Article

Barriers to and Facilitators of Nurses' Political Participation in Ghana

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Abstract

All aspects of nursing practice are regulated by politics and affected by changes in public policy. For that reason, nurses need to be active in the political process through which they may influence public policies on health. However, nurses' participation in political activities in many countries is either low or moderate at best. Studies that explore political participation among nurses are rare in Africa. We conducted this study to identify factors that may enhance or hinder nurses' political participation. Through a cross-sectional survey, we collected data from 225 registered nurses sampled from three hospitals and two nursing training schools in Tamale, Ghana, using a structured questionnaire. We analyzed the data using descriptive statistics and correlations. The most frequently reported barriers to political participation were having little free time, lack of trust in politicians, fear of conflict/confrontation, lack of educational preparation, and lack of access to the right connections. The major facilitators of political participation were identified as availability of free time and money, civic skills, personal interest in politics, self-belief and confidence, and a strong party affiliation. These findings call for integration of political content into the nursing education curriculum and for professional nursing organizations to create opportunities for their members to learn about the political process.

Keywords

politics, public policy, barriers, facilitators, nurses, political participation

Nurse scholars active in policy, politics, and nursing practice; professional nursing organizations; and other national and international organizations in health recognize and underscore the need for nurses to be politically active and visible. The extent to which nurses participate in the political and policy process, barriers, and strategies to enhance their participation in the process have been the subject of many studies across the world, particularly in the United States and Europe (Avolio, 2014; Juma, Edwards, & Spitzer, 2014; Montalvo & Byrne, 2016; O'Rourke, Crawford, Morris, & Pulcini, 2017; Primomo & Bjorling, 2013; Vandenhouten, Malakar, Kubsch, Block, & Gallagher-Lepak, 2011). These studies are necessary in our quest to develop workable solutions to increase nurses' political participation and visibility. However, such studies are rare in Africa and virtually nonexistent in Ghana (where there is no published study on the subject). Given the paucity of studies on nurses and political participation in Africa, this study was conducted to enhance understanding of the factors that serve as barriers to or facilitators of political participation among nurses in Ghana. The purpose of this article is to present the findings from this study. Major topics covered are background and conceptual framework, methods, findings, and implications for practice, policy, and research.

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Background and Conceptual Framework

Background

For nearly 40 years, nurse scholars, professional nursing organizations, and other health-focused groups have been calling for professional nurses to enhance their political visibility and activities (Avolio, 2014; Juma et al., 2014; Montalvo & Byrne, 2016; O'Rourke et al., 2017; Primomo & Bjorling, 2013; Vandenhouten et al., 2011). This call is needed for nurses to perform their advocacy role effectively in combating the disparities and inequities within the health care system. Nurses are often witnesses to these disparities because of their long and close contact with clients and consumers of health care (Avolio, 2014; Juma et al., 2014). The call for increased political participation among nurses is also to protect the profession from certain policies that could negatively affect the profession and are usually channeled through politics (Kelly, 2007). This is particularly important in the wake of increasing polarization of health reform along political and partisan lines, especially in the United States (Keepnews, 2012). Being the largest health care profession globally (Avolio, 2014; Ghana Health Service, 2017; Juma et al., 2014; U.S. Bureau of Labor Statistics, U.S. Department of Labor, 2013), nurses can use their numerical strength as leverage to influence health policies at all levels. For instance, in Ghana, student nurses were able to demand restoration of student allowances because they constitute a large voter population (Yeboah, 2018).

Nurses also have an ethical-moral obligation and the requisite education, experience, and legacy to address the social determinants of health, which have an enormous impact on the health of populations (Institute of Medicine, 2011; Lathrop, 2013). Fifteen years ago, Falk-Rafael (2005) was one of the first nurses to describe the need to address social structures through political involvement as a means to achieve social justice, and called it an "expression of caring" (p. 213).

Despite this glaring need for nurses to participate in political activities, the response of nurses to the call to political action has been slow and variable, with two studies reporting moderate levels of political participation of nurses in Kenya and Canada (Ahoya, Abhichartibuttra, & Wichaikhum, 2016; Avolio, 2014), while one study in the United States reported that nurses rarely participate in other forms of political activities beyond voting and registering to vote (Vandenhouten et al., 2011). Cohen and Muench (2012) reported that nurses in the United States are sometimes invited to testify before Senate or Congress committees, and these testimonies raise the visibility and participation of nurses in the political arena. In addition, many nurses in the United States may influence policy through their professional nursing organizations. For instance, the Political Action Committee of the American Nurses Association (ANA) provides support to federal candidates who share their concern for the nursing profession and the clients it serves, regardless of party affiliation. The ANA Political Action Committee fights to give voice and visibility to nursing within the halls of Congress (ANA, 2018). The ANA also organizes nurse legislative days during which nurses get the opportunity to interact directly with legislators and other policy makers. This exercise provides invaluable experiential learning opportunities for nurses in the policy process (Primomo & Bjorling, 2013).

But this is not the case in Ghana. Many nurses in Ghana lack the skill and opportunity to influence the political process either on their own or through their professional nursing organizations. The only professional nursing organization in Ghana, the Ghana Registered Nurses and Midwives Association (GRNMA), has a nonpolitical and nonpartisan ideology. As such, it does not take stances on political issues in the country, let alone declare support for any political candidates.

Previous studies have identified factors that hinder nurses' political participation and factors that may enhance it. Exposure to politically relevant stimuli or content in education (Byrd et al., 2012; Primono, 2007), membership in a professional nursing organization (Avolio, 2014; Primomo & Bjorling, 2013; Woodward, Smart, & Benavides-Vaello, 2016), and active psychological engagement (Cramer, 2002; Vandenhouten et al., 2011) have all been identified as factors that enhance nurses' political participation. Barriers to political participation as contained in the literature include time constrains (Avolio, 2014; Boswell, Cannon, & Miller, 2005; Des Jardin, 2001), fear of conflict and confrontation (Antrobus, Masterson, & Bailey, 2004; Sumner & Danielson, 2007), lack of educational preparation for political activity owing to the lack of political content in the curricula of nursing education programs (Avolio, 2014; Gebbie, Wakefield, & Kerfoot, 2000; O'Niell-Conger & Johnson, 2000; Primono, 2007; West & Scott, 2000), and fear of victimization (Avolio, 2014). Many of these studies about political participation of nurses were conducted in Europe and the United States with only one in Africa (Shariff, 2014). The latter was conducted in the East African countries of Kenya, Uganda, and Tanzania. Our study aimed to contribute to filling this gap in the rest of Africa.

