Political Astuteness and Efficacy and Health Advocacy Engagement Among Nurse Leaders in Region I, Philippines

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ABSTRACT

Nurse leaders play a vital role in influencing health systems; however, empirical evidence on nurse leaders' political capacities and health advocacy engagement in the Philippines remains limited. A sequential explanatory mixed-methods design was employed to examine nurse leaders' political astuteness, political efficacy, and health advocacy engagement in Region I, and to explore the experiences, motivations, and barriers influencing their advocacy and policy engagement. A survey of 162 nurse leaders from nursing schools and government hospitals was conducted and analyzed using descriptive statistics. Thirteen purposively selected nurse leaders participated in semi-structured interviews analyzed using thematic analysis. Findings were integrated through joint displays and mixed-methods meta-inferences guided by the Sessler-Branden Advocacy Matrix. Results showed beginning-level political astuteness characterized by strong ethical sensitivity but limited procedural knowledge of political systems. Nurse leaders demonstrate moderate political efficacy, with greater confidence in influencing local contexts than national policy arenas, and moderate health advocacy engagement, primarily focused on patient and community concerns, with limited participation in legislative or system-level initiatives. Qualitative findings explained these patterns through three themes: Ethical-Professional Identity as the Moral Root of Political Awareness; Political Self-Perception and the Uneven Development of Political Efficacy; and Advocacy as a Continuum of Ethical Action and Emerging Political Agency. Integrated findings revealed that nurse leaders demonstrate ethically grounded yet evolving political capacities. Strengthening political competence requires structured leadership development initiatives, including policy education, mentorship, and experiential exposure to health governance processes.

Keywords: *health advocacy; health policy; nurse administrators; Philippines; policy making*

INTRODUCTION

The role of nurse leaders in shaping health systems and influencing policy has become increasingly important as healthcare environments grow more complex and reform-driven. Nurse leaders occupy a strategic position within healthcare organizations and play a pivotal role in driving positive change through leadership, advocacy, and political engagement (Clarke et al., 2021). Despite their recognized importance, nurse leaders often report limited preparedness and participation in policy processes, with advocacy efforts frequently concentrated on implementation rather than policy development and reform (Asuquo, 2019; Hajizadeh et al., 2021).

Advocacy has long been embedded in nursing practice, evolving from patient-centered representation to broader system-level and policy engagement (Chui et al., 2021; Madigan et al., 2023; Matthews et al., 2020). In the Philippines, advocacy is formally embedded in professional standards, reinforcing nurses' responsibility to engage in policy processes and to assume leadership roles within health governance (Professional Regulation Commission-Board of Nursing, 2017). At its core, advocacy involves recognizing issues, mobilizing support, and influencing decision-making bodies to achieve desired outcomes (Farias et al., 2023; Goes, 2025). Consequently, advocacy represents a central dimension of nurse leaders' sociopolitical responsibilities (Han et al., 2025).

Effective advocacy requires political awareness, a strategic understanding of policy processes, and confidence in influencing decision-making systems (Bernardino et al., 2023; Clarke et al., 2021; Gooch, 2025). These competencies are reflected in the concepts of political astuteness and political efficacy, which are considered foundational to sustained advocacy engagement. Political astuteness refers to an individual's awareness of policy issues, understanding of legislative processes, and ability to navigate political environments to advance professional or societal goals (Primomo & Bjorling, 2013). Political efficacy, on the other hand, reflects individuals' belief in their capacity to participate in political processes and their perception that political systems are responsive to their actions (Chen & Madni, 2024; Willeck & Mendelberg, 2022). Political efficacy includes internal political efficacy (IPE), confidence in one's knowledge and skills to engage in political processes, and external political efficacy (EPE), belief in the responsiveness of governmental institutions (Levy, 2013). Empirical studies consistently demonstrate that nurses and nurse leaders tend to report beginning or low levels of political astuteness and low to moderate levels of political efficacy, particularly among nurse practitioners, educators, and emerging leaders (AbuAlRub & Abdulnabi, 2020; Curry & Fitzpatrick, 2024; Gooch, 2025; Longshore, 2022; Rogers & Gaffney, 2025).

Active and sustained nurse involvement in health advocacy is especially critical in low- and middle-income countries, where persistent health inequities demand efforts to ensure healthcare remains equitable, accessible, efficient, and cost-effective (Etowa et al., 2023; Hajizadeh et al., 2021; Kuehne et al., 2022).In the Philippines, systemic workforce challenges, including understaffing, migration, limited professional growth, and constrained participation in decision-making, further hinder advocacy engagement (Alibudbud, 2022; Alvarez, 2023; Bonito et al., 2019). These concerns are evident in the Region I, where contextual and cultural factors shape leadership and advocacy roles (Savella, 2018; Talosig et al., 2021).

Despite increasing recognition of nurses' roles in policy and advocacy (White et al., 2025; WHO, 2021), research examining political astuteness, political efficacy, and health advocacy among nurse leaders in decentralized regions remains limited. This gap is particularly evident in Region I, where little is known about how nurse leaders navigate local political structures, exercise influence, and engage in advocacy within resource-constrained, culturally grounded contexts. Addressing this gap requires an approach that not only measures levels of political competence but also explores the contextual experiences that shape these capacities.

Guided by the Sessler-Branden Advocacy Matrix Theory (SBAMT) (2012), this study employed a sequential explanatory mixed-methods design to examine the political capacities and advocacy engagement of nurse leaders of Region I, Philippines. The study sought to answer the following research questions (RQs):

RQ1. What is the degree of political astuteness of nurse leaders?

RQ2. What is the degree of political efficacy of nurse leaders?

RQ3. What is the degree of health advocacy engagement among nurse leaders?

RQ4. What accounts for the beginning political astuteness among nurse leaders?

RQ5. What accounts for the moderate political efficacy among nurse leaders

RQ6. What accounts for the moderate health advocacy engagement among nurse leaders?

Integrating quantitative breadth with qualitative depth provided a more comprehensive understanding of the sociopolitical conditions shaping nurse leaders' advocacy engagement and informed strategies for nurse leaders, professional nursing organizations, educational and healthcare institutions, policymakers, and researchers by guiding leadership development, informing advocacy-focused education and practice, and supporting evidence-based policies for leadership development of political capacities and capacity building in the region.

METHODS

Research Design

A sequential explanatory mixed-

methods design guided by a pragmatic approach was used to address the RQs. The study was conducted in two phases. In the first phase, a quantitative descriptive study was used to examine nurse leaders' levels of political astuteness, political efficacy, and health advocacy engagement. In the second phase, a qualitative descriptive study was done to explore the contextual factors shaping nurse leaders' political capacities and advocacy engagement through semi-structured interviews. The findings from the quantitative phase guided the development of the interview protocol and the selection of participants for the qualitative phase using a connecting-and-building strategy. Quantitative and qualitative data were integrated through joint displays and narrative weaving to generate mixed-methods meta-inferences by examining confirmation, complementarity, expansion, and discordance across the data (Fetters, 2019; Younas et al., 2023).

Mixed-methods research integrates quantitative and qualitative data within one study to address specific research questions. The combination and triangulation of these approaches allow for a deeper, more comprehensive understanding of the complex processes involved in leadership and advocacy, given their multifaceted, content-dependent nature (Stentz et al., 2012), thereby enabling the study to move beyond mere description toward meaningful interpretation and actionable recommendations. The study followed the latest Mixed Methods Appraisal Tool (MMAT) checklist to help ensure clarity and quality in the research process (Hong et al., 2018).

Quantitative Phase

Locale and population

Nurse leaders from government hospitals and higher education institutions with nursing programs in Region I, Philippines were included. From a population of 279 nurse leaders, a sample of 162 participants was determined using the Raosoft sample size calculator at a 95% confidence level and 5% margin of error (Raosoft, 2004). Stratified random sampling with proportional allocation across the provinces of Ilocos Norte, Ilocos Sur, La Union, and Pangasinan was applied, followed by simple random sampling within each stratum.

Eligible participants included 1) officers of nursing professional organizations, or department chairperson/dean of the School of Nursing, program chairs, coordinators, chief nurses, assistant chief nurses, nurse supervisors, or nurse consultants regardless of their age and sex; 2) working in a government or private health or educational institutions; and 3) willing to participate in both phases of the study. Nurse leaders on leave during data collection were excluded.

Data gathering tools

Data were collected using standardized self-administered questionnaires distributed in hard copy or through Google Forms.

Political astuteness was measured using the 40-item Political Astuteness Inventory (PAI) developed by Clark (1984). Items were scored dichotomously (1 = positive response; 0 = negative response), with total scores categorized as completely politically unaware (0–9), slight awareness (10–19), beginning political astuteness (20–29), and politically astute (30–40). The instrument demonstrates content validity based on established political assessment frameworks (Modene, 2018). Previous studies reported good internal consistency reliability with Cronbach's alpha values of 0.81 (Primomo, 2007), 0.84 (Byrd et al., 2012), and 0.945 (Primomo & Bjorling, 2013). In the present study, the PAI yielded a Cronbach's alpha of 0.881.

Political efficacy was measured using Levy's (2013) Political Efficacy Scale, a 15-item instrument assessing internal political efficacy: (IPE) knowledge (3 items) and skills (5 items) and external political efficacy (EPE): local (4 items) and distal (3 items). Items were rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). Previous studies reported reliability coefficients of 0.85 (Ahoya et al., 2016, as cited in AbuAlRub & Abdulnabi, 2020) and 0.831 (Osei & Lacanaria, 2023), while Levy (2013) reported a Cronbach's alpha of 0.95, supporting the scale's reliability and validity.

Health advocacy engagement was assessed using Dean's Social Justice Advocacy Scale (Dean, 2009), a 43-item instrument with four dimensions: collaborative action (20 items), social/political advocacy (7 items), client empowerment (8 items), and

client/community advocacy (8 items). The scale was adopted to a 5-point Likert format ranging from 1 (completely untrue actions) to 5 (completely true actions). The instrument demonstrated strong construct validity and reliability, with Cronbach's alpha reported at 0.94 (Dean, 2009). In the present study, the scale yielded a Cronbach's alpha of 0.941.

