See **The ideal** below).

The ideal

One student from a private institution said, *'I would not like to be assessed here, although we do our clinicals here, we sometimes we borrow packs from another nursing home during assessments. It is not ideal. This is not what we were taught. We are taught to support the perineum well, it must not tear, but here things are different'.*

Having a complete delivery pack in many labour wards is something akin to a miracle, drapes were a nonentity. Some weird practices continue to exist (I can bet a few coins maybe even as you read this they still do) where delivery in low-resource facilities could be conducted using: a surgical blade instead of a pair of episiotomy scissors, 2 to 3 cord clamps, gauze, 1 or 2 pads if you are lucky, some cotton wool and some gloves wrappings and you are good to go. Never mind if there was no needle-holding forceps, one could always stitch an episiotomy freehand.

These comments are indefensible if they happen to be facts but they point to some real gaps between theory and practice as a minimum.

We cannot afford to behave like the developed countries since we lack in so many learning materials but we have the patient and that is the most important resource, let our student at least be very exceptionally good in hands on even if they would likely have one or two deficiencies in some areas.

Everywhere the Kenyan nurse has outmigrated to worldwide they had come out exceptional in terms of diligence, we can only step up this. On the few occasions when it happened and these were rare and far between when we were students we still remember reassuring words like in **Hands on** below.

With the interest of the patient at heart and for the sake of quality undergraduate nursing education the regulatory body should move in quickly to ensure that these standards are met for Kenya. It is likely to have a far-reaching impact on imparting the right knowledge, attitudes, and skills to the next generation. This would ensure quality provision of health care.

In their paper entitled '*Fundamentally updating fundamentals*,' two renowned nurse educationists Armstrong & Barton (2013) argued that quality (and patient safety for that matter) is no longer an elective content area in nurse education basic training. However, many curricula in Kenya are yet to include this concept.

To appreciate the challenges of offering quality care working in diverse settings, students undertaking health discipline courses are exposed to some of these rural settings as undergraduates through Community Based Education & Service (COBES).

COBES is a program of Moi University undertaken by all undergraduate disciplines in College of Health Sciences. Maseno University and the University of Kabianga also run a

modification of such a program using modalities that encourage active learning in the context in which students will later function as health professionals.

9.5 The expertize nursing education doesn't have and the experts it has chosen to ignore

Even as nursing education in Kenya continues to face glaring shortages of nurse educators, a rising demand for degree nurses and the threat of some institutions being closed by the regulatory bodies for non-compliance; nursing educators chose to ignore something rather obvious.

The universities offering undergraduate courses in nursing continued to ignore a critical mass of qualified nurses who have come up through the system from diploma to higher diploma(s) to a basic degree with many years of experience.

These were people who had trained at great length and expense. To maximize the potential value of their additional education, nurses (or other professionals for that matter) should be encouraged to pursue graduate degrees early in their careers.

Nevertheless, this critical mass being referred to here were what had come to be referred to as 'career students' but then better them than those who 'graduated forever ago'. A scholar must continuously experience growth and self-discovery. For a good number of them, they might never get a chance to take full advantage of their qualifications;

Hands on
'When you come to my ward I will show you...., infact right now we have a patient with..., remind me to show you..., this is how we do it here.... The books might say that but....when you come I will show you.....

Let's go and I will show you... we have an interesting... You might not have reached there yet but this is a rare one you must see... Even if you are in another rotation please make a point to pass by my ward...This is what I expect you to do when you come to my ward...

Would just any PhD do?
In one university 3/4 of the nursing faculty was pursuing a similar non nursing PhD program being offered in a particular university at more or less the same time. Why? - it had become incresingly difficult to get admitted into the few nursing programs in the country. Precedence had it that there was also a higher chance of matriculation and progress in non nursing programs. Pressure was mounting to get PhD, time was limited. One of them argued - that a doctorate is a doctorate, at least as far as CUE and the employer was concerned.

for one academia doesn't want them (not that they don't need them). It was quite possible that many of them would be a ready and willing critical group that the universities could engage.

It was just hard to find a match for them even among masters' holders unless the latter practice what they have mastered – excellent; otherwise this could be regarded as a fair observation. While referring to this category of nurses it is a different story when we talk about lifelong learning. In fact, lifelong learning should be made a priority so that nurses are prepared to work in evolving health care environments.

Even amidst glaring faculty shortages, most Kenyan universities had chosen look down on professional qualifications below an undergraduate degree. This was not going to add value when it came to practical science programs like nursing, computing or engineering for that matter. In the perspective of a career degree like BSN this was committing a serious omission or to say it in another way it is academic ignorance.

Implementing an undergraduate BSN curriculum would least likely offer any meaningful challenge to this group of nurses. The most that had been offered to this group were adjunct faculty jobs or menial jobs within the undergraduate programs. Even when they did get an MSN their other qualifications were disregarded.

It seemed to this author that a Higher National Diploma and years of service were inferior in some instances to a single article in an open access journal whose singular merit was the ability to pay an author processing fee.

Commission for University Education (CUE) guidelines effected from July 2014 were not cognizant of historical trends in nursing education or the independence of each university to be run under the university senate. The clinical nursing had become a better option and was giving the nursing education a run for their money. The standard of nursing education would likely continue to suffer if we did not work towards identifying the weaknesses of these CUE guidelines and seek for some form of waiver.

Perhaps CUE was pushing the university reforms too far! Prof Lukoye Atwoli, then Dean School of Medicine, Moi University expressed in his posting on his Facebook wall on 18th August 2017. The posting attracted thousands of likes, reactions and comments from subscribers.

But then, this was also the era of indigenization *watu wetu kwa vyuo vilivyo kwetu* Swahili for local/our man syndrome for indegenization of the vice chancellor's (VC) position to be reserved for locals. According to Prof. David Some, formerly VC Moi University and CUE boss this was against the spirit of Univerities' Act 2012 Article 38 which set out merit as the main considerations for any such apointment.

If indeed universities should be at liberty to incubate their students the best way each of them knew how. He felt that interference by CUE towards 'standardization' of university education in Kenya was inhibiting creativity, innovativeness in terms of research and scholarly pursuits. Universities were supposed to be centres of excellence.

Nursing faculty positions advertised in the press might not have been worthy enough going by the paltry number of applicants who responded. There would be a few bold ones while only a few applicants qualify.

Even trying to reach out to the nursing fraternity through other means (e.g. on social media walls) to apply did not always yield much either. By the time the interviews season were over the few candidates with MSN had gone to each and every interview in the last couple of months.

In other words, all the universities had been cycling between or else interviewing the very same candidates. The candidates then had the last laugh as they go for the highest suitor. For the losers' it had been a waste of time, effort, and money. For some universities especially those in the rural parts of Kenya, they have to resort to depending on part-time lecturers for specialized courses and basic sciences.

Anecdotal evidence showed that many more students wanted to pursue nursing degree especially now that they were able to choose their career after the Form 4 results unlike when they did it before the exams. Nursing had become attractive for many reasons to students.

For example after graduating (and candle lighting) only a few months earlier, BSN graduates in their one-year internship were making good money in job group 'K' under the Ministry of Health sponsored program. These earnings were equivalent to (but usually) more than graduate assistants, senior technicians and clinical instructors who had taught them in some if not most universities.

The Nursing Council of Kenya, the statutory body in charge of regulating nursing practice and education continued to accredit many more universities for undergraduate BSc Nursing which was a good thing although in some instances *tutoring started without tutors*.

Another issue, a belated concern though, some institutions functioned with very meagre infrastructure, continued to have cohorts of students graduating from them year in year out yet they did without the necessary infrastructure like basic sciences labs.

It was alleged that in a certain (unnamed) county referral hospital, (not a very big one for that matter) had up to 3 universities and 2 MTCs clamouring to have it as their teaching hospital. They were all accredited. Officials from statutory bodies came to this same hospital despite having been there a month earlier and 'inspected' it all over again each time, but the difference was the same, *one could easily read it all over their faces...*

There was need for introspection into some of the motives (one perhaps being the accreditation fee) behind such irrelevant activities. The regulatory bodies' education & standards committee fidelity towards the profession as guided by the law and other sacrosanct policy documents must be beyond reproach.

Despite the lofty ideals of universities, they were not doing any better on the above issue. Instead of appropriating knowledge that they created in the university (e.g. exploiting intellectual property patents) they were competing to open more campuses all over the country. The unexpected was a convergence in this horizontal competition at some point.

Directors of these campuses had their work cut out for them –to generate income. Module II programs by virtue of profiteering were given prominence at the expense of regular ones. These campuses failed to get as many students as planned or had no lecturers to teach. This will be seen below. Nonetheless, in April 2017 the Cabinet Secretary for Education required universities to wind up some campuses and suspended opening of more campuses. Certainly there was a grip of quality crisis. many such campuses had a handful of staff mmainly tutorial fellows , technicians and administrative staff. Did not have basic facilities like a library, lab, internet access etc.

The staffing shortage phenomenon in the nursing education defied the kind of panacea that Commission for University Education (CUE) had prescribed for higher education in Kenya. Anecdotal evidence showed that larger usually older universities infrequently used bureaucratic application processes, they even placed a caption on requirements for candidates in special fields concerning doctoral status (ongoing or completed), rarely asked for several copies of the application, some did not have advert reference numbers.

One particular one advertised for all teaching positions in health sciences discipline as one flowing paragraph with only commas between medicine, nursing, public health. Generally, they took a shorter time to shortlist and call for interviews.

Some other big universities were known to be *recruiting all the time* with summarized lists of potential candidates ever being processed by concerned departments. One, in particular, was known to constitute impromptu panels to interview 'endorse' one candidate.

This process was inexpensive but perhaps not competitive, it was prone to abuse. As such they rarely advertised and if they ever did, it was either they were desperate or to meet some policy regulations/constitutional requirement, in other words, *a formality*. They were more likely to employ someone with a higher grade, and even when this was not the case their offers for a start were favourable.

On the other hand, it was observed that smaller, usually newer universities appeared to be trying their best to implement the CUE guidelines. They tended to use a lot of bureaucracy in their adverts, complete with reference numbers to quote. They required ten copies of the application, needed referees to send recommendation letters by certain dates. It was observed that they took the shortlisting process more seriously, perhaps taking longer to arrive at the candidates to call for an interview.

They were mostly located in the less urban areas. Were more likely to employ someone with a lower qualification in order to break even, and even when this was not the case their offers were less favourable. For example offer a candidate the position of Tutorial Fellow who, with the same qualification gets a Lecturer position elsewhere (usually in larger universities). With all these factors they were more likely going to lose out altogether in the process with programs like nursing sciences taking large tolls. This is an area ripe for research.

Competition between universities and institutions based on the state of facilities and remunerations remains both a threat and challenge which may lead to loss of core staff. Some of those teaching staff already inside some of the universities would be applying either to get out or for positions higher up within. Something even more critical was that it was typical in many Kenyan universities for teaching staff to leave their previous positions in their university in order to get promoted to a higher one elsewhere.

Some staff had shared that it was difficult to get incremental credit after acquiring higher education let alone promotion internally in many local universities. This affected the staffing in health sciences a great deal even though medical courses remained high in terms of demand.

The problem was that some CEOs would not buy to that line of argument. Taking cognizance of the fact that the country's economy had not been very vibrant, as reflected in the rate of unemployment and the consequent careful selection of degree programs by students. Kenya, at 40%, had the highest rate of unemployment in the region United Nations Development Programme's Human Development Index report (2016). Approximately 200,000 students graduated per year.

A typical scenario was that between 2016 and 2019 the following institutions advertised for almost similar teaching positions in nursing sciences: Maasai Mara University (MMU), University of Kabianga (UoK), Kenyatta University (KU), South Eastern Kenya University (SEKU), Great Lakes University of Kenya (GLUK), Kisii University, Maseno University, Masinde Muliro University of Science & Technology (MMUST), ZITECH University, Meru University of Science & Technology[MMUST], KabarakUniversity, Kenya Medical Training College, Kibabii University among others.

A good number of them for whatever reasons re-advertised a number of times in that period. Consider the following short answer questions below that touched on the nursing faculty at different times.

Inside information had it that one of them had advertised for teaching positions in nursing and other 2 programs received less than 10 applicants (all the 3 programs combined). Competition from other universities and institutions with better facilities and remunerations was both a threat and challenge which may have lead to loss of core staff.

One university had requested candidates to apply for RN-BSN in their adverts and flyers brochures but after that, the applicants were put on hold, some for more than 5 years due to human resource-related constraints. Meanwhile, some of these aspiring RN-BSNs went elsewhere.

Short Answer Question 1

AX left *Zendi University* for *Kijani* on promotion from Assistant Lecturer Grade '11' to a Lecturer grade '12'. He felt he was overdue or was being bypassed for promotion by his former employer. *QP* was hired as an Assistant Lecturer at *Zendi* in the immediate follow-up period after *AX* left. QP however appointed on a starting salary at 91K which was higher compared to what *AX* began with at 84K *Kijani*. (Explain these from a human resources perspective).

Short Answer Question 2

Butis worked for *Zendi University* as an Assistant Lecturer, but for the same qualification, *Desktop* was poaching her to become a Lecturer. *Butis* was more at home at *Zendi University* but it was becoming difficult to move up, so she left. *Zendi University* was at a loss because this was the third time in 3 years that they were losing a faculty member to *Desktop* under similar circumstances. Infact they had similarly lost another one to *CPU University* 2 years earlier. But then they were citing CUE guidelines. They could not comprehend how *Desktop* and *CPU* were able to flaunt the rules, may be a question of values. Indeed it was said that none of the nursing faculty at *Desktop* or *CPU* had been appointed at less than lecturer. Sources from an UASU official on national radio during the academic staff union that lasted 78 days, which only managed to secure a counteroffer of 1.25% spread out in 4 years. In March 2018 *Citizen Radio* Good Morning Kenya' indicated that it had become common knowldge in some public universities that a Graduate Assistant(GA) -the lowest grade in teaching staff that depending on who, the GA could earn as much as an Associate Professor. (Explain).

Long Answer Question 1. A narrow window of opportunity did happen quite rarely but it did. A time during which the strict requirements by CUE were somehow relaxed (that for one to be a lecturer one must have a PhD). This especially happened in late 2017, some universities went ahead to advertise in the media putting a caption candidates must be registrable for PhD, or must be on data collection stage of their PhD. A few universities like Moi and Egerton went ahead and did internal

advertisements for their staff who were tutorial fellows, graduate assistants and assistant lecturers to apply for reviews.