Ghana in Context

Demography. Ghana is an independent West African State situated on the Atlantic Ocean. Stretching from south to north, it covers about 670 km and has a maximum east–west extent of about 560 km. It shares boundaries with the Republic of Togo to the east, Burkina Faso

to the north, and Cote d'Ivoire to the west. On its southern border is the Atlantic Ocean that forms a 550-km long coastline. Ghana's population is estimated to be 29,749,993 people as of 2018, with an annual growth rate of 2.2% (World Population Review, 2018a). The vast majority of Ghanaians (more than 98%) are Black Africans belonging to different ethnic groups in Ghana such as the Akan (47.5%), Dagbamba (17%), Ewe (14%), Ga-Adangbe (7%), Gurma (6%), Guan (4%), Gurunsi (2.5%), and Builsa (1%).

Ghana has a total land area of about 238,539 km^2 and about 136,000 km^2 covering approximately 57% of the land is classified as "agricultural land area" (Food and Agriculture Organization of the United Nations, 2018).

Economy. Ghana has a market-based economy that relies heavily on export of primary products (cocoa, gold, and timber) and import of manufactured goods, making the economy vulnerable to price fluctuations at the world market (AQUASTAT, 2005; Index Mundi, 2018). The gross domestic product (GDP) of Ghana as of 2017 was US$130.2 billion (Index Mundi, 2018). The agricultural sector was the major driving force of the Ghanaian economy for many years, contributing significantly to employment and GDP. Presently, the services sector is the leading contributor to the GDP. In 2017, it contributed about 52% to GDP while employing about 41% of the economically active population. The agricultural sector continued to be the leading employer in 2017, with about 44% of the labor force employed in that sector while contributing about 18% to the GDP (Index Mundi, 2018).

In the past decade, loose fiscal policy, high budget and current account deficit, and a depreciating currency have plunged Ghana's economy into crisis. To overcome this crisis, Ghana signed a $920 million extended credit facility with the International Monetary Fund in April 2015 (Index Mundi, 2018).

Governance structure and politics. After a series of military coup d'etats in the 1970s and 1980s, Ghana became a stable democracy in 1992 following successful presidential and parliamentary elections in that year. Ghana is now a constitutional republic with a unitary system of government. It has a unicameral parliament with 275 members who are directly elected by universal adult suffrage for 4-year terms. Parliament is headed by a Speaker and two deputies. The executive president is the head of state and government. The president usually appoints ministers to form a cabinet. The 1992 Constitution also has provisions for an independent judiciary headed by the Chief Justice.

Even though Ghana is a unitary state, it has a decentralized local government system. This system is set in the constitution, under the Local Government Act 1993 (Act 462). The country is divided into 10 administrative regions, each headed by a regional minister, whom the president appoints (Commonwealth Local Government Forum, 2018). Processes are underway to increase the number of administrative regions to 16 to further decentralize the governance process and promote participatory governance (Ghanaweb, 2018a).

Since becoming a multiparty democracy in 1992, Ghana has seen many political parties come and go. As of 2018, the Electoral Commission of Ghana (2018a) had at least 24 political parties listed on its website. However, the two dominant political parties are the National Democratic Congress and the New Patriotic Party. The National Democratic Congress won the presidential and parliamentary elections in 1992, 1996, 2008, and 2012. The New Patriotic Party won the presidential and parliamentary elections in 2000, 2004, and 2016 (Electoral Commission of Ghana, 2018b).

Health care delivery. The Ministry of Health and its agencies provide most of the health service in Ghana. The Ministry of Health formulates health policies and provides strategic direction to its agencies. The Ghana Health Service implements all government health policies. It has a mandate "through its directorates and health facilities to provide preventive, promotive, rehabilitative and curative health services at all levels, to ensure continuous contact and a seamless referral system that enables continuity of health services to every person" (Ghana Health Service, 2016, p. 5). Health service in Ghana is organized at five different levels in an increasing order of capacity: (a) health posts or Community-Based Health Planning and Services compounds, (b) health centers and clinics, (c) district hospitals, (d) regional hospitals, and (e) teaching hospitals. As at 2016, Ghana had 4,185 Community-Based Health Planning and Services compounds, 1,003 clinics, 855 health centers, 34 polyclinics, 137 district hospitals, 10 regional hospitals, 4 teaching hospitals, and 3 psychiatric hospitals (Ghana Health Service, 2017). The government of Ghana (GOG) owns 78.7% of these facilities, while the private sector owns 16.9%. The Christian Health Association of Ghana, an organization of all Christian missionary health facilities, owns 3.6% of these health facilities, and the remainder is classified as quasi-government facilities (Ghana Health Service, 2017).

In terms of human resource, as of 2016, there were 56,605 nurses in Ghana with a nurse to population ratio of 1:542. This ratio exceeds the threshold of the World Health Organization of one nurse to 1,000 people for developing countries. The nurse population consists of registered general nurses, registered midwives, community health nurses, and enrolled nurses. As of 2016, Ghana had 3,365 physicians, with a physician to population ratio of 1:8,481. Apart from Western medicine, many Ghanaians also rely on traditional medicine and other

alternative healing approaches such as Chinese medicine, Ayurvedic medicine, chiropractic, and acupuncture to meet their health needs (Kretchy, Owusu-Daaku, & Danquah, 2014). Table 1 shows data for other key health status indicators from 2003 to 2014.

Health care financing. Similar to the *provision* of health care service in Ghana, *funding* for health services is largely provided by the GOG with support from donor funds, insurance, and out-of-pocket payments (de-Graft Aikins & Koram, 2017). The approach to financing health care in Ghana has gone through many changes from the pre-colonial era to present day. After independence in 1957, all health services were provided to citizens free of charge in line with the government's socialist ideology (Adams et al., 2015). However, this free medical care for all Ghanaians was abandoned in the 1970s and 1980s when the country ran into economic crisis and turned to the World Bank for financial aid. As part of its agreement with the World Bank, the government agreed to charge a fee for medical services in an effort to achieve full cost recovery (Adams et al., 2015; de-Graft Aikins & Koram, 2017). This decision brought into being the "cash and carry" system that required consumers to pay for health care service at the point of delivery. The cash and carry system led to a sharp decline in use of health services of 50% nationwide and 70% in rural areas, as people turned to traditional medicine and self-medication (The Association of Chartered Certified Accountants, 2013).

