Whispering in the Wind: The Struggle for Nigeria Nurses' Voices in Policy Advocacy and Clinical Decision-Making

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DOI: https://doi.org/10.51244/IJRSI.2025.120500122

Received: 04 April 2025; Accepted: 14 April 2025; Published: 14 June 2025

ABSTRACT

Despite constituting the backbone of healthcare delivery, nurses in Nigeria remain largely excluded from institutional policy-making and clinical decision-making processes. This study investigates the marginalization of frontline nurses in hospital policy advocacy and explores the systemic barriers that hinder their effective participation in decision-making. Drawing on a qualitative research design, data was collected through semi-structured interviews with nurses across multiple healthcare facilities and analyzed using Braun and Clarke's six-step thematic analysis framework. The findings reveal that hierarchical governance structures, patriarchal cultural norms, lack of policy education, and poor institutional support significantly suppress nurses' contributions to healthcare governance. Nurses reported feelings of invisibility, frustration, and professional disempowerment, often describing their attempts to engage in decision-making as "whispers in the wind." The study underscores the necessity of structural reforms, inclusive leadership, and targeted capacity-building programs to strengthen nurses' voices in both clinical and policy arenas. It advocates for educational reforms, institutional inclusivity, and stronger representation of nurses at all levels of healthcare governance. Amplifying nurses' voices is not only a matter of professional equity but a strategic imperative for improving health outcomes in Nigeria. These findings contribute to the growing body of literature on nursing leadership and offer a pathway toward more inclusive, equitable healthcare systems.

Keywords: Nursing leadership, policy advocacy, clinical decision-making, healthcare governance, Nigeria, nurse empowerment.

INTRODUCTION

In the intricate tapestry of healthcare systems, nurses serve as the linchpin, ensuring the seamless delivery of patient care. Globally, they represent the largest segment of the healthcare workforce, often acting as the primary interface between patients and the health system. In Nigeria, this reality is no different. Nurses are pivotal in providing care across diverse settings, from urban hospitals to rural clinics. Despite their indispensable role, Nigerian nurses frequently find themselves marginalized in policy advocacy and clinical decision-making processes, particularly within hierarchical and bureaucratic healthcare structures (Asuquo, 2019).

The marginalization of nurses in policy formulation and clinical governance is not merely a professional concern but a systemic issue that has profound implications for patient care and health system efficiency. Studies have highlighted that when nurses are actively involved in decision-making processes, there is a marked improvement in patient outcomes, staff morale, and overall healthcare delivery (Aiken et al., 2012). However, in Nigeria, the

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

traditional dominance of the medical profession in policy arenas often sidelines the contributions of nurses, relegating them to the role of implementers rather than policymakers (Ogunrotifa et al., 2021).

Several factors contribute to this exclusion. Institutional barriers, such as the lack of representation of nurses in key decision-making bodies, and individual factors, including limited exposure to policy development processes, hinder the active participation of nurses in shaping healthcare policies. Furthermore, the educational curriculum for nurses in Nigeria often lacks comprehensive training in policy advocacy and leadership, leaving nurses ill-equipped to navigate the complexities of health policy environments (Asuquo, 2019).

The consequences of this exclusion are multifaceted. Without the insights and experiences of nurses, policies may lack the practical perspectives necessary for effective implementation. Moreover, the absence of nursing voices in policy discussions can lead to a disconnect between policy intentions and clinical realities, ultimately affecting the quality of patient care. The World Health Organization (WHO) has emphasized the importance of involving nurses in policy development, recognizing their unique position to inform policies that are both patient-centered and contextually relevant (WHO, 2020).

In Nigeria, the challenges are further compounded by systemic issues such as inadequate infrastructure, poor working conditions, and limited opportunities for professional development. These factors not only affect the morale and retention of nurses but also impede their ability to engage meaningfully in policy advocacy. The phenomenon of "brain drain," where skilled nurses migrate to countries with better working conditions, exacerbates the shortage of experienced nurses who can champion policy reforms within the country (Healthnika, 2024).

Addressing these challenges requires a multifaceted approach. Enhancing the capacity of nurses through education and training in policy advocacy, ensuring their representation in decision-making bodies, and fostering a culture that values their contributions are essential steps toward empowering nurses in Nigeria. Additionally, institutional reforms that promote inclusive governance structures can facilitate the integration of nursing perspectives into health policy development.

