Work Empowerment and Decisional Involvement among Nurses in University Hospitals, Kathmandu, Nepal

การเสริมสร้างพลังอำนาจในงานและการมีส่วนร่วมในการตัดสินใจของพยาบาลในโรงพยาบาลมหาวิทยาลัย กรุงกาฐมาณฑุ ประเทศเนปาล

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บทคัดย่อ

การศึกษาเชิงพรรณนานี้มีเป้าหมายเพื่อศึกษาระดับของการเสริมสร้างพลังอำนาจในงานและการมีส่วนร่วมในการตัดสินใจ เปรียบเทียบการมีส่วนร่วมในการตัดสินใจจริงกับการมีส่วนร่วมในการตัดสินใจที่ต้องการ และหาความสัมพันธ์ระหว่างการเสริมสร้างพลังอำนาจในงานและการมีส่วนร่วมในการตัดสินใจจริงตามการรับรู้ของพยาบาลเก็บรวบรวมข้อมูลจากพยาบาลจำนวน 247 คนโดยใช้การสุ่มตัวอย่างแบบชั้นภูมิวิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนาการทดสอบค่าทีแบบคู่และการวิเคราะห์ค่าสัมประสิทธิ์แบบจัดอันดับเสปียร์แมนผลของการวิจัยนี้แสดงให้เห็นว่าการรับรู้การเสริมสร้างพลังอำนาจในงานของพยาบาลอยู่ในระดับปานกลาง โดยการเข้าถึงพลังอำนาจแบบไม่เป็นทางการในระดับมากที่สุดและการเข้าถึงพลังอำนาจแบบเป็นทางการในระดับน้อยที่สุด พยาบาลรับรู้ระดับการมีส่วนร่วมในการตัดสินใจจริงในระดับต่ำและต้องการมีส่วนร่วมในการตัดสินใจ พบความแตกต่างระหว่างค่าในภาพรวมและในทุกด้านของการมีส่วนร่วมในการตัดสินใจจริงและการมีส่วนร่วมในการตัดสินใจที่ต้องการอย่างมีนัยสำคัญ การเสริมสร้างพลังอำนาจในงานมีความสัมพันธ์เชิงบวกในระดับปานกลางกับการมีส่วนร่วมในการตัดสินใจจริง ผลของการศึกษาในครั้งนี้ เป็นประโยชน์สำหรับผู้บริหารโรงพยาบาลและผู้บริหารการพยาบาลในการส่งเสริมให้เกิดการเสริมสร้างพลังอำนาจในงานเพื่อให้พยาบาลมีส่วนร่วมในการตัดสินใจ ซึ่งจะทำให้พยาบาลปฏิบัติหน้าที่อย่างมีประสิทธิภาพมากขึ้น ทำให้เกิดผลลัพธ์ที่ดีต่อผู้ป่วย พยาบาลและองค์กรต่อไป

คำสำคัญ: การเสริมสร้างพลังอำนาจในงาน การมีส่วนร่วมในการตัดสินใจ การมีส่วนร่วมในการตัดสินใจจริง การมีส่วนร่วมในการตัดสินใจที่ต้องการ

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Abstract

This descriptive correlational study aimed to examine the level of work empowerment and decisional involvement, to compare actual and preferred decisional involvement, and to identify the relationship between work empowerment and actual decisional involvement as perceived by nurses. Data were collected using stratified random sampling on 247 nurses. Descriptive statistics, paired t-test and Spearman rank coefficient analysis were used. The results of this study indicated that work empowerment as perceived by nurses was at a moderate level with greatest access to informal power and least access to formal power. The nurses perceived low level of actual decisional involvement and preferred to have shared decisional involvement. There was a statistically significant difference between overall and all aspects of actual decisional involvement and preferred decisional involvement. Work empowerment had a significant moderate positive relationship with actual decisional involvement. The results of this study could be used by hospital and nurse administrators to promote work empowerment in order to involve nurses in decision making so that nurses could work for positive outcomes for patients, staffs, and the organization.