In 1997, the GOG piloted a health insurance scheme in four districts to test the feasibility of establishing a mutual health insurance for poor and rural communities in 1997 (de-Graft Aikins & Koram, 2017). The pilot program proved to be successful in member subscriptions, finance strategy, and sustainability. Based on the success of this pilot scheme, in 2003, Ghana's National Health Insurance Scheme (NHIS) was established to provide equitable access to health for all citizens (Adams et al., 2015; de-Graft Aikins & Koram, 2017). There are six main sources of funding for the NHIS: (a) the National Health Insurance Levy, which is a 2.5% value added tax levied on selected goods and services; (b) a 2.5% social security deduction from salaried workers in both government private sectors; (c) GOG annual budgetary allocations proposed and approved by parliament to the National Health Insurance Fund (NHIF); (d) returns on investments of surplus funds held in the NHIF by the National Health Insurance Council (NHIC); (e) grants, gifts, and donations made to the NHIF; and (f)) premiums and contributions paid by NHIS subscribers (Adams et al., 2015). Since its inception in 2003, the NHIS has been a major contributor to the financing of Ghana's health care. It provides financial cover for 95% of disease conditions and includes inpatient and outpatient services for general and specialist care, surgical operations, maternity care, and emergency treatment (The Association of Chartered Certified Accountants, 2013).

Nursing education. Since independence from Great Britain in 1957, Ghana has strived to improve the quality and raise the level of nursing education. These efforts have culminated in the provision of nursing education from certificate to postgraduate levels, including many specialities. Presently, the lowest points of entry for nursing education in Ghana are the certificate in Nurse Assistant Clinical or the certificate in Nurse Assistant Preventive.

Ghana's diploma in basic nursing focuses on registered general nursing, registered mental nursing, registered midwifery (females only), and registered community health nursing. The duration of training is 3 years, and students must pass licensing exams organized by the Nursing and Midwifery Council of Ghana before being allowed to practice.

Opportunities also exist for those who wish to pursue a nursing collegiate degree. All public universities in Ghana and many private universities now offer degrees in nursing. In addition, certain nursing schools offer training for various specialties (Arko, 2017).

In terms of postgraduate nursing education, the University of Ghana and the University of Cape Coast offer master's level programs with options in areas such as public health nursing, mental health, maternal and child health, administration, and advanced nursing practice. In 2011, the Ghana College of Nurses and Midwives was established to promote specialist education in

Table 1. Selected Health Status Indicators for Ghana: 2003, 2008, and 2014.

Indicators	2003	2008	2014
Infant mortality rate (per 1,000 live births)	64	50	41
Mortality rate for children younger than 5 years of age (per 1,000 live births)	111	80	60
Neonatal mortality rate (per 1,000 live births)	43	30	29
Life expectancy at birth (in years)	58	60	62

Note. Adapted from the Ghana Demographic and Health Survey (2003, 2008, and 2014) by Ghana Statistical Service (2014). The Demographic and Health Survey in Ghana is conducted every 5 years. Data for 2019 were unavailable when this article was submitted for publication.

nursing, midwifery, and related disciplines. As of October, 2018, there were 118 institutions comprising 78 government and 40 private institutions providing education in nursing and midwifery in Ghana (Nursing and Midwifery Council of Ghana, 2018).

Nursing organizations.

GRNMA. The GRNMA, formed in March 1960 through the merger of the Qualified Nurses Association and the State Registered Nurses Association, is the professional association for all categories of nurses in Ghana (Ministry of Health, Ghana, 2018). Initially registered as Ghana Registered Nurses Association, the association changed its name to GRNMA in 2015 to incorporate midwives into the association and unite all members of the nursing and midwifery profession under one umbrella (Ghana News Agency, 2015). GRNMA has its headquarters in Accra, the capital of Ghana, with branches throughout the country. Membership of the association is open to all categories of nurses and midwives registered by the Nursing and Midwifery Council of Ghana, including nurse assistants (Ministry of Health, Ghana, 2018). As a result of its diverse membership, GRNMA has many specialized groups such as the Nurse Educators' Group, Public Health Nurses Group, Mental Health Nurses Groups, Psychiatric Nursing Group, and Community Health Nurses Group. By the dictates of the association's constitution, one becomes a member of the association only after completion of a membership registration form. In practice, however, any nurse who is successfully appointed by the GOG and put on the government payroll is automatically drafted into GRNMA as a member and makes monthly payments to the association through automatic deductions from their salary to maintain membership. As of November, 2017, GRNMA's membership stood at 52,153 nurses (Ofori-Ampofo, 2017). This means that more than 92% of the nurses in Ghana are members of GRNMA.

GRNMA operates as an independent, nonpartisan organization that does not take stances on political issues. As a result, the association rarely makes public pronouncements on major national issues, even when they affect health care issues for which the organization and its members are major stakeholders. Apart from engaging in strikes to push for demands for better working conditions, the association does not take any leading role in shaping government policy despite its significant numerical strength.

For example, when the GOG agreed to use drones to transport blood and emergency medical supplies to remote areas of the country (Ampomah, 2018), many Ghanaians opposed the decision. Other major stakeholders in health care, such as the Ghana Medical Association, the Biomedical Scientists Association, and individual physicians, publicly stated their disagreements with this policy through press releases and media interviews (Ghanaweb, 2018b). However, the GRNMA never made any public statement on the issue until Parliament approved the use of drones for transporting the supplies. This silence has been typical of the GRNMA over the years and has diminished nursing's voice on many important national issues.

Conceptual Framework

The conceptual framework that underpinned this study is Verba, Schlozman, and Brady's (1995) civic voluntarism model (CVM) of 1995. Verba et al. observed that although citizens have equal opportunity to influence government, participation is voluntary, and there is great variation in the level of participation among social groups. The CVM explains why such variations exist. According to the original version of the model, the political participation of ordinary citizens is primarily influenced by three interacting factors: resources, psychological engagement, and recruitment networks.

Resources refer to a person's ability to participate and include time, money, and civic skills. Psychological engagement entails a person's desire or motivation to get involved in political activities. Specific dimensions under the domain of psychological engagement include political interest, political efficacy, political information, partisanship, and family influences. Recruitment networks encompass a person's exposure to political signals or calls to action as well as direct invitations for political participation. Recruitment networks include civic, religious, and professional organizations (Vandenhouten et al., 2011).

The CVM posits that citizens who have resources that can enhance political participation and people who are psychologically motivated to participate in politics will be more active in politics than citizens who lack resources and motivation. Furthermore, citizens who are psychologically motivated to participate in politics and have the needed resources to participate are expected to participate more frequently if they have access to political recruitment networks, in which citizen mobilization takes place through overt requests for political action (Verba et al., 1995).

