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Reflecting on Leadership Development through Community Based Participatory Action Research

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Abstract:
The need for leadership in nursing is well-documented and Domain Six of the doctoral section of the National Nursing Education Framework of the Canadian Association of Schools of Nursing (CASN) is Leadership. While there are likely many paths to achievement of these leadership components, the intent of this paper is to share my journey through iteration of and reflection on my PhD dissertation research focused on a four-cycle community-based participatory action research study (CBPR) related to clinical teaching in Ghana. The focus of CBPR is to engage the researcher and the participant group (community) in collaborative, and egalitarian processes to assess and problem solve an issue in the community. Similarly, leadership promotes collaborative interpersonal relationships among leaders and followers to address issues and institutes change strategies in policies. This paper presents my experiences in building leadership capacity through this scholarly endeavor (PhD thesis) in relation to the CASN guideline.

Keywords: community-based participatory action research, Ghana, leadership, nursing education

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The need for leadership in nursing is well-documented (Cummings et al., 2018; Scully, 2015) and Domain Six of the doctoral section of the *National Nursing Education Framework* of the Canadian Association of Schools (CASN, 2015) is Leadership. The guiding principle states: "Programs prepare graduates to be leaders in advancing the discipline of nursing" (p. 17). Three essential components that PhD graduates should demonstrate are identified as:

– Leadership through scholarly inquiry and the scholarship of discovery, integration, application and teaching.

– Leadership in the development, implementation, knowledge translation and mobilization of an intra/interdisciplinary program of research.

– Leadership in building scholarly capacity, policy development, and creating change within organizational systems.

What is not provided are guidelines as to how these goals may be achieved in a doctoral program in nursing. While there are likely many paths to achievement of these leadership components, the intent of this paper is to share my journey through iteration of and reflection on my PhD dissertation research that involved the development and implementation of a four-cycle community-based participatory action research study (CBPR) related to clinical teaching in nursing education in Ghana. It was as I reflected on what I had learned after the completion of Cycle Three that I realized the connection between CBPR and capacity building for leadership. In this paper my experiences are preceded by brief reviews of literature pertaining to CBPR, leadership, and the connections between them in building leadership capacity.

Community-based participatory action research

Community-based participatory action research (CBPR) is a research process that engages the researcher and stakeholders or representatives from the participant group (community) in collaborative, egalitarian, and partnership processes to assess and problem solve an issue that, in ideal circumstances, is chosen by the community (Bomar, 2010; Caine & Mill, 2016; Oetzel et al., 2018). The term "community" in this case may not refer to a suburb or a neighborhood but rather a community of interest or a unit of identity with shared values or common

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symbol system that is identified by the target group in collaboration with researchers (Bomar, 2010; Collins et al., 2018). Features of CBPR include: the centrality of community to the research; a commitment to changing the balance of power by the researcher; a different role for the researcher from that in traditional forms of research; active participation of participants in all stages of the research process; production of useful knowledge; and, a commitment to action (Northway, 2010; Oetzel et al., 2018). The community is placed at the heart of the research rather than the researcher or the research question which the community seeks to address.

Participatory research often involves engaging communities whose voices have been marginalized or who have experienced a form of oppression (Caine & Mill, 2016; Lakes & Wendland, 2018). Examples of such groups are people with learning disabilities and mental health problems (Northway, 2010). Healthcare professionals, nurses in particular, are also viewed as people whose voices have been marginalized (lacking a voice) in the healthcare community (Caine & Mill, 2016; Holmes & Gastaldo, 2002). Northway (2010) explained further that communities could be geographically bounded (a group of people living in one locality) or geographically dispersed (a group of people living in different localities but who share a common identity or interest) and cautioned that group members in the community may have different views as to the best way to address issues. These different views need to be carefully addressed within the research system. Similarly, there could be repercussions in terms of power dynamics within the community where the research is being undertaken (Caine & Mill, 2016; Israel et al., 2010; Oetzel et al., 2018). For instance, local leaders or chairs of local action groups or patient groups are often chosen to facilitate activities in the research process. There is the risk of marginalizing people who are not opinion leaders or chairs of the group (Northway, 2010). It is therefore important that participatory action researchers pay attention to the voices of both leaders and members within the community.

