

**A DESCRIPTIVE CORRELATIONAL STUDY ON THE RELATIONSHIP
BETWEEN KNOWLEDGE AND PRACTICE OF NURSING ADVOCACY
AMONG BACCALAUREATE NURSE EDUCATORS IN UGANDA**

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**UGANDA CHRISTIAN
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Declaration

I Nuwamanya Isaac, hereby declare that this dissertation titled "A Descriptive Correlational Study on the Relationship Between Knowledge and Practice of Nursing Advocacy Among Baccalaureate Nurse Educators in Uganda" represents my own original work. It has not been submitted before for any other degree at any other institution of higher learning or university for any academic award.

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Date...18th June, 2026.....

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Dedication

This thesis is dedicated to God, my family, and all those who supported, guided, and encouraged me throughout my academic journey.

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List of Acronyms

ANOVA – Analysis of Variance

CPD – Continuing Professional Development

I-CVI – Item-Level Content Validity Index

KR-20 – Kuder–Richardson Formula 20

NCHE – National Council for Higher Education

REC – Research Ethics Committee

SBAT – Situation-Background-Assessment-Task (conceptual framework)

S-CVI/Ave – Scale-Level Content Validity Index (Average)

SPSS – Statistical Package for the Social Sciences

UCU – Uganda Christian University

UNMC – Uganda Nurses and Midwives Council

Abstract

Background/Purpose: Nursing advocacy constitutes a core professional responsibility, particularly for baccalaureate-prepared nurses in Uganda, where the Uganda Nurses and Midwives Council emphasizes safeguarding patient rights, promoting safe environments, and addressing unmet healthcare needs. Despite growing recognition of advocacy's importance, limited evidence exists regarding baccalaureate nurse educators' knowledge and actual engagement in advocacy practices. This gap may hinder effective role modelling and the preparation of future nurses. The purpose of this descriptive correlational study was to assess levels of knowledge of nursing advocacy, examine the extent of engagement in advocacy practices, and determine the relationship between knowledge and practice among baccalaureate nurse educators in Uganda's Central Region.

Theoretical/Conceptual Framework: The study was guided by the Sessler Branden Advocacy Theory, which posits that advocacy is a dynamic process influenced by internal foundational conditions (such as knowledge, values, and personal attributes) and external contextual factors (such as clinical opportunities and institutional support) that mediate the translation of knowledge into actual advocacy enactment.

Method: A quantitative, descriptive correlational cross-sectional design was employed. Multisite convenience sampling yielded 64 baccalaureate nurse educators from public and private nursing training institutions in Uganda's Central Region. Data were collected using a structured, content-validated questionnaire with knowledge items, Likert-scale practice items, and open-ended questions. Data were analysed using descriptive statistics, t-tests, ANOVA, Pearson correlation, and content analysis.

Results: Findings revealed very high knowledge levels, with participants achieving near-perfect scores on ethical foundations, safe environments, policy roles, and community needs. Participants reported moderate to high advocacy practice, particularly in teaching, mentorship, direct interventions, empowerment of students and patients, and promoting supportive environments. However, engagement was lower in policy participation and coalition-building. No significant relationship emerged between knowledge and practice, $r^2(62) = .02$, $p = .878$. Clinical engagement was the strongest factor associated with higher practice scores.

Conclusion: Consistent with the Sessler Branden Advocacy Theory, the results indicate a pronounced knowledge-practice gap. While internal foundational conditions (knowledge) were strong, external contextual factors—particularly clinical involvement—play a critical role in translating knowledge into advocacy behaviour.

Recommendations: The study recommends strengthening simulation-based and experiential advocacy training, promoting continued clinical engagement for nurse educators, establishing institutional mentorship systems, and enhancing organizational cultures that support advocacy participation and interdisciplinary collaboration.

Key Terms: Nursing advocacy, baccalaureate nurse educators, knowledge of advocacy, advocacy practice, Sessler Branden Advocacy Theory, Uganda.

Operational Definitions of Key Terms

Nursing Advocacy. A dynamic process through which the nurse engages in a set of actions with broadly stated goals ultimately affecting a desired change at any level of patient care, healthcare systems and health policy (Sessler Branden, 2021)

Nurse Educators. This is defined as an educator, who teaches the theoretical and practical content to baccalaureate nursing students in educational institutions.

Knowledge of Nursing Advocacy. Facts and information acquired by nurse educators in nursing advocacy. This is based on the scope of practice for nurses and midwives which includes knowledge of baccalaureate nurse educators on advocating for patient's rights, a safe therapeutic environment for both staff and patients, and promotion of access to care for the vulnerable population.

Practice of Nursing Advocacy. The active engagement of baccalaureate nurse educators in advocating for patient's rights, a safe therapeutic environment for both staff and patients, and access to care for the vulnerable population. This definition is based on the scope of practice for nurses and midwives in Uganda.

Chapter One: Introduction

Nursing advocacy is a cornerstone of professional nursing practice, emphasizing the protection of patient rights, promotion of social justice, and advancement of the nursing profession (Arabi, Rafii, Cheraghi, & Ghiyasvandian, 2014). As healthcare systems become increasingly complex, advocacy has emerged as a critical skill enabling nurses to influence decisions, policies, and practices that shape patient outcomes and professional standards (Salvage & White, 2019). Within nursing education, the ability of nurse educators to model and teach advocacy is essential for preparing competent graduates who can uphold ethical and professional responsibilities in diverse healthcare contexts (Staebler et al., 2017; Thomas et al., 2020).

This study focuses on understanding how baccalaureate nurse educators in Uganda translate their knowledge of nursing advocacy into practice. Nurse educators in Uganda lack meaningful engagement with national policies which limits the positive impact that these policies have on health outcomes. It seeks to describe and examine the relationship between what nurse educators know about advocacy and how they engage in advocacy related activities within academic and clinical environments. The population of interest includes baccalaureate nurse educators across nursing institutions in Uganda during the 2025–2026 academic period (Ministry of Health, 2022).

The study is significant because nurse educators serve as catalysts for instilling advocacy competencies in future nurses. Their knowledge and practice influence curriculum development, student mentorship, and participation in health policy dialogues (Uganda Nurses and Midwives Council, 2016; Fulton, 2022). By identifying existing strengths and gaps, the findings will inform strategies for professional development, curricular enhancement, and policy formulation.

Ultimately, this research aims to strengthen nursing education and advocacy culture, contributing to improved healthcare delivery and equity in Uganda.

Background to the Study

Nursing has a long history of contributing significantly to healthcare, often working alongside other health professionals to deliver quality care. While the profession was once primarily seen as supportive, the inception and growth of baccalaureate nursing education in Uganda have reshaped this image. Today, nurses are increasingly recognized as capable of critical thinking, decision-making, and leadership skills that position them as strong advocates for patients and communities (Fulton, 2022).

This transformation is further supported by the Uganda Nurses and Midwives Council, which has clearly outlined advocacy roles within the scope of practice for bachelor-prepared nurses. These include safeguarding patients' rights to dignity, privacy, confidentiality, and self determination; ensuring safe therapeutic and professional environments; promoting equitable access to resources; and identifying and addressing unmet healthcare needs at all levels of the system (Ministry of Health, 2022). Such provisions provide a solid foundation for advocacy to flourish as a core responsibility of the nursing profession.

Across Africa and globally, there is growing recognition of the value nurses bring to policy development and health system reform. For example, studies from Kenya, Ghana, and Jordan highlight that nurses are increasingly being included in policy spaces and are building momentum in influencing decisions that affect patient care and professional practice (Abualrub & Foudeh, 2016; Juma, Edwards & Spitzer, 2014; Laari & Duma, 2021). These examples demonstrate the opportunities that Ugandan nurses can also leverage to strengthen their voice in health policy.

Equally important, nurse leaders and educators in Uganda can build essential advocacy skills such as data-driven decision-making, professional writing, effective communication, and coalition-building. With support from professional bodies, mentorship, and targeted training, these skills can transform nursing advocacy into a powerful driver of systemic change. Rather than being viewed as challenges, these areas represent exciting opportunities for growth and professional advancement.

Nurse educators, in particular, are at the centre of this transformation. By equipping students with advocacy competencies and modelling advocacy behaviours, they prepare a new generation of nurses to take leadership in shaping health policies and addressing social determinants of health (Staebler et al., 2017; Thomas et al., 2020). Indeed, advocacy education is increasingly seen as an investment in public health, fostering equity and systemic improvements that benefit entire communities.

Workshops and international collaborations have already begun to highlight these opportunities. For instance, the Uganda National Academy of Sciences and the University of Michigan emphasized the importance of nurse educators' engagement in national policy processes as a pathway for improving health outcomes (Uganda National Academy of Sciences & University of Michigan, 2019). Building on such initiatives, there is enormous potential for Uganda's nurse educators to advance nursing advocacy and lead the way in integrating advocacy more meaningfully into education and practice.

Statement of the Problem

Although nursing advocacy is recognized as essential, there is limited evidence on how nurse educators in Uganda understand and apply advocacy principles. Recent regional studies show that limited educator preparedness contributes to missed opportunities for influencing health policy, participating in curriculum reforms, and shaping professional standards (Atuheire & Nakate, 2023; Munabi-Babigumira et al.,

2020). Gaps in knowledge may hinder effective advocacy modelling and teaching, potentially affecting the competencies of graduating nurses.

For example, a 2022 evaluation of nursing programs in East Africa found that less than 40% of nurse educators felt confident teaching or engaging in health policy advocacy despite acknowledging its importance (Omunyidia, 2022). This study addresses this knowledge–practice gap by examining the relationship between knowledge and practice of nursing advocacy among baccalaureate nurse educators in Uganda, generating evidence to inform educational strategies and policy.

Purpose of the Study

The purpose of this study is to describe the levels of knowledge of nursing advocacy among baccalaureate nurse educators in Uganda, assess their engagement in advocacy practices, and examine the relationship between these two variables. The study aims to generate empirical evidence that can inform improvements in nurse educator preparation, curriculum development, and policy engagement within nursing education.

Research Questions

1. What is level of knowledge of nursing advocacy among baccalaureate nurse educators in Uganda?
2. What is the extent of engagement of baccalaureate nurse educators in nursing advocacy practices among in Uganda?
3. What is the relationship between knowledge of nursing advocacy and engagement in advocacy practices among baccalaureate nurse educators in Uganda?

Objectives

- To assess the knowledge levels of nursing advocacy among baccalaureate nurse educators in Uganda.

- To examine the extent of engagement in nursing advocacy practices among baccalaureate nurse educators in Uganda.
- To determine the relationship between knowledge of nursing advocacy and engagement in advocacy practices among baccalaureate nurse educators in Uganda.

Significance of the Problem

The study may help the baccalaureate nurse educators know their strengths and weaknesses in their knowledge of nursing advocacy. They may also learn their engagement in practicing it as specified by the Uganda nurses' and midwives' scope of practice. This may lead them to plan for their own continuing education and development of skills in nursing advocacy.

Those in the academic leadership of nurse educators may learn about the baccalaureate nurse educators' knowledge and their engagement in nursing advocacy. This will help in identifying their strengths and weaknesses and thus plan for ways to support them to be competent themselves to improve the skills of nursing students in nursing advocacy. The Uganda Nurses and Midwifery Council may also understand the nurse educators' knowledge and engagement in nursing advocacy. This will help them to identify the needs of baccalaureate nurse educators and thus plan how to ensure their growth in knowledge and skills in nursing advocacy.

This study will provide critical insights that can inform the design and implementation of continuous professional development initiatives for nurse educators. It will identify specific gaps in understanding and practice that CPD programs can address. The findings will help adapt CPD content to not only enhance theoretical comprehension but also promote active involvement of nurse educators in advocacy efforts. Ultimately, the findings of this study will support the development of more

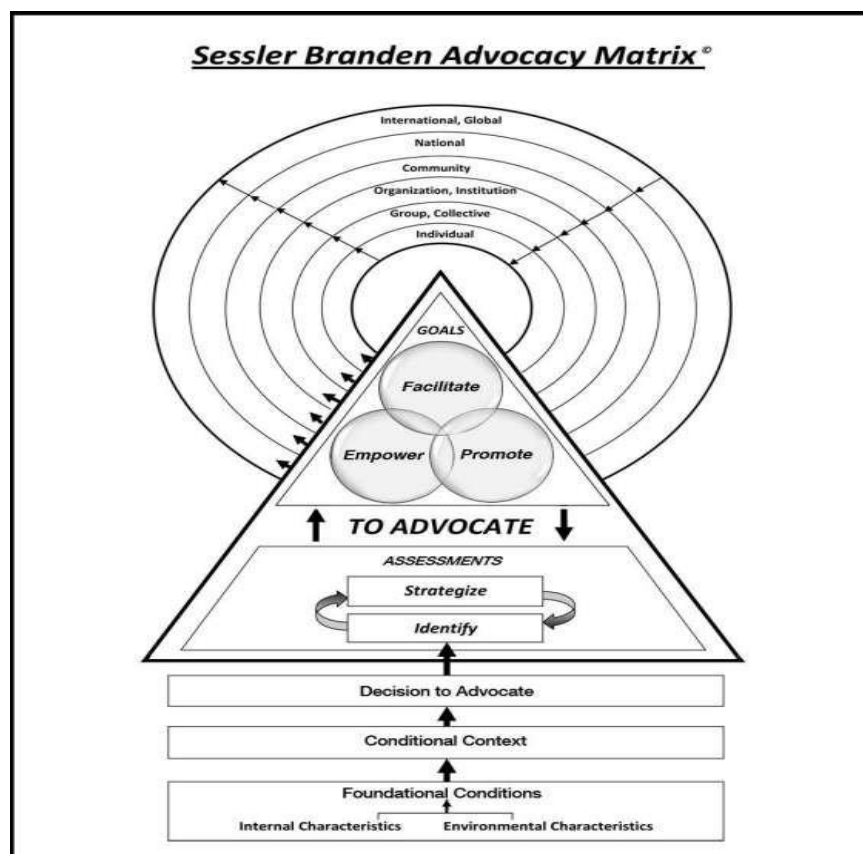
effective, targeted, and sustainable professional development strategies that empower nurse educators to advance advocacy within academic and clinical settings.