We chose this model as the theoretical basis for our study because it offers a comprehensive explanation for differences in level of political participation of citizens and why those differences occur. In their study on political participation of registered nurses, Vandenhouten et al. (2011) used the CVM as the conceptual framework to guide the study and identified psychological engagement as the most important predictor of political participation. In 2002, Cramer also used the CVM to study organized political participation in nursing and identified free time and personal efficacy as the strongest

predictors for organized political participation. For the purpose of this study, we modified the model to include a fourth element—barriers to political participation—to accommodate the second major element in this study—barriers to nurses' political participation. The adapted version of the model is presented in Figure 1.

Methods

Design and Setting

We conducted this study using a cross-sectional survey with a quantitative approach. The study was conducted in Tamale, the capital town of the Northern Region of Ghana. Tamale is the fourth largest city in Ghana and the fastest-growing city in West Africa (Ghanaweb, 2014). It has a population of 360,579 people (World Population Review, 2018b). Due to its central location, Tamale serves as a hub for all administrative and commercial activities in the Northern region. It is the political, economic, and financial capital of the Northern region and has three major hospitals and two educational facilities where the study participants were drawn from.

The city is characterized by high levels of political activities, such as television and radio discussions, rallies, mounting of billboards and party flags, and street carnivals, especially during electioneering campaigns. This generally high level of political participation among residents of Tamale makes it an ideal setting to study political behavior among a group of people.

Sampling

We used proportional stratified sampling to ensure equal distribution of participants across the different study sites. We segmented the participants into five mutually exclusive subsets based on the facility in which they practiced (three hospitals and two nursing schools). Then, we selected a number of nurses in each facility based on the percentage of nurses from that facility in the total population. For instance, nurses from a particular hospital constituted 9.6% of the total population, so 26 nurses, representing 9.6% of 272 (the sample size), were selected from that facility.

After determining the sample units for the various facilities, we requested the nominal roll of the registered nurses in each facility, which we used as the sampling frame for the facilities. Then, we used the Statistical

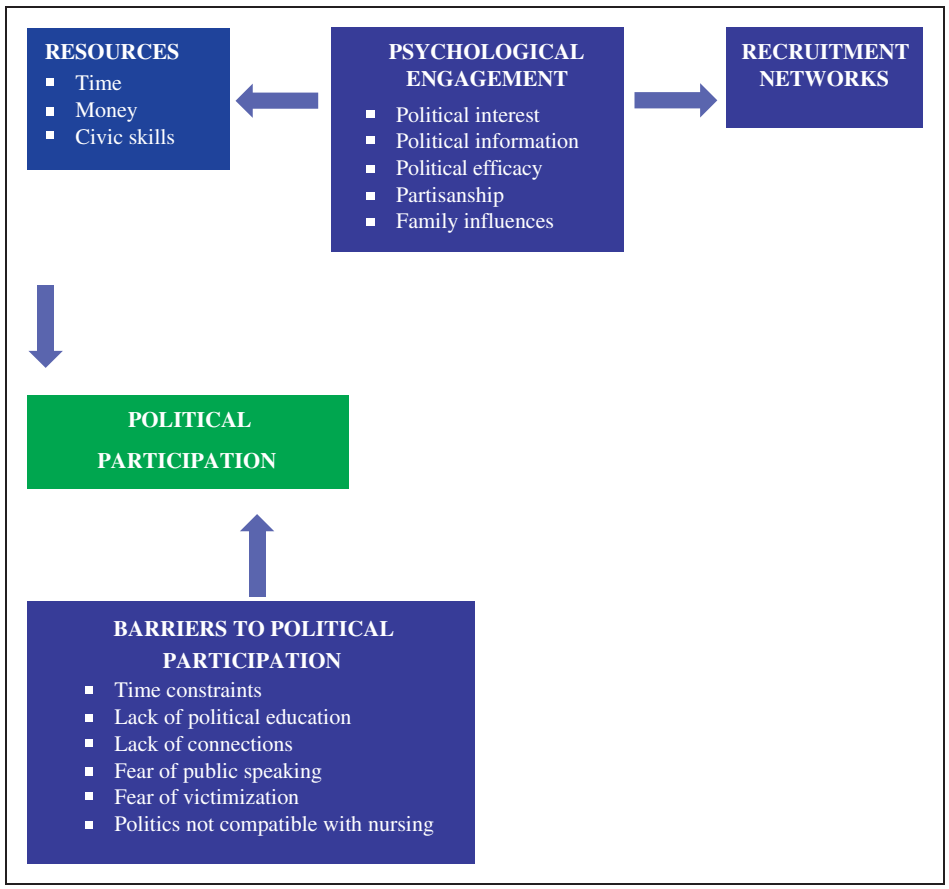

Figure 1. The civic voluntarism model (adapted from Verba et al., 1995).

Package for Social Sciences, version 21 (IBM, 2015) to generate a random sample from the sampling frame of each facility. Names of nurses sampled who had retired or transferred to different facilities were removed, and new random samples were generated again.

Sample Size

From a target population of 853 nurses, we selected a sample of 272 nurses using the Yamane (1967) formula. This formula takes into account the target population and the margin of error or level of precision. The formula is expressed as follows:

$$n = \frac{N}{1 + N(e)^2}$$

where n is the sample size, N is the population size, and e is the level of precision. The precision level for this study was 0.05. The estimated size of the total population was 853. Substituting these values into the previous formula, the sample size was calculated as follows:

$$n = \frac{853}{1 + 853(0.05)^2} = 272.3065$$

Therefore, the sample size for this study was 272 nurses.

Data Collection Instrument

We developed the questionnaire for this study based on the research objectives, the constructs of the CVM, and other useful resources identified from the literature. It was a structured questionnaire with mainly close-ended questions. The questionnaire had three main sections designed to capture data on respondents' demographic characteristics, barriers to political participation, and facilitators of political participation.

Section A contained questions about participants' demographics, such as age, gender, academic qualification, and area of practice. Section B explored the factors that facilitate political participation as posited by the constructs of the CVM. The items in this section were taken from a sample questionnaire developed by Vandenhouten et al. (2011) for a similar study. This section contained scales and subscales that measured the three constructs of the CVM—resources, psychological engagement, and networks of recruitment. It contained a total of 42 items with a Cronbach's alpha of .85. Finally, Section C contained questions about barriers to political participation. The items in this section were based on factors that have been identified in the literature as barriers to political participation, for example, time constraints, lack of political content in nursing education curriculum, fear of victimization, and so on. It also had a questionnaire that had been used in a similar study (Avolio, 2014). There were 11 items in this section, and the Cronbach's alpha stood at .74. The tool was therefore found to be highly reliable because all the various sections scored high on the reliability analysis. There were a total of 56 items in the entire questionnaire.

