Iranian Nurses' Status in Policymaking for Nursing in Health System: A Qualitative Content Analysis

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Abstract: Presence of nurses in policy making will result improvement of nursing practice, and increase qualification of patients' care, but still few nurses are involved in policy debates and health reforms and their status in policy making for nursing is not clear. The aim of this study was to elucidate Iranian nurses' status in policy making for nursing in health system. This is a qualitative study. Using purposive sampling 22 participants were interviewed to gain deep understanding from the phenomenon of status of nurses in policy making. Of these 2 were not nurses but the members of Iran's council for health policy making. Data were analyzed by employing conventional content analysis. Nurses' status in policy making declared base on the implications of three main themes including "the policy making framework", "perceived status of nurses in policy making", and "the manner of nurses' participation in policy making". The conclusion of the present study is that Policy making for nursing is a subcategory of Iran's macro health policies. What made the status of nurses more efficient in policy making for nursing was their practice and rate of participation in the appointed positions and the society. Results of this study represented major points of weakness in nursing policies and some recommendations for modifications.

Keywords: Conventional content analysis, Iran, nursing, participation, policy making, status.

INTRODUCTION

One of the challengeable issues in health system is professional status. Making clear of professional status have individual and organizational effects and is related to psychiatric security of health team [1]. One of theses professional statuses is nurses' status in policy making for nursing in health system. In a wide inspection what nurses do for their patients is determined by resources and structures which have been selected by policymakers in high levels [2]. Nurses spend the most contacting time with patients and their families. They burden various tasks in public health including prevention and care in acute and chronic diseases [3]. Nurses can deal with various aspects of health issues in policy agendas [4]. Presence of nurses in policy making will result improvement of nursing practice, and increase qualification of patients' care [5]. Nurses value in development of health policies is clear, but still few nurses especially in clinical settings are involved in policy debates, even if to be a nursing issue [6]. They have specialty and ability to make change in health system but often their voices not been heard [7] and their presence and real status in key points of health and nursing policies had been feeble [3]. Results of a survey by Robert Wood and Johnson

Foundation about the perception of healthcare managers and authorities of the effects of various professions and individuals on revision of health affairs represented that nurses had been in the sixth or the last grade with considerable difference comparing with others. What is more significant in this survey is that patients had more effectiveness than nurses (20 percent versus 14 percent) [8]. Mason *et al.* (2011) define health policy as preferences of government with considering health priorities and ways to allocating resources in order to gain goals [9] Hennessy and Spurgeon (2000) also simply defined health policy as strategies and actions which been adopted by government to well maintain and improve health [10]. According to these definition policy making is the task of government or nurse leaders who have been appointed to governmental affairs, but since the body of nursing is nursing practice and nursing practice is a reflection of total health policies [11], so nurses in echelons of practice management also need to participate in developing strategies and to modifying policies [12]. That is why Huges (2005) had linked policy analysis to nursing process which central to both is gathering information, problem identification and adoption of strategies [1].

BACKGROUND IN IRAN

Iran as a developing country has the second largest population in the Middle East and North Africa region (78 million people) after Egypt and population growth rate of

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1.247 percent in 2012. It is the second largest economy in the Middle East and North Africa region In terms of **Gross Domestic Product** (GDP) (496.243 billion US$) after Saudi Arabia in 2012 [13]. Health expenditures have allocated 3.9 percent of Gross Domestic Products (GDP) in Iran whereas this is almost 6 for Saudi Arabia [14].