This was not the case in others, it was reported that some treated it as an opportunity to pick and promote their cronies, the reviews being done within two to three days after the concerned was notified in what had become a fairly secretive business. (Discuss recent trends in reforms by the Ministry of Education)

[While the situations were real, fictional titles and names were used. In all these cases the candidates held fairly similar qualifications at MSc level. K was a short code for Kenya shillings (Ksh) as used in conversations meant the same thing] [script shared covertly by some dons]

Desperate times in nursing sciences were not unusual when staffing ratios were at critical levels. During such, Chairs of departments had been known to personally search everywhere for those with the qualifications.

The season could get frantic: phones, forwarded emails and Short Messages (SMS) were rife with *'are you interested, have you applied? Umesikieko (colloquial Swahili for - have you heard)? Have you read? Let me nikuzambazieko (conversational Swahili for - can I forward to you)?'* All these while it seemed some Universities' CEOs and human resource departments, education regulators and statutory bodies had not woken up to the reality.

Many universities lacked the doctorate, Ph.D. faculty to teach and supervise the students. Some especially those that relied on external partners to run the MSN programs had stalled, restarted or perhaps received few interested students applicants. *'Great universities worldwide are known for a reputable component of postgraduate (Masters, Doctorate, and Ph.D.) programs'.*

Prof. Jacob Kaimenyi (formerly Kenya's Cabinet Secretary for Education). But only a few of the 72 universities in Kenya (except may be Masinde Muliro University of Science & Technology - MMUST) seemed to be aggressively responding in terms of offering diverse postgraduate nursing programs. Few were able to start a stand-alone school of nursing and midwifery. For the few who try some had ended up with, some one or two-staff run departments or one with several thematics merged.

One veteran non-teaching staff commented on one university draining another. When the former principal of a university college left he left with literally all the former grade '10's from his former employer. In the new place, he prevailed upon them to advertise for grade '11's. *'You know these were the ones who run universities, they do the donkey work. Most had stagnated in lower grade despite having necessary qualification to move up'.* Imagine all the senior technicians and clinical instructors one could fish in nursing sciences just by giving them a grade higher.

A lot of nurses could be waiting in the wings to take off into academia but not sufficiently attracted by the offers the universities were giving. However, might consider a grade '11'. These mainly consisted of those either pursuing Masters or planning to do so. These tended to be quite productive; they formed a critical mass that would likely stay put with an employer for as long as it took them to break the *glass ceiling*.

Anecdotal evidence showed that 2-3 years was on average that most time middle-level nursing faculty (grade '11's and above) stayed with a single employer. But then wasn't it more lucrative to join the university sick bay as a nurse? There one could progress faster

than in the academia. A senior nursing officer in the student's clinic was at grade '12', but was not required to have the equivalent of their counterpart in teaching.

Apparently, some university CEOs in Kenya concentrated on infrastructure with a passion and sort of neglected human resources needs. In one such distinguished university, the health sciences had amazing everything else but very few teaching staff to the student population. The number was not even a bare minimum.

Lecturers were forced to take on many extra courses on part-time after full load and also to teach courses they themselves barely passed as undergraduates *if you ever did it at some point it does not mean you can teach it!* This is hardly an explanation some universities' management are willing to listen to. The days that courses were taught by specialists are vanishing very fast (see **External part-timers** below).

I might not be forgiven for thinking so but I feel that nursing education to degree and postgraduate without the adequate/adequately-prepared nurse educators (and therefore students) does NOT help quality health care and patient outcomes for that matter in this country. Are we kind of mismanaging nursing education right, left and centre?

What can we learn from the past? For example, several BSN programs were started by nurses who had advanced diplomas (and a Master's degree). This original lot still exists in some of the Medical Training Colleges and Universities, though to remain relevant in the university some have had to do a Ph.D.

There is a new crop of nurses who have gone through the mature entrance BSN or RN_BSN upgrading. For some of these, a Master's degree becomes a necessity for recognition otherwise how much else can one explain a nurse who had a 3 and 1/2 year diploma, a 1 year higher diploma (some had two or three higher diplomas or an advanced diploma) and now a Bachelor's degree? What some cynical faculty call …*lots of horizontal mobility with little or no vertical mobility*.

If we take it that this nurse has been working and specializing in midwifery and neonatal nursing or renal and critical care nursing then getting a master in maternal and neonatal or critical care nursing respectively becomes a formality. Does the nursing component in the education system for these cohorts need to be relooked? *'Eti nursing ni ile'* paraphrased from Kiswahili to say teaching the same nursing the same old way and expecting better results (nurses) just will not do.

Having the perfect plan to do the *wrong thing* takes us nowhere. It seems sometimes that many problems are solved just by planning, even if it is not the only area we need to improve. Many upgrading nursing students know the pain they suffered inflicted especially by some faculty who seem less knowledgeable compared to the students. How do we add real value not just a better paper to them? How can we spice up these programs for them so that they are not just repetitious of what they previously learned? How do we ensure they get out better, changed to give better care?

Nevertheless, it had been shown that these RN-BSN were the backbone of many teaching hospitals and that undergraduate students learnt a lot from them. Training must be related to industrial practice, and this was what these lot had more than the average BSN. They possessed many transferable skills that could land them a job in many areas of the healthcare industry apart from teaching.

For unknown reasons perhaps founded on suspicion, this group had not been allowed to shine by the said nursing faculty. Occasionally, they would be allowed to handle clinical assessments or clinical instructions (usually on a voluntary basis). A quick inquiry from among the BSN students' fraternity showed that they were good if not better, apart from being quite relevant; summed up in one sentence by one student ...*they knew what they were saying and doing* (see **hands on** above).

External part-timers

One (sought after specialty) part-time lecturer in health sciences recounted If I calculate how much I will be losing by coming there to teach instead of how much I will make, distance notwithstanding, I would have no reason to come.

Some of the things they (part-timers) are capable of being outrageous. For example, one could teach all the 3 units of a course in a day then drive another university 200km away to teach the following day. Then let's say hop from Kitale to Eldoret teach there too the next day, get a plane to Nairobi teach some more, then off to Kisumu for an evening lecture.

We have not seen anything yet! Another part-timer who worked in some West African country said 'Kenyans were like the clock, very fast upstairs but stationary at the same time because they have not invested in the fast train and the local air travels. Local air travels are so expensive I wonder why. Systems do not work well here in Kenya, when you say the bus comes at 9 am it should and if it should leave 30minutes later there should be no issue, but that rarely happens here. The traffic jams in the city break your nerves. It was estimated that Nairobians lost an hour a day in the traffic snarl ups. That is why I say there is nothing comparable to international exposure, to witness that systems can work and they do, it's a very humbling experience. The more perspectives one has on an issue the more likely their critical thinking as well as being pragmatic solution providers'. Where he worked he claimed it was possible to cover a total of 2000km in 48 hours part timing. Waaoh! As to whether this hands off would mold the students into better health care givers is a discussion for another time.

Non-teaching teaching staff

Universities in Kenya had continued to use a section of their nonteaching staff and technical staff on an internal part-time basis or otherwise to cover for teaching staff shortage. As to whether this made economic sense was a matter beyond the scope of this book. For one to qualify as an internal part-time lecturer one required to meet the same qualifications as would the teaching staff- a minimum Masters degree. It had become increasingly common to find a nonteaching staff who apparently had more teaching units on their hands than their teaching staff counterpart. Some of these were usually courses that most teaching staff regarded as inferior or else 'what no one wants to touch'. Anecdotal evidence showed these were scheduled on Monday mornings and Friday afternoons or other considered 'inconvenient times' to core teaching staff.

A friend who now works as a private nurse practitioner gave these words of advice many years ago and I still follow them today: "They (patients) don't care how much you know as long as they know how much you care".

The patient will notice the difference between the health care providers with a false smile, one who says without meaning it - 'If you need something please let me know!' versus the nurse who is in touch, who is there for them, does something helpful even without asking/being asked to. They are able soon after admission, to differentiate the regular ward nurse and this 'big nametag-bearing nurse with a clipboard', 'who walks the corridors and not by their bedside' who is not of much use to them.

Some colleagues used to refer to these breed as 'sterile nurses' that is, they would not want to get their hands on the patient. They occasionally strut the ward aisles, manage

students from the hospital and corridors rarely next to a patient, fear to talk aloud in case they might be saying ('teaching') something outdated or eccentric, behave as outsiders looking in. This author participated in a multisite international study (McEnroe, et al 2016). Some of the questions included in *Nursing students' caring behaviour as an outcome of instructors' caring* was - "Spends Time with the Patient".

Another one said of some nurse educators - *who are 1km wide and 1cm deep knowledge-wise*. This type might teach well but when it came to testing – there was a big gap on examining what had been taught. There was a lot of recycling of past papers. They at times appeared to have no idea *of the what's or how's to* be examined in the practicums of the courses they themselves taught.

Going forward, I guess no discipline would wish for a disconnect between theory and practice and nursing in Kenya is no exception. This is one undesirable direction it could take and it has to change or else…

Just like we mentioned above concerning patients. It does not help the students much that the teacher feels himself like an overspecialized academician. The academia cannot forever dwell in the past as if it was the desirable constant. Just like many other fields today the profession may not care about what one did in the past in academia (unless it has really made a big difference in the lives of others).

The fraternity yearns to know what you can do for/in the future; 'you are as good as your current assignment'. What transferable skills for students or to anyone you got? Critical-thinking skills, networking skills, interpersonal skills, team work, and results etc. Keeping in mind that the more effort and work you put in collaborations the more you will get out of it. We need to give our graduates the ability to be able to take over the mantle of developing Kenya and the region.

But then there were other skills that had been explored elsewhere and found to be quite useful for the students' future. According to Dr Bitange Ndemo[78], an ICT expert and Associate Professor University of Nairobi it was about time our education system started giving the young minds on how to code which was a powerful thing in the era of digital transformation. This was useful in what had come to be referred to as the 'Gig economy' – where one could receive compensation for one key performance as opposed to being an employee etc.

This author felt that for a resource-constrained setting like ours, a career program like nursing needs more caring nurses to teach it. Can our educators shine through in the caring attitude? We can ill afford to delineate the practice from the tutor nurse.

It would not be good for us and the future of nursing for our country. Already cracks have started showing and it could get bad and the patient might fall through: Why do several BSN students abhor clinicals? A clique of soon to graduate BSNs was contemplating doing away with the 1-year internship; a memorandum to this effect had already been discussed at high levels around September 2015.

Anecdotal evidence showed that even though for many it was clear that there was a job market for MSN prepared nurses, many BSN graduates especially those graduating from Kenya's public universities go on to do graduate degrees in other disciplines. They have used a nursing degree as a stepping stone to something else.

It had also become clearer that most of the faculty positions in public, as well as private

universities in Kenya were held by those who got their undergraduate BSN from private universities. The same might be said of nurses with degrees in the country's healthcare system.

At the risk of being accused of being biased, this author observed some kind of cycle-in-cycle-out phenomena: BSN graduates from private universities practice nursing in the public health care system, go on to public universities for MSN, go to teach in a public universities (as well as private universities). As for BSN graduates from public universities, few were to be found in Kenya's health care system or practice nursing, a few do MSN and then teach (mainly in public universities), a sizeable number go on to do graduate studies in non-nursing programs or exit nursing altogether. This pre-2015 trend may change as more of them graduate from the 21 or so BSN-accredited universities.

Fewer graduates from public universities secured jobs in nursing practice and it took more years on average for them to matriculate into a Master's Degree program compared to BSN graduates from private universities who registered sooner. The whole line of argument might apply to nurses who upgrade in RN-BSN programs. This is an area that needs some research from several angles.

A good number of BSN's were opting to go for the one year Higher Diploma (tailored for basic diploma holders, offered in Medical Training Colleges) in specialized areas like critical care, nephrology, operating room nursing etc. The effect this might have was yet to be ascertained.

It would be advisable for the faculty to reach out to this critical group, recognize them for who and what they are, pay them in commensurate and develop them. Some of them possessed the higher diploma(s) before getting the BSN and apparently had plenty of knowledge. They are a treasure that could be reasonably tapped.

May be it was about time we started recruiting for nursing from other undergraduate programs in Kenya. Borrowing from what was referred to as Healthcare Interest Program (HIP) the University of Colorado Denver. HIP is a pre-health pipeline program for undergraduates interested in a healthcare career and it involves mentoring, clinical shadowing, monthly didactics, and opportunities for community outreach and clinical research.

This Hospitalist mentoring program was tailored to sustain interest in healthcare careers. This is a year-long, comprehensive program called the Healthcare Interest Program (HIP) that included pairing each student with a hospitalist for mentoring and job shadowing. At the end of the first year of HIP, students were surveyed, and 2 years later they were contacted for follow-up.

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[78]Dr B. Ndemo, Develop digital skills among our youth. *Business Daily* 30th Aug 2017. businessdailyafrica.com

Cervantes *et al* (2014) did a study with 26 HIP students, they found out that 95% remained committed to a career in healthcare, 86% had graduated, and 29% were enrolled in postgraduate healthcare training. The program was also recommended as a good way of recruiting minority under-represented groups into healthcare careers.
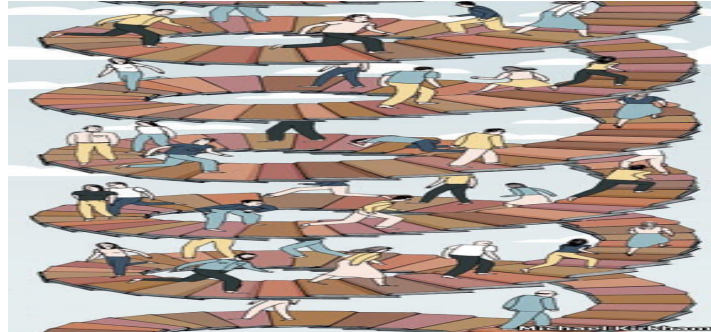

Fig: Academic excellence in nursing sciences for quality health care(Adapted from Michael Kirkman)

9. 9. 3 Epilogue

I have reserved the best for the last. This epilogue can be best understood when read in the same context as the preface at the beginning of this book. As we interrogate the quality of health care we provide in our settings we must ask questions: the risky, the unaskable and the unmentionable ones and also be part of the solutions.