Key words: Work Empowerment, Decisional Involvement, Actual Decisional Involvement, Preferred Decisional Involvement, Nurse

Background and significance

Nurses constitute the largest group in the health workforce and provide the majority of health services in almost every country (International Council of Nurses, 2009). Given the current situation of health work force shortages with increasing demand for health care, a World Health Organization (WHO) policy paper emphasized the importance of creating a supportive work environment that enables health workers to perform effectively to achieve high quality health care services (World Health Organization, 2010). Promoting nurse involvement in organizational and clinical decision making processes of health care facility improves the retention of nurses and enhances patient care and safety (Institute of Medicine Report, 2003; Havens & Vasey, 2003).

Decisional involvement is defined as a pattern of distribution of authority for decisions and activities that govern nursing practice policy and the practice environment (Havens & Vasey, 2003). Based on the work of Scott and Aydelotte, Havens and Vasey (2003) proposed six constructs of the decisional involvement which were derived empirically through structural equation modeling and factors analysis: (1) unit staffing, (2) quality of professional practice, (3) professional recruitment, (4) unit governance and leadership, (5) quality of support staff practice, and (6)

collaboration and liaison activities. The two aspects of decisional involvement are actual decisional involvement, the degree to which decisions are the responsibility of staff nurses and the administration/ management, and preferred decisional involvement, in which group staff nurses prefer to have the primary responsibility for decision or activity(Havens & Vasey, 2003). According to Havens and Vasey (2003), a gap between actual and preferred degree of decisional involvement is decisional dissonance which occur when nurses are asked to be more involved in decisions than they wish, known as decisional saturation or when they are not involved as they desire, known as decisional deprivation. Previous studies have found that higher levels of decisional involvement were associated with high job satisfaction (Nooritajer & Mahfozpour, 2008), reduced turnover, practice productivity (Hung, Rundall, Cohen, Tallia & Crabtree, 2006) and better patient outcomes (Higgins, 1999). If nurses desire but are not permitted to have this decisional autonomy, job tension and dissatisfaction results (Alutto & Vredenburgh, 1977; Ddwyer, Schwartz, & Fox, 1992). Thus, considering satisfaction and work environment initiatives and inconsistencies in results from previous studies (Mangold, Pearson, Schmitz, & Specht, 2006; Scherb, Specht, Loe, & Reed, 2010; Jaafarpour & Khani 2011), it is imperative to know the nurses' level of actual and preferred decisional involvement.

Nurses, whose work brings them in close contact with patients, need to be empowered to make decisions about their practice (Barden, Quinn, Donabue & Fitzpatrick, 2011). Kanter has defined work empowerment as the extent to which employees feel that they have access to opportunity, information, support, resources, formal power and informal power in their work settings. According to Kanter (as cited in Laschinger, Sabiston & Kutszcher, 1997), employees who have access to opportunity, information, support, resources, formal power and informal power experience more power and exercise greater control over their work conditions, which results in increased worker autonomy, increased involvement in organizational decisions, and improved organizational effectiveness. However, when individuals do not have access to empowering structures, they experience powerlessness which results in frustration and failure and they exclude from involvement in organizational decision making (Laschinger, 1996).

WHO has categorized Nepal as having a critical shortage of health workers with less than 23 health workers per 10,000 population (World Health Organization, 2012). The number of nurses/ midwives in Nepal per 10,000 population is 4.6 (Global health workforce alliance, 2010), while around 5,000 nurses are being produced every year. Many Nepalese nurses are leaving the country; the records of Nepal Nursing Council showed a total of 3,461 Nepalese nurses have gone abroad between 2002 to 2011 (Institute of Local Governance Studies, 2011). Since, previous studies have found the positive effect of decisional involvement in retention of nurses and quality of care, it is imperative to know the decisional involvement of nurses in Nepal to improve quality of health care.

Moreover, in Nepal, nursing service is not prioritized by national health care policy

(Tuladhar, 2006), almost all top positions in the government are occupied by doctors (Minca, 2011) and nurses are considered assistants to the doctors (Akiyama, 2004). There is a lack of autonomy for nursing professional development (Shrestha, Bhandari & Singh, 2010) and nurses are not involved in any decision affecting their practice (DFID, 2008). Furthermore, Nepalese nurses experience poor opportunities for promotion, lack of recognition, and little support to accomplish their work (Mehta & Chaudhary, 2005). Most government hospitals have poor physical facilities and lack equipment/ supplies (Ministry of Health and Population, 2012). In spite of government expenditure on health, 7.24% of the overall government budget, the delivery of quality health services in Nepal remains a challenge with high morbidity and mortality especially among women and children, and there is difficulty in achieving the Millennium Development Goals and health plans targets (Ministry of Health and Population, 2012).

