RESEARCH ARTICLE

On Becoming A Nurse: A Grounded Theory of Self-Advocacy in Nursing

Rosenda Ayson Niturada Jaramillo, PhD, RN[1]
and **Erlinda C. Palaganas**, PhD, RN, FAAN[2]

Abstract

Aim. This study explored the developmental process of self-advocacy among nurses and proposed a conceptual framework, *The Nurse Becoming Model of Self-Advocacy*, to contribute to middle-range theory development.

Methods. A constructivist grounded theory design guided this study. Data was gathered from 29 nurses through in-depth individual and group interviews across academe, hospitals, and professional organizations in Region I and the Cordillera Administrative Region. Theoretical and disconfirming sampling was used to refine categories. Data was analyzed using constant comparative methods.

Findings. Self-advocacy emerged as a developmental trajectory comprising four interrelated stages: self-preservation, self-development, self-actualization, and self-transcendence. Novice nurses often relied on protective strategies such as silence and conformity, while experienced nurses engaged in assertiveness, credibility-building, leadership, and collective advocacy. Nurses emphasized that self-advocacy extended beyond the individual to encompass patients, the profession, and society, while highlighting its relational and collective nature.

Conclusion. Self-advocacy is a dynamic process and core dimension of professional identity. It evolves through stages of growth, integrating self-care, competence, engagement, and transcendence. Supporting self-advocacy through education, mentoring, reflective practice, and enabling organizational structures enhance nurses' well-being and strengthens their capacity to advocate for patients, advance the profession, and contribute to societal transformation. *The Nurse Becoming Model of Self-Advocacy* offers a transferable framework to guide nursing research, education, and policy toward empowerment and resilience.

Keywords: *Self-advocacy; nursing; grounded theory; professional development; empowerment; leadership; resilience*

Introduction

Advocacy as a widely recognized fundamental part of nursing practice is rooted in the profession's ethical, legal, and social responsibilities. The International Council of Nurses (ICN, 2021) states that nurses are responsible for protecting the dignity, rights, and well-being of patients and communities, while the American Nurses Association (ANA, 2017) describes advocacy as a moral duty. At its core, advocacy means raising the voices of those who are vulnerable, marginalized, or unable to express their needs within healthcare systems.

Despite this recognition, most scholarship and frameworks conceptualize advocacy primarily in relation to patients and populations and thus, leave self advocacy among nurses on a personal and professional level to be relatively underexplored. Yet, without the capacity to assert their own rights, articulate needs, and protect well-being, nurses may find their ability to advocate for others diminished in the face of demanding and hierarchical work environments.

Across disciplines, self-advocacy is defined as the ability to recognize and to communicate one's needs, exercise agency,

[1] Currently based in the United Kingdom as a PHINMA Clinical Competency Program Global Specialist; Email: rnjaramillo.up@phinmaed.com
[2] Professorial Lecturer, College of Nursing , University of the Philippines, Manila, Philippines; Visiting professor, Saint Louis University, School of Advanced Studies

and act on one's behalf to achieve goals or protect well-being (Goodley, 2000; Pennell, 2001). In disability and education studies, it is framed as empowerment and participation (Frawley & Bigby, 2015); in gerontology and chronic illness care, it is linked to patient autonomy and improved outcomes (Hagan & Donovan, 2013; Novinmehr et al., 2019). Within nursing, however, self-advocacy remains insufficiently theorized. Existing models of nursing advocacy (Reburon, 2018; Vaartio & Leino-Kilpi, 2005) emphasize patient, professional, and political domains but seldom articulate advocacy for self as a distinct dimension. This omission is problematic given systemic challenges such as horizontal violence, inequitable workloads, and lack of autonomy that undermine nurses' voices (Kerley & Toney-Butler, 2020).

Research shows that nurses often encounter silencing behaviors and oppressive workplace cultures that constrain self-advocacy. Horizontal violence among colleagues contributes to emotional exhaustion and turnover (Nemeth et al., 2017), while hierarchical structures marginalize nurses' perspectives in decision-making (DeMarco et al., 2008). In resource-constrained settings, speaking up may be misconstrued as insubordination, further deterring advocacy (Cakiroglu & Seren, 2019). In the Philippines, these challenges are magnified by systemic issues such as inadequate compensation, unsafe nurse-patient ratios, and exploitative volunteerism (Anquillano-Carsola, 2015; Barcelo, 2014). Many Filipino nurses endure years of unpaid or underpaid work at the start of their careers, while migration pressures shape professional trajectories and sometimes silence dissent (Masselink & Lee, 2010). Although organizations such as the Philippine Nurses Association (PNA) have long campaigned for improved conditions, nurses at the ground level continue to face barriers to asserting themselves. These realities underscore that self-advocacy is both a local and global challenge that is shaped by cultural, structural, and systemic contexts.