Some we can only ask and pause at the same time. In journalism they say *do not ask your readers questions, it is your job to find out and tell them*. But then flagging out issues as was being done in this book cannot be the same as asking questions in a controlled environment nor were some of the questions upto scratch as would by a panellist.

Someone commented that if you ask a stupid question you look a fool for only 5 minutes but if you fail to ask you remain a fool forever. Indira Gadhi said that 'questioning is the key to all progress…' This author comes from the school of thought that questions may even tell us more than answers would. Nevertheless the writing did contain some of the answers to not only the issues raised but to others too. I believe these required an independent mind.

Some of the things discovered during these recollections undertaking of *The future of nursing education and practice in assuring quality health care in resource-constrained settings* were encouraging, borne out of creativity and resilience. Quite a number were heart breaking though. The suggestions put across some will say were easier said than done, but it's a matter of trying, what if it works. For a good number though there is evidence that they do work elsewhere, but then can they be transplanted?

It is humbling to admit that some nondescript individuals who asked the right questions brought the world some of the innovations we have today. Yet, no one ever had all the answers and so this author tried but did not have most of them. We need to access these answers, the information, the resources etc.

We need to input our commitments and efforts in a more significant manner. We must build relationships within our teams and stakeholders in order to realize Universal Health Coverage (UHC): by supporting the staff to help them grow. In taking risks, tinkering, creativity, continuous evaluations, allowing for open and vulnerability leadership, with a resilience that has brought many developed nations to where they are today.

It is this author's believe that if these ingredients are put in place we have great opportunities to improve the quality of health care at the entity level and across the system. If the solutions were straight forward the health care system would be on its way to being fixed but that is not the case. However, with more effort, I think we could have had a better health system than we now have.

Apparently, the average consumer of health care was neither used to raising or consuming questions (A) nor looking for answers (B). How do we inculcate in (A), a move from (A) to (B) and vice versa?

Posterity can muse upon whether the quality of our health care improved with yet another framework or by understanding the reality of what we are seeing by asking questions (asking who? Who cares? But why - some might ask. What if there are no answers?).

Ask the right questions. Not everyone will give you answers. Infact quite a number would not be bothered, while the rest would rather you didn't ask.

What Now? Should it rather be "What problems can we solve", "what model/framework do we want to have"? A framework or a book for that matter alone is not the change we seek in the health system in Kenya and other low- income countries. It is another chance to make that change, but that cannot happen if we go back to the way things were.

According to Kenya's Vison-2030, this shift will involve moving from a limited sense of urgency to relentless follow-up; from slow reactive to fast paced mechanism of handling issues; from low and dispersed to high ring-fenced budgeting; from the shortage of skills to war for skills. Namely - from business-as-usual to business-unusual.

There is a bespoken functionality in asking questions. All around us we have ready access to people who are actually doing what we are doing, what we are interested in: our team members, collaborators, online blogs etc. Ask them.

Papers, books tend to tell you how to do something, but don't give you a sense of what it is to actually do that something. But then what options are there if we don't ask? Some of the practices that were assumed to be cast on stone may actually be inaccurate, a good number have reached us through perpetual duplication of misinterpreted, misdocumented information.

There is a saying that "a nurse knows that a nurse that knows everything is a dangerous nurse". I say keep on tinkering, asking questions and you will go far! Don't fall into the trap of thinking that your non-expert questions will annoy the experts; they can answer at their discretion. Let them see it as flattery if that is the lowest they can.

It may be true for many challenges highlighted here could be traced to uncoordinated leadership and uncoordinated resource allocation in the health sector. Someone somewhere might suffer or die because of the decision we make or lack of it on our part. For the rest (and that includes us and everybody else), as someone put it, we will be killing them softly.

That is why in resource-constrained settings we need to continuously query the systems. The day we stop doing that is the day we start doing everything electively, optionally, but health care rarely accords us room for such indifference. In all the cited explanations in this book, a good number were system related. Luckily most have since been rectified. This author had no reason whatsoever to accuse anyone but where need be there might be

ground to investigate and take corrective measures.

It is not necessarily that the questions asked are directed to others. Infact far from it, the solutions must first and foremost come from within. Falter (2012) wrote, it does not help much when a "we/they" thinking creeps into our understanding of our own leadership role. *They are leaders, I am not.* We need to *turn on the leader light bulb in all of us* (Falter Elizabeth is the executive director of the Arizona Healthcare Leadership Academy, US).

Accordingly, she said, "I believe nursing leadership begins at the bedside. Whether you are in charge of 5 patients or a staff of 50, leadership skills are necessary to achieve quality outcomes. There are many outstanding emerging leaders if only they did their part, emerge from the bubble.

The human mind is a great source of information, may be better than any other. We query the mind by asking ourselves questions and challenging it to come up with answers[79]. Our minds will give us amazing answers, usually relevant answers that are related to our needs. Why relevant?– because it understands our situations and circumstances better than anything you might get from online, books, journals etc.

In many African cultures there was this belief that no event had one version as what happened. The stories could vary depending on the beholder. Stored up in our minds are observations, experiences, lessons, locally available resources, what works and concepts that we have internalized. These can be brought up using critical thinking, meditating or just stepping back to assess the situation among many other techniques that psychologists talk about. Let the mind of the health care providers do the thinking.

By working together with others we can create environments where ideas can connect and people can collaborate. The options we can generate together would be unlimited to help us face or solve perennial challenges.

If indeed the scenario can change overnight just because a dignitary was visiting our facility or there was a visiting team for a surgical camp, then there was no reason why that one day cannot be sustained into many more. Just wondering aloud - what is so difficult about that? After all, it's the people that matter, the people of Kenya and not any dignitary.

There is an urgent need for refocusing action to ensure that change results into better care for the people who are the focus of our work. Each of us has experiences that can be compiled and put into context and who knows - several other volumes like this one are awaiting to be written. The value of information can never be underestimated in this age.

If we add evidence-based practice (EBP) to great people and great books, we will grow! Many times the vision, mission, and burden of assuring quality health care to our people in resource-limited settings will have to be accomplished in the solitary places, where it is only you the care provider (or your team) to make a difference, on the journey to bettering our lot.

History has proved: That one man/woman can make a difference! … In a unit/ward. . . In a health centre . . . In a hospital… In a health care system…In the world. In all of the eternity.

The legendary French aviation pioneer and author Antoine de Saint-Exupйry (1900-1944) as quoted by Stephen Few (2004) in *Common Mistakes in Data Presentation* said, "In anything at all, perfection is finally attained not when there is no longer anything to add,

but when there is no longer anything to take away". This is a guiding principle in communication and as such there could be better ways of putting these together.

Social media has apparently has been cut out for more people to express themselves, but only a few bloggers coming from low-resource countries dare to touch health care, yet this is an overripe untapped area where unconventional book writers like this author can tap from.

Once a blog is up and going, it is more than worth it in terms of financial returns commercial advertisements utilizing search engine optimizers (SEO) like Google and Bing were looking for high volume (must read) websites to promote their online shopping products. I regularly snoop around one Brittney Wilson, BSN, RN *nerdy nurse* blog http://thenerdynurse.com.

Nerdy nurse is a living proof that *what's on your mind,* experiences we have are worth more than we will ever get to know. *WordPress* is an open source software and can be used to create a beautiful website, blog, or app. It might be helpful to join *nurse blog support* on social media. One of the founders Ashley Pofit, RN runs regular opportunities to expose their *nurse by heart* articles.

Compleat Health Systems http://www.compleathealthsystems.com is a blog that I run. I post on social media using the name *Compleat_Nurse*. This is a living testimony. A lot of the stuff I have shared in this book were hatched in the blog and vice versa. The blog has been a good testing ground for my ideas.

A lot will always be left out within the constrained space of a journal article. I have sampled a few articles that I have authored (but most of them with others) for my readers for the following reasons: one to show them that it can be done and two it does not have to be a lot of work though you might need some help or work as a team. It might seem hard to start with, but just run along and never behind.

No one person can ever be a - been here, been there and seen it all. Infact someone said that one is too small a number for greatness. That is why this book incorporated *voices from the field* in a very big way. It would be great to hear what others think, to have another version, anything but silence.

I believe that information, or the lack of it, is the really critical factor in judging any issue of public importance such as healthcare, which continues to be a going concern for consumers and providers. More critical was reading a lot, listening, asking, picking cues from wherever, having a third eye to observe what goes on around us, having the language and the articulacy of putting it across. Giving experiences, words new meanings.

Perhaps using long words to name little things, or used little words in a big way. Either was hard to do – i.e. when you know what you mean but it's hard to say what you mean – paraphrased from SSC Booknews (July 1981). What started as reflective journals and field notes transformed over the years into this book. In the words of Mark Twain "…*brevity is indeed an art and a skill! I didn't have time to write a short letter, so I wrote a long one instead".*

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Lastly, remember that you cannot expect to get all the credit no matter how original the idea/action you had was. Someone somewhere will want to take it. Managers, politicians especially would like an idea that they can pick and run with it, get the credit.

The same way they sometimes like it when someone picks ideas from them and runs with it. But so what? If you got something for the patients and your colleagues in the process, that is something to write home about. Maybe not as awesome as you thought, but so much for that even if it might not seem to contribute something to the state of the art.

This author was amazed by the volumes of reports, manuals, frameworks, models and concepts on Kenya's health systems, much of which was donor-funded work. How have they helped us deal with the hard and soft issues (raised here and elsewhere) in the short and long term?

What became apparent (and this applied to many of them) was some disconnect with each other. They ought to speak to one another. The models and frameworks ought to make (or have made) a difference in identifying points where we believe the trajectories give us the best chances of succeeding. Why was this not the case? Nevertheless, the availability of many of these documents freely as PDFs and linkups were most helpful. Each of them provided credible soundings for me while writing this book.

Resolving some of these concerns requires a coordinated response from a variety of stakeholders representing all levels of the healthcare system and even beyond. But it begins by asking, seeking to find answers, engaging etc. By being with people in the moment, trying to understand what they think and feel about the issues. Being with them in their time of need, on their way to work, in the workplace, their homes, or at an event.

What has been the people's journey up to this point, and where were they going? What was important to them? It's the people that matter! and *it's the gravity of the weight of the matter that matters*, as one of my mentors used to put it.

Like a longtime friend turned motivational speaker/writer Radido Dooso wrote - *I am the author who wrote a book so I can learn from its contents.* This book apparently has been about *everything.* As a student of leadership in health care systems and until I know what it's not, I see that everything matters. Hopefully, I have not explained myself too thin. Like many new authors, getting published is a dream that got started with diary, blogging, ghostwriting, and reflective notes. None of that compares to the thrill of having authored this book. My prayer is that we in Kenya become a reading society.

Delimitations & Conflict of Interests

The author declares no conflict of interests. Some emergent issues as well as coincidences came through scanning current affairs, learning from real life scenarios. Made relevant applications to the professional work environment and specific career challenges and citizens' aspirations which this author believed were unique to resource-constrained settings. As for the people involved – all attempts were made to describe them by their role rather than by name, except for exceptional cases.

Due respect and considerations were accorded to trade unions, colleagues, supervisors, healthcare providers, faculty, patients and subordinates as key types of individuals used in perspective. No harm or malice was/is intended to any of the individuals, their office or organization mentioned here.

Attempts were made to reach original users of graphics, frameworks, and models inserted

in this book and where this was possible permission to use them was sought for and granted. In all other circumstances under the fair dealing concept, the owner of data was acknowledged. Excerpts from social media, concluded court cases, legislative assemblies, mass media, and the press releases were assumed to be in public domain.

The book contains affiliate links and hyperlinks in text and in the references. Efforts have been made to ensure that the links worked and were not broken by the date of publishing. This style of writing would become a great resource to those who will use the Kindle edition or other authorised forms of soft copy.

I would be proud if the frameworks originating in this book were interrogative and representative of health systems in resource-constrained settings. It is indeed a privilege being able to say that. The frameworks may not nearly be as great as finding the next cure for cancer, but it was really important to take that bold step.

Please, anyone, jump in if I'm wrong - and I'm sure you will hopefully not by analyzing every text and byte but the spirit. Certainly the fabric here is not suffiient to come up with a complete suit called the health system. Go ahead and test these ideas (of course with necessary acknowledgment to copyrighted property). Do a review or make a verdict as a reader, user etc. Visit my blog www.compleathealthsystems.com and follow, tag; subscribe to keep update with some of my work. I can comfortably conclude that Kenya's health systems will continue to be a going concern.

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Chapter 10

Framing the Debate for Universal Health Coverage and Making a Case for a Health Service Commission: A Reflective Analysis of The Nursing Situation in Kenya

10.1 Introduction

Since health workers failed to insert a Health Service Commission (HSC) into The Constitution of Kenya in 2010 to deal with human resources for health all other attempts so far had failed. Nurses in Kenya have been faced with a need to rise to demands of frequent policy changes among other challenges in the last couple of years including: devolution of health services; piloting of universal health coverage (UHC), Covid-19 pandemic. Initiatives proposing for the creation a statutory HSC among others. This was an emergent design doing a reflective analysis of the nursing situation in Kenya amidst frequent policy changes. The author has been studying the happenings with interest. Started as a trail on media postings including blogs by various actors. Includes a theoretical review: SWOT analysis of nurse unionism, Maslow's Motivation Theory, Hummelbrunner's Systems Theory and lastly, Florence Nightingale's Theory of Modern Nursing.

In terms of rigor, attempt was made to control for reflexivity; the author is first a trainer in nursing education, leadership and health system administration; then as my doctoral thesis touches on the nurses' role in the advent of UHC in Kenya. In conclusion, nurses need a voice that advocates for their needs felt they might be better off in a commission (HSC). Kenya has remained in some kind of constitutional making moment for over 20 years now (though driven more by political interests). While UHC will mean that Kenyans could be able to access affordable care, it appears like there was some disharmony between supporting structures which raises significant challenges in terms of assuring quality health services.

10.1 Introduction

This is a reflective analysis of the nursing situation in Kenya. It explores 'what if' possibilities for framing the debate for a Health service Commission and making a case for Universal Health Coverage.

It highlights the day-to-day conundrums that nurses in Kenya faced in the advent of policy change demands in the past. It follows a trail of media postings by various individuals grossing on the subject over time, employing back links to related materials.