Data gathering procedure

Quantitative data were collected after obtaining ethical clearance and institutional approvals from participating hospitals and academic institutions in Region I. Questionnaires were distributed in printed form or via Google Forms with the assistance of a trained research enumerator and institutional focal persons, and participants completed the survey in approximately 20–30 minutes.

Statistical treatment

Quantitative data were analyzed using IBM SPSS version 23, employing descriptive statistics such as frequencies, percentages, means, and standard deviations to describe nurse leaders' levels of political astuteness, political efficacy, and health advocacy engagement.

Qualitative Phase

Setting, participants, and sampling technique

Using sequential nested sampling, a purposive subsample of 13 nurse leaders was drawn from the quantitative respondents to explain emerging patterns, particularly those with high or low scores in political astuteness, efficacy, and advocacy engagement, including unexpected result profiles. Interviews were conducted until thematic saturation was reached.

Data collection

A semi-structured interview guide was developed following preliminary quantitative analysis using a building integration strategy (Creswell & Plano Clark, 2018; Tanner, 2023). The guide was reviewed by three qualitative research experts and pilot-tested with two nurse leaders to refine clarity, question flow, and probing prompts prior to data collection.

The researcher conducted all qualitative interviews. Transitioning from a predominantly quantitative background to qualitative and mixed-methods research, the researchers strengthened rigor through mentorship, literature review, and professional development.

Thirteen in-depth interviews were conducted, each lasting 45–60 minutes in private settings from May to July 2024. Interviews were audio-recorded with consent, transcribed verbatim, and supplemented with field notes.

Data management and analysis

Qualitative data, including audio recordings, transcripts, and field notes, were securely stored and de-identified before analysis. Data were analyzed using Braun and Clarke's (2019) reflexive thematic analysis, following six iterative phases: 1) immersion in the data through transcription and repeated reading of each transcript, 2) generation of initial codes to capture meaningful features, 3) clustering of related codes into potential themes, 4) reviewing themes against the coded data and full dataset for coherence, 5) refining and defining themes to clarify their scope and meaning, and 6) writing the analytical narrative supported by illustrative data excerpts. Microsoft Excel was used to organize codes, support memo writing, and maintain transparency in the analytic process. Using reflexive thematic analysis allowed core patterns, meanings, and narrative structures to surface organically and accurately depict participant's lived experiences.

Trustworthiness and Rigor

To ensure trustworthiness and rigor, multiple strategies were employed. Sustained interaction with participants member checking, and peer debriefing enhanced credibility. Transferability was supported by purposive sampling of nurse leaders from diverse clinical and academic institutions across Region I and by providing rich contextual descriptions. Dependability was ensured by maintaining a clear and well-documented audit trail covering the development of the interview protocol, purposive and nested sampling procedures, participant recruitment, data collection, and analysis. Confirmability was maintained through a structured codebook, iterative theme refinement, and reflexive journaling to ensure that findings remained grounded in participants' narratives rather than in the researcher's assumptions.

Ethical Considerations

Ethical approval was obtained from the Saint Louis University Research Ethics Committee (SLU-REC 2024-033) and relevant institutional review boards of participating hospitals and nursing schools in Region I, including Union Christian College (2024-MAN-EXT-006), Lorma Colleges, Inc. (REC 2024-114), Region 1 Medical Center (Protocol No. 2024-076), and Don Mariano Marcos Memorial State University (RETC Code 2024-384). Institutional permissions and informed consent were secured prior to data collection. Participants were informed of the study's purpose, procedures, voluntary participation, risks, and right to withdraw without penalty. Confidentiality and anonymity were ensured through coded identifiers, secure data storage, and restricted access to research materials. Interviews were conducted in private settings, and findings were used strictly for academic purposes. Grammarly was used to improve language clarity and assess the manuscript's similarity index.

RESULTS AND DISCUSSION

Quantitative Phase

This part presents the levels of political astuteness (RQ1), political efficacy (RQ2), and health advocacy engagement (RQ3) among nurse leaders in Region I.

Political astuteness of nurse leaders.

Table 1 shows that most nurse leaders fall under the beginning (42.59%) and slightly aware (27.16%) categories, while 29.01% fall under the politically astute category. Only 1.23% fall under the totally unaware category.

Table 1. Political astuteness of nurse leaders

Scale	Score Range	n	%
Totally unaware politically (scores 1-9)	1–9	2	1.23
Slightly aware (scores 10-19)	10–19	44	27.16
Beginning astuteness (scores 20-29)	20–29	69	42.59
Politically astute (scores 30-40)	30–40	47	29.01

**N=162 Categories adopted from Clark (2008). Higher scores indicate greater political astuteness.*

Varying levels of involvement are observed across the dimensions of political astuteness as seen in Table 2. Nurse leaders demonstrate high awareness of health issues, voting participation, and professional organization membership; however, engagement in procedural political activities, such as lobbying, contacting legislators, attending policy hearings, or drafting policy papers, remains low. Familiarity with legislative processes and policymakers' voting histories is also limited. These findings suggest that while nurse leaders possess strong ethical commitment and contextual awareness, they remain procedurally underprepared for strategic policy engagement.

This aligns with literature indicating that although nurses demonstrate civic responsibility, many lack the political literacy necessary for effective policy influence (Longshore, 2022; Rasheed et al., 2020). Voting and professional membership require relatively little procedural knowledge, whereas strategic political engagement, advocating for legislation, drafting position papers, or influencing policy agendas, demands more sophisticated political competence (Clarke et al., 2021; Brown et al., 2020). Beginning-level astuteness may reflect strong moral commitment but limited experiential opportunities, mentorship, gaps in nursing curricula, and institutional support for policy engagement within hierarchical healthcare systems, compounded by workload and organizational hierarchies, further hinder advanced political engagement (Cariaso et al., 2024; Savella, 2018; Han & Kim, 2023; Brenner, 2022; Curry & Fitzpatrick, 2024; Gentry et al., 2024). Political astuteness appears developmental, progressing from awareness to strategic action (Clark, 2008).

Table 2. Dimensions of political astuteness of nurse leaders

Dimensions	N	%
Voting Behavior		
1. I am registered to vote.	157	96.91
2. I know where my voting precinct is located.	156	96.30
3. I voted in the last general election.	153	94.44
4. I voted in the last two elections.	150	92.59
5. I recognized the names of the majority of candidates on the ballot in the last election.	146	90.12
6. I was acquainted with the majority of issues on the ballot at the last election.	142	87.65
Participation in professional organizations		
7. I belong to a professional nurses' organization.	146	90.10
8. I participate (as a committee member, officer, etc.) in this organization.	106	65.4
9. I attended the most recent meeting of my local nurses' association	82	50.62
10. I attended the last provincial or national convention held by my organization.	92	56.79
11. I am aware of at least two issues discussed and the stands taken at this convention.	99	61.11
12. I read literature published by my professional nurses' association, a professional magazine, or other literature on a regular basis to stay abreast of current health issues.	108	66.67
Awareness about health policy issues		
13. I stay abreast of current health issues.	155	95.68
14. I know of at least two issues related to my profession that are currently under discussion.	143	88.27
15. I know of at least two health-related issues that are currently under discussion at the local or national level.	141	87.04
16. I find myself more interested in political issues now than in the past.	116	71.60
Knowledge of the legislative and policy processes		
17. I know whom to contact for information about health-related issues at the local or national level.	130	80.25
18. I know whether or not my professional organization employs lobbyists at the local or national level.	99	61.11
19. I know how to contact these lobbyists.	66	40.70
20. I know the process by which a bill is introduced in my Senate or House of Representatives.	82	50.60
21. I know which senators or representatives are supportive of nursing.	99	61.70
22. I know which House and Senate committees usually deal with health-related issues.	88	54.32
23. I know the committees of which my representatives are supportive of nursing.	97	59.90
24. I am aware of the composition of the Professional Regulatory Commission-Board of Nursing which regulates the practice of my profession.	104	64.20
25. I know the process whereby one becomes a member of the Board of Nursing, which regulates my profession.	99	61.11
Knowledge of legislators		
26. I know the names of my senators.	146	90.12
27. I know the name of my district representatives.	140	86.42
28. I know the name of the name of the party list that supports health policy.	110	67.90
29. I know the name of the Sanguniang Bayan/Sanguniang Panlalawigan member of my local government unit.	126	77.78
30. I am acquainted with the voting record of at least one of the above in relation to a specific health issue.	99	61.11
31. I am aware of the stand taken by at least one of the above in relation to a specific health issue.	107	66.05
Involvement in the political process		
32. I contribute financially to my local and national professional organization's political action committee.	47	29.00
33. I give information about effectiveness of elected officials.	48	29.62
34. I actively supported a senator or representative during the last election.	45	28.40
35. I have written to one of my local or national representatives in the last year regarding a health issue.	20	12.34
36. I am personally acquainted with a senator or representative or a member of his or her staff.	23	14.19
37. I serve as a resource person for one of my representatives on his or her staff.	19	11.73
38. I am a member of a health board or advisory group to a health group to health organization or agency.	6	16.04
39. I attend public hearings related to health issues.	30	18.50
40. I have written a letter to the editor or other piece for the lay press speaking out on a health-related issue.	1 6	9.88

Note. n=162; N=frequency; %=percentage

Political efficacy of nurse leaders

Overall, nurse leaders demonstrate a moderate political efficacy ($\bar{x}$ = 3.48). Varying levels of involvement are explicitly observed in Table 3.