The absence of explicit recognition of self-advocacy in professional standards and curricula compounds these challenges. For example, the Philippine Commission on Higher Education (CHED) Memorandum Order No. 15 (2017) and the National Nursing Core Competency Standards (NNCCS) highlight advocacy, but situate it primarily in relation to patients and to communities (Barcelo, 2014). Similarly, global competency frameworks emphasize leadership and advocacy for others but rarely designate self-advocacy as a learning outcome (ICN, 2021).

However, evidence indicates that developing self-advocacy skills is critical for nurses' well-being, job satisfaction, and leadership capacity (Laschinger et al., 2012; Choi et al., 2014). Global movements for clinicians' well-being recognize that safeguarding health professionals is essential for patient safety and quality of care (National Academy of Medicine, 2019). The WHO's *State of the World's Nursing Report* (2020) further calls for investment in education, leadership, and workforce empowerment, while situating self-advocacy as central to achieving Sustainable Development Goals (SDGs).

Despite these imperatives, explicit theorization of self-advocacy in nursing remains minimal. Key questions remain unanswered: How do nurses themselves construct the meaning of self-advocacy? What strategies do they use to preserve themselves, to assert their needs, and to expand their influence? How does self-advocacy develop across professional stages and contexts? Addressing these questions is vital for advancing educational frameworks, practice guidelines, and policies that prepare nurses to advocate not only for others but also for themselves.

This study aimed to explore the concept and developmental process of self-advocacy among nurses using a constructivist grounded theory approach. By examining nurses' lived experiences across academe, hospital, and organizational settings in the Philippines, the study generated **T**he **Nurse Becoming a Model of Self-Advocacy**, which conceptualizes self-advocacy as a developmental trajectory evolving through four interrelated stages: self-preservation, self-development, self-actualization, and self-transcendence. This model contributes to theory-building in nursing by positioning self-advocacy as both a personal competency and a professional responsibility that is integral to sustaining nursing practice, while advancing advocacy, and strengthening healthcare systems globally.

Methods

Research Design

This study employed a **constructivist grounded theory (CGT) approach** as articulated by Charmaz (2006, 2014). Grounded theory is particularly suited to exploring under-theorized phenomena because it allows theoretical concepts to emerge inductively from data rather than imposing a priori frameworks. The constructivist variant acknowledges the co-construction of meaning between researcher and participants and thereby recognizing that findings are shaped by both participants' lived realities and the researcher's interpretive lens. Given the study's aim to uncover the process and meaning of **self-advocacy among nurses t**his epistemological stance was an essential concept that remains underdeveloped in nursing theory.

CGT was also chosen because it emphasizes **processes and actions,** what participants do, how they interpret their

experiences, and how these meanings shift over time and across contexts. Since the focus of this study was on self-advocacy as a developmental phenomenon, the methodological fit was strong.

Research Setting

The study was conducted in Region I (Ilocos Region) and the Cordillera Administrative Region (CAR) in the northern Philippines. These regions were selected because they represent diverse healthcare and educational contexts, including tertiary hospitals, primary care centers, community health facilities, and nursing schools. Both regions are characterized by a mix of rural and urban populations, with limited health resources in some areas, and high rates of nurse migration. These contextual features provided a rich backdrop for exploring how nurses negotiate self-advocacy in environments that is marked by both opportunities and constraints.

More importantly, the Philippine setting reflects broader global issues in nursing such as precarious work conditions, hierarchical organizational structures, and professional migration, and thus, making this study's findings relevant not only locally but also internationally.

Participants and Sampling

A total of 29 participants took part in the study. They were selected using purposive and theoretical sampling that is consistent with grounded theory methodology (Corbin & Strauss, 2015).

Inclusion criteria: registered nurses with at least one year of practice experience, currently working in either hospital, community, academe, or professional organizations; willingness to share personal experiences of self-advocacy; and fluency in English, Filipino, or Ilocano.

Diversity of roles: participants included novice staff nurses, advanced beginners, nurse educators, clinical specialists, and leaders in professional organizations. This heterogeneity allowed exploration of how self-advocacy is shaped across different stages of professional development and contexts of practice.

