



Patient Characteristics that Influence the Advocacy Role of Nurses in Ghana: A Qualitative Study

Grace Dadzie^{1*}, Lydia Aziato¹ and Ama de-Graft Aikins²

Abstract

Study background: Several factors influence nurses to advocate for patients in the course of their work including particular patient characteristics. These characteristics however, are under reported in Ghana.

Methods: The objective of the study was to determine the patient characteristics that influence the advocacy role of nurses. Ethical approval was obtained from the appropriate bodies and the study employed a qualitative exploratory descriptive design. A sample size of 15 nurses working in a regional hospital in Ghana was used and the participants voluntarily consented to participate in the study. Data was collected using a semi-structured interview guide and analyzed using content analysis.

Results: The participants advocated for patients who were neglected, vulnerable, uninformed, intimidated and dissatisfied. They advocated for those whose relatives failed to provide them with food, drugs and care. The participants also advocated for unconscious patients, children and apathetic patients. Their advocacy was also sometimes geared towards the protection of patients from paternalism, the profit-oriented health system and the complexity of the health system. Additionally, they advocated for the poor, uninformed and anxious patients and those who were dissatisfied with their care.

Conclusion: The characteristics of patients that elicit nurses' advocacy roles are diverse and may be context specific. The study provides an insight into patient characteristics which elicit nurses' advocacy. Findings could be useful in enhancing the advocacy role of nurses to improve quality of care, patient satisfaction and patient autonomy.

Keywords

Ghana; Nursing; Patient advocacy; Patient characteristics; Qualitative research

Introduction

Patient advocacy is an iterative process of analyzing, counselling, and responding to patients' care and self-determination preferences [1]. The advocacy role of nurses has been established as a key factor in enhancing positive patient health outcomes [1,2]. It is regarded as

one of the fundamental concepts of nursing ethics [3]. Historically patient advocacy arose partly in response to physician paternalism and abuse of patients' rights and to help health care professionals deal with ethical issues in their practice [4].

The role of nurses as patient advocates in healthcare settings thrives on the current support for patient autonomy thus when nurses identify patients who are unable to make autonomous decisions, then that patient becomes reliant on the nurse's advocacy for him or her to make decisions and to stand up for their views and beliefs [5,6]. However nurses also benefit from the role by experiencing a feeling of satisfaction when they advocate for patients [7]. Patient advocacy is often necessary in the health system due to poor patient conditions, the profit-oriented health system and the paternalistic attitude of some health professionals [2,8,9]. Patient safety depends on nurses because of their proximity and continuity with patients and a culture of safety in organizations make patient advocacy a responsibility of all, especially nurses [10].

African healthcare practitioners and policy-makers including Ghana still tend to practice paternalistic medicine, with little patient participation in treatment decision-making. Low literacy levels, lack of access to the internet, gender inequity in most African communities are responsible for this situation [11]. Also in sub-Saharan Africa, health care systems that are committed to patient-centred care and non-hierarchical interactions between patients and healthcare providers are rare due to limited resources, traditional beliefs and limited health education programs leading to poorly informed clients [12]. However, there is the need for patient inclusion in all key healthcare decisions to ensure a more egalitarian healthcare approach.

Patient characteristics that influence patient advocacy however, have not been well explored in Ghana hence the need for this study. This work is part of a wider study on patient advocacy by the first author.

Methods

Research design

The study was approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research (NMIMR-IRB CPN 018/15-16) and the Ghana Health Service Ethics Review Committee (GHS-ERC: 04/10/15). The qualitative exploratory descriptive design was employed to investigate patient characteristics that influence the advocacy role of nurses in Ghana [13]. This research design enables the probing of issues to gain a full understanding of the phenomenon being studied. The study was conducted at the theatre/recovery, male medical and children's wards of the Effia-Nkwanta Regional hospital, a government hospital in the Western Region of Ghana. The use of the three units enabled the researchers to sample the views of a wider group of nurses in the hospital. The participants were nurses who could provide in-depth information on patient characteristics that influence nurses to advocate for them. There were 14 females and a male, 12 of them were aged between 25-35 years, one between 36-45 years and two others were above 55 years. Nine participants had diplomas in either Nursing or Midwifery and six had Bachelor of Science in either Nursing or Midwifery. Six participants had between

*Corresponding author: Grace Dadzie, School of Nursing, University of Ghana, P.O. Box LG43, Legon, Ghana, Tel: 233201514442; E-mail: gracedcom222@gmail.com

Received: November 14, 2017 Accepted: March 05, 2018 Published: March 14, 2018

3-5 years working experience, four between 6-10 years and five had more than 10 years working experience.