Nurses in Kenya have been faced with a need to rise to demands of frequent policy changes in the last couple of years, though generally the human resources for health in Kenya has undergone a difficult period ranging from industrial unrest to frequent policy changes. But the most critical so far has been the devolution of health services from the national government to county governments and the advent of Covid-19 pandemic.

The government nevertheless had seen to it that with the rolling out of universal health coverage (UHC) Kenyans could be able to access affordable care. However, this raises significant challenges in terms of assuring quality health services.

Staffs need a voice that advocates for their needs and nurses just like other health care providers felt that they might be better off with a Health Service Commission (HSC) which will take care of their welfare and iron out most pending issues. This article attempts to look into the intrigues of HSC and UHC and why it might be in the nurses' best interests to pursue these noble agendas.

10.2 Explaining the reflective approach toward nursing situation in Kenya

This is an emergent design, performing a reflective analysis of the nursing situation in Kenya amidst frequent policy changes. Started as a trail on media postings including blogs by various actors. Includes a systems theoretical review: SWOT analysis of nurse unionism, Maslow's Motivation Theory, Hummelbrunner's Systems Theory and lastly, Florence Nightingale the founder of modern nursing legacy.

Rigor: To control for reflexivity the author is first a trainer in nursing leadership and health system administration; then as a doctoral candidate, thesis touching on the nurses' role in the advent of Universal Health Coverage in Kenya. It addresses the nurse component in human resources for health (HRH) as a catalyst for change. It attempts to juxtapose UHC and HSC in an effort to bracket two seemingly dissimilar concepts. It also employs back links to related materials and, maintains an active voice based on a dated follow-on reflective journal.

10.3 Why bother?

The last 2 years or so have been incredibly challenging for the nurses in Kenya. COVID-19 had shown us that our weak health systems nearly collapsed and had it not been for

adaptive behaviour, resilience, selflessness and innovation on the part of nurses things would have been different.

Whether Pre- or even post Covid this writer submits that nurses in Kenya need to abandon almost everything else for a Health Service Commission (HSC) and Universal Health Coverage (UHC). Why – One: because every move by the nurses in Kenya was being watched by all and, Two: because HSC and UHC are and need to be our higher aspirations.

Let's put this into context: The nurse is the fulcrum of the moving parts in universal health coverage and the system realizes that (see Figure below). Every other cadre in the health system it seemed expected the hunter (in this case nurses) to wrestle the prey (a less than perfect health sector), but it was becoming next to impossible in Kenya to pick their battles. It seemed something was not quite right with strikes affecting human resources for health.

Previously around February 2019 the Kenya National Union Nurses' (now almost moribund) had nurses in some counties on strike over failure by the county governments to honour the return to work formula (RTWF) as agreed in November 2017 #PayNursesKe #IMPLEMENTRTWF. Nurses working in the public health sector were on yet another strike which began in December 2020 mainly over extraneous and health risk allowances.

It seemed like things were nolonger at ease in the health sector. At various times staffs at different counties were either on go-slow or on strike literally over myriad of complaints. For instance in 2019 many were due to delayed salaries in one or the other month(s) occasioned by an impasse´ over the revenue allocation bill. The Senate, parliament, governors and even the highest office in the land had variously pronounced themselves on these matters. At some point the matter was complicated by the National Treasury's decision to withhold funds for counties which had pending bills owed to suppliers.

Figure (above): A section of nurses in Kenya stage a sit-in outside the Ministry of Health headquarters in a past industrial action [Courtesy of nationalnurseunited.org]

10.3.1 Health Service Commission

Since HRH failed to insert the Health Service Commission (HSC) into The Constitution in 2010 to deal with human resources for health all other attempts so far had failed. It had become very elusive as we shall see. This meant that HRH would remain devolved, under what many detested: the governors, and some mainly handpicked County Public Service Boards and County Executive Members (CEM) of Health in some counties. This is something that can be rectified in our lifetime if we work together.

Allowing that we could make a fair guess here (though we cannot be too certain about) that: That at least Kenyans know by now that the idea of health workers under the county governments does not seem to work or was unlikely to work properly.

Not every other generation in any given country gets a referendum opportunity. When the moment christened change constitution initiative started way back in 2004 it was time for - On Your Marks - Set Go! But were we as HRH set and ready to go? The answer unfortunately was a No. Nevertheless it was through a spirited effort that we managed to lobby to have a HSC item included in the Building Bridges Initiative (BBI) change katiba initiative even though we did not get it into Punguza Mzigo (PMI).

In view of the initiatives this far: PMI flopped, even though it was done with collecting views before they could slot HSC in. PMI seemed to have been prematurely hatched. The Ugatuzi (devolution) initiative was taking its sweet time reading the times and fate of others before it.

BBI report had proposed some form of Health Service Commission (HSC) in clause 163 section: A and B. Even then BBI failed by not expressly proposing the creation of a constitutional HSC. The dye was cast for health workers and personal convictions aside most were unlikely to support it. Whether there is anything else that HRH will find good to write home about as far as the BBI was concerned is another matter altogether. Nevertheless there is some merit in looking at what if it had? Was all lost or not? That is what this article tries to address.

Even after the BBI team was granted a goodwill extension to fine-tune the recommendations they did not live up to the expectations of HRHs. In the next phase the real work began. This included the national debate where it was passed by both parliament and senate by a majority vote. It also got 45 out

of 47 county assemblies' 'YES' nod (minimum needed was 25/47). Kenyans would have had a final say in a referendum but this was never going to be. On 30th March 2022, the Supreme Court of Kenya ruled that the BBI process was unconstitutional.

Lawyers liked saying that the law or the constitution for that matter was very clear. This writer is no authority in matters law but sees that the bearing for clarity concerning the HSC 'burden of prove' will have to be borne by the HRH themselves in the hope that Kenyans will be willing to listen and buy it.

It will not be that easy to withdraw a function of the county government like devolved health services by the stroke of a pen. With the rolling out of universal health coverage (UHC), there will be some contradiction in saying - devolve all pillars of health care and leave the HRH central or else with a HSC. With counties going to be getting 35% of previous last audited GDP fiscal year (if BBI had gone through), there will be a push-pull situation since an idealistic HSC would have taken back some of that funding (in the form of HRH personnel emolument), or else it will mean counties get less of that.

If the BBI had passed in the referendum the counties would be getting 35% allocation up to not less than 15% guaranteed in the 2010 constitution. A tall order considering that the government was struggling to fulfil the mandatory15% requirement.

Even though the change constitution momentum was seemingly being driven by political considerations of power sharing, as HRH we need to be careful whether to push for Kenyans' agenda or our HRH agenda.

Had we gotten a constitutional HSC, as the political class fought for whether we should have a parliamentary or a presidential system, we would have needed to worry if they too would have convinced Kenyans (or why would it be so hard to convince the Kenyans). That it was for their own good to have a Health Service Commission into the referendum question and subject it to a YES/NO vote or a no contested multi-choice question referendum. With BBI we almost got a HSC.

Perhaps we did not manage to convince the drafters of BBI that HSC has been a long time coming; that it was not a new idea. HRH have been championing for it for over a decade now. Moreover it is well articulated in by the Institute of Human Resource Management IHRM and Kenya's Vision 2030.

10.3.2 Previous attempts at HSC

HSC was in both the Bomas Draft of 2004 and the Waki Draft. The HSC got buried somewhere in between and finally the Naivasha Draft omitted HSC. Why was it dropped? Were there

any minutes to that effect? Or was it an error of omission? What were the real concerns? For instance - concerning its mandates, structures, composition etc. What possibilities what can we adapt? Can we convince Kenyans?

In the pre-2010 constitution making period there were those who wanted HRH in the mix and, that is still a complicated situation we need to be worried about if Kenya gets into another constitutional review moment proper. However, we have to say any of this with a lot of caution. Many were those who would like us to enter into 'non-HSC issues' like 'when does life begin? 'Abortion is illegal, except..' like it happened in 2004 at Bomas.

10.3.3 Eating the cake and having it at the same time

Kenyans were no longer naïve. It seemed a valid observation (and BBI seemed to have captured their imaginations in Clause 163b) that Kenyans might have wished to 'eat their cake and have it' by leaving 'their health' devolved. As to whether public health services would remain a devolved function or not needed not be the question since it would most likely mix up HSC issues. Furthermore, it might end up being a county by county basis. Anecdotal evidence from previously 'hardship' areas like Lamu County seemingly had benefitted more from devolution of health (as well their HRH) and might prefer it remains so.

As health care workers we could perhaps not lobby that the health docket goes back to the national government (much as we should forever be watching out such a possibility) but rather let other quarters drive that part of the agenda.

Our gem remains the Health Service Commission. It is our thing and let's always pray that Kenyans would be less reluctant to let us have it. At least it would be taking nothing away from them; instead it will be taking away what counties were struggling with – the HRH. Perhaps the Council of Governors (COG) would at some point find it a relief since HRH had given them enough trouble already. COG at different points have admitted that they did not have the capacity to handle HRH (Munywoki et al., 2020).

It had earlier been thought that the formation of HSC would undermine devolution. That is a battle we be ready to fight going forward to convince everybody otherwise. That is even though there will be numerous occasions that we the HRH will need to shed off every hard skin for this one thing – HSC.

But this is how it might look, in this writer's view. With all health workers in the Health Service Commission (HSC) we will be like 'seconded to' or affiliates to the county government by the HSC, a very potent lot. Imagining the value of HSC with no role in recruitment is not easy to fathom. Nevertheless, some HRHs in counties like Lamu had expressed on social media wall that they would rather

counties were left to do recruitment, approve study leaves and such.

Anyhow, perhaps counties can be left to employ some of their own in a parallel recruiting, even though they already messed it up by grossly underpaying those on contractual arrangement. For instance the pay disparity between the nurses on contractual terms and those on permanent & pensionable terms was exponentially wide.

Such a leeway might help counties retain some sense of control which would not be absolute. It's like the public schools have some teachers employed by the schools' board of governors but the bulk of them by the national Teachers' Service Commission (TSC). Without a doubt this could somehow balance out workload and perhaps boosts performance.

10.3.4 Universal Health Coverage and the nurse

UHC emphasizes that people must have reasonably equal access to covered health services, without becoming poorer as a result. Key to the success in providing effective coverage to the population was the readiness of the health service sector (Lu & Chiang, 2018). The study referred to Taiwan's experience towards UHC which it achieved in 1995.

Achieving UHC involved distributing resources, especially human resources for health (HRH), to match population needs. Countries aspiring for this must show financial commitments on HRH in support of UHC. It called for evidence to inform practice and transform various health policies (Campbell et al., 2013).

However, it seemed that the Jubilee government of Kenya decrees assumed an existing knowledge and readiness of systems when it pronounced itself UHC in August 2017. The Kenya Kwanza (KK) government which took over from Jubilee in September 2022 pledged to follow through on the UHC agenda. HRH had signed a charter with KK during its campaigns and recommended a HSC. A to whether this promise would materialize when they got to power is yet another thing (see sec 10.4.7 below).

Nurses have remained steadfast and committed to their allegiance to serve despite the difficult situations in their work environment. However, evidence showed that many nurses just like other health care workers had a challenge understanding the complexities of health care systems as a starting point (Porter-O'Grady, 2015). Such was also observed by Kurth et al., (2016) in 'Investing in Nurses is a Prerequisite for Ensuring Universal Health Coverage'. This deficiency was also highlighted in the Institute of Medicine IOM (2001) in their distinguished blueprint The Future of Nursing.

There were often conflicting requirements of donors and governments weighing on the implementers in some cases. These could have led to transformation fatigue especially on health care providers as often happens when they were faced with a battery of frequent, often contradicting 'often unsuccessful' policy initiatives. This was also one of the key observation by Armstrong & Rispel (2015) in a South African study on nurses and social accountability.

UHC was still fairly new in Kenya, just past the piloting phase. This far UHC episodes were more likely to be reported in the media than in academic publications (Russo et al., 2019). From Kisumu County the media reported during a nurses' industrial action by that '..gross understaffing has ballooned the crisis even further, and the universal health coverage program, only adding insult to injury, raising the number of patients they serve per month to about 2000 concerning a level 2 facility' (Otieno, February 7th, 2019).

With the piloting over it ought to have been all systems go. But subsequent national rollout of Universal Health Coverage (UHC) was apparently stalling. Every other program failure was being blamed on Covid-19 pandemic. Indeed Covid-19 and the subsequent health workers' industrial action almost brought the health system to its knees and we are not out of the woods yet.

But Covid-19 aside, and narrowing down to UHC, were the nurses in Kenya … set..and, ready to go? That is a question that nurses will need to answer. What will be their contribution towards UHC? What were the emerging nurses' roles in universal health coverage (UHC)? These are all fertile research questions. This author was working on a doctoral project entitled - Challenges & Perceptions Affecting Kenyan Nurses on the Implementation of Universal Health Coverage During and Post Piloting Phase; Implications for Nursing Education.

Further, this author had observed that a good number of people both in policy making and training believed that if a nurse did all they had been trained they will be able to assure Kenyans of universal health coverage. It will be by fair chance that they could be able to meet many of the UHC requirements if they did that.

Far from that, nurses were concerned about their enhanced and new roles in UHC since they tend to spend more time with patients than other clinicians (Schveitzer et al., 2016) and (Koon et al., 2017). The later studied 'nurses' perceptions of universal health coverage and its implications for the Kenyan health sector'.

The government perhaps knew for a fact there would be no UHC without HRH and that quality care was at the centre of this (Wangia, 2019). There were many goals to score for the Kenyan nurse. perhaps this was going to be reaping time for

health workers in this country, but did they see it coming or were they too impatient to wait?

According to Crisp, Brownie & Refsum (2018) nurses were well positioned to provide simultaneous health-promotion and disease-prevention activities and take on roles in coordinating and supporting teams in Universal Health Coverage. Notably, Prof. Sharon Brownie the co-author in (Crisp, Brownie & Refsum, 2018) is the Dean School of Nursing, Agha Khan University, Kenya.

10.3.5 UHC: Our higher aspiration

This author (and hopefully others) was working from the assumption that nurses will have the interest of UHC at heart and that universal health coverage was an ultimate aspiration for the patients as well as for nurses themselves. WHO's Director General was candid about it when he wrote, 'we have a moral duty to look after the people who look after us when we are at our most vulnerable...it is a reasonable social contract' (Ghebreyesus, 12th Dec. 2019).