The primary difference between CBPR and other research methods lies in the power relations within the research process. In traditional research, the researcher is considered to be a powerful expert. This can be disempowering for participants who are assigned to play a passive role in the research process (Caine & Mill, 2016). On the other hand, CBPR seeks to challenge this type of power (Lake & Wendland, 2018; Northway, 2010; Oetzel et al., 2018). One of the aims of CBPR is to recognize power dynamics and to use these to explore ways to empower community members to effect change (Israel et al., 2010; Northway, 2010; Oetzel et al., 2018; Collins et al., 2018). In traditional research, researchers are expected to play an objective role by separating themselves from the research process (Northway, 2010). In CBPR, however, researchers are expected to be committed participants. It is important to note that CBPR is an educational process and as the researcher and the community work together they all, including the researcher, become educated through the process (Northway, 2010; Oetzel et al., 2018). The researcher has expertise about the topic and the research process but the community members are the experts about their social situation (the context).

Participants are involved in decision making in all the stages of the CBPR research process. Community involvement is needed during the definition of research questions to be addressed (Lake & Wendland, 2018; Northway, 2010). Participants are invited to take an active part in designing the research process, seeking ethical approval, securing funding, implementing the research design, analyzing the research data, reporting the research findings/interpretations and acting on the research results, although an analysis of four case studies revealed that community partners appear to be less frequently involved in data analysis and interpretation than in other research activities (Cashman et al., 2008; Collins et al., 2018). To promote the involvement of all participants in data analysis and interpretation in all phases of the study, six strategies are suggested: open dialogue and consensus regarding participants' specific roles in data analysis and interpretation; use of participants' prior experiences in research endeavors; engagement of community members in an explicit iterative experience; simplification of the data to aid understanding (for example, having trained academics to take the first step in structuring data analysis, while the community members contribute by sharing insights into realities reflected in the raw data); a longer time-line for the study; and, use of experiential learning approaches to engage all partners in data analysis and interpretation of findings (Cashman et al., 2008; Collins et al., 2018; Oetzel et al., 2018). While roles of community members and academic partners are different, they are complementary. Involving participants in all the stages of the research process enriches the interpretation of findings of the study. Such strategies are likely to promote participants' sustained involvement as "active participation is seen as the gateway into a CBPR project, whereas knowledge attainment and power are the stimuli for continuing participation" (Van der Velde, Williamson, & Ogilvie, 2009, p. 1293).

Information gathered in the CBPR process often has practical application in the day to day lives of participant. Three types of knowledge have been identified: instrumental knowledge, relational knowledge and critical knowledge (Northway, 2010). Instrumental knowledge is technical knowledge used to control the physical environment. This type of knowledge is usually produced by traditional research. Relational knowledge is acquired from interaction with and learning from people. Critical knowledge is acquired from critical reflection and action. All of these knowledge types are generated in CBPR and one should not be viewed as more valuable than another. For example, interviewing increases awareness of an issue through listening (relational knowl-

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edge). Information may be gained about an intervention such as techniques of taking medication (instrumental knowledge). Finally, reflection is fostered about the need for change (critical thinking) (Northway, 2010).

While the primary focus on traditional research is to test hypotheses, CBPR seeks to provide the community with knowledge and tools that bring about social change (Caine & Mill, 2016; Lake & Wendland, 2018; Northway, 2010). Action can be undertaken in different forms. It can take the form of health promotion initiatives valuable to community members or development of theatre or other art-based representations to create awareness of issues in the community (Northway, 2010; Ward et al., 2018).

Therefore, CBPR is focused on active engagement of the people in a community in a research process that provides an enabling ethos for all-inclusive decision making to facilitate changes for enhancing achievement of goals identified by the community. The collaborative processes in CBPR promote leadership.