Therefore, in context of Nepal, work setting of nurses is not empowering which have limited the nurses' involvement in decision making. Previous studies in US by Beauchamp (2006) and in Taiwan by Liu (2008) have found a relationship between work empowerment and decisional involvement, and none has been found among Nepalese nurses. It has been considered that organizational structure, social context, and cultural values affect work empowerment and decisional involvement; circumstances which are different in Nepal than in these countries (Laschinger, 1996; Matthews, Laschinger, and Johnstone 2006; McDonald *et al.*, 2010). In addition, results of previous studies have found work empowerment and decisional involvement was different and low in government and teaching hospitals than in private and community hospitals (Havens 1994; Mangold et al. 2006; Liu, Fellows, & Chiu, 2007; Ahmed & Safadi 2013). Therefore, further investigation is required to gather evidence regarding the relationship between these two variables, and a study in university hospitals in Nepal was conducted.

This study aimed to examine work empowerment and decisional involvement among nurses, to compare the actual and preferred decisional involvement among nurses, and the relationship between work empowerment and decisional involvement among nurses in two university hospitals in Kathmandu, Nepal. The results of this study will be beneficial in providing information for hospital and nurse mangers to plan efficient and effective strategies to enhance work empowerment which may influence nurses' involvement in decision making, also affecting nursing practice policy and the practice environment.

Conceptual Framework

The conceptual framework of work empowerment is based on Kanter's structure power theory. It consists of six dimensions: the structure of opportunity, the structure of support, the structure of resources, the structure of information, formal power and informal power. Furthermore, the concept of decisional involvement is based on Havens and Vasey, (2003). There are two aspect of decisional involvement: actual decisional involvement and preferred decisional involvement. According to Kanter, employees who have access to

opportunity, information, support and resources are empowered and have control over the conditions resulting in increased worker autonomy and involvement in organizational decisions.

Methodology

Study design

A descriptive correlational design was used to collect data from two university hospitals in Kathmandu, Nepal. Proportionate stratified random sampling was used to select nurses from each ward/unit. The sample consisted of 247 nurses who worked as a nurse in these hospitals for at least one year.

Research Instrument

The instrument used in this study consisted of three parts: demographic data form, Condition for Work Effectiveness Questionnaire II (CWEQ II) developed by Laschinger et al. (2001), and Decisional Involvement Scale (DIS) developed by Havens and Vasey (2003). Work empowerment was measured by CWEQ II which consisted of 19 items measuring six dimensions: opportunity, information, support, resources, formal power and informal power. Nurses who scored between 6-13 perceived work empowerment to be low, between 14-22 moderate, and 23-30 perceived high levels of work empowerment. In this study, the Cronbach Alpha of overall CWEQ II was .83. Decisional involvement of nurses was measured through the Decisional Involvement Scale which consisted of 21 items for each actual and preferred decisional involvement and used a five-point Likert-type scale. Response choices were as follows: 1 = administration/ management only; 2 = primarily administration/ management with some nurse input; 3= shared by administration/ management and nurses; 4 = primarily nurses with some administration/ management input; and 5 = nurses only. A high mean score suggests a high degree of staff RN involvement, a low mean score suggests a low degree of staff RN involvement, and a midrange mean score suggests a state of sharing in decision making between administration/management and staff RNs. The Cronbach Alpha of overall DIS was .94 and for actual DIS and preferred DIS, it was .90 and .93, respectively.

Data collection and ethical consideration

This study received ethical approval from the Research Ethic Review Committee at the Faculty of Nursing Chiang Mai University, Thailand. After receiving permission to collect data from both hospitals, the purpose, benefits and procedures of the study were explained to hospital unit managers. Questionnaires were distributed in envelopes to 280 nurses after obtaining voluntary informed consent. Questionnaires were identified by code number only and participants returned their completed questionnaire in the sealed envelopes. The study had a response rate of 91.42% with 256 questionnaires returned. Among them nine incomplete questionnaire were excluded and 247 (88.21%) questionnaires were included in the data analysis.