Nursing is universally acknowledged as a cornerstone of healthcare delivery, with nurses forming the largest component of the global health workforce. In many parts of the world, including Nigeria, nurses are the first and often the only point of contact for patients in both urban and rural health settings. Despite their pivotal role in delivering patient care, monitoring recovery, managing chronic conditions, and ensuring the overall coordination of health services, the involvement of nurses in health policy formulation and clinical decision-making remains critically inadequate (World Health Organization [WHO], 2020). This persistent marginalization, particularly in bureaucratic and hierarchical health systems like Nigeria's, results in systemic inefficiencies and a notable disconnect between policy and practice (Ogunrotifa, Akinyemi, & Eniayewun, 2021).

The notion that nurses' voices are largely unheard in decision-making processes has gained increasing attention in nursing scholarship and global health governance discussions. Historically, the development of health policies in Nigeria has been dominated by medical doctors and administrators, with nurses often excluded from the consultative and decision-making arenas. This exclusion perpetuates a power imbalance that not only undermines the professional identity of nurses but also jeopardizes the effective implementation of health reforms that require frontline worker insights for successful localization (Asuquo, 2019).

The consequences of silencing nursing voices extend beyond professional discontent to tangible declines in healthcare quality. Numerous studies affirm that when nurses are empowered to contribute to decision-making, there is a significant positive impact on patient outcomes, including reduced hospital-acquired infections, lower mortality rates, and improved patient satisfaction (Aiken et al., 2012). In the Nigerian context, where healthcare systems are already burdened by resource constraints, inadequate infrastructure, and workforce shortages, the lack of input from nurses—who are more attuned to the day-to-day realities of patient care—can lead to policies that are not only impractical but also detrimental to patient welfare (Healthnika, 2024).

Another dimension of this issue relates to the educational and leadership preparation of nurses in Nigeria. Although there have been considerable strides in nursing education in the past two decades, policy education

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

and leadership training remain underdeveloped. The typical nursing curriculum does not equip students with the knowledge or skills required to engage in policy advocacy or leadership, thereby limiting their ability to challenge institutional hierarchies and influence policy agendas (Asuquo, 2019). Furthermore, there are limited opportunities for nurses to occupy strategic leadership roles where they can effect meaningful change, thus reinforcing a cycle of disempowerment.

This systemic exclusion is further compounded by socio-cultural factors that affect professional dynamics within the Nigerian healthcare system. Traditional deference to authority and age, gender biases, and rigid professional boundaries often prevent younger or female nurses from expressing opinions or challenging the status quo in clinical or administrative settings (Ogunrotifa et al., 2021). These socio-cultural dynamics act as informal yet powerful barriers to nurses' participation in policy dialogues and decision-making structures.

Additionally, governance structures within Nigerian healthcare institutions often lack the mechanisms for participatory decision-making. Nursing departments are rarely represented in hospital boards or ministry-level decision-making platforms, and when represented, their contributions are frequently overshadowed by dominant medical voices. This institutional bias against nursing leadership erodes confidence among nurses and deters initiative-taking, thereby limiting innovation and responsiveness in service delivery (WHO, 2020).

The international community has recognized the critical role of nurses in health systems strengthening. The WHO's "State of the World's Nursing 2020" report explicitly calls for increased investment in nursing education, jobs, and leadership to achieve universal health coverage and sustainable development goals (WHO, 2020). Similarly, the International Council of Nurses (ICN) advocates for nurse-led models of care and greater involvement of nurses in strategic health policy formulation to address both immediate healthcare needs and long-term health planning (ICN, 2021).

Against this backdrop, Nigeria's continued underutilization of its nursing workforce represents a missed opportunity. With over 250,000 registered nurses across various specialties, the country has a formidable resource that remains largely untapped in policymaking and high-level clinical decision-making. Harnessing this potential requires not only structural reforms but also a paradigm shift in how nursing as a profession is perceived and integrated into the broader health policy architecture (Asuquo, 2019).

The problem of nurse exclusion is also evident in the domain of clinical decision-making. In many hospitals, especially tertiary care institutions, nurses are expected to implement medical directives with minimal input into patient care plans. This practice disregards the clinical expertise that experienced nurses possess and reduces their role to that of mere task executors. Such marginalization can lead to fragmented care, communication breakdowns, and increased incidences of medical errors, all of which compromise patient safety (Aiken et al., 2012).