Leadership

Leadership is manifested in our day to day lives and practices. Leadership is a necessary component of identifying, planning and implementing change strategies, as well as in effecting change policies (Al-Yami, Galdas, & Watson, 2018; Cummings, 2012). There is a proliferation of definitions of leadership and leadership theories. Thus, leadership is perceived as "being able to see the present for what it really is, see the future for what it could be and then take action to close the gap between today's reality and the preferred future of tomorrow" (Cummings, 2012, p. 3325). It is processual in nature (Tourish, 2014), has a vision for future change (Cummings, 2012; Gandolfi & Stone, 2018) reflects a collaborative endeavor (Iachini et al., 2019; Scully, 2015) that promotes good interpersonal relationships among leaders and followers, influences collective achievement of set goals (Cummings et al., 2018; Wolinski, 2010), and develops through nurturing of experience in practice and educational endeavour (Canadian Association of Schools of Nursing [CASN], 2015; Cumming et al., 2008; Iachini et al., 2019).

Leadership theories are evolving continuously. Early leadership theories included great man theory, trait theory, and situational theory (Gandolfi & Stone, 2018; Scully, 2015; Wolinski, 2010). More recently, skills theories such as path-goal, transactional, servant, transformational and charismatic leadership reject the earlier leadership theories and hold that leadership is learned, developed, and acquired through knowledge (Boamah & Tremblay, 2018; Cummings, 2012; Gandolfi & Stone, 2018; Scully, 2015; Skendzel, Holtan, & Finch-Guthrie, 2019; Sylvester, 2018; Wolinski, 2010). Thus, skills theory is congruent with recent work on the importance of leadership development through education and experience in practice (Al-Yami et al., 2018; , 2015; Cummings et al., 2008; Scully, 2015). The path-goal leadership theory lays emphasis on the importance of motivating or developing followers (Skendzel et al., 2019; Wolinski, 2010). Similarly, transactional theory focuses on exchanges that take place between leaders and followers with clear laid down expectations to follow a "status quo" like in management theory (Boamah & Tremblay, 2018; Scully, 2015; Wolinski, 2010). Currently, in nursing practice there is a paradigm shift in scholarly focus from management to leadership (Cummings et al., 2018; Fernandes, Araújo, & Pereira, 2018; Grossman & Valiga, 2017; Scully, 2015).

Contemporary theories of leadership mentioned in the literature as appropriate for nursing practice include resonance, shared, and transformational leadership (Boamah & Tremblay, 2018; Cummings et al., 2008, 2018; Fischer, Horak, & Kelly, 2018; Registered Nurses Association of Ontario (RNAO), 2013; Scully, 2015). Resonant leaders are expected to possess an attribute of emotional intelligence and knowledge of contemporary issues in nursing, as well as sociopolitical relationships in the workplace (Laschinger, Wong, Cummings, & Grau, 2014; Scully, 2015). Shared leadership allows for sharing or distribution of activities among members of a team to address the needs of a situation (Fischer et al., 2018). Transformational theory holds that leadership is a process which involves engaging and connecting with others to increase motivation and morality in both followers and leaders (Skendzel et al., 2019; Wolinski, 2010). The Registered Nurses' Association of Ontario (RNAO, 2013) iterates the five main practices of transformational leadership as building relationships/trust, creating an empowering work environment, creating a culture that supports knowledge development and integration, leading and sustaining change, and balancing the complexities of the systems through managing competing values and priorities. It is worth knowing that resonant and shared leadership mirror transformational leadership theory and function effectively in today's interdisciplinary and inter-professional education as well as nursing practice settings. Cummings et al.'s (2008) report that practice of leadership skills and roles significantly influences leadership development, traits and characteristics of individual leaders is relevant for my discussion of the connections between CBPR and the development of leadership capacity.

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Connecting CBPR and capacity building for leadership

Community-based participatory action research provides an environment conducive to capacity building of team leadership skills of all participants through active involvement, consensus decision making, collaborative problem solving, and an enabling ethos that combines unique knowledge, skills, and resources (Caine & Mill, 2016; Oetzel et al., 2018). It demands that the facilitator (researcher) utilize leadership skills that move the project forward. This connection to leadership development is recognized by other researchers engaged in action research (Ailey, Lamb, Friese, & Christopher, 2014; Asadizaker, Abedsaeedi, Abedi, & Saki, 2016).