Data Analyses

Data were analyzed using the SPSS statistical software package. Descriptive statistics were used to describe the demographic characteristics of samples, and levels of work

empowerment and decisional involvement. paired t-test was used to examine the differences in actual and preferred decisional involvement, while Spearman's rank correlation coefficient analysis was used to examine the relationship between work empowerment and actual decisional involvement.

Results

Demographic data

The majority of subjects (41.7%) were between the age of 21 – 25 with an average mean age of 27.96 years old (SD = 6.88). More than half of the subjects (51%) held a bachelor degree and the majority (71.3%) were working in a temporary post. Most of the nurses (58.3%) have worked for less than 5 years with mean experience of 6.92 years (SD = 6.94) and the majority worked in critical care areas.

Work empowerment of the subjects

The overall work empowerment as perceived by subjects was at a moderate level ($\overline{X}$ = 15.42, SD = 2.23). The results illustrated that subjects perceived having the greatest access to informal power ($\overline{X}$ = 2.92, SD = .56), and the least access to formal power ($\overline{X}$ = 2.23, SD = 0.60) (Table 1).

Table 1 Mean, Standard Deviation and the Level of Overall and Each Dimension of Work Empowerment as Perceived by the Subjects (n = 247)

Work empowerment	$\overline{X}$	S.D.	Level
Total work empowerment	15.42	2.23	Moderate
Opportunity	2.63	0.55	
Information	2.46	0.66	
Support	2.65	0.65	
Resources	2.53	0.61	
Formal power	2.23	0.60	
Informal power	2.92	0.56	

Decisional Involvement of the subjects

Actual decisional involvement of the subjects

The total actual decisional involvement of subjects was at a low level ($\overline{X}$ = 1.74, SD = .29). Regarding each aspect of actual decisional involvement, subjects perceived that collaboration and liaison activities had the most actual involvement ($\overline{X}$ = 2.29, SD = 0.61) while unit governance and leadership ($\overline{X}$ = 1.54, SD = 0.44) had the least amount of decisional involvement (Table 2).

Preferred decisional involvement of the subjects

Subjects in this study preferred shared decisional involvement ($\overline{X}$ = 3.02, SD = .52). Collaboration and liaison activities were the most preferred aspect of decisional involvement in their work setting ($\overline{X}$ = 3.46, SD = 0.70) whereas the least preferred aspect of preferred decisional involvement was professional recruitment ($\overline{X}$ = 2.80, SD = 0.86) (Table 3).

Table 2 Mean, Standard Deviation and Degree of Overall and Each Aspect of Actual Decisional Involvement as Perceived by the Subjects (n = 247)

Actual decisional involvement	$\overline{X}$	S.D.	Degree of involvement
Total actual decisional involvement	1.74	0.29	Low
Unit staffing	1.82	0.68	Low
Quality of professional practice	1.73	0.48	Low
Professional recruitment	1.60	0.53	Low
Unit governance and leadership	1.54	0.44	Low
Quality of support staff practice	1.69	0.58	Low
Collaboration/liaison activities	2.29	0.61	Low

Table 3 Mean, Standard Deviation and Degree of Overall and Each Aspect of Preferred Decisional Involvement as Perceived by the Subjects (n = 247)

Preferred decisional involvement	$\overline{X}$	S.D.	Degree of involvement
Total preferred decisional involvement	3.02	0.52	Shared
Unit staffing	2.96	0.68	Low
Quality of professional practice	3.08	0.66	Shared
Professional recruitment	2.80	0.86	Low
Unit governance and leadership	2.92	0.73	Low
Quality of support staff practice	2.90	0.70	Low
Collaboration/liaison activities	3.46	0.70	Shared

Differences in actual and preferred decisional involvement

There was a statistically significant difference in overall actual and preferred decisional involvement (t = - 36.98, p<.01) in the subjects. Statistically significant differences were also found for all other six aspects of actual and preferred decisional involvement (Table 4) as well.

Relationship between work empowerment and actual decisional involvement

The Spearman's rank-order coefficient for total work empowerment and actual decisional involvement as perceived by nurses was statistically significant (r = .39,p<0.01). There was a moderate positive correlation between work empowerment and overall actual decisional involvement. Work empowerment had a weak significant positive relationship to all aspects of actual decisional involvement except for collaboration/liaison activities which had no relationship with work empowerment (Table 5).

