Original Article

Interpersonal and Institutional Challenges to Advocacy in Nursing Practice in Khartoum State, Sudan

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Abstract

Background: Nurses play a pivotal role in advocating for their patients and have a substantial impact on healthcare policies at local, regional, and national levels. Their advocacy efforts influence not only the overall health of the population but also the advancement of the nursing profession. Despite this, nurses face significant barriers in fulfilling their advocacy roles. This study aims to identify the interpersonal and institutional challenges faced by nurses in patient advocacy across three nursing disciplines in Sudan: clinical practice, community health, and nursing education.

Methods: This is a descriptive cross-sectional design. Data were gathered from 148 nurses working in clinical practice, community health, nursing, and education using structured Likert-scale questionnaire. The data were analysed using frequency distribution, arithmetic mean, weighted arithmetic mean, standard deviation, and a one-sample t-test.

Results: The study identified multiple interpersonal and institutional challenges affecting nurses' advocacy efforts across clinical, educational, and community health settings. These challenges included limited organizational support, imbalance of force with physicians, lack of nurses' knowledge and competency to decide, as well as not having enough nurses to meet the growing healthcare needs of patients. The nurses' responses to these aspects were mostly "agree" and "strongly agree". This makes it harder for nurses to effectively advocate for their patients.

Conclusion: Ethical and social factors emerged as critical influences on nurses' advocacy efforts. Common strategies employed by these healthcare professionals included prioritizing patient safety and educating clients about their rights.

Keywords: Advocacy; Health Personnel Attitudes; Community Health Nursing; Nursing Care; Education.

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Introduction:

Advocacy, as one of the ethical issues, has been a critical challenge for nurses to practice. Vulnerable patients require an advocate to facilitate their care and support. (1) The nurse's role is to apply policies and procedures with patients, reduce medical errors, and develop professional competence to enhance self-confidence. (2,3) Advocacy is a concept that has been widely acknowledged in other professions besides nursing. For instance, the law firm describes advocacy as pleading the cause of a client in the court of justice, while supporting and protecting the interests and rights of individuals in a constituency, which is also referred to as advocacy in politics. Advocacy in the nursing clinical setting is unique compared to other careers in that it involves a giving of oneself (the nurse) to an individual (the patient). Patient advocacy in a clinical setting focuses on health conditions, healthcare resources, patient needs, and public needs as well (4). Various studies have indicated that nurses frequently face ethical problems related to informed consent, communication difficulties with patients and families, disagreement regarding treatments among healthcare professionals, care omission, and ethical decision-making for dying patients' care. Many researchers have further indicated that institutional factors such as conflicts between institutional policies and patients' needs, deficit of health resources, shortage of nursing staff with work difficulties and overload, and lack of deep recognition of the nursing profession's code of ethics have led to rising ethical conflicts for nurses. Studies interpreted that the skills and knowledge of nurses can be improved by training and higher education (3, 5)

As in many countries, nurses in Sudan may face many ethical challenges or moral distress in their everyday practice. Nurses often struggle when they feel that a situation is beyond their control. For instance, the economic status in Sudan leads to a scarcity of health care service resources. Nurses may feel pressured if there are actions in line with client's needs, but it may interfere with the institutional rules as the result of limited resources concerning staff shortages and outdated medical equipment. Furthermore, a deficit of healthcare resources leads to increased workload and, hence, results in inappropriate ethical practices. (6) In addition to socio-economic factors shaping the institutional policies, personal factors and experience may serve as significant contributors to Sudanese nurses' challenge to advocacy. Nurses have a long history of advocating for patients and are concerned about caring for the patient as a whole and not just their physical health condition. (7) Nevertheless, critics are of the view that nurses should not be the ultimate patient advocates due to their conflicting loyalty to both the employer

and the patient. Nurses may choose not to advocate if the advocacy process becomes very complex and they fear losing their jobs. (8) The current emphasis on patient safety has increased the awareness of the critical role advocacy plays in promoting safe clinical practice. Studies have indicated that the absence of patient advocacy has negative consequences (8, 9). The limited research and documentation about how nurses define and practice patient advocacy in Sudan healthcare settings reveal a knowledge gap and pose a threat to patients' safety and quality of care. It will also enhance advocacy strategies and optimal quality care in the Sudan Health Services. Other challenges, all of which may be interrelated, are low salaries, heavy workloads, high turnover, and the attraction of working abroad. (10, 11) Evidence has shown that a health facility's goal of providing quality care to patients cannot succeed in the absence of nursing advocacy (8). The absence of guidelines, fear of making mistakes, and unknown consequences prohibit some nurses from advocating for patients. (12) The negative consequences that result from lack of patient advocacy are said to include prolonged patient recovery and death, which contradicts health institutions' goal of saving lives. (4, 8). Hence, the need to research barriers that hinder nurses from advocating for patients in the healthcare setting in the Sudanese context.