Meetings were organised to explain the purpose of the study to prospective participants and were provided with participant information sheets which contained additional information about the study and the first author's contact for further enquiries. They were then invited to take part in the study. Also the nurse managers helped to identify nurses who could provide in-depth information about the patient characteristics that influence patient advocacy. Those who agreed to take part in the study signed consent forms and were recruited using the inclusion criteria of more than two years working experience and an educational qualification of at least a diploma. Newly qualified nurses were excluded from the study.

Seventeen professional nurses and midwives were then purposively sampled initially from a population of 190. The sample size was however determined when no new finding was generated (saturation) as the study progressed. Saturation was achieved with 15 participants. A semi-structured interview guide designed based on the study objective and literature review was used to collect data from participants' at their preferred venues at the hospital where there was privacy. Participants were asked questions like: What challenges do patients face at the hospital? Why should nurses advocate for patients? In what situations do nurses advocate for patients? Individual participant interviews were conducted in English and audio taped with participants' permission. The interviews lasted between 33 – 57 minutes. The audiotapes were transcribed verbatim by the first author. Each transcribed interview was saved with a different font colour for easy identification of responses from different participants. Also a seven centimetre margin was left to provide space for writing codes during data analysis.

The objective of the study was explained to participants and they consented to participate in the study by signing a consent form. Participation in the study was voluntary and participants were assured that their names or any identifying information about them would not be mentioned in the study. They were assigned unique numbers during recruitment into the study. These numbers were used when quoting verbatim expressions of participants in the findings section to ensure anonymity. Also hard copies of the interviews were separated from the consent forms which had identifiable information and kept under lock and key in a cabinet at the first author's office. Soft copies of the interviews were also saved on a password protected computer. Only the researchers had access to the raw data.

The data was analyzed concurrently with data collection using content analysis which involved organizing and integrating narratives into relevant themes and concepts [14]. The techniques of data reduction, data display, conclusion and verification [14,15] were applied. Rigour was also ensured by satisfying criteria for achieving credibility, dependability, confirmability, transferability and authenticity of the data [16]. The researchers ensured that the findings reflected participants' own experiences by using verbatim quotes. Also observations made during the interviews were noted in field notes and a journal was kept to provide context and background for the analysis. This established confirmability of the data. Transferability was also ensured through the provision of a detailed description of the research setting, methodology and background of the sample used in the study. Additionally, an audit trail of documents and the transcribed data was kept for reference purposes.

Results

The participants perceived that patients whose relatives failed to provide them with food, purchase their drugs or assist with their care at the hospital as neglected and required nurses' advocacy to obtain food, drugs and necessary nursing and medical care. They also believed that unconscious patients, children and patient who showed apathy concerning their care were vulnerable thus needed nurses' advocacy. Moreover factors such as paternalism, the profit-oriented health system, poverty and the complex health system made some patients vulnerable. Some also advocated for patients who lacked information about their health issues and those who were anxious of possible death or their diagnosis and those who were afraid of some staff and the crowd at the hospital. Moreover, they advocated for dissatisfied patients to get better care including those who complained about the uncomfortable hospital environment, delays at the hospital, lack of drugs, poor meals and poor staff attitude. These patient characteristics formed the five themes namely neglected patients, vulnerable patients, uninformed patients, intimidated patients and dissatisfied patients for the study.

Neglected patients

The direct involvement of both the nuclear and extended family in patient care at the hospital is an expectation in the Ghanaian culture. Most hospitals provide two meals a day for just three days and some drugs are not covered by the National Health Insurance Scheme. Relatives are thus expected to regularly visit patient to provide food, buy prescribed drugs and assist in their care. However, many participants (40%) revealed that some relatives did not visit their patients.

"Sometimes they don't have food because no relative is visiting ... it doesn't even help the patient recover fast" (Nurse 14).

"Some come here and finding a relative to bring money for drugs sometimes is a problem" (Nurse 14).

"At times relatives are not coming...here in this hospital relatives are needed because they help us in caring for the patients like going to buy their drugs and even feeding" (Nurse 10).

Vulnerable patients

There were a few participants (20%) who pointed out that unconscious patients were vulnerable and could not communicate their problems and relied on the nurse's advocacy to have their needs met. Moreover, the conditions of children with infectious diseases like malaria which is common in Ghana deteriorated faster and they developed complications quickly thus needed advocacy to receive prompt attention. This is because long queues and delays often characterize attendance to government hospitals moreover, triaging is a new concept that is being introduced in the Ghanaian health system thus hospitals usually operate on first-come, first-served basis. Such situations could be detrimental to children who report late with severe conditions.