Table 3. Political efficacy of nurse leaders

Dimensions	M	SD	Interpretation
External Political Efficacy-Distal (National)			
1. If there's a serious national problem, I can do something to get national government officials to improve the situation.	3.00	1.23	Moderate efficacy
2. If there's a serious problem in my province, I can do something to get provincial government official to improve the situation.	3.10	1.24	Moderate efficacy
3. Public officials care what people like me think.	3.32	1.18	Moderate efficacy
Composite mean	3.14	1.22	Moderate efficacy
External Political Efficacy-Local			
1. Leaders in my community care what people like me think.	3.45	1.20	Moderate efficacy
2. I can make a difference in my community.	4.07	1.18	High efficacy
3. If I think there's a serious problem in my community, I can do something to improve the situation.	3.84	1.23	High efficacy
4. If there's a serious local problem, I can do something to get local government officials to improve the situation.	3.61	1.24	High efficacy
Composite mean	3.74	1.21	High efficacy
Internal Political Efficacy-Knowledge			
1. I feel that I have a pretty good understanding of the important political issues facing our country.	3.97	1.18	High efficacy
2. I feel that I have a pretty good understanding of the important political issues facing our world.	3.80	1.22	High efficacy
3. I consider myself well-qualified to participate in politics.	2.83	1.42	Moderate efficacy
Composite mean	3.54	1.27	High efficacy
Internal Political Efficacy-Skills			
1. I am confident that I can construct good arguments about political issues.	3.10	1.26	Moderate efficacy
2. When I share my ideas about political issues, people listen to me.	3.38	1.18	Moderate efficacy
3. When I have to work with other people towards a goal, I can get others to work towards that goal.	3.82	1.22	High efficacy
4. I can persuade my peers of my point of view on political issues.	3.52	1.20	High efficacy
5. I am confident in my public speaking abilities.	3.59	1.13	High efficacy
Composite mean	3.49	1.19	Moderate efficacy
Overall mean	3.48	1.22	Moderate efficacy

1.00- 1.83: very low efficacy 1.84-2.67: low efficacy 2.68-3.51: moderate efficacy 3.52-4.35: high efficacy 4.36-5.0: very high efficacy

Internal political efficacy is stronger for knowledge-related items, with nurse leaders reporting high awareness of national ($\bar{x}$ = 3.97) and global health issues ($\bar{x}$ = 3.80). However, political skill-related items, such as constructing policy arguments or communicating with policymakers, score lower ($\bar{x}$ = 3.10). External efficacy shows a similar pattern: local political efficacy is high ($\bar{x}$ = 3.74), while distal efficacy is moderate ($\bar{x}$ = 3.14), indicating greater confidence in influencing community decisions than national policy processes. These findings suggest that while nurse leaders understand policy issues, their confidence in engaging in political action remains moderate and context-dependent. Nurse leaders perceive themselves as significantly more capable of influencing decisions within their communities than at the provincial or national levels.

Consistent with prior studies, nurses often demonstrate policy awareness but hesitate to see themselves as political actors (Rasheed et al., 2022; Etowa et al., 2023; Han & Kim, 2025). Their political voice weakens in formal policy arenas characterized by bureaucratic complexity and hierarchical structures (Hajizadeh et al., 2021; O'Rourke et al., 2017). The findings likely reflect the relational and accessible nature of local governance in the Philippines, where nurse leaders frequently collaborate with local officials in implementing health programs, fostering a tangible sense of influence (Palompon et al., 2024; Waring et al., 2023). In contrast, national policy processes are perceived as centralized and less penetrable, diminishing confidence in broader system-level engagement (Han & Kim, 2025). Within the SBAMT framework, this pattern indicates that although nurse leaders possess foundational political knowledge, the skills and confidence needed for sustained policy engagement remain underdeveloped. Political efficacy, a known predictor of participation (Oser et al., 2022),

therefore emerges as moderate but fragile, strong in familiar, relational contexts yet limited in formal legislative domains.

Health advocacy of nurse leaders.

Overall, nurse leaders demonstrate a moderate health advocacy engagement ($\bar{x}$ = 3.29), with particularly strong scores in patient-focused and community-oriented advocacy. Varying levels of involvement are explicitly observed in the different domains of health advocacy engagement in Table 4.

Table 4. Dimensions of health advocacy engagement

Dimensions	M	SD	Interpretation
Collaborative Action			
1. I network with community groups/ colleagues with common concerns related to healthcare issues.	3.46	0.89	high engagement
2. I have knowledge of national laws and relevant policies pertaining to populations I am likely to see.	2.92	0.95	moderate engagement
3. I stay abreast of current laws and policies affecting populations with which I work.	3.70	2.38	high engagement
4. I create written materials to raise awareness about issues that affect my clients.	2.85	1.10	moderate engagement
5. I encourage clients to research the laws and policies that apply to them.	2.97	1.07	moderate engagement
6. I collaborate with potential allies for social change.	3.04	1.11	moderate engagement
7. I work to bring awareness to the public regarding issues that affect my clients.	3.36	0.97	moderate engagement
8. I teach my colleagues to recognize sources of bias within the institutions and agencies in which I am involved.	3.31	0.93	moderate engagement
9. I typically seek feedback regarding the effects of my interactions with the communities with which I work.	3.38	0.91	moderate engagement
10. I carry out my plans of action for confronting barriers to my clients' wellbeing.	3.41	0.89	high engagement
11. I build relationships with trusted community members and establishments in which I work.	3.54	0.96	high engagement
12. I work with professional organizations to influence public policy pertaining to social justice.	3.20	1.06	moderate engagement
13. I use creative means to bring attention to client issues and perceived injustices.	3.11	1.08	moderate engagement
14. When working with community groups, I conduct assessments that are inclusive of community members' perspectives.	3.30	0.99	moderate engagement
15. I seek feedback from my clients regarding the impact of my advocacy efforts on their behalf.	3.31	0.94	moderate engagement
16. I assess the influence of my public information/awareness efforts.	3.28	0.96	moderate engagement
17. When working with community/organizational groups, I routinely seek information regarding the history of the problem from the community members.	3.23	1.06	moderate engagement
18. I collect data to show the need for social change to the institutions with which I work.	3.34	2.66	moderate engagement
19. I assess the effects of my interactions with the community.	3.33	1.76	moderate engagement
20. I identify potential allies for confronting barriers to my clients' wellbeing.	3.07	1.09	moderate engagement
Composite mean	3.26		moderate engagement
Social/Political Advocacy			
1. I contact legislators on behalf of clients' needs.	2.46	1.10	low engagement
2. I communicated with my legislators regarding social issues that impact my clients.	2.86	1.21	moderate engagement
3. I contact my legislators to express my views on proposed bills that will impact client problems.	2.47	1.09	low engagement
4. I do know of any counselors who lobby legislators and/or other policy makers.	2.83	1.16	moderate engagement
5. I engage in legislative and policy actions that affect marginalized groups.	2.57	1.12	low engagement
6. I work with professional organizations to influence public policy pertaining to social justice.	2.70	1.18	moderate engagement
7. I work to change existing laws and regulations that negatively affect clients.	2.65	1.10	moderate engagement
Composite mean	2.65		moderate engagement
Client Empowerment			moderate engagement
1. I work with clients to develop action plans for confronting barriers to their wellbeing.	3.18	0.99	moderate engagement
2. I strive to examine problems for a systems perspective in an effort to understand their influences on client concerns	3.22	0.91	moderate engagement
3. I use interventions that utilize client resources to buffer against the effects of oppression.	3.09	0.94	moderate engagement

- Table 4 continued-

4.	My research interest focuses on giving voice to underserved populations.	3.24	1.02	moderate engagement
5.	I support my clients' self-advocacy efforts.	3.51	0.95	high engagement
6.	I understand the effects of multiple oppressions on clients.	3.49	0.96	high engagement
7.	I work to understand clients as they are impacted by social problems.	3.40	0.99	high engagement
8.	I assess whether client concerns reflect responses to oppression.	3.38	0.94	moderate engagement
	Composite mean	3.13		moderate engagement
	Client/Community Advocacy			
1.	I assist my clients in developing the communication skills needed to serve as self-advocates.	4.20	0.76	very high engagement
2.	Serving as a mediator between clients and institutions is an appropriate role for a nurse.	4.07	0.88	high engagement
3.	Assisting clients in calling national and local agents and navigating other bureaucracies is appropriate for counselors.	3.81	0.90	high engagement
4.	I use effective listening skills to gain understanding of community groups' goals.	3.78	1.00	high engagement
5.	I believe I am able to distinguish those problems that can best be resolved through political advocacy.	3.78	0.78	high engagement
2.	My skills as a nurse transfer to work with community groups.	4.10	0.79	high engagement
3.	I feel prepared to seek feedback regarding others' perceptions of my advocacy efforts.	3.95	0.83	high engagement
4.	My interventions with clients of color include strengthening their racial and ethnic identities.	4.06	0.81	high engagement
	Composite mean	3.96		high engagement
	Overall mean	3.29		moderate engagement

1.00- 1.79: very low engagement; 1.80-2.59: low engagement; 2.60-3.39: moderate engagement ; 3.40-4.19: high engagement ; 4.20-5.0: very high engagement

Client/community advocacy obtained the highest mean ($\bar{x}$ = 3.96), followed by collaborative action ($\bar{x}$ = 3.26) and client empowerment ($\bar{x}$ = 3.13), both at moderate levels. Nurse leaders frequently advocate for patient rights, equitable care, and access to services—activities closely aligned with their professional roles. However, involvement declines in areas requiring systemic or political action ($\bar{x}$ = 2.65), such as legislative lobbying, coalition-building, policy formulation, and media engagement. This pattern suggests that while nurse leaders are active advocates within relational and practice-based contexts, their participation in broader system-level advocacy remains limited.