Sampling unfolded in three stages:

Initial purposive sampling recruited participants through professional networks, nursing organizations, and institutional contacts.

Theoretical sampling followed, where emerging categories guided recruitment of additional participants who could deepen or challenge developing insights (e.g., nurses with international work experience).

Disconfirming sampling ensured analytic rigor by including participants whose experiences diverged from the majority, such as those who openly resisted advocacy or described prolonged silencing.

Participant demographics reflected a broad range of ages (22–60 years), years of experience (1–39 years), and practice settings (hospital, community health, academe, administration, professional organizations, and overseas employment).

Data Collection

Data was collected over a period of one year (October 2021–September 2022) using semi-structured interviews and focus group discussion (FGD).

Individual interviews (n = 25) lasted 60–90 minutes and explored participants' understandings, experiences, and strategies of self-advocacy. Questions were open-ended (e.g., “How do you define self-advocacy in your nursing practice?”; “Can you recall a time you chose to speak up, or stay silent, and why?”).

FGD (n = 1 group, 4 participants) allowed exploration of collective dynamics, shared meanings, and peer validation of emerging concepts. FGD lasted 120 minutes.

Memo-writing and field notes captured nonverbal cues, contextual factors, and the researcher's reflexive insights.

All interviews and FGD were conducted in English or Filipino, with occasional use of Ilocano by participants. These were audio-recorded with consent and transcribed verbatim. Where translation was required, back-translation ensured accuracy.

Data Analysis

Analysis followed the constant comparative method (Glaser & Strauss, 1967; Charmaz, 2006), unfolding in iterative cycles of coding, memo-writing, and category development:

Initial coding used line-by-line and incident-by-incident approaches to stay close to the data. In vivo codes (using participants' own words) were employed to preserve authenticity. For example, codes such as “silence is safer” or “doing my job correctly means credibility” became analytic anchors.

Focused coding identified recurring patterns and clustered them into more abstract categories (e.g.,

"strategic silence," "building credibility," "collective advocacy").

Axial coding (Corbin & Strauss, 2015) connected categories through conditions, actions, and consequences, highlighting the developmental trajectory of self-advocacy.

Theoretical coding integrated the categories into a coherent model, which was eventually conceptualized as The **Nurse Becoming a Model of Self-Advocacy**.

Manual encoding using MS Word was used for data management, facilitating systematic coding, retrieval, and comparison.

Rigor and Trustworthiness

The study employed strategies to ensure credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985):

Credibility was enhanced through prolonged engagement in the field, triangulation of data sources (interviews, FGD, memos), and member checking with selected participants to validate emerging themes.

Dependability was supported by maintaining an audit trail of coding decisions, memos, and reflexive journals.

Confirmability was ensured through reflexivity, including explicit acknowledgment of the researcher's positionality as a nurse-educator and advocate. Peer debriefing with qualitative research colleagues also minimized bias.

Transferability was addressed by providing rich, thick descriptions of context and participants, that allowed readers to assess applicability to their own settings.

Ethical Considerations

Ethical approval was obtained from the **University Research Ethics Board** and permissions were secured from institutional partners. Participation was voluntary, with informed consent obtained before interviews and FGD. Anonymity was maintained by assigning pseudonyms (e.g., "Nurse Evelyn," "Nurse Gene"). Participants were informed of their right to withdraw at any stage without penalty. Given the potential sensitivity of discussing workplace dynamics, confidentiality was emphasized, and interviews were conducted in private, comfortable settings.

Reflexivity

As the primary researcher was herself a nurse and educator, reflexivity was integral to the research process. Field notes documented preconceptions, emotions, and evolving interpretations. Regular memoing helped bracket assumptions and foreground participants' voices. Reflexivity was especially important in interpreting narratives that resonated with the researcher's own professional experiences in order to ensure that insights remained grounded in participants' accounts rather than researcher bias.

Findings

Nurses' Experiences of Self-Advocacy

Participants initially described self-advocacy as safeguarding the self: energy, integrity, and psychological safety, amid demanding and hierarchical environments.