"An unconscious patient on the ward would not be able to tell you the place is noisy, whether there is a bad smell or maybe even the way he or she is being handled he does not like it and that is the time the nurse has to stand in and advocate for the patient" (Nurse 9).

"If a child gets malaria in no time there will be haemolysis, anaemia... they just die or they go into cerebral malaria. The child may have cerebral palsy so in cases like this we treat it as emergency" (Nurse 13).

There were also suggestions among some (13.3%) that some patients were apathetic about what went on in their own care. However, some of them were not allowed to have a say in their own care even when they wanted to.

“Some people ask us about the way forward, the next thing to be done but some don’t care” (Nurse 3).

“We the health workers don’t want them to tell us what to do for them and those who are trying to voice out are seen as being difficult” (Nurse 14).

Nurse 9 was of the view that patients often underwent numerous diagnostic tests which were usually expensive.

“They have to pay for most of the investigations, most of them are expensive. For my ward they will do the labs ...the blood culture and sensitivity test and blood electrolytes” (Nurse 9).

In some instances (20%) participants felt that uninsured and poor patients who could not settle their bills needed advocacy especially when the health insurance scheme did not cover the cost of all the drugs and services.

“Most of them don’t have health insurance or money therefore when it comes to the bill we have to call the social worker to come” (Nurse 2).

“Now we have some drugs that health insurance does not cover as well as laboratory and some other things” (Nurse 5).

Other participants (26.7%) explained that some patients lost their way in the hospital and others could not navigate the health system and others could not communicate with nurses because of language barrier.

“I once encountered a patient who had difficulty in locating the lab... maybe she couldn’t read” (Nurse 5).

“Some don’t know where to start from, they don’t even know when to go for the laboratory results and come and see the doctor. They don’t come for review” (Nurse 7).

“Sometimes we are not able to communicate with our patients due to language barrier” (Nurse 11).

Uninformed patients

Over a half of the participants (79.3%) disclosed that some healthcare professionals failed to discuss patients’ treatment with them, explain procedures or educate them about their condition; thus, some patients relied on often inaccurate information from the internet about their condition.

“At the operating theatre a patient might come for surgery, he has signed the consent form but he doesn’t know the type of operation they are going to do” (Nurse 14).

“As for the treatment here, sometimes the doctor won’t discuss with you which one you prefer...no because he knows the best for you” (Nurse 11).

“Sometimes we even do retroviral screening without the patient’s notice. We think they will withdraw in giving their consent if they are informed prior to the test” (Nurse 1).

“Some patients if they know their diagnosis they go back home and read about it on the internet. It’s not everything that is on the internet that is true though” (Nurse 5).

One participant thought that screens that sometimes separated patients from healthcare professionals prevented them from asking questions.

“Some of our structures do not encourage patients to ask questions ...when you are putting down your folder you have to be peeping through a small window. They are at the other side so (sighs) it’s quite difficult” (Nurse 4).

Intimidated patients

For some participants (20%) advocacy was necessary for patients who were anxious of possible death or about their diagnosis.

“A patient who was admitted and just that evening two people near him died and he wanted to go home” (Nurse 3).

“There is the fear of the unknown ...we have to finish with the investigations before we educate them about their condition so while waiting they will be in fear” (Nurse 9).

Most participants (80%) were also influenced to advocate for patients who were intimidated by the presence of the numerous staff and other patients at the hospital and failed to ask staff questions for fear of being ridiculed. However, some patients spoke to nurses but not doctors.

“Some people easily get intimidated by crowd. Maybe they are a little shy so they don’t feel comfortable opening up” (Nurse 13).

“Most of our people are not educated so when they come they are not even bold to ask what is wrong with them” (Nurse 9).

“They don’t want to be ridiculed after asking questions ...some feel threatened asking us questions” (Nurse 10).

“Some of them will rather talk to the nurses after the doctor is gone. Our society hails doctors and so they don’t have the courage to ask them questions” (Nurse 4).

Dissatisfied patients

Participants reported that in some instances (13.3%) mosquitoes and noise at the hospital disturbed patients as Nurse 6 explains.

“Patients on admission complain that the environment itself is not inviting; mosquitoes here and there as well as disturbances even from us the health workers” (Nurse 6).

