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Context and practices of health advocacy role by nurses in Ghana: A qualitative study

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ABSTRACT

Background & Aim: Nurses play a crucial role in health advocacy, which is both morally obligatory and has significant consequences for the clinician. However, there is a paucity of empirical evidence regarding its context and practices. The location, method, and rationale behind nurses fulfilling their health advocacy duties are crucial in hospital settings. This study explored and described where and under what circumstances nurses fulfill their health advocacy responsibilities in Ghana.

Methods & Materials: The study employed an inductive qualitative exploratory descriptive design to gather and analyze data from 24 nurses and midwives. Using a semi-structured interview guide, participants were selected from three regional hospitals in the upper, middle, and southern zones of Ghana, and qualitative content analysis was performed.

Results: Nurses and midwives carried out their health advocacy roles both inside and outside of healthcare institutions, using both proactive and reactive advocacy practices to initiate their role performance. Although reactive advocacy roles were reported more, the nurses and midwives identified unfair client treatment, health professionals' errors or omissions of procedure, and social injustice as the driving forces behind their advocacy.

Conclusion: Although health advocacy is performed by both nurses and midwives in hospitals and outside the hospitals, they are mostly reacting to situations. Teaching biopsychosocial assessment techniques to students during training and providing them with coaching and mentoring during clinical practice may enhance their ability to assess clients for unmet advocacy needs, enabling them to be proactive in their role performance.

Introduction

Health advocacy is the act and art of mediating, negotiating, and speaking out to protect the vulnerable and empower the disadvantaged and less privileged in relation to their health (1). Internationally, healthcare recognizes this crucial role (2); however, the context in which nurses practice this role remains undefined, particularly in Ghana, leading to a predominance of moral arguments in the absence of empirical evidence. Humanistic arguments that promote health advocacy as a moral phenomenon are captivating, yet what makes nurses perform the health advocacy role and where this role is performed have not been empirically clarified and understood. Although reports indicate that nurses serve as patient advocates, safeguarding patients' moral and legal rights, which they regard as paramount professional values (3). The context and the rationale for the role performance are inadequate in the literature because nurses in certain healthcare settings still overlook patients' autonomy and decision-making rights requiring that clinical nurses, managers, educators, and nursing researchers implement practical strategies and programs across various operational levels to enhance patient autonomy (4).

The term advocacy comes from the Latin word 'advocatus' which means someone summoned to give evidence (5), originally arising in law. An advocate in law is described as a lawyer who is consulted by a client before taking a case to a court of law. The lawyer gets

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the right to speak on behalf of the client in court to defend the client. In a similar fashion, nurses ensure patients/clients and their families are protected, respected, treated with dignity, and given the highest standard of person-centered care (6). Nurses are duty-bound to adhere to their professional code of conduct to advocate in most countries (5, 7).

Health advocacy is not new; authors including Hubinette, Dobson (8), De Campos Oliveira, and Martins Rios da Silva (9) have used the term before. According to Hanks (10), there have been calls for decades about nurses collectively advocating at a broader societal level for change in society rather than the nurse-patient relationship that only happens in the hospital environment. Particularly in Africa, with its fractured health system and widespread inequities, this call holds significant importance (11), because health advocacy binds the fundamental basis and the philosophical foundation that uniquely defines the essence of nursing practice and possesses the tool that brings equity and social justice (12). Historically, it was first used by Florence Nightingale, who saw the world as unsafe and required patients to be protected from its environmental and social effects on health. Today, in keeping up with the health landscape and for patient safety, it is vital for nurses to understand and practice the health advocacy role without seeing themselves as subservient (13). This is considered a strategy to reduce inequities, especially those considered unfair and unnecessary, in order to change the structural or institutional factors that contribute to inequitable and otherwise unacceptable conditions (14).

There is strong theoretical support to advocate for healthy public policies, including those that address the root causes of ill health, such as social and economic exclusion (12). Falk-Rafael and Betker (15) argue that advocacy for social justice and equity is a moral imperative for nurses and is required around the globe. It also defends the silenced and challenges ideologies that exclude some groups for the benefit of others (15). As a result, health advocacy is contextually diverse, depending on the situation and the individual performing the action (7, 16, 17), as many nurses engage in health advocacy within the hospital environment and outside the hospital, including the utilization of social media for universal coverage (18).

