

Barriers to nurses using their health advocacy role in nursing practice: A Ghanaian perspective

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Research article

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Abstract

Background: While nursing is complex, transforming and multi-faceted profession, its focus of providing a safe and caring environment that promotes client health and wellbeing has remained unchanged. To do this, nurses need to use their professional roles and skills to advocate for such an environment to provide quality nursing care. However, this can be difficult, as health advocacy is a contextually intricate and complex component of nursing practice.

Speaking up to protect clients' rights is a key ethical and moral mandate for nurses, with many remaining silent, even when presented with circumstances that require them to use their health advocacy role during their practice. The barriers to Ghanaian nurses using their role as health advocates for clients in the healthcare and communities' settings are not well understood. Identifying and describing these barriers is important to inform contextually relevant strategies to empower nurses to use their health advocacy role in their daily nursing practice.

Methods: An inductive descriptive qualitative design, based on Strauss and Corbin Grounded Theory, was used to collect and analyse data on barriers that prevent nurses from practising their health advocacy role in Ghana. Twenty-four professional nurses were recruited from three regional hospitals in Ghana and interviewed using a semi-structured interview guide. Data were analysed using Strauss and Corbin's general guidelines and framework.

Results: Three categories emerged as barriers to the health advocacy role practice by nurses, these being intra-personal, inter-personal and structural barriers.

Conclusion: The barriers to nurses using their health advocacy role in practice are many and complex and have implications for nursing practice. Incorporating health advocacy into their curriculum may help address the barriers to nurses' practice of health advocacy.

Background

Nurses primary responsibilities are to their patients, and not the institution or other healthcare workers [1], with health advocacy being an expected and central role in their practice. The practical implications of acting as a health advocate sometimes having unexpected repercussions, with some nurses viewing the consequences as a career dilemma [2]. Others perceive it as risk-taking that may have negative

consequences, with effective advocacy sometimes being associated with feelings of frustration and anger, and disrupting peer relationships, some health advocates being labelled as disruptive [1].

Nurses are not only expected to advocate for clients at the bedside, but also for change within and across institutions, communities and societies [3]. Over the decades, nurses have advocated for people and communities in need, as reflected in the work of early nurse pioneers [4]. For instance, Florence Nightingale pursued environmental health advocacy and reforms, particularly for British soldiers during the Crimean War [5]; Lillian Wald advocated for home health nursing programs, the reform of child labour practices, and workplace protections in the United States of America (USA) [6]; and Margaret Sanger fought for access to birth-control information and services for vulnerable and underserved populations in the USA [4]. These nurses not only advocated for vulnerable populations that they worked with, but also pushed for policy changes at the health systems level. The circumstances under which these nurses worked as pioneers for health advocacy have not changed, instead they have become more complex. This is evident in Ghana, where the healthcare system is considerably under-resourced and in need of nurses being health advocates for health policy changes.

Some nurses are unwilling to risk conflict on behalf of their clients, despite this being unethical and possibly increasing the vulnerability of clients to health inequities [7]. Advocating on behalf of the patients requires nurses to be knowledgeable about and accepting of their health advocacy role, as well as to understand the risks associated with accepting and neglecting this role. Mardell [8] warned about these risks, stating that health advocacy may predispose the nurse to conflict with their medical colleagues and management, the employer, which can lead to job termination. However, Winslow [9] argues that accepting the risks creates an ideal ethical basis for professional practice, with 'shying' away from health advocacy being comparable to medical negligence [10].

Although nurses know and understand their role as health advocates, most studies show that advocating in health is contextually complex and is a controversial and risky component of nursing practice. The reluctance of nurses to engage in advocacy has been reported in some parts of the world, with lack of advocacy training; failure to strategically frame advocacy issues; lack of organisational support for health employees to pursue advocacy; unwillingness on the part of health organisations to engage in public controversy; insufficient data; lack of interdisciplinary collaboration; and lack of policy analysis capacity in the health sector having been reported as barriers to nurses performing their health advocacy role [1, 11, 12]. Little attention in health professionals' and public health practitioners' education is noted on how to advocate for policy and social change to redress health inequities, with health advocacy barely being a sub-discipline, this being a major barrier to nurses and other health professionals performing their health advocacy roles [11].