Materials and Methods:

Study design, area and population

This descriptive cross-sectional study was conducted to explore various interpersonal and institutional challenges faced by nurses when acting as patient advocates across three areas of nursing practice in Khartoum State, Sudan. The study invited licensed professional nurses working in government hospitals, nursing faculties, and health centres. Participants were eligible if they had been in practice for two or more years.

Study sample

The required sample size was calculated using the formula: $n = Z^2 pq/e^2$. where n is the required sample size, Z = 1.96 for a confidence level of 95%, p = proportion of the problem understudy, (Taken as 0.5). q = (1- p) and e2= 0.05, the accepted margin of error.

The minimum required sample size was calculated as 385 nurses. Due to the anticipated constraints a design effect (deff = 0.4) was used giving a total sample size of 154.

This sample size was distributed in proportion to the size of the different categories of the study population based on updated data from the Sudan National Council for Medical and Health Professions (9,427 nurses in Khartoum State). This is illustrated in Table 1.

Table 1 illustrates the distribution of nurses in Khartoum State

Categories of Nurses	Study Population (N= 9427)	Percent	Proportion from sample size (n = 154)	Completed Responses
Clinical nurses	8953	95	146	141
Community nurses	44	0.5	1	1
Nursing educators	430	4.5	7	6
Total	9427	100	154	148

A convenience sampling technique was employed due to the unstable political conditions.

Data Collection Tools and Techniques

Data were collected using a questionnaire developed by the researchers following an extensive search. The questionnaire comprised four sections: demographic information; challenges nurses faced when advocating for patient's rights across the three areas defined; activities that facilitate patient advocacy; nurses' experiences as advocates for their patients. The questionnaire was validated by experts in the three nursing areas, necessary revisions were made. A pre-test pilot was conducted with a small sample from each category of the population not including the targeted ones. Internal consistency of the questionnaire was assessed using Cronbach's alpha, yielding a reliability score of 0.863. Responses were digitally coded using a Likert scale: 5 points for "strongly agree," 4 for "agree," 3 for "neutral," 2 for "disagree," 1 for "strongly disagree." The self-administered interview, distributed online via Google Forms, with extra space provided for additional respondent comments.

Data analysis

Data were analyzed using SPSS version 24.0. The analysis included frequency distributions arithmetic means, along with weighted arithmetic means to assess the response tendencies for each statement based on a five-point Likert scale as follows.

Weighted average	Degree of paragraph approval
1 to 1.79	Strongly disagree
1.8 to 2.59	Disagree
2.6 to 3.39	Neutral
3.4 to 4.19	Agree
4.2 to 5	Strongly agree

Standard deviations were calculated to measure data dispersion. A One-Sample T-test was conducted to compare the sample mean against a hypothesized value.

Ethical approval:

This study received approval from the National Health Research Ethics Committee at the Ministry of Health, following the submission of the required ethical approval form, then approval letter from hospitals, primary health centres and university managers.

Results:

A total of 148 participants responded giving a response rate of 96%, of them 74.3% were females 58.1% had a bachelor's degree. In terms of professional experience, 41.9% had 10 or more years of experience the majority (95%) were clinical nurses.

Table 2: Participants' General Characteristics

Variable	Category	Frequency	Per cent
Gender	Male	38	25.7
	Female	110	74.3
	Total	148	100
Qualification	Diploma	11	7
	Bachelor	86	58
	Master	35	24
	PhD	16	11
	Total	148	100
Professional experience	2–5 years	62	41.9
	6-9 years	24	16.2
	10-13	17	11.5
	≥ 14 years	45	30.4
	Total	148	100
Nurse Category	Clinical nurses	141	95%
	Community nurses	1	1%
	Nursing educators	6	4%
	Total	148	100%

Table 3: The Iterative Distributions Descriptive Analysis of Challenges Facing nurses in Advocating for Clients' Rights (N = 148)

Table 3A shows that most nurses were facing operational systemic challenges mainly the supply demand imbalances.