Oh, how true this could be; excerpts from media reports from Kisumu County during one of the several of nurses' industrial action cited, 'the ultimate aspiration ought to be universal health care for the all patients (as well as for care providers themselves) and not just universal health cover' (Otieno, 7th February 2019).

'Some nurses cannot access the same services they provide when they need them', snapped Alfred Obuya, the Chair National Nurses Association of Kenya (NNAK) during a conference (Wamochie, 17th Oct. 2019).

The nursing leadership should deliberately rally their followers behind the two issues – UHC and HSC. Neither HSC nor UHC was a walk in the darkness or a walk in the park. HSC was a dream while UHC was like a free kick as they say in football.

UHC was a free kick – take the ball and run with it. As for what we can do with it, the opportunities were enormous. It was quite presumptuous for nurses to believe that the government and donor partners would play hide and seek with its pet program UHC. All eyes were on Kenya, perhaps as a beacon of hope for Africa.

10.3.6 What exactly ails the HRH in Kenya?

In this author's observation, whenever there was a dissenting voice on HRH and health system it was from certain quarters, while a majority of HRH were passive, docile or perhaps mute. But it cannot be about doctors, nurses and clinical officers every time and all the time, there were other health care cadres too. The health care system has many actors. We

need a strategy that takes care of all the HRH, just as we say in UHC leaving no one behind.

Any other approach will yield not just inequity inter, intra-professionally but between individuals who ought to be earning the same amount for equal effort and experience. With a HSC in place when HRH says 'add' – they will, when we say 'top up' – they will want to know if we have any discrepancies they can address.

The main borne of contention in nursing in this country has been first and foremost a poor working environment, a disregard for patient safety due to unsafe nurse to patient ratios. Then we have everything else one could think of including: lack of meritocracy in appointments, discrepancies in pay, re-deployment upon specialization, inaccessible posting out-of-county, delayed promotions, skewed incremental credits, poor absorption of degree nurses into public service and, what many felt was a fairly inept regulatory body etc.

Emerging issues include nurses' safety and needless to say we now have some fairly careless and negative lot who are practicing nursing in our midst. Miscellaneous ones might include perennial cadre rivalry and, the sometimes overlooked cross-generational issues etc.

For all these and more we have fought (sometimes with each other). A strike will never solve a bulk of them, a HSC will. But who would believe this? Seems nobody wanted to wait here in Kenya. The bottom line – a strike at certain moments in time could be ill-advised.

The effect of many strikes going forward rounded off will be the same: a dissatisfied human resource for health, with barely nothing to show for the strike. No amount of allowances will iron out the crux of the matter – that we have a crisis in human resources, and there seems to some people who benefit from the confusion.

Those apparently in this radar include: some of the union leaders seeking political mileage, its being said some elements in Afya House, some commissions, private hospitals and power brokers etc. The answer for all of them lies in the creation of a health service commission.

It was unfortunate that the union leadership chose to look at the pay aspect almost exclusive of every other aspect. HRH (including nurses) were mainly concerned about the financial aspect (-what they earn, -ought to be earning, -who is earning what and how much more or less and, - why and why not?). The-me-too approach driven more by lack of equity (more of why's – bona huyu, -bona wale and -kwa nini?) Swahili for why this one and not the other was getting so much. A strike will never solve that even into the infinite future!

Looking at Maslow's Theory of Motivation (1946) salary is not even in the 1st hierarchy, it's in the second hierarchy, and there were 3 levels above it like: Social needs - being part of a team, healthy work relations, feeling wanted; esteem needs- achievement and status, responsibility, reputation; Self-actualization - job fulfilment, value addition and higher purpose. The reader is encouraged to critique the two lower rank of the pyramid (See Figure below).

Self-actualization
Job Fulfilment, Value Addition, Higher Purpose

Esteem needs
Achievement, status, responsibility, reputation, etc

Social needs
Being part of Team, healthy work relationships, Feeling Wanted, etc.

Safety needs
Healthy and safe environment, HR policies, Salary, etc.

Physiological needs
basic work needs – comfortable environment, tools, amenities, etc.

Figure (above): An ideal Health Service Commission will take a holistic, human and personal approach health worker's needs (derived from Maslow's Theory of Motivation. Framework courtesy of Vipin Ramdas (2016)

Let's face it honestly. In this era of austerity measures a few steps into realizing the truth were key. Not many civil servants in Kenya got these quantities and quality of allowances. At least that for sure we know, and the Salaries and Remuneration Commission (SRC) has noted and we know how obstinate they can become.

10.3.7 Can we get anywhere near perfect health system?

We will see why human resources for health (HRH) need to shed off every hard skin for this One, if not Two things -The Health Service Commission and Universal Health Coverage. The Ministry of Health used to run the whole system almost exclusively so we know what it is capable of doing. Infact it

will be a shocker for it to lose its staff to HSC. We are also not blind to see what has been happening with Teachers Service Commission (TSC). So HSC will not get us anywhere near perfect health system, but it is a step in the right direction.

I for one have always felt that the county governments have been entering into a discussion which was not theirs in the first place. They seem so eager to be the ones calling the shots in these matters. Health is a viable currency for political negotiation, and that is why we now have Universal Health Coverage. One of the best legacies any government would want to be remembered for is health care. It was unfortunate Kenyans have only come to realize it after so long.

You see the health system is complex and nowhere is it perfect. It's been said that the closest we have to a near perfect is Australia and Canada. Japan celebrated 50 years of universal health coverage (UHC) in 2011 and South Korea did its 40th anniversary the other day. What can we borrow?

10.3.8 Uganda has a Health Service Commission

Just next door Uganda has a health service commission. This is not a by the way. Even though UG is not the best prototype but truth be said, they are ahead of us in this matter. From the website the vision of UHSC (HSC Act, 2001) '....fully resourced health workforce that is responsive, efficient and effective in Uganda socio-economic transformation process'. Mission 'to build a fundamentally strong and completent human resource base for efficient and effective health service delivery.' Just take a second look at the mission statement.

This author was especially attracted to the phrase complement human resource base. He was almost tempted to think the most appropriate word could have been competent, but how wrong he was. Oh how real the phrase was, indeed every cadre is incomplete in itself but HRH complement each other for efficient and effective health service delivery. He also found out that individuals post their resume and keep updating it via the self-service health workers' portal, while job recruitment was done online.

10.3.9 Too much mistrust

Contrary to our Ugandan counterparts, the Kenyan health care providers are very sceptical about formation and effectiveness of HSC, maybe because of the previous working relationship especially between doctors' and other health professions. There has been suspicion that there may not be equity in terms of representation in the Health Service Commission to be.

Anyhow these challenges can be discussed and resolved now that we have the new Health Laws (Amendment) Act 2019. We

need a well-resourced, all inclusive forward looking HSC which would help resolve many of the long-standing human resource related issues (see Figure above).

For that reason, we have come to a point as a nursing fraternity in Kenya needs to be ready and willing to critique every move (that we and others make). We ought to think, plan and act strategically. First stop the infighting and get to work. Never losing focus of the big goals HSC and UHC. In this we should live for, work for, move to any length and breadth and have our being.

That is the legacy we can bequeath the next generation. I remember when BSNs were routing to be included in the internship kitty, them of those times did not benefit themselves but today BSN interns in Kenya earn a pretty amount of Ksh 97,000 (97USD) per month throughout the one year of internship.

10.4.0 HRH was now 'a system'

May be thinking from a systems approach might help (borrowing from postulates of Hummelbrunner (2000; 2011). The human resources for health (HRH) have come full circle in Kenya, someone even called what was happening in the health sector a movement.

We have come so far, it will never be business as usual. So much damage has been caused that will need some healing time. The employers need to realize that HRH can no longer be actively maintained as the naïve, altruistic cadre of workers. This is not possible anymore; we have long crossed the chasm of decision making.

Really can nursing remain stable in a changing operating environment? Moreso, or rather how do we navigate a changing profession? That should be our prime concern. There are conflicting and often poorly thought out themes and policies. The health care system is perhaps unwilling to yield to its nurses space and the time which are the key resources they could exploit to make it run smoothly.

10.4.1 Does nursing faculty have a role in all these?

What is the role of nursing faculty in nursing politics or the politics of the health system? One is to do research around pertinent issues in order to demystify processes. They fight alongside those in clinical practice, albeit not always from the visible front. They do commentaries to frame the thinking of the nurses as was observed by Nyangena (2006).

Though some may dismiss them as too theoretical, it is a role few are able to play except for the self-inspired. Basically, a thankless undertaking. But then we realize that by virtual of being nurses ourselves, apart from

moulding the future workforce we need to give back to the profession; we owe so much to it (Kamau, 2019).

Faculty cannot take it for granted that nurses in clinical practice sacrifice more fighting for allowances that others end up enjoying. For these we are forever grateful. For instance those of us in health sciences faculty earn much more than the rest of dons in the university because of extra allowances (clinical, risk/extraneous, uniform allowances etc.).

The university administration has a hard time understanding for instance why a nursing don the level of an Assistant Lecturer/Tutorial Fellow could earn much more than a Lecturer in non-health programs. These others were not entitled to such allowances nor did many have such prospects whatsoever.

10.4.2 The media and us

The media is often recognized as the fourth estate (unofficially) of government. We will need to use the media to our advantage but not to highlight internal wrangles. The media often find health matters expose´ quite newsworthy, the perception seems to be that the media's agenda is to make us "look bad". Failures in the health care system do unfortunately impact more upon community attitudes towards HRH performance than all the examples of success.

The last time the media had a field day seeking counter sentiments from each nurses' union faction. Different factions fought each other in public and more fiercely on social media platforms. As usual, they disagreed on virtually everything. At some point on 27th July 2017 in a meeting with the Council of Governors (CoG), the nurses' union factions were requested to leave the venue and agree between themselves first. We can ill afford that now.

10.4.3 Leadership with a conscience

Everything will need to be done from a strategic point of view. It is a time when our nurse leaders ought to accept and be willing to be put on the spot, to tell the truth as they know it. Be willing to take up position on the pedestal of truth, to tell the truth, the whole truth and nothing but the truth. No room for presumptions any more.

However for leaders in the system (including the union leaders) telling the truth means they ought to be good learners and listeners, their opinion should come last. Infact they might just as well not say it, we have heard them long enough. Their words can never be regarded as innocent. They have led to intense suffering to the public. No wonder Kenyans were asking – 'it's you again!?' Every time they saw these familiar faces on their TV screens they had learnt to associate with not very pleasant memories.

We do appreciate that our union leaders have done so much on our behalf. They also know so much from so many but nevertheless in telling the truth need to use some discretion. What can be left out without jeopardizing this understanding? What we call a minimalist approach when dealing with the public (and in some instances their nurse followers).

There is no sense of going into the boardrooms for negotiations then emerge from the revolving doors to diverge everything (to the press and all) dressing it up mostly with our personal vendettas (and hitherto withheld opinions). On the other hand, the other party knows how much was said in there and that the press conference was being treated to some theatricals.

The aim of <u>nurse leaders</u> need not necessarily be that of whipping the "soft spots", capable of triggering strong reactions from their constituents as has been the case. They just need to be factual and truthful.

10.4.4 Problems and solutions

We will need to define problems from solutions and vice versa (Hummelbrunner, 2011) <u>systems theory and systems thinking</u>. Problems are: situations regarded by someone as undesired, which need and can be changed (at least in principle). But we too can construct problems that become the systems' problems. You can think of a few examples and be part of the change (see Figure below).

What is considered problematic for one actor might be meaningless or even considered a solution by others. Indeed some sections of HRH have reaped massively from divide and rule tactics in equal measures. Prof Atwoli PhD, a professor of medicine wrote on 16th February 2019 that <u>'labour relations in health sector were a disaster'.</u>

Therefore we are talking about a problematic situation that has often led to specific patterns where not only systems are creating problems, but problems are also creating systems. For example, we now have a <u>system called </u>HRH crisis in Kenya.
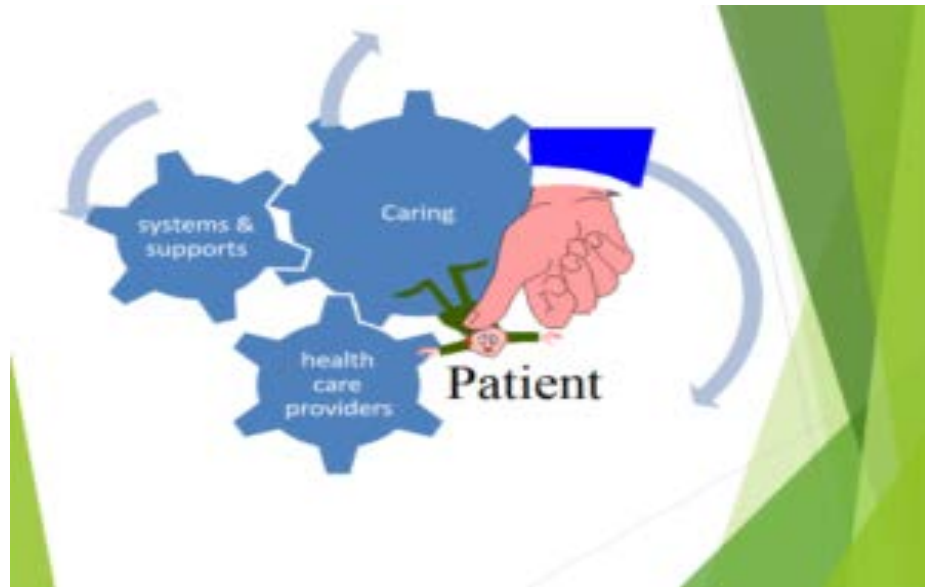
Figure (above): The cog wheels of health system (Courtesy of Compleat Nurse 2019©)

[The author's impression of the nurse as the fulcrum in the moving cog wheels of health care system. Why? This was because caring was at the centre of nursing and quality people-centred services for UHC since the nursing cogwheel is the engager. In any case if the moving parts conspire against the fulcrum the integrity of the system can no longer hold, the patient might 'get crushed' or 'fall through the cracks'.]