In Iran, a study conducted to identify the barriers to advocacy reported powerlessness; lack of relevant laws, a Code of Ethics, support for nurses and physicians as leaders; time constraints forcing nursing to revise work patterns to complete many tasks in a limited time, and poor communication [13]. Other studies in the United Kingdom and the USA reported loyalty to peers and lack of motivation as barriers to the nurses' practising their health advocacy roles [14, 15].

In Ghana, a study conducted on advocacy characteristics reported that nurses' state of fatigue and frustrations were hampering their ability to perform their health advocacy roles [16]. These findings were similar to those recorded earlier in the USA, where the advocacy role was reported to cause stress, fatigue and depression among nurses [17].

Methods

Design

An inductive, descriptive, qualitative design, based on Strauss and Corbin [18] Grounded Theory, was used to collect and analyze qualitative data on barriers that hinder nurses from using their health advocacy role in practice in Ghana. Qualitative data was obtained using interviews to enable the Ghanaian nurses to share their views on what hinders them from performing their ethical and professional role as health advocates.

Study setting

The study was conducted in three purposefully selected regional government hospitals in Ghana to ensure cultural homogeneity of the results. These facilities serve as referral, research and teaching hospitals for nurses and other health professionals, and facilitated a comparison of the findings during the data analysis, which is a key feature in Grounded Theory [19].

Participants and Sampling

A sample of 24 participants, seven male and 17 female professional nurses, were interviewed, their education ranging from Diploma to PhD qualifications. The age of the participants ranged from 31 to 51 years. Their years of clinical nursing experience ranged between five years to 15 years.

Open and theoretical sampling techniques were used to identify the 24 nurses, these being the main sampling methods used in Grounded Theory [20]. During the initial stages of data collection, open sampling was used to select and recruit the first five professional nurses who met the inclusion criteria in each of the regional hospitals, equating to 15 nurses. The additional nine participants, consisting of three from each hospital, were recruited later using theoretical sampling to maximize the opportunity to establish variations among concepts and to densify categories through constant comparisons. The sample size was based on the data saturation principle [21], which means that sampling stopped when no new information was obtained.

Data Collection

Data collection and analysis were conducted concurrently between August 2018 to February 2019, this being in line with Grounded Theory and fully accepted in qualitative studies [19, 22]. The individual interviews were conducted using a semi-structured interview guide that was developed by the researchers, according to the study objective. The semi-structured interviews approach enabled in-depth probing while permitting the interviewer to keep the interview within the parameters outlined out by the objective, as supported by Berry [23]. The interviews were conducted in English, the formal communication language in healthcare in Ghana, lasted 60 – 90 minutes, and were audio-recorded, with field notes being made as part of data collection.

Data analysis

The recorded interviews were transcribed verbatim within 24 hours of collection and saved in Word documents, after which they were uploaded into QSR International NVivo version 12 for Macintosh for analysis. The transcripts were read over systematically to carefully review and analyse the contents, and if need be, refine the interview questions to ensure that the phenomenon under investigation was well defined and understood, in accordance with the principles of Noiseux et al [24] and supported by Morse [22]. Immediate data analysis following the collection of the initial data assisted in constant comparative analysis and theoretical sampling, with [Strauss and Corbin's general guidelines and framework being used for the data analysis](#). The recursive line by line data analysis entails three stages, namely; Open coding, Axial coding and Selective coding: the first two being performed concurrently. Open coding was done to identify concepts and their properties from the data [19] and involved two processes, namely labelling and categorising, with the steps repeated by an inter-coder. Axial coding then made it possible for the generated codes to be regrouped to generate conceptual codes. Subsequently, a search was done to establish any relationship among the concepts from data, with selective coding helping to integrate, refine and describe the concepts [25].