Iran possesses almost 730 medical establishments (e.g. hospitals, clinics) with a total of 120000 beds, of which 488 medical establishments (77,300 beds) are directly affiliated and run by the Ministry of Health and Medical Education (MHME) and 120 (11,301 beds) owned by the private sector and the rest belong to other organizations, such as the Social Security Organization (SSO) [15]. According to Iranian Nursing Organization (INO) nowadays the number of nurses in the public and private sectors is 230000 by estimation. There were about 2.1 nurses per 10,000 [14] and 16 to 17 hospital beds per 10,000 populations [15]. The nurse to bed ratio is 0.8. Whereas standard is 1.5-2, i.e. 2 nurses for each bed [16], and global average of the nursing and midwifery personnel as per 10,000 individuals is 28 people [17]. This is while we need 500000 nurses by estimation. In addition patients already needed 4 hours care in 24 hours but nowadays with development in specialized surgeries such as cardiac surgeries and liver transplantation, we need 20 hours care in 24 hours [18]. In Iran health policies in general are made in the Ministry of Health Policy Making Council. Besides the Deputy of Nursing in ministry of health, has main responsibility for making clinical nursing policies and the Committee for Planning and Evaluation of Nursing Discipline (Iran's Board of Nursing), has main responsibility for making educational nursing policies. One typical useful educational policy which had been made by this committee in previous years when Iran had been imposed to war with Iraq, was converting bachelor of sciences in nursing to associate degree in nursing in order to compensate immediate need for nurses.

Other entities related to policy making for nursing in Iran are non-governmental organizations (NGOs) which can be divided into two categories. The first one is those which protect professional profits of nurses in general, include Iranian Nursing Organization (INO) and Iranian Nursing Association (INA). The second one is those which work in especial fields related to nursing, include Iranian Nursing Scientific Association (ANSA) and Iranian Cardiac Nursing Association (ICNA). INO is the most known nonprofit nursing organization in Iran [19]. These are examples of fragmented policy making which had been held by Iranian nurses in recent years as to modifying parts of massive nursing issues in related to nursing shortage, organizing nursing care in clinical settings and improving of patients care. But still there is less clear structured policy making activities based on master health plans which lead the pathway of nursing policy making towards a scientific action. For example, according to the five year rules of Iran's economic, social and cultural development program and also Iran's health map, we can find numerous potential aspects which are related to nursing's fields of action, Such as, increasing access to pre-hospital emergency services, increasing protection of nosocomial infections, empowering people for improving their own health [20,21], and so on, however there is not any clear policies related to nurses' status in handling these fields of action. However although in

recent three decades Iranian nurses have struggled to increase their participation in policy making for nursing affairs, but still their status in nursing policy making is not clear. There is not any research study about status of nurses in policy making in Iran. So the aim of this study was to making clear the status of Iranian nurses in policy making for nursing and to elucidate nurses' portion and participation in policy making for nursing in health system.

METHODS

Design

In order to gain deeper understanding of the status of nurses in policy making for nursing a qualitative method employed. By using qualitative method researcher has enough time to be in relation with data and immerse in them to learn more and more about the phenomenon under study [22]. Qualitative researches carry on by several approaches [23]. We applied qualitative content analysis approach which is an identified method of research and also a method of data analysis. Qualitative content analysis as a method is a systematic, objective and flexible means for understanding a phenomenon, labeling and interpretation of data in its own context [24]. In this study since there are limited ideas [25] and also fragmented knowledge [24] about the phenomenon of nurses' status in policy making for nursing in Iran's context, we selected qualitative content analysis which produces knowledge and new insight and facts related to phenomenon under study [25]. This study is a part of wider project as a PhD dissertation.

Participants

Like other qualitative designs we used purposive sampling procedure [22] and tried to select the most key informants among nurse leaders from all levels of management or administration and also non nurse policymakers who were involved with nursing policy making issues. Non nurse participants were two senior policymakers from MHME. One of them was a physician and another was an epidemiologist. Most nurse leaders were from the high-ranking policy making positions in MHME and INO, and the rest were from nursing service managers or matrons. Most participants were male. The mean age of participants was 52.3 years. The mean job experiences were 27.5 years and the mean managerial experience was 7.84 years. Table **1** shows the characteristics of participants in this study.

Data Collection

Data were generated by semi structured face to face in-depth interviews. All the interviews employed by corresponding author in the participants' offices. First of all the interviewer introduced herself and gave some information about the study and its purposes. Then a consent form along with the cell phone number and email address of interviewer given to participants for possible willing of withdrawal. For some participants the interviewer had to get previous appointment which sometimes it had been taken by one month. So the interviews first started by participants who where more accessible. Duration of interviews varied and the mean time was 70 minutes. In order to attain

Table 1.   Participants' characteristics.