This pattern aligns with the existing literature, which indicates that nurses are more comfortable engaging in micro-level advocacy embedded in care delivery than in formal political arenas that require strategic negotiation and policy navigation (Hajizadeh et al., 2021; Madigan et al., 2023). Nurses naturally advocate for vulnerable populations, aligning with global research that affirms that micro-level advocacy is deeply embedded in nursing identity (Brenner, 2022; Etowa et al., 2023; Laari & Duma, 2023; Williams et al., 2018). The accessibility of local structures and established professional roles likely facilitate community-level engagement, whereas bureaucratic complexity, institutional hierarchies, and limited policy exposure constrain higher-level advocacy (Han & Kim, 2025; Scott et al., 2023). The divergence between micro- and macro-level advocacy reflects global findings that nurses' strongest advocacy occurs where their professional identity is most salient, while policy-level advocacy remains limited due to structural and cultural constraints (Nsiah et al., 2019; Scott et al., 2023; Ojemeni et al., 2023). Limited involvement in producing policy briefs or advocacy materials indicates gaps in strategic communication and policy framing skills, which are rarely developed without targeted training (Ahoya et al., 2016; Chiu et al., 2021; Turale & Kunaviktikul, 2019).

The quantitative results reveal a developmental pattern across political astuteness, efficacy, and advocacy engagement. Nurse leaders demonstrate ethical commitment and situational awareness but exhibit emerging political competencies. Limited familiarity with policy processes contributes to moderate levels of efficacy and restricts engagement in broader advocacy activities. Consistent with prior studies (Clark, 2008; Han & Kim, 2020), political awareness supports efficacy, which in turn influences political action. Overall, nurse leaders are politically aware but remain constrained by limited political literacy,

strategic skills, and institutional support for sustained policy engagement.

Qualitative Phase

The qualitative phase deepened understanding of what accounts for the beginning political astuteness (RQ4), moderate political efficacy (RQ5), and moderate health advocacy engagement among nurse leaders (RQ6). Using reflexive thematic analysis (Braun & Clarke, 2019), three themes emerged as seen in Figure 1.

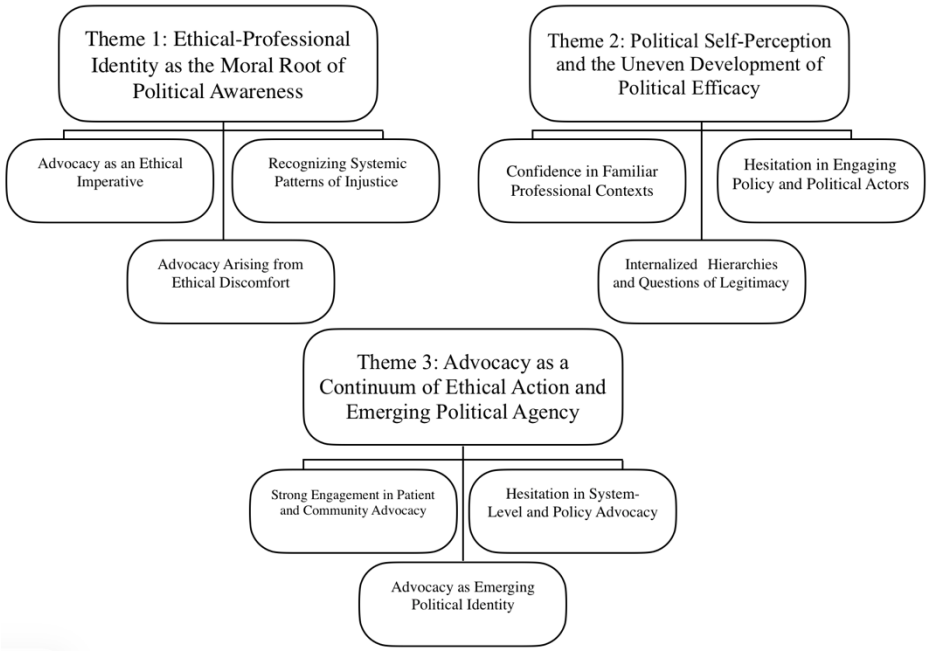

Figure 1. Themes and subthemes of the study

Theme 1: Ethical-professional identity as the moral root of political awareness.

This theme captures how nurse leaders' political awareness emerged not from formal political exposure or deliberate policy engagement but from deeply internalized ethical and professional commitments. As participants narrated their journeys toward recognizing political concerns, it became evident that their earliest encounters with politically relevant issues were grounded in the moral logic of nursing practice itself.

Subtheme 1: Advocacy as an ethical imperative. Nurse leaders described their early advocacy actions as extensions of their ethical responsibility to serve patients and communities. Participants framed these experiences as inherently moral and relational, embedded in what it means to be a nurse, rather than driven by political ambition."

> "I feel like it is my responsibility… that I need to give back to the community. When it comes to serving the community, I am truly committed." (P6)

> "I advocate for patients' rights and ensure that they receive compassionate, patient-centered care. I work to address any concerns or barriers that patients may encounter in accessing healthcare services and strive to promote their well-being and satisfaction." (P2)

Subtheme 1.2: Recognizing systemic patterns of injustice. Repeated encounters with patients suffering led participants to notice patterns that could not be solved through clinical interventions alone. This recognition marked an early form of political astuteness, even before mastery of political processes. Exposure to resource limitations, inequities, and preventable harms gradually sharpened their awareness of systemic drivers of health issues.

> "Their challenges became my motivation to help. You see the same problems again and

again, I think, there is a need to change in the system." (P1)

"I've witnessed firsthand how policies, systemic issues… negatively impact patient care and health outcomes…The shortage of nurses and lack of access in rural communities prompted me to look more for workforce and health equity reforms." (P10)

Subtheme 1.3: Advocacy arising from ethical discomfort. Many participants described speaking up not because they felt politically equipped, but because remaining silent would violate their ethical commitments. Ethical discomfort, rather than political intention, served as the emotional and experiential catalyst that propelled them toward early forms of advocacy. This reinforces that political awareness is rooted first in values and moral experience.

"Even though I'm not used to these kinds of discussions, I still speak up because the patients have no one else to speak for them." (P8)

"The way they were treated in other hospitals…I believe that I could be one of their advocates in in expressing their needs… I feel that I could be of help to them." (P10)

Participants' narratives showed that their ethical consciousness shaped how they interpreted injustice, allowing them to recognize the political dimensions of health care long before they had the language or skills to navigate formal policy arenas. Through repeated encounters with resource shortages, inequities, and systemic barriers, they began to see these challenges as structural rather than isolated issues. Within the framework of the SBAMT, these experiences correspond to the foundational conditions stage, where advocacy is rooted in values, moral clarity, and a deep sense of responsibility to others. Participants' narratives illustrated that their ethical consciousness served as an interpretive lens, sensitizing them to patterns of injustice long before they began to understand or navigate the formal political landscape. They felt the consequences of political structures through their clients' stories, long before they possess the language or procedural knowledge to label those experiences as political. This realization marked the emergence of beginning political astuteness, an awareness of the political dimensions of health work without yet having the strategic capacity or procedural fluency to act on that awareness.

Thus, the meaning of these findings lies in the recognition that political awareness was embodied before it was articulated. This aligns with studies that described advocacy as inherent to nursing's professional mandate, where moral responsibility naturally leads nurses to engage with community concerns and broader social issues (Ramsay et al., 2025; Ojemeni et al., 2023; Benjamin, 2024). Nurses begin to see politically because their ethical commitments demand that they interrogate the structures that perpetuate suffering. This form of knowledge is deeply relational, morally grounded, and experientially shaped, a form of political consciousness rooted in lived practice rather than abstract theory. As nurses make these connections, their clinical observations evolve into political insights that allow them to articulate needs to policymakers, collaborate with others facing similar challenges, and advocate for evidence-informed reforms (Clarke et al., 2021). However, without structured mentorship and policy exposure, nurses remain politically inactive (Etowa et al., 2023). The findings reveal a developmental gap in nurse leaders' political competence: while they possess strong ethical commitment, this does not automatically translate into political capability without structured education, mentorship, and institutional support.

Theme 2: Political self-perception and the uneven development of political efficacy.

The second theme highlights the uneven and transitional development of political efficacy among nurse leaders. Qualitative narratives indicate that their sense of political efficacy is context-dependent—strong in familiar clinical or community settings but weakened by perceived limitations, professional hierarchies, and limited familiarity with policy discourse. This theme thus reflects a developmental midpoint between recognizing political issues and feeling capable of addressing them.

Subtheme 2.1: Confidence in familiar professional contexts. Participants expressed strong confidence when advocating in clinical,

managerial, or community environments. These domains represent spaces where their expertise is validated, and their authority is recognized. Within clinical, managerial, and community contexts, they feel competent to lead, guide others, and advocate effectively because these spaces affirm their authority and skill.

> "I really had good time relating to people in the community and uhh...actually that gave me also a chance to be really advocating for health with the community people." (P10)

> "Maybe my position as a supervisor is a good factor. As I lead the group, I am able to tell my staff what needs to be done.." (P4)

Subtheme 2.2: Hesitation in engaging policy and political actors. Participants reported feeling uncertain or intimidated when envisioning interactions with policymakers, legislators, or formal political bodies. This reflects a perceived gap between understanding systemic issues and knowing how to communicate them effectively within political arenas.

> "Even if I know the issue, it's still hard to talk about it in front of policymakers. I still feel like I lack the confidence when it comes to constructing arguments." (P3)

> "So, for me, my voice is only effective here at my level because you cannot bring it out to higher authorities, they will not listen to you. That is one of my frustrations..." (P6)

> "It is difficult to talk to the policymakers if you do not know anything. For me, my lack of experience affects my knowledge, ability, and confidence in dealing with them especially when dealing with them…" (P12)

Subtheme 2.3: Internalized hierarchies and questions of legitimacy. Several nurse leaders expressed doubts about whether they are the right individuals to engage in political processes. Their hesitations suggest that political efficacy is shaped not only by self-perceived competence but also by structural signals about who is considered authorized to speak in policy spaces.