Theoretical Framework

The Sessler Branden Advocacy Theory (SBAT) is a midrange, pragmatic nursing theory developed to identify, examine, and define the advocacy process as it relates to the nurse's role of advocacy. Advocacy is defined as a dynamic process through which the nurse engages in a set of actions with broadly stated goals ultimately affecting a desired change at any level of patient care, healthcare systems and health policy (Sessler, 2021). The Sessler Branden Advocacy Matrix diagram shows the dynamic process in which nurses identify, implement, and evaluate the core phenomenon of advocacy.

This theory comprises of foundational conditions which include internal and environmental characteristics, the conditional context for the advocacy event, the nurse's decision to advocate, and the five components of advocacy. These five components include: to identify, strategize, facilitate, empower, and promote. The levels at which advocacy occurs begins with the individual, and then group/collective organization/institution, community, national, and international/global (Dolinta, 2022).

Figure 1: Sessler Brendon Advocacy Matrix Theory



Note. As cited from Morse et al. (2021)

Relationship among Components of the Framework

Foundational conditions (internal and environmental characteristics), conditional context, decision to advocate, assessments (identify, strategize), and goals (facilitate, empower, promote) are essential elements that lead to advocacy. The connections between the various elements of the framework that this study used are described in more detail below.

Foundational Conditions: Internal and Environmental Characteristics. The process of advocacy commences with identifying the internal and environmental characteristics around the nurse thus forming conditions. The internal characteristics include making one's opportunities, willingness to take a stand, being a risk taker, upbringing, desire to make a difference, desire to do what is right, knowledge of health, identifying one's person, being a good communicator, having perseverance and the

ability to look outside of oneself. The external or environmental characteristics that can affect the nurse's course of action include opportunity, mentor relationships, incentive and role models (Morse et al., 2021).

Conditional Context. The coming together of the aforementioned characteristics in multiple combinations forms a context within which there exists a potential for successful advocacy. They are referred to as conditions needed for advocacy process (Morse et al., 2021).

Decision to Advocate. After ascertaining the conditional context, the nurse decides to proceed with an advocacy act (Morse et al., 2021). A nurse chooses to speak up, act or emphasize his/her needs or interests.

To Advocate. After choosing to decide to advocate, the nurse initiates the major action "to advocate" which occupies the centre triangle by engaging in its essential components of the process and goals, also known as stages. The process comprises of interactions to identify and strategize. The goals are to facilitate, to empower and to promote. The process leads to the goals (Morse et al., 2021).

Identify. This includes interactions/actions when the nurse can recognize a need, analyse the system first or gather information, and understand the issues, systems and community (Morse et al., 2021). A nurse acknowledges that action is needed to address the identified need.

Strategize. The next step after identifying is to strategize. To achieve this, the nurse can partner/build coalitions, examine the context, determine means and relationships to accomplish goals by planning, organizing, negotiating, and or persuading. If the nurse advances to strategize step and finds that there is not enough information with which to put together a strategic plan to achieve one or more of the goals, then the nurse may be required to return to the identify step as the arrows indicate in the above diagram (Morse et al., 2021).

Goals. In every given act of advocacy, one or two, or all three goals can be realized. These goals include the nurses' ability to facilitate where the purpose is to become a relationship/coalition builder, communicator, liaison, and establish mentor/mentee relationships. Another goal is to empower. This includes taking responsibility for one's own actions, being an active member in a professional nursing organization, and educating and giving a voice to the voiceless. The final goal is to promote that involves engaging in issues, working for social justice and disseminating information (Morse et al., 2021).

The levels of the Sessler Branden Advocacy Theory in which advocacy action occurs comprise individuals, groups, organizations, communities, national, international and global arenas. Success on one level prepares the nurse for success on the next level. If a nurse moves across levels and does not achieve success at a higher subsequent level, there may be a need to return to the previous level of success with reassessment of what was successful and what could be changed (Morse et al., 2021).

Operationalizing the Theory to this Study

In this study, I will use the following aspects: foundational conditions (internal and external characteristics), identify, strategize, empower, and promote.

Foundational Conditions. These are characteristics that may lead a nurse to advocate. They include internal and external or environmental characteristics. Internal characteristics are early life experiences essential to nurses' engagement in advocacy. I will assess the nurse educators' internal characteristics. They include making the most of one's opportunities, willingness to take a stand, being a risk taker, upbringing, desire to make a difference, desire to do what is right, being a good communicator and the ability to look outside oneself. External or Environmental Characteristics represent an environment that gives a nurse an opportunity to advocate. I will inquire from the nurse

educators whether they have had opportunities to advocate, whether they have had mentors in advocacy and whether they have role models to follow in advocacy.

Identify. This is the development of a deeper understanding of the advocacy issue under study: In this step, I will be able to describe the nurse educators' ability to identify a need, analyse the system and understand the issues. These issues include the ability to address gaps in resources such as lack of mentorship, and support services. Monitoring policies that affect nursing students such as curriculum gaps, and unfair assessment methods. Advocating for evidence-based policies, and educational reforms that advance nursing practice and consequently patient outcomes.

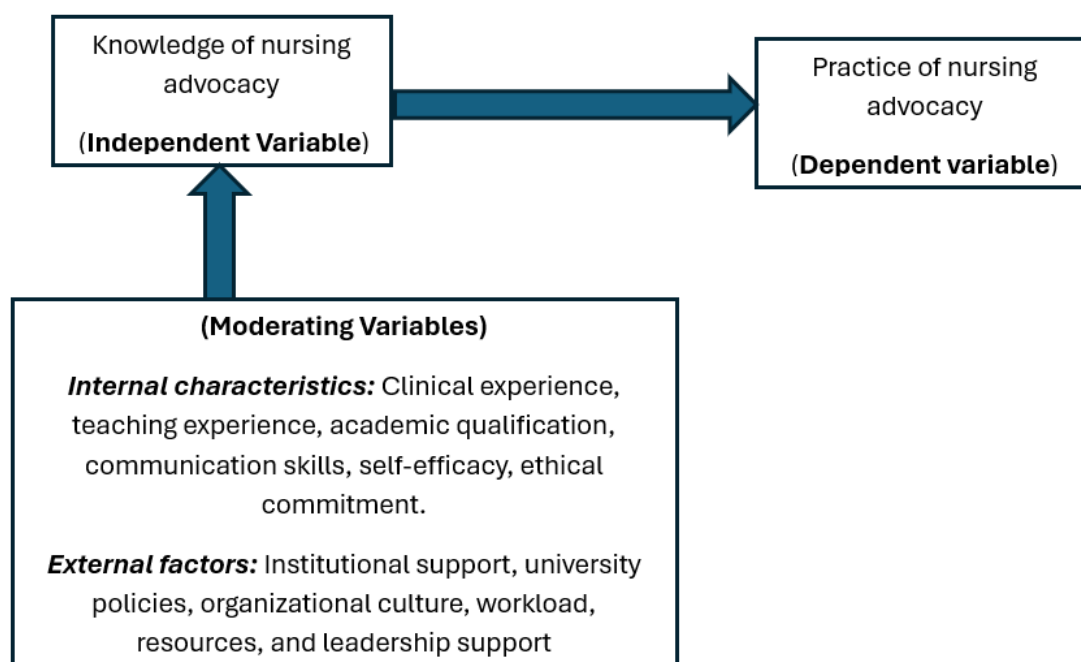
Strategize. This is the act of fostering relationships and coalitions, developing plans, organizing and evaluating goals. I will describe the nurse educators' ability to build coalitions, examine the contexts, and determine means to accomplish the goals through planning, negotiating and or persuading. Furthermore, I will describe the nurse educators' ability to join organizations to reinforce advocacy efforts for example the Uganda nurses and Midwives Union, participate in conferences and collaborative research initiatives. In addition, I shall also describe their ability to collaborate with healthcare leaders to implement evidence-based practices in nursing education, and patient care.

Empower. This is the capacity of a nurse educator to take responsibility for his/her own actions. I will describe the nurse educators' membership in professional nursing organizations, education, and giving a voice to the voiceless. Supporting policies that warrant diverse and inclusive nursing programs. Ability to advocate for resources such as scholarships. Write articles and research papers on serious healthcare issues.

Support students to participate in leadership roles where they can advocate for reforms in policy.

Promote. The readiness of a nurse to take up advocacy roles. I will describe the nurse educators' engagement in working for social justice and dissemination of information. Advocate for policies that develop healthcare access for underserved people. Advocate for innovative solutions to reach communities that are marginalized.

Figure 2: The Relationship Between Knowledge of Nursing Advocacy and Advocacy Practice: The Role of Foundational Conditions



This conceptual figure illustrates the relationship between knowledge of nursing advocacy (independent variable) and engagement in advocacy practice (dependent variable) among baccalaureate nurse educators in Uganda. It emphasizes the mediating influence of foundational conditions, which serve as enablers or barriers in translating knowledge into practice. These foundational conditions are categorized into internal characteristics such as clinical experience, teaching experience, academic qualification,

and self efficacy. External influences include institutional support, university policies, organisational culture, workload, resources and leadership support.

Summary

This chapter introduces the topic, background, statement of the problem, the purpose of the study, research question, objectives, significance of the study, and the theoretical framework which clarifies the concepts mentioned in the study. Chapter 2 will provide a detailed literature review of the study. The review will explore existing evidence on knowledge and advocacy practices globally and regionally. Chapter 3 will introduce the research methodology and design of the study.

Chapter Two: Review of Literature

This chapter presents literature related to the knowledge and engagement of baccalaureate nurse educators in nursing advocacy under three concepts. The first concept is on knowledge levels of nursing advocacy among baccalaureate nurse educators. The second concept presents the extent of engagement in nursing advocacy among baccalaureate nurse educators. The third concept discusses the relationship between knowledge of nursing advocacy and engagement in advocacy practices.

Knowledge Levels of Nursing Advocacy among Baccalaureate Nurse Educators

Historically, both globally and in Uganda, nursing was traditionally viewed as a nurturing, subservient role, primarily supporting physicians and not involving advocacy (Gandra et al., 2023). This perception limited nurses' participation in decision making and advocacy efforts (Water et al., 2016). However, Florence Nightingale fundamentally redefined nursing by emphasizing advocacy, formal education, and policy influence to improve health outcomes (Steabler et al., 2017).

Modern conceptualizations of advocacy in nursing are broad and multifaceted. Walker et al. (2015) propose a holistic advocacy model that includes legal, moral-ethical, political, spiritual, and substitutive advocacy, highlighting diverse knowledge and skills required for effective advocacy. Despite these evolving definitions, many nurses still lack clarity about what advocacy truly means and how it should be implemented in practice (Water et al., 2016). Nursing faculty often view advocacy as an ethical obligation that encompasses social justice (Akin & Kursun, 2020).

In addition to theoretical knowledge, contemporary frameworks increasingly define specific advocacy activities that nurses must understand. These include safeguarding patients' dignity, privacy, confidentiality, and self-determination; ensuring safe and therapeutic environments; promoting equitable access to resources; and identifying and addressing unmet health needs at individual and community levels

(Ministry of Health, 2022). Understanding these domains reflects comprehensive knowledge that extends beyond patient care into policy, education, and community health precisely the dimensions evaluated in current research instruments.

Despite the growing recognition of advocacy's importance, significant knowledge and educational gaps persist among nursing educators and within nursing curricula, both globally and in Uganda. Current teaching methods often inadequately prepare nurses for advocacy roles (Gandra et al., 2023; Steabler, 2017). For example, Bachelor of Science in Nursing (BSN) programs frequently do not prioritize advocacy knowledge (Walker et al., 2015). Additionally, many faculty members lack expertise in policy advocacy, which further limits their ability to effectively teach these concepts. As a result, students may fail to recognize the relevance of advocacy in nursing practice (Stea bler, 2017).

