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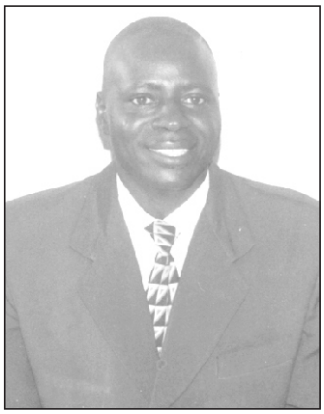
EDITORIAL COMMENT



The most authenticated age to which a human being ever lived is122 years,164 days. The person here was a French woman named Jeanne Claimant. She died in 1997. On the other hand, the greatest age to which any man ever lived is 120 years 257days.The man here was Shigechiya Izumi of Isen Takunashima in Japan. He was recorded as a sixty-year old in Japan's first census in 1871.He worked until he was 105.He died of pneumonia in 1911.Though controversy has trailed the age of an Egyptian man, Amm Atwa Moussa, a fisherman, because there is no evidence to prove it, he is said to have lived for 150 years. The question one may ask here is, why did they lived that long? Though many questions may arise here, International Professional Nursing Journal believes that if quality care is extended to the public they will live as those of the previous centuries. To this end this edition of the journal has gone extra mile to document how cervical cancer, criminal abortion can be handled, how to enhance rapid recovery of patients during hospitalization; how the elderly can be handled to prolong their lives, among other scholarly and well researched articles to expand the horizon of nurses and other health personnel. Savour the content and get enlightened.

Happy reading

Andy Anso
(Executive Editor)

Table Of Content

IMPACT OF CRIMINAL ABORTION ON TEENAGE GIRLS IN AMASSOMMA OGBOIN NORTH LOCAL GOVERNMENT AREA, BAYELSA STATE, NIGERIA

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Abstract
This study was designed to survey the impact of criminal abortion in teenagers in Amassomma Community of Bayelsa State, Nigeria. Criminal abortion is a common act among teenage girls today, such actions are associated with some obvious problems such as increased sterility, serious pain, severe infections, perforations of uterus and even death. No doubt the high incidence of teenage pregnancies/abortions is a serious threat to whatever the dividend of democracy in this region with unending implication on the individuals, families, communities and society at large. 200 teenage girls with a mean age of 15.5 were conveniently selected for the study. Attitudes Towards Abstinence (ATA) questionnaire was used to collect the data, five research questions with two hypotheses used for the study and tested at the significance level of 0.05. The study revealed that most of the participants were not informed about sex education neither were they aware of family planning services not to talk of assessing the services which reflected the high incidence of criminal abortion. It is then recommended that teenage girls are provided with adequate information on sexuality and the danger of criminal abortion so that they can learn to live a decent life to avoid teenage pregnancies and attendant effects.

Key words: Criminal abortion, Teenage girls, Attitudes, Abstinence, Family Planning Services

Introduction

Criminal abortion is the evacuation of the product of conception from the uterus by an unauthorized and inexperienced person. Abortion Campaign Team (2005) reported that the number of abortions done every year is ten times more than the number of other surgeries and these are done to destroy rather than to save lives. Today, many young girls indulge in sexual relations without knowing the implications and when they get pregnant, because they are not prepared to be mothers, they then take to criminal abortions. These abortionists may either be a medical, paramedic, traditional birth attendant (TBA) or the individual herself. Hazardous means are used to perform this act thereby causing danger to the victim. In some cases, this act which was performed earlier in life can affect the individual adversely later in life.

Criminal abortion is a crime against humanity and a sin against God. Teenage girls who had intentionally or due to a reason or the other terminated pregnancies suffer from a condition called "Abortion Trauma Syndrome", a negative feeling of guilt, anxiety, depression and low self-esteem (Dachemy & Agel, 1997).

Geddes and Grosset (2001) asserted that the incidence of criminal abortion among teenage girls today is generally very high which is largely responsible for a high percentage of infertility, maternal mortality rates and broken marriages. There has been witness of death of several teenage girls which occurred as a result of criminal abortion.

