

Full Length Research Paper

Perceived relative factors influencing nurses' practice of health promotion for women in Calabar, Cross River State, Nigeria

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Socio-cultural factors negate the health of women. Therefore, health promotion as a focus of nursing practice aimed at capitalizing on the inherent capacities of women to establish health priorities, goals and strategies to improve their health. A descriptive survey with the purpose of ascertaining the influence of culture, social and health policies on nurses' practice of health promotion was undertaken. Three hypotheses were formulated to guide the study. A sample of one hundred and thirty six nurses participated in the study. A validated questionnaire with a test-retest reliability coefficient (r) of 0.79 was used for data collection. Correlation analysis was carried out to test hypotheses. The results revealed that 132 (97.1%) participants were female with a mean (SD) age of 40 ± 7.29 . Many participants 58 (42.6%) perceived that social policies have high influence on their practice of health promotion. The results also showed significant negative correlation between culture and practice of health promotion ($r = -0.532$; $p = 0.01$) while the practice of health promotion was significantly and positively correlated with social policies ($r = 0.515$; $p = 0.01$). It was recommended that negative cultural practices be addressed through social policies and health education of women on negative cultural practices in order to enhance the practice of health promotion for them.

Key words: Culture, health policy, health promotion, nursing practice of health promotion for women, social policies.

INTRODUCTION

In developing countries including Nigeria, women's health is influenced by a series of factors: culture, tradition and religion; socio-economic status, illiteracy, unequal distribution of public health services and absence of proper programmes for maternal and child health promotion. Additionally, women are discriminated against at the health sector levels. They face discrimination in the health care system as users and providers, in access and in availability of quality services throughout life cycle, in allocation of resources, in participation in policy and decision making and in the type of health research that is carried out (World Health Organization (WHO), 2000a; International Council of Nurses (ICN), 2013). Poverty,

lack of insurance coverage and less employment have worked against women's health. Nurses also carry the heaviest burden for the provision of health care for women since they constitute the largest group in the health team. Coincidentally, nurses who are predominantly women share the common health experiences or problems affecting women.

Health promotion is a new public health strategy to improve health, control health cost and reduce unnecessary sickness and death (Smeltzer et al., 2010; WHO, 2005). The need for nurses to practice health promotion for women to reduce morbidity and mortality require proper understanding as regards the concept of health promotion

and factors which may influence appropriate practice of health promotion. However, nurses practice of health promotion has been inundated with reports of misinterpretation of the concept and inappropriate practice which is based on biomedical model of practice (Whitehead, 2006, 2010; Chambers and Thompson; 2008; Casey, 2007a, b; Piper, 2008; Wilson and Palha, 2007; Runciman et al., 2006; Berg et al., 2005; Scriven, 2005). Several nursing authors have noted that the goal of health promotion are consistent with the broader and more holistic philosophical underpinning of nursing and client care, but the imposition of bio-medically determined models of care limit this scope (Whitehead, 2010; Chambers and Thompson, 2008; Scriven, 2005). Accordingly, nurses define and practice health promotion in the narrowest terms of health education (Kelly and Abraham, 2007) focusing on health information giving and disease prevention (Berge et al., 2005; Casey, 2007).

Lack of practice of health promotion by nurses is exemplified in a study by Wilhelmson and Lindberge (2009) among Swedish nurses, which revealed that despite health promotion being the central part of their training and a professionally legislated-for competence, they were not able to practice it. It was reported that medicalized tasks were the norm and far more respected than much more lower priority of health promotion. Nurses do not know what is needed to be done to be health promoters and there is lack of practical prescriptions as to what constitute health promotion activity and how it is applied in nursing practice (Caelli et al., 2003). If the confusion as to what constitutes health promotion and how it is applied to nursing is noted in developed countries, then in developing countries, it is expected that there would be more confusion because health promotion has not yet been addressed in some of the basic curriculum of training nurses. Nurses' practice of health promotion for women implies the process of enabling women increase control over their health and its determinants and thereby improve their health.