> "I try my best to speak, but sometimes silence is safer. I save my energy for what really matters." (Nurse Gene)

Silence, often labeled passivity, was reframed as a deliberate conservation strategy. Alongside protective tactics, participants emphasized proactive self-improvement as advocacy:

> "You can't give your best without improving yourself first… build yourself so you can give your 101% to others." (Nurse Evelyn)

Altruism and collectivism surfaced early while linking personal credibility to the capacity to advocate for others:

> "Self-advocacy is bringing out the best in oneself so that you can be an instrument to improve others too." (Nurse Faye)

Construction of Self-Advocacy in the Social World

Self-advocacy was experienced within relational, organizational, and cultural ecologies that either enabled or constrained action. Enablers included supportive leadership, mentoring, and solidarity:

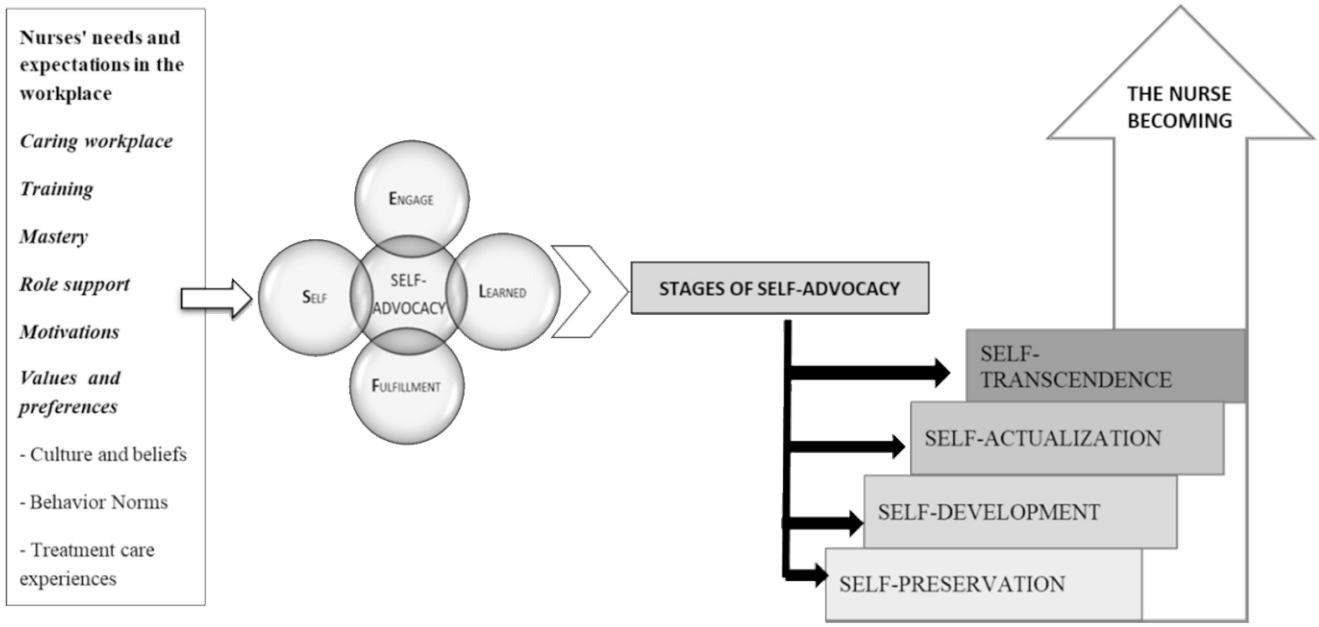
> "The more I have this responsibility, the more eager I am to lead—not just for myself but for others and my department." (Nurse Evelyn)

> "Please be with me. I cannot do this alone. United we stand…" (Nurse Virginia)

Constraints included rigid hierarchies, punitive cultures, and migration-related pressures:

> "In Saudi, life was just work, work, work… too many restrictions… I came home because I needed freedom." (Nurse Madeleine)

Figure 1. *The Nurse Becoming Model of Self-Advocacy*



Note: The model illustrates four developmental stages (self-preservation, self-development, self-actualization, self-transcendence) and the reciprocal relationships among self, learning, engagement, and fulfillment.

Developmental Stages of Self-Advocacy

Analysis surfaced four fluid, non-linear stages. Participants could advance, plateau, or revert depending on context.

Self-Preservation (protecting the self).
"Sometimes you just accept things… because you can't change the system." (Nurse Logan)

Self-Development (building credibility and voice).
"Doing my job correctly and honestly means that when I speak up, there's no point against me." (Nurse Lydia)

Self-Actualization (integrating advocacy into identity).
"I should always be helpful. I know I can help in my little way." (Nurse King)

Self-Transcendence (leading beyond the self).
"I've been there before. Now I can lead and give my best, not just for myself but for others." (Nurse Evelyn)

The Nurse Becoming Model of Self-Advocacy

Synthesizing categories yielded The Nurse Becoming Model of Self-Advocacy. This said model comprised of four linked concepts: Self, Learned, Engage, and Fulfillment, as well as, propositions about how self-advocacy develops. The model also illustrates a reciprocal process where learning enhances engagement, self-care underpins advocacy, and fulfillment culminates in both personal growth and social contribution.(Figure 1)

Propositions

The model advances several propositions:

Nurses who are learned become more confident, credible, and engaged.