Amosike (2006) was of the view that abortion has become controversial because there are diametrically opposed views held by different groups who support their views with strong arguements; the divergence of opinions has divided philosophers, legislators, doctors, and theologians since the beginning of western civilization. Michel (2006) confirmed that about 1,800 abortions are performed monthly in Nigeria.

Causes of Criminal Abortion

1. **Ignorance:** Amosike (2006) affirmed that the first among the causes of criminal abortion is a widespread popular ignorance of the true character of a crime, a belief, even among mothers themselves that the foetus is not alive till after the period of quickening.
2. **Poverty:** Insufficient economic support for teenage parents and the foetus as well as poverty in their immediate family increases the chances of criminal abortion.
3. **Delay in Moral value and Ethics:** Ogunsanya and Ogunyemi (1999) brought to light that abortion is a vice, an evil that ought to be given all the discouragement necessary to ensure its eradication, instead people have come to tolerate and condole it as they ended up saying that the environment and society at large only pay lip services to its eradication.
4. **Inter-Family Conflict:** This happens when a man impregnates a girl from a family that is not in good terms with his own family. In order not to bring shame to herself or her family, she prefers to terminate the pregnancy.
5. **Disapproval of Single Motherhood:** Some teenage parents commit abortion because of

the widespread disapproval of single parenthood. Generally, it is believed that any child born by a woman outside wedlock is a bastard, and that children brought up by single mothers lack certain values in life.

6. **Social stigmatization:** American Medical Association (2004) revealed that most teenage girls who are pregnant prefer to murder their unborn babies due to fear of stigmatization, and that if they carry the pregnancy to term and deliver the baby, people will see them as "second-hand" women. Ralph (1983) said in order to prevent this social stigma or public embarrassment, they take to criminal abortion.
7. **Parental pressure:** When some parents come to know that their daughters are illegitimately pregnant, they maltreat or even threaten to disown them, sequel to this, she may opt for criminal abortion while some parents in some cases even sponsor the act.
8. **Religious factors:** Awosike (2006) said that some religious dis-fellowship any of its members that become pregnant out of wedlock. If a girl from such religious sect becomes pregnant, she terminates it so as to avoid embarrassment and disgrace. Whatever the reasons for abortion, the Roman Catholic Church in 1869 prohibited abortion under any circumstance. Several fundamentalists and evangelical protestant agreed with the Catholics by saying that abortion is inhuman (Luker, 2004).
9. **Peer group influence:** Most teenage girls are compelled by their peers to commit criminal abortion because they have done it in the past. The fact that they don't want to be odd among their mates pressurize them. They want to dress, play, eat and move about like their mates without any restrictions or disturbances (Ogunsanya & Odeyemi, 1999).

Implications of Criminal Abortions

There has been controversy over a number of proposed risks and effects of criminal abortions on teenage girls. However, American Medical Association (2004) said that the unborn child is not the only victim of criminal abortion but the teenage girls, doctors and nurses are all victims as well.

A. Effects on teenage girls

The Anti-abortion Campaign Team said teenage girls have not been told of the true nature of the unborn child, they have not been shown the true facts of what an abortion really is, and that the teenage girls in their increasing numbers of hundreds, thousands and tens of thousands have had their uterus destroyed, rendered infertile, some had major and severe heamorrhage, cervical incompetence, infections such as HIV/AIDS, hepatitis, breast cancer, hysterectomy and impaired mental health status, all as a result of the operation they have no true knowledge about.