Participants' Position and Demographic Characteristics	No.*	Percent*
Position		
Members of the Iran's board of nursing in Ministry of Health	5	22.72
Deans of nursing faculties	7	31.82
Members of the board of auditors in universities	1	4.54
The director of nursing office in universities	2	9.09
Members of the supreme council of Iranian Nursing Organization	3	13.63
Chairmen of the boards of director in Iranian Nursing Organization	2	9.09
Members of the Nursing Supreme Council in Ministry of Health (now is disbanded)	5	22.72
Members of the Ministry of Health Policymaking Council	2	9.09
The Deputy of Nursing in Ministry of Health	1	4.54
The previous advisor to the health minister in nursing affairs	1	4.54
Chairmen of Nursing Associations	2	9.09
Matrons	3	13.63
Sex		
Male	14	63.63
Female	8	36.36
Educational Level		
PhD	14	63.63
Master degrees	5	22.72
Bachelor degree	3	13.63

*Some participants had more than one position so the sum of the numbers is more than 22 and the sum of percentage is more than 100.

Table 2.   Categories and subcategories related to Iranian nurses' status in policymaking.

Categories	Subcategories
Framework for policymaking	Profile of health policymaking
	Profile of nursing policy making
Perceived status of nurses	Acquired status
	Appointed status
	Challenges with appointed status
Manner of nursing participation	Participation at the level of ministerial area
	Participation at the level of nursing organization and associations
	Participation at the level of lineup (operational management)

maximum variation sampling we selected key informants from two sex and various age, management levels and job conditions. We tried to use a similar direction for gathering data. The key questions were "What is your contribution portion in policy making for nursing?" "Please tell me about your experiences of involvement in policy making for nursing?" In order to achieve deeper understanding, the interviewer used the probing phrases like "why?", "What do you mean?" and "tell me more about it". The process of data gathering continued until achievement of data saturation. All interviews were digitally recorded and then turned to transcripts immediately.

Data Analysis

A conventional content analysis was employed for analyzing data. This is an inductive approach of qualitative content analysis in which for coding and classification of data, researcher avoid from existing structures. Instead allows researcher to be directed by data toward making appropriate categorization. By this way latent content of data will better revealed and qualitative content analysis better maintain its interpretation essence [26]. For analyzing data first each digitally recorded interviews immediately were transcribed verbatim and read several times by the

corresponding author to gain a general impression. The units of meanings were separated from the text of each interview, which were then condensed one or more times, abstracted and coded. Then according to similarities and differences between these codes they were arranged into subcategories. After frequent negotiation between all authors the subcategories were integrated and main categories as the themes of interpretation were introduced. We used MAX Q DA software (VERBI GmbH, Berlin, Germany version 10) for arrangement of codes, subcategories and categories. When the process of categorization and interpretation of data was completed data were prepared for recording [24, 26].

Rigor

Findings of qualitative data should have trustworthiness [22]. In order to get credibility 4 participants were conducted to approve open coding and the interpretations [26, 27]. Encoding and categorizing were several checked by all authors to gain consensus. We invited an external reviewer who had sufficient experiences in conventional content analysis to check the process of coding data, interpretation and categorization. Data collection started from June to December 2012, to have sufficiently engagement with the data [26]. In order to get dependability we kept the same key questions for data collection and tried to do all interviews in a fixed range of time. We also attended to audit trial and tried to explain all the process of research precisely [26, 27].

Ethical Consideration

Participants were asked to sign a consent form and were informed that withdrawal of the study at any time was possible. We get enough confidence to participants about the privacy of their information. All participants were informed about the purpose of the study. We also did a brief explanation about the design and asked the participants about their willing for being informed about the results. Meanwhile Tehran University of Medical Sciences Research Ethics Board approved ethical consideration for current study (Number: 91/d/130/169, in 2012/25/5).

RESULTS

Analysis of the data resulted in 224 initial codes that were introduced within 8 subcategories and 3 categories. By this way Iranian nurses' status in policy making for nursing is explicable by "the policy making framework ", "perceived status of nurses in policy making", and "the manner of nurses' participation in policy making".