Table 4 Mean, Standard Deviation and t-value of Overall and Each Aspects of Actual and Preferred Decisional Involvement as Perceived by the Subjects (n = 247)

Items	$\overline{X}$ actual DI	$\overline{X}$ Preferred DI	t-value
Total decisional involvement	1.74	3.02	- 36.98*
Unit staffing	1.82	2.96	- 18.38*
Quality of professional practice	1.73	3.08	- 27.35*
Professional recruitment	1.60	2.80	- 22.49*
Unit governance and leadership	1.54	2.92	- 26.93*
Quality of support staff practice	1.69	2.90	- 23.10*
Collaboration/liaison activities	2.29	3.46	- 18.52*

*p <0.01

Table 5 Relationships Between Total Work Empowerment and Overall and Each Aspect of Actual Decisional Involvement of the Subjects (n=247)

Actual decisional involvement	Total work empowerment
	r
Total actual decisional involvement	0.39*
Unit staffing	0.22*
Quality of professional practice	0.23*
Professional recruitment	0.16*
Unit governance	0.28*
Quality of support staff practice	0.22*
Collaboration/liaison activities	0.11

*p<0.01

Discussion

Nurses in this study perceived overall work empowerment at a moderate level ($\overline{X}$ = 15.42, SD = 2.23). The possible reason for these findings was that nursing in Nepal is usually under the supervision of physicians; physicians often serve as deans and medical faculty hold higher posts (Department for International Development 2008). Nursing is considered a lower position within the bureaucratic structure and this may impede visibility of the profession on a broader organizational level, leading to feelings of disempowerment. Moreover, university hospitals in Nepal are the largest health care systems and have hierarchies that promote a top-down management system with many levels (McDonald, McGuinness, Madigan & Shively, 2010) which might lead to feelings of impaired authority and powerlessness among nurses.

However, more than half of the subjects in this study held bachelor degrees which can contribute to some sense of empowerment. Nurses who hold higher degrees have been found to be more empowered than nurses with only a diploma (Kluska, Laschinger & Kerr, 2004). Similarly, the majority of nurses in this study worked in critical care areas and it has been documented that nurses working in critical care

areas perceived greater opportunity than nurses working in other units (Laschinger & Havens, 1996). Furthermore, the Nepalese prefer to work in groups rather than individually which is a result of the country's strong collectivist culture and hierarchical social structure (Gautam, Dick, Wagner, & Davis, 2005). This group working-style can also lead to feelings of empowerment.

Overall and different aspects of actual decisional involvement were found to be at low levels. This suggests that nurses perceived that decisions in their work setting were primarily made by administrators and managers with the exception of collaboration/liaison activities, which nurses perceived to have some involvement. The study finding was consistent with the previous studies of Mangold et al. (2006) in North Iowa ; Jaafarpour and Khani (2011) in Iran ;Houston et al. (2012) study in non magnet facility in USA; and study of Scherb et al. (2010) in USA. However, it was different from the study by Ahmed and Safadi (2013) in government hospitals in Jordan which found shared actual decisional involvement. A possible explanation for these findings might be due to the centralized bureaucratic decision making process being followed in Nepalese health care organizations (Ministry of Health and Population, 2012). In a bureaucratic organizational structure, the leader neither trusts followers nor makes decisions oneself (Sullivan & Decker, 2005). Similarly, in Nepalese nursing culture, there is hierarchical relationship among nurses, juniors always respect seniors, follow them and also agree on what seniors said (Shrestha, Bhandari, & Singh, 2010). These types of relationship in Nepalese communication culture might have created communication gap and prevented nurses from expressing their feelings and perceived low decisional involvement (Noah, 2008). Furthermore, nurses in Nepal are all female and according to Liu (2008) females generally perceive having fewer opportunities to participate in decision making. These above discussed factors; organizational structure, nursing culture and only female nurses could contribute to nurses perceiving a low degree of decisional involvement.