> "But when it comes to my level, it feels very difficult. It's not impossible, but it is really a challenge. If, for example, someone at my level wants to pursue advocacy, it would truly be hard, especially when it comes to anything legislative." (P6)

> "Which congressman should we approach, where should we go… We are not born to become politicians." (P9)

> "When we look to doctors, we will see them as powerful people…Nurses are not looked up to when it comes to policy-making… their influence is very limited… nurses are in the middle of the hierarchy." (P7)

> "Our heads are really the ones who help lobby the advocacies. They are the ones closer to the legislators. They are the ones who know people up there. They know how to work with the legislative processes." (P4)

This tension reflects the SBAMT's capacity dimension, wherein individuals begin to evaluate whether they possess the knowledge, skills, and self-assurance required for advocacy. For many participants, this stage is only partially developed. Many participants interpreted their professional identity through a hierarchical lens, believing that elected officials, administrators, or physicians are more legitimate political actors. This belief, internalized over years of working in hierarchical systems, diminishes nurses' sense of political agency despite their substantive expertise. Furthermore, the difficulty participants described in finding the words to express political issues underscores another developmental tension; they understand the problem experientially, but struggle to translate that understanding into policy language. This highlights a linguistic and discursive gap between clinical reasoning and political communication, an important factor influencing political efficacy.

These findings help explain why nurse leaders' political efficacy is neither fixed nor absent; it is emergent but uneven, strong where professional identity is affirmed, and fragile where role expectations become ambiguous. Their narratives demonstrated that the development of political efficacy is closely tied to the interplay between personal identity, organizational culture, and broader sociopolitical structures. Across studies, undervaluation of nursing expertise and persistent institutional power imbalances erode nurses' confidence and marginalize their voices in policy and decision-making spaces (Laari & Duma, 2023; Han & Kim, 2023; Hajizadeh et al., 2021). This lack of confidence in nurse

leaders affects their ability to express their perspectives on policy issues to policymakers (Shariff, 2014). Without intentional policy education, mentorship, and advocacy training, political efficacy remains context-bound, strong locally but weak in broader arenas. Strengthening political efficacy, therefore, requires institutional commitment to equip nurse leaders with the skills, confidence, and exposure necessary for sustained policy engagement.

Theme 3: Advocacy as a continuum of ethical action and emerging political agency

The third theme illuminates how nurse leaders translate their ethical commitments and evolving political self-perception into concrete advocacy behaviors. Building on the moral foundations identified in Theme 1 and the uneven development of political efficacy explored in Theme 2, this theme illustrates how advocacy is lived out across different levels of practice, with a strong presence at the patient and community level, yet a more tentative one within broader policy and system-level contexts. This theme thus captures the dynamic interplay between ethical identity, political self-belief, and the evolving agency required for system-level advocacy.

Subtheme 3.1: Strong engagement in patient and community advocacy. Participants' narratives show that patient and community advocacy is deeply embedded in their professional identity, reflecting a natural extension of their ethical commitment. Their ability to recognize needs, mobilize support, and champion improvements within their immediate environments demonstrates strong micro-level advocacy.

> "I believe that I have my own purpose. And I believe that I could be an advocate for change to those people." (P10)

> "We empower our teams…advocate for safe nurse-to-patient ratios, adequate resources, and supportive work environments…and advocate for necessary changes within the clinical setting." (P1)

> "That's where you really feel the needs of the people; that's where I sense that they truly need someone who can help them." (P6)

Subtheme 3.2: Hesitation in system-level and policy advocacy. Although participants demonstrate strong moral commitment to advocacy, many expressed uncertainty and discomfort when engaging in higher-level policy processes such as lobbying, legislative communication, and policy development. This reveals a developmental boundary between localized advocacy and broader political engagement because they are constrained by limited exposure, unfamiliarity with political processes, and fear of institutional repercussions.

> "I know what the community needs, but it's different when it comes to the policy level… it feels like I'm still far from that." (P11)

> "It is difficult to talk to the policymakers if you do not know anything. For me, my lack of experience affects my knowledge, ability, and confidence in dealing with them especially when dealing with them." (P12)

> "You are in the government… you cannot be seen as… You don't even know who you should approach, and sometimes it's frightening because you might get blacklisted, right?" (P6)

> "So those are the barriers we cannot, we cannot have control over all of these things. Yes, ma'am, we want the lobby…but it's difficult to connect with politics. It's also very difficult to connect with politicians." (P9)

Subtheme 3.3: Advocacy as emerging political identity. Several participants described a growing realization that their professional insights can contribute meaningfully to policy discussions but acknowledged the need for structured learning, mentorship, and institutional support to strengthen this evolving role. The accounts under this subtheme illustrate the early formation of advocacy identity among nurse leaders.

> "Maybe we should also be equipped… in the PhD program we learn about the legislative process… maybe we can even take Public Administration as well… it gave me more opportunity to understand the process." (P9)

> "I am already with my position and background, but my mentors possess deep knowledge and experience in policy advocacy… sharing their insights, best

practices, and evidence-based strategies. Their expertise inspires me to navigate complex health issues, understand policy implications, and advocate effectively." (P1)

"Support and collaboration from the administration, healthcare professionals, community organizations, policymakers, and other stakeholders…we can leverage collective expertise and resources to address complex healthcare issues and drive positive change, especially in policy advocacy." (P2)

The participants' accounts indicate that they possess the values and commitment necessary for advocacy but do not always have the procedural literacy, political framing skills, or institutional access required for effective policy influence. This explains the significance of moderate advocacy: advocacy is not absent, but it is bounded by the skills and structures that shape where nurses perceive they can act effectively. Moreover, participants' hesitations highlight how organizational and socio-political hierarchies shape advocacy engagement. While they recognized the value of their lived experiences and community insights in informing policy, they also acknowledged a developmental gap between understanding frontline needs and influencing higher-level decisions. This pattern reflects the SBAMT's distinction among foundational values, capacity, and action. Although nurse leaders demonstrate strong values and emerging capacities, structural and perceptual barriers influence the extent to which these translate into political advocacy.

Advocacy, therefore, becomes an evolving practice shaped by both personal commitment and systemic limitations. For nurse leaders, maintaining commitment and a positive disposition toward advocacy nurtures political self-belief and strengthens engagement in policy activities (Tadie et al., 2024). However, systemic obstacles reinforce a cycle of disempowerment, in which nurses, despite being aware of policy issues, feel limited in their ability to translate intent into action (Nsiah et al., 2019; Laari & Duma, 2023). Therefore, building a culture of advocacy requires not only training but also organizational reforms that validate nurses as contributors to policy dialogue.

Finally, this theme integrates seamlessly with the broader developmental storyline emerging from Themes 1 and 2. Ethical identity (Theme 1) provides the moral impetus for advocacy, while developing political efficacy (Theme 2) shapes whether nurses feel capable of engaging beyond familiar spaces. Advocacy engagement (Theme 3) reveals where those identities and perceptions translate into action. This implies that strengthening nurse leaders' advocacy requires interventions that address all three developmental layers: reinforcing ethical clarity, cultivating political self-efficacy, and creating accessible pathways for system-level participation.

Integration of Quantitative and Qualitative Findings

Integration of findings on political astuteness.

The integration of quantitative and qualitative findings indicates that nurse leaders' political astuteness (Table 5) is still in its early developmental stage. This is not due to a lack of moral commitment, but rather because their political awareness is largely grounded in ethical and clinical experience rather than formal political preparation.

Integrated findings reveal a developmental gap: nurse leaders possess strong moral and experiential foundations for advocacy but lack structured political education, mentorship, and institutional support to translate awareness into effective policy action. Their political astuteness is morally grounded but procedurally underdeveloped, resulting in a form of "ethical political awareness" that is rich in values yet constrained in action. This clarifies why political astuteness remains at the beginning stages.

Advocacy as a moral imperative grounded in their responsibility to patients and communities, their frontline experiences serve as catalysts for political awareness (Leyva et al., 2024; Etowa et al., 2023). Their repeated exposure to systemic inequities shapes their recognition of the political roots of health outcomes (Hajizadeh et al., 2021; Chiu et al., 2021). However, this strong advocacy identity rarely translates into structured policy influence

Table 5. Joint display on the integration of quantitative and qualitative findings on political astuteness

Quantitative Result	Qualitative Explanation	Integrated Interpretation / Meta-Inference	Implications for Practice
Majority are at beginning (42.59%) or slightly aware (27.16%). Only 29.01% are politically astute.	Subtheme 1.1: Advocacy as an Ethical Imperative Subtheme 1.2: Recognizing Systemic Patterns of Injustice Subtheme 1.3: Advocacy Arising from Ethical Discomfort	Political astuteness originates from moral experience rather than political education. Nurse leaders have values-driven awareness but lack procedural political knowledge. This explains why awareness is present but strategic competence remains underdeveloped.	Institutionalize political competence training. Build from nurses' strong ethical foundations by offering structured policy education, mentorship from politically engaged nurses, and real exposures to political processes. Strengthen SBAMT foundational conditions by linking ethical motivation with political skills.

without intentional capacity-building (Han & Kim, 2023; Zalon et al., 2024). They lack the procedural skills needed for meaningful political action, including legislative knowledge, lobbying techniques, policy analysis, and stakeholder negotiation (Gentry et al., 2024; Curry & Fitzpatrick, 2024; Brenner, 2022; Elliott, 2024). The limited political education among nurses is a recurrent theme in the literature, with many scholars noting that political content is inconsistently integrated into nursing curricula (Philip, 2018; Fernandez et al., 2022; Elliott, 2024). Without structured exposure to policymaking spaces, nurses remain politically aware but not politically effective (Waring et al., 2023; Zalon et al., 2024).

These findings highlight the need to institutionalize political competence within nursing education and leadership development. Embedding civic and political engagement in curricula and trainings can support the enhancement of nurses' long-term advocacy capacity (Turale & Kunaviktikul, 2019; Rogers & Gaffney, 2025). Integrating policy literacy, legislative exposure, strategic advocacy training, and mentorship into curricula and professional programs can bridge the gap between ethical motivation and political capability. Through structured capacity-building aligned with the SBAMT, nurse leaders can evolve from morally driven advocates to politically competent actors capable of influencing policy and systemic reform.