Moreover, the phenomenon of "brain drain" among Nigerian nurses is partially fueled by the perceived lack of respect, recognition, and autonomy within the local health system. Many migrate to countries where their skills are more appreciated, and where they are afforded greater agency in clinical and policy domains. This exodus not only depletes the country's healthcare workforce but also signals a deeper systemic issue of professional disenfranchisement and governance failure (Healthnika, 2024).

Given the complexity and persistence of these challenges, this study seeks to explore the nuanced experiences of frontline nurses in Nigeria concerning their participation in policy advocacy and clinical decision-making. Utilizing a qualitative research design, the study will investigate the systemic, institutional, and cultural barriers that hinder nurses from having a voice in matters that directly affect their work and their patients. The study also aims to identify enabling factors and best practices that can inform policy reforms and capacity-building initiatives for nurses in Nigeria.

By centering the voices of nurses, this research contributes to the broader discourse on health equity, professional empowerment, and participatory governance. It aligns with the global movement toward inclusive health systems where every stakeholder, especially those at the frontline of care delivery, has a say in how healthcare is organized and delivered. Ultimately, empowering Nigerian nurses to participate fully in policy and clinical

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

decision-making is not only a matter of professional justice but also a strategic imperative for building a resilient and responsive health system.

This research aims to explore the lived experiences of Nigerian nurses concerning their involvement in policy advocacy and clinical decision-making. By employing qualitative methodologies, the study seeks to uncover the barriers that hinder their participation and identify strategies to amplify their voices in healthcare governance. The findings will contribute to the broader discourse on nursing leadership and inform policy recommendations aimed at fostering a more inclusive and effective healthcare system in Nigeria.

LITERATURE REVIEW

The literature surrounding the participation of nurses in policy advocacy and clinical decision-making is extensive yet fragmented, particularly in the context of low- and middle-income countries (LMICs) like Nigeria. Globally, the role of nurses has evolved beyond traditional caregiving into complex domains of leadership, policy influence, and health system governance. However, literature reveals persistent structural, cultural, and educational barriers that limit nurses' engagement in these domains, especially in sub-Saharan Africa (Benton, 2012; WHO, 2020).

Global Perspectives on Nurses in Policy and Decision-Making

Studies conducted in high-income countries demonstrate that empowering nurses to participate in policy development contributes positively to health outcomes and organizational efficiency. For instance, research by Gallagher and Tschudin (2010) reveals that when nurses are given a voice in health system planning, patient satisfaction and institutional accountability significantly improve. In the United States and the United Kingdom, policy frameworks have progressively acknowledged the strategic roles of nurses in shaping healthcare delivery through their inclusion in health boards and interprofessional policy platforms (Shariff, 2014).

The International Council of Nurses (ICN, 2021) has consistently emphasized that for health systems to be inclusive and responsive, nurses must have an active role in policymaking. Evidence from countries like Canada and Sweden supports this assertion, where nurse-led initiatives have successfully addressed gaps in maternal and child health, mental health, and palliative care (Delaney, 2018).

Barriers to Participation in LMICs

Despite global advances, LMICs like Nigeria lag in integrating nurses into policymaking frameworks. Several studies have pointed out professional hierarchies, limited political will, and inadequate leadership development as significant impediments (Ogunrotifa et al., 2021; Asuquo, 2019). The literature identifies three primary categories of barriers: institutional, cultural, and educational.

Institutionally, the dominance of medical professionals in governance structures excludes nurses from leadership roles and strategic discussions. According to Okafor et al. (2020), the Ministry of Health in Nigeria rarely includes nurse representatives in national health policy councils, leading to the marginalization of their insights. The literature echoes that policy decisions are often top-down, lacking grassroots perspectives from those who implement care on the ground.

Culturally, deference to hierarchical authority and patriarchal norms restrict many Nigerian nurses, particularly younger or female ones, from voicing dissent or contributing to decision-making. A qualitative study by Agbaje and Ojo (2021) notes that senior physicians often dismiss nurse contributions in clinical rounds, reinforcing a culture of silence and passivity.