Unlike Africa, where barriers thwart most nurses from advocating (7, 11), developed countries such as Canada, the United States, and the United Kingdom consider health advocacy an ethical deontology that is highly rated (15). Nurses in developed countries are involved in many policy advocacy initiatives that directly address the social determinants of health and reduce health inequities (16). In an attempt to perform health advocacy outside the walls of the hospitals, they have advocated for policies that ensure access to affordable healthy housing, address food security and the building environment, address gender and racial inequities in healthcare access, improve transportation infrastructure (19), and promote environmental justice (20). The literature also captures the role of politics and political ideology as determinants of the equitable distribution of health prerequisites, an area in which non-organizational health advocacy has been taking place (21). For instance, Raphael (21) notes Finland, Norway, and Sweden as leaders in proactive approaches to public policy that provide a more equitable distribution of the fundamentals of health. The UK and other European Union nations have at least documentary proof of commitment to reducing social inequalities in health (12, 21). Although the literature search did yield some studies on health advocacy in Africa, those studies did not explore the context and practice of health advocacy. Therefore, understanding where and how nurses perform their health advocacy role is an area worth describing in the current study.

Methods

Design

An inductive qualitative exploratory descriptive design by Creswell and Poth (22) was used to gather and analyze qualitative data on the context and practice of nurses' health advocacy role performance in Ghana. It was determined that a qualitative exploratory descriptive design was the most suitable approach that would allow nurses in Ghana to

share their views on where they performed their health advocacy roles and the circumstances that motivated them to speak out. A qualitative descriptive study was used because of its ability to allow more detailed information about the context and practices of health advocacy to be gathered from the participants. The findings are reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ) (23).

Study setting

Three Ghanaian regional hospitals were chosen purposefully for this study. These are referral hospitals that house teaching facilities for nurses and other health professionals. These hospitals were chosen from the upper, middle, and coastal sectors of the 16 regions of the country.

Participants and sampling

A purposive sample of 24 participants, nurses, and midwives, were selected for an in-depth, semi-structured interview. Seven of these participants were male and 17 were female professionals. Their level of education ranged from a diploma in nursing to a PhD level. Ages ranged from 31 to 51 years, with clinical nursing experience ranging from 5 to 15 years. Details of the participants are shown in Table 1.

Table 1. Demographic characteristics of participants

Zone	Participants	Sex	Category	N	
Upper zone	9	Male	Nurses	4	4
		Female	Nurses	1	5
			Midwives	4	
Middle zone	8	Male	Nurses	2	2
		Female	Nurses	2	6
			Midwives	4	
Southern zone	7	Male	Nurses	2	2
		Female	Nurses	1	5
			Midwives	4	
Total sample	**24**			**24**	**24**

During the initial stages of the data collection, professional nurses and midwives who met the inclusion criteria in each of the regional hospitals were recruited. These participants were recruited based on their previous involvement in the health advocacy role or having observed a colleague advocating. The sample size was based on data saturation.

Data collection

Data was collected and analyzed concurrently. The researcher developed a semi-structured interview guide based on the study's objectives and questions. The following research questions helped to facilitate this interview: (1) Where have you practiced, and where, in your opinion, should nurses perform their health advocacy role? (2) Describe the circumstances that prompted you to intervene as an advocate along with the actions you took in response. The answers from participants generated prompts and follow-ups. For instance, some individuals have identified social injustice as a situation in which they intervene in their community. What is your opinion?

The face-to-face semi-structured interviews allowed for a thorough exploration while also allowing the interviewer to stay within the study's defined objectives. The author, a male healthcare professional with a doctoral degree and a qualitative researcher, conducted all of the interviews in English, which is Ghana's formal communication language in healthcare. This also helped with the transcription and analysis of data. The author conducted audio recordings during the interviews and took field notes as part of the data-gathering process. Only the participant and the researcher participated in the 45–60-minute interviews, which took place in the nurses' office.