Leadership opportunities in the CBAR project

I now turn to my experiences leading a CBPR project for my PhD research and the influence of this experience in furthering my leadership capacity. This discussion will be organized in relation to the three components of leadership articulated in the CASN PhD-level Leadership Domain: leadership through scholarly inquiry and the scholarship of discovery, integration, application and learning; leadership in the development, implementation, knowledge translation and mobilization of an intra/interdisciplinary program of research; and, leadership in building scholarly capacity, policy development, and creating change within organizational systems (CASN, 2015). First, however, is a brief description of the research design. The research purpose was to build on my Masters of Nursing research on preceptorship in clinical nursing education in Ghana (Asirifi et al., 2017; Asirifi, Mill, Myrick, & Richardson, 2013) through engagement of stakeholders in a research process that would "assess the strengths and weaknesses of the current model(s) of one undergraduate baccalaureate nursing program in Ghana; and offer strategies to enhance clinical teaching and effectiveness that will meet or surpass national standards and are feasible within current and potential resources" (Asirifi et al., 2017).
Figure 1 depicts the four cycles of this CBAR project. What it does not illustrate are the research planning and the implementation of the proposed changes phases. The planning phase incorporated the development of a four-member Collaborative Research Team in Ghana. The team members were faculty members at the selected school of nursing. They are also the team designated as the change agents for implementation of change strategies arising from the research. These team members reviewed the initial research proposal and made suggestions for change based on their contextual knowledge prior to my PhD candidacy examination and the approval of the proposal. They also assisted with the ethics review process in Ghana. Thus, collaboration began before Cycle One of the research project.

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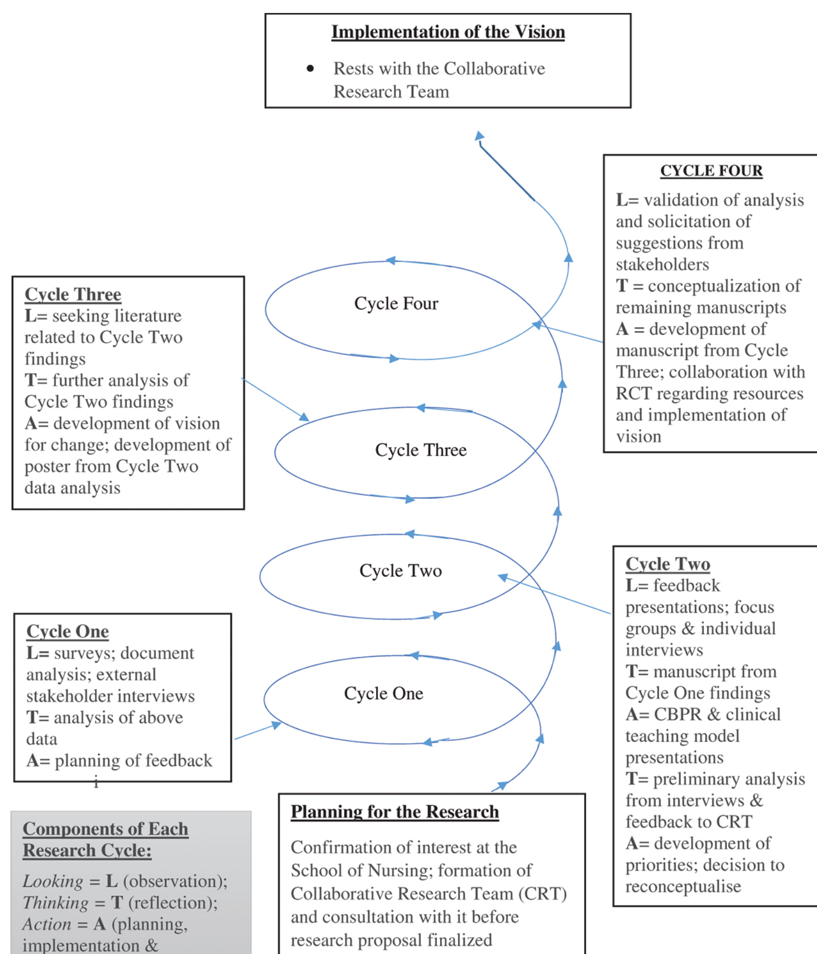

Figure 1: The four cycles in the community-based participatory action research process.