The Policy Making Framework

The first category is the policy making framework. Nursing policies are part of master health plans. Master health plans have been compiled based on constitution, society needs and country vision. By following this systematic and scientific process, and deriving nursing policies from master health plans, nursing plans will be adjustable with general health needs. Then this is the first step for all health professions to gaining status in making policies. The two subcategories were policy making profile

at the macro level of health and policy making profile at nursing.

Policy Making Profile at the Macro Level of Health

Participants explained about formulating Iran's health macro plan and gave their recommendations to apply it in various corporations.

> "*We've done the designing; how?; we paid attention to what the constitution says, and extracted the principles of value; then, what the twenty-year vision of the country was ... and that if we want to reach there from here, what shortcuts there should be*". (A non nurse participant from the Ministry of Health policy making council)

> "*We recommended the national innovation scheme in eight layers…. Now if corporations or professions want to have a good derivation from master health map they need to apply it through this scheme*". (A non nurse participant from the Ministry of Health policy making council)

Policy Making Profile at Nursing

> "*Policy making means generality. The macro plan says to expand postgraduate fields and research centers. This is a general policy ... well; nursing also should think about expanding postgraduate and research center in its own fields*". (A ministerial nurse with 10 years managerial experience).

When nurse leaders are designing a plan to be set for agenda they first need to acquired sufficient information about governmental or master policies related to this plan and get assurance that this plan have not serious conflict with their design.

> "*Now it is seven years that we got approval for tariff-setting for nursing services, but still it is not implementable. Why! Because we did not have a wide inspection of the payment system in adjust to government's policies and master health plans when we were designing this bill*". (A chairman of one of the Iranian nursing associations)

Perceived status of Nurses in Policy making

In this study participants had clear perceptions of nurses' status in policy making. These perceptions have been classified under three subcategories.

Acquired Status

A part of Nurses' status in policy making is acquired and a part is through their appointment. Nurses should first acquire their service-providing position through good practice in order to gain their real status in policy making. Examples of quotations are presented below.

> "*If you and I have worked in a way that people feel they need us, they defend us. It's not like I*

try to convince the superiors why nurses are not part of family physician team and so on. Then, people do go and say why you didn't include nurses that we accept in the team". (A ministerial nurse from board of nursing)

"*If we only stop talking and take actions, and our practices find status for us, then, nobody withstands*". (A director of nursing office in university)

In addition to performing acceptable service-providing nurses also need to appreciate a kind of knowledge which is special to nursing. In the other hand, nurses need to claim they enjoy a kind of knowledge which no other health profession has it and that is the knowledge of care.

"*Knowledge and power are inseparable. They are two sides of a coin. If you gain knowledge, power is in your hand; if you gain power, status follows. What gives us power is what others don't know, I mean, the knowledge of care*". (A chairman of the board of director in INO)

Appointed Status

Assigning Iranian nurses in managerial positions like advisor to minister and nursing deputy in ministry of health in recent years has had an unprecedented growth although more changes are still needed in this regard.

"*If we have a deputy minister for nursing affairs in the university, under direct supervision of the university chancellor, it will be a source of power*". (A dean of faculty with 5 years managerial experience)

"*They haven't designed hospital organizational chart well. For example, the Social Security Organization has classified nursing service manager as a subclass of hospital's manager. However, based on the scientific documents, nursing service manager has potentials to be considered a senior manager*". (A member of the supreme council of INO)

Challenges of the Appointed Status

Assigning of Iranian nurses in higher administrative positions in recent years had always been followed with some challenges. One of these challenges is promotion without enough authority because in these positions nurse leaders did not have the considerable executive power.

"*The advisor to the minister can advise only when the minister deems it appropriate. If he/she doesn't deem it appropriate, he/she doesn't ask the advisor's opinion*". (Chairman of one of the Iranian nursing associations)

"*They appoint one of us in somewhere but they fasten her/his hands. For example, they tell us to plan. We plan, but they veto it. What it is useful for, it's futile. We can not account it as*

an appointment…". (A ministerial nurse from the board of nursing)

The Manner of Nurses' Participation in Policy Making

In this study nurses' experiences of participation in policy making revealed that how Iranian nurse leaders had grasped or had lost opportunities for making policies. Meanwhile these experiences exposed the points of strength and weaknesses in nurses' participation and also nursing issues that need to be more attention in policy agendas in future. These experiences had their own characteristics according to different areas and levels of nursing management and have been classified into three subcategories as follow:

Participation at the Level of the Nursing Ministerial Area

A part of quotes in relation to participation and policies which had been made by this level were greeted and is a point of strength of this level but a part of them were censured. First we have settled to the point of strength.