Recent Ugandan developments, including directives from the Uganda Nurses and Midwives Council, emphasize that bachelor-prepared nurses must possess not only theoretical understanding but also knowledge of data-driven decision-making, professional writing, effective communication, and coalition-building as critical advocacy competencies. These cognitive domains align with awareness of policy, ethics, and social justice.

Research indicates that targeted educational interventions can improve both students' and licensed nurses' understanding and engagement in advocacy (Perry & Emory, 2017). Examples include experiential learning opportunities that allow students to participate in advocacy activities within organizational settings (Peltezer et al., 2016). Integrating leadership competencies with population-health policy advocacy in curricula has also shown to enhance students' understanding of policy processes and readiness to engage in advocacy (Cropley et al., 2024). Such educational strategies have promoted a deeper appreciation of advocacy significance in healthcare (Peltezer et al., 2016).

Extent of Engagement in Nursing Advocacy among Baccalaureate Nurse Educators

Nurse educators play a critical role in fostering advocacy by equipping students with competencies to engage in policy and activism (Steabler, 2017). However, there is limited engagement in advocacy among nurse educators due to institutional constraints, lack of supportive policies, and perceived risks of punishment for engaging in advocacy (Laari & Duma, 2023). In Ghana and Ethiopia, barriers such as timidity, fear of conflict, lack of assertiveness, and institutional cultures discourage active advocacy engagement (Tadie et al., 2023; Laari & Duma, 2023).

Globally, nurses often feel powerless and voiceless in advocating within healthcare settings, with administrators disregarding their input unless aligned with institutional budgets (McMillan & Peron, 2020). Engagement in advocacy is further constrained when institutions do not recognize the ethical responsibility of nurses to speak up when witnessing infringement on patients' rights (Water et al., 2016). In a study on the impact of education on student nurses' advocacy and ethical sensitivity, researchers showed that advocacy education increased social justice advocacy skills among the participants (Nesiime & Belgin, 2022). Researchers further advocated for an integration of advocacy initiatives into care practices to promote advocacy skills (Nesiime & Belgin, 2022).

Beyond classroom instruction, nurse educators' engagement can also be observed in practical advocacy actions, such as role-modelling advocacy behaviours in clinical settings, encouraging students to speak up for patients, participating in institutional policy discussions, and collaborating with other professionals in coalition-building. The Uganda Nurses and Midwives Council (2022) reinforces these expectations by including advocacy within the professional scope of practice for nurse educators and emphasizing their obligation to uphold patient rights, promote safe environments, and champion equitable access to healthcare.

Despite the barriers that nurse educators face in fostering advocacy, there are positive examples of successful engagement and best practices that show what effective advocacy education and involvement can look like. For example, the American Nurses Association California (2023) gives a range of advocacy success stories including integration of policy literacy in nursing curricula, founding of professional associations, and legislative efforts that improved maternal outcomes. These success stories demonstrate how nurse educators can mentor students in policy leadership by sharing real-world advocacy experiences.

Additionally, best practices include incorporating policy and advocacy skills into curricula, providing students with real-world policy experiences through internships, and leveraging technology for interactive learning and virtual simulations. In Uganda, emerging collaborations such as the Uganda National Academy of Sciences and University of Michigan partnership (2019) highlight workshops where nurse educators learn to engage in national policy processes; activities that directly correspond to the questionnaire's items on coalition-building, policy participation, and mentorship. These approaches empower nurses to participate in policy change and promote a culture of advocacy within healthcare organizations, demonstrating a positive impact of structured advocacy education and engagement (Foundations of Nursing Excellence, 2025).

Relationship between Knowledge of Nursing Advocacy and Engagement in Advocacy Practices

Research indicates a strong relationship between nurses' knowledge of advocacy and their engagement in advocacy practices. Advocacy practices involve ethical principles, empathy, responsibility, and assertive communication (Heck, Mendes & Ventura, 2022). Nurses with clearer understanding and training in advocacy roles are more likely to engage effectively in safeguarding patient rights, mediating with

healthcare teams, and promoting social justice (Abbisinia et al., 2020; Walker et al., 2015).

Educational preparation in advocacy significantly impacts nurses' confidence and willingness to engage in advocacy practices. Inadequate curriculum coverage and lack of empowerment from educators limit both knowledge and subsequent engagement in advocacy (Laari & Duma, 2023). Faculty expertise and active participation in policy and advocacy correlate with students' inclination to engage in advocacy upon graduation (Steabler et al., 2017).

Studies from Ghana, Kenya, Ethiopia, Jordan, and Canada consistently reveal that nurse educators and practicing nurses face challenges in engaging with advocacy, though the nature and intensity of these challenges vary. In Ghana and Ethiopia, cultural barriers such as timidity and fear of conflict hinder advocacy efforts (Laari & Duma, 2023; Tadie et al., 2023). In Jordan, nurses reported low involvement in policy formulation due to limited education and institutional support (Abualrub & Foudeh, 2016). Meanwhile, Canadian nursing education emphasizes advocacy as a professional responsibility, supported by national frameworks and policy engagement opportunities (Canadian Nurses Association, 2024). These comparisons demonstrate that while advocacy is widely recognized as essential, its integration into nursing education is inconsistently shaped by sociopolitical contexts and institutional readiness.

Although international research has established correlations between knowledge and practice, few Ugandan studies have analyzed how educators' understanding of specific advocacy activities such as mentoring students, using evidence for decision-making, or promoting community health equity which translates into practice. The present study addresses this gap by assessing both knowledge (ethical, policy, and procedural awareness) and practice (behavioural engagement, coalition-building, and mentoring), as operationalized in the questionnaire.

Despite widespread agreement on the importance of advocacy in nursing, contradictions emerge in how it is taught and practiced. For instance, while some studies advocate for experiential learning and policy engagement (Cropley et al., 2024; Peltzer et al., 2016), others reveal that nurse educators themselves lack policy knowledge and confidence to teach advocacy effectively (Steabler et al., 2017; Water et al., 2016). This gap between theoretical endorsement and practical implementation suggests a disconnect in curriculum design and educator preparedness. Moreover, while advocacy is considered an ethical obligation, institutional cultures often discourage assertiveness, creating a paradox where nurses are expected to advocate but penalized for doing so. These contradictions demonstrate the need for systemic reforms that align educational goals with institutional realities.

Global findings offer valuable insights but may not fully apply to Uganda because of contextual differences in healthcare systems, cultural norms, and educational infrastructure. For example, advocacy in Western contexts often assumes a certain level of autonomy and institutional support that Ugandan nurse educators may not have. The nature of Uganda's healthcare system hierarchy and historical subservience of nurses to physicians (Fulton, 2022; Nsiah et al., 2019) limits the applicability of models that rely on individual assertiveness and policy engagement. In addition, Uganda's nursing education system faces resource constraints and limited exposure to policymaking processes, unlike countries with established advocacy curricula. Therefore, while global best practices can inform Uganda's approach, they must be adapted to local realities, emphasizing mentorship, cultural sensitivity, and gradual empowerment within existing structures.

The first Uganda National Nursing and Midwifery Draft Policy emphasizes the importance of ensuring that nurse educators possess qualifications that exceed those of students they instruct, thereby reinforcing their credibility and capacity to model

professional standards. It further advocates for standardized degree-level courses in nursing and midwifery, recognizing the role of educators in shaping competent, advocacy-driven practitioners. The policy underscores the need for nurse educators to be equipped not only with advanced knowledge but also with the ability to advocate for quality education and professional growth within the nursing workforce (Ministry of Health, 2016).

The Uganda Nurses and Midwives Council also emphasizes that continuous professional development (CPD) is essential for nurse educators to maintain high standards in teaching, leadership, and advocacy. By actively engaging in CPD, nurse educators update their own knowledge and skills while modelling lifelong learning, ethical conduct, and professional growth. This ongoing process equips educators to mentor future nurses, advocate for patients, uphold professional standards, and respond to evolving healthcare demands. CPD activities especially those focused on communication, coalition-building, and evidence-based advocacy mirror the competencies assessed in the current study's questionnaire and represent a tangible pathway to strengthening advocacy capacity in Uganda's nursing education system (Uganda Nurses and Midwives Council, 2016).

Integration of the Existing Literature with the Sessler Branden Advocacy Theory

The reviewed studies reflect the dimensions of the Sessler Branden Advocacy Theory. The “identify” dimension is shown in how nurse educators and students are encouraged to recognize gaps in advocacy knowledge and practice such as lack of clarity on advocacy roles, limited curriculum content, and institutional barriers. Studies by Steabler et al. (2017) and Gandra et al. (2023) highlight the need for deeper understanding of advocacy concepts and systemic issues surrounding nursing education. The “strategize” component is seen in the literature's emphasis on integrating advocacy into nursing curricula, forming coalitions, and participating in policy discussions. For

example, Cropley et al. (2024) and Peltzer et al. (2016) discuss experiential learning and development as strategic approaches to integrate advocacy in nursing education.

The "empower" and "promote" aspects are also strongly represented.

Empowerment is seen in the call for nurse educators to model advocacy behaviours, support student leadership, and engage in professional organizations as emphasized by Steabler et al. (2017) and Nesiime & Belgin (2022). These actions help build confidence and responsibility among educators and students. Promotion is reflected in the advocacy for social justice, equitable healthcare, and policy reforms with studies urging educators to disseminate information. This aligns with SBAT's goal of achieving systemic change through informed, strategic and ethical nursing advocacy.

Despite global recognition of advocacy's importance, there remains a lack of systematic, concrete training that links knowledge to practical advocacy engagement, necessitating a curriculum inclusion to emphasize advocacy as a core component of nursing education (Gandra et al., 2023; Water et al., 2016). No studies have been done to describe the knowledge and engagement of baccalaureate nurse educators in nursing advocacy in Uganda. Thus, this study will focus on describing the knowledge and practice of baccalaureate nurse educators in nursing advocacy in Uganda.

Summary

This literature review highlights that while advocacy is integral to nursing, baccalaureate nurse educators often lack adequate knowledge and do not fully engage in advocacy practices due to institutional, educational, and cultural barriers. It also shows a strong relationship between knowledge and practice further underscoring the need for nurse educators with advocacy competencies to prepare nurses for effective patient advocacy. Chapter three will present the methodology for assessing the knowledge, practice and their relationship in nursing advocacy among baccalaureate nurse educators in Uganda.

Chapter Three: Methodology

This chapter described the methodology that was used in this study. This included the method and design, study setting, the study population, sampling and sample size calculation. The chapter further described the procedure of data collection, and data collection tools that were used in this study. The plan for data analysis, how data were presented, and how ethical issues were addressed.

Method and Design

This study used a mixed method, descriptive correlational cross-sectional design to explore the knowledge and practice of baccalaureate nurse educators about nursing advocacy. The descriptive aspect aimed to assess the levels of knowledge and practice related to nursing advocacy among baccalaureate nursing educators. It provided a comprehensive overview of the knowledge base and frequency of advocacy practices applied in nursing education. This component allowed for the identification of gaps in knowledge and practice, thus informing future pedagogical strategies and curriculum development.

The correlational aspect of the design examined the relationship between levels of knowledge and practice of nursing advocacy among participants. By employing statistical analysis, the study determined whether higher knowledge levels were associated with more effective advocacy practices. As a cross-sectional study, the quantitative and qualitative data were collected from the target population at a single point in time. This approach provided insight into the current state of knowledge and practice among baccalaureate nurse educators facilitating a timely assessment of their readiness and capacity to engage in nursing advocacy.

It further facilitated quick gathering of data from a diverse sample of participants, thus helping in establishing baseline knowledge and practices within this population. The descriptive correlational cross-sectional design was well suited for this research as it

enabled a thorough assessment of the levels of knowledge and practice, along with an exploration of their interrelationship, contributing valuable insights to the field of nursing education and advocacy.

The study also incorporated a qualitative component through open ended questions included in the data collection instrument. These qualitative responses provided contextual information that complemented and supported quantitative findings by illustrating how participants understood and enacted advocacy in their educational and clinical roles.

Population

Although baccalaureate nurse educators were distributed across all regions of Uganda, this study focused on those teaching in universities located in the Central Region. The Central Region hosted a high concentration of universities offering baccalaureate nursing programmes, including both public and private providers, which increased the likelihood of obtaining an adequate and diverse sample of nurse educators within the available time and resources.

Setting

This study was conducted in selected nursing training universities located within the Central Region of Uganda that offered baccalaureate nursing programmes. The Central Region provided an ideal context for this study because it hosted a high concentration of universities involved in training undergraduate nurses, including both public and private institutions. This diversity offered access to a broad and representative range of baccalaureate nurse educators within a manageable geographical scope. The study setting provided access to participants in their natural teaching environments.