Leadership through scholarly inquiry and the scholarship of discovery, integration, application and teaching

As a doctoral student, it is an expectation to gain knowledge and skill in scholarly inquiry. Through courses, research leading to new knowledge, and the ability to synthesize, apply and communicate scholarly work, all doctoral students should achieve this component of the leadership domain. While my CBPR project assisted me in achieving the capacities outlined in this goal, other research methodologies would have served this purpose equally well with a few exceptions. The CBPR process has a greater emphasis on practical application than most other research methodologies. There was also a greater emphasis on collaboration and teaching in the implementation of the research process. This approach mirrors Scully's (2015) explanation of a renaissance leadership style where the leader takes the initiative to identify the current issues and to understand circumstances that inhibit or promote the future of nursing practice. Also, it is worthwhile to note that CBPR has been successfully applied in nursing education programs to improve teaching and learning outcomes for quality care through active engagement and equitable collaborative partnership among stakeholders of nursing education and, within the collaborative process, increased the leadership abilities of all parties involved (Asadizaker et al., 2016).

Leadership in the development, implementation, knowledge translation and mobilization of an intra/interdisciplinary program of research

This research project was developed as a partial fulfilment of my PhD program. The proposal developed for this research project was submitted to the collaborative research team and they agreed with the content. The research proposal received ethical clearance in Canada and in Ghana before the implementation of the project.

I had the opportunity to implement the iterative processes and activities involved in the four cycles of this CBPR project. As indicated in Figure 1, data collection in Cycle One involved a survey (distribution of

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open-ended questionnaires to undergraduate nursing students, nurse interns, graduate students and faculty members) and individual interviews with external stakeholders of nursing education in Ghana. The individual interviews were conducted with six external nurse stakeholders associated with the Ministry of Health (MOH), the Nursing and Midwifery Council of Ghana (NMC), and the Ghana Registered Nurses' and Midwives' Association (GRNMA). I did a preliminary analysis of the data collected in Cycle One and presented it to interested students and faculty for further input in Cycle Two. The data obtained in Cycle One identified challenges of clinical teaching in Ghana (Asirifi et al., 2017) and were published in Cycle Two. Through the inclusion of the stakeholders in the research project, they acknowledged the challenges and need to restructure the clinical teaching approach to enhance clinical teaching and learning. The approach of engaging and building relationships with the stakeholders reflects resonant leadership which is critical in achieving partnership and collaborative decision making in the research process (Laschinger et al., 2014). Furthermore, the CBPR project enabled me to use a strategic approach to purposefully identify and engage the key stakeholders to assess as well as identify current issues in clinical nursing education. This is congruent with Skelton-Green, Simpson, & Scott's (2007) assertion that leaders use strategic means to identify challenges and problems that their project will address. Similarly, Maxwell (2017) observed that successful leaders know how to get along with people, actively listen to the voices of the people and encourage followers to tell what the leader needs to know but not what the leader wants to hear.

Furthermore, in Cycle Two, presentations on "eight clinical teaching models" used world-wide which were identified in the literature and on "CBPR" were presented to graduate students and faculty members. I conducted focus group interviews separately for a group of six graduate students and a group of eight clinical teachers in one of the clinical agencies in Ghana. Individual interviews were conducted with seven faculty members. A preliminary analysis of data obtained in Cycle Two was shared with the Collaborative Research Team for feedback. This allowed the Collaborative Research Team members to decide which clinical teaching model would be most appropriate for clinical teaching and learning in Ghana. From the feedback obtained, preceptorship was the clinical teaching model preferred and the stakeholders acknowledged the need for reconceptualising it to work in the Ghanaian context.