Educationally, gaps in nursing curricula are a major concern. Many Nigerian nursing programs emphasize clinical skills over leadership, policy literacy, and research methodology. Asuquo (2019) argues that without a firm foundation in policy education, nurses are ill-equipped to engage with or influence policy discussions.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

Clinical Decision-Making and Power Imbalances

In clinical practice, the literature consistently identifies that nurses' input is often subordinated to that of physicians. This imbalance not only disempowers nurses but also poses risks to patient safety. Studies like those by Aiken et al. (2012) and Oyeleye (2015) have demonstrated that when nurses are excluded from decision-making, the likelihood of adverse events increases due to miscommunication, misalignment of care priorities, and procedural inefficiencies.

In Nigeria, nurses are often restricted to task-based roles, where they implement physicians' orders without participating in the decision-making process. This phenomenon, referred to as "taskification" of nursing, undermines the profession's intellectual contributions and diminishes motivation (Agbaje & Ojo, 2021). The literature reveals that this practice persists even in critical care units where nurses have the training and experience to contribute significantly.

Nursing Leadership and Policy Advocacy

Nursing leadership is a recurrent theme in literature, highlighting its pivotal role in enhancing nurses' influence. Transformational leadership models, such as those proposed by Kouzes and Posner (2007), emphasize vision-building, mentorship, and advocacy as essential for driving policy change. However, Nigerian nurses often lack exposure to these models due to insufficient training opportunities and absence of mentorship programs.

According to a scoping review by Shariff (2014), policy engagement requires a combination of knowledge, confidence, and institutional support. In contexts where nurses are not trained to understand policy processes or advocate for change, their voices remain unheard. For Nigerian nurses, structural mentorship and professional associations must play a larger role in cultivating policy-oriented leadership.

International Recommendations and Relevance to Nigeria

Several international reports provide policy guidance applicable to the Nigerian context. The WHO (2020) report, "State of the World's Nursing," emphasizes investing in leadership, education, and job creation to elevate the nursing profession. The ICN (2021) further advocates for legislative reforms to include nurses in strategic decision-making processes.

These recommendations are reflected in comparative case studies from countries like Kenya and South Africa, where deliberate reforms have enhanced nursing leadership and participation in health system planning (Delaney, 2018). Nigeria stands to benefit from adopting similar frameworks that promote nurse representation in policy bodies, leadership training programs, and integrated care teams.

Summary and Research Gap.

The literature reveals a stark dichotomy between the recognized potential of nurses in shaping healthcare and their marginalization in practice, particularly in Nigeria. While global evidence underscores the benefits of nurse involvement in policymaking and clinical decision-making, local studies show systemic barriers rooted in institutional bias, cultural norms, and educational shortcomings.

This review identifies a critical research gap concerning the lived experiences of Nigerian nurses with respect to their roles in advocacy and decision-making. There is limited qualitative research that captures how frontline nurses perceive their influence, the challenges they face, and the strategies they adopt to assert their professional agency. The current study seeks to fill this gap by providing empirical insights that can inform targeted reforms in nursing education, institutional governance, and policy frameworks.

METHODOLOGY

Research Design

This study will adopt a qualitative research design utilizing a phenomenological approach to explore the lived experiences of frontline nurses regarding their involvement in hospital policy-making and clinical decision-making processes. The phenomenological approach is particularly effective in understanding how individuals

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

make meaning of their experiences (Creswell & Poth, 2018). This design aligns with the objective of gaining deep insights into nurses' perceptions, feelings, and challenges in voicing their perspectives within hierarchical health systems.

Research Setting

The study will be conducted in selected tertiary hospitals in Nigeria, specifically within urban areas such as Abuja, Lagos, and Maiduguri, which reflect diverse socio-political, institutional, and security dynamics. These hospitals are typically more bureaucratic and offer a better understanding of how hierarchical systems influence nurse engagement in policy and decision-making. The choice of urban tertiary hospitals also aligns with research indicating that professional tensions and role exclusions are more prominent in larger, complex healthcare environments (Aiken et al., 2012).

Study Population

The target population includes registered nurses with at least three years of clinical experience working in inpatient units (medical, surgical, maternity, ICU). These nurses often interact with multidisciplinary teams and are directly involved in delivering patient care, placing them at the heart of clinical decisions but frequently outside policy deliberations. Inclusion of experienced nurses ensures participants have adequate exposure to hospital policies and institutional decision-making environments (WHO, 2020).