1. **Sterility and Infertility:** Criminal abortion causes infertility which is the inability to conceive, this is due to structural problems in which the fallopian tubes are damaged or blocked by infection after an abortion. The infections that causes infertility includes Chlamydia and gononrhrea (Geddes & Grosset, 2001).
2. **Major heamorrhage:** Burrow and Ferris (1995) asserted that as with most surgical procedure, there is a risk for heamorrhage. The amount of blood loss may depend on the method used. When the instrument is inserted into the uterus to remove the foetus, there is laceration and damage to the blood vessels and endometrium causing bleeding and sometimes heamorrhage may occur up to 14 days.
3. **Perforated uterus:** This occurs due to trauma to the uterus. A vigorous uterine curtage can perforate the uterus during dilation and curetage operation and manual manipulation.
4. **Hysterectomy:** To Burrow and Ferris (1995), teenagers who engage in criminal abortion risk having their uterus removed especially in cases of severe infection and damage. The type of hysterectomy carried out depends on the degree of damage to the uterus which could be subtotal, total or radical.
5. **Severe infections:** Serious infections such as HIV/AIDS and hepatitis may be contacted during the abortion procedures. This is obvious as the instruments used by the abortionist are not sterile or are contaminated.
6. **Breast Cancer:** The Abortion-Breast Cancer (ABC) hypothesis poses a causal relationship between having an induced abortion and a higher risk of developing breast cancer in future. An increased level of oestrogen in early pregnancy helps to initiate cellular differentiation (growth) in the breast in preparation for the lactation. If this process is terminated through abortion before full differentiation in the third trimester, then more vulnerable undifferentiated cells will be left than there were prior to the pregnancy. It is proposed that this might result in an elevated risk of breast cancer.
7. **Psychological trauma:** Dechemery and Agel (1997) were of the view that some teenage girls have negative feelings as a result of criminal abortion (abortion syndrome) which is a set of symptoms associated with the period following an abortion which includes guilt, anxiety, sleeping disorders and suicidal thoughts. Furthermore, Knight (2003) stressed the fact that abortion is devilish, criminal, violence and killing of babies. It can lead to a lifetime sorrow and is not just an offence against humanity but it is also a sin against God.

B. Effects on Doctors and Nurses

Doctors and nurses are also victims of criminal abortion for instance it is not legalized here in Nigeria and one of the hypocratic oaths taken by all medical doctors and nurses' pledge before they receive their certificates is to save lives but today, most medical doctors and nurses are making bloody fortunes from abortion. They have turned themselves to killers and their hospitals to abattoirs where lives are being destroyed on daily basis. Sequel to this, doctors and nurses are loosing their reputation of truthfulness, calmness, honesty and sincerity (Knight, 2003). WHO (1995) reported that about 20 million women undergo the hazards of unsafely induced abortion every year, and about 70,000 of them die as a result and million more suffer long-term morbidity and disability.

Theoretical Framework

This study is based on psychosocial development theories by Erik Erickson (1964). He focused his theory on psychosocial development such relationship with physical growth. He identified eight stages of growth and development such as: infancy/toddler (18 months to 3 years): autonomy versus shame and doubt, early childhood/pre-school (3-5 years): initiative versus guilt, school age (middle childhood, 6-12 years): industry versus inferiority, adolescent (12-18 years): identity versus role conflict, young adult/ early adulthood (18-35 years): intimacy versus isolation, middle aged adult (35-65 years): generativity versus stagnation and late adulthood (65 years to death): integrity versus despair. The study looks at identity versus role conflict and this is the adolescent stage which is seen or regarded as a critical development stage of life in which the adolescent searches for current knowledge and self-identity to acquire self-image and sexual identity develops. The adolescent wants to be identified by the opposite sex and to be independent. At this stage, there is a great psychological change as the secondary sex characteristics appear, hence there is need for parents to be close to their children at this stage and to provide their basic psychological needs. Proper health education especially on sex should not be ruled out. All these will give them a positive life-style on how to relate with their friends especially the opposite sex. Where these are not done, the adolescent child is misinformed, misguided and misled by friends, wrong teachings and peer pressure or group leading to premarital sex which will result in pregnancy and then criminal abortion will be their next option.

Methodology

This is a descriptive non-experimental survey which intends to identify and describe the implications of criminal abortion on teenagers of Amassomma Ogboin North Local Government Area of Bayelsa State, Nigeria.

Target Population

The population of the study was all teenage girls with mean age of 15.5 years in Amassomma Community of Ogboin North Local Government of Bayelsa State, Nigeria irrespective of their educational status.

Sample and sampling technique

200 teenage girls were conveniently selected for the study. The community is made up of 20 compounds hence, 10 participants were conveniently selected per compound (20 x 10=200)

Instrument for Data Collection

The instrument for data collection was a questionnaire which had two sections, Section A was on demographic data of the participants while Section B contained 12-item scale on Attitudes Towards Abstinence (ATA) developed by Miller, Norton, Fan and Christopherson (1998) and adapted for the study. The participants were to make a response from either Strongly disagree (SD), Disagree (D), Neutral (N), Agree (A) or Strongly agree (SA) and they were to complete the questionnaire within 15 minutes.