Data analysis

The qualitative content analysis approach by Graneheim and Lundman (24), was used to analyze the transcripts. This method

entails identifying both tangible and conceptual patterns in the similarities and differences among the data collected from the participants (24). The author studied and compared the interview transcripts with the recorded interviews to weed out inaccuracies. After this, he reread the interviews multiple times to comprehend the unit of analysis. Once a comprehensive understanding was reached, meaningful segments, or statements that revealed anything pertinent to the objective, were identified, extracted from the text, and transferred to a distinct MS Word document. Subsequently, each meaning unit was condensed and assigned a code, representing a brief explanation of its content.

The author deliberated on the subthemes before consolidating them into themes, analyzing their variations by oscillating between different components. The author analyzed the resulting codes, organized them into themes, and found subthemes based on their similarities and differences. Following Graneheim and Lundman's (24) approach to abstracting subthemes and themes, three primary themes and a total of ten subthemes were identified.

Ethical considerations

This study got approval from the University of KwaZulu Natal (UKZN) Ethics Review Committee in South Africa and the Ghana Health Services (GHS) Ethics Review Committee in Ghana, with reference numbers HSS/0289/018D and GHS-ERC 007/05/18, respectively. Permission letters were also obtained from data collection sites. Participation was voluntary, and participants' rights were ensured during this study. In a meeting organized with the assistance of the administrator of nursing services, the selected participants were given the information sheets, and those who agreed to participate were recruited and asked to sign the informed consent forms before interviews. During and after collecting data, the author adhered to the principles of anonymity and confidentiality.

Rigour

Member checking and validation were performed by revisiting 11 participants and providing them with their interview transcripts to ensure trustworthiness. An intercoder, who is an expert in qualitative content analysis, assessed and agreed with the codes generated from the raw data to ensure confirmability. Accurate data, such as field notes, was kept creating an audit trail documenting the decisions made during the research. The audit trail provides a rationale for the researcher's methodology and interpretive judgment, which can assist in enhancing transferability. Qualitative content analysis methods were meticulously applied to ensure reliability.

Results

Four main themes were curved from the data after analysis. These themes were institutional advocacy context, non-institutional advocacy context, proactive advocacy practice, and reactive advocacy practice, with ten subthemes, as shown in Table 2. Parts of these findings in summary were published in a grounded theory (1).

Table 2. Context and practice of health advocacy

Themes	Subthemes
Institutional advocacy context	▪ Noticing an unfair treatment of the client ▪ Noticing medical omissions and misapplications ▪ Noticing clients are unjustly delayed for treatment ▪ Noticing clients' rights are denied
Non-institutional advocacy context	▪ When there is social injustice in the communities ▪ When the disadvantaged and less privileged are ignored
Proactive advocacy practice	▪ Championing the course of clients during treatment ▪ Speaking against threats to clients' healthcare needs
Reactive advocacy practice	▪ Speaking to facilitate access to healthcare ▪ Responding to the clients' need for health advocacy

Institutional advocacy context

This refers to a type of health advocacy that is performed within an organization. Nurses engage in it when they feel compelled to voice their opinions within the boundaries of an organization or a healthcare facility. The institutional advocacy context emerged with four subthemes. These subthemes were reported as reasons that gave nurses and midwives the impetus to advocate. (1) noticing unfair treatment of the client, (2) noticing medical omissions and misapplications, (3) noticing clients unjustly delayed for treatment and (4) noticing clients denied their rights in a health facility.

Noticing unfair treatment of a client in an institution emerged from the data, and participants reported unfavorable cost of services in the hospital, maltreatment of clients by the professionals, and sometimes when clients' rights are infringed upon and ignored during labor. Participants reported the above situations as reasons for approaching authorities and powers in their institutions.

''In this hospital, there have been lots of contexts that pushed me to advocate…sometimes the cost of treatment is unnecessarily high for a client who does not have health insurance registration'' (PN05).

''There were times I went to the hospital authorities because some of the situations involved policies or rules that were hard to break and were leading to unfair treatment of our clients, for instance, deposit before treatment'' (PN19).