Many participants (46.7%) also reported that patients were often unhappy with the delays they experienced at the hospital.

“There are a lot of people yet the personnel to take care of them are only few. This situation causes them to wait for a long time. This sometimes leads to chaos” (Nurse 5).

“There would be a diabetic with foot gangrene in the medical ward and we call on the surgeons to come and inspect the foot but they don’t come. The person will be fine but we can’t discharge him. Even when you explain, the patient doesn’t understand. They wonder why they are still here” (Nurse 10).

“At the records sometimes they don’t find their folders. The patient comes back to the ward and we say you have to get your old folder” (Nurse 1).

A few of them (13.3%) also hinted that sometimes the hospital did not have enough drugs and patients had to buy drugs from outside.

“There has been shortage of drugs and sometimes patients have to go out and purchase their own drugs” (Nurse 8).

Again Nurse 9 explained that some patients complained about poor meals at the hospital which calls for advocacy.

“They serve two meals and always it is rice and beans so for some it’s a problem” (Nurse 9).

A sizeable number of the participants (33.3%) also admitted that patients complained about the poor attitude of some staff especially those who often visited the hospital.

“They see us mostly to be rude. Some have had bad experiences especially those with the chronic diseases ...they come to the hospital more often” (Nurse 4).

Discussion

The study showed that the participants advocated for neglected, vulnerable, uninformed, intimidated and dissatisfied patients. Their advocacy role was triggered when patients had been neglected by their families who failed to provide them with food, purchase their drugs or assist with their care. These findings however contradict findings from other studies in Ghana and Iran that indicate that the family assists with patient care due to the shortage of nurses and buy prescribed drugs for their patients [17,18]. The family’s neglect of patients which could be attributed to caregiver fatigue [19]. The change in trend could be attributed to changes in the family system as a result of western influence which focuses more on the nuclear family. The family may thus neglect a member who may fall ill. Nurses thus need to advocate for patients to have such needs met. Nurses might therefore need material and financial support to do this effectively.

Concerning the vulnerability of patients the reliance of unconscious patients on nurses’ advocacy in this study is known in literature [20] and the rapid deterioration in children’s condition due to their immature immune system is similar to findings from the Papua New Guinea context [21] hence such children were treated with priority to save lives. However the failure of some patients to participate in their own care in this study contradicts earlier findings that patients prefer shared or autonomous decision-making [22]. The findings are also consistent with previous studies in the USA which indicated that some patients were subjected to many and unnecessary tests to generate more funds for the hospital [8]. Other studies suggest that sometimes laboratory tests are conducted without patients’ consent and some doctors fail to discuss treatments with patients [9,23]. The labelling of patients who tried to express their views as difficult has been reported in some North American studies [2,24]. The need to use tactfulness in raising patients’ issues such as the need for patient education and involvement in care with other team members is thus important.

The lack of health insurance coverage, high levels of poverty and patients’ inability to settle hospital bills have already been reported in Ghanaian and South African literature [25,26]. In Ghana, citizens are encouraged to join the National Health Insurance Scheme (NHIS). However, no policy compels them to do so. Through advocacy nurses could include the importance of health insurance in patient education and liaise with social workers for financial assistance for patients. Patients’ difficulty in navigating the health system [8] and challenges with communication with nurses due to language barrier at the hospital occur in other contexts [1]. Often there were no interpreters

to assist patients who speak different languages to communicate in the hospital. Nurses could advocate for more directional signs to be installed in the hospital and also for some language classes to be organised for staff to learn other languages patients speak. To effectively advocate for such vulnerable patients in the hospital nurses need to be skillful and empathetic to be able to prioritize care and teach patients about their rights.

The failure of some healthcare professionals to give adequate patient education about their condition which compelled some patients to rely on the internet for unreliable information is in tandem with findings from studies conducted in the USA [22,24]. Additionally the layout within some hospital units became a physical barrier to communication [27]. The fear of death and anxiety over diagnosis among patients have been reported in the North American context as well [2,28]. Intimidation by crowd and some hospital staff is also known [2,24]. Some however, had the courage to talk to nurses but not doctors [29]. The failure of staff to establish therapeutic relationships with patients and reassure them can increase their anxiety at the hospital; thus, by identifying such anxious patients nurses can reassure them through patient advocacy.