Rigour

Lincoln and Guba's model of trustworthiness [26] was used to ensuring rigour of the findings. Member checking and validation entailed asking nine participants to read the interview transcripts for confirmation to ensure credibility. For confirmability, the senior researcher and co-author assessed and validated the codes from the raw data, with adjustments being made to the subcategories and the categories as needed. Detailed data, including field notes, were kept to enable an audit trail, which entailed outlining the decisions made throughout the research process. This provided a rationale for the methodology and interpretative judgement of the researchers, as supported by Houghton, Casey, Shaw and Murphy [27], and may assist in transferability. An inter-coder was used to repeat the Open coding process, and a calculation of intercoder reliability established, as recommended by Yang, Pankow, Swan, Willett, Mitchell, Rudes, Knight and Quantity [28]. Dependability was ensured by accurately applying all the Grounded Theory principles and procedures of data analysis.

Findings

The data analysis revealed three categories, namely: intra-personal, inter-personal and structural barriers that hinder nurses from practising their health advocacy role in their daily nursing practise, as summarised in Table 1.

A. Intra-personal barriers

The intra-personal barriers refer to the innate characteristics of the individual that prevent the nurse from practising their health advocacy role. Three subcategories were identified, these being nurse's personal fears, nurses' personality attributes and nurses' professional inadequacies.

a. Nurses personal fears

This subcategory related to their real and or perceived fears of punishment for practising their health advocacy role. Participants mentioned the fear of being labelled 'as knowing too much, getting into trouble and being victimised as preventing them from performing their health advocacy role, as indicated in the following data extracts:

"They have labelled some of us as being too knowing because we speak out for our clients" (PN02, 39-year-old Female).

"We are not able to speak for our clients, most of us wouldn't speak out, we fear to get into trouble or to be labelled too known" (PN15, 43-year-old Female).

"Well, if it is a very sensitive issue...you might not be bold to come out, because the fear that people will lambaste or victimize you is evident" (PN23, 51-year-old Male).

b. Nurse's personality attributes

This subcategory relates to the individual nurse's personality attributes that prevent them from practising their health advocacy role. These personality traits included being timid, unassertive and lacking confidence, as demonstrated in the following extracts from participants' data:

"With nurses, a lot of us are timid, we are not able to speak for our clients, most nurses wouldn't speak out, they will be pushing others that they believe are brave and can speak to go forward" (PN11, 41-year-old Male).

"A lot of us are unassertive and that is why we cannot perform the advocacy role...we need to be assertive" (PN19, 41-year-old Female).

"Nurses are not bold to come out because they fear the outcome to speak up for their clients" (PN23, 51years old Male).

“Most nurses lack the bravery to stand up for their clients,” (PN05, 31-year-old Male).

c. Nurses’ professional inadequacies

This subcategory relates to the nurses’ inadequacies that are profession related and prevent them from practising their health advocacy role. These inadequacies include professional inexperience and lack of confidence, as depicted in the following extracts:

“The confidence and the knowledge are what we mostly lack, if these two things are there we can advocate very well” (PN01, 33-year-old Male).

“Sometimes, you are limited as to what you can do, as a professional even though you have the desire to speak for a client, you lack the experience” (PN20, 33-year-old Male).

“You don’t even want to say what you think and what you see if you don’t have the knowledge because you don’t know what is happening” (PN19, 41-year-old Female).

B. Inter-personal barriers

The inter-personal barriers relate to the relationship between the nurse and their patient clients as well as other health professionals. The two subcategories being clientele traits and perceived collegial persecution emerged.

d. Clientele traits

These participants reported their clients’ inconsiderate behaviours as barriers that prevent them from performing their advocacy role. These include situations where patients are seen to be inattentive to the nurses’ professional advice, and lack of gratitude for what the nurses do, as demonstrated in the following extracts comments from data:

“Clients themselves are part of it, you will stand up for them and at the end of the day some of them will behave in a way that will rather make it difficult to advocate for them in future” (PN16, 31-year-old Female).