Some participants reported that noticing medical omissions and misapplications, which, according to them, may lead to commission or omission by a professional, motivated them to speak out to rectify them. Omission of a step of clinical procedure by professionals, failure to recognize clients' rights during treatment, and misdiagnosing a client by a colleague professional were reported. Others indicated that in situations where a client's treatment regimen may lead to a serious complication of the client's condition, they did not keep silent.

''I usually speak out when I identify an omission of a procedure or a colleague giving a medicine that will affect the client's health negatively'' (PN05).

''I remember this situation in this hospital environment where we stood our ground as professionals because a medical officer prescribed a medicine that was contraindicated and would not agree to be corrected'' (PN03).

When clients are unjustly delayed for treatment or professionals delay in referring clients to a better clinical facility for treatment, the nurses speak out. The participants reported unnecessary delays in providing health service or treatment to the client or canceling a booked operation without reason as unacceptable and that clients should not be treated in such a manner of injustice.

''There were times we had to confront a physician for unnecessarily delaying a client's treatment because he was delaying in referring him (the patient) to a better place to access facilities that would assist in his recovery'' (PN05).

''There are several examples…some surgeons will book a client for an operation, and we prepare the client by not allowing them any food for the whole day, only to get a phone call in the evening informing us that the operation has been canceled without reason. We can't treat human beings like that. We speak out about it, and we don't take it kindly for our clients'' (PN19).

The participants expressed concern about the denial of client rights. The nurses advocated for clients who faced denial of their social and ethical rights to freedom of choice. Nurses viewed the right to treatment and the necessary resources to care for clients as rights, not privileges. Senior nurses saw the unhygienic hospital environment as poor service to the client and did not take that lightly.

''I don't joke with my client's environment, and when the conditions our clients sleep in are poor, I don't take it kindly with those in charge. The cleanliness of the environment is important because it can breed mosquitoes or lead to nosocomial infections'' (PN18).

''Nurses, we are always in a constant battle with the authorities regarding the right

resources needed to ensure clients get the right care. We do this because of our clients; it is our duty to speak for them'' (PN01).

Non-institutional advocacy context

The nurses did not only advocate in organizations or health institutions. There were nurses who actively advocated for issues related to social determinants of health within their communities. Non-institutional advocacy context was reported as situations and events that propelled nurses to speak out in their daily lives, not necessarily situations that occurred in an organization. Social injustice, such as the unjust treatment of an individual by society through no fault of his or her own, in the case of stigmatizing a client for giving birth to a deformed baby. Nurses and midwives also spoke when social amenities were not provided for communities and when clients were rejected from their homes and communities due to their health conditions. Midwives, for instance, saw the bad road network as an issue to speak about since it relates to factors that may delay the arrival of women in labor.

"We also have a lot of responsibilities when it comes to road networks, especially as midwives. They referred a client from XXX, and because of the bad road network, she got here in a terrible state. I spoke passionately about the loss because I felt if the roads were good with a good transportation system, she would have arrived here early, and we would have done a better job. I see it as our duty to speak out for these communities'' (PN03).

''I have spoken to families concerning them stigmatizing clients, clients like those with HIV and AIDS, and even pregnant teenagers who were unjustly stigmatized for getting pregnant while in school. I stood up for them in the communities, and after that, I provided some health education" (PN07).

Ignoring the disadvantaged and less privileged prompted some nurses and midwives to advocate. This included speaking for some non-insured clients during emergencies and intervening when individuals with mental health conditions were neglected at home. They reportedly stood up for those whose voices remained unheard in the community and spoke up when the less privileged faced neglect.

''This man (a psychiatric patient) was tied to a tree, and all activities of his daily living were carried out under this tree... We felt it was inhumane; we went to the pastor to speak up for him'' (PN20).

''You see, our profession entails a lot; we have spoken to authorities before regarding good drinking water for one community because we realized, they were disadvantaged and less privileged. We 'fought' for them, and now they have potable water'' (PN12).

In exploring the context of health advocacy roles by nurses and midwives, two practice initiatives were identified based on the situation the participants found themselves in, and these were proactive advocacy practice and reactive advocacy practice (1)

Proactive advocacy practice

This relates to controlling a situation and not responding to it after it has happened. In proactive advocacy, the participants initiate without demand or prior notice from the client. Proactively, they helped clients meet their unmet needs and championed situations until solutions were obtained. Championing the cause of clients during treatment and rights, demanding an apology for ill-treated clients, and fighting to get basic things to care for clients were situations that nurses and midwives proactively performed during advocacy.