Participants greeted the participatory manner of the nursing supreme council in ministry of health and introduced it as a valuable unit for policy making which again needs to be retrieved.

"*We had the supreme council in past years and we need to retrieve it again. That was an excellent unit in which nurse leaders from ministry, academic, associations and clinical setting gathered together to make nursing multidimensional policies*". (Chairman of one of the Iranian nursing associations)

Two ministerial nurses also greeted of the nursing supreme council struggles:

"*One of the outputs of nursing supreme council was expanding entrepreneurship in nursing by getting the license for nursing consultation clinic. All nurses can go to the treatment deputy, submit their certificates, and receive a license for a clinic*". (A ministerial nurse who were a member of the nursing supreme council)

"*Of the actions of nursing supreme council was ratification of a law called nurses' hard duty allowance, I mean, nursing was included in hard jobs; and also nurses' retirement after twenty years. At that time, they fussed us a lot that this law would make the Islamic Republic of Iran indebted*". (A ministerial nurse who were a member of the nursing supreme council)

Participants also greeted of nursing deputy in ministry of health for debating and give recommendations about nursing shortage.

"*Then, a meeting was held about shortage of nurses. We suggested that nursing students work [voluntarily] from the fifth semester on and compulsorily in the last year, this means working along with learning … So, you see*

we're involved in these matters. These all came out of our words". (A ministerial nurse with 10 years managerial experience)

The participants greeted efforts for designing nursing roadmap which is a basic strategic need for scientific planning in nursing.

"Now, much effort has been made for the roadmap. Our colleagues in the health ministry have done a very good job. They've used nursing representatives across the country and held assessment meetings to cooperate in developing nursing roadmap. This is a very good job". (Chairman of one of the Iranian nursing associations)

Beside these greetings much censures also mentioned about making policies in this level of nursing.

Lack of clear agenda in meeting had been criticized. Here is a description of a participant from her feelings of presence in one meeting:

"We have meetings, for example, they say that there is a policy making meeting tomorrow at 8-10 am. ... But there is not a clear agenda. Sometimes I ask myself what is the benefit of my presence in here. Really we make no decision for what is good and what is bad for nursing". (A ministerial nurse from the board of nursing)

Being back from the new world was another criticism:

"Nursing now needs entrepreneurship. What nutritionist also did and succeeded. We need to think about how to expand palliative care. We need to expand tele-nursing in which I'm in my office and the patient is at home. She/he shows me her/his wound and I advise her/his about it. We had been taken back from the technology and changes in new world". (A dean of nursing faculty who were member of the nursing supreme council in past years)

Participation at the Level of the Nursing Organization and Associations

Like the level of ministerial area a part of quotes in relation to bills which had been made by this level have been greeted but there are also some important censures. Here is a typical quote about effective interaction of INO with parliament (Majles) which had been introduced as one of the points of strength in this level:

"Two major laws, productivity and tariff-setting, were ratified and enforced in the parliament…These laws were not easily obtained but through interactions with the parliament and other ruling sectors". (A member of the supreme council of INO)

The one dimensional activity of the INO had been criticized by participants.

"The INO works mostly on professional rights and doesn't pay enough attention to nursing

competency and patients' rights". (A matron who was a member of nursing supreme council in past years)

Another criticism is not to INO or nursing associations but is from the part of academic and PhD nurses for their derisible protection of INO and nursing associations. This have run INO and nursing associations toward unproductiveness. Whereas participants believed that these parts of nurses are pensive nurses whom their participation in this area will be taken exampled for other nurses.

"Unfortunately high literacy level in nurses hesitates from fortification of INO…We are expected from PhD nurses to analysis professional issues and give strategies". (A ministerial nurse with 2 years managerial experience)

Participation at the Level of Lineup (*Operational Management*)

The faded role of matrons and lack of policy procedure manual in hospitals are among the most experiences of this level.