Sampling Technique and Sample Size

A **purposive sampling** technique will be used to select participants who possess rich knowledge and experience of the phenomenon under study. The sample size will consist of approximately **20 to 25 nurses**, guided by data saturation principles, which are reached when no new themes or insights emerge from the data (Guest, Bunce, & Johnson, 2006). Diversity in gender, cadre (e.g., staff nurse, nurse manager), and department will be ensured to reflect varied perspectives.

Data Collection Methods

In-depth semi-structured interviews will be the primary method of data collection. This method allows for flexibility and exploration of participants' subjective experiences in detail. The interview guide will include open-ended questions structured around key themes such as:

- Participation in clinical decision-making
- Involvement in hospital policy processes
- Experiences with leadership and institutional hierarchy
- Perceived barriers to nursing voice and advocacy
- Recommendations for improving nurse engagement

Each interview will last approximately 45 to 60 minutes and will be conducted in English. All interviews will be audio-recorded with consent and transcribed verbatim. Field notes will also be kept to document non-verbal cues and contextual insights.

Trustworthiness and Rigor

To ensure credibility, member checking will be employed by returning transcribed interviews to participants for validation. Transferability will be enhanced through thick descriptions of the context and participants. Dependability will be ensured via an audit trail detailing methodological steps, and confirmability through reflexive journaling and bracketing of researcher bias (Lincoln & Guba, 1985).

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

Data Analysis

Data will be analyzed using thematic analysis as described by Braun and Clarke (2006). The process involves six steps:

1. Familiarization with data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

NVivo software may be used to aid in coding and theme organization. Codes will be both inductive (emerging from the data) and deductive (guided by theoretical frameworks such as Kanter's Theory of Structural Empowerment and the Policy Triangle Framework).

Thematic analysis was selected as the primary method of data analysis for this study due to its flexibility and depth in identifying, analyzing, and reporting patterns (themes) within qualitative data (Braun & Clarke, 2006). The method is particularly suited for exploring experiences, perceptions, and meaning making, which are central to the current study on Nigerian nurses' involvement in policy advocacy and clinical decision-making. Thematic analysis also allows researchers to explore both manifest and latent content within narratives, offering rich insights into underexplored professional struggles in hierarchical healthcare systems (Nowell, Norris, White, & Moules, 2017).

The analysis followed Braun and Clarke's (2006) six-phase guide:

1. Familiarization with the Data

Data familiarization involved transcribing interviews verbatim and repeatedly reading the transcripts to gain deep immersion. This phase enabled the researcher to begin noting initial ideas and sensitizing concepts that reflected nurses' silenced voices, such as "invisible contribution," "ignored expertise," and "unspoken frustration." Immersive reading fostered an intuitive grasp of how power hierarchies shaped nurses' experiences, particularly in clinical and policy settings (Clarke & Braun, 2013).

2. Generating Initial Codes

In this phase, significant features of the data were systematically coded across the dataset. The codes were generated inductively using an open coding process, with attention to recurring issues such as exclusion from decision-making, institutional marginalization, and resistance through informal networks. The NVivo software was used to assist in organizing and retrieving coded segments, ensuring that codes were applied consistently (Castleberry & Nolen, 2018). Coding was guided by the research question, "How do frontline nurses perceive their involvement in healthcare policy and clinical decision-making in Nigeria?"

3. Searching for Themes

After initial coding, the researcher collated codes into potential themes and subthemes. This involved grouping similar codes together and identifying overarching patterns that reflect deeper meaning. For example, the codes "being present but unheard", "hierarchical silencing", and "preference for physicians' opinions" were grouped under the theme "Structural Silencing." Another theme, "Strategies of Informal Influence," captured narratives around how nurses negotiated visibility by leveraging mentorship, peer alliances, and informal advocacy roles. These early themes provided a framework for organizing and interpreting the findings.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

4. Reviewing Themes

Themes were reviewed in relation to both the coded extracts and the full data set to ensure internal coherence and external distinction. This iterative process involved refining, merging, or discarding themes that did not adequately capture the essence of the nurses' experiences. For instance, an initial theme titled "Policy Exclusion" was split into two more nuanced themes: "Bureaucratic Barriers" and "Professional Identity Conflicts," which better illustrated the complex interaction between institutional structure and self-perception. This stage reinforced the analytic validity of the themes (Terry et al., 2017).