“Some of the patients are ungrateful when you speak up for them, they don’t appreciate so, you don’t even have the zeal to do it for somebody else” (PN02, 39-year-old Female).

e. Perceived collegial persecution

Nurses behaviours, as perceived by other health professional colleagues, prevents them from performing their advocacy role. The collegial persecution reported was intimidation from other professionals and senior colleagues, and name-calling and victimization from colleagues as barriers, as depicted in the following comments:

“Sometimes, even our colleague nurses would intimidate you just because you stand up for client rights, especially if it is against a professional” (PN01, 33-year-old Male).

“They have given some of us names because we speak for the less privileged clients” (PN04, 37-year-old Female).

“What am saying is, as a nurse, I may know or would have seen that it is right to be a health advocate, but may not want any trouble, or want other people to sabotage me. So, I keep quiet to prevent victimisation from others, including my own colleagues and seniors” (PN22, 35-year-old Male).

C. Structural barriers

The structural barriers are organisational and institutional issues that prevent nurses from practising their health advocacy role. The four subcategories were red tape, professional alienation, poor educational preparation and structural victimisation.

f. Red Tape

This subcategory emerged from data related to [excessive and rigid conformity to redundant formal rules and processes within the health organisations](#). The barriers included institutional bureaucracy, inappropriate policies and ineffective management. Delays in acting on matters reported during advocacy were depicted in the following extracts:

“It’s the dysfunctional chain that we go through that impedes our desire to advocate” (PN11, 41years old Male).

“Some policies in this institution are just not favourable for nurses to work as advocates” (PN19, 41years old Female).

“We don’t advocate sometimes because people have advocated and did not see any result” (PN15, 43years old Female).

g. Professional alienation

This subcategory emerged from data related to isolation and divisions within the profession that prevent nurses from advocating. This includes the ‘keep quiet and obey syndrome’, professional snobbery and negative professional socialization, as indicated in the following comments:

“You have to keep quiet and obey, when you step behind the nurse-in-charge to take any action you may be in trouble” (PN11, 41-year-old Male).

“We are not able to advocate because the seniors will snob us if we try to suggest or initiate any action of advocacy” (PN18, 50-year-old Female).

“Professionally we are negatively socialised, and this has some impact on us with regards to not advocating...we are negatively influenced” (PN24, 33-year-old Male).

h. Poor educational preparation

This subcategory emerged from data related to the absence of health advocacy in the nursing curriculum and a lack of students’ empowerment to advocate during training. The barriers include inadequate curriculum content and training on health advocacy, and not being empowered to advocate, as depicted by the following extracts:

“The content in the curriculum did not adequately prepare us to be serious health advocate [or advocate for health]” (PN23, 51years old Male).

“Well, I think that health advocacy is not that much heard during training,” (PN15, 43years old Female).

“Personally, I hold a view that our training from the nursing schools, particularly the nurses training, most of the time don’t empower us as health advocates,” (PN14, 37years old Female).

In addition to the poor educational preparation, the nurses reported a poor description of health advocacy in the curriculum, with little attention being paid by instructors as a barrier to its success. They stated that instead of tutors cultivating assertiveness during training they encourage submissive attitude in all instances, without critically considering the situation, as reported by some participants:

“It starts from the training schools, in school you don’t want to be seen as someone who speaks out, or stands up for your rights, because all those that do that, the tutors will have their eyes on them and they will frustrate them with their grades” (PN20, 33years old Male).

“There is something going on that you don’t like but you can’t talk for fear that from the final exams they will fail you” (PN15, 43years old Female).

“So sometimes we see problems as nurses and are unable to voice it out because of the way we were trained at school” (PN21, 31years old Male).

i. Structural victimisation

This subcategory emerged from data related to direct or indirect victimization of the nurse as barriers that hinder them from performing the health advocacy role, including healthcare settings and nursing education institutions. The barriers are institutional victimisation, fear of institutional punishment and victimisation during training, as demonstrated in the extracts below:

“Some nurses fear that the authorities will lambaste them or victimize them...so victimization is also a hindrance” (PN23, 51years old Male).