Integration of findings on political efficacy

The integration of quantitative and qualitative findings shows that political efficacy among nurse leaders is moderate and unevenly developed. This is not due to a lack of political interest or awareness, but because their confidence is strongly shaped by context, professional identity, and perceived legitimacy (Table 6).

Table 6. Joint display on the integration of quantitative and qualitative findings on political effficacy

Quantitative Result	Qualitative Explanation	Integrated Interpretation/ Meta-Inference	Implications for Practice
Moderate overall efficacy ($\bar{x}$ = 3.48). Stronger internal efficacy in knowledge and team influence; weaker political communication skills. Higher local than national efficacy.	Subtheme 2.1: Confidence in Familiar Professional Contexts Subtheme 2.2: Hesitation in Engaging Policy and Political Actors Subtheme 2.3: Internalized Hierarchies and Questions of Legitimacy	Political efficacy is context-dependent. Nurse leaders feel effective where they hold relational authority but lack confidence in formal political arenas. The gap between awareness and political readiness explains the "moderate" result. Structural and cultural factors reduce political self-belief.	Develop political communication competencies. Offer training in policy framing, drafting position papers, and strategic messaging. Create political role models. Highlight nurse leaders engaged in policy work to counter internalized hierarchies. Facilitate policy exposure to strengthen national-level efficacy.

Integrated interpretation reveals that political efficacy is not merely a psychological construct; it is shaped by identity, legitimacy, and structural opportunities. The moderate

efficacy score represents a midpoint on a developmental trajectory in which political knowledge exists, but readiness for political engagement is incomplete.

The integrated findings consistently align with studies and revealed that nurses exhibit higher efficacy in local or community settings where relationships, familiarity, and direct influence pathways exist than in national or legislative arenas, where bureaucratic distance and hierarchical cultures reduce confidence (Waring et al., 2023; AbuAlRub & Abdulnabi, 2020; Scott et al., 2023). Although nurses often possess strong awareness of policy issues and can articulate community needs, this knowledge is seldom translated into political action due to limited exposure to policymaking, insufficient role modeling, and inadequate training in political communication and argumentation (Myers, 2020; Han & Kim, 2023; Etowa et al., 2023). Internalized professional hierarchies, as captured in sentiments such as "I am just a nurse," further erode national-level efficacy by undermining perceived legitimacy in political spaces (Sharpnack, 2022; Hajizadeh et al., 2021). Political efficacy is strengthened not only through cognitive understanding but also through experiential engagement, mentorship from seasoned advocates, and supportive organizational cultures that normalize nurses' participation in policy work (O'Rourke et al., 2017; Madigan et al., 2023; Han & Kim, 2023).

Integrated findings suggest that strengthening political efficacy requires deliberate capacity-building beyond clinical contexts. Developing political communication skills, providing legislative exposure, and promoting politically engaged nurse leaders as role models can enhance confidence and legitimacy in policy arenas. These strategies can expand nurses' influence from local settings to broader system-level engagement.

Integration of findings on health advocacy engagement

The integrated findings show that nurse leaders' health advocacy engagement is strongest at the micro and community levels but remains constrained at the system level, revealing advocacy as a developing continuum rather than a fully matured competency, a trend consistently supported by both quantitative results and qualitative narratives (Table 7).

Table 7. Joint display on the integration of quantitative and qualitative findings on health advocacy engagement

Quantitative Result	Qualitative Explanation	Integrated Interpretation / Meta-Inference	Implications for Practice
Moderate overall advocacy engagement ($\bar{x}$ = 3.29). Strongest in patient/community advocacy ($\bar{x}$ = 3.96). Lowest in system-level advocacy ($\bar{x}$ = 2.46–2.85).	Subtheme 3.1: Strong Engagement in Patient and Community Advocacy Subtheme 3.2: Hesitation in System-Level and Policy Advocacy Subtheme 3.3: Advocacy as Emerging Political Identity	Advocacy is robust where nurses have experiential authority but weak where policy structures require political empowerment. Advocacy identity is present but incomplete. Systemic constraints explain weaker macro-level scores.	Create structured advocacy pathways. Formalize participation in policy bodies and intersectoral committees. Institutional support for advocacy. Protect nurses who speak on system issues. Advance SBAMT action stage by equipping leaders with lobbying, coalition-building, and legislative skills.

Integrated interpretation shows a clear pattern: ethical and community advocacy were well-developed, while system-level advocacy remained emerging and constrained. Consistent with SBAMT's action stage, values and capacity are present, but structural opportunities, mentorship, and institutional backing are insufficient for nurses to advance into policy influence. Thus, nurse leaders possess the motivation and readiness for advocacy, but systemic constraints hinder their transition into sustained policy-level engagement.

Studies show nurses consistently demonstrate strong grassroots advocacy because it aligns with their ethical commitments and everyday clinical work (Madigan et al., 2023; Waring et al., 2023; Chiu et al., 2021). However, engagement declines at the policy level due to limited training in political communication, coalition-building, and

legislative processes (Hajizadeh et al., 2021; Ojemeni et al., 2023; Benjamin et al., 2024). Structural exclusion from decision-making, hierarchical systems, and weak collective political voice further restricts nurses' influence in formal policy arenas (Rasheed et al., 2020; Bekemeier et al., 2021; Laari & Duma, 2023). Time pressures, lack of protected advocacy space, and insufficient institutional support also hinder sustained political action (Etowa et al., 2023; Sulosaari et al., 2023).

Integrated findings emphasize the need for structured advocacy pathways that formally involve nurse leaders in policy processes and decision-making bodies. Institutions must foster supportive cultures that protect and legitimize policy engagement while building competencies in lobbying, coalition-building, and legislative communication. Strengthening these structures and skills can elevate nurse leaders' advocacy from emerging potential to sustained system-level influence.

Cross-cutting meta-inferences

Integrating the quantitative and qualitative findings generates cross-cutting meta-inferences that clarify the developmental trajectory of political competence among nurse leaders in Region I. Grounded in the SBAMT, these insights reveal how political astuteness, efficacy, and advocacy engagement evolved through the interaction of ethical identity, professional culture, organizational structures, and sociopolitical contexts.

1. Ethical commitment is foundational, but it is insufficient for political competence. Across all constructs, nurse leaders demonstrated strong ethical commitment grounded in patient welfare and social justice, consistent with SBAMT's foundational conditions for advocacy. However, the findings show that moral commitment alone does not lead to strategic political engagement. This confirms the global scholarship which argues that political competence requires deliberate cultivation through structured education, experiential learning, and mentorship, rather than mere professional dedication (Han et al., 2025). The integration of both strands demonstrates that while ethical consciousness serves as the emotional and moral catalyst for advocacy, it cannot substitute for procedural political literacy, fluency in policy discourse, familiarity with institutional decision-making, and confidence in political communication. Thus, nurse leaders' political development remains constrained not by lack of moral courage but by limited structured opportunities to cultivate essential political competencies.
2. Political development is uneven, reflecting a profession in a transitional phase. Examining the three constructs together reveals an uneven developmental trajectory: political astuteness remains at a beginning level, political efficacy is moderate, and advocacy engagement is moderate but confined mainly to micro-level contexts. This indicates that nurse leaders are in a transitional stage, ethically grounded and politically aware, yet still developing the knowledge, confidence, and skills needed to influence policy. Consistent with Waring et al. (2023), their political identity evolves gradually and is shaped by opportunities, role modeling, and professional reinforcement. The differences across constructs show a gap between awareness, confidence, and action, indicating that political growth is not automatic. Instead, it depends on personal initiative, supportive organizational culture, and access to political processes.
3. Structural, cultural, and organizational barriers strongly shape political behavior. A powerful meta-inference emerging from integration is that political participation among nurse leaders is not merely a matter of personal disposition or individual capacity; organizational and cultural structures profoundly influence it. Hierarchical norms within Philippine healthcare institutions, deference to authority, gendered expectations of nursing, fear of institutional repercussions, lack of formal pathways for policy involvement, limited institutional encouragement, and the absence of political mentorship restrict nurses' ability to act in political domains. This reinforces the argument that political competence is context-dependent and socially constructed ability, rather than

individually derived (Waring et al., 2022).

4. Professional identity simultaneously empowers and constrains political action. A key meta-inference is the dual role of professional identity in shaping political behavior. Nurses' caregiving identity strengthens advocacy in clinical and community settings, where compassion and relational expertise are valued. However, this same identity becomes constraining in formal political arenas where authority is associated with technical policy expertise, institutional power, or traditional political roles. Statements such as "I am just a nurse" reflect internalized hierarchies that limit perceived political legitimacy. Thus, while professional identity drives moral advocacy, it can also restrict engagement in broader policy processes. This dynamic reflects identity theory, which posits that individuals' perceived role boundaries influence the types of actions they feel entitled to perform (Stryker & Burke, 2000). Within SBAMT, this tension manifests as a barrier in the capacity and action dimensions, where self-perceptions and external expectations intersect to determine the scope of advocacy. Thus, while professional identity fuels moral action, it also constrains political participation by reinforcing boundaries around what nurses believe they should or can do within political structures.

Overarching meta-inferences

The following overarching meta-inferences synthesize these insights and highlight the imperative of embedding political capacity-building within nursing's educational, organizational, and policy infrastructures.

1. Ethical grounding is a necessary but incomplete foundation for political leadership. Nurse leaders possess deep moral commitment, but moral obligation alone does not equip them with the procedural, analytical, and strategic competencies required for policy engagement. Political competence requires intentional scaffolding, including political education, exposure, and mentorship.
2. Political competence must be intentionally cultivated within nursing as a professional mandate. Leadership experience does not inherently produce political readiness. To embed political competence into professional identity, nursing education, leadership development programs, and institutional policies must explicitly integrate political learning, policy experience, and opportunities for structured advocacy.
3. System-level advocacy requires institutional courage, protection, and role modeling. Without environments that normalize political participation and protect nurses who speak about systemic issues, political engagement will remain localized and fragmented. Institutions must establish policies that support advocacy, foster psychological safety, and encourage nurse leaders to occupy political spaces.
4. Strengthening political capacity is central to advancing nursing's strategic contribution to health system governance. The findings demonstrated that political identity, readiness, and advocacy must be recognized as essential leadership competencies, rather than optional extensions of nursing practice. Empowering nurse leaders to act as political agents is critical for shaping equitable, responsive, and resilient health systems in the Philippines.