Sample

Multisite convenience sampling was used to recruit available and willing baccalaureate nurse educators from nursing training institutions in Central Uganda. This

population was selected because they integrate clinical practice with teaching, enabling them to model and teach nursing advocacy in both academic and clinical settings.

Sampling Plan

A multisite convenience sampling approach was used to recruit eligible baccalaureate nurse educators who were available and willing to participate during the data collection period. This approach enabled the inclusion of participants from the accessible population within the Central Region of Uganda.

Sample Size

To determine the minimum required sample size for the study, Krejcie and Morgan's (1970) table was used. With an estimated population of approximately 90 baccalaureate nurse educators in Central Uganda, the corresponding recommended sample size was 73 participants. A total of 64 participants participated. The achieved sample was therefore considered adequate to provide a substantial representation of the accessible study population.

Inclusion Criteria

Participants were baccalaureate nurse educators in Central Uganda because they were directly responsible for imparting professional values such as advocacy and were best positioned to provide insights into their knowledge and practice. Educators were required to be currently teaching in either public or private nursing training universities. This ensured that participants were actively engaged in teaching and could provide up-to-date information based on their ongoing experiences.

Exclusion Criteria

Visiting nurse educators who were not consistently involved in the teaching–learning process were excluded if their limited engagement prevented them from providing reliable insights into routine advocacy teaching and practice.

Data Collection

Nurse educators were invited to participate through formal invitation letters issued at least one week before data collection. Follow-up reminders were sent by email or delivered in person. Participation was voluntary, and each potential participant received clear information about the study. Written informed consent was obtained prior to administering the questionnaire. A structured questionnaire was administered in person by the researcher at a designated location within each institution. Participants were given 20–30 minutes to complete the questionnaire. Completed questionnaires were collected in sealed envelopes and stored securely by the researcher.

Data Management

Electronic data were entered into a password-protected database, while hard copies were locked in a cupboard accessible only to the researcher. Data were retained for five years and then securely destroyed.

Data Collection Tool

The research investigator created a study questionnaire using guidance from existing literature. A self-administered questionnaire was used because it was economical, lowered interviewer bias, and reduced insufficient responses. The questionnaire contained both open- and closed-ended questions.

Item Analysis

The questionnaire was structured into five sections to comprehensively explore the knowledge and practice of baccalaureate nurse educators regarding nursing advocacy. Section A had six questions (1–6) concerning demographic data. The section consisted of six items, which included age, gender, highest nursing qualification, years of teaching experience, institution type, and whether the participant had current practice responsibilities. Descriptive methods were used to describe the participants based on age, gender, highest nursing qualification, institution type, and current clinical responsibilities.

Section B had five questions (7–11) regarding knowledge about nursing advocacy, which were measured using a structured set of objectives, content-validated items, consistent with Polit and Beck's (2021) recommendations for assessing cognitive constructs. The items assessed factual, conceptual, and procedural knowledge related to nursing advocacy, including understanding of patient rights, ethical foundations, safe practice environments, policy engagement, and advocacy responsibilities as outlined in national standards.

Each item had a single correct response (multiple-choice or true/false), allowing for objective scoring. A value of 1 was assigned to each correct answer and 0 to each incorrect answer. Total scores were summed and converted into percentages to facilitate comparison across participants. Following established practice in knowledge assessment, percentage scores were categorized as follows: >80% = high knowledge, 70–79% = above-average knowledge, 50–69% = moderate knowledge, and <50% = low knowledge.

Section C had five questions regarding advocacy practice, measured on a Likert scale with the “never” option awarded 0 and the “always” option awarded a score of 4. The mean score was calculated. Participants whose mean score fell between 1.00–1.80 were considered to have very low or no practice, 1.81–2.60 indicated low practice, 2.61–3.40 indicated moderate practice, and 3.41–4.20 indicated high practice (Boone & Boone, 2012). This scale was used to interpret the average mean score and helped to identify whether nurse educators were adequately modelling and supporting advocacy practice in their roles.

Section D had two open-ended questions designed to elicit deeper insights into participants' understanding of and engagement with nursing advocacy.

Pilot Plan

Before full-scale data collection, the questionnaire was piloted with a small sample of 15 baccalaureate nurse educators who met the inclusion criteria but did not

participate in the main study. The pilot aimed to assess the clarity of instructions and questions, the appropriateness of response options, the time required to complete the questionnaire, and the internal consistency of scale-based items. Feedback from the pilot was used to revise ambiguous items, adjust language for clarity, and ensure logistical feasibility. The pilot also helped to estimate the average completion time and refine the data collection procedures.

Validity

The content validity of the questionnaire was established through expert evaluation, consistent with Polit and Beck's (2021) recommendations for ensuring that an instrument adequately represented the construct being measured. At least three experts in nursing advocacy, curriculum development, and quantitative research independently reviewed the instrument. They assessed each item for relevance, clarity, representativeness, and alignment with the conceptual domains of nursing advocacy (knowledge and practice). Using a structured content validity form, experts rated each item, and their ratings were used to compute the Item-Level Content Validity Index (I-CVI) and the Scale-Level Content Validity Index (S-CVI/Ave). Items that received an I-CVI score below the recommended threshold of 0.78 were revised or removed. Expert feedback also guided refinement of wording, elimination of redundancy, and strengthening of conceptual coverage to ensure that the instrument reflected core advocacy competencies.

Reliability

Reliability was assessed using procedures appropriate for the measurement scales included in the instrument. For Section B (knowledge), which consisted of dichotomous items scored 0 or 1, internal consistency reliability was evaluated using the Kuder–Richardson Formula 20 (KR-20), as recommended by Polit and Beck for objective knowledge tests. For Section C (advocacy practice), which used a 0–4 frequency Likert

scale, internal consistency was assessed using Cronbach's alpha. A reliability coefficient of greater than or equal to 0.70 was considered acceptable for both KR-20 and Cronbach's alpha, indicating adequate internal consistency. Reliability analyses conducted during the pilot study guided refinement of the tool. Items that reduced reliability or demonstrated poor discrimination were revised or removed before final data collection.

Data Analysis

After data entry, coding, and verification, IBM SPSS Statistics (version 24) was used for data analysis. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were computed to summarize demographic information and responses related to knowledge, practice, and barriers. For the major sections on knowledge and practice, independent samples *t*-tests were used to compare advocacy knowledge and practice between groups. These groups included nurse educators from public institutions and those from private institutions. One-way analysis of variance (ANOVA) was used to determine statistically significant differences in advocacy scores across levels of educational qualification and teaching experience.

To examine the relationship between knowledge and practice scores, Pearson's correlation coefficient was applied. To minimize errors and ensure data accuracy and integrity, SPSS was used to screen for missing data. Surveys with excessive missing values were excluded from the analysis, while isolated missing responses were imputed using mean substitution. To detect manual data entry errors, double data entry was conducted for 10% of the questionnaires. Range checks were applied to ensure that responses fell within expected values for Likert-scale items. Boxplots and Z-scores were used to identify outliers.

Analysis of Responses to Open Ended Questions

Open-ended responses were analyzed using conventional content analysis, including familiarization, manual coding, category development, theme generation, and integration with quantitative findings. Illustrative quotations were used.

Presentation of Results

Quantitative results were presented in tables and figures. Qualitative findings were presented narratively with supporting quotes, and triangulation was undertaken.

Demographics

The first section contained demographic data. Descriptive methods were employed to describe the participants according to specific categories. Frequencies and percentages were used to analyze characteristics such as age, gender, highest nursing qualification, years of teaching experience, institution type, and whether the participant had current practice responsibilities. Frequencies and percentages were obtained for demographic data to describe the distribution of the study population, and these were reported in the form of tables.

Knowledge

Each participant's overall score was calculated as a percentage and assigned a category. Overall group scores were identified by calculating the mean percentage. The performance of each question was analyzed by determining the percentage of participants who answered each question correctly and the percentage who answered incorrectly. Questions with higher percentages of correct responses were considered areas in which participants had strong knowledge, while questions with lower percentages were regarded as areas where participants had limited knowledge.

Practice

Each individual participant's responses were calculated using the mean score and assigned to a category. Overall group scores were analyzed by examining the group mean

and the frequency distribution across categories expressed as percentages. The data were compared and presented in tables. Each individual item on the questionnaire was analyzed to determine the group's reported practice by calculating the mean score for each item.

Participants whose mean scores ranged from 1.00–1.80 were considered to have very low or no practice, scores of 1.81–2.60 indicated low practice, scores of 2.61–3.40 indicated moderate practice, and scores of 3.41–4.20 indicated high practice (Boone & Boone, 2012). This scale was used to interpret the average mean score and helped to identify whether nurse educators were adequately modelling and supporting advocacy practice in their roles.

Data Analysis Plan

Data analysis was conducted using the Statistical Package for the Social Sciences (SPSS) version 24. The analysis followed a systematic approach that included data cleaning, coding, descriptive analysis, and inferential statistics. The goal of the analysis was to describe the levels of knowledge and practice of nursing advocacy among baccalaureate nurse educators in Central Uganda and to determine the relationship between the two variables.

Data Preparation

Data Cleaning

All completed questionnaires were checked for completeness before data entry. Data were screened for errors through double data entry for 10% of the questionnaires to ensure accuracy. Range checks were applied to identify values outside the expected bounds (0–1 for knowledge items and 0–4 for practice items). Missing data were handled as follows: Questionnaires with excessive missing values were excluded from the analysis. Isolated missing responses were imputed using mean substitution, where appropriate.

Coding

Knowledge items (Section B) were coded as follows: 1 = correct, and 0 = incorrect.

Advocacy practice items (Section C) were coded using the absolute-zero Likert scale: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Often, and 4 = Always. Demographic variables were coded according to predetermined categories.

Descriptive Analysis

Demographics

Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize Age, gender, highest qualification, years of teaching experience, type of institution, and current practice responsibilities.

Knowledge Scores

Individual knowledge scores were calculated by summing correct responses (0–5). Scores were converted into percentages using the formula: $(\text{Total correct} \div 5) \times 100$. Participants were categorized as follows: 80% = High knowledge, 70–79% = Above-average knowledge, 50–69% = Moderate knowledge, and <50% = Low knowledge. The mean and standard deviation of overall knowledge scores were computed.

Advocacy Practice Scores

Each participant's advocacy practice score was calculated by computing the mean of all 12 practice items (each scored from 0–4). Practice levels were interpreted using the following ranges: 0.00–0.80 = Very low or no practice, 0.81–1.60 = Low practice, 1.61–2.40 = Moderate practice, 2.41–3.20 = High practice, and 3.21–4.00 = Very high practice. Group mean scores and standard deviations were computed for all practice items.

Inferential Analysis

Relationship Between Knowledge and Practice

The primary research question was addressed using Pearson's Product-Moment Correlation (r) because: Knowledge scores were continuous (0–100%), advocacy practice scores were continuous (0–4), and the analysis aimed to measure the strength and direction of the linear relationship. Assumptions of normality, linearity, and homoscedasticity were checked using normal Q-Q plots and scatterplots.

Group Comparisons

To explore whether advocacy knowledge or practice varied according to demographic factors, independent samples t -tests were used to compare scores between: Public and private institutions, and educators with and without current clinical practice. One-way analysis of variance (ANOVA) was used to compare scores across: Levels of qualification (Bachelor's, Master's, PhD), and categories of years of teaching experience. Where the ANOVA results were statistically significant, post hoc tests using Tukey's HSD were conducted.

Open-Ended Questions

Open-ended questions were included in the questionnaire to provide contextual descriptions of advocacy behaviors and to support interpretation of quantitative findings related to advocacy practice. These questions were analysed using conventional content analysis. This involved data familiarization, initial coding, category development, theme generation, and interpretation with integration of quantitative results. Illustrative quotations were used where appropriate.

Presentation of Results

Quantitative results were presented in tables and figures summarizing demographics, knowledge levels, practice levels, correlation coefficients, and group

comparisons. Qualitative themes were presented narratively with supporting quotations. Triangulation of findings was discussed in line with the conceptual framework (SBAT).

Ethical Considerations

Ethical approval was obtained, informed consent was secured, privacy and confidentiality were ensured, risks were minimized, and participation was voluntary.

Ethical Approval

The proposal was submitted to the Research Ethics Committee (REC) of Uganda Christian University (UCU). A letter of introduction was then obtained from the Head of the Nursing Department of UCU and presented at the study sites.

Informed Consent

The research investigator provided an informed consent form to participants before their involvement in the study. The form contained the study title, name of the investigator, study purpose, supervisor details, potential benefits of the study, potential risks, reimbursements, confidentiality and privacy assurances, expected duration of participation, study approval information, and details regarding participants' rights to withdraw and contact information for ethical concerns. Obtaining informed consent allowed participants to take part in the research study voluntarily and with full understanding of what participation entailed.