Reliability of Instrument

The instrument adapted and used for the study was a standardized type with reliability (Cronbach alpha) of 0.85. (Miller et al, 1998)

Data analysis

The information gathered by the researchers was analyzed using simple percentages and t-test statistical tool for the testing of the hypotheses at a significant level of 0.05.

Ethical Consideration

The Head of the community with the compound chiefs were met by the researchers to explain the intention of the researchers and to solicit for their maximum cooperation. The leadership of the community expressed their joy for the study as the subject-matter was a great concern to them, and they made arrangement with the researchers on how to organise their compounds for effective administration of the study instrument. Adequate measures were taken to ensure participants' confidentiality and informed consent was also obtained from the participants when they were met at different dates of meeting in their compounds with their chiefs.

Results and Discussion

Five research questions and two hypotheses were used for the study.

Research question 1: Why do teenage girls in Amassomma Community terminate pregnancies?

Table 1: Respondents' reasons for terminating pregnancies

Variable	*f*	*%*
Ignorance	10	5
Fear of parents	50	25
To continue education	40	20
Never terminated	20	10
Not ready to be a mother	80	40
Total	**200**	**100**

The table 1 above showed that 5% of the participants terminate their pregnancy as a result of ignorance, 25% for fear of parents, 20% in order to continue their education, 10% never terminated their pregnancies, and 40% were not ready to mother any child. Ralph (1983) was of the view that most teenage girls terminate pregnancies for fear of parents.

Research Question 2: What are the methods used in procuring criminal abortion?

Table 2 : Participants' response to methods of procuring abortion

Variable	*f*	*%*
Surgical means	50	30
Medicinal	40	20
Herbs	80	40
None	20	10
Total	**200**	**100**

From the above table, it showed that 30% used surgical means to procure criminal abortion, 20% used medicinal, 40% used herbs and 10% used no means rather left the pregnancies to fruitition.

Research Question 3: What are the implications of criminal abortion on teenage girls?

Table 3: Response on effects of criminal

Variable	*f*	*%*
Severe infections	10	5
Psychosocial trauma	20	10
Lower abdominal pain	60	30
Prolonged bleeding	80	40
Infertility	30	15
Total	**200**	**100**

Table 3 showed the implications of criminal abortion as 5% severe infections like HIV/AIDS, 10% as psychological trauma, 30% as lower abdominal pain, 40% as prolonged bleeding and 15% as infertility. Dacheny and Agel (1997) said teenage girls who commit criminal abortion experience negative feelings after the procedure. A feeling of depression, guilt and even suicidal attempt as manifested by those involved.

Research Question 4: To what extent are teenage girls aware of family planning services?

Table 4 : Participants' response on awareness of family planning services.

Variable	*f*	*%*
Traditional methods	20	10
Natural	10	5
Diaphragms	10	5
Injectables	20	10
Oral contraceptives	10	5
Condoms	20	10
Implant	Nil	Nil
Intra uterine contraceptive	Nil	Nil
Surgical	Nil	Nil
None	110	55
Total	**200**	**100**

The above table showed that 10% were aware of traditional methods, 5% natural methods, 5% diaphragms, 10% injections, 5% oral contraceptives, 10% condoms, Nil for implants, Intra uterine contraception and surgical methods and 55% with no awareness about any method of family planning.

Research Question 5: Does lack of sex education contribute to the high incidence of criminal abortion?

Table 5 : Responses to lack of sex education contributing to high incidence of criminal abortion

Variable	*f*	*%*
Yes	50	25
No	80	40
Undecided	40	20
Dont know	20	10
May be	10	5
Total	**200**	**100**

Table 5 showed that 25% of the participants have had knowledge of sex education, 40% had no knowledge of sex education, 20% were undecided whether they had knowledge of sex education or not while 5% responded as may be. Konyaa (2003) emphasized that concerning sex education that parents must avoid an attitude of pretence and timidity and that the truth and dangers of pre-marital sex must be exposed to teenage children so that they are better informed by their parents.