Self-advocacy begins with the self but extends to patients, communities, and systems.

Fulfillment is both personal and collective, and thereby beneficial to not only nurses but also to those they serve.

Self-advocacy development depends on professional experience, reflective practice, and organizational support.

Nurses who achieve self-advocacy function optimally, experience justice, and attain holistic well-being.

Model Dynamics

The model illustrates reciprocal relationships among its concepts. Learning enhances engagement, while engagement reinforces nurses' perspectives and values thereby creating a

feedback loop. Self-care and self-assertion are prerequisites for external advocacy in order to ensure that nurses have the confidence and resilience to act. As advocacy expands outward, it culminates in fulfillment, marked by personal growth, professional legitimacy, and social contribution.

Discussion

This study generated The Nurse Becoming Model of Self-Advocacy, while conceptualizing self-advocacy as a developmental, relational, and context-sensitive process that evolves from self-preservation to self-transcendence. The findings extend nursing advocacy scholarship by articulating self-advocacy, often implicit or subsumed under patient advocacy, as a distinct yet interdependent domain foundational to professional identity and to nurses' capacity to advocate for patients, teams, and society.

Self-Advocacy as Developmental Trajectory

The four interrelated stages demonstrate that self-advocacy is not a fixed trait but a process contingent on both capability and context. This staged progression resonates with Benner's (1984) novice-to-expert framework, where competence and situated judgment legitimize voice. In early practice, participants' strategic silence aligned with Levine's conservation principles (1990) and also reframed silence as adaptive self-preservation rather than passivity.

As competence accrued, nurses engaged in credibility-based advocacy that is consistent with Hanks (2010) who argued that performance and integrity grant moral authority. At higher levels of self-actualization and transcendence, advocacy became a value-congruent habitus that is aligned with Fawcett's (2005) metaparadigm emphasizing dynamic person–environment interactions.

By distinguishing self-preservation (legitimate protection) from self-development (capability building), the model prevents the common conflation of “speaking up” with “being empowered,” and also clarifying developmental specificity in advocacy theory.

From Individual Agency to Collective Advocacy

Consistent with **Vaartio and Leino-Kilpi (2005)**, advocacy emerged as most potent when collectivized. Filipino nurses' emphasis on *bayanihan* (communal unity) framed self-advocacy not as individual assertiveness but as a gateway to collective action. This prosocial, culturally embedded framing broadens advocacy models developed in more individualist contexts and aligns with evidence linking authentic leadership and empowerment to reduced burnout and enhanced advocacy (Laschinger et al., 2012; Choi et al., 2014).

Thus, self-advocacy in the Filipino context extends beyond the individual, and as result, underscore that the nurse's growth contributes to collective resilience and systemic advocacy.

Contexts that Shape Voice

Organizational and cultural conditions decisively shaped whether nurses advanced, plateaued, or regressed along the trajectory. Rigid hierarchies, punitive norms, and migration-related constraints curtailed voice, echoing DeMarco et al. (2008), Nemeth et al. (2017), and Kanaris (2023) on structural disempowerment and patient-safety risks in hierarchical systems. Conversely, mentorship, psychological safety, and solidarity catalyzed advancement toward self-actualization and transcendence, that is consistent with Munyewende et al. (2014) on enabling environments.

This context sensitivity highlights the necessity of supportive structures, policies on safe staffing, anti-bullying enforcement, recognition pathways, for sustained advocacy and workforce sustainability.

Implications of the Nurse Becoming Model

The Nurse Becoming Model underscores that advocacy begins with the self and expands outward to patients, the profession, and society. By framing self-advocacy as the umbrella under which other advocacies are sustained, the model positions clinician well-being as the bedrock of patient safety and system transformation (National Academy of Medicine, 2019; Black, 2011).

Its staged design offers clear implications:

Education: Embed self-advocacy outcomes in curricula (reflective practice, assertive communication, speaking-up simulations, ethics of self-care). Early experiences should normalize self-preservation as legitimate while scaffolding transition to self-development.

Practice/Leadership: Build psychological safety and just culture norms; formalize mentorship; use peer reflection and structured feedback to routinize advocacy. Link recognition systems to constructive voice and quality-improvement leadership.