Data Collection Procedure

Data collection was done between March 27 and April 14, 2017. Following institutional approval, the questionnaires, along with a cover letter to introduce the study purpose and participants' rights, were hand delivered to the participants by the researcher and two volunteers. The participants were then requested to read the consent form and sign to give their consent if they agreed to take part in the study, after which they should proceed to complete the survey. Participants were given 1 week to complete the survey. The researcher then went to each of the facilities to collect the completed surveys, which were usually left with a designated nurse on the ward. Those unable to complete the survey in 1-week were given a 1-week extension, after which the researcher again visited each facility and collected completed questionnaires. During the third week, all remaining questionnaires were collected.

Data Management

During the data collection process, the questionnaires from each facility were kept in a separate envelope marked with the name of that facility to track the rate of retrieval from each facility. During data entry, after completing entry of each individual questionnaire, it was marked as entered to avoid duplicate entries. At the end of each day, the data were backed up on an external drive as well as Microsoft OneDrive online.

Data Analysis

Data analysis was performed using the Statistical Package for Social Sciences, version 21 (IBM, 2015). The data were first tested for normality, and some variables were found not to follow a normal distribution. As such, non-parametric techniques were employed to analyze those components of the data. Demographic characteristics of participants were described using frequencies, percentages, and means. Descriptive statistics (frequencies and percentages) were used to describe barriers to political participation; correlations were used to identify facilitators of political participation. Spearman's correlation was used to test relationships between political participation and independent variables extracted from the CVM. Barriers to political participation were tested collectively against political participation using Spearman's correlation to determine the relationship between the two variables. An alpha value of .05 was used in all statistical tests.

Ethical Considerations

Because we adapted some tools from other researchers, we sought their permission to use their tools in this study. We acknowledged if a tool was available for use without requiring prior permission of the researcher. Because the study was conducted in health care facilities, we sought permission from the Northern Regional Health Directorate to carry out the study at two of the hospitals that were under the jurisdiction of the directorate. For the third hospital, a tertiary health facility with autonomous status, we obtained ethical clearance from the Research and Development unit of the hospital. The two training schools did not have institutional review boards, but their Academic Boards reviewed our proposal and granted permission for us to conduct the study. We obtained ethical clearance from the institutional review board of the University of Cape Coast. Written informed consent was obtained from the participants, and confidentiality of all data was ensured.

Study Variables

The definitions of the study variables, given in the following section, were modeled after the description of similar variables by Vandenhouten et al. (2011), with some modifications.

Political participation. The dependent variable, political participation, was defined as nurses' involvement in activities considered to be political in nature. Example voting, campaigning, attending rallies, volunteering, contacting elected officials, working with others on local problems or issues, and being a member of nursing or nonnursing organizations that take stands on political issues. This variable was measured using an adapted version of the Political Astuteness Inventory.

Resources. Resources were defined as time/money and civic skills available to a person to enable engagement in political activities. The time/money that an individual is willing to contribute for political purposes was measured by six items. Civic skills were defined as knowledge and skills of political activities that enable individuals to participate effectively in politics. The resource score was the sum of the time/money and civic skills subscale scores (possible range of scores: 0–19).

Psychological engagement. Psychological engagement was defined as a desire or motivation toward political stimuli. Dimensions of psychological engagement included political interest, political efficacy, political information/knowledge, partisanship, and family influences. The psychological engagement score was calculated from 27 items (possible range of scores: 0–63).

Political interest was defined as curiosity, concern, and information seeking behavior about political issues and elections. Scores were calculated from responses to five items such as "How often do you seek information about politics from television/radio?" (possible range of scores: 0–21).

Political efficacy was defined as a participant's own conviction in his or her ability to influence governmental decisions. The scores in this subscale were calculated from responses to six items such as "I believe I have power to influence political affairs" (possible range of score: 0–24).

Political information/knowledge was defined as knowledge about the theory and practice of government. Items were selected from textbooks on citizenship education in Ghana. There were eight items in this subscale with additive scoring of correct answers resulting in a possible range of 0 to 8. Examples of items include "Who is the commander-in-chief of the Ghana Armed Forces?"

Partisanship was defined as the degree to which a person was affiliated with a political party. Only one item was used to calculate the partisanship score with scores ranging from 0 to 3. The item used was "How strongly are you affiliated to a political party?"

Family influences were defined as exposure to politically relevant stimuli while growing up. The scores were calculated from three items such as "When you were growing up, how frequent were political discussions held in your home?" (possible range of scores: 0–7).

Recruitment networks. *Recruitment networks* were defined as sources (e.g., churches, workplaces, and schools) that encourage individuals to become politically active. A score was computed from participants' responses to six items. An example item was "Has someone at your job, past or present, ever asked or suggested that you become politically active?" (possible range of scores: 0–6).

Barriers to political participation

We added a dimension not included in the original version of the CVM, which we defined as factors that hinder nurses' participation in political activities. Scores in this scale were calculated from responses to 11 items with scores ranging from 11 to 44. The following are two examples of items in this scale: "I have little free time" and "I am anxious about public speaking."

Results

Background Characteristics of Respondents

Out of the initial sample of 272 registered nurses who the questionnaires were administered to, 225 participants eventually completed the survey (retrieval rate of

Table 2. Background Characteristics of Respondents (July 2017).

Variable	Frequency	% age $n = 225$
Age		
20–24	9	4
25–29	79	35.1
30–34	105	46.7
35–39	21	9.3
40–44	7	3.1
45 and older	4	1.8
Gender		
Male	124	55.1
Female	101	44.9
Position		
Staff nurse	85	37.8
Senior staff nurse	58	25.8
Nursing officer	44	19.6
Senior nursing officer	33	14.7
Principal nursing officer	3	1.3
Deputy director of nursing services	3	0.9
Area of practice		
Clinical nurse	205	91
Nurse educator	20	9
Highest academic qualification		
Diploma	128	56.9
Bachelor's degree	86	38.2
Master's degree	11	4.9

82.7%). The characteristics of this sample are presented in Table 2. Most of the participants were in their 30s (M age = 30.84, $Mdn = 30.00$). Males were slightly more (55.1%) than females. The majority (63.6%) was in the junior ranks—that is staff nurse and senior staff nurse. A similar trend was observed in the academic qualification with 56.9% having a diploma.

Barriers to Political Participation

The first research question in this study was barriers to nurses' political participation. Here, participants were asked to identify common factors that they consider as barriers to their participation in political activities. The responses in this section were analyzed using frequencies and percentages (Table 3). The most frequent reported barriers to political participation were identified as having little free time (74%), lack of trust in politicians (72%), fear of conflict/confrontation (71.9%), and lack of educational preparation (65%).