Privacy

Ensuring the privacy of participants was a core principle of this study. The contact information of the researcher was provided, allowing participants the freedom to raise any concerns or issues. Participants were not required to provide names, institutional names, or any personally identifying information on the questionnaire. The study involved digital administration of the survey using Google Forms, which did not require login credentials. Submissions did not log email addresses or IP addresses. Participants were explicitly informed that their responses had no influence on their employment

performance evaluations. Participation was entirely voluntary, and no punitive measures resulted from refusal or withdrawal. Electronic data were stored on a password-protected device with encrypted backup in cloud storage on Google Drive. Only the investigator accessed the raw data for the purpose of analysis.

Confidentiality

Data generated electronically were stored in a password-protected folder, which limited access to authorized individuals only. The research investigator was the primary person mandated to access the data, while the supervisor was able to access the data as needed. During presentation and publication of the findings, care was taken to avoid the use of participants' names or any identifying information.

Benefits

This study generated evidence on the existing knowledge and practice of baccalaureate nurse educators regarding nursing advocacy. The findings informed institutional policies that support advocacy education. Enhancement of advocacy competencies among nurse educators contributed to improved patient outcomes, greater respect for patients' rights, and the promotion of social justice in healthcare delivery.

Risks

No physical, psychological, or social harm was anticipated since the data collection involved only a self-administered questionnaire.

Incentives

Participants were paid 20,000 Uganda shillings as a token of appreciation for the time they devoted to the study.

Social or Cultural Issues

There were potentially two social or cultural issues in the study. The researcher was male, and some participants were female. Neutral language was used throughout the

study, and emphasis was placed on voluntary participation, confidentiality, and respect for diverse perspectives.

Conflict of Interest

This study involved no conflict of interest.

Benefits

The findings provided valuable insights into the current levels of knowledge and engagement in nursing advocacy among baccalaureate nurse educators in Central Uganda. These results informed institutional strategies for strengthening advocacy teaching, guided the development of targeted continuing professional development (CPD) programs, and supported improvements in curriculum design.

Dissemination of Findings

The findings of this study were disseminated to key stakeholders involved in nursing education, regulation, and policy in Uganda. A summary report was shared with participating institutions in the Central Region to inform faculty development initiatives and curriculum enhancement processes. Results were presented to the Uganda Christian University Research and Ethics Committee as part of the study closure requirements.

To contribute to national discourse, the study findings were shared with the National Council for Higher Education (NCHE) and the Uganda Nurses and Midwives Council (UNMC), as these bodies play central roles in accrediting programmes and guiding professional standards. The results were also disseminated through academic seminars, workshops, and conferences focusing on nursing education and policy advocacy. Where appropriate, the study was prepared for publication in peer-reviewed nursing or health education journals to ensure broader visibility and scholarly engagement. This approach enabled other educators, policymakers, and researchers to use the evidence to support improvements in advocacy teaching and engagement within nursing programmes.

Study Limitations

Several limitations were anticipated in this study. First, the cross-sectional design captured data at a single point in time, which limited the ability to infer causal relationships between knowledge and advocacy practice. The findings therefore represented associations rather than causation. Second, the study relied on self-reported practices, which may have been influenced by social desirability bias, as participants might have overestimated their engagement in advocacy activities to align with perceived professional expectations.

Third, the study focused on baccalaureate nurse educators in the Central Region of Uganda, which may have limited the generalizability of the findings to educators in other regions with different institutional contexts or resource environments. Fourth, although the questionnaire underwent expert review and pilot testing, some measurement error may still have occurred, particularly in assessing abstract constructs such as advocacy. Additionally, factors not examined in the study, such as institutional culture, leadership support, or workload, may have influenced advocacy engagement but remained outside the study's scope. These limitations were acknowledged when interpreting the results and discussing implications for practice and policy.

Summary

Chapter 3 summarized the methods that were used in this study, including the research design, study population, study setting, sample, and sampling frame. Sample size determination and inclusion criteria for participants were also described. The chapter further covered data collection tools, the pilot plan, validity, reliability, and data analysis procedures. In addition, the chapter addressed ethical considerations, potential benefits and risks, use of incentives, and social or cultural issues.

Chapter Four: Results

This chapter presents the results of the study on the relationship between knowledge and practice of nursing advocacy among nurse educators. Data were entered into SPSS and analyzed accordingly. The chapter describes the demographic characteristics of the study participants and presents findings based on the three objectives that guided the study. The first objective assessed the level of knowledge of nursing advocacy among baccalaureate nurse educators in Uganda. The second objective examined the extent of engagement in nursing advocacy practices among baccalaureate nurse educators in Uganda. The third and final objective determined the relationship between knowledge of nursing advocacy and engagement in advocacy practices among baccalaureate nurse educators in Uganda. A total of 64 nurse educators provided informed consent and completed the study, representing a 100% response rate. All 64 participants were included in the final data analysis.

Reliability of the Research Tool

The 12-item advocacy practice scale demonstrated good internal consistency (Cronbach's $\alpha = .83$), comfortably exceeding the acceptable academic threshold of .70. Item-total statistics identified data and research utilization as the scale's strongest psychometric driver ($r = .918$), while macro-level engagement specifically institutional or national policy development proved to be the weakest component ($r = .070$). Removing this policy-related item would optimize the scale's overall reliability to its maximum potential value ($\alpha = .859$). Conversely, the knowledge scale yielded zero variance due to ceiling-level participant consensus, making an internal consistency coefficient uncomputable for that specific instrument.

Demographic Data

The demographic characteristics of the study participants were taken to describe the composition of the study sample and to provide background information relevant to the interpretation of the study findings. The demographic data were analyzed using descriptive statistics and are presented as frequencies and percentages in Table 1.

Table 1

Demographic Distribution of Study Participants

Category	<i>f</i>	%
Age		
20-29	7	10.9
30-39	22	34.4
40+	35	54.7
Gender		
Male	28	43.8
Female	36	56.3
Years of Teaching Experience		
<1	6	9.4
1-5	14	21.9
6-10	17	26.6
>10	27	42.2
Highest Qualification Attained		
Bachelors	9	14.1
Masters	40	62.5
PhD	15	23.4
Institution of Affiliation		
Private	55	85.9
Public	9	14.1
Current Clinical Practice Responsibilities		
Yes	47	73.4
No	17	26.6

As shown in Table 1, majority (56.3%) of the participants were female, aged 40 years or older (54.7%), and employed by private institutions (85.9%). The majority (62.5%) held a Master's degree, had over 10 years of teaching experience (42.2%), and maintained current clinical practice responsibilities (73.4%).

Knowledge of Nursing Advocacy Among Baccalaureate Nurse Educators

This data was collected to determine respondents' level of understanding of key nursing advocacy concepts; this was assessed using five dichotomous items, with results summarized in terms of frequencies, and percentages. The results are presented in Table 2.

Table 2

Item-Level Performance on Knowledge of Nursing Advocacy Among Nurse Educators

Statement	Correct (%)	Incorrect (%)
1. The ethical foundation of nursing advocacy involves protecting patients' rights and interests.	95.3	4.7
2. A key component of nursing advocacy is speaking on behalf of patients to safeguard their rights.	93.8	6.3
3. Maintaining a safe and therapeutic care environment includes preventing harm and promoting professional standards.	100.0	0.0
4. A nurse educator's role in policy engagement includes participating in discussions that influence nursing education standards.	100.0	0.0
5. Identifying unmet healthcare needs in the community does not occur without recognizing gaps in services or resources and advocating for action.	98.4	1.6

Note: The correct answer for items (1–5) is "Correct." Percentages may not sum to 100% due to rounding.

As presented in Table 2, all respondents (100.0%) identified how to maintain a safe and therapeutic care environment. Similarly, all respondents (100.0%) identified the nurse educator's role in policy engagement. The majority (98.4%) of respondents identified unmet healthcare needs in the community. Furthermore, the majority (95.3%) recognised the ethical foundation of nursing advocacy. In addition, the majority (93.8%) identified a key component of nursing advocacy.

Nurse Educator Perceived Advocacy Roles

To provide contextual descriptions that supported interpretation of the knowledge findings on nursing advocacy, participants provided open ended narratives to describe their perceived roles as nurse educators/nurses in advocating for students or patients and

provide examples from their experiences. Responses were analysed using conventional content analysis and organised into categories reflecting participants' understanding of advocacy roles. In total, 29 codes were identified from 64 responses. These codes were further summarised and grouped into 3 distinct themes. Table 3 presents the identified categories and representative responses.

Table 3

Content Analysis Matrix of Open-Ended Responses, Codes, and Categories Regarding Nurse Educator Perceived Advocacy Roles

Participant Response	Code	Category
"My role as an advocate for children with albinism in the community: I am advocating for inclusive education for children with albinism in schools." (Participant 4)	Advocacy & Empowerment	Advocacy & Empowerment for Students and Patients
"Everyone deserves the right to quality healthcare, so I always teach my students to stand up for patients since most times patients are too timid..." (Participant 15)	Advocacy & Empowerment	Advocacy & Empowerment for Students and Patients
"Training, Mentoring, Coaching, Research, community Engagement" (Participant 6)	Teaching & Mentorship	Teaching, Mentorship & Professional Development
"Ensuring that students receive enough contact time on ward as paid for or stipulated in the curriculum" (Participant 2)	Teaching & Mentorship	Teaching, Mentorship & Professional Development
"Always remove learning barriers, make sure all the necessary resources are available... and build partnership." (Participant 1)	Environment & Quality Care	Supportive Environment, Collaboration & Quality Care
"To bring awareness to all nurses the realistic importance in patients advocacy and the role in creating a therapeutic environment..." (Participant 14)	Environment & Quality Care	Supportive Environment, Collaboration & Quality Care
"I had to seek the social worker and the nutritionist to advocate for considerations of the nutritional needs of the baby." (Participant 13)	Environment & Quality Care	Supportive Environment, Collaboration & Quality Care

The high knowledge scores were supported by participants' descriptions of advocacy as empowering patients and students, providing mentorship, and promoting quality care.

"Everyone deserves the right to quality healthcare, so I always teach my students to stand up for patients" (Participant 15).

"Training, Mentoring, Coaching, Research, community Engagement" (Participant 6).

"Always remove learning barriers, make sure all the necessary resources are available" (Participant 1).

Practice of Nursing Advocacy among Baccalaureate Nurse Educators

This data was collected to assess the extent of nursing advocacy practice among baccalaureate nurse educators. This analysis aligns with the study objective of determining the level of engagement in advocacy-related activities within teaching and professional practice. Table 4 presents the distribution of responses on nursing advocacy practice, as measured across key domains of advocacy engagement.

Table 4*Item-Level Advocacy Practice Performance Among Nurse Educators*

Item	Never %	Rarely %	Sometimes %	Often %	Always %
1. I regularly discuss advocacy in my teaching	0.0	4.7	23.4	32.8	39.1
2. I role-model advocacy in clinical or classroom settings.	0.0	6.3	28.1	25.0	40.6
3. I support students in raising ethical or academic concerns.	0.0	3.1	9.4	29.7	57.8
4. I intervene when I observe patients' rights being violated.	0.0	1.6	23.4	23.4	51.6
5. I encourage students to speak up for patients in clinical practice.	0.0	1.6	6.3	35.9	56.3
6. I advocate for safe and therapeutic working environments.	0.0	0.0	1.6	39.1	59.4
7. I participate in identifying and addressing unmet healthcare needs in the community.	0.0	9.4	20.3	48.4	21.9
8. I engage in coalition-building or	1.6	6.3	31.3	40.6	20.3
9. collaborations to promote nursing issues.					
10. I take part in institutional or national policy development activities.	7.8	18.8	28.1	23.4	21.9
11. I mentor junior nurses and students to develop advocacy skills.	0.0	1.6	12.5	25	60.9
12. I use data or research evidence to support advocacy initiatives.	3.1	6.3	26.6	39.1	25.0
13. I promote actions that address social determinants of health in my teaching or practice.	0.0	3.1	15.6	29.7	51.6

As shown in Table 4, the majority (60.9%) of participants always mentored junior nurses and students to develop advocacy skills, advocated for safe and therapeutic working environments (59.4%), and supported students in raising ethical or academic

concerns (57.8%). The majority (56.3%) always encouraged students to speak up for patients in clinical practice. In contrast, broader advocacy activities were most commonly reported as occurring often, including identifying unmet healthcare needs in the community (48.4%), engaging in coalition-building or collaborations (40.6%), and using research evidence to support advocacy initiatives (39.1%). Participation in institutional or national policy development activities was least frequently reported (23.4%).

Participant Responses Regarding Advocacy Actions

Participants provided brief, open-ended descriptions of their advocacy practice actions. Responses were analysed using conventional content analysis and organised into categories reflecting participants' responses of advocacy actions in teaching and clinical settings. In total, 21 codes were identified from 64 responses. These codes were summarised and grouped further to create 3 distinct themes. Table 5 presents the identified categories and representative responses.