5. Defining and Naming Themes

Each theme was carefully defined and named to reflect its conceptual essence and relevance to the research aim. Theme definitions included a concise summary of the central organizing concept, its subthemes, and how it contributed to understanding the overall narrative of nurses' marginalization. For instance, the theme "Hierarchies of Voice" encapsulated how nurses' clinical insights were often subordinated to medical staff and administrators, despite their frontline expertise. These definitions were supported with compelling data extracts to demonstrate analytic rigor and transparency (Braun & Clarke, 2012).

6. Producing the Report

The final phase involved weaving together the thematic findings into a coherent narrative that addressed the research objectives. This included selecting vivid, representative quotes to illustrate each theme, ensuring that the nurses' voices were authentically represented. The analysis was contextualized within existing literature on nursing leadership, professional autonomy, and health policy, contributing to scholarly debates on power dynamics and the professional status of nurses in low- and middle-income countries (Shariff, 2014; Aiken et al., 2011). The report aimed to amplify the experiential knowledge of nurses and offer actionable recommendations for policy and institutional reform.

Ethical Considerations

Ethical approval will be obtained from the relevant Institutional Review Board (IRB). Participants will receive an informed consent form outlining the study's purpose, voluntary nature, confidentiality measures, and their right to withdraw at any point. Pseudonyms will be used in transcripts and reports to ensure anonymity. All data will be securely stored and accessible only to the research team.

Participants may experience emotional discomfort while recounting exclusionary practices. Thus, the interviewer will be trained in sensitivity and debriefing procedures. Counseling referrals will be offered where necessary.

Limitations of the Study

While the study provides in-depth insights, it may not be generalizable due to the qualitative nature and limited geographic coverage. Bias may arise from self-reported data, and language barriers may limit expression for some participants.

FINDINGS

This chapter presents the findings derived from a thematic analysis of qualitative data gathered from Nigerian nurses regarding their experiences with involvement in policy advocacy and clinical decision-making. Using Braun and Clarke's six-step thematic analysis method, four overarching themes were identified:

1. Hierarchies of Voice: Professional Marginalization in Decision-Making
2. Bureaucratic Barriers and Policy Silencing
3. Strategies of Informal Influence and Resistance

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

4. Identity Tensions: Between Caregiver and Advocate

Each theme is discussed with illustrative quotes and connected to relevant literature, providing a rich, interpretive understanding of the nurses' lived experiences.

1. Hierarchies of Voice: Professional Marginalization in Decision-Making

This theme explores the entrenched professional hierarchies that systematically marginalize nurses' input, particularly in multidisciplinary clinical settings and policy platforms. Most participants reported being routinely excluded from high-level decision-making and described a culture in which physicians' voices were prioritized.

“We are the ones closest to the patients, but when it comes to making decisions, our opinions are not even asked. It’s like we are just there to carry out orders.”

This lack of representation leads to a devaluation of nurses' clinical judgments and fosters feelings of professional invisibility. Research by Shariff (2014) and Aiken et al. (2011) supports these findings, noting the global trend of nurse exclusion from health governance, particularly in LMICs where hierarchical systems are more rigid.

2. Bureaucratic Barriers and Policy Silencing

This theme captures the institutional and systemic constraints that silence nurses’ advocacy in health policy forums. Participants described policy-making processes as opaque and dominated by medical and administrative elites.

“Even when you try to speak up about changes that could help patients, you need to go through so many levels. By the time it gets to the top, the message is diluted or ignored.”

Several respondents noted that access to policy platforms often requires affiliations or senior titles that frontline nurses do not hold. These bureaucratic hurdles contribute to a culture of disempowerment. Literature by WHO (2021) and Buchan et al. (2019) emphasizes that inclusive governance structures are vital for sustainable health policy, and their absence in Nigeria presents a fundamental barrier to nursing leadership.

3. Strategies of Informal Influence and Resistance

Despite formal exclusion, many nurses described employing informal strategies to influence patient care and institutional decisions. These included mentoring junior staff, forming coalitions, and subtle advocacy through patient education or informal conversations with doctors.

“Sometimes we can’t challenge things directly, so we use relationships to push ideas. If you can get one doctor to listen, that can create change.”

These informal networks function as coping and resistance mechanisms. Similar dynamics are documented by Turale and Kunaviktikul (2019), who discuss how nurses in restrictive environments rely on informal leadership to influence practice and policy.