In Cycle Three I used the interpretive descriptive approach to analyze the data obtained from Cycle Two in order to gain deeper understanding of the meaning of clinical teaching and learning in Ghana, with further literature review conducted to substantiate and explain the findings. The foci for Cycles Two and Three were to examine current issues in clinical nursing education and envision possibilities for improvement in collaboration with stakeholders. Taking into consideration the focus of Cycles Two and Three, a vision and strategies to implement the vision for effective clinical teaching in Ghana were developed in collaboration with the Collaborative Research Team. A poster on the visions and strategies was developed to for presentation to stakeholders for input. The collaborative processes involved in Cycles Two and Three enabled me to demonstrate leadership attributes such as ability to engage stakeholders in identifying gaps, addressing needs, and measuring outcomes that support addressing of those needs (Graebe & Shinners, 2017).

In Cycle Four, where data validation occurred, I had the opportunity to promote knowledge translation and mobilization by sharing (through poster presentation) the recommended vision and strategies for implementing the vision with the Collaborative Research Team, faculty members, clinical teachers at the clinical agency, and the external stakeholders of nursing education in Ghana for further input. The processes practiced in Cycle Four are congruent with leadership qualities such as the ability to engage with people to develop a vision (Cummings, 2012), to lift peoples' performance to higher sights or standards, suggest rather than dogmatize (Grossman & Valiga, 2017), and to promote a strong desire for success, knowledge sharing and ability to have influence on others (Maxwell, 2017).

Leadership in building scholarly capacity, policy development, and creating change within organizational systems

This CBPR project has high potential for influencing policy development in clinical nursing education in Ghana. When the new vision and strategies for reconceptualising preceptorship in Ghana were presented to key stakeholders from the Ministry of Health and other nursing leaders with influence on policy making in nursing education in Ghana, they agreed with the proposed strategies and demonstrated interest in moving forward with the recommendations. This enabled me to demonstrate promotion of evidence-based practice in clinical education in Ghana, which is an important component of nursing leadership (Cummings, 2012). Also, the collaborative approach embedded in the CBPR project increased my communication skills and promotion of respectful collaborative decision making with stakeholders which provided research-based understanding about the complex issues in nursing education in Ghana, the resources needed to move forward, and a template for action. This is congruent with Mayan, Lo, Oleschuk, Pauchulo, & Laing's (2016) explanation that leadership in

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CBPR partnership is demonstrated through: a) individual characteristics such as credibility, trustworthiness, and boldness; b) valuing collective partnership to push forward; and, (c) demonstration of a collective approach where the team of leaders are viewed as having a common goal.

Conclusions

Some of the recommended leadership attributes needed for nursing practice include; coach, mentor, learner, listener, change agent, organizational skill, assertive and effective communicator, and the ability to promote collaboration in practice. The concept of leadership in nursing practice is similar to leadership in CBPR. Just like nursing leadership, CPBR is also focused on empowering and increasing the capacity of community members to identify ways of developing new knowledge to change the situation of the community or organization. Leadership in nursing is promoted through knowledge and skills in nursing practice, positive experience of leadership, promotion of evidence-based practice, and leadership development through educational programs. Leadership development is essential in nursing practice and CBPR. A reflection on my leadership development through this CBPR project in relation to the CASN PhD level leadership development components has been presented. Specifically, I had the opportunity to develop my leadership skills through: a) scholarly inquiry and the scholarship of discovery, integration, application and teaching; b) leadership in the development, implementation, knowledge translation and mobilization of an intradisciplinary program of research, and c) building scholarly capacity, policy development, and creating opportunities for change within an organizational system. Also, this CPBR project enabled me to demonstrate leadership styles relevant for nursing practice such as resonant, relational and renaissance leadership which are all rooted in transformational leadership styles through qualities such as confidence, commitment, effective communication skills, motivation of others, respect for the contributions that people bring to the team, encouragement of collaborative decision making, promotion of evidence-based practice, advocacy, risk-taking and creativity. These qualities are essential in nursing leadership.

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References

Ailey, S., Lamb, K., Friese, T., & Christopher, B. (2014). Educating nursing students in clinical leadership. *Art & Science Clinical Nurse Role*, *21*(9), 23–28.