Table 5*Content Analysis Matrix of Participant Responses Regarding Advocacy Actions*

Participant Response	Code	Category
"When a situation arises that compromises student learning, patient safety, or professional standards, immediate assessment of the issue is undertaken." (Participant 3)	Situational Assessment & Advocacy Judgement	Initial Situational Assessment and Subsequent Choices to Undertake Advocacy Actions
"Have a one to one correspondence with the affected or concerned individuals, brainstorm on possible causes so as to get informed decisions and solutions. Never hurry to judge but clearly understand the situation" (Participant 2)	Situational Assessment & Advocacy Judgement	Initial Situational Assessment and Subsequent Choices to Undertake Advocacy Actions
"If patient safety is at risk, I intervene directly and respectfully to prevent harm while maintaining the dignity of the student or staff involved." (Participant 5)	Direct Advocacy Interventions	Direct Advocacy Interventions for Student and Patient Protection
"I report to my senior, or else advise the students to approach their elders/representatives to make their concerns heard." (Participant 4)	Direct Advocacy Interventions	Direct Advocacy Interventions for Student and Patient Protection
"Address it immediately, I ensure safe environment, I educate, I hold debrief and incidence meetings to ensure learning and do escalate if need be!" (Participant 1)	Regulatory & Preventive Actions	Regulatory and Preventive Actions for Strategic Student and Client Advocacy
"At Mulago National Referral Hospital, patient safety is my first priority. I immediately assess the level of risk, intervene to prevent harm, and escalate concerns to the in-house intensivist using clear communication (e.g., SBAR)." (Participant 6)	Regulatory & Preventive Actions	Regulatory and Preventive Actions for Strategic Student and Client Advocacy

The advocacy practice findings were supported by participants' reports of assessing situations, intervening to prevent harm, and promoting safe environments.

"If patient safety is at risk, I intervene directly and respectfully to prevent harm"
(Participant 5).

"Immediate assessment of the issue is undertaken" (Participant 3).

"Address it immediately, I ensure safe environment, I educate, I hold debrief and incidence meetings" (Participant 1).

Relationship Between Knowledge and Practice of Nursing Advocacy Among Baccalaureate Nurse Educators.

A Pearson correlation analysis was conducted to determine the strength and direction of the association between knowledge and practice of nursing advocacy among baccalaureate nurse educators, and the findings are presented in Table 6.

Table 6

Pearson Correlation Between Knowledge and Practice of Nursing Advocacy Among Baccalaureate Nurse Educators

Variables	<i>r</i>	<i>p</i>
Knowledge and Advocacy Practice	.02	.878

Note. *r* = Pearson correlation coefficient; *p* = significance level (two-tailed).

As shown in Table 6, the relationship between knowledge and practice was not statistically significant, $r(62) = .02, p = .878$

Independent Samples t-test Results Comparing Knowledge and Advocacy Practice by demographic characteristics

Independent samples *t*-tests were used to evaluate differences in advocacy and knowledge scores based on demographic characteristics as shown in Table 7.

Table 7

Independent Samples t-test Comparing Knowledge and Advocacy Practice by Demographic Characteristics

Category	Knowledge of Nursing		Advocacy Practice		<i>t(df)</i>	<i>P</i>
	(<i>M</i>)	(<i>SD</i>)	(<i>M</i>)	(<i>SD</i>)		
Institution of Affiliation						
Public	95.56	8.82	2.93	0.420	-1.16(62)	.252
Private	97.82	6.29	3.13	0.489	-0.94(62)	.349
Clinical Practice						
With	4.89	0.31	39.45	6.00	-0.74(62)	.462
Clinical Practice Without clinical practice	4.82	0.939	33.24	6.74	3.54(62)	.001*
Gender						
Male					0.38 (62)	.709
Female					0.83(62)	.409

Note. *M* = mean; *SD* = standard deviation; *t* = independent samples *t*-test; *df* = degrees of freedom; *p* = significance level (two-tailed).

As shown in Table 7, educators from public institutions ($M = 95.56$, $SD = 8.82$) and private institutions ($M = 97.82$, $SD = 6.29$) reported comparable knowledge scores, with no statistically significant difference, $t(62) = -1.16$, $p = .252$. Similarly, advocacy practice scores did not differ significantly between educators from public institutions ($M = 2.93$, $+SD = 0.42$) and private institutions ($M = 3.13$, $SD = 0.49$), $t(62) = -0.94$, $p = .349$.

Educators with current clinical practice ($M = 4.89$, $SD = 0.31$) and those without clinical practice ($M = 4.82$, $SD = 0.39$) also demonstrated similar knowledge scores, $t(62) = -0.74$, $p = .462$. However, educators engaged in clinical practice reported significantly

higher advocacy practice scores ($M = 39.45$, $SD = 6.00$) than those without clinical practice ($M = 33.24$, $SD = 6.74$), $t(62) = -3.54$, $p = .001$. Open-ended responses supported this finding, with participants describing active patient advocacy and student mentorship during clinical work. Gender did not significantly influence knowledge of nursing advocacy, $t(62) = 0.38$, $p = .709$, or advocacy practice, $t(62) = -0.83$, $p = .409$.

One-Way ANOVA Comparing Knowledge and Advocacy Practice by Demographic Characteristics.

A one-way analysis of variance (ANOVA) was used to evaluate the impact of demographic characteristics on advocacy and knowledge. The resulting descriptive statistics and significance levels are summarized in Table 8.

Table 8

One Way Anova Comparing Knowledge and Advocacy Practice by Demographic Characteristics

Category	<i>F</i>	Knowledge of Nursing Advocacy		Advocacy Practice		<i>P</i>
		(<i>M</i>)	(<i>SD</i>)	(<i>M</i>)	(<i>SD</i>)	
Years of Experience						
<1	6	4.83	0.41	40.67	7.09	
1–5	14	4.93	0.27	38.57	9.86	
6–10	17	5.00	0.00	37.71	5.46	
>10	27	4.78	0.42	36.81	5.51	.161/.615
Age						
20-29	4	100.00	0.00	42.50	3.42	
30-39	26	98.46	5.44	38.00	7.85	
40 and above	34	96.47	7.74	37.09	5.99	.390/.314
Level of Qualification						
Bachelors	9	4.89	0.33	35.33	9.17	
Masters	40	4.88	0.34	38.90	6.57	
Phd	15	4.87	0.35	36.33	5.18	.988/.228

Note. *f* = frequency; *M* = mean; *SD* = standard deviation; *p* = significance value obtained from one-way analysis of variance

(ANOVA).

As shown in Table 8, advocacy practice across levels of qualification, there was no statistically significant difference among participants with Bachelor's ($M = 35.33$, $SD = 9.17$), Master's ($M = 38.90$, $SD = 6.57$), and PhD qualifications ($M = 36.33$, $SD =$

5.18), $p = .228$. Similarly, there was no statistically significant difference in knowledge scores across Bachelor's ($M = 4.89$, $SD = 0.33$), Master's ($M = 4.88$, $SD = 0.34$), and PhD participants ($M = 4.87$, $SD = 0.35$), $p = .988$.

Across years of experience, advocacy practice did not differ significantly among participants with less than 1 year ($M = 40.67$, $SD = 7.09$), 1–5 years ($M = 38.57$, $SD = 9.86$), 6–10 years ($M = 37.71$, $SD = 5.46$), and more than 10 years of experience ($M = 36.81$, $SD = 5.51$), $p = .615$. Similarly, knowledge scores did not differ significantly among participants with less than 1 year ($M = 4.83$, $SD = 0.41$), 1–5 years ($M = 4.93$, $SD = 0.27$), 6–10 years ($M = 5.00$, $SD = 0.00$), and more than 10 years of experience ($M = 4.78$, $SD = 0.42$), $p = .161$.

Across age groups, advocacy practice did not differ significantly among participants aged 20–29 years ($M = 42.50$, $SD = 3.42$), 30–39 years ($M = 38.00$, $SD = 7.85$), and 40 years and above ($M = 37.09$, $SD = 5.99$), $p = .314$. Similarly, knowledge scores did not differ significantly among participants aged 20–29 years ($M = 100.00$, $SD = 0.00$), 30–39 years ($M = 98.46$, $SD = 5.44$), and 40 years and above ($M = 96.47$, $SD = 7.74$), $p = .390$.

Summary

Chapter four presented the results of the study in relation to the study objectives on knowledge and practice of nursing advocacy among baccalaureate nurse educators in Uganda. The findings indicated that while knowledge of nursing advocacy was uniformly high, nurse educators who were actively engaged in clinical practice demonstrated significantly higher advocacy practice than those without clinical roles. Chapter Five presents the discussion, conclusions, implications, recommendations, and areas for future research.

Chapter Five: Discussion, Conclusions, and Recommendations

This chapter interprets the findings of the study in relation to the study objectives, conceptual framework, the Sessler Branden Advocacy Theory, and existing empirical literature on nursing advocacy among baccalaureate nurse educators. The study described the level of knowledge and advocacy practice among nurse educators, explored the relationship between knowledge and advocacy practice, and assessed the influence of selected demographic characteristics.

The findings demonstrated high levels of knowledge of nursing advocacy among the participants, whereas advocacy practice varied across advocacy domains and contextual conditions. Clinical practice engagement emerged as an important factor influencing advocacy practice, while knowledge levels remained relatively consistent across demographic and institutional categories. The study further identified a weak, non-significant relationship between knowledge and advocacy practice, suggesting that knowledge alone may not sufficiently explain advocacy behavior.

This chapter moves beyond the presentation of results to interpret the observed patterns, compare them with existing literature, and explain possible contextual influences affecting advocacy practice. The discussion is organised according to the study objectives and examines knowledge of nursing advocacy, advocacy practice, the knowledge–practice relationship, demographic and institutional influences, and the role of clinical practice engagement. The chapter concludes with the study implications, conclusions, recommendations, limitations, and areas for future research.

Discussion of Findings

The discussion is organized according to the study objectives and guided by the conceptual framework, which proposed that knowledge of nursing advocacy influences advocacy practice, while internal and environmental conditions mediate this relationship.

The findings are interpreted within the context of the Sessler Branden Advocacy Theory and existing literature.

Knowledge of Nursing Advocacy

The findings demonstrated that baccalaureate nurse educators possessed a very high level of knowledge of nursing advocacy. The majority correctly identified the ethical foundation of advocacy, components of advocacy practice, the nurse educator's role in policy engagement, safe and therapeutic care environments, and the identification of unmet community health needs. The limited variability in knowledge scores further showed a relatively consistent understanding of advocacy concepts among participants.

The findings align with the theoretical frameworks of Abbasinia et al. (2020) and Nsiah et al. (2019), who characterize patient advocacy as a core, constitutive element of nursing identity and professional responsibility." Similarly, Heck et al. (2022) argue that contemporary nursing education increasingly equips nurses with ethical, legal, and professional competencies necessary for advocacy.

Participants' descriptions of their perceived roles in nursing advocacy further supported this strong knowledge foundation. Most participants identified teaching, mentorship, and professional development as their main advocacy role, which directly aligns with the high frequency of educators who reported always mentoring junior nurses and students. Additionally, participants described their role in terms of advocacy and empowerment of students and patients. This qualitative emphasis directly explains the high quantitative metrics showing that participants consistently support students in raising concerns, encourage students to speak up for patients, and intervene when rights are violated.

Furthermore, participants emphasized promoting a supportive environment, collaboration, and quality patient care. This priority manifests in their everyday practices, where the vast majority always advocate for safe and therapeutic working environments

and actively promote actions addressing social determinants of health. Collectively, these responses demonstrate that educators translate their theoretical knowledge into concrete, localized actions within the learning and clinical environments.

From the perspective of the Sessler Branden Advocacy Theory, the observed high knowledge levels reflect strong internal foundational conditions, including ethical awareness, professional values, and recognition of advocacy responsibilities. Participants appeared to understand advocacy roles related to patient protection, promotion of safe environments, equity in healthcare access, and policy involvement.

Despite these high knowledge levels, the findings showed minimal differences across demographic and institutional groups. This suggests that knowledge alone may not adequately explain variations in advocacy behavior. Curtis et al. (2011) similarly argue that knowledge serves as an important prerequisite for advocacy but does not automatically translate into practice. The conceptual framework therefore remains relevant in demonstrating that knowledge requires interaction with contextual and motivational factors before influencing advocacy behaviour.

Practice of Nursing Advocacy

The findings showed moderate to high levels of advocacy practice among nurse educators; however, practice varied across specific advocacy activities. Participants reported higher engagement in advocating for safe and therapeutic environments, encouraging students to speak up for patients, supporting students in ethical concerns, mentoring learners, and promoting actions addressing social determinants of health. In contrast, lower engagement was observed in policy participation and coalition-building activities. These findings are consistent with Vaartio et al. (2006) and Laari and Duma (2021), who reported that nurses generally understand advocacy principles but experience challenges in translating them consistently into practice.