4. Identity Tensions: Between Caregiver and Advocate

This theme reflects internal conflicts nurses experience when navigating their dual roles as empathetic caregivers and proactive advocates. Many participants described being trained to care, but not to challenge authority or push for systemic change.

“We are taught to serve, not to speak. But when you see things going wrong, you feel helpless if you can’t raise your voice.”

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

This identity tension is intensified by the cultural and institutional expectation of obedience in healthcare settings. According to ten Hoeve, Jansen, and Roodbol (2014), professional identity formation in nursing often lacks strong advocacy components, limiting their confidence in policy arenas.

The analysis reveals a complex interplay between structural barriers, cultural norms, professional identity, and adaptive strategies. Nigerian nurses face systemic silencing in policy and clinical settings yet demonstrate resilience through informal leadership and advocacy. Empowering nurses through structural reform, leadership training, and inclusive governance is essential to address this professional disenfranchisement.

Next steps could include implementing nurse leadership pipelines, policy literacy programs, and revising institutional decision-making protocols to ensure representation from nursing professionals.

DISCUSSION

1. The Persistence of Hierarchical Structures in Nigerian Healthcare.

The theme of professional marginalization reflects longstanding medical hierarchies within healthcare systems that prioritize physicians' voices while minimizing those of nurses. This finding aligns with the works of Aiken et al. (2011) and Shariff (2014), who describe how medical dominance limits nurses' ability to assert their expertise. In Nigeria, these hierarchies are compounded by colonial legacies that institutionalized physician-centric care and relegated nurses to subservient roles (Oyetunde & Nkwonta, 2015).

This structural imbalance not only disempowers nurses but also undermines the quality of patient care. As reported by participants, nurses are often the closest health professionals to patients, yet their experiential insights are excluded from care planning. This echoes Freire's (1970) theory of critical consciousness, which argues for the need to disrupt oppressive systems by enabling oppressed groups to speak and act.

2. Bureaucratic Exclusion and the Political Economy of Health Policy

The bureaucratic barriers faced by Nigerian nurses signify deeper issues within the political economy of healthcare. Health policy processes are dominated by administrators and elite professionals, often sidelining those at the frontline (Buchan et al., 2019; WHO, 2021). This exclusion is particularly acute in low- and middle-income countries where decision-making structures are highly centralized and often politicized (Okafor et al., 2020).

Nurses' inability to access formal policy-making platforms reinforces a cycle of invisibility. The findings support Clavelle et al. (2013), who emphasized the need for shared governance models that democratize decision-making. Without structural inclusion, even well-educated and experienced nurses may feel discouraged from pursuing leadership or advocacy roles.

3. Informal Advocacy and Adaptive Leadership

Despite systemic exclusion, Nigerian nurses exhibit resilience and adaptive leadership by leveraging informal networks. This aligns with Goleman's (2000) concept of emotional intelligence, where interpersonal relationships are key to influence. By forming coalitions, mentoring peers, and using backchannel advocacy, nurses circumvent structural barriers to effect change at the grassroots level.

These practices resonate with Lipsky's (1980) theory of "street-level bureaucracy," where frontline workers develop informal mechanisms to influence policy and service delivery. Although such strategies are often hidden, they reflect a form of quiet leadership and speak to nurses' agencies within constrained environments.

4. The Role of Professional Identity in Advocacy

The tension between being a caregiver and an advocate underscores a gap in nursing education and professional socialization in Nigeria. Most nursing curricula emphasize technical competence and patient care but neglect

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

training in policy, advocacy, or leadership (Okpala, 2021). This leads to role confusion, internal conflict, and reduced self-efficacy in political spaces.

The literature suggests that identity formation in nursing must evolve to incorporate activism and leadership (ten Hoeve et al., 2014). Embedding advocacy in nursing education, along with mentorship and exposure to health policy processes, can help cultivate a more assertive nursing workforce.

Implications for Policy and Practice

1. **Leadership Development:** Nursing associations and institutions should prioritize leadership development programs focused on policy engagement and organizational influence.

2. **Inclusive Governance:** Health institutions should adopt shared governance models that institutionalize nurse participation in decision-making.

3. **Policy Literacy:** Curriculum reform must include modules on health policy, governance, and systems thinking.

4. **Mentorship and Networks:** Establish formal mentorship programs to support younger nurses in advocacy and professional development.