As part of this construct, nurses were asked about their opinion regarding the statements "women don't belong in politics" and "politics is not the concern of nurses." Their responses to these statements are presented in Table 4.

A Spearman's rank-order correlation was used to determine the relationship between barriers and political participation. There was a weak, negative correlation between the two, which was statistically significant, $r_s(223) = -.228^{**}$, $p = .001$. These results are logical in that participation in political activities would decrease as barriers to such participation increased and vice versa.

Table 3. Barriers to Political Participation (July 2017).

Barrier	Frequency	% age ($n = 225$)
Little free time	167	74.2
Lack of trust in politicians	164	72.9
Fear of conflict or confrontation	161	71.9
Lack of educational preparation	147	65.4
Lack of right connections	117	52
Fear of victimization	107	47.5
Fear of public speaking	76	33.7
Confusing political language	69	30.6
Lack of understanding of the political system	49	21.7
Lack of personal efficacy	41	18.3

Note. There were multiple choice options in this section, and respondents were asked to choose all that applied.

Facilitators of Political Participation

The second research question sought to find out factors that may facilitate nurses' involvement in political activities. To answer this question, the main constructs, as well as the subconstructs of the CVM were correlated against political participation to determine if the CVM factors enhanced political participation. Even though the scores for political participation were normally distributed, all the independent variables (except psychological engagement) were not normally distributed. As such, the Spearman's correlation was used to determine these relationships. However, Pearson's correlation was used in the case of psychological engagement because that one was normally distributed. For the main constructs, there were strong, positive, statistically significant correlations between resources and political participation, $r_s(223) = .653^{**}$, $p = .001$, as well as psychological engagement and political participation, $r(223) = .589^{**}$, $p = .001$. However, the correlation between recruitment networks and political participation was weak, but positive and statistically significant, $r_s(223) = .299^{**}$, $p = .001$. Apart from the main constructs, further dimensions of each construct were also correlated separately against political participation to determine the relationships between them. Results of all correlations are presented in Table 5.

Based on the results in Table 5, the following were identified as the facilitators for nurses' involvement in political participation: availability of free time

Table 4. Participants' Responses to Common Perceptions About Nurses and Politics (July 2017).

	Responses in % ages ($n = 225$)			
Variables	Strongly agree	Agree	Disagree	Strongly disagree
Women don't belong in politics	4.0	5.3	45.3	44.9
Politics is not the concern of nurses	10.2	11.1	47.6	31.6

Table 5. Correlations Between Political Participation and Civic Voluntarism Model Factors (July 2017).

Variables	Spearman's rho	*N*	Sig.(*p*)—2-tailed
Political participation and resources	.653**	225	.001
Political participation and psychological engagement (*Pearson's correlation*)	.589**	225	.001
Political participation and recruitment networks	.299**	225	.001
Political participation and time/money	.527**	225	.001
Political participation and civic skills	.594**	225	.001
Political participation and political interest	.508**	225	.001
Political participation and political efficacy	.450**	225	.001
Political participation and political information	.203**	225	.002
Political participation and partisanship	.369**	225	.001
Political participation and family influences	.224**	225	.001

Note. **Correlation is significant at the 0.01 level (2-tailed).

and money, civic skills, personal interest in politics, self-belief and confidence, and a strong party affiliation. Among these, availability of resources, such as time and money, appears to be the most important facilitator as evidenced by the strong positive correlation between that factor and political participation.

Discussion

In this section, we summarize the barriers and facilitators to Ghanaian nurses' political participation based on our findings. We identify limitations of the study and propose implications of our work for practice, research, and policy.

Barriers to Political Participation

Consistent with previous studies, time constraint was the most frequently identified barrier to political participation. Nurses often experience work–life balance struggles that include the demands of home, family, and career (Boswell et al., 2005). This is further complicated by long work hours and the mental and physical challenges of the work they do. In many hospitals, nurses have to contend with high number of patients and severe understaffing. This leaves very little time for them to engage in other activities such as politics.

Similar to the present study, Ennen (2001) identified lack of trust in politicians as a barrier to political participation. Perhaps, this emanates from the negative images of politicians in the media (Avolio, 2014). In addition, many participants in this study identified fear of conflict or confrontation as the main reason they avoided political activities.

Lack of educational preparation for political activity, owing to the lack of political content in the curricula of nursing education programs, has been cited prominently in the literature as a barrier to nurses' political participation (Avolio, 2014; Gebbie et al., 2000; O'Niell-Conger & Johnson, 2000; Primomo & Bjorling, 2013; Primono, 2007; West & Scott, 2000). Our study also affirmed the findings of these previous studies. Political astuteness requires awareness and understanding of health policy, politics, and different types of policy contexts, such as legislative and executive arenas. Nurses need education in these areas to acquire confidence, knowledge, and skills to advocate politically on behalf of their communities (Primono, 2007). However, nursing education mainly concentrates on clinical skills and theory related to patient care and management, not on leadership development or policy issues (Fletcher, 2006).

Apart from a study on political advocacy of registered nurses in Canada (Avolio, 2014), there are no other studies that report fear of victimization as a barrier to nurses' political participation. In contrast, our findings show this to be a barrier to political participation of nurses. Perhaps, in Ghana, this is because of a common perception that political opponents are denied promotions or given inconvenient transfers, just to humiliate and frustrate them for their political views. People who are

scared of such political backlash might avoid active political involvement.

Facilitators of Political Participation

One of the objectives of this study was to identify factors that might facilitate or enhance nurses' political participation. Of the three main constructs in the CVM (resources, psychological engagement, and recruitment networks), resources had the most significant positive relation with nurses' political participation. This finding is consistent with the constructs of the CVM in which greater emphasis is put on resources, and it appears first in the line of predictors of political participation. It, however, differs from the findings of Vandenhouten et al. (2011), who identified psychological engagement as the most predictive factor for nurses' political participation.

Other dimensions of the two leading elements of the CVM (resources and psychological engagement) were also explored separately to determine their individual relation with participation. Contrary to the findings of Cramer (2002) and Vandenhouten et al. (2011), who found free time and money to be more predictive of political participation than civic skills, our study found civic skills to be more predictive than free time and money.

Regarding other dimensions of psychological engagement, the most important facilitators were (in order of importance) political interest, political efficacy, and partisanship. Similarly, Vandenhouten et al. (2011) also found political interest and political efficacy to be the most important predictors of nurses' political participation. The findings from our study and that of Vandenhouten et al. (2011) suggest that one's knowledge of politics and government (political information) does not necessarily enhance political participation as much as a belief in one's ability to influence political affairs (political efficacy).