10.4.5 HRH have come full circle

The cogwheels of the health system have come full circle in the politics of health and politics in health (see Figure above). These were hardly their concern for a long time as evidenced by the fairly 'indifferent' attitude in the run-up to the constitution 2010.

But the problematic system needs to be identified. "Everything changes unless someone/-thing ensures that things remain as they are", Hummelbrunner (2011). It would be important to learn how problems are maintained, who and what contributes to 'stabilise' the situation as it is? Are there actions which take place but should not happen? Are there actions which do not take place but would be needed?

But at this stage, it is also important to analyze the state of affairs we have (here and now, the Kenya 2019/2022). We will need to make a distinction between problems and difficulties. Difficulties are undesired states, which can either be solved by simple corrective actions or have to be lived with because no solution is known. Let us not be hesitant to think of a lofty dream – What is the good in the

bad, what would happen if the problem disappears? (See Figure above).

Coming full circle also means we now have some level of maturity compared to 1 or 2 years back, as to whether a strike ought to be the new normal in our profession. Whether we can continue being accused of planning for the next strike during the strike, but how has that worked so far? We do have a postscript. Especially what emanated from the dreary five-month long strike of 2017?

The fact remains more than ever before we need reforms now. The beauty of it is that the occasion has been presented to us. Just like Rwandese President Paul Kagame once said:

Do not be afraid to face our challenges head on. If you don't work hard and fight hard to be at the table, you become the menu…, you must fight to be at the high table. We have been items on the menu for too long…

The above statement could have referred to the nursing vis-à-vis health system in Kenya situation for far too long. We need to be involved with shaping the healthcare delivery model, at the both at the micro and macro level. However, Howard Fuller (in Figure below) underscored that even as we join the table can we read the menu? There was need for equipping ourselves with information. Nothing can replace information, facts and evidence when it comes to empowerment.
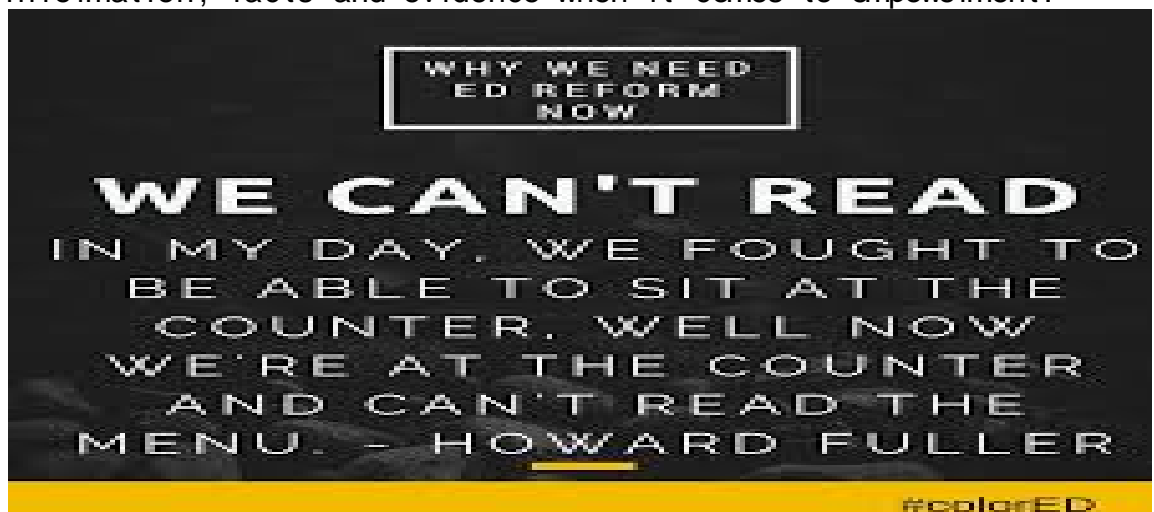
Figure (above): Why we need reform now [mural courtesy of colorED]

10.4.6 We can afford to analyze previous attempts for solutions

What should not be tried anymore? Past solutions are often the key to present problems. This is particularly true in cases where false solutions have been applied on difficulties and thus have turned them into real problems. Is the context the same? Even applying proven solutions in a changed context may not be the right thing to do Hummelbrunner (2011).

We need to identify the crucial factors capable of bringing forth change, what is referred to as the leveraging effect. Who and what is needed and who and what can be left out? What points at future directions? 'Problem talk often creates problems, solution talk creates solutions,' Dr K.N. Jacob one of mentors I follow is fond of saying.

I will work from the simplistic approach and propose what might be least costly but most effective. What is the smallest unit needed to bring forth a solution?

Due to the constructed nature associated with HRH's problems and solutions, the focus cannot be placed on the past (that is in trying to answer the question why?), but on the present (what?). What happens now and what can be done about it? This becomes especially important where actors are too entangled in their problems to see a way out or only tend to see the old solutions to new problems. Or were part of the problem themselves.

There are numerous pillars in the health system and HRH is just one of them, so HSC would be the least likely panacea for all of them. Then there are the constitutional functions of Salaries Remuneration Commission (SRC), Public Service Commission, Ministry of Labour, Ministry of Health etc.

Technicalities like -what will be the structure of HSC, whys and why not? Or maybe just anchor HSC through an act of parliament to start with. Why did we not consider this option? We didn't need #BBI to see, acknowledge the need for an HSC..' cited a posting from social media. Its become obvious that BBI failed to factor in a constitutional HSC we wanted but instead proposed a statutory body HSC with only advisory role.

10.4.7: Health Commission proposed in Constitution of Kenya, 2010 (amendment) Bill, 2022

Some quarters mainly from people at KMPDU even suggest it is very much possible to get a HSC through an act of parliament. It's possible KMPDU might be having something worked out, hopefully with everyone's interest at heart. Infact they did so only it seemed that they were on their own or should we say they did it on their own or so it appeared. The proposed Constitution of Kenya, 2010 (amendment) Bill, 2022. Amendment of Article 254.

254A- There is established a commission to be known as the Health Commission.

(2)The Commission shall constitute the following persons appointed by the President with the approval of the National Assembly:-

(a) a chairperson who shall be an advocate of the High Court of Kenya as nominated by the Law Society of Kenya; and

(b) six members, nominated by the Kenya Medical and Practitioners Board with equal representation of both genders.

(3) The members of the Commission shall hold office for a term of 4 years.

Already the rest of HRH have disowned this proposal in that only doctors, dentists and pharmacists would compose the six members of the proposed health commission (HC) through their Kenya Medical and Practitioners Board. The HC chair would be an advocate of the High Court as nominated by Law Society of Kenya.

The rest of HRH read a lot of mischief in these clauses 254A, Sec. 2 (a) & (b). It sparked a lot of debate among HRH on social media and even as at the time of publishing this article it was sensitive topic among the medics. This was even though the momentum for the amendment had slowed down drastically and we will see why in a short while. Anyhow, instead of scuttling this latest effort for lack of inclusivity perhaps there is no problem with each cadre coming up with a draft then comparing notes.

But there were even larger challenges. The Constitution of Kenya, 2010 (amendment) Bill, 2022 containing HC also happened to have controversial proposals that Kenyans in general were not happy with. They felt some items had been sneaked in that spoiled the whole document thus it might not sail through. For instance Article 138 touching on general elections; Article 38 barring outgoing governors from vying for senator until after 5 years; barring any one political party from sponsoring a candidate for the position of Senator and Governor in the same county.

Without going into its details, Article 88 on the Independent Electoral & Boundaries Commission was the most controversial such that even President Dr William Ruto said he would not be party to mutilating the constitution in what he termed as selfish, parochial gains. Was this the last we would see of our pet HSC? I believe not.

10.4.8 A SWOT analysis of nurse unionism in Kenya

Even as we seek change, we need to be made aware what should be maintained. A SWOT analysis might help us to strategize. SWOT stands for Strengths, Weaknesses, Opportunities, and Threats. Strengths and weaknesses are usually regarded as internal while opportunities and threats as external but this may not always be the case (see Table 1 below).

SWOT analysis in our strategic planning should help us to balance out nurses' contradictions and ambivalent tendencies (e.g. good in the bad, bad in the good, the good with the not so good) cross tabulate the matrix on and on as follows:

Each of the attributes can have a small letter that can be matched with it or any other attribute. For instance <u>W</u>eakness can be matched with <u>o</u>pportunity (Wo) and then we see what we can get. Often the lack of unity among nurse leaders matched with <u>o</u>pportunity to rally the troops behind a WORTHY cause like HSC (Wo). Nurses' numerical strength (So) matched with a lifetime opportunity for HSC/UHC in this time and season (e.g. HSC and UHC).

In terms of metrics about 75% of all health tasks and almost 50% of health indicators were directly tied to <u>nursing services</u>. Every other metric on which hospitals (and healthcare for that matter) were evaluated - from quality outcomes; patient safety; patient satisfaction; staffing efficiency; medical staff confidence were dependent upon having a staff of nurses who felt valued on the job (<u>Mitchell</u>, 2009; Nyangena, 2006)).

<u>Table (below): A SWOT/Swot analysis matrix</u>

Attributes	S	W	O	T
S	Ss	Ws	Os	Ts
W	Sw	Ww	Ow	Tw
O	So	Wo	Oo	To
T	St	Wt	Ot	Tt

[Courtesy of Compleat Nurse 2019[©]]

What are we bad at doing? What are we good at doing? What do we want to defend against? Certainly the <u>t</u>hreats and <u>w</u>eaknesses (Tw) includes lack of unity. Why do we need to have five nurses' associations or do I say unions? These can all be easily collapsed into one.

What do we want to take advantage of? <u>O</u>pportunity and <u>s</u>trength (Ot) our numerical strength and our undisputed <u>trust with patients</u>. We can successively argue that point with <u>evidence</u>, backed by years of surveys worldwide. For the US according to <u>Gallup (2018)</u>, for the last 16 years, Americans' ratings of the honesty and ethical standards of 22 occupations found nurses at the <u>top of the list</u>.

The American Nurses' Association (ANA) president Ernest Grant, Ph.D., RN said this in response to the <u>2019 survey</u>, "Nurses occupy many roles in our society and are on the front lines when it comes to immunizations, natural disaster preparedness, shaping health policy, and advocacy. For this reason, nurses are critical in improving the landscape of health and health care because an effective health care system is one that values all nurses."

Nyangena (2006) had foreseen that there would come a time that Kenyan nurses would be all over the globe. Today we have

a large Kenyan nurse's population in the diaspora, no mean feat by any standards especially since the advent of Covid 19. A point worth noting is that this has led to a rare disquiet in nurse activism. One nurse commented on social media that the only thing that seemed to bother Kenyan nurses nowadays was how to majuu (or rather how to migrate). Majuu is Swahili slang for abroad, overseas, flying out. Some agencies even have the guts to start processing nurses who are still in internship, in other words licensure to follow.

Anyhow we still sneed to ask ourselves these: What do we want to improve that we have or are not doing right opportunities weaknesses? (Ow) like wanting to do things like doctors, teachers and, soldiers yet we are not, if anything can be better! Nonetheless in terms of resilience and perseverance I feel nurses might be likened to soldiers.

Developing a factual base for our opinions ensures an informed dialogue with others, supports our views with hard data or factual evidence to increase our credibility. Nurses' knowledge about patients, ability to translate patient care systems into financial language, and ability to focus on how to design future patient-centred systems of care is a significant contribution that no successful health system can afford to ignore (Kamau, 2019).

"Nursing is a business and it is in the profession's best interest to craft our arguments in a business-like manner" (John Welton Ph.D., RN) as he proposed on Paying for Nursing Care in Hospitals. He has done a lot of work nursing care costs, nursing billing, and reimbursement. In his argument, prospective payment system ought to more accurately represent nursing care. One way was by utilizing nursing intensity billing (Welton, 2006).

10.4.9 Balancing the act by use of external interveners

What if we kept our interventions balanced by exposing to external views in a moderate way, negotiating without confronting openly? Due to the selective processes of self-referenced unionists, each only sees specific parts and is not aware of the blind spots, since 'we don´t see that we don´t see'. This can only be achieved by increasing the reflective capacity, and for this external assistance might be of great help.

Every system, in the end, does what it does best according to its logic but what of trying to utilize mediation, interveners? We have not tried this and failed if we gave it a fair chance. Let's give it the power and resources. Regard interventions as a cyclic process. There will always be another day to try some of what we feel ought to be implemented now-now! (Hummelbrunner, 2011).

But just a minute – What if we tried something else? The last minute; what if? Just a minute approach quite often the

suggestion came from the least of those involved. I believe some of us have used SBAR; Situation, Background, Assessment, Recommendation. SBAR is a framework for communication between members of the health care team, a concrete mechanism useful for framing any conversation, especially critical ones, requiring the other party's immediate attention and action.

External observers are much sought after nowadays in the corporate world; they will provide that additional perspective and help us overcome internal blockages. Above everything else we need to spell out their terms of reference, narrow them to specifics.

10.5.0 Working collaboratively with others

We cannot anymore operate in silos. The silos of – 'those, them and we nurses'. We can work collaboratively with Kenya Medical, Pharmacists & Dentists' Union (KMPDU), and Kenya Union of Clinical Officers (KUCO) among others.

The way into the future is skills-mix, task-shifting, task-sharing inter-disciplinary, inter-sectoral and we cannot possibly avoid it on our path to UHC as a low and middle-income country (LMIC) (Rubinstein et al., 2018). If that is the way we will work why not start from the welfare point of view? (See Figure below).

An anonymous post to a social media wall read '...I long for a time when KNUN and KMPDU can merge and push pertinent issues affecting us in a more powerful manner' [End of quote]. After all, what has working each on their own achieved anyway?