In Nigeria, the health promotion policy was launched in 2006 by the Federal Government (Federal Ministry of Health (FMOH), 2006). The practice of health promotion by healthcare providers is supposed to show an improvement on the health indicators as portrayed in the Demographic Health Survey (DHS). However, National Demographic Health Survey (2008) revealed a dismal performance of the health system. Accordingly, communicable diseases along with maternal, perinatal and nutritional conditions accounted for an estimated 67% majority of all mortality in 2008; while non-communicable diseases accounted for 28% of all mortality (Nexus Strategic Partnership Limited, 2013a, b). Furthermore, Nigeria National Population Commission (2008) DHS revealed that maternal mortality ratio was 545/100,000 live birth, 20% of Nigerian women were teenage mothers, 50% of women participate in decision about health, 37% were circumcised, 43% of women and 30% of men

agreed that a husband was justified in beating the wife for certain reasons. FMOH also noted that utilization of primary health care facilities was 5 to 10% due to consumers' loss of confidence in them. These depressing health indicators may be attributed to none or minimal practice of health promotion (FMOH, 2006).

Therefore, in order to enhance nurses' practice of health promotion, government has developed the Health Promotion Policy in 2006; there has been reorientation of nurses through sponsoring of conferences, workshops and continuing education programmes. Additionally, nurses are appointed into Directorate position which is supposed to influence policy decisions. Despite all these efforts to improve health promotion practices of nurses, observation revealed that health promotion is still haphazardly practiced with little or no impact on women's health, some of the barriers which have hindered the practice of health promotion for women include culture, social policy, health policy, lack of support by primary health care sector, tight schedules due to nursing commitments, lack of adequate knowledge of health promotion needs of women, difficulty with population based practice among others and these have resulted in the increase of morbidity and mortality (Akpabio, 2006; Samson-Akpan et al., 2012).

Health and disease are now known to be determined by a combination of supportive environment, health and social services, personal skills, community action and healthy public policies (Hoppenbrouwer, 2000; World Health Organization (WHO), 2005; FMOH, 2006). According to Dahlgren and Whitehead (1991) socio-ecological theory of health, individuals are surrounded by health influences that can be modified: personal behavior, social and community networks and structural factors which are believed to influence health generally including women's health and nurses practice of health promotion.

Actually, health promotion process and activities are politically based, driven and expedient (Mason et al., 2007; Nettleton, 2006; Bamba, 2005). Therefore, health professionals, including nurses are supposed to be politically expedient entities that are able to move relatively freely in and out of the policy machinations of health care delivery system (Laverack, 2004; Scriven, 2005; Mc Murray, 2007). Nevertheless, many critics have noted the collective lack of will power and/or opportunity in nursing to initiate and lead on matters relating to its own health related policy agendas. Indeed nurses are viewed as political bystanders or health policy victims (Whitehead, 2010; Hewison, 2007; Des Jardin, 2001; Gebbie et al., 2000). Nurses need to be social activist in the area of health promotion and be in the forefront of policy making; otherwise, health promotion role of nursing will continue to be defined according to the priorities of other professional groups (Falk-Rafael et al., 2004). Many nursing health-related agendas and practices have been determined by far more powerful political lobby of

the medical profession (Powers, 2002; Tovey and Adams 2003; Hyde et al., 2005). However, for nurses to be effectively engaged in health promotion activities, they are required to know how they can contribute to the development of health policy and related socio-political strategy (Hewison, 2007).

The necessity of policy changes is highlighted in International Council of Nurses (ICN) (2009) statement that the aim of health promotion is to create a healthy public policy in which different sectors integrate health priorities into their policies and programmes so as to enable people have control over their health and make health choices to be easy choices. Therefore, Pender et al. (2006) emphasize that intervention through public policy may offer a very immediate way to impact health problems such as obesity. Actually, the importance of advocacy as one of the nurses' role in health promotion is well documented in literature (Modrein-Talbott, 2002; ICN, 2009; FMOH, 2006). FMOH (2006) posits that advocacy can be used to influence policy makers to adopt healthy public policies and enact/enforce law that promote health and consumers' right.

Culture is another factor which influences the health of women and nurses practice of health promotion (Tandon, 2006; Timmerman, 2007; Berman and Snyder, 2012). Socio-cultural practices may include denial of access to education, female circumcision, burden of care, poverty, early marriage, violence among others. All these socio-cultural practices endanger the health of women and also affect nurses' practice of health promotion among them. Cultural practices may impair the accessibility and acceptability of general/nutritional education, sanitation practices, modification of life styles and others.

It is commonly accepted that health promotion interventions should be culturally relevant (Crane and McSweeney, 2003; Garcia, 2006; James, 2004) and that health care professionals including nurses should be culturally competent (Brown et al., 2002; Birkett et al., 2004). This view is supported by Kelinger's Sunrise Model (Berman and Snyder, 2012).