Policy: Institutionalize structural empowerment (safe staffing, fair workloads, grievance pathways, anti-bullying enforcement). Align with national efforts (e.g., PNA campaigns) to amplify nurses' voices and integrate self-advocacy into competency and leadership frameworks.

Research: Test and refine the model across diverse

settings (public/private, rural/urban, overseas), examine associations with burnout, retention, and patient safety, and evaluate interventions such as mentorship programs and speaking-up curricula.

By bridging the personal and the structural, the model demonstrates how individual acts of self-advocacy scale into organizational culture and societal transformation.

Contribution to Nursing Knowledge

This study contributes to nursing knowledge by: (a) conceptualizing self-advocacy as a developmental trajectory; (b) situating it within relational and cultural contexts; and (c) framing it as foundational for broader advocacy efforts.

By integrating Filipino cultural values of *bayanihan* into advocacy theory, the study enriched global discourse and offered a culturally grounded model with applicability across diverse health systems. It responded to gaps in professional standards where advocacy is often narrowly framed as patient-centered (Barcelo, 2014; CHED CMO 15, 2017), while arguing for explicit integration of self-advocacy in competency frameworks.

Limitations

Findings derived from Region I and CAR used purposive/ theoretical sampling; while transferability rested on contextual resonance rather than statistical generalizability. Data relied on interviews and FGD as observational data could have deepened process tracing. Manual coding enhanced closeness to the data, but future research may triangulate with qualitative software audits to bolster rigor.

Conclusion and Recommendations

Self-advocacy is a **dynamic core of nursing professionalism**. Nurses progress from protecting the self to leading beyond the self, contingent on competence and context. By designing educational, organizational, and policy levers that align with each stage of the trajectory, systems can strengthen nurses' well-being and expand their capacity to advocate for patients, the profession, and society.

This grounded theory study articulated The Nurse Becoming Model of Self-Advocacy, conceptualizing self-advocacy as a developmental and context-dependent process that evolves through four interrelated stages: self-preservation, self-development, self-actualization, and self-transcendence. At its foundation, self-advocacy begins with protective strategies such as self-care and self-assertion, often observed among novice nurses navigating hierarchical systems. With growth in knowledge, skills, and attitudes, nurses progress toward competence and credibility so as to enable them to engage actively in collaboration, leadership, and advocacy for others. Ultimately, self-advocacy culminates in transcendence, where nurses extend their influence to patients, the profession, and society at large.

Findings affirmed that self-advocacy is not a fixed trait but a dynamic trajectory requiring self-knowledge, reflection, and accountability. It manifested along a spectrum, from silence and conformity to assertiveness and leadership, and is shaped by individual agency, organizational culture, and broader social structures. More importantly, it is both a personal competency and a social responsibility. By advocating for themselves, nurses strengthen their capacity to advocate for others and act as transformative agents in healthcare and society.

Aligned with the four stages of the model, several practical directions emerged:

Nursing education should support self-preservation and self-development through reflective pedagogies, mentorship, and simulation-based scenarios that transform survival tactics into professional growth.

Nursing practice should enable self-actualization by fostering psychologically safe and empowering environments. Mechanisms such as peer reflection, interprofessional collaboration, and structured feedback normalize advocacy as part of professional identity.

Nursing policy and leadership should advance self-transcendence through structural empowerment, recognition systems, and leadership development, thereby amplifying nurses' voices in organizations and policymaking.

Nursing research should refine and expand the model across diverse cultural and institutional contexts, thereby examining links to workforce sustainability, job satisfaction, patient safety, and organizational performance, as well as, cross-cultural variations in advocacy trajectories.

By situating self-advocacy as integral to professional identity, this study underscored that nurses' ability to advocate for patients and systems is rooted in their capacity to advocate for themselves. Supporting nurses across all stages of the trajectory is therefore essential, not only for resilience and well-being but also for sustaining the profession and advancing the broader goals of global health systems.

Closing Perspective

These recommendations demonstrate how interventions can be intentionally aligned with the stages of *The Nurse Becoming*

Model of Self-Advocacy. Education supports self-preservation and development by building reflective and skill-enhancing spaces. Practice fosters self-actualization by creating environments of trust and credibility. On the other hand, policy and leadership enable self-transcendence by institutionalizing empowerment and amplifying nurses' voices. Finally, research ensures sustainability by testing, refining, and globalizing the model proposed.