CONCLUSION

Political leadership among nurse leaders in Region I is shaped by a deeply rooted ethical commitment to patient welfare and social justice, reflecting the moral core of nursing practice. This ethical foundation fosters political awareness; however, without structured exposure to policy processes and institutional support, such awareness remains largely at a beginning stage. While nurse leaders demonstrate moderate political efficacy, particularly within local and relational contexts, their confidence diminishes in national policy arenas where hierarchical norms and limited political socialization constrain participation. Advocacy engagement follows a similar pattern, remaining strong at the clinical and community levels but weaker at the system and legislative levels.

Consistent with the SBAMT, nurse leaders possess strong foundational values and emerging political capacities but lack the structural reinforcement necessary to translate ethical commitment into sustained policy influence. These findings should be interpreted with consideration of several methodological limitations. The Political Astuteness Inventory was originally designed for general nurses rather than nurse leaders. Although pilot testing was conducted, the instruments were not formally content-validated within the Philippine context. Additionally, the study was conducted within a single region, which may limit the breadth and transferability of the findings.

Despite these constraints, the study provides important insights into the developmental nature of nurse leaders' political competence. Strengthening political competence requires intentional capacity-building across nursing education, professional organizations, healthcare institutions, and policy structures. Integrating policy education, mentorship, and experiential engagement in governance processes can equip nurse leaders with the skills and confidence necessary for sustained advocacy. Advancing nurse leaders' political competence is therefore not only a professional imperative but also a strategic pathway toward more equitable and responsive health governance.

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References

AbuAlRub, R. F., & Abdulnabi, A. (2020). Involvement in health policy and political efficacy among hospital nurses in Jordan: A descriptive survey. *Journal of nursing management*, 28(2), 433–440. https://doi.org/10.1111/jonm.12946

Ahoya, C., Abhichartibuttra, K., & Wichaikhum, O. (2016). Political efficacy and political participation among nurses in tertiary hospitals, the Republic of Kenya. *Journal of Community & Public Health Nursing*, *02*(04), https ://doi.org/10.4172/2471-9846.1000142

Alibudbud, R. (2022). When the "heroes" "don't feel cared for": The migration and resignation of Philippine nurses amidst the COVID-19 pandemic. *Journal of Global Health, 2*, 03011. https://doi.org/10.7189/jogh.12.03011

Alvarez, V. (2023). On the crossroads: The nurses' leadership journey from bedside to the countryside. *Philippine Journal of Nursing,93*(1)

Asuquo, E. F. (2019). Nurses leadership in research and policy in Nigeria: A myth or reality?. *Journal of Nursing Management*, *27*(6), 1116-1122.

Benjamin, L. S., Shanmugam, S. R., Karavasileiadou, S., Hamdi, Y. S. A., Moussa, S. F., & Gouda, A. D. K. (2024). Facilitators and barriers for advocacy among nurses - A cross-sectional study. *The Malaysian Journal of Nursing*, *16*(01), 178–188. https://doi.org/10.31674/mjn.2024.v16i01.018

Bernardino, G., Samson-Cordero, J., De Guzman, C., Althuhaini, A., Palaganas, E. (2023). Nursing shortage in the Philippines: Dissecting an entanglement of issues. *Philippine Journal of Nursing,93*(1)

Bonito, S., Balabagno, A., Pagsibigan, J., Sereneo, K. (2019). Nursing workforce in the Philippines: Data and issues. *Philippine Journal of Nursing,89*(1)

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676x.2019.1628806

Brenner, G. M. H. (2022). *Political astuteness of nurse educators* (Doctoral dissertation, University of Northern Colorado). Digital UNC. https://digscholarship.unco.edu/dissertations/907

Brown, C. L., Raza, D., & Pinto, A. D. (2020). Voting, health and interventions in

healthcare settings: A scoping review. *Public Health Reviews*, *41*, 16. https://doi.org/10.1186/s40985-020-00133-6

Byrd, M. E., Costello, J., Gremel, K., Schwager, J., Blanchette, L., & Malloy, T. (2012). Political astuteness of baccalaureate nursing students following an active learning experience in health policy. *Public Health Nursing*, *29*(5), 433-443. http://dx.doi.org/doi: 10.1111/j.1525-1446.2012.01032.x

Cariaso, J. E., Bonito, S. R., Dones, L. B., Melendres, J. C., & Sebastian, C. J. (2024). Perceived competencies and training needs of public health nurses in the Philippines. *Acta Medica Philippina, 58*(12), 78. https://doi.org/10.47895/amp.v58i12.9301

Chen, M., & Madni, G. R. (2024). Unveiling the role of political education for political participation in China. *Heliyon*, *10*(10), e31258. https://doi.org/10.1016/j.heliyon.2024.e31258

Chiu, P., Cummings, G. G., Thorne, S., & Schick-Makaroff, K. (2021). Policy advocacy and nursing organizations: A scoping review. *Policy, politics & nursing practice*, *22*(4), 271–291. https://doi.org/10.1177/15271544211050611

Clark, M. (1984). *Community nursing: health care for today and tomorrow*. Reston, VA:
Appleton and Lange.

Clark, P. E. (2008). Political astuteness inventory. In M. J. Clark (Ed.), Community assessment reference guide for community health nursing (pp. 1–2). Upper Saddle River, NJ: Pearson Education.

Clarke, J. M., Waring, J., Bishop, S., Hartley, J., Exworthy, M., Fulop, N. J., Ramsay, A., & Roe, B. (2021). The contribution of political skill to the implementation of health services change: a systematic review and narrative synthesis. *BMC Health Services Research*, *21*(1), 260. https://doi.org/10.1186/s12913-021-06272-z

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE Publications.

Curry, J. O., & Fitzpatrick, J. J. (2024). The level of political astuteness in nursing leaders. *JONA the Journal of Nursing Administration*, *54*(3), 172–176. https://doi.org/10.1097/nna.0000000000001403

Dean, J. (2009). Quantifying social justice advocacy competency: Development of the social justice advocacy scale. Georgia State University. https://doi.org/10.57709/1061384

Elliott, R. S. (2024). Every nurse can become an advocate: Pathways for meaningful policy change. *Journal of Radiology Nursing*. https://doi.org/10.1016/j.jradnu.2024.10.004

Etowa, J., Vukic, A., Aston, M., Iduye, D., Mckibbon, S., George, A., Nkwocha, C., Thapa, B., Abrha, G., & Dol, J. (2023). Experiences of nurses and midwives in policy development in low- and middle-income countries: Qualitative systematic review. *International Journal of Nursing Studies Advances*, *5*, 100116. https://doi.org/10.1016/j.ijnsa.2022.100116

Farias, O., Miranda Fontenele, M. G., Teixeira Lima, F. E., Gimeniz Galvão, M. T., & Lopes, O. (2023). Analysis of the health advocacy concept from the perspective of the evolutionary method. *Revista da Escola de Enfermagem da USP*, *57*, e20230170. https://doi.org/10.1590/1980-220X-REEUSP-2023-0170en

Fernández, M. a. S., Giordano, D. P., & Gutiérrez, T. M. (2022). Participación de enfermería en Políticas Públicas, ¿Por qué es importante?: Revisión integrativa de la literatura. *Enfermería Global*, *21*(1), 590–624. https://doi.org/10.6018/eglobal.455361

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs-principles and practices. *Health Services Research, 48*(6), 2134–2156. https://doi.org/10.1111/1475-6773.12117

Fetters, M. D. (2019). *The mixed methods*

research workbook: Activities for designing, implementing, and publishing projects (Vol. 7). Sage Publications

Gentry, H., Patton, R. M., Lindell, D., & Ludwick, R. (2024). Civic knowledge and self-reported political astuteness of academic nurse educators in the United States. *Journal of Professional Nursing*, *54*, 85-91. https://doi.org/10.1016/j.profnurs.2024.06.001

Goes, A. R. (2025). Advocacy for Health and Health Equity: A Call to Public Health Professionals. *Portuguese Journal of Public Health*, *43*(1), 1. https://doi.org/10.1159/000545038

Gooch, T. (2025). Political astuteness in Tennessee Nurse Practitioners: Strategies to inform. *Medical Research Archives*, *13*(7). https://doi.org/10.18103/mra.v13i7.6617

Hajizadeh, A., Zamanzadeh, V., Kakemam, E., Bahreini, R., & Khodayari-Zarnaq, R. (2021). Factors influencing nurses' participation in the health policy-making process: A systematic review. *BMC Nursing*, *20*(1), 128. https://doi.org/10.1186/s12912-021-00648-6

Han, N. K., & Kim, G. S. (2023). The barriers and facilitators influencing nurses' political participation or healthcare policy intervention: A systematic review and qualitative meta-synthesis. *Journal of Nursing Management*, *2024*(1), 2606855. https://doi.org/10.1155/2024/2606855

Han, N. K., & Kim, G. S. (2020). Concept development of political competence for nurses. *Journal of Korean Academy of Nursing*. Korean Society of Nursing Science. https://doi.org/10.4040/jkan.2020.50.1.81

Han, M. K., Kim, J., Lee, M., & Shin, S. (2025). Enhancing political competency among nurses and nursing students: A scoping review. *Nurse Education in Practice*, *87*, 104497. https://doi.org/10.1016/j.nepr.2025.104497

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M. P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. C., Vedel, I., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information, 34*(4), 285-291. https://doi.org/10.3233/EFI-180221