In view of the new public health approach which is health promotion, nurses working in diverse setting provide ideal opportunities to implement health promotion interventions. Nurses cannot perform their roles and functions effectively if they are encumbered by many socio-cultural factors as witnessed in the setting of the study (Calabar, Nigeria). These factors include female circumcision, fattening room practices, widowhood rites, patronage of untrained traditional birth attendants and churches for care during pregnancy. During the course of literature review, there was no past study emanating from Calabar, Cross River State which has identified the factors influencing nurses' practice of health promotion among women.

The specific objectives which guided the study were to: determine extent to which nurses practice health promotion among women; determine the relationship

between culture and nurses' practice of health promotion in Calabar; ascertain the influence of social policies on nurses' practice of health promotion among women in Calabar; ascertain the influence of health policies on nurses' practice of health promotion among women in Calabar.

Significance of the study

A study to establish the relationship between culture, social policy, health policy and the nurses' practice of health promotion among women in Calabar will add to the already existing database. It will also assist government and other stakeholders in the health sector to develop an appropriate intervention policy that would address these factors that hinder the practice of health promotion for women. If these determinants of health are addressed, then nurses' practice of health promotion will yield positive results.

Theoretical framework

This study is based on Precede Model developed by Lawrence Green. This model classifies the variables which affect health behaviour as predisposing, enabling and reinforcing factors (Achal, 2001).

The Precede Model helps one to classify the factors influencing the practice of health promotion for women, ascertain the possibility of initiating and sustaining the practice of health promotion for women through enabling factors and provision of reinforcement through encouragement and approval of nurses' practice of health promotion for women.

MATERIALS AND METHODS

This study was a descriptive survey. The study took place in two out of three public hospitals and all primary health care centers in Calabar, Cross River State. These sites were selected because they had the highest number of women concentration for consultation. Calabar is located in the rain forest belt in the South-South Geopolitical Zone of Nigeria. Calabar is made up of two local government areas, Calabar South local Government area and municipality. Calabar is the capital of Cross River State and is developing into a tourist centre. It has two universities, an airport, seaport, many public and private enterprises.

Study population

The study population consisted of 871 registered nurses working in public hospitals owned by federal and state governments in Calabar and all primary health care centres. A purposive sampling method was used to select a sample of 136 nurses drawn from units that were not involved in shift duties in the institutions. These first contact nurses were chosen, because they were in a better position to practice health promotion for women when these women come in contact with them (nurses) at a point they (women) are eager to learn about health as they come to the health institutions. The breakdown was as follows: 87 nurses were drawn from health

Table 1. Summary of participants' characteristics.

Characteristic	N	%
Sex		
Male	4	3.0
Female	132	97.0
Marital Status		
Single	13	9.6
Married	102	75.0
Widowed	15	11.0
Divorced/separated	6	4.4
Educational Status		
Diploma	84	62.0
B.Sc	48	35.0
Master's degree	4	3.0
*Professional Qualification		
Registered nurse	136	100.00
Registered midwife	134	98.5
Registered nurse psychiatrist	11	8.1
Total	136	100

*Multiple responses allowed

centres in the two local government areas, and 49 from the antenatal clinics of the two public hospitals in Calabar.

Data collection

A self developed and well validated questionnaire was used in the collection of data. The variables used in the construction of the questionnaire were based on Precede Model (Achalu, 2001); ICN document on mobilizing nurses for health promotion (ICN, 2009); Arizona Nurses Association Position statement on women's health (Arizona Nurses Association, 2001); Agenda for women's health promotion: A Working Group Report (Tandon, 2006). The questionnaire had two sections with 32 items: Section A with 8 items that covered socio-demographic characteristics of the participants, while Section B with 6 items that had Likert scale covering extent of practice of health promotion by nurses. The Likert scale had very often = 3; often = 2; fairly often = 1; and none = 0.

Factors influencing nurses' practice of health promotion had 6 items each for social policies, health policies and culture = 18 items. The items were rated on a Likert scale of very much = 0; much = 1; fairly much = 2; and not all = 3. In order to determine the level of practice, total practice score was calculated for each participant; the total obtainable score was 18; participants who scored between 1 and 12 were grouped as having inappropriate practice of health promotion while those who scored between 13 and 18 were grouped as having appropriate practice. The test-retest reliability coefficient (r) of the instrument was 0.79 which was considered appropriate for the study. Face validity of the instrument was ascertained by one professional in Health Education and Promotion and an epidemiologist. They scrutinized the instrument to ensure that all the objectives were covered. The copies of the questionnaire were administered face to face to participants with the aid of trained research assistants. Completed copies of the questionnaire were retrieved from participants on the spot.