Table 3A: Operational and Systemic Challenges

No.	Challenge	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Answer Direction
1	Supply demand	0.7%	2.0%	2.7%	37.2%	57.4%	4.49	0.714	Strongly agree
2	Workload	1.4%	12.8%	13.5%	25.7%	46.6%	4.03	1.115	Agree
3	Lack of time	2.7%	14.2%	16.9%	41.9%	24.3%	3.71	1.071	Agree
4	Shortage of staff	11.5%	14.2%	4.7%	18.2%	51.4%	3.84	1.466	Agree
5	Institutional policy	0.0%	6.8%	14.9%	45.9%	32.4%	4.04	0.864	Agree

Table 3B shows professional ethical challenges especially knowledge competency issues.

Table 3B: Professional and Ethical Challenges

No.	Challenge	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Answer Direction
1	Nurses' knowledge and competency	2.0%	6.8%	8.1%	36.5%	46.6%	4.19	0.985	Agree
2	Ethical reasons	4.7%	16.9%	20.3%	35.1%	23.0%	3.55	1.157	Agree
3	Lack of autonomy	5.4%	16.9%	12.8%	36.5%	25.7%	3.57	1.218	Agree
4	Lack of supportive groups	6.1%	21.6%	8.1%	35.1%	29.1%	3.59	1.277	Agree
5	Lack of communication	7.4%	23.0%	10.1%	28.4%	31.1%	3.53	1.337	Agree
6	Personal characteristics of nurses	0.7%	6.1%	12.8%	43.9%	36.5%	4.09	0.891	Agree

Table 3C shows Interpersonal and social challenges mainly family wishes and imbalance of power with physician.

Table 3C: Interpersonal and Social Challenges

No.	Challenge	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Answer Direction
1	Family wishes	2.7%	14.9%	25.7%	35.1%	21.6%	3.58	1.069	Agree
2	Non-supportive family	7.4%	29.1%	16.9%	29.1%	17.6%	3.20	1.245	Neutral
3	Imbalance of power with physician	2.0%	12.2%	18.2%	45.9%	21.6%	3.73	1.001	Agree
4	Fear of losing job	11.5%	26.4%	16.9%	28.4%	16.9%	3.13	1.295	Neutral

Table 4: The iterative distributions Descriptive Analysis of the strategies nurses apply to successfully advocate in the clinical nursing setting (N=148)

Table 4A shows that there was strong agreement with the contribution of advocacy to patient's safety.

Table 4A: Advocacy Through Professional Competency and Safety Measures

No.	Strategy	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Response Direction
1	Avoid errors	0.0%	0.0%	2.1%	43.2%	54.7%	4.53	0.540	Strongly agree
2	Ensure patient safety	1.4%	2.1%	2.1%	23.6%	70.9%	4.61	0.753	Strongly agree
3	Competency to make immediate decisions	0.0%	1.4%	3.4%	42.6%	52.7%	4.47	0.633	Strongly agree

Table 4B shows the positive nurses' perception regarding the way they contributed to patient advocacy.

Table 4B: Advocacy Through Communication, Education and Organizational Action

No.	Strategy	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Response Direction
1	Give patients a voice	0.0%	4.7%	10.1%	43.9%	41.2%	4.22	0.613	Strongly agree
2	Educate clients about their rights	0.0%	2.7%	7.4%	30.4%	59.5%	4.47	0.751	Strongly agree
3	Address source of the problem directly	1.4%	8.8%	9.5%	35.1%	45.3%	4.14	1.003	Agree
4	Use organizational channels	2.0%	4.1%	6.8%	46.6%	40.5%	4.20	0.886	Strongly agree
5	Refer cases to ethical committees	2.7%	1.4%	10.8%	50.0%	35.1%	3.14	0.862	Neutral

Table 5: The iterative distributions Descriptive Analysis of Factors Influencing Nurses' Experience of Patient Advocacy (N=148)

Table 5A shows the major factor influencing nurses' experience of patient advocacy in regard to the intrinsic factors including the nurses' cultural beliefs, to a lesser extent was the nurses' personal characteristics,

Table 5A: Intrinsic Factors; Cognitive, Personal, Professional Attributes

No.	Factor	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Response Direction
1	Nurses' cultural beliefs	0.0%	0.7%	1.4%	43.2%	54.7%	4.52	0.565	Strongly agree
2	Knowledge of patient advocacy	1.4%	3.4%	5.4%	47.3%	42.6%	4.26	0.820	Strongly agree
3	Nurses' personal characteristics	0.7%	4.1%	12.2%	43.9%	39.2%	4.17	0.844	Agree
4	Nurses' professional characteristics	0.0%	2.7%	9.5%	37.8%	50.0%	4.35	0.764	Strongly agree
5	Quality of nurse–patient relationship	0.0%	2.1%	6.8%	41.2%	50.0%	4.39	0.706	Strongly agree

Table 5B shows that the contextual environmental factors had less effects on nurses' advocacy practice.