Two hypotheses were used for the study, t-test statistical tool was used and tested at the significance level of 0.05

Hypothesis 1: There is no significant relationship between lack of sex education and the incidence of criminal abortion.

Table 6: t-test summary of high and low sex education and incidence of criminal abortion.

Variable	N	$\bar{x}$	SD	t-tab	t-cal	Remark
High education	60	46.75	8.32			
Low education	140	45.28	12.56	2.31	7.96	S**

Significant level at 0.05

The table showed a t-table value of 2.31 and calculated value of 7.96 at the significant level of 0.05 which showed a greater calculated value than the table value which means that the difference is significant, hypothesis 1 is therefore rejected hence there is a significant relationship between sex education and the incidence of criminal abortion. To Ozioko (2006), sex education is not really education about sex but rather an extensive programme of systematic behavioural modification during which the

children are taught to think in a new way, for instance, that unwanted pregnancy and that parents are the only people to educate their children in the proper way while Konyaa (2003) emphasized that parents must enforce on their children by example and discipline the adoption of proven moral standards. Parents must also avoid an attitude of pretence and timidity in discussing with their children issues that concern their lives and security, the truth and dangers of sex must be exposed to teenage children for them to be aware of the life hazards into which their delinquent behaviours would certainly plunge them. Ogunsanya and Odeyemi (1999) were of the view that in order to combat the company of bad friends, parents can encourage their children to bring their friends home when they are in the house, take time to study the friends and by so doing, the will be able to advise their children either to retain the friendship of a particular friend or cut off from the relationship. The parents should take time out to sex educate their teenagers about the dangers of pre-marital sex, emphasis must be laid on the dangers of indiscriminate sex and effects of criminal abortions on the future fertility and marriage of these teenage girls.

Hypothesis 2: Economic status of the parents of the participants is significantly related with the incidence of criminal abortion in Amassomma.

Table 7 : t-test summary of parental economic status of the participants and incidence of criminal abortion.

Variable	N	$\bar{x}$	SD	t-tab	t-cal	Remark
High socio-economic status	65	70.04	8.01			
Low socio-economic status	135	78.08	8.64	2.31	1.40	**S**

Not significant at 0.05

The table above showed a t-calculated value of 1.40 and a t-table value of 2.31, the t-calculated value is lower than the t-table value hence, the hypothesis is accepted so parental economic status of the participants is significantly related with the incidence of criminal abortion. The finding of this hypothesis showed that economic status is a determining factor of criminal abortion. Some of the reasons given by the poor economic status participants included lack of basic necessities of life, the need to belong to social class, while the subjects with high economic background gave theirs as need to be social and be high up, also saw it as a form of relaxation and enjoyment but Geddes and Grosset (2001) stated that teenagers whether from poor or rich home background due to curiosity and peer pressure re engaged in untoward sex leading to criminal abortions. Culturally, early marriage is a norm between the ages of 13 and 28 in the study area, polygamy and concubinage are widely practiced while cohabitating among the sexually active is widely condoned.

Conclusion and Recommendation

Conclusion

The result of the study provided a greater understanding of teenage girls' behaviours in respect of criminal abortion in Amassomma Community. The data revealed that most of the participants were not aware of family planning services available to them, and their knowledge of sex education was quite inadequate hence the high incidence of criminal abortion, no doubt when these teenage girls are provided with adequate information on sexuality and the danger of criminal abortion, they will learn to live a decent life, avoid teenage pregnancies and be educationally productive to give a good future to the community and society at large.

Recommendation

Based on the findings of the study, the following recommendations are made to increase the awareness of sex education and family planning services in order to reduce or eradicate criminal abortion among the teenage girls.

- Sex education should be included in the schools' curricula.
- The community health workers should emphasize on the dangers of criminal abortion.
- Family Planning Services should be provided and be made accessible to all in the community.
- Parents should devote time to health educate their children especially teenagers on sexuality.
- Schools, churches, mosques, clubs should organise seminars, workshops for the teenagers on moral education.
- Healthy parent-child relationship should be encouraged.