''I believe in customers' rights regardless; we have demanded an unqualified apology for a lot of our clients here when they have been abused by other health professionals'' (PN04).

''Sometimes things pushed us to the point where we spoke a language that sounded like threats to management before things were done; sometimes if the most basic things are not there and all you are telling me is to manage, manage with what?... These are the lives we talk about'' (PN13).

The nurses and midwives also spoke against threats to the client's healthcare needs. Anytime they noticed a potential risk, they proactively initiated strategies to provide a solution. Some of these situations led to

confrontations with management, requiring them to restock essential medicines for clients.

When clients request simple emergency medicines and they are not available, we voice our concerns. That is dangerous for the clients; we cannot keep quiet for people's significant others to die; it is unacceptable" (PN24).

Reactive advocacy practice

Reactive advocacy practice involves acting in response to meet clients' needs rather than controlling the situation by initiating without request. Nurses and midwives, in reacting to clients' requests, spoke to facilitate access to healthcare and responded to the various needs of the clients to advocate. They spoke for a reduction in the cost of clients' treatment and taught and led clients to access care. They responded to threats encountered by patients during care and answered queries raised by clients concerning their care in the facilities.

"There are delays at the pharmacy sometimes, and when they come back to request assistance, we follow up and speak for them [the patients] to speed up their access to medicines. We do this only if they request or complain of delays" (PN02).

"We felt she was not treated right, so we reacted to that and followed up with the right offices to make sure that all her needs regarding her healthcare were met" (PN03).

Responding to clients' unmet needs for advocacy means facilitating and mediating for a client's rights to a variety of treatments. In response to client complaints, the nurse performed the health advocacy role.

"I remember an orphan who was treated here for a road traffic accident. After the treatment, she contacted me about her benefits. Therefore, I took the initiative to act as a mediator, facilitating her benefits after her recovery (PN20).

"We respond and act whenever they request our assistance because unless they request it, we will not know they need some assistance or have some unmet needs not directly related to their health" (PN03).

Discussion

The objective of this study was to explore and describe the context and practices of the health advocacy role of nurses and midwives in Ghana. The findings show that nurses and midwives in Ghana practice health advocacy both inside and outside of institutions. Medical omissions, misapplications, and social injustice propelled nurses and midwives to speak out.

The findings of the current study reveal that health advocacy happens in most healthcare facilities whenever the participants notice unfair treatment of the clients, observe medical omissions and misapplications, see clients unjustly delayed for treatment, and when clients' rights are violated. These conditions and situations, when present, pushed the nurses in the health institutions to speak out. The current findings are similar to findings from a previous study by Flores, and Laws (25), where it was reported that errors in medical interpretation and their potential clinical consequences in pediatric cases were noted as the most common errors, making up more than 50% of the total. More than half of these errors, including omitting questions about drug allergies and omitting instructions on the dose, frequency, and duration of antibiotics, had potential clinical consequences that the nurse's advocacy role could help to curb. Similar findings were also reported by Osmon and Harris (26) who discovered that medical errors that may have contributed to patient deaths were identified and reported by nurses. Osmon, and Harris (26), concluded that while some fraction of medical errors might be considered inevitable, nurses' ability to advocate reduced medical errors drastically.

Our findings also categorized situations that pushed nurses to speak out outside the confines of the health facilities as a non-institutional advocacy context. The study findings indicate that nurses voiced their opinions when they observed social injustices in their communities and when the disadvantaged and less privileged received no attention. Participants reported speaking out on issues that needed policy consideration, where some communities were deprived and had experienced their voices not being heard. Spenceley, and Reutter (27) also reported that the moral and ethical obligation of nurses to engage in strategies to effect policy change for healthcare had been increasing because nursing had been well-positioned to

participate successfully in policy advocacy, even though Spenceley, Reutter (27) also argue that the literature on policy advocacy was not well developed in nursing, and might not have had an impact at the policy level. The current findings have revealed that nurses have been professionally committed to the goals of improving healthcare, and their responsibility to advocate at the policy level has been openly recognized. This commitment and desire to advocate are the right steps towards change.