According to the Sessler Branden Advocacy Theory, advocacy practice represents the enactment phase in which individuals recognize needs, formulate actions, and pursue advocacy outcomes. The variability observed across advocacy domains therefore suggests differences in external foundational conditions, including institutional support, workload demands, policy exposure, professional autonomy, and availability of advocacy opportunities.

Open-ended responses on participants' advocacy practices further reinforced these findings. Most participants reported direct advocacy interventions as their primary response to compromised learning and patient safety. Additionally, participants reported regular preventive actions in such circumstances. Furthermore, participants indicated situational assessment and advocacy judgement as their main advocacy actions. These responses align with the theory's core actions of promote, facilitate and empower", particularly in clinical contexts where participants described direct advocacy activities such as addressing unsafe practices, escalating patient concerns, protecting patient rights, and responding to unmet needs. Conversely, participants without clinical engagement mainly described advocacy through classroom teaching, ethical discussions, and instructional support. These difference highlight the contextual nature of advocacy and demonstrate that opportunity and role engagement influence advocacy enactment as posited by the Sessler Branden Advocacy Theory.

Knowledge–Practice Relationship

The findings revealed no statistically significant relationship between knowledge and advocacy practice, indicating that increased knowledge did not necessarily correspond with increased advocacy engagement. This finding contrasts with studies reporting positive knowledge–practice associations but supports the knowledge–practice gap described by Curtis et al. (2011).

Within the Ugandan context, this gap may reflect contextual barriers that influence advocacy implementation despite adequate knowledge. The Sessler Branden Advocacy Theory assumes that advocacy decisions emerge from interactions between knowledge and environmental conditions such as institutional support, professional autonomy, clinical exposure, and organizational culture.

This interpretation is supported by Munabi-Babigumira et al. (2020), who observed that structural barriers and policy limitations may reduce advocacy participation despite adequate professional preparation, particularly in low- and middle-income settings. Open-ended responses further supported this observation. Participants indicated that advocacy implementation depended on opportunities for direct engagement, access to clinical settings, and role expectations. These findings therefore strengthen the conceptual proposition that foundational conditions mediate the conversion of knowledge into advocacy behaviour.

Demographic and Institutional Factors

The findings showed that demographic and institutional characteristics had limited influence on knowledge and advocacy practice. Knowledge and practice scores remained relatively similar across institution type, gender, age groups, level of qualification, and years of experience. These findings agree with Akin and Kursun (2020) and Woodward et al. (2016), who stated that advocacy behavior is shaped more strongly by contextual influences than by demographic characteristics alone.

The similarity across institutional and academic categories may reflect the effect of standardized nursing curricula, professional regulations, and common educational expectations among nurse educators. This suggests that strengthening advocacy practice may require greater emphasis on institutional culture, organizational support systems, and practice environments rather than focusing solely on demographic differences.

Clinical Practice Engagement

Clinical engagement emerged as the most influential factor affecting advocacy practice. Educators actively involved in clinical practice reported significantly higher advocacy practice scores than those without clinical roles, although knowledge levels remained comparable between groups. This finding supports experiential learning principles and aligns with Peltzer et al. (2016), who emphasize that advocacy competencies develop through direct practice experiences and repeated engagement in clinical situations.

Within the Sessler Branden Advocacy Theory, clinical exposure provides the environmental conditions necessary to activate advocacy decisions and actions. Participants engaged in clinical practice described identifying risks, escalating concerns, protecting patient safety, addressing unmet needs, and collaborating with multidisciplinary teams. These activities correspond directly with the theory's advocacy processes of identifying needs, planning interventions, and achieving advocacy outcomes.

In contrast, educators without active clinical roles primarily described advocacy in educational and advisory terms rather than direct action. Similar observations were reported by Staebler et al. (2017) and Akin and Kursun (2020), who noted that educators lacking clinical engagement may conceptualize advocacy more theoretically than practically. The findings therefore emphasize the importance of sustained clinical involvement, experiential exposure, and role modelling in strengthening advocacy practice among nurse educators.

Conclusions

The study concludes that baccalaureate nurse educators possessed very high knowledge of nursing advocacy; however, advocacy practice varied across domains and was not directly influenced by knowledge alone. The absence of a significant

knowledge–practice relationship confirmed the presence of a knowledge–practice gap and highlighted the mediating role of contextual conditions. Clinical engagement emerged as the strongest determinant of advocacy practice, demonstrating that experiential exposure and real-world interaction play an important role in translating knowledge into advocacy behaviour.

Implications

The findings have implications for nursing education, institutional leadership, and professional regulation. Nursing programmes should move beyond theoretical advocacy instruction and strengthen experiential learning, simulation activities, role modelling, and clinical exposure. Institutions should establish supportive environments that encourage advocacy participation, protect professionals who raise concerns, and increase opportunities for policy engagement and leadership involvement. Professional regulators may also strengthen continuing professional development requirements by emphasizing practical advocacy competencies and clinical application.

Recommendations

Promote continued clinical engagement among nurse educators. Academic institutions should encourage and support faculty members in maintaining active clinical practice or clinical oversight to ensure their practical advocacy experiences remain current and directly applicable to classroom teaching.

Establish institutional mentorship systems and protected opportunities. Health care organizations and academic institutions should design formal mentorship frameworks alongside protected time, ensuring nurses and educators have the dedicated availability required for meaningful advocacy and policy participation.

Enhance organizational cultures that support advocacy and interdisciplinary collaboration. Leadership within both clinical and academic sectors must actively foster

open, collaborative workplace environments that validate nursing advocacy and promote seamless interdisciplinary teamwork.

Limitations

The study was limited by possible ceiling effects in knowledge assessment, the use of self-reported measures, and the cross-sectional design, which restricted causal interpretation.

Future Research

Future studies should examine institutional and cultural barriers influencing advocacy practice, explore longitudinal relationships between knowledge and practice, and evaluate interventions aimed at strengthening practical advocacy competencies among nurse educators.

Summary

Chapter Five discussed the study findings in relation to existing literature and the Sessler Branden Advocacy Theory. The chapter highlighted that despite high knowledge of nursing advocacy among baccalaureate nurse educators, effective advocacy practice was significantly influenced by engagement in clinical practice rather than knowledge alone. The chapter concluded with implications, recommendations, limitations, and directions for future research.

References

- Abbasinia, M., Ahmadi, F. & Kazemnejad, A. (2020). Patient advocacy in nursing: A concept analysis. *Nursing Ethics*, 27 (1), 141-151. Doi 10.1177/0969733019832950.
- Abualrub, F. R., & Foudeh, N. F. (2016). Jordanian Nurses' involvement in health policy: perceived benefits and barriers. *International Nursing Review*.
<https://doi.org/10.1111/inr.12249>
- Akin, B., & Kursun, S. (2020). Perception and opinion of nursing faculties regarding advocacy role: A qualitative research. *Nursing Forum*, 55(4): 637-644.
Doi:10.1111/nuf.12480
- American Nurses Association California. (2023, April 3). *Nursing advocacy success stories*. <https://www.anacalifornia.org/post/advocacy-success-stories>.
- Arabi, A., Rafii, F., Cheraghi, M. A. & Ghiyasvandian, S. (2014). Nurses' policy influence: A concept analysis. *Iranian journal of nursing and midwifery research*, 19(3), 315–322.
- Atuheire, C., & Nakate, G. (2023). *Preparedness of nurse educators for policy engagement in East Africa: A cross-sectional analysis*. *African Journal of Health Professions Education*, 15(2), 85–92. <https://doi.org/10.7196/AJHPE.2023.v15i2.1461>
- Boone, H. N., & Boone, D. A. (2012). Analyzing likert data. *Journal of Extension*.
<https://open.clemson.edu/joe/vol50/iss2/2/>
- Canadian Nurses Association. (2024). *Help shape the future of nursing in Canada*.
<https://www.cna-aiic.ca/en/policy-advocacy/advocacy-priorities>.
- Cropley, S., Hughes, M., & Belcik, K. (2025). Qualitative analysis of integrated curricular strategy to develop health policy advocacy. *Nurse Educator*, 50 (1), 46-50. <https://doi.org/10.101097/NNE.0000000000001715>
- Demiroren, N., & Akin, B. (2022). Impact of education on student nurses' advocacy and ethical sensitivity. *Nursing Ethics*, 29 (4), 899-914.

Dolinta, J. (2022, August 24). *Nursing through the lens of political advocacy*.

<https://nursology.net/2022/08/23/nursing-through-the-lens-of-political-advocacy/>

Gandra, Elen, C., da Silva & Kenia, L. (2023). *Teaching strategies for health advocacy for undergraduate nursing students: A scoping review*. Nursing Education Perspectives. 44(2), 92-97. Doi:10.1097/01.NEP.0000000000001085.

Fulton, J., S. (2022). Using our voice. *Clinical nurse specialist*. 36(1):5-6.

DOI:10.1097/NUR.0000000000000652

Heck, L. O., Carrara, B. S., Mendes, I. A. C. & Ventura, C. A. (2022). Nursing and advocacy in health. An integrative review. *Nursing Ethics*, 29 (4), 1014-1034.

Doi:10.117/09697330211062981

Juma, A. P, Edwards, N. & Spitzer, D. (2014). Kenyan nurses' involvement in national policy development processes. *Nursing Research and Practice*.

<https://dx.doi.org/10.1155/2014/236573>

Laari, L., & Duma, S. E. (2021). Facilitators of the health advocacy role practice of the nurse in Ghana: A qualitative study. *Health science reports*, 4(1), e220.

<https://doi.org/10.1002/hsr2.220>

McMillan, K., & Perron, A. (2020). Nurses' engagement with power, voice and politics amidst restructuring efforts. *Nurs Inq*. 27, e12345. <https://10.1111/nin.12345>

Ministry of Health. (2022). Scope of practice for nurses and midwives in uganda.

www.unmc.ug

Ministry of Health. (2016). *The first uganda national nursing and midwifery policy (draft)*. Kampala, Uganda: Ministry of Health, Nursing Department.

Munabi-Babigumira, S., Glenton, C., Lewin, S., Nabudere, H., & de Vries, D. H. (2020).

Policy and practice barriers to nurse involvement in health policy development in low- and middle-income countries: A qualitative synthesis. BMC Nursing, 19(1), 1–

12. <https://doi.org/10.1186/s12912-020-00456-1>

- Nsiah, C., Siakwa, M., & Ninnoni, J. P. K. (2019). Registered nurses' description of patient advocacy in the clinical setting. *Nursing open*, 6(3), 1124-1132.
<https://doi.org/10.1002/nop2.307>
- Omair, A. (2016). Selecting the appropriate study design: Case control and cohort designs. *Journal of health specialties*, 4(1), 37-41. <http://www.thejhs.org>
- Omuniyida, E. (2022). *Competence of nurse educators in teaching health policy and advocacy in East Africa*. *Journal of Nursing Education and Practice*, 12(4), 44–53.
<https://doi.org/10.5430/jnep.v12n4p44>
- Peltzer, J. N., Teel, C. S., Frank-Ragan, E., & Nelson-Brantley, H. V. (2016). Strategies for building advocacy skills among undergraduate and graduate nursing students. *The Journal of Nursing Education*, 55(3), 177-181.
<https://doi.org/10.3928/01484834-20160216-11>
- Perry, C., & Emory, J. (2017). Advocacy through education. *Policy, Politics & Nursing Practice*, 18 (3), 158-165. <https://doi.org/10.1177/1527154417734382>
- Salvage, J., & White, J. (2019). Nursing leadership and health policy: Everybody's business. *International Nursing Review*, 66(2), 147-150.
- Sessler, B. P., Shelly, R. & Sandra, H. (2022). Using action research to mentor nursing students in global health advocacy. *Journal of nursing education*. 6(4), 193-196.
DOI:10.3928/01484834-20220209-04
- Staeblet, S., Campbell, J., Cornelius, P., Fallin, B., Amanda, Fly-Bowers, E., Kung, M. Y., LaFevers, D., & Miller, J. (2017). Policy and political advocacy: Comparison study of nursing faculty to determine current practices, perceptions, and barriers to teaching health policy. *Journal of Professional*. 33(5), 311-396.
- Tadie, A., Muche, M., Liknaw, T., and Edmealem, A. (2023). Nurses attitude towards patient advocacy and its associated factor in east gojamm zone, public hospitals, northwest Ethiopia. *BMC Nursing*, 23 (561).