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KNOWLEDGE, ATTITUDE AND PRACTICE OF CERVICAL CANCER SCREENING AMONG SECONDARY SCHOOL TEACHERS IN ENUGU STATE

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Abstract

A cross sectional, descriptive study directed by three objectives was used to determine the knowledge, attitude and practice of cervical cancer screening among secondary school teachers. Population was secondary school teachers in Enugu State. Sample size of 380 teachers was determined using multi-stage sampling technique and subsequent proportionate stratified random sampling. Instrument used was questionnaire. Data were presented in tables and analyzed using measures of central tendencies and percentages. Findings revealed relative good knowledge, positive attitudes, poor practice. It was recommendations that more health facilities offering cervical cancer screening services should be established.

Key words: Knowledge, Attitude, Practice, Cervical Cancer Screening, Secondary School Teachers.

Introduction

Cervical cancer is the second commonest malignancy in women after the breast cancer worldwide, and the commonest in the developing countries especially Central

America and Sub-Saharan Africa. In Nigeria, over 25000 new cases of cervical cancer are expected annually (Adefuye,2006). Nigeria has a population of 40.43 million women aged 15 years and older who are at risk of developing cervical cancer, current estimates indicate that every year 9922 women are diagnosed with cervical cancer and 8030 die from the disease (Sherrin,Herdman,&Elias, 2001). Also, cervical cancer ranks as the 2nd most frequent cancer among women in Nigeria, the 2nd most frequent cancer among women between 15 and 44 years of age, and about 23.7% of women in the general population are estimated to harbour cervical human papillomavirus (HPV) infection at a given time, and according to Encarter dictionary (2006), 70% of invasive cervical cancer cases are attributed to HPVs 16 or 18.

Cervical dysplasia being the first sign produce no symptoms and can be prevented using relatively cheap screening and treatment technologies that can detect dysplasia before it progresses to invasive cancer, thereby preventing most deaths due to cervical cancer. This relatively cheap cervical cancer screening is done using a test called a Pap smear. A pap smear, which is performed during a pelvic examination, can detect cervical dysplasia at an early, very curable stage before it progresses into cervical cancer. If a Pap smear is positive for cervical dysplasia or cancerous cells, other tests are performed to confirm a diagnosis of cervical cancer. From this discussion, cervical cancer is both preventable and curable, through an effective cervical cancer screening (using Pap's smear test) leading to early detection and treatment. Yet, only about 5% of women in the developing countries have been screened for cervical dysplasia in the past 5 years compared to 40-50% of women in developed countries (Encartar dictionary, 2006). The available statistics shows that in Enugu the cervical cancer screening resources are underutilized, as only a small percentage of the women population avail themselves to this test. As posited by Mutyaba, Mmiro, & Weiderpas, (2006), significant proportion of our screening is also on opportunistic rather than systematic basis. According to WHO in Adefuye (2006), lack of knowledge/ ignorance among women about this problem and related factors is the major contributory factor?

The researcher therefore wants to determine the knowledge of, attitude and practice of cervical cancer screening among secondary school teachers in Enugu State. Since teachers are one of the change agents, efforts around them usually produce multiplier effect.

Specifically, the objectives of the study are;-

1 To determine the knowledge of cervical cancer screening among the secondary school teachers in Enugu State.
2 To find out their attitude towards cervical cancer screening
3 To determine the practice of cervical cancer screening among them.

Significance of Study

The study will reveal gaps in the knowledge of cervical screening among secondary school teachers in Enugu state, their attitude, whether positive or negative and the extent of their practice of cervical cancer screening.

The findings, therefore, will help the researcher and the general public, especially the health workers to appreciate where the problem related to the under utilization of cancer screen services lie.

Review of Related Literature

The Concept of Cervical Cancer Screening according to US, NCI, is the first step in the treatment of cervical cancer is prevention through the use of cervical smear cytology otherwise called Pap smear, on symptom free women to detect the pre-cancerous and early cancerous lesions. Thus, a key reason for the much higher cervical cancer incidence in developing

countries is lack of effective screening program aimed at detecting and treating pre-cancerous conditions.