Nurses advocating for good road networks, disabled-friendly buildings, and the proper citation of factories in communities were revealed, which is consistent with other authors' findings as a matter of social justice. Participants stood up for and spoke for the communities affected (28). Our findings suggest that health advocacy is an all-round nursing activity that can reduce health inequities in societies if nurses maintain it as a critical professional role.

The findings in this study reveal that nurses perform health advocacy roles proactively, initiating and playing a role in preventing health issues in a health facility or the community. This is viewed as a preventive approach, actively intervening to address a client's situation after conducting an assessment. Proactive health advocacy practice emerged as participants reported championing the cause of clients during treatment and speaking against threats to their healthcare needs. Participants believe championing the cause involves a situation where the nurse initiates without demand or prior notice from the client and aids the client in meeting the unmet needs based on the nurse's assessment and previous experience. The nurse advocates for the clients and persistently pushes for a resolution to the situation. These findings validate previous reports by Bu and Jezewski (29) that, among other roles, nurses championing social justice were performed as advocates. Championing social justice also suggests speaking for the social determinants of health, which were previously reported by other authors (15, 21).

Participants reported that nurses speak against threats to clients' healthcare needs, taking the initiative without the client's request and speaking out against any anticipated risks to maintain the client's internal and external equilibrium. The participants believed this involved making resources available for the nurses to assist the client, or for the client to perform the task unaided with prompting from the nurse. This also suggests the nurse providing the right information or creating awareness as reported by Dadzie, Aziato (30). The current study also identified that one way to perform health advocacy is to provide the necessary material or information needed for the client to complete the task unaided.

The study revealed reactive advocacy practice, in contrast to proactive advocacy practice. Participants reported executing certain health advocacy roles at the client's request. This was evident as participants mentioned having assisted every client that had a request, either for information or for a task to be performed. This was conceived as reacting to the situation or events and performing a curative activity, suggesting that the nurse's assessment of the client was insufficient. Reactive advocacy practice has been published in previous studies by other authors (12). Our findings reveal that some participants in this study only spoke to facilitate access to healthcare and as a response to the client's need for health advocacy. These findings suggest inadequate knowledge of biopsychosocial assessment of clients for health advocacy needs and hence, participants sometimes only responded to clients' requests without initiation.

Conclusion

The findings suggest that regarding location, method, and rationale for health advocacy, the nurses performed the role in both institutional and non-institutional contexts. The nurses interviewed executed the advocacy role either reactively or proactively, citing the injustice and unfair treatment of clients as their justifications. However, many of the participants reported practicing reactive advocacy rather than the ideal proactive advocacy. Training nurses and midwives in health advocacy are required to equip them with the necessary knowledge on how to identify clients who need the role of a nurse.

Further studies are needed in health advocacy, utilizing nurses from private healthcare

institutions in rural and suburban areas, to better understand their communication skills in these settings. Furthermore, the research reveals nurses' deficiency in evaluating clients' health advocacy role performance needs, prompting an exploratory investigation to uncover effective strategies to enhance the health advocacy role's performance.

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Conflict of interest

The author declares there are no conflicts of interest concerning the research and the publication of this article.