Membership in a professional nursing organization has been cited as a facilitator of political participation for nurses (Avolio, 2014; Cramer, 2002; Woodward et al., 2016). However, in the context of our study, membership, alone, was not a facilitator of political participation. We found no correlation between membership in GRNMA and the political participation of respondents ($p = .089$). However, there was a moderately strong and statistically significant correlation between attendance of GRNMA regional symposia and political participation, $r_s(223) = .418$, $p = .001$. This finding suggests that when members actively participate in the programs and activities of professional organizations, they may become politically savvy.

Study Limitations

The data collection tools used in this study was all originally developed in other countries with different political contexts from Ghana. We therefore had to modify them for use in Ghana, and this may have affected their validity and reliability. In addition, we used correlations between political participation and the CVM factors to determine what constitutes facilitators of political participation. The facilitators identified through this method may not be the actual views of the participants. It also made it impossible to identify other facilitators beyond the scope of the CVM. The relatively small sample size drawn from only one major city in Ghana may not be representative for the whole of Ghana.

Implications for Practice, Education, and Research

To simplify political language and the political system and increase networking opportunities for nurses, the GRNMA should emulate the example of the American Nurses' Association by introducing the concept of Nurse Legislative Day or Nurse Lobby Day in Accra and all regional capitals to provide both educational and experiential activities about how to influence the legislative process through political advocacy. Also, to do away with the fear of victimization, the GRNMA should sensitize all stakeholders and employers to understand that political advocacy is an essential role of a professional nurse. The association must take measures to ensure that nurse activists perform their roles of political advocacy without any fear of victimization or retaliation from their employers.

In view of the finding that lack of educational preparation for political activity constitutes a major barrier to political participation, the Nursing and Midwifery Council of Ghana should consider revising some elective nursing courses to address political content. If political content is incorporated into nursing education curricula, and student nurses are exposed to political education, they are more likely to be politically active.

Our study sought to identify barriers to and facilitators of nurses' political participation in the Ghanaian context. The method used to identify facilitators in this study could be modified to use a more direct approach rather than using inferences from the data. Similar studies could be conducted in other parts of the country with larger samples to evaluate the findings in the present study. More important, there is the need to develop research instruments in this area that are relevant and suitable to the Ghanaian context.

Conclusion

The findings of this study show that there are numerous barriers to Ghanaian nurses' participation in political activities. Many of the factors that have been identified as barriers in this study, including lack of free time and money, lack of trust in politicians, fear of conflict, and lack of educational preparation, were previously identified in other studies as barriers to political participation. However, findings from this study revealed that nurses do not necessarily feel they do not belong in politics. Instead, our study shows that if nurses are given increased political and civic education as well as enhanced self-confidence and if their political interest is well nurtured, they may become more politically active to advocate for the profession and our client populations at the local, regional, and national levels.

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References

Adams, I., Owusu-Ansah, E., Degbotse, D., Dusu, H., Agongo, E., Bannermann, C., . . . Awittor, E. (2015). *Ghana health financing strategy*. Retrieved from http://www.moh.gov.gh/wp-content/uploads/2016/02/Health-Finance-Strategy-160203045304.pdf

Ahoya, C. K., Abhichartibuttra, K., & Wichaikhum, O. (2016). Political efficacy and political participation among nurses in tertiary hospitals, the Republic of Kenya. *Journal of Community & Public Health Nursing*, *02*(04), 142. doi:10.4172/2471-9846.1000142

Aikins, A. D., & Koram, K. (2017). Health and Healthcare in Ghana, 1957-2017. In Aryeetey, E. & Kanbur, R., *The Economy of Ghana Sixty Years after Independence* (pp. 365–384). Oxford University Press. Retrieved from https://doi.org/10.1093/acprof:oso/9780198753438.003.0022

American Nurses Association. (2018). *Political action committee*. Retrieved from https://ana.aristotle.com/SitePages/pac.aspx

Ampomah, S. (2018). *Health Ministry signs MoU to deploy drone technology*. Retrieved from http://www.moh.gov.gh/health-ministry-signs-mou-to-deploy-drone-technology/

Antrobus, S., Masterson, A., & Bailey, J. (2004). Scaling the political ladder. *Nursing Management*, *11*(7), 23–28.

AQUASTAT. (2005). *Irrigation in Africa in figures*. Retrieved from http://www.fao.org/nr/water/aquastat/countries_regions/GHA/GHA-CP_eng.pdf

Arko, J. (2017, April 11). *Admission requirements for nursing programmes—Ministry of Health (MOH)*. Retrieved from https://nursinginghana.com/admission-requirements-nursing-programmes-moh/

Avolio, C. D. (2014). *Political advocacy: Beliefs and practices of registered nurses* (master's thesis). University of Windsor, Canada. Retrieved from http://scholar.uwindsor.ca/etd/5064/

Boswell, C., Cannon, S., & Miller, J. (2005). Nurses' political involvement: Responsibility versus privilege. *Journal of Professional Nursing*, *21*(1), 5–8. doi:10.1016/j.profnurs.2004.11.005

Byrd, M. E., Costello, J., Gremel, K., Schwager, J., Blanchette, L., & Malloy, T. E. (2012). Political astuteness of baccalaureate nursing students following an active learning experience in health policy. *Public Health Nursing*, *29*(5), 433–443. doi:10.1111/j.1525-1446.2012.01032.x

Cohen, S. S., & Muench, U. (2012). Nursing testimony before congress, 1993-2011. *Policy, Politics, & Nursing Practice*, *13*(3), 170–178. doi:10.1177/1527154412471201

Commonwealth Local Government Forum. (2018). *The local government system in Ghana*. Retrieved from http://www.clgf.org.uk/default/assets/File/Country_profiles/Ghana.pdf

Cramer, M. E. (2002). Factors influencing organized political participation in nursing. *Policy, Politics, & Nursing Practice*, *3*(2), 97–107. doi:10.1177/152715440200300203

Des Jardin, K. E. (2001). Political involvement in nursing—Politics, ethics, and strategic action. *AORN Online*, *74*(5), 613–615.

Electoral Commission of Ghana. (2018a). *Profile of registered political parties in Ghana*. Accra, Ghana: Author.

Electoral Commission of Ghana. (2018b). Retrieved from www.ec.gov.gh

Ennen, K. A. (2001). Shaping the future of practice through political activity: How nurses can influence health care policy. *AAOHN Journal*, *49*(12), 557–569.

Falk-Rafael, A. R. (2005). Speaking truth to power: Nursing's legacy and moral imperative. *Advances in Nursing Science*, *28*(3), 212–223.