The subjects in this study preferred to have shared decisional involvement, however, there are differences in each aspect of decisional involvement with lowest level of preferred involvement in aspect of professional recruitment and highest score in aspect of collaboration/ liaison activities. The possible explanation for such findings might be due to the educational status of the nurses, majority of them were having bachelor degree (Table 1). According to Mangold *et al.,* (2006) nurses with higher education have invested more time and energy into their nursing education and may wish to have more professional accountability and involvement in decision making. Similarly, to collaborate with other disciplines, nurses must have the knowledge, skills and resources to successfully collaborate (Scherb *et al.,* 2010). Therefore, nurses education might have built confidence for decision related to collaboration/ liaison activities which in turn resulted in subjects' highest score in preference to involve in collaboration/liaison activities. Furthermore , nurses working in these hospitals are full-time staff and have similar working hours. Full-time staff prefers to be involved in decision making

more than part-time workers (Huston, Leveille & Luquire, 2012). According to Mangold *et.al.* (2006), it may be easier to deal with the decision that are being made for nurses than to invest time and energy in decision making process. So, subjects might have preferred to have only some input in decision regarding professional recruitment with lowest score. Similarly, study of Glennie (1996) also reported that majority of nurses do not want to be involved in selection process of new staffs. On the other hand, in none of these six areas of decisional involvement nurses did not express a desire to have high level of involvement and the reason for this may need further exploration. According to Scherb et al. (2010), it is unknown why nurses did not desire more involvement in decision making, through may be due to their efforts for involvement being ignored by decision makers or that the permitted decisions have little consequence.

The findings of this study showed a statistically significant difference between overall actual decisional involvement and preferred decisional involvement and as well as differences in actual and preferred involvement scores across all subscales. The results suggest that nurses are not making decisions as their wishes and require more involvement in decision making than previously. The possible explanation of such findings might be culture of centralized administration and management and bureaucratic decision making practice in Nepal (Ministry of Health and Population, 2012) which resulted in top to bottom flow of authority and did not allow nurses significant decisional involvement even they preferred to be involved. According to Kanter, decentralized structures in the organization decreases the layers of decision making authority and allow those who are close to work to make suggestions and decisions (Laschinger, Sabiston, & Kutszcher, 1997).

There was a statistically significant moderate positive correlation between work empowerment and actual decisional involvement. There was weak positive corelationship between work empowerment and all other aspects of actual decisional involvement except collaboration/ liaison activities, which had no relationship with work empowerment. The findings indicate that the higher the level of work empowerment, the higher the degree of actual decisional involvement as perceived by nurses in the hospital. This supports Kanter's structure power theory (1977, 1993) which states that employees who have access to opportunity, information, support, resources, formal power and informal power are empowered and have control over their conditions which results in increased worker autonomy and involvement in organizational decisions. When nurses perceived having work empowerment, they feel that they can work confidently with more information and thus make better decisions. This study result also indicated that work empowerment did not relate to actual decisional involvement in collaboration/liaison activities. The possible explanation might be that collaboration generates new ideas and new solutions that emerge from experience and knowledge that help us get work done, coming from people both inside and outside an organization, well known and, yes, even strangers (Callahan,

Schenk & White, 2008). Thus, decisional involvement in collaboration/liaison activities may come from other factors too, not just from work empowerment.

Conclusions

The level of work empowerment among nurses sampled was at a moderate level, whereas nurses perceived having low actual decisional involvement and preferred to have shared decisional involvement. There were statistically significant differences in overall and all aspects of actual and preferred decisional involvement. A moderate positive correlation was found between work empowerment and actual decisional involvement.

Implications and recommendations

Nurse and hospital administrators could take study findings into consideration to develop strategies that promote empowerment in the work environment and improve the decisional involvement of nurses. This should include a redesign of the work environment using evidence-based leadership style, decentralization and shared governance, providing opportunities for nurses to advance through conferences, trainings, and continuing education, improving access to information using the intranet, bulletins, and newsletters. Similarly, with coordination to the Ministry of Health and Population Nepal, the hospital and nurse administrators should take initiation to solve staff shortage by recruiting more nurses and resources shortages by providing more supplies and equipment. Moreover, recognition programs should be initiated to reward and celebrate achievements through organization and in newsletters, local newspapers, and award ceremonies for individual and group achievements. Based on these findings, it is recommended that future studies can be carried out in other types of hospitals and in other regions of Nepal. Studies are needed to identify factors that improve or impede decisional involvement among nurses e.g. leadership style, organizational structures, demographic variables. It is also recommended to conduct intervention studies to examine the effectiveness, efficiency and cost benefit of different strategies aimed in improving work empowerment and balance actual and preferred decisional involvement of nurses in Nepal.

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