Al-Yami, M., Galdas, P., & Watson, R. (2018). Leadership style and organisational commitment among nursing staff in Saudi Arabia. *Journal of Nursing Management*, *26*(5), 531–539. doi:10.1111/jonm.12578

Asadizaker, M., Abedsaeedi, Z., Abedi, H., & Saki, A. (2016). Design and evaluation of reform plan for local academic nursing challenges using action research. *Asian Nursing Research*, *10*(2016), 263–270.

Asirifi, M., Ogilvie, L., Barton, S., Aniteye, P., Stobart, K., Bilash, O., … Kwashie, A. (2017). Assessing challenges of clinical education in a baccalaureate nursing program in Ghana. *Journal of Nursing Education and Practice*, *7*(10), 109–118.

Asirifi, M. A., Mill, J. E., Myrick, F. A., & Richardson, G. (2013). Preceptorship in Ghanaian context: Coaching for a winning team. *Journal of Nursing Education and Practice*, *3*(9), 168–176.

Boamah, S. A., & Tremblay, P. (2018). Examining the factor structure of the MLQ transactional and transformational leadership dimensions in nursing context. *Western Journal of Nursing Research*, *40*, 1–19. doi:10.1177/0193945918778833

Bomar, P. J. (2010). Community-based participatory action research: A culturally focused case study. *Japan Academy of Nursing Science*, *7*, 1–8. doi:10.1111/j.1742-7924.2010.00145.x

Caine, V., & Mill, J. (2016). *Essentials of community-based research*. U.S.A: Left Coast Press Inc.

Canadian Association of Schools of Nursing. (2015). *National nursing education framework: Final report*. Retrieved from https://www.casn.ca/wp-content/uploads/2014/12/Framwork-FINAL-SB-Nov-30-20151.pdf

Cashman, S. B., Adeky, S., Allen III, J. A., Corbum, J., Isreal, B. A., Montano, J., … Eng, E. (2008). The power and promise: Working with communities to analyze data, interpret findings and get to outcomes. *American Journal of Public Health*, *98*(8), 1407–1417.

Collins, S. E., Clifasefi, S. L., Stanton, J., Straits, K. J. E., Gil-Kashiwabara, E., Espinosa, P. R., & Leap, A. B. (2018). Community-based participatory research (CBPR): Towards equitable involvement of community in psychology research. *American Psychologist*, *73*(7), 884–898. doi:10.1037/amp0000167

Cummings, G. (2012). Your leadership style – how you are working to achieve preferred future? *Journal of Clinical Nursing*, *21*, 3325–3327. doi:10.11/j.1365-2702.201204290.x

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Cummings, G., Lee, H., MacGregor, T., Davey, M., Wong, C., Paul, L., & Stafford, E. (2008). Factors contributing to nursing leadership: A systematic review. *Journal of Health Services Research & Policy*, *13*(4), 240–248. doi:10.1258/jhsrp.2008.007154

Cummings, G. G., Tate, K., Lee, S., Wong, C. A., Paananen, T., Micaroni, S. P. M., & Chatterjee, G. E. (2018). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, *85*, 19–60.

Fernandes, R., Araújo, B., & Pereira, F. (2018). Nursing management and leadership approaches from the perspective of registered nurses in Portugal. *Journal of Hospital Administration*, *7*(3), 1–8. doi:10.5430/jha.v7n3p1

Fischer, S. A., Horak, D., & Kelly, L. A. (2018). Decisional involvement differences related to nurse characteristics, role, and shared leadership participation. *Journal of Nursing Care Quality*, *33*(4), 354–360.

Gandolfi, F., & Stone, S. (2018). Leadership, leadership styles, and servant leadership. *Journal of Management Research*, *18*(4), 261–269.

Greabe, J., & Shinner. (2017). From the field: A panel on leadership in continuing education. *The Journal of Continuing Education in Nursing*, *48*(11), 489–491.

Grossman, S., & Valiga, T. M. (2017). *The leadership challenge: Creating the future of nursing* (5th ed.). USA., Philadelphia: Davin Company.