We can do some circular dialogues with the help of external facilitators. Mixing efforts might yield divergent results sometimes but it is never too late to work together if we can reduce our suspicions of each other's intentions.
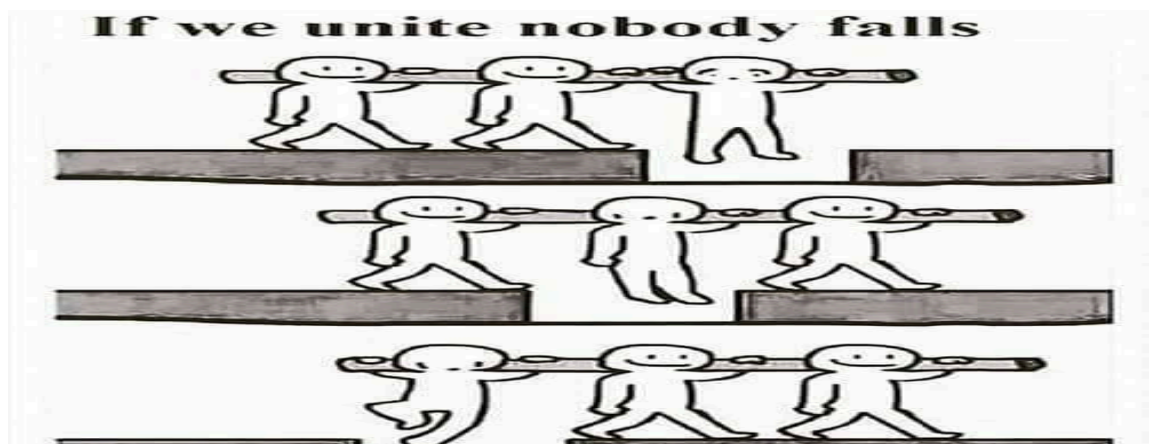
Figure (above): If all the HRH unite nobody falls [Courtesy of the clip developer]

Lastly and, this is the crux of the matter – will the all too frequent rallying nurses back to the streets be the best option? Nothing could be worse than leading a scared lot on the streets of Kenya today, especially after apparent waning of public sympathy for the cause of the industrial action in the health sector. Ask many a Kenyan, they will tell you with some degree of certainty what will happen. It follows a certain predictable pattern:

Unionists will want us to believe these were the stages of a strike, they perhaps could be knowing what they were saying. But I learnt too that unionists ought to prepare the striking workers to save beforehand what can sustain them for a minimum of 3 months during the strike.

A lot of bickering culminates into a call into industrial action, and the industrial action takes place, in some areas more intense than others. Leaders get divided. Some court battles become a necessity to keep the tempo, then time drags along and the public loses interest.

The strike dissipates, with a sizeable number having resumed duties, finally when it cannot hold; some crafty decision is taken to call it off. Much of the action will be virtual, taking place in the media, social media and commentaries (like this one). Meanwhile, the county governments' bigwigs do their jig of beating the drums so loud that the song is not heard. That is assuming the battle is theirs (when it never was in this writer's opinion), it belongs to Health Service Commission (HSC), if we let us work towards making it a reality.

The rummaging effect of the industrial action notwithstanding, the aftermath is felt for a long time. This author was avoiding referring to the sick here because that would deviate the debate, but they remain the most important stakeholders whichever way we look at it. The patient ends up as pawns in the fight; some getting crushed or falling through the cracks

Whatever statements were being issued from the highest office in the land, to the county governors tell a different note – i.e. times have changed. Even the KNUN top organ was had at some point said it was the branches that called the strikes and not the national organ. KNUN said that it would recognize the RTWF with counties, in effect making the national RTWF of 27th November, 2017 a lame duck. Different counties including: Kiambu, Machakos and Kakamega had signed RTWF in a strike that started in December 2020.

Perhaps we need to look at the fruits hanging up there, not just the low hanging ones (like CBAs). The fruit up there is hidden in Health Service Commission and Universal Health Coverage. Now is the time, Nursing Now!

We need to desist from roasting colleagues who dare challenge the decisions made by our leaders in HRH. If anyone followed this writer's posts, never ever did he insinuate that nurses should not be paid what is due to them since he was one of them. All he was trying to do was to frame the debate for our weighing and consideration.

It is his humble submission then that nurses in Kenya should work towards ensuring the formation of a Health Service Commission (HSC) one way or the other and the realization of Universal Health Coverage (UHC) wherever and whenever possible.

The year 2020 meant something to the good lady as envisioned in the Figure below. At some point she was also inspired to write the following:

"May we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard, practical work, the difficulties and the joys of organizing nursing reforms, and who will lead far beyond anything we have done."

Have we lived up to the dream?

Figure (above): Nightingale and the Year of the Nurse 2020
[Courtesy of the clip developer]

These were golden times. Whenever we get the forum we need to acknowledge, appreciate and address the challenging conditions we face; and advocate for increased investments in high quality workforce. We have an opportunity like never before. The year 2020/2021 became WHO's Year of the Nurse in commemoration with the bicentenary (200th) birthday of Florence Nightingale, the founder of modern nursing.

10.5.1: Covid -19: Was it a blessing in disguise?

Even though Covid -19 might have robbed us of the pomp and colour of the year of the nurse; the heroes that nurses were had become more indisputable (however short-lived, at least this fame would last through the 2020-21 Covid waves). Actually anecdotal evidence from the agitation showed that Kenyan nurses who were hired by the government during the crises also known as UHC Nurses were abandoned when the epidemic subsided. Nevertheless, Covid-19 unearthed the weaknesses of health systems all over the world. Countries were removing the amber alert on outmigration of foreign nurses. Nurses were on demand everywhere and Kenyan nurses were leaving for greener pastures in droves. Even though the brain drain was a real threat the timing could not be more perfect.

10.5.2: Health care assistants/ Patient Attendants quickly filling in the space

Even Health Care Assistants or what we here like to refer to as Patients Attendants, some with only a few months' training and experience were quickly filling in the space. Doing some of the 'nursing work'. Institutions offering Care Giver courses started mushrooming in literally all urban areas. In a rare development some universities started daring into in training Care Giver short courses. One example was Mt Kenya University who in collaboration with Germany were to train those with a 'B2' level German language with an assurance of jobs.

The future of nursing begins with you and I....

Be part of the change you wish to see in Nursing *(adapted from Mahatma Gandhi 1869-1948)*

Figure (above): The future of nursing is by deliberately taking an active part of the change

10.6.0 Proposed Way forward

Need we wait for our messiah still? We ought to get it into any other change constitution caucus which may come up anytime and every time this year, next year, some time, never. Never is the least likely. In the meantime nurses in Kenya need to somehow rise to demands of frequent policy changes with ease.

While universal health coverage (UHC) could mean that Kenyans will be able to access affordable care, it appears there was some disharmony between supporting structures for UHC or more likely the system supporting UHC. From now on all effort should be about how to get past the riddle of getting a Health Service Commission (HSC) for all health care providers and how get them to support UHC. HSC and Universal health coverage (UHC) need to be our higher aspirations. Hopefully other stakeholders too will be looking at these as alternative ways of dispute resolution to the troubled health sector.

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APPENDIX I

Best Care Anywhere Organizing Framework for Resource-Limited Health Care Settings in Kenya (QHCOFR-LS)

Construct No. 1

-Giving a service +No harm or complaints arise ≠ that we did the job well?

Construct No. 2

-Are there areas we may have done badly yet things do not turn out as bad? The patient even comes back to say THANK YOU

Construct No. 3

What happens when we / someone close to us becomes the customer of the very service we either give or don't give?

Construct No. 6

-Bridging these gaps is about assuring access to Quality Care 'Best Care Anywhere'

Construct No. 5

-How much are we prepared to put in to make sure quality care occurs in every health care setting?

Construct No. 4

-Is there really a way that there can be a Continuous supply of basic cross-cutting equipment and drugs?

Key Features of the bridge we aspire (materials needed)

CONCEPTUALIZING THE UHC GAP

Interval
-Disparate
-Usurder
-Apart,
-Interlude,
-Between,
-Separate,
-Non convergence

Refers to

-What type of bridge?
-Who knows of the best bridge?
-Where are they?
-What can we borrow from them?
-How shall we know when we get there?
-How do we know its going to be different
from the one already there?
-What about the cracks?
-What is the cost?
-What if it doesn't work?
-How do we sustain: maintain, repair, cost,
knowhow?
= **Attainment of UHC for all**

Making a connection

-Sealing,
-Narrowing,
-Occluding,
-Interface
-Joining

Between two or more items
which were hitherto separate

Otherwise coming up with,
Or assume

Requires

What matters?
Which gap?
What, who created it?
Why the gap?
How long has it existed?
What are the effect?

-Cohesive forces
-Effort
-Configuration
-Attraction
-modification
-Manipulation
-Treatment/Intervention
-Creating interest

To make

-A composite
-Compound
-End result
-Complete
-Congruent
-Fairer or better than sum
total of @separate items

KEY
UHC: Universal Health Coverage

Figure: Bridging the UHC Gap
Kamau S. Macharia © 2019

What is the best cover-care anywhere? In the given circumstances

Is anyone doing better than us under similar circumstances?

What can we learn from them?

Can other systems be transplanted here?

Best care/ cover

Anywhere

Interrogating Universal Health Coverage [UHC] in resource constrained settings

How do we interrogate?

Tools and tests-

Which resources?

Resource constrained

Interrogating

Are three parameters?

reliability, precision, accurate, validity

How is it currently?

Models/ Frameworks

Why resource constrained settings? What is unique/

Effective use, rationing etc.

Which frameworks/models have been used?

What have been the implication, assumptions, strengths, weaknesses?

What challenges /barriers to UHC provision here?

Where do we want to go from here?

With what success? Amazing, going out of the way

How do they compare?

Equalizer =± Universal Health Coverage How do we get there?

How might these challenges be overcome?

Best Case scenarios frameworks, testing

ultimate

Interrogating Universal Health Coverage [UHC.] in resource constrained settings
Kamau S. Macharia 2018©

Monday, December 24, 2018

Appendix IV

Figure: UHC Anywhere in Resource Constrained Settings
Kamau S Macharia
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KEY
UHC: Universal Health Coverage

Appendix V

Figure: UHCc for 'Whoever' in Resource Constrained Settings

Kamau S. Macharia ©2018

Key

UHCc: Universal Health Coverage
VIP: very important persons
UAMA: unknown African Male Adult
NHIF: National Hospital Insurance Fund

Figure: COULD UHC ANYWHERE BE A REALITY?

Kamau S. Macharia © 2019

Appendix VII

The *Compleat* Nurse in UHC

To mean

But not

A hero, an epitome of excellence either

Not necessarily

Competent, ethical etc.

Otherwise referred to

One who cannot get burnout or compassion fatigue etc.

The Compleat Nurse in Universal Health Coverage [UHC]

Expert at workaround, improvising

But one who

Utilises

Needs to be supported, needs tools of work, debriefing, needs to rewind etc.