"Those at high positions don't consider us qualified enough to participate ... for example, we had a meeting last week about productivity that had reduced working hours. Matrons said this didn't have any effect on nursing because still nurses should work more to compensate the shortage". (A matron who was the member of supreme council in INO)

Another matron referred to a deficiency:

"One problem is the unclear policy procedure manual. For example, what time should the doctor visit patients? Could he/she visit patients whenever he/she wants? This damages nurses' practice and care". (A matron with 30 years job experience)

DISCUSSION

The results according to the first category showed that through establishing nursing policy making based on macro documents of health policies, nurses' status in policy making can be shaped. Indeed each discipline should apply its knowledge and skills and follow macro documents of the policy making in order to develop a plan for its relevant corporation. Hughes [28] emphasized that pay attention to general ruling policies from the side of senior nurses as a factor, reducing the spread of personal ideas in policy making and being a guarantee for not separating the governmental policies from nursing practice.

In this study the acquired and appointed status oriented toward the perceived status of nurses in policy making has been introduced. Antrobus and Kitson [29] introduced Quadruple domains of leadership in nursing include clinical, academic, executive, and political. They emphasized that nurse leaders' knowledge and thought in all of four domains were directly or indirectly inspired by clinical practice, and indeed this granted them the right of leadership. This is close

to the perception of acquired status in this study. Toofany [6] also stated that the more attention the nurses paid to their practice and other performance levels in the society, the higher their participation in policy making, and the more enhanced their status is. This is likewise close to the perception of acquired status in this study. Furthermore, Hughes [28] emphasized the appointed status of nurses in government. He said that nurses' viewpoint in policy making was exclusive, patient-oriented, fundamental, and critical, which could be an appropriate reason for appointing senior nurse leaders in the government. However, it is inevitable to resort to both perspectives in describing nurses' status in policy making.

Assigning nurses to positions, namely, the advisor to the health minister and so on, on the part of senior authorities of the Ministry of Health, in recent years has caused ambiguities in the domain of powers and the extent to which they can interfere in macro decision-making in nursing. These ambiguities have challenged assigning nurses to the above position. Challenges of the appointed status and levels of authority had been considered in a study by Salmon and Rambo [30]. They defined three levels of authority for the senior policymaker nurses included the senior executive management, the senior advisory, and dispersal. In the senior executive management, nurses enjoyed direct authority on nursing services and problems due to their power to inquest and discuss problems. Some of the domain of activities and powers of the senior executive management involved: the possibility to correspond with the most prominent individuals in the ministry, membership in the ministry's senior policy making committees, being the representative of the ministry in the World Health Assembly, and having a key role in supplying nursing human resources through the ministry. The last two domains have been introduced by them as the indicators of enjoying executive senior management position in nursing. In senior advisory, senior nurses were effective due to their advisory role in policy making. However, certain activities of the senior executive management might also exist in this position although these activities never included the representativeness of the ministry in the World Health Assembly, and the direct responsibility for nursing human resource management which are the indicators for the senior executive management. In the dispersal positions, senior nurses did not enjoy specific titles and positions and were often far from the core of decision-making although they partly influenced the policy making as members of the multidisciplinary health team.

Now where is the status of Iranian nurses according to these two indicators? Iran is a member of the International Council of Nurses (ICN) and one of the 24 countries in the Eastern Mediterranean Region Office (EMRO) in the area of nursing. The Iranian senior nursing managers cooperate with this office as Iran's representatives in formulating the strategy of the office and attends annual assembly of ICN, WHO, and EMRO in Geneva. Moreover, The Thirty Joint Programs of the nursing deputy in Ministry of Health and INO also pointed out that three parts of the program were allotted to supplying human resources by nursing deputy. The three parts included the preparation and formulation of the document for supply and demand of nursing human resources, planning for removing shortage of nurses in short

and long terms, and a plan for employing nursing students in clinics [31]. Therefore, if we have a vision to the status of nursing in past recent years it can be concluded that the status of policymaker nurses in Iran during the last three decades, gradually changed from dispersal positions to the advisory position through stabilizing the Iranian Nursing Associations and establishing the INO and currently more changed from the advisory position to the senior executive management position through promoting the advisor to the minister to the nursing deputy in Ministry of Health. Moreover, considering that supplying nursing resources is a complex process that is necessarily based on general policies of the health system, the rate of participation and effectiveness of nursing senior managers in supplying nursing human resources needs further investigation that is not in the scope of this study. In this respect, in terms of supplying nursing human resources, an intermediate position between the senior executive management and senior advisory can better define the status of nurses in nursing policy making in Iran's health system.