Holmes, D., & Gastaldo, D. (2002). Nursing as means of governmentality. *Journal of Advanced Nursing*, *38*(6), 557–565.

Iachini, A. L., DeHart, D. D., Browne, T., Dunn, B. L., Blake, E. W., & Blake, C. (2019). Examining collaborative leadership through interprofessional education: findings from a mixed methods study. *Journal of Interprofessional Care*, *33*(2), 235–242. doi:10.1080/13561820.2018.1516635

Israel, B. A., Combe, M. C., Cheezum, R. R., Schulz, A. J., MacGranaghan, R. J., Lichtenstein, R., … Burris, A. (2010). Community-based participatory research: A capacity building approach for policy advocacy aimed at eliminating health disparities. *American Journal of Public Health*, *100*(11), 2094–2102.

Lake, D., & Wendland, J. (2018). Practical, epistemological, and ethical challenges of participatory action research: A cross-disciplinary review of the literature. *Journal of Higher Education Outreach and Engagement*, *22*(3), 11–32.

Laschinger, H. K. S., Wong, C. A., Cummings, G. G., & Grau, A. L. (2014). Resonant leadership and workplace empowerment: The value of positive organizational cultures in reducing workplace incivility. *Nursing Economic*, *32*(1), 5–44.

Maxwell, J. C. (2017). *The 21 irrefutable laws of leadership*. California: Yates and Yates LLP.

Mayan, M., Lo, S., Oleschuck, M., Pauchulo, A. L., & Laing, D. (2016). Leadership in community based participatory research: Individual to collective. *Engaged Scholar Journal*, *2*(2), 11–24.

Northway, R. (2010). Participatory research part 1: Key features and underlying philosophy. *International Journal of Therapy and Rehabilitation*, *17*(4), 174–179.

Oetzel, J. G., Wallerstein, N., Duran, B., Sanchez-Youngman, S., Nguyen, T., Woo, K., & Alegria, M. (2018). Impact of participatory health research: A test of the community-based participatory research conceptual model. *BioMed Research International*, *2018*, 1–12. doi:10.1155/2018/7281405

Registered Nurses of Ontario Association. (2013). *Developing and sustaining nursing leadership best practice guideline*. Retrieved from http://rnao.ca/sites/rnao-ca/files/LeadershipBPG_Booklet_Web_1.pdf

Scully, N. J. (2015). Leadership in nursing: The importance of recognizing inherent values and attributes to secure a positive future for the profession. *Collegian*, *22*(2015), 439–444.

Skelton-Green, J., Simpson, B., & Scott, J. (2007). An integrated approach to change leadership. *Nursing Leadership*, *20*(3), 1–15. doi:10.12927/cjnl200719277

Skendzel, S., Holtan, S. G., & Finch-Guthrie, P. (2019). Application of path-goal and transformational leadership theory to improve patient and provider satisfaction with APP-led survivorship care: A quality improvement initiative. *Biology of Blood and Marrow Transplantation*, *25*, S373. doi:10.1016/j.bbmt.2018.12.605

Sylvester, J. (2018). Charismatic leadership' roles for general practice nurses. *Primary Health Care*, *28*(3), 6–6. doi:10.7748/phc.28.3.6.s2

Tourish, D. (2014). Leadership more or less? A processual, communication perspective on the role of agency in leadership theory. *Leadership*, *10*(1), 78–98. doi:10.1177/1742715013509030

Van der Velde, J., Williamson, D. L., & Ogilvie, L. (2009). Participatory action research: practical strategies for actively engaging and maintaining participation in immigration and refugee community. *Qualitative Health Research*, *19*, 1293. doi:10.1177/1049732309344207

Ward, M., Schulz, A. J., Israel, B. A., Rice, K., Martenies, S. E., & Markarian, E. (2018). A conceptual framework for evaluating health equity promotion within community-based participatory research partnerships. *Evaluation & Program Planning*, *70*, 25–34. doi:10.1016/j.evalprogplan.2018.04.014

Wolinski, S. (2010). *Leadership theories*. Retrieved from https://managementhelp.org/blogs/leadership/2010/04/21/leadership-theories/

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