Table 5B: Contextual Environmental Factors affecting Advocacy Practice

No.	Factor	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Response Direction
1	Unit culture	1.4%	4.1%	12.8%	45.9%	35.8%	4.11	0.874	Agree
2	Anticipated negative outcomes of advocacy	3.4%	17.6%	20.3%	36.5%	22.3%	3.57	1.120	Agree
3	Limited time	3.4%	12.8%	14.2%	40.5%	29.1%	3.79	1.102	Agree

Overall Summary:

Category	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean	SD	Response Direction
All factors combined	1.27%	5.93%	10.31%	42.04%	40.45%	4.15	0.849	Agree

Discussion:

Nurses play a critical role in advocating for clients, significantly influencing local, state, and federal healthcare policies that impact both public health and the nursing profession. In this study, 74.3% of participants were female. About 42% had between 2-5 years of experience. Most participants (71%) had received training in patients' rights, and the largest group (47%) worked as clinical nurses. Regarding nurse-to-patient ratios, 30% reported caring for 2-4 patients, and the majority (57%) worked 8-hour shifts per day. Similar findings were reported in a study by Abbaszadeh et al. in Iran, where 93.6% of participants were female, 70.1% had 6-10 years of experience, but most (62.8%) had not participated in patient rights workshops. (13) This study highlights that, nurses in Sudan face medium-level challenges in standing up for clients' rights. These challenges include supply and demand imbalances, knowledge and competency issues, workload, time constraints, staff shortages, ethical conflicts, family wishes, power imbalances with physicians, institutional policies, lack of autonomy, insufficient support groups, poor communication, and individual nurse characteristics. Consistent with numerous studies, including Bremnes' research in Tanzania (14), feelings of demoralization among healthcare workers were notably prevalent, largely stemming from a lack of support from leadership and insufficient appreciation from patients. Additionally, shortages of resources and personnel contributed to excessive workloads, complicating the provision of adequate care (14). Similarly, a study conducted in Cyprus explored midwives' perceptions as client advocates for normal childbirth. It identified barriers to adopting an advocacy role, specifically a lack of professional recognition and deficiencies in both basic and continuing education (15). According to Filby et al., their study highlights significant gaps in social, cultural, economic, and professional barriers that hinder the provision of quality midwifery care in low- and middle-income countries (16). Similarly, Nsiah et al. identified a lack of cooperation among healthcare teams, care recipients, and health institutions. This includes challenges within the work environment, ineffective communication, and interpersonal relationships, as well as influences from patients' families and their religious and cultural beliefs (12). Furthermore, Fannie noted that as a result of advocacy efforts, more women were delivering in health facilities; however, they often encountered shortage of healthcare workers, which challenges and compromises the quality of care provided (17). Similarly, research by Laari et al. identified interpersonal and structural barriers as significant obstacles that nurses face when fulfilling their health advocacy roles (18). The

study by Tomas et al. identifies several barriers that may hinder nurses in their advocacy roles for patients. These include: medical control, insufficient time, extreme workload, problems in communicating with patients or healthcare staff, insufficient knowledge, helplessness, fear of risk, fear of conflict, lack of independence, and lack of authority to take decisions and lack of support on the part of the institution (19). Our study found that the strategies nurses employ to advocate effectively in clinical settings were rated highly by participants. Key strategies included: avoiding errors, ensuring patient safety, demonstrating competency to make an immediate decision, giving patients a voice, educating the clients about their rights, going directly to the source of the problem, going through organizational channels, going to the ethical committees. These findings align with advocacy efforts aimed at promoting midwives and the midwifery profession, as noted by Fannie, who emphasized the importance of encouraging women to deliver in health facilities (20). Similarly, Laari's study in Ghana highlighted that providing nursing students with positive role models in both classroom and clinical settings can enhance their effectiveness as health advocates (18). According to Gallup's annual Honesty and Ethics survey, nurses have been recognized as the most trustworthy profession for the 22nd consecutive year, surpassing trust levels for medical doctors and pharmacists. This high level of trust likely stems from the essential role nurses play in healthcare, characterized by their unwavering focus on patient care (21). Additionally, findings from oncology nursing highlight the importance of empowering both patients and nurses with self-advocacy skills. This approach ensures that patient priorities are at the forefront of care. By fostering collaborative relationships between patients and cancer care teams, ambiguity in decision-making and communication can be reduced. Encouraging patients to articulate their needs and expectations guarantees that their voices are integral to all treatment decisions, while also helping them seek and accept necessary support (22). Our study reveals that nurses in clinical settings perceive their advocacy role to be highly effective, as reflected in the participants' views on various practices. Key behaviors include: utilizing publicly funded services, assessing care environments, advocating for patient rights, obtaining informed consent for medical interventions, providing accurate medical information, maintaining patient confidentiality, communicating in patients' preferred languages, and effectively engaging with patients who have limited health knowledge. Additionally, nurses are proactive in using effective and low-cost services and are not hesitant to care for seriously infected patients, including planning for discharge. Consistent with findings by Abbaszadeh et al. in Iran, there was a positive correlation between nurses' advocacy behaviour and their attitudes. Nurses