References

1. Laari L, Duma SE. Health advocacy role performance of nurses in underserved populations: A grounded theory study. Nursing Open. 2023 Sep;10(9):6527-37.
2. Negarandeh R, Oskouie F, Ahmadi F, Nikravesh M, Hallberg IR. Patient advocacy: Barriers and facilitators. BMC Nursing. 2006;5:1-8.
3. Žiaková K, Kohanová D, Čáp J, Kurucová R. A thematic analysis of professionalism from the perspective of nurse managers. Nursing Practice Today. 2023; 10(4): 344-55.
4. Beykmirza R, Negarandeh R. What are the factors influencing nurses to neglect patients' autonomy and decision-making? Nursing Practice Today. 2017;4(4):212-5.
5. Alexis O, Cooke J, Shimumbi L, Worsley A. The role of the nurse advocate in health and social care. Mediterranean Nursing and Midwifery. 2022;2(3):140-6.
6. Negarandeh R, Oskouie F, Ahmadi F, Nikravesh M. The meaning of patient advocacy for Iranian nurses. Nursing Ethics. 2008;15(4):457-67.
7. Laari L, Duma SE. Barriers to nurses health advocacy role. Nursing Ethics. 2023 Sep;30(6):844-56.
8. Hubinette M, Dobson S, Scott I, Sherbino J. Health advocacy. Medical Teacher. 2017 Feb 1;39(2):128-35.
9. De Campos Oliveira MA, Martins Rios da Silva T. Health advocacy in nursing: contribution to the reorientation of the Brazilian healthcare model. Revista Brasileira de Enfermagem. 2018;71:700-3.
10. Hanks RG. Social advocacy: a call for nursing action. Pastoral Psychology. 2013;62(2):163-73.
11. Laari L, Duma SE. Facilitators of the health advocacy role practice of the nurse in Ghana: A qualitative study. Health Science Reports. 2021;4(1):e220.
12. Cohen BE, Marshall SG. Does public health advocacy seek to redress health inequities? A scoping review. Health social care in the community. 2017;25(2):309-28.
13. Laari L, Duma S. A call for total nursing role reformation: Perceptions of Ghanaian nurses. Nursing Inquiry. 2023:e12549-e.
14. Almidei N. So you want to make a difference: Advocacy is the key. Washington DC: OMB Watch. 2010.
15. Falk-Rafael A, Betker C. Witnessing social injustice downstream and advocating for health equity upstream: "The trombone slide" of nursing. Advances in Nursing Science. 2012;35(2):98-112.
16. Kahlke R, Scott I, van Der Goes T, Hubinette MM. Health advocacy among medical learners: Unpacking contextual barriers and affordances. Medical Education. 2023;57(7):658-67.
17. Laari L, Duma SE. Barriers to nurses using their health advocacy role in nursing practice: A Ghanaian Perspective. 2020.
18. Ezeilo CO, Leon N, Jajodia A, Han H-R. Use of Social Media for Health Advocacy for Digital Communities: Descriptive Study. JMIR Formative Research. 2023;7:e51752.
19. Ingram M, Schachter KA, Sabo SJ, Reinschmidt KM, Gomez S, De Zapien JG, Carvajal SC. A community health worker intervention to address the social determinants of health through policy change. The Journal of Primary Prevention. 2014 Apr;35:119-23.
20. McAndrews C, Marcus J, Research. Community-based advocacy at the intersection of public health and transportation: The challenges of addressing local health impacts within a regional policy process. Journal of Planning Education. 2014;34(2):190-202.
21. Raphael D. Beyond policy analysis: the raw politics behind opposition to healthy public policy. Health Promotion International. 2015;30(2):380-96.
22. Creswell JW, Poth CN. Qualitative inquiry and research design: Choosing among five approaches: Sage Publications; 2016.
23. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and

focus groups. International Journal for Quality in Health Care. 2007;19(6):349-57.
24. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures, and measures to achieve trustworthiness. Nurse Education Today. 2004;24(2):105-12.
25. Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics. 2003;111(1):6-14.
26. Osmon S, Harris CB, Dunagan WC, Prentice D, Fraser VJ, Kollef MH. Reporting of medical errors: an intensive care unit experience. Critical Care Medicine. 2004;32(3):727-33.
27. Spenceley SM, Reutter L, Allen MN. The road less traveled: nursing advocacy at the policy level. Policy, Politics, & Nursing Practice. 2006;7(3):180-94.
28. Allender J, Rector CL, Warner KD. Community health nursing: Wolters Kluwer Health/Lippincott Williams & Wilkins; 2010.
29. Bu X, Jezewski MA. Developing a mid-range theory of patient advocacy through concept analysis. Journal of Advanced Nursing. 2007;57(1):101-10.
30. Dadzie G, Aziato L, Aikins AD. "We are the best to stand in for patients": a qualitative study on nurses' advocacy characteristics in Ghana. BMC Nursing. 2017 Dec;16:1-8.