Ethical consideration

The proposal for the study was sent for approval to the Ethical Review Committee of State Ministry of Health and the tertiary health institution. In addition, written permission was also obtained from the hospital management and primary health care coordinators of the health centres. Verbal consent was also obtained from the nurses who participated in the study after the purpose of the study had been explained to them. Participants were not identified by name rather copies of the questionnaire were assigned numbers to ensure anonymity.

Data analysis

A total of 136 copies of the questionnaire were distributed and retrieved from participants. Simple percentages and Pearson product moment correlation were used to analyze the data. Three hypotheses served as a guide in carrying out the analysis and presentation of the findings:

- H₁: There is no significant relationship between culture and nurses' practice of health promotion in Calabar.
H₂: Social policies do not significantly influence nurses' practice of health promotion among women in Calabar.
H₃: Health policies do not significantly influence nurses' practice of health promotion among women in Calabar.

RESULTS

Socio-demographic characteristics of respondents

The mean (SD) age of respondents was 40 ± 7.29 years while the mean (SD) years of working experience was 17.2 ± 7.86. The results in Table 1 showed that majority of the respondents belonging to the female gender, were all Christians. Majority of the respondents were married, had diploma certificate and were registered nurses. As regards the rank of the respondents, about half of the participants were Chief Nursing Officers.

Determination of nurses' extent of practice of health promotion among women

The results showed that 50 (36.8%) of the respondents provided nutritional education for women very often while 61 (44%) did it often. Many of the respondents, 72 (52%) advocated for improvement in women's nutrition.

Only 50% of the respondents demonstrated exercises to women based on needs. With regards to education on stress prevention, only 49 (36%) and 47 (34.6%) practiced this strategy very often and often. Many of the respondents, 51 (37.5%) educated women on post menopausal syndrome management often, while some of the respondents, 81 (59.6%) advocated for elimination of genital mutilation. Only half, 68 (50.0%) of the participants demonstrated appropriate practice while another half did not.

H₁: There is no significant relationship between culture

Table 2. Correlation analysis of the relationship between culture and nurses' practice of health promotion for women in Calabar.

Variable	Mean	SD	N	Pearson Correlation Coefficient ®	P	Remark
Practice of health promotion	12.43	3.14	136	0.53	0.01	Significant
Culture	12.25	3.90	-			

P<0.01; Critical r = 0.23; df = 134; SD: Standard deviation; N: Number.

Table 3. Correlation analysis of the relationship between social policies and nurses' practice of health promotion for women in Calabar.

Variable	Mean	SD	N	Pearson Correlation Coefficient ®	P	Remark
Practice of health promotion	12.43	3.14	136	0.515	0.01	Significant
Social policies	13.77	4.92	-			

P<0.01; Critical r = 0.23; df = 134; SD: Standard deviation; N: Number.

and nurses' practice of health promotion in Calabar.

To test this hypothesis, an evaluation was made of the linear relationship between participants' perception of culture and their practice of health promotion among women using Pearson's correlation. The analysis using Pearson's correlation coefficient presented in Table 2 indicates a highly significant negative relationship between culture and nurses' practice of health promotion ($r(136) = -0.53$; $p = 0.01$). For these data, the mean (SD) for culture was 12.25 (3.90) and health promotion practice was 12.43 (3.14).

H₂: Social policies do not significantly influence nurses' practice of health promotion among women in Calabar.

To test this hypothesis, an evaluation was also made of the linear relationship between participants' perception of social policies and their practice of health promotion among women using Pearson's correlation.

The analysis using Pearson's correlation coefficient presented in Table 3 signifies a highly significant direct, positive relationship between social policies and nurses' practice of health promotion ($r_{(136)} = 0.515$; $p = 0.01$). For these data, the mean (SD) for social policies was 13.77 (3.90) and health promotion practice was 12.43 (3.14).

H₃: Health policies do not significantly influence nurses' practice of health promotion among women in Calabar.

To test this hypothesis, an evaluation was also made of the linear relationship between participants' perception of health policies and their practice of health promotion among women using Pearson's correlation. The analysis connoted a significant negative relationship between health policies and nurses' practice of health promotion ($r_{(136)} = -0.203$; $p = 0.05$). For these data, the mean (SD) for social policies was 9.23 (5.13) and health promotion practice was 12.43 (3.14).