EBP, Nursing theory. Is a change agent

With the interests of

Requires

By looking for ways of

A *carelee*- carer of the compleat nurse care provider

Creating new energy for self and workplace

Carer at heart Patients at heart

Lead to continuum of

KEY

UHC: Universal Health Coverage
EBP: Evidence Based Practice

A *Compleat* nurse suited for UHC in resource constrained setting

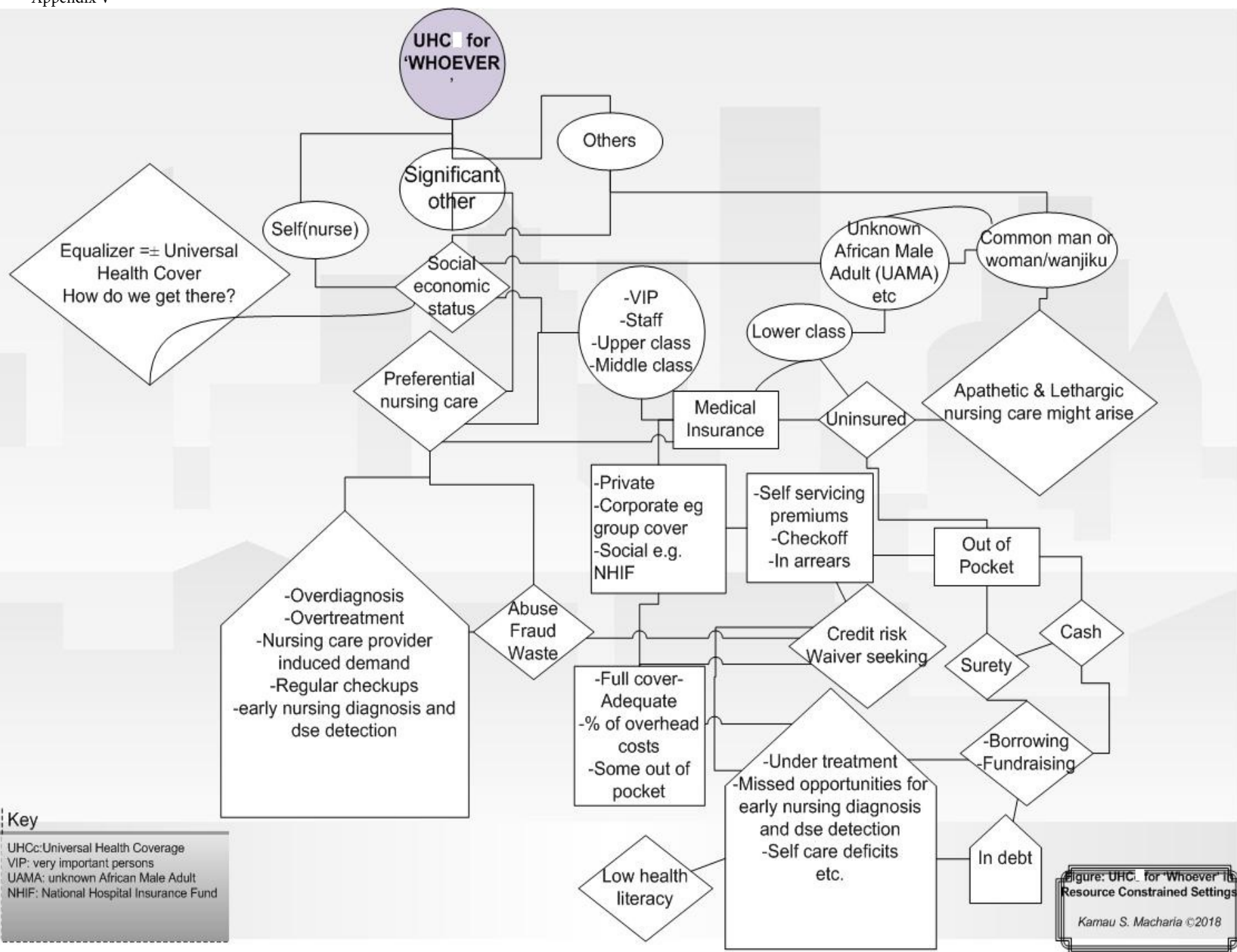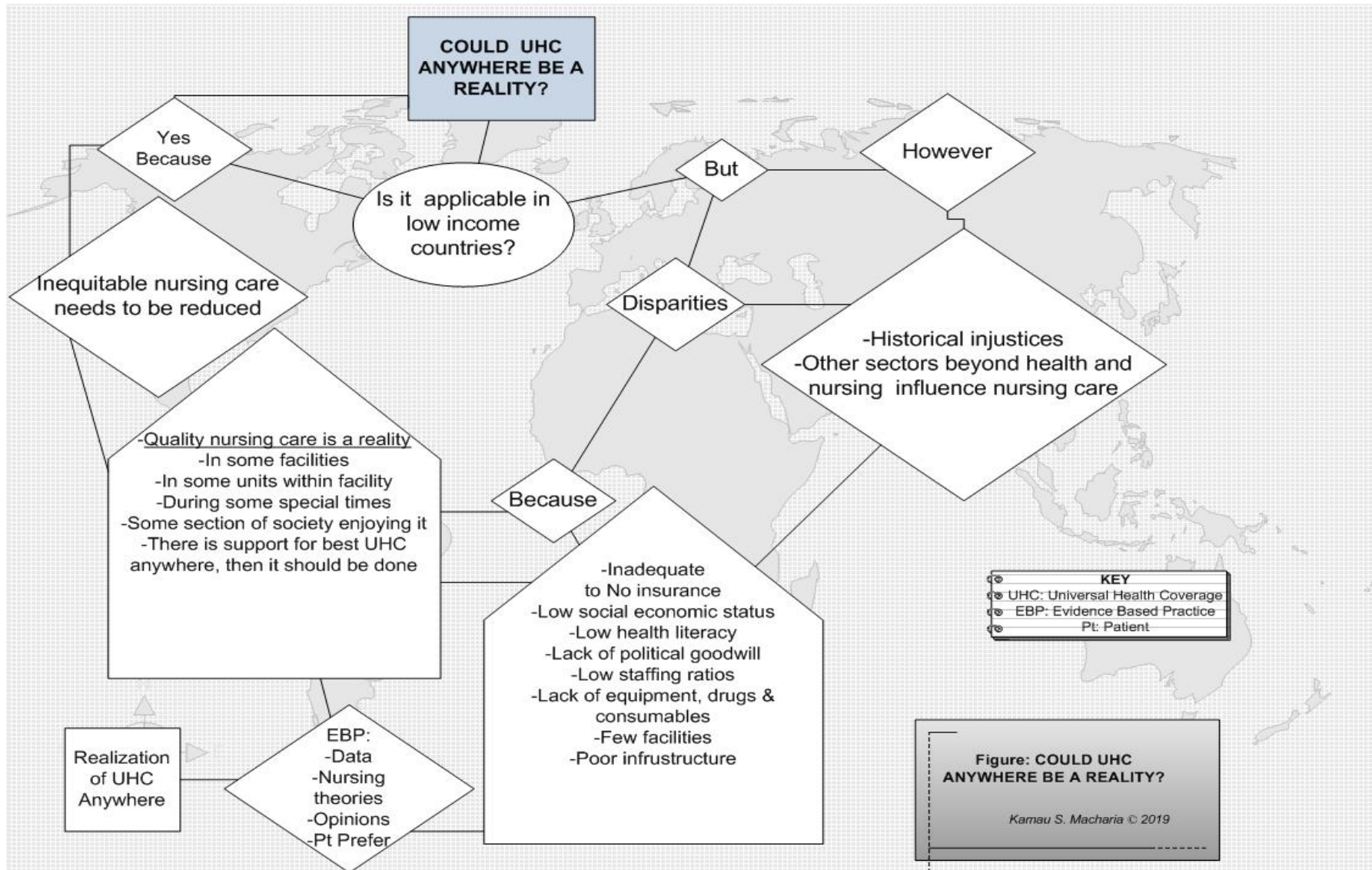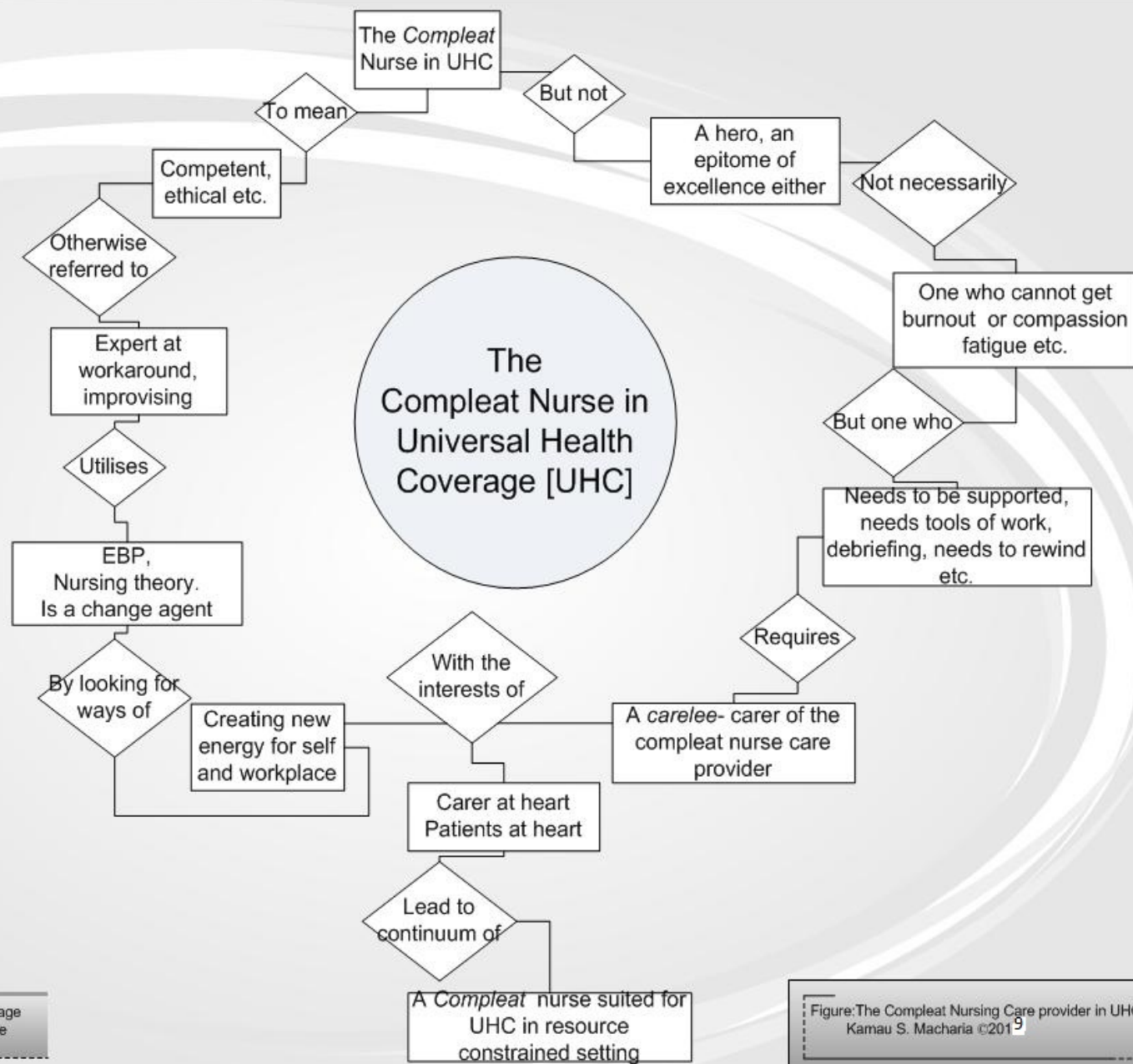Figure:The Compleat Nursing Care provider in UHC
Kamau S. Macharia ©2019

About the author

Simon Macharia Kamau is a Doctoral candidate in Medical Education studies at Moi University. Holds MSc Nursing Leadership and Health Systems Administration alongside Innovation in Leadership & Administration (iLEAD) from University of Colorado Denver USA, BSc Nursing from Moi University, Higher Diploma Critical Care Nursing (CCN) and Diploma Kenya Registered Nursing (KRN) from Kenya Medical Training College, Nairobi.

His professional career spans over 27 years. Currently teaches in the health sciences programmes at University of Kabianga, Kericho County, Kenya. Previously taught in the Higher Diploma in Critical Care Nursing, Higher Diploma in Nephrology Nursing and Diploma in Kenya Registered Nursing at Moi Teaching & Referral Hospital Training (MTRH) Centre. Served as the Nursing Services Manager of Critical Care Division MTRH for 5 years.

Has served in various capacities at national and institutional working committees. He served as a guest editor with *American Journal of Nursing Science*, *Nursing Education & Research,* and a distinguished reviewer for *Human Resources for Health Journal (HRH)* among others. Has published and presented at both local and international forums.

He has also authored other books:

(1) *Inventory on Job Description of Nurse Managers in Developing Countries: Rising above the Challenges and Demands Placed on The Nurse Manager in a Changing Work Environment* (ISBN 978-3-659-17612-8).

(2) *Ethical Dilemmas on End of Life Issues Vs. Faith of Clinicians in Kenya* (ISBN 978-3- 659-42049-8).

(3) *English/Kiswahili Medical Glossary: Matumizi ya maneno ya Kiswahili katikautabibu Hesperian Health Guides*

(4) *Interrogating Health Systems in Resource-Constrained Settings: Frameworks for Quality Health Care in Kenya.* Compleat Health Systems, Nairobi Kenya. e-book Available:https://www.amazon.com/dp/B077MLZ3JN

Has published widely, online URL:
https://www.researchgate.net/profile/Simon_Kamau/publication s/

Readers and fans can also follow this author's blog on social media http://www.compleathealthsystems.com where he posts as *Compleat Nurse*. Let's connect and share there too.

<div align="center">Welcome and Thank you.</div>

The author's experiences in the Kenya health care system

Station	County	Period	Status
Kenyatta National Hospital	Nairobi	1986-1990	Student KMTC Nairobi
		1996-1997	Student KMTC Nairobi
Moi Teaching & Referral Hospital	Uasin Gishu	2001-2011	Staff
		2003-2007, 2018-2019	Student Moi University
Rift Valley Level Six General Hospital	Nakuru	1992-2001	Staff
Aga Khan University Hospital	Nairobi	2000-2001	Pool nurse
Kericho County Referral Hospital & Kapkatet Sub-County Hospital	Kericho	2011-to date	Supervising undergraduate students
Londiani District Hospital	Kericho	1990-1992	Staff
Kapenguria County Referral Hospital	West Pokot	2006	COBES IV/ student Moi University
Karuri Rural Demonstration Health Centr	Kiambu	1988	Community health nursing attachment KMTC Nairobi
Tenges Health Centre/ Mugorwa Health Centre	Baringo	1992	Yellow fever campaign
Sirisia Health Centre	Bungoma	2003	COBES I/ student Moi University
Turbo Health Centre	Uasin Gishu	2004	COBES II/ student Moi University
Mathari Mental Hospital	Nairobi	Now and then	Student, Tutor, Lecturer
Njoro Health Centre	Nakuru	2008	Internship after BSN
Koiwa, Ainamoi, Mogogosiek, Cheptalal Gesima, Manyoror, Sosiot, Roret, Esani, Ndanai, Health Centres & Sigowet, Meteitei Sub-County Hospitals, Alupe su County Hospital, Port Victoria Sub County Hospital.	Kericho, Bomet, Nandi, Kisii	2011-to date	Supervising COBES BScN & BSc EVH students of University of Kabianga
Longisa County Referral Hospital, St. Clare Mission Hospital Kaplong, AIC Litein Mission Hospital	Bomet, Kericho	2016-2017	Supervising undergraduates students

i COBES: Community Based Education & Service

Key Features of this book:

-Distils lengthy and complex systems into bite size pieces of clear, concise information, making them easier to embrace and incorporate into practice in resource constrained settings;

-It is a practical book providing quick access to some policy matters on health care in Kenya and the rationale behind them. This is neither meant to be prescriptive nor all- encompassing;

- It strives to inspire change and influence policy development process within the context where nurses practices and nurse educates.

-Shares first hand experiential information (memoirs) from the field about individual nursing care providers with the client in mind;
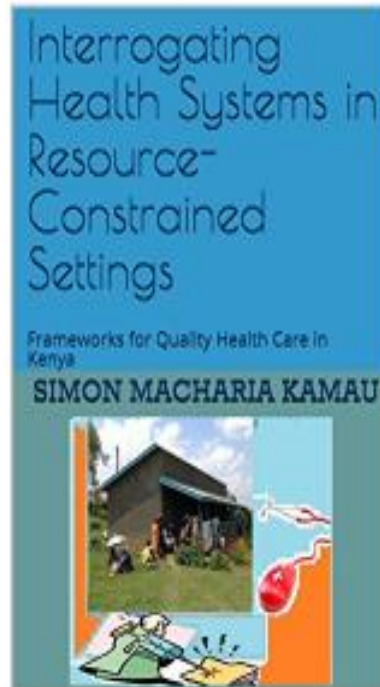
-Provides crucial information, statements of facts and best practice standards drawn from elsewhere that might be applicable at the operational level/ point of service in Kenya;

-Covers state-of-the-art, current affairs, topical & emerging Health Information Technology issues with a *future-today* approach with an eye for evidence based practice;

-Dissipates disillusionment with our health care system and instils nurses with hope and encouragement about how they can make a difference;

- Exposes everything from trivia to mega that ails the health systems, nursing education and health infrustructures in resource constrained settings.

-Apart from being scientific, it does not shy away from everyday communication: mass media, social media, politics, sociology of health, tagged news touching on health.

-In some way endeavours to make the challenges healthcare providers and educators face visible to the person responsible and to whom it may concern. A good deal from the nursing angle.

-Introducing an innovative way of textbook writing. On the Kindle *e*-book platform it was possible to continue editing and updating your publication almost indefinitely without necessarily affecting its availability to customers. This was a great innovation authors needed take advantage of. To give the reader what we have ahead of time, or help to hurry up and wait. As the world is moving in terms of communication so should those us who write!

Also authored the following e-Kindle book
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Health Systems in
Resource-
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Settings

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Kenya

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