In line with findings from previous studies some patients complained of disturbance by mosquitoes and noise at the hospital [30,31]. Queuing at the hospital for long periods to access healthcare is in keeping with findings from studies in South Africa and Pakistan [26,32] as a result of shortage of specialists [32,33] and often patients’ medical records could not be traced adding to delays [8]. The periodic drug shortage in the hospital is a common phenomenon in the African context [34] and often meals served were not of patients’ choice as has been reported in the North American context [28]. Often government hospitals are poorly resourced to tackle some of these problems thus stronger advocacy is required for these problems to be solved to enhance patient satisfaction and comfort. Nurses thus need to involve themselves in hospital decision-making and accept leadership roles to become effective patient advocates. Complaints from chronically ill patients who often visited the hospital about the poor attitude of some staff has already been found in the Ghanaian and Swedish contexts [35,36] and can be attributed to poor communication between the staff and patients.

Conclusion

Nurses were influenced to advocate for patients who were neglected by their families, vulnerable in the health care system, uninformed about their condition and care, intimidated by the hospital environment and some staff and those who were dissatisfied with the care they received. These findings are similar to those identified in Finland, Sweden and USA and show that the key motivation for patient advocacy at the theatre/recovery, male medical and children’s wards of Effia-Nkwanta Regional Hospital is to satisfy patients’ unmet needs making patient advocacy is an ethics-based practice. These findings highlight the need for nurses to establish therapeutic relationships with patients to enable them identify those who may need advocacy; be willing to advocate for them; educate and encourage them to participate in decision-making in their care.

Implications for Practice and Further Research

Findings from the study could serve as a resource for students and professional nurses to enhance their roles as patient advocates. It could also encourage nurses to build therapeutic relationships with patients to enable them identify their need for advocacy. The findings

could also be used as a guideline for improving patient autonomy through the recognition of patients' choices in their own care; the core aim of patient advocacy. It could also inform policy formulation in the health sector to support patient advocacy to improve patient satisfaction and quality of care. Further research to explore the attitude of healthcare professionals towards patient involvement in their care and assess the challenges patients face in hospitals in Ghana could also highlight the kind of advocacy patient require most in their care.