Results of this study represented the manner of nurses' participation in policy making in three subcategories. The first was the level of the nursing ministerial area. A part of nursing ministerial area in past years had been the nursing supreme council. This council was a policy making unit working in 1998-2005 with the aim of handling nursing issues in the Ministry of Health. Members of this council were assigned with the order of the minister. Upon changes in ruling affairs, the council was disbanded after several years. Atrobus and Kitson [29] stated that the development of a political voice of nursing would work through establishing one or more policy making units. Fyffe [32] also referred to the introduction of a policy making unit for nursing by the British Royal College in order to focus on advancement of policy making in nursing since 1999. Najar and Hubbard [33] also examined experiences of some senior nurses of participation in National Advisory Committee in the United States. The presence of physicians, nurses, lawyers, general policymakers, and others has developed various viewpoints.

The other part of the nursing ministerial area is Iran board of nursing. This committee has taken positive steps especially toward promotion of nurses' education up to the doctorate degree and also increasing and enhancing fields of nursing at the master's degree. However, most of the participants' experiences implied ambiguities in the duty description, powers, and mode of supervision of nursing services in Iran. An overview of the powers of nursing boards in the United States and Australia revealed that board activities are organized toward the execution of a law titled *Nurse Practice Act* ratified by the legislative assembly. This law reduced the ambiguities in the duty description and powers of nursing boards and brought about some kind of independence and autonomy within certain formats for these units. One of the main characteristics of the *Nurse Practice Act* is the assignment of direct supervision of nursing services to the nursing boards [34].

The second subcategory is the level of nursing organization and associations. Generally nursing professional associations and organizations in all over the world play an important role in policy making for nursing

[35]. The appropriate interaction with the parliament in recent years from the side of INO is a significant struggle which brought about two important laws for Iranian nurses. One law was the *Promotion of Productivity* of nursing services that resulted in reduction of nurses' working hours from 44 to 36 hours per week and increased payment coefficient of holidays. Implementation of this law is under pilot. The other law was the nursing service *tariff-setting* that defined and allocated proper tariffs to each nursing service [19]. Rafferty and Traynor [36] also mentioned the need to converge with the ruling disciplines in order to promote nursing research in the agenda of policy making. Also in another study had been referred to three key effects of senior policymaker nurses on their stronger presence in policy making. The effects included how to interact with political structures, how to intercommunicate with the Health Ministry, and how to use the first two effects to organize the nursing profession [28]. One of the problems discussed in the present study was the criticism posed to the one-dimensional activities of the INO. Although the INO as a corporation should attain nurses' rights which indirectly affect the increase in the quality of patient care, the direct supervision of the quality of nursing services and struggling for increasing the quality of patient care are also among the INO's responsibilities that have received little attention. Whereas according to the INO's duty description the supervision of nursing services is also one of the duties of this organization [37]. Expectation from PhD nurses for more cooperation with INO is a real necessitate for enhancement of efficacy and effectiveness of INO's activities. Expectation from PhD nurses for more cooperation with INO and nursing associations is a real necessitate for enhancement of efficacy and effectiveness of these center's activities. Cheraghi *et al.* [38] stated that PhD nurses have forgotten being a nurse. They are expected to convene social needs and to meet policy requirements of nursing practice.