References

American Nurses Association. (2017). *Healthy work environment for nurses*. ANA Enterprise. https://www.nursingworld.org/ practice-policy/work-environment/

Anquillano-Carsola, L. (2015). Workplace realities of Filipino nurses: Burnout and coping. *Philippine Journal of Nursing*, *85*(1), 45–53.

Barcelo, J. M. (2014). The National Nursing Core Competency Standards: Implications for nursing education. *Philippine Journal of Nursing*, *84*(1), 5–13.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Addison-Wesley.

Black, L. M. (2011). Tragedy into policy: A quantitative study of nurse advocacy, error, and error reporting. *Journal of Nursing Law, 14*(4), 135–142. https://doi.org/10.1891/1073-7472.14.4.135

Cakiroglu, K., & Seren, S. (2019). The impact of organizational change and culture on nurses' self-advocacy. *Journal of Nursing Management, 27*(3), 520–528. https://doi.org/ 10.1111/jonm.12709

Charmaz, K. (2006). Constructing Grounded Theory: A Practical Guide through Qualitative Analysis. London: Sage Publications.

Charmaz, K. (2014). Constructing Grounded Theory. Los Angeles: Sage.

Chen, F., Liu, Y., Wang, X., & Dong, H. (2021). Transition shock, preceptor support and nursing competency among newly graduated registered nurses: A cross-sectional study. *Nurse Educ Today, 7*(102):104891. doi: 10.1016/ j.nedt.2021.104891. Epub 2021 Apr 7. PMID: 33866200.

Choi, M., Douglass, C., & McDonagh, K. (2014). The impact of hospital-based advocacy programs on nurses' empowerment and job satisfaction. *Journal of Nursing Administration, 44*(2), 79–85. https://doi.org/10.1097/NNA.0000000000000036

Commission on Higher Education. (2017). CMO No. 15, s. 2017: Policies, Standards and Guidelines for the Bachelor of Science in Nursing (BSN) Program.

Corbin, J., & Strauss, A. (2015). Basics of Qualitative Research. Thousand Oaks, CA: Sage.

DeMarco, R., Roberts, S., Norris, A., & McCurry, M. (2008). The development of the Nurse Workplace Advocacy Scale. *Journal of Nursing Scholarship, 40*(2), 151–157. https://doi.org/10.1111/j.1547-5069.2008.00218.x

Fawcett, J. (2005). *Contemporary nursing knowledge: Analysis and evaluation of nursing models and theories* (2nd ed.). F. A. Davis.

Frawley, P., & Bigby, C. (2015). Self-advocacy and inclusion: The role of self-advocacy groups in supporting lifestyle changes. *Disability & Society, 30*(1), 1–15. https://doi.org/ 10.1080/09687599.2014.984651

Goodley, D. (2000). *Self-advocacy in the lives of people with learning difficulties*. Open University Press.

Hagan, T. L., & Donovan, H. S. (2013). Self-advocacy and cancer: A concept analysis. *Journal of Advanced Nursing, 69*(10), 2348–2359. https://doi.org/10.1111/jan.12112

Hanks, R. G. (2010). The medical-surgical nurse perspective of advocate role. *Nursing Forum, 45*(2), 97–107. https://doi.org/ 10.1111/j.1744-6198.2010.00169.x

International Council of Nurses (2021). The ICN Code of Ethics For Nurses. https://www.icn.ch/sites/default/files/inline-files/ICN_Code-of-Ethics_EN_Web.pdf

Kanaris, C. (2023), Mind the power gap: How hierarchical leadership in healthcare is a risk to patient safety. *Journal of Child Health Care*. *27*(3), 319-322. doi:10.1177/ 13674935231196197

Kerley, L., & Toney-Butler, T. (2020). Nursing advocacy. In StatPearls. StatPearls Publishing, LLC.

Kubsch, S.M., Sternard, M.J., Hovarter, R., Matzke, V.(2004). A holistic model of advocacy: factors that influence its use. *Complementary Therapies in Nursing & Midwifery, 10*(1):37-45. doi: 10.1016/S1353-6117(03)00083-0. PMID: 14744505.

Laschinger, H. K. S., Wong, C. A., & Grau, A. L. (2012). Authentic leadership, empowerment, and burnout: A comparison in new graduates and experienced nurses. *Journal of Nursing Management, 20*(3), 522–532. https://doi.org/10.1111/ j.1365-2834.2011.01291.x

Levine, M. E. (1990). The conservation principles of nursing: Twenty years later. National League for Nursing.