who demonstrate positive behaviour and cognitive aspects of their attitudes are more likely to act as advocates compared to those who do not share these views (13). In their study, Comfort et al. identified a significant barrier to practicing patient advocacy in healthcare settings: a lack of cooperation among the healthcare team, care recipients, and the health institution. This absence of collaboration emerged as the overarching theme affecting advocacy efforts (12). Our study reveals that participants perceived the level of factors influencing nurses' advocacy roles as moderate. Key factors included nurses' cultural beliefs, knowledge of patient advocacy, unit culture, the quality of the nurse-patient relationship, personal characteristics, professional attributes, anticipated negative outcomes of advocacy, and limited time. Similarly, a study conducted in Cyprus identified three structural factors that discouraged midwives from advocating for their clients: 'physician dominance, "medicalization of childbirth,' and 'lack of institutional support' (15). In a contrasting study by Laurie et al. conducted in Georgia, it was found that factors necessitating support and educational intervention included legislative issues, media training, and social and political advocacy interventions. Additionally, lack of time emerged as a significant barrier to advocacy experienced by many nurses (23). Conversely, research by Ji-Young identified that optimism, human rights sensitivity, and clinical experience negatively correlated with nursing advocacy. The final model derived from these factors accounted for 19% of the variance in nursing advocacy (24). The lack of systemization, unclear job descriptions, and a prevailing sense of inferiority contribute to many nurses not envisioning nursing in their future plans. As a result, they often feel little to no connection to the profession, leading to widespread dissatisfaction with nursing. This environment diminishes the priority placed on advocacy. In this study, nearly half of the participants cited fear of job loss as an interpersonal factor hindering their advocacy practice. This finding raises an ethical dilemma, as Geng emphasized, advocacy is universally regarded as a moral obligation in nursing, integral to the profession's identity across various contexts and cultures (25).

Conclusion:

Ethical and social influences significantly impact how nurses engage in advocacy. Ethically, nurses are bound by professional codes of conduct and ethical obligations to prioritize patient well-being, yet they often face challenges such as a lack of autonomy, fear of losing jobs, workload, time constraints, nurses' knowledge, and institutional policy. For example, in settings where physicians and doctors dominate, nurses may struggle to voice concerns about inadequate care without facing professional repercussions. The primary

advocacy strategies employed by these professionals include ensuring patient safety and educating clients about their rights.

The findings of this study have important implications for both practice and research. In practice, healthcare institutions should strengthen policies that empower nurses to advocate effectively without fear of punishment. This includes implementing clear reporting mechanisms, fostering ethical leadership, and providing continuous training on advocacy skills and patients' rights. Additionally, integrating advocacy principles into nursing curricula can better prepare future professionals to navigate ethical dilemmas. Further studies are needed to explore how different healthcare systems influence nurses' advocacy roles and to evaluate strategies that enhance their ability to address ethical challenges.

Limitations:

A significant limitation of this study arises from the data sources used. In descriptive research, recent data were collected via electronic tools, which pose inherent challenges. The sampling method and data collection techniques have limitations, as participants were invited to respond to an electronic questionnaire while being affiliated with various institutions impacted by war in Sudan. This context has led to disruptions in internet access and the cessation of services at some institutions. Additionally, the reliance on self-reported information through a self-administered questionnaire may not accurately reflect real-life situations, potentially skewing the findings.

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