Fletcher, K. (2006). Beyond dualism: Leading out of oppression. *Nurse Forum*, *41*(2), 50–59.

Food and Agriculture Organization of the United Nations. (2018). *Ghana at a glance*. Retrieved from http://www.fao.org/ghana/fao-in-ghana/ghana-at-a-glance/en/

Gebbie, K. M., Wakefield, M., & Kerfoot, K. (2000). Nursing and health policy. *Journal of Nursing Scholarship*, *32*(3), 307–315.

Ghana Health Service. (2016). *Ghana Health Service annual report*. Retrieved from https://www.ghanahealthservice.org/downloads/GHS_ANNUAL_REPORT_2016_n.pdf

Ghana Health Service. (2017). *The health sector in Ghana; Facts and figures*. Accra, Ghana: Author.

Ghana News Agency. (2015, November 11). *GRNA now Ghana Registered Nurses and Midwives' Association*. Retrieved from http://www.ghananewsagency.org/health/grna-now-ghana-registered-nurses-and-midwives-association-96914

Ghana Statistical Service. (2014). *Health status indicators*. Accra, Ghana: Author.

Ghanaweb. (2014). *Ghana City Tamale*. Retrieved from http://www.ghanaweb.com/GhanaHomePage/geography/tamale.php

Ghanaweb. (2018a). *Creation of new regions: "There can be no excuse for any disturbance or violence" – Nana Addo*. Retrieved from https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Creation-of-New-Regions-There-can-be-no-excuse-for-any-disturbance-or-violence-Nana-Addo-710267

Ghanaweb. (2018b). *Suspend planned drone services – GMA to government*. Retrieved from https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Suspend-planned-drone-services-GMA-to-government-708155

IBM. (2015). *Statistical package for social sciences (Version 21) [Windows]*. New York, NY: Author.

Index Mundi. (2018). *Ghana economy profile 2018*. Retrieved from https://www.indexmundi.com/ghana/economy_profile.html

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.

Juma, P. A., Edwards, N., & Spitzer, D. (2014). Kenyan nurses involvement in national policy development processes. *Nursing Research and Practice, 2014*, 1–10. doi:10.1155/2014/236573

Keepnews, D. M. (2012). Health policy, politics, and partisanship. *Policy, Politics, & Nursing Practice*, *13*(4), 183–183. doi:10.1177/1527154413490566

Kelly, K. (2007). From apathy to political activism. *American Nurse Today, 8*(2).

Kretchy, I. A., Owusu-Daaku, F., & Danquah, S. (2014). Patterns and determinants of the use of complementary and alternative medicine: A cross-sectional study of hypertensive patients in Ghana. *BMC Complementary and Alternative Medicine*, *14*(1).

Lathrop, B. (2013). Nursing leadership in addressing the social determinants of health. *Policy, Politics, & Nursing Practice*, *14*(1), 41–47. doi:10.1177/1527154413489887

Ministry of Health, Ghana. (2018). *Ghana registered nurses and midwives*. Retrieved from http://www.moh.gov.gh/ghana-registered-nurses-and-midwives/

Montalvo, W., & Byrne, M. W. (2016). Mentoring nurses in political skill to navigate organizational politics. *Nursing Research and Practice*, *2016*, 1–8. doi:10.1155/2016/3975634

Nursing and Midwifery Council of Ghana. (2018, October). *List of approved institutions and programmes*. Accra, Ghana: Author.

Ofori-Ampofo, P. (2017). *Report of 16th biennial delegates conference*. Cape Coast, Ghana: Ghana Registered Nurses and Midwives Association.

O'Niell-Conger, C., & Johnson, P. (2000). Integrating political involvement and nursing education. *Nurse Educator*, *25*(2), 99–103.

O'Rourke, N. C., Crawford, S. L., Morris, N. S., & Pulcini, J. (2017). Political efficacy and participation of nurse practitioners. *Policy, Politics, & Nursing Practice*, *18*(3), 135–148. doi:10.1177/1527154417728514

Primomo, J., & Bjorling, E. A. (2013). Changes in political astuteness following nurse legislative day. *Policy, Politics, & Nursing Practice*, *14*(2), 97–108. doi:10.1177/1527154413485901

Primono, J. (2007). Changes in political astuteness after a health systems and policy course. *Nurse Educator*, *32*(6), 260–264.

Shariff, N. (2014). Factors that act as facilitators and barriers to nurse leaders' participation in health policy development. *BMC Nursing, 13*(1), 1. Retrieved from http://bmcnurs.biomedcentral.com/articles/10.1186/1472-6955-13-20

Sumner, J., & Danielson, E. (2007). Critical social theory as a means of analysis for caring in nursing. *International Journal for Human Caring*, *11*(1), 30–37.

The Association of Chartered Certified Accountants. (2013). *Key health challenges in Ghana*. Retrieved from https://www3.accaglobal.com/content/dam/acca/global/PDF-technical/health-sector/tech-tp-khcg.pdf

U.S. Bureau of Labor Statistics, U.S. Department of Labor. (2013). *Occupational outlook handbook* (2010th–2011th ed.). Retrieved from http://www.bls.gov/oco/ocos083.htm

Vandenhouten, C. L., Malakar, C. L., Kubsch, S., Block, D. E., & Gallagher-Lepak, S. (2011). Political participation of registered nurses. *Policy, Politics, & Nursing Practice*, *12*(3), 159–167. doi:10.1177/1527154411425189

Verba, S., Schlozman, K. L., & Brady, H. E. (1995). *Voice and equality: Civic voluntarism in American politics*. Cambridge, MA: Harvard University Press.

West, E., & Scott, C. (2000). Nursing in the public sphere: Breaching the boundary between research and policy. *Journal of Advanced Nursing*, *32*(4), 817–824.

Woodward, B., Smart, D., & Benavides-Vaello, S. (2016). Modifiable factors that support political participation by nurses. *Journal of Professional Nursing*, *32*(1), 54–61. doi:10.1016/j.profnurs.2015.06.005

World Population Review. (2018a). *Ghana population 2018 (demographics, maps, graphs)*. Retrieved from http://worldpopulationreview.com/countries/ghana-population/

World Population Review. (2018b). *Population of cities in Ghana*. Retrieved from www.worldpopulationreview.com

Yamane, T. (1967). *Statistics: An introductory analysis* (2nd ed.). New York, NY: Harper and Row.

Yeboah, R. M. (2018). *Nursing training allowances restored – Government of Ghana*. Retrieved from http://www.ghana.gov.gh/index.php/news/4064-rnursing-training-allowances-restored

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