DISCUSSION

Nurses' practice of nutritional education for women and advocacy for improvement of women's nutrition are supported by ICN (2013, 2009), Park (2007) and FMOH (2006). The average demonstration of physical exercise may be attributed to the busy schedule of nurses and the dearth of nurses in health care settings. It may also reflect the general lack of interest for exercise by the populace including nurses who are supposed to be physically fit for their jobs and also act as models. The respondents educated women on stress prevention, post menopausal syndrome management, and advocated for elimination of genital mutilation.

These actions are supported by Park (2007), FMOH (2006), and ICN (2009, 2013), as steps in the right direction to promote women's health. The average level of practice of health promotion by nurses in this study is not good enough and this may be related to the misconception of the meaning of health promotion and focus on medicalized tasks. Nurses lack of knowledge as to what is needed to be done to be health promoters and lack of practical prescriptions as to what constitute health promotion activity and how it is applied in nursing practice (Caelli et al., 2003), may be a great hindrance to health promotion for the populace including women.

The negative relationship between culture and nurses' practice of health promotion is supported by Tandon (2006), Timmerman (2007), and Berman and Snyder (2012). Some of the socio cultural practices that affect women's health are female circumcision, burden of care, violence, and early marriage among others. Indeed, socio cultural practices may impair accessibility and acceptability of general and nutritional education, sanitation practices and life style modification in the course of nurses' practice of health promotion for women which in turn

endanger women's health. The women's health in the setting of the study are influenced by all these cultural factors, that's why fattening room practices are still being practiced, because obesity is associated with good health and affluence. Female circumcision is done to prevent promiscuity, and women bear the burden of care because they are by nature supposed to be caring. In view of the negative influence of culture on nurses' practice of health promotion, Crane and Mc Sweeny (2003), Garcia (2006) and James (2004) posit that health promotion intervention should be culturally relevant and health professionals including nurses should be culturally competent (Brown et al., 2002; Birkett et al., 2004).

Healthy public policies have been identified by WHO (2005), ICN (2009), Tandon (2006), and FMOH (2006) as one of the determinants of health. These public/social policies have direct or indirect effect on the delivery of health care. Actually, nurses require these policies to guide them in the planning and administration of care that would meet the needs of the populace especially the vulnerable groups which include women.

The negative relationship between health policies and nurses' practice of health promotion may be related to the fact nurses are still bio-medically inclined and have refused to act as social activists. They do not seem to realize the relationship between health policy and nurses practice of health promotion. However, health promotion process and activities are politically based, driven and expedient (Mason et al., 2007; Nettleton, 2006; Bamba, 2005). Therefore, health professionals including nurses are supposed to be politically expedient entities that are able to move relatively freely in and out of the policy machinations of health care delivery system (Laverack, 2004; Scriven, 2005; Mc Murray, 2007). Nevertheless, many critics have noted the collective lack of will power and/or opportunity in nursing to initiate and lead on matters related to its own health related policy agendas. Indeed, nurses are viewed as political bystanders or health policy victims (Whitehead, 2010; Hewison, 2007; Des Jardin, 2001; Gebbie et al., 2000). Nurses need to be social activist in the area of health promotion and be in the forefront of policy making; otherwise, health promotion role of nursing will continue to be defined according to the priorities of other professional groups (Falk-Rafael et al., 2004). Nurses in Nigeria may also have the opportunity of influencing health policy if only they understand and participate in the health services political activities through their appointments in to directorate positions.

This study was limited to public hospitals and primary health centres in Calabar, Cross River State. It cannot be generalized to the whole state or private hospitals in Calabar. A complementary approach like focus group discussion and observation were not used to corroborate information collected. Therefore, future studies may utilize these approaches for further authentication of information.

It was concluded that nurses' were of the view that their practice of health promotion for women in Calabar, Nigeria negatively correlated with culture while it positively correlated with social policy. The result therefore highlighted the need to enhance nurses' practice of health promotion which implies that the identified factors must be addressed by nurse managers and the government at the state and local government level; nurses should also be culture sensitive while providing health promotion for women, social policies should be used to address negative cultural practices. Nurses should health educate women on negative cultural practices in order to enhance their practice of health promotion; government and nurse managers should motivate nurses to engage in women's health promotion at every opportunity in order to enhance women's health promotion.

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