The third subcategory was the level of lineup or operational levels. Operational levels, especially matrons, had less been involved in decision-making relevant to nursing care in our medical centers. Kowalik and Yoder [39] emphasized the effectiveness of magnet hospitals in power distribution in medical centers and its effect on participation in policy making. In such hospitals, the method of power distribution is horizontal and, consequently, facilitates the participation of clinical nurses in decision-making. Mangold [40] said While, nurses are not normally included in decision-makings due to the policies and problems of the workplace, encouraging and including nurses in decision-making improve nurses' performance environment, occupational satisfaction, and the quality of care. Therefore, it seems that a step needs to be taken toward managing Iran's medical centers in a participatory manner through establishing hospital management councils with constant presence of matrons. The absence of executive instructions for implementation of policy procedure manual in medical centers was another problem discussed in this study. These instructions involve policies of each medical center in relation to patient management, the manner of providing emergency services, nursing management, patient safety [9], and so forth, which should be executed by all personnel of medical centers. Although no medical center in Iran is void

of policy procedure manual, it cannot be ignored that many of such instructions do not exist at all or do not have any strong executive support to make personnel of the medical center execute them. According to Buerhause *et al.* [41] Medical centers need three items to succeed in making re-engineering the workplace as follows: Firstly, a specific model for planning; secondly, a method for executing the model and acquiring prerequisites for successful execution of the model, and thirdly, execution of the model at a large scale. Regarding the foregoing, it seems essential to formulate policy procedure manuals in medical centers within general and specific policies of each medical center considering the geographical location in Iran.

Implications

Finding of this study can be employed in four pillars of nursing, education, management, clinical, and research.

Education: Educational nursing policies need to be directed toward adding the educational courses which are remarkable to nursing care for more effective training of caring as especial knowledge of nursing discipline. Also modifying nursing curriculum in undergraduate and graduate levels based on society needs is recommended in order to train nurses who will be more able to demonstrate abilities of nurses in prevention of disease and health promotion and by this way finally demonstrate nurses' status in health of community.

Management: Nurses need to have a unit of policy making which the members are the representatives of various managerial, administrative, clinical and academic domains in order to precede nursing policies toward a common aim. Engineering of nurses' rules and regulations according to nursing roadmap which has been derived from master health plans is also needed. By this way nurses can strongly defense of their issues in policy agendas in adjustment with macro policies.

Clinical settings: This study has two clear implications for clinical settings. One is compiling and implementation of both referenced and local policy procedure manuals in clinical settings. The second is planning for establishment of "*best practice*" approach and applicable strategies for increasing the quality of patient care which finally will highlight the nurses' status in society and policy making areas.

Research: Lack of credible information to rely on in policy making meetings is a necessitation for nurse policymakers. We recommended that by a credible informational bank for nursing we will be able to defense of our plans in policy agendas base on documented data. Also it will be a good recommendation to have a policy implication at the end of every research project in nursing.

CONCLUSION

Results of the present study revealed that Policy making for nursing is a subgroup of Iran's macro policy making in the area of health. Health policy making in Iran became a scientific process in recent years through formulating health macro documents. These health macro documents have determined major pathways to Iran's 2024 vision in

compliance with the constitution and values governing the society. This scientific process has also begun upon developing the nursing roadmap in Iran. The results of the present study showed that what made the status of nurses more efficient in policy making for nursing was their practice and rate of participation of nursing policymakers in the available positions and also in the society. We need to acquire status through performing the best practice in society. In other words, the status of nurses in policy making for nursing is not separable from their status in the society because the senior policymaker nurses are primarily social servants prior to being an innovator of policy making. Results of this study represented major points of weakness in nursing policies and some recommendations for modifications. Lack of organized policies to focus on caring as nursing exclusive knowledge in nursing education, dispersion in making policies, besides to nonexistence of regular nursing appraisal and guarantee of nurses' competency were among the most weaknesses in nursing policies in Iran.

LIMITATION

In this study we achieved results by which we can clearly describe the status of Iranian nurses in policy making for nursing but since policy making for nursing is affected by total governmental, economic and social issues in each country, result of this study just represents nurses' status in policy making for nursing in Iranian context and like other qualitative researches transferability of the findings should be limited.

ABBREVIATIONS

ACNA   =   Iranian Cardiac Nursing Association

GDP   =   Gross Domestic Products

INA   =   Iranian Nursing Association

INO   =   Iranian Nursing Organization

INSA   =   Iranian Nursing Scientific Association

MHME   =   Ministry of Health and Medical Education

NGO   =   Non-Governmental Organization

SSO   =   Social Security Organization

CONFLICT OF INTEREST

The authors confirm that this article content has no conflict of interest.

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