“Some of us are usually afraid of the fact that we may be penalized by the authorities if they speak out” (PN03, 36years old Female).

“The principal had to report him to Nursing and Midwifery Council and every year he was referred. Every year he was referred until about 6 years before he passed. The intimidation is real during training so how can you speak out when you qualify” (PN20, 33years old Male).

Discussion

Our findings show that many barriers prevent Ghanaian nurses from practising their health advocacy role in their daily practice. These range from their own innate personality traits as barriers to structurally related challenges.

Our findings revealed that perceived or real fears of being labelled as knowing too much can hinder nurses from doing the right thing in an environment where members are punished or not encouraged to stand up for their beliefs. Similar findings were reported in Zimbabwe, where nurses under-reporting of immunization adverse effects were found to be due to fear of their superiors [29].

Personality attributes, such as timidity, was reported as a barrier that prevents the nurses from practising their health advocacy role in Ghana. A lack of courage and confidence of some nurses made them timid and prevented them from speaking out whenever issues of health advocacy arose. Others have reported that timidity makes nurses lack courage and boldness to initiate their health advocacy role on their own [13, 30].

Professional inadequacies due to a lack of knowledge and practical experience in health advocacy have been reported as intra-personal barriers to nurses using their health advocacy role in both Ghana and the USA [1, 16, 31]. Professional inadequacies were also reported in the teaching field in a study by Lindqvist, Weurlander, Wernerson and Thornberg [32], where newly qualified teachers reportedly felt professionally inadequate during emotional stress. The nurses in Ghana also reportedly felt professionally inadequate when confronted with health advocacy issues, and suggests little exposure to this area during their clinical training.

A study in Ghana reported Inter-personal barriers similar to our findings, with Dadzie, Aziato and Aikins [16] noting that a lack of appreciation from clients was found to hinder the performance of their health advocacy role. Our participants reported that clients’ inconsiderate behaviours and lack of appreciation for the nurses were barriers that prevent them from using their health advocacy on their behalf. Unlike the norm of thanking a client after a procedure, it was reported that nurses expected to be thanked by the client. This suggests that speaking out for a disadvantaged patient is seen as favour rendered by the nurse and hence the expectation for appreciation.

This study also discovered that fear of victimisation of nurses from their seniors, colleagues and other health professionals were barriers preventing many nurses from speaking out. The victimization was

reported to come in the form of rejection from colleagues who disapprove of nurses speaking out for their clients. Previous studies have also reported that health advocates are perceived in some situations by their colleagues as disruptive and stubborn [1, 2]. Our findings revealed that nurses would rather not advocate for their clients than to be rejected by their colleagues.

Red tape, the excessive and rigid conformity to redundant formal rules within the health organisations, were reported to hinder nurses to use their health advocacy role due to the delay in response from management and unfavourable institutional policies. Cawley and McNamara [33] and Foley, Minick and Kee [34] have reported similar findings, where participants complained about institutional policies and delays from management as blocking and frustrating nurses efforts to advocate. While orderly and systematic management of issues in health institutions are necessary, their rigid and cumbersome processes can cause delays that retard progress and productivity.

Professional alienation and snobbery, as well as 'nurses eating their young', was reported as situations where junior nurses who were vocal or stood up to confront poor client care or working conditions were alienated by their colleagues and senior management. This has long been identified as a barrier to health advocacy performance among nurses [35, 36]. The existence of solidarity often observed in other health professionals who stand together to fight for their rights, or those of patients, was reported to be lacking within the nursing fraternity in Ghana. This was reported to stem from professional socialization to nursing, which was identified by one participant as the "keep quiet and obey syndrome". Many African culture and traditions appear to promote the "keep quiet and obey syndrome", where the young are not expected to have a say, but to obey and do whatever they are told. This was confirmed by participants who reported "being treated as children at work" and prevented them from standing up for their and their clients' rights. The culture of never challenging authority has been reported to make the practice of advocacy role very frustrating, leading to feelings of powerlessness and a lack of enthusiasm to intervene on behalf of clients [11, 13, 16].