- Teel, C (2016). Strategies for building advocacy skills among undergraduate and graduate nursing students. *The Journal of Nursing Education*.
https://www.academia.edu/84105707/Strategies_for_Building_Advocacy_Skills_Among_Undergraduate_and_Graduate_Nursing_Students
- The Uganda National Academy of Sciences and University of Michigan. (2019). *The future of nursing in uganda. Governing a shared vision*.
https://www.academia.edu/43343052/The_Future_of_Nursing_Education_in_Uganda_A_Workshop_Summary
- Thomas, T., Martsof, G., & Puskar, K. (2020). How to engage nursing students in health policy: Results of a survey assessing students' competencies, experiences, interests, and values. *Policy, Politics, & Nursing Practice* 21 (1) 12-20. <https://doi-org.ezproxy.bethel.edu/10.1177/1527154419891129>
- Uganda Nurses and Midwives Council. (2016). *Continuing professional development framework for nurses and midwives in Uganda*. Ministry of Health, Government of the Republic of Uganda. <https://www.unmc.ug>
- Water, T., Ford, Spence, D & Rasmusse, S. (2016). Patient advocacy by nurses. Past, present and future. *Contemporary Nurse*, 54 (6), 696-709.
<http://dx.doi.org/10.1080/10376178.2016.1235981>.
- Walker, D. K., Barton-Burke, M., Saria, M. G., Gosselin, T., Ireland, A., Norton, V. & Newton, S. (2015). Everyday Advocates. *AJN, American Journal of Nursing*, 115 (8), 66-70. doi: 10.1097/01.NAJ.0000470409.04919.0f.
- Woodward, B., Smart, D., & Benavides-Vaello, S. (2016). Modifiable factors that support political participation by nurses. *Journal of Professional Nursing*, 32(1), 54-61. <https://doi.org/10.1016/j.profnurs.2015.06.005>

Appendix A: Questionnaire

Topic: Relationship Between Knowledge and Practice of Nursing Advocacy Among Baccalaureate Nurse Educators in Uganda

Instructions:

This questionnaire is designed for academic purposes only. Your responses will remain confidential. Please answer all questions honestly.

Section A: Demographic Information

Question	Response Type
1. Age	___ years
2. Gender	☐ Male ☐ Female ☐ Other
3. Highest nursing qualification	☐ Bachelor's ☐ Master's ☐ PhD ☐ Other: _____
4. Years of teaching experience	☐ < 1 ☐ 1–5 ☐ 6–10 ☐ > 10
5. Institution type	☐ Public ☐ Private
6. Do you have current clinical practice responsibilities?	☐ Yes ☐ No

Section B: Knowledge of Nursing Advocacy

Instructions: Each item has one correct answer. Select the best option.

Scoring: Correct answer = 1 point; incorrect answer = 0 points.

7. Which of the following best describes the ethical foundation of nursing advocacy?

- a) Ensuring nurses receive promotions
- b) Protecting patients' rights and interests
- c) Reducing hospital costs
- d) Supporting only institutional policies

☐ a ☐ b ☐ c ☐ d

8. Which statement correctly identifies a key component of nursing advocacy?

- a) Avoiding involvement in patient decisions
- b) Speaking on behalf of patients to safeguard their rights
- c) Delegating advocacy roles to other professionals
- d) Focusing only on clinical tasks

☐ a ☐ b ☐ c ☐ d

9. Which of the following is TRUE about maintaining a safe and therapeutic care environment?

- a) It is optional unless requested by patients
- b) It includes preventing harm and promoting professional standards
- c) It only applies in emergency departments
- d) It is the responsibility of administrators only

☐ a ☐ b ☐ c ☐ d

10. Which option reflects a nurse educator's role in policy engagement?

- a) Ignoring changes in institutional policy
- b) Participating in discussions that influence nursing education standards
- c) Limiting teaching to clinical procedures only
- d) Avoiding collaboration with professional organizations

☐ a ☐ b ☐ c ☐ d

11. Identifying unmet healthcare needs in the community involves:

- a) Waiting for administrators to provide solutions
- b) Recognizing gaps in services or resources and advocating for action
- c) Focusing only on classroom teaching
- d) Leaving community issues to public health workers

☐ a ☐ b ☐ c ☐ d

Section C: Advocacy Practice

Instructions: Select the option that best describes how often you engage in the activity.

Scale: 0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Always

	Statement	0	1	2	3	4
12	I regularly discuss advocacy in my teaching.	☐	☐	☐	☐	☐
14	I role-model advocacy in clinical or classroom settings.	☐	☐	☐	☐	☐
15	I support students in raising ethical or academic concerns.	☐	☐	☐	☐	☐
16	I intervene when I observe patients' rights being violated.	☐	☐	☐	☐	☐
17	I encourage students to speak up for patients in clinical practice.	☐	☐	☐	☐	☐
18	I advocate for safe and therapeutic working environments.	☐	☐	☐	☐	☐
19	I participate in identifying and addressing unmet healthcare needs in the community.	☐	☐	☐	☐	☐

20	I engage in coalition-building or collaborations to promote nursing issues.	☐	☐	☐	☐	☐
21	I take part in institutional or national policy development activities.	☐	☐	☐	☐	☐
22	I mentor junior nurses and students to develop advocacy skills.	☐	☐	☐	☐	☐
23	I use data or research evidence to support advocacy initiatives.	☐	☐	☐	☐	☐
24	I promote actions that address social determinants of health in my teaching or practice.	☐	☐	☐	☐	☐

Section D: Open-Ended Questions

1. In your own words, describe what you believe your role is as a nurse educator/nurse in advocating for students or patients. Please give at least one example from your experience.

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- ..
2. What actions do you take when you notice a situation in your teaching or clinical environment that compromises student learning, patient safety, or professional standards?
-
-

Appendix B: Informed Consent

Title of Study: A Descriptive Correlational Study on the Relationship Between Knowledge and Practice of Nursing Advocacy Among Baccalaureate Nurse Educators in Uganda.

No.	Name of Investigator	Designation	Address/Telephone/E mail	Institution of Affiliation
1	Nuwamanya Isaac	Principal Investigator	0775149865 inuamanya5@gmail.com	Uganda Christian University
2	Dr Sebuliba Faith	Academic supervisor	0779399797 sebulibafaith@gmail.com	Uganda Christian University

1. Introduction and rationale of the Study

You are invited to participate in a research study that aims to examine the relationship between baccalaureate nurse educators' knowledge of nursing advocacy and their engagement in advocacy practices in Central Uganda. Nursing advocacy is an essential professional responsibility that involves protecting patient rights, promoting safe care environments, and contributing to health policy and social justice. Nurse educators play a key role in teaching and modelling these advocacy skills to future nurses.

Rationale

There is limited evidence on how well nurse educators understand and apply advocacy principles in their teaching and professional roles. Understanding their current levels of knowledge and practice will help identify strengths and gaps that may inform curriculum development, continuing professional development programs, and institutional strategies

that support effective advocacy. Your participation will contribute to improving nursing education and strengthening the advocacy capacity of the nursing workforce in Uganda.

2. Description of the Research

This is a descriptive cross-sectional correlational study examining the knowledge and advocacy practices of baccalaureate nurse educators in Central Uganda covering public and private universities offering baccalaureate nursing programs.

3. Participation

The participants are baccalaureate nurse educators currently teaching in public and private universities in Central Uganda. They are being selected because they are directly responsible for preparing undergraduate nursing students and play a key role in teaching and modelling nursing advocacy. Their insights are essential for understanding the current levels of knowledge and engagement in advocacy within nursing education.

4. Potential Risks and Discomforts

This study poses minimal risk to participants. The only potential discomfort may come from responding to questions about your knowledge or advocacy practices, which some individuals may find sensitive or reflective. To minimize this, you are free to skip any question that makes you uncomfortable and may withdraw from the study at any time without any consequences. No harm, penalty, or impact on your employment will result from your decision to participate or withdraw.

5. Potential Benefits

There are no direct personal benefits to you for participating in this study; however, your participation may contribute to several important indirect benefits. The findings may help nursing institutions better understand the current levels of knowledge and engagement in nursing advocacy among baccalaureate nurse educators. This information can guide improvements in teaching methods, curriculum development, and continuing professional development programs that support stronger advocacy skills. The study may also inform

national regulatory bodies such as the National Council for Higher Education and the Uganda Nurses and Midwives Council as they work to strengthen nursing education standards. Overall, the results may contribute to improved advocacy capacity among nurses, better protection of patient rights, enhanced quality of care, and stronger health policies that benefit the wider Ugandan society.

6. Confidentiality

The information you provide will be kept strictly confidential and used only for the purposes of this study. Your name or any identifying details will not be recorded at any point, and nothing you share will be linked back to you in any report or publication. The questionnaire will ask about your knowledge and engagement in nursing advocacy, but if you prefer not to answer a particular question, you may simply decline, and we will not insist. All responses will remain anonymous and securely stored. Every participant will be asked to sign a written informed consent form before taking part in the study to ensure voluntary participation and full understanding of the research.

7. Procedure

You will be asked to complete a self-administered questionnaire about your knowledge and engagement in nursing advocacy. The questionnaire contains both closed-ended and open-ended questions and will be completed in a quiet area within your institution. No physical procedures, injections, or medical interventions are involved. The entire process will take approximately 20–30 minutes.

8. Voluntary Participation

Your decision to participate in this study is completely voluntary. If you decide not to participate in this study, it will not affect your work in any way.

9. Withdrawal from the Study and/or Withdrawal of Authorization

As a participant in this study, you have the full right to withdraw at any time if you choose not to continue. You also have the freedom to decline answering any specific question that makes you uncomfortable without withdrawing from the entire study.

10. Reimbursements

Each participant will receive 20,000 Uganda shillings as reimbursement for their time and participation in the study. This amount is not a salary or payment but a token of appreciation to cover any inconvenience or time spent completing the questionnaire. You will receive this reimbursement whether you choose to answer all questions or decide to withdraw from the study.

11. Whom to contact in case of ethical related concerns.

a) Prior Ethical approvals and permissions.

This study has not received any foreign research ethics approval, as it is being conducted entirely within Uganda and does not involve any international collaboration requiring external review.

b) Local authorities and approvals.

This study was Approved by Uganda Christian University Research Ethics Committee (UCUREC) and cleared by Uganda national Council for Science and Technology (UNCST), In case of any Ethical or your rights related concerns or inquiries, please contact UCU REC

Chairperson; Prof. Peter Waiswa, 0772405357, pwaiswa@musph.ac.ug or UCUREC

Manager, Mr. Osborn Ahimbisibwe, 0775737627 or oahimbisibwe@ucu.ac.ug.

UNCST: Tel; +256 414 705500, info@uncst.go.ug

STATEMENT OF CONSENT

I voluntarily agree to participate in this research program; to tick appropriately.

Yes☐**No**☐

I understand that I will be given a copy of this signed Consent Form.

Name of Participant:

Signature:

Date:

Name of Researcher/designee:

Signature:

Date:

Appendix C: Introductory Letter



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Office of the Vice Chancellor
Research Ethics Committee UG-026



12th January, 2026

NUWAMANYA ISAAC
Uganda Christian University
inuwamanya5@gmail.com
0775 149865



UG-REC-026 APPROVAL NOTICE

To: Nuwamanya Isaac; Principal Investigator

Re: UCU-REC Application titled: *A Descriptive Correlational Study on the Relationship between Knowledge and Practice of Nursing Advocacy among Baccalaureate Nurse Educators in Uganda.*

Application Number: UCUREC-2025-2005

Version: 4.1

Type of Review:

- ☐ INITIAL REVIEW
- ☐ Protocol Amendment
- ☐ Letter of Amendment
- ☐ Continuing Review
- ☐ Material Transfer Agreement
- ☐ Other, Specify:

I am pleased to inform you that the UG-REC-026; UCUREC under expedited review approved the above referenced application.

Approval of the research is for a period from 12th January, 2026 to 12th January, 2027.

This research is considered minimal risk category.

As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and additions to the protocol or the consent form must be submitted to the REC for re-review and approval prior to the activation of the changes. The REC application number assigned to the research should be cited in any correspondence.



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Research Ethics Committee UG-026



3. Reports of unanticipated problems involving risks to participants or other must be submitted to the REC. New information that becomes available which could change the risk: benefit ratio must be submitted promptly for REC review.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by subjects and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Regulations require review of an approved study not less than once per 12-month period. **Therefore, a continuing review application must be submitted to the REC eight weeks prior to the above expiration date of 12th January, 2027 in order to continue the study beyond the approved period.** Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study, at which point new participants may not be enrolled and currently enrolled participants must be taken off the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. Your research details have been shared with the Executive secretary of Uganda National Council for Science and Technology (UNCST) and you are **not** required to get clearance. Refer to UNCST Research registration and clearance Policy and guidelines (July 2016) in Uganda section 6.

The following is the list of all documents approved in this application by UG-REC _026:

No.	Document Title	Language	Version	Version Date
1.	Protocol	English	1.0	2026-01-12
2.	Budget	English	1.0	2026-01-12
3.	Study work plan	English	1.0	2026-01-12
4.	Research Tools	English	1.0	2026-01-12
5.	Informed Consent forms	English	1.0	2026-01-12

Signed and Stamped

Prof. Peter Waiswa
UCUREC Chairperson
pwaiswa@musph.ac.ug