References

- Vaartio-Rajalin H, Leino-Kilpi H (2011) Nurses as Patient Advocates in Oncology Care: Activities Based on Literature. *Clin J Oncol Nurs* 15: 526-532.
- McDonald KM, Bryce CL, Graber ML (2013) The patient is in: patient involvement strategies for diagnostic error mitigation. *BMJ Qual Saf* 7: 1-7.
- International Council of Nurses (2012) The ICN Code of Ethics for Nurses. International Council of Nurses.
- Rasmussen LM (2012) Patient Advocacy in Clinical Ethics Consultation. *Am J Bioeth* 12: 1-9.
- Cole C, Wellard S, Mummery J (2014) Problematizing autonomy and advocacy in nursing. *Nurs Ethics* 21: 576-582.
- Shah K, Garg S (2011) Patient advocacy groups: Need and opportunity in India. *Perspect Clin Res* 2: 4-7.
- Sundqvist A-S, Carlsson AA (2014) Holding the patient's life in my hands: Swedish registered nurse anaesthetists' perspective of advocacy. *Scand J Caring Sci* 28: 281-288.
- Klein MN (2012) Advocacy for the older patient. *Perioper Nurs Clin* 2012: 7447-7459.
- Vaartio H, Leino-Kilpi H, Suominen T, Puukka P (2009) Nursing Advocacy in Procedural Pain Care. *Sage Nurs Ethics* 16: 340-362.
- Zolnierek C (2012) Speak to be heard: Effect nurse advocacy. *Am Nurse Today* 7: 10.
- Asante-Shongwe K (2013) Perspective of an Advocate - political advocacy in African cancer dialogue. *BioMed Cent* 8: 1.
- De-Graft Aikins A (2014) 1.22 Barriers to patient empowerment in sub-Saharan Africa: a social psychological evaluation. *Diabetes Res Clin Pract* 103: S7.
- Mayan MJ (2009) Essentials of qualitative inquiry. Left Coast Press Inc, California, USA.
- Punch KF (2005) Introduction to social research: Qualitative and Quantitative approach. Sage Publications Ltd, USA.
- Miles MB, Huberman MA (1994) Qualitative data analysis: An expanded source book. Sage Publications Ltd, USA.
- Guba EG, Lincoln YS (1989) Fourth generation evaluation. Newbury Park: Sage Publications Ltd, USA.
- Aziato L, Adejumo O (2014) Psychosocial factors influencing Ghanaian family caregivers in the post-operative care of their hospitalised patients.
- Khosravan S, Mazlom B, Abdollahzade N, Jamali Z, Mansoorian MR (2014) Family participation in the nursing care of the hospitalized patients. *Iran Red Crescent Med J* 16: e12686.
- Mattoo KA, Shalabh K, Khan (2010) Geriatric forensics: A dentist's perspective and contribution to identify existence of elder abuse among his patients. *J Forensic Dent Sci* 2: 81-85.
- Mahlın M (2010) Individual patient advocacy, collective responsibility and activism within professional nursing associations. *Sage Nurs Ethics*. 17: 247-54.
- Stanisic DI, Fowkes FJ, Koinari M, Javati S, Lin E, et al. (2015) Acquisition of antibodies against *Plasmodium falciparum* merozoites and malaria immunity in young children and the influence of age, force of infection, and magnitude of response. *Infect Immun* 83: 646-660.
- Chewning B, Bylund CL, Shah B, Arora NK, Gueguen JA, et al. (2012) Patient preferences for shared decisions: a systematic review. *Patient Educ Couns*. 86: 9-18.
- Stiggelbout AM, Van der Weijden T, De Wit MP, Frosch D, Légaré F, et al. (2012) Shared decision making: really putting patients at the centre of healthcare. *Bmj* 27: e256.
- Frosch DL, May SG, Rendle KAS, Tietbohl C, Elwyn G (2012) Authoritarian Physicians And Patients' Fear Of Being Labeled 'Difficult' Among Key Obstacles To Shared Decision Making. *Health Aff* 31: 1030-1038.
- Aziato L, Adejumo O (2015) An ethnographic exploration of postoperative pain experiences among Ghanaian surgical patients. *J Transcult Nurs* 26: 301-307.
- Coetzee SK, Klopper HC, Ellis SM, Aiken LH (2013) A tale of two systems—nurses practice environment, well being, perceived quality of care and patient safety in private and public hospitals in South Africa: A questionnaire survey. *Int J Nurs Stud* 50: 162-173.
- Baker T, Warren A (2015) The Nine Common Barriers to Communication. In: *Conversations at Work*. Conversations at Work. Springer, USA.
- Goering S (2009) Postnatal Reproductive Autonomy: Promoting Relational Autonomy and Self-Trust in New Parents. *Bioethics* 23: 9-19.
- Phillips CB, Pearce C, Hall S, Kljakovic M, Sibbald B, et al. (2009) Enhancing care, improving quality: the six roles of the general practice nurse. *Med J Aust* 191: 92-97.
- Anand MB, Sudharshan GM, Nagaraja SR (2013) Customer satisfaction towards hospitals: A study on selected hospitals at Shivamogga City. *Innovare J Bus Manag* 1: 15-18.
- Hsu T, Ryherd E, Waye KP, Ackerman J (2012) Noise pollution in hospitals: impact on patients. *JCOM* 19: 301-309.
- Jafree SR, Zakar R, Zakar MZ, Fischer F (2016) Nurse perceptions of organizational culture and its association with the culture of error reporting: a case of public sector hospitals in Pakistan. *BMC Health Serv Res* 16: 1.
- De-Graft Aikins A, Boynton P, Atanga LL (2010) Developing effective chronic disease interventions in Africa: insights from Ghana and Cameroon. *Glob Health* 6: 6.
- Labhardt ND, Balo J-R, Ndam M, Grimm J-J, Manga E (2010) Task shifting to non-physician clinicians for integrated management of hypertension and diabetes in rural Cameroon: a programme assessment at two years. *BMC Health Serv Res* 10: 1.
- Adu-Gyamfi S, Brenya E (2016) Nursing in Ghana: A Search for Florence Nightingale in an African City. *Int Sch Res Not* 2016: 1-14.
- Wessel M, Helgesson G, Olsson D, Juth N, Alexanderson K, et al. (2013) When do patients feel wronged? Empirical study of sick-listed patients' experiences with healthcare encounters. *Eur J Public Health* 23: 230-235.

Author Affiliations

Top

¹Department of Adult Health, School of Nursing, University of Ghana, Legon, Accra, Ghana

²Regional Institute for Population Studies, University of Ghana, P. O. Box LG 96, Legon, Accra, Ghana

Submit your next manuscript and get advantages of SciTechnol submissions

- ❖ 80 Journals
- ❖ 21 Day rapid review process
- ❖ 3000 Editorial team
- ❖ 5 Million readers
- ❖ More than 5000 
- ❖ Quality and quick review processing through Editorial Manager System

Submit your next manuscript at • www.scitechnol.com/submission