Although professional alienation has been identified as a structural barrier to the practice of health advocacy in other countries [35, 36], it was found to be entrenched in the cultural socialization of children through the "keep quiet and obey syndrome". This cultural socialization behaviour thrives in the nursing profession in Ghana for many reasons. Firstly, many participants reported that health advocacy is not taught or poorly taught in most nursing schools in Ghana, and where it is taught, there are no positive role models for nurses to emulate in clinical settings. Instead they reported experiencing the opposite in clinical settings of what they are taught, with students and junior nurses not being allowed to speak out at work, but to keep quiet and obey what they are told to do. The absence of health advocacy role models in the clinical settings has been reported by others as a hindrance to nurses performing their health advocacy role [37, 38].

While nurse educators have many opportunities to prepare nurses as health advocates, these are often missed when they fail to nurture assertiveness among student nurses and be role models, and perpetuate professional timidity by silencing those students who are seen to be confrontational and vocal in raising

critical issues affecting their or the clients' lives in the learning environment [39]. The participants reported that they had observed situations where student nurses who were vocal in raising issues during training were openly castigated by nurse educators. This behaviour instilled fear and caused insecurity among the students, which then become a barrier to health advocacy during training and later in their professional life.

Conclusions

The barriers to nurses using their health advocacy role in nursing practice in Ghana are many and complex, and are due to intra-personal, inter-personal and structural factors. Barriers to nursing performing health advocacy role in Ghana are also entrenched in the cultural traditions, such as the socialization of children to keep quiet and obey, to do what they are told by adults, and not to question whether that is wrong or right. This cultural tradition permeates the walls of nursing education and healthcare settings, thus creating an impossible environment for practising health advocacy among nurses.

Incorporating health advocacy into the nursing curriculum may help challenge and overcome previously upheld cultural traditions preventing nurses from fulfilling this role, and will assist in addressing most of the intra-personal, inter-personal and structural barriers to nurses' practice of health advocacy. Providing nursing students with positive role models, both in the classroom and the clinical setting, can help to empower nurse practitioners as health advocates. Addressing cultural and professional traditions that enforce timidity and professional alienation in the nursing profession is important for eliminating structural barriers to the practice of health advocacy among nurses.

Limitations

Data collection for this study was conducted in three regional public hospitals in urban settings, and excluded the views of nurses in private hospitals as well as clinics in the rural areas of the country. Information from these categories would have provided more insight into the barriers experienced by these nurses to practice health advocacy.

Recommendation And Further Research

Based on the findings, the authors recommend further studies on the skills and tools needed for nurses to perform their health advocacy role, and a review of institutional policies to ensure that such efforts are taken seriously and expedited to support and encourage nurses to provide high-quality care to their patients. Based on the findings, the authors recommend further studies on the skills and tools needed for nurses to perform their health advocacy role, and a review of institutional policies to ensure that such efforts are taken seriously and expedited to support and encourage nurses to provide high-quality care to their patients.

Declarations

Ethics approval and consent to participate

Ethical clearance was obtained from the University of KwaZulu-Natal's (UKZN) Ethics Review Committee in South Africa (No. HSS/0289/018D), and the Ghana Health Services (GHS) Ethics Review Committee in Ghana (No. GHS-ERC 007/05/18) before data collection started.

Consent for publication

Not applicable

Availability of data and materials

Not applicable

Competing interests

The authors declare they have no conflict of interest.

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Authors' contributions

Both LL and SED conceptualised the idea, wrote the proposal and design the instruments for data collection. LL collected the data and analysed while SED reviewed and made corrections. LL and SED read and approved the manuscript. Both authors contributed to the paper.

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Tables

Table 1: Summary of findings

Categories	Sub-categories
A. Intra-personal barriers	a. Nurses personal fears b. Nurses personality attributes c. Nurses professional inadequacies
B. Inter-personal barriers	d. Clientele traits e. Perceived collegial persecution
C. Structural barriers	f. Red tape g. Professional alienation h. Poor educational preparation i. Structural victimisation