Kuehne, F., Kalkman, L., Joshi, S., Tun, W., Azeem, N., Buowari, D. Y., Amugo, C., Kallestrup, P., & Kraef, C. (2022). Healthcare provider advocacy for primary health care strengthening: A call for action. *Journal of Primary Care & Community Health*, *13*, 21501319221078379. https://doi.org/10.1177/21501319221078379

Laari, L., & Duma, S. E. (2023). Barriers to nurses' health advocacy role. *Nursing ethics*, *30*(6), 844–856. https://doi.org/10.1177/09697330221146241

Laari, L., & Duma, S. E. (2023). Health advocacy role performance of nurses in underserved populations: A grounded theory study. *Nursing Open*, *10*(9), 6527–6537. https://doi.org/10.1002/nop2.1907

Levy, B. (2013). An empirical exploration of factors related to adolescents' political efficacy. *Educational Psychology*, *33*(3), 357–390. https://doi.org/10.1080/01443410.2013.772774

Leyva, E. W. A., Soberano, J. I. D., Paguio, J. T., Siongco, K. L. L., Sumile, E. F. R., & Bonito, A. S. R. (2024). Pandemic impact, support received, and policies for health worker retention: An environmental scan. *Acta medica Philippina, 58*(12), 8–20. https://doi.org/10.47895/amp.v58i12.9346

Longshore, M. W. (2022). *Factors influencing political self-efficacy and political astuteness in undergraduate nurse educators* [Doctoral dissertation, University of Northern Colorado]. Digital UNC. https://digscholarship.unco.edu/dissertations/898

Madigan, E. A., McWhirter, E., Westwood, G., Oshikanlu, R., Iregi, Z. M., Nyika, M., & Bayuo, J. (2023). Nurses finding a global voice by becoming influential leaders through advocacy. *Clinics in Integrated Care*, *20*, 100165. https://doi.org/10.1016/j.intcar.2023.100165

Modene, R. C. (2018). *Health policy engagement among nurse educators: A descriptive, cross-sectional study into political astuteness and political self-efficacy and the impact of personal and professional factors.* https://www.proquest.com/dissertations-theses/health-policy-engagement-among-nurse-educators/docview/2089421259/se-2

Nsiah, C., Siakwa, M., & K Ninnoni, J. P. (2019). Barriers to practicing patient advocacy in healthcare setting. *Nursing Open*, *7*(2), 650. https://doi.org/10.1002/nop2.436

Ojemeni, M., Jun, J., Dorsen, C., Gerchow, L., Arneson, G., Orofo, C., Nava, A., & Squires, A. (2023). A scoping review of nursing and midwifery activism in the United States. *OJIN the Online Journal of Issues in Nursing*, *28*(2). https://doi.org/10.3912/ojin.vol28no02st03

O'Hanlon Curry, J., & Fitzpatrick, J. J. (2024). The level of political astuteness in nursing leaders: A baseline assessment. *The Journal of Nursing Administration*, *54*(3), 172–176. https://doi.org/10.1097/NNA.0000000000001403

O'Rourke, N. C., Crawford, S. L., Morris, N. S., & Pulcini, J. (2017). Political efficacy and participation of nurse practitioners. *Policy, Politics & Nursing Practice*, *18*(3), 135–148. https://doi.org/10.1177/1527154417728514

Osei, S. & Lacanaria, M. (2023). Political efficacy and health policy advocacy among nurses as mediated by political astuteness. *Philippine Journal of Nursing, 93*(1),86. https://drive.google.com/file/d/16Y3iGmAk7fDB50thYsEWsI7KcLMNB5l5/view

Oser, J., Grinson, A., Boulianne, S., & Halperin, E. (2022). How political efficacy relates to online and offline political participation: A multilevel meta-analysis. *Political Communication*, *39*(5), 607-633.

Palompon, D. R., Naranjo, M. A., Abalos, E., Omus, N., & A Flores, P. J. (2024). Nurses-Led Municipal leadership and governance program: Experiences of local chief executives in Central Visayas, Philippines. *Belitung Nursing Journal*, *10*(3), 312. https://doi.org/10.33546/bnj.3349

Philip, M. (2018). Lobbying in nursing: Overcome the hurdles to flourish. *Indian Journal of Holistic Nursing,9*(3), 35-36. https://journals.indexcopernicus.com/api/file/viewByFileId/516702

Primomo, J. (2007). Changes in political astuteness after a health systems and policy course. *Nurse Educator*, *32*(6), 260-264.

Primomo, J., & Bjorling, E. A. (2013). Changes in political astuteness following nurse legislative day. *Policy, Politics, & Nursing Practice, 14*(2), 97–108. https://doi.org/10.1177/1527154413485901

Professional Regulation Commission-Board of Nursing (2017). The Philippine Professional Nursing Practice Standards (PPNPS)

Ramsay, A., Hartin, P., McBain-Rigg, K., & Birks, M. (2025). Advocating for patient safety: Power dynamics in nurse advocacy practice in Australia—An integrative review. *Collegian*, *32*(2), 84-99. https://doi.org/10.1016/j.colegn.2025.01.003

Raosoft (2004) Raosoft Sample Size Calculator. Raosoft, Inc., Seattle. http://www.raosoft.com/samplesize.html

Rasheed, S. P., Younas, A., & Mehdi, F. (2020). Challenges, extent of involvement, and the impact of nurses' involvement in politics and policy making in the last two decades: An integrative review. *Journal of Nursing Scholarship, 52*(4), 446–455. https://doi.org/10.1111/jnu.12567

Rogers, S., & Gaffney, T. A. (2025). Exploring

the political astuteness of registered nurses. *Journal of Nursing Education and Practice, 15*(4), 19. https://doi.org/10.5430/jnep.v15n4p19

Savella, M. (2018). The local health care system of the province of Ilocos Sur. *Asian Journal of Health,* 1-13. https://doi.org/10.7828/ajoh.v8i1.1295

Scott, J., Burrison, S., Barron, M., Logan, A., & Magwood, G. S. (2023). Exploring nursing strategies to engage community in cardiovascular care. *Current Cardiology Reports*, *25*(10), 1351. https://doi.org/10.1007/s11886-023-01949-9

Sessler Branden, P. (2012). *T*he nurse as advocate: A grounded theory perspective (Order No. 3556945). *Available from ProQuest One Academic.* (1330787354). https://www.proquest.com/dissertations-theses/nurse-as-advocate-grounded-theory-perspective/docview/1330787354/se-2

Shariff, N. (2014). Factors that act as facilitators and barriers to nurse leaders' participation in health policy development. *BMC Nursing*, *13*, 20. https://doi.org/10.1186/1472-6955-13-20

Sharpnack, P. (2022). Overview and summary: Nurses' impact on advocacy and policy. *OJIN The Online Journal of Issues in Nursing*, *27*(2). https://doi.org/10.3912/ojin.vol27no02manos

Stentz, J. E., Plano Clark, V. L., & Matkin, G. S. (2012). Applying mixed methods to leadership research: A review of current practices. *The Leadership Quarterly*, *23*(6), 1173-1183. https://doi.org/10.1016/j.leaqua.2012.10.001

Stryker, S., & Burke, P. J. (2000). The past, present, and future of identity theory. *Social Psychology Quarterly, 63*(4), 284–297. https://doi.org/10.2307/269584

Sulosaari, V., Kosklin, R., & De Munter, J. (2023). Nursing leaders as visionaries and enablers of action. *Seminars in Oncology Nursing*, *39*(1), 151365. https://doi.org/10.1016/j.soncn.2022.151365

Tadie, A., Muche, M., Liknaw, T., & Edmealem, A. (2024). Nurses' attitude towards patient advocacy and its associated factors in East Gojjam Zone public hospitals, Northwest Ethiopia. *BMC Nursing, 23*, 561. https://doi.org/10.1186/s12912-024-02206-2

Talosig, M., Sanchez, R., II, & Soriano, G. (2021). Lived experiences of emergency department (ed) nurses with comorbidities amidst COVID-19 Pandemic at Candon City of Ilocos Sur: A Phenomenological Study. *International Journal of Health Sciences and Research*, *11*(9), 216–229. https://doi.org/10.52403/ijhsr.20210934

Tanner, P. (2023). Nested sampling in sequential mixed methods research designs: Comparing recipe and result. Forum Qualitative Sozialforschung Forum: Qualitative Social Research, 24(1). https://doi.org/10.17169/fqs-24.1.4004

Turale, S., & Kunaviktikul, W. (2019). The contribution of nurses to health policy and advocacy requires leaders to provide training and mentorship. *International Nursing Review*, *66*(3), 302-304. https://doi.org/10.1111/inr.12550

Waring, J., Bishop, S., Clarke, J., & Roe, B. (2023). Becoming active in the micro-politics of healthcare re-organisation: The identity work and political activation of doctors, nurses, and managers. *Social Science & Medicine, 310*, 116145. https://doi.org/10.1016/j.socscimed.2023.116145

White, J., Gunn, M., Chiarella, M., Catton, H., Stewart, D., (2025). *Renewing the Definitions of 'nursing' and 'a nurse'. Final project report*. International Council of Nurses

Williams, S., Phillips, J., & Koyama, K. (2018). Nurse advocacy: Adopting a health in all policies approach. *OJIN the Online Journal of Issues in Nursing*, *23*(3). https://doi.org/10.3912/ojin.vol23no03man01

Willeck, C., & Mendelberg, T. (2022). Education and political participation. *Annual Review of Political Science*, *25*(1), 89-110

Younas, A., Fàbregues, S., & Creswell, J. W. (2023). Generating metainferences in mixed methods research: A worked example in convergent mixed methods designs. *Methodological Innovations*. https://doi.org/10.1177/20597991231188121

Zalon, M. L., Ludwick, R., & Patton, R. M. (2024). Strengthening nurses' influence in health policy. *AJN American Journal of Nursing*, *124*(9), 28–36. https://doi.org/10.1097/01.naj.0001028316.80475.bf

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