Lincoln, Y.S. and Guba, E.G. (1985) Naturalistic inquiry. Sage Publication, Thousand Oaks.

Masselink, L.E.,& Lee, S.Y. (2010). Nurses, Inc.: expansion and commercialization of nursing education in the Philippines, *Social Science Medicine, 71*(1):166-72. doi: 10.1016/ j.socscimed.2009.11.043. Epub 2010 Mar 20. PMID: 20399550.

Munyewende, P.O., Rispel, L.C., & Chirwa, T. (2014).Positive practice environments influence job satisfaction of primary health care clinic nursing managers in two South African provinces. *Human Resource Health 5*(15), 12-27. doi: 10.1186/1478-4491-12-27. PMID: 24885785; PMCID: PMC4024627.

National Academy of Medicine. (2019). Taking action against clinician burnout: A systems approach to professional well-being. http://bit.ly/NT-NAM-burnout

Nemeth, L. S., Lashley, M., & Stullenbarger, E. (2017). Advocacy in nursing practice: A concept analysis. *Journal of Nursing*

Administration, 47(9), 433–439. https://doi.org/10.1097/NNA.0000000000000516

Novinmehr, N., Brown, C., & Smith, L. (2019). Self-advocacy in older adults with chronic illness: A scoping review. *Patient Education and Counseling, 102*(6), 1037–1048. https://doi.org/ 10.1016/j.pec.2019.01.012

Pennell, R. (2001). Self-advocacy and psychiatric survivors. *Psychiatric Rehabilitation Journal, 24*(3), 199–206. https://doi.org/10.1037/h0095092

Poorchangizi, B., Farokhzadian, J., Abbaszadeh, A., Mirzaee, M., & Borhani, F. (2019). The importance of professional values from nursing students' perspective. *BMC Nursing, 18*(26), 1–7. https://doi.org/10.1186/s12912-019-0351-1

Post, S. G. (2005). Altruism, happiness, and health: It's good to be good. *International Journal of Behavioral Medicine, 12*(2), 66–77. https://doi.org/10.1207/s15327558ijbm1202_4

Reburon, J.L. (2018). Nursing Advocacy of Ilocano Nurses. Saint Louis University: Baguio City, Philippines.

Schaefer, K. M. (2005). Levine's conservation model. In M. E. Parker (Ed.), *Nursing theories and nursing practice* (2nd ed., pp. 161–178). F. A. Davis.

Soosai-Nathan, L., Negri, L., Delle Fave, A., & Pawelski, J. O. (2013). Happiness and altruism among Malaysian adolescents. *Journal of Moral Education, 42*(2), 199–211. https://doi.org/10.1080/03057240.2013.785941

Vaartio, H., & Leino-Kilpi, H. (2005). Nursing advocacy: A review of the empirical research 1990–2003. *International Journal of Nursing Studies, 42*(6), 705–714. https://doi.org/10.1016/j.ijnurstu.2004.11.005

ABOUT THE AUTHORS

Rosenda Ayson Niturada Jaramillo, PhD, RN, is currently based in the United Kingdom as PHINMA Clinical Competency Program Global Specialist - PHINMA Education University of Pangasinan, focusing on harmonizing theory and practice in nursing education. A distinguished alumna of the University of Pangasinan, she holds a Master of Arts in Nursing from Lyceum Northwestern University, a Diploma in Health Professional Education from the University of the Philippines, and a Doctor of Philosophy in Nursing from Saint Louis University. Her professional journey spans roles as faculty member, Coordinator, and Dean of the College of Allied Health Sciences at PHINMA Araullo University. Passionate about transformative pedagogy, She develops engaging, evidence-based learning materials that promote educational excellence and global competence in nursing practice.

Erlinda C. Palaganas, PhD, RN, FAAN, is an esteemed leader, advocate, and trailblazer in community health nursing and research. A retired Professor 12 and University Scientist III at the University of the Philippines Baguio, she has dedicated her career to championing nurses' rights, equitable healthcare, and qualitative research. She graduated cum laude with a Bachelor of Science in Nursing from UERMMMCI in 1979, receiving the Community Health Service Award. She then earned her Master of Public Health from the UP College of Public Health in 1985, In 1996, she completed her Doctor of Philosophy (PhD) in Nursing at the University of Sydney, Australia, further solidifying her expertise in health sciences and qualitative research. Her research interests include social determinants of health on issues such as migration, climate change, indigenous knowledge and practices, poverty.

"Nursing is the meeting place of science and soul, where knowledge touches suffering and becomes compassion."