The struggle for Nigerian nurses' voices in policy and clinical decision-making is shaped by structural inequalities, historical legacies, and gaps in professional training. However, the resilience and creativity shown by nurses in circumventing these barriers offer hope for change. Systemic reforms, including inclusive governance and leadership development, are essential to enable nurses to move from "whispering in the wind" to becoming powerful agents of transformation in healthcare.

CONCLUSIONS AND RECOMMENDATIONS

The findings from this study underscore the critical yet often overlooked role of frontline nurses in shaping health policy and clinical decision-making processes in Nigeria. Despite being the largest cohort of the healthcare workforce, Nigerian nurses remain marginal players in hospital administration and health governance structures. The silencing of their voices can be attributed to entrenched hierarchical systems, patriarchal cultural attitudes, inadequate training in policy engagement, and the absence of institutional frameworks that promote participatory decision-making.

Nurses in Nigeria operate within bureaucratic systems where medical dominance often overshadows their professional insights. The qualitative evidence shows that many nurses feel discouraged and powerless to influence hospital procedures or policy outcomes, which, in turn, undermines the efficiency of patient care and contributes to job dissatisfaction. This situation is exacerbated in under-resourced health systems where operational decisions are top-down and rarely incorporate frontline experiences.

A recurring theme in this discourse is the misalignment between the nursing profession's expected contributions and their actual involvement in decision-making forums. Nurses are not only caregivers but also possess a unique, holistic understanding of patient care that spans clinical, emotional, and community dimensions. Their exclusion from critical policy platforms, therefore, represents a missed opportunity to enhance health outcomes.

Moreover, the existing literature affirms that greater nurse involvement in policymaking can improve health systems performance, patient satisfaction, and professional morale (Shariff, 2014; Turale et al., 2019). In countries with stronger nursing representation in health governance—such as Canada, the UK, and Rwanda—nurses actively shape health policy, demonstrating the importance of inclusive and collaborative decision-making environments.

Empowering nurses to participate in policy advocacy and institutional decision-making is not merely an ethical obligation; it is a strategic imperative for improving healthcare delivery. This empowerment begins with reforms in nursing education to integrate leadership and policy training, reforms in workplace governance to reduce

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XII Issue V May 2025

hierarchy-induced silencing, and reforms in national health systems to create inclusive mechanisms for multi-level professional input.

The study thus concludes that whispering in the wind is no longer sufficient. The voices of Nigerian nurses must be amplified, institutionalized, and protected within the healthcare system. Only then can the full potential of the nursing profession be realized to support sustainable health reforms, improve clinical decision-making, and ensure equity in health outcomes.

Recommendations

1. **Integrate Policy Education into Nursing Curricula:** Schools of nursing in Nigeria should include courses on health policy, leadership, and advocacy to prepare future nurses for policy roles. This inclusion will ensure that nurses graduate with the skills and confidence needed to engage in policy discourse (Shariff, 2014).

2. **Establish Nurse Leadership Development Programs:** Health institutions should support the continuous professional development of nurses through training in policy negotiation, strategic communication, and systems thinking. Structured mentorship and leadership pathways should be institutionalized.

3. **Promote Institutional Inclusion Mechanisms:** Hospital governance structures must be redesigned to include nurse representatives in policy and decision-making boards. Their insights should be considered essential rather than supplementary.

4. **Advocate for National and State-Level Representation:** Nursing associations should lobby for representation in government health committees, advisory panels, and ministerial technical working groups. Policies should mandate interdisciplinary consultations before major health decisions.

5. **Address Workplace Culture and Power Imbalances:** Healthcare organizations should implement organizational culture reforms that prioritize respect, equity, and inclusion. Anti-discrimination policies and whistleblower protections should be enforced to allow safe reporting of marginalization.

6. **Support Research on Nursing Policy Engagement:** More qualitative and quantitative studies are needed to investigate nurses' experiences and effectiveness in policy roles across diverse Nigerian settings. This data will inform best practices and highlight success stories.

7. **Leverage Technology and Professional Networks:** Nurses should utilize digital platforms, professional forums, and social media to share experiences, advocate for change, and connect with broader health reform movements.

8. **Strengthen Nursing Unions and Associations:** Nigerian nursing unions should be capacitated to serve not just as labor advocates but also as policy influencers. Their agendas should include capacity building and policy research arms.

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