In a study to determine the attitude and beliefs about cervical smear testing in ever-married Jordanian women, using 760 women attending obstetric & gynecological clinics in Irbid, Jordan, by Loxton, Powers, Schofield, ,Hussain,& Hosking, 2009) it was discovered that knowledge of cervical cancer and the pap smear test was inadequate in less educated and older patients. Of the 109 women who had previously had the test, 104 (95.4%) had opportunistic testing. Major barriers to the testing include inadequate knowledge about the test and fear of having a bad result. In reviewing the burden of cervical cancer in South Africa, Clogg, et al (2009), discovered that it remains the most common cancer among the South African women particularly women with least access to cervical cancer screening. It was also illustrated that cervical cancer screening offers unique opportunities for prevention at both primary and secondary levels. In an investigation of association between partner violence and inadequate cervical cancer screening among mid-aged Australian women by Akinsola (2005), a negative relationship between cervical cancer screening and partner violence was confirmed, with a suggestion that a good access to physician of choice appears to significantly decrease the negative relationship[19]. It was also noted that known barriers to screening included education, income management and chronic conditions.

Methodology

Research design: A cross sectional, descriptive study was adopted for the study.

Population of the study (Study Participants)

The study population consists of the secondary school teachers in Enugu State. They are found in the two hundred and eighty seven public schools owned by the state including those built by the Missions and handed over to the state government), and secondary schools in the seventeen (17) Local Government Areas of Enugu State.

Sample and sampling technique: Multistage sampling technique was used in sampling 598 subjects. Proportionate stratified random sampling on the basis of gender was used; equal number of female teachers were selected from each of the fourteen (14) schools under study totaling 380 subjects.

Instrument for Data Collection/ method of administration.

The instrument for collecting data was questionnaire composed of structured questions covering the content adequately in line with the stated objectives of the study. It has two sections section A for demographic data and section B for items on knowledge of, attitude and practice of cervical cancer and its screening test. It was self administered, distributed through group administration for according to Nwabuokei (1986), it maximizes the number of completed questionnaires and allow the researcher to clarify any possible misunderstanding about the items. On the spot collection of the instrument was also done.

Method of data analysis: The data was analyzed using measures of central tendencies and percentages.

Results:

The demographic characteristics of age, religion and marital status of the respondents: Table 1 below shows that the majority of the respondents (85% and 92% respectively) are married, thus are presumably sexually active which makes them a good sample for the study on cervical cancer screening. The data in this table indicates that majority of the respondents (85% and 92% respectively) are married, thus are presumably sexually active which makes them a good sample for the study on cervical cancer screening. The table further revealed that the respondents are all Christians. Implying that religion will have zero influence on the respondents with regards to the concept under study.

Age	Pre		Post	
	Number	%	Number	%
30 34	33	8.7	70	22.7
35 -39	169	44.5	100	32.5
40 -44	9	2.4	13	4.2
45 +	169	44.5	125	40.6
Total	**380**	**100**	**308**	**100**
Marital statue	Pre		Post	
Single	49	12.9	24	7.8
Married	324	85.3	284	92.2
Widowed	7	1.8	-	-
Total	**380**	**100**	**308**	**100**
Religion				
Christianity	380	100%	308	100%
Total	**380**	**100**	**308**	**100**

Table 2: Knowledge of cervical cancer

Items	Pre	
	Number	%
Heard about cervical cancer Yes No	 323 56	 85.3 14.7
Total	**379**	**100**
Source of information Hospital Seminar Journal Radio/ TV Others	 49 69 23 171 13	 15.1 21.2 7.1 52.6 4.0
Total	**325**	**100**
Statements about cervical cancer:	True	False
Cancer of neck of items	320 (94.7)	18 (5.3)
Commonest cancer in women	237(76.9)	71(23.1)
Kills a woman every 2 minutes	110(42.6)	148(57.4)
Early diagnoses increase survival	266(84.2)	51(15.8)
Risk factors include:		
Human Papilloma Virus	214(90.7)	22(9.3)
Initiation of sex before 18yrs	184(73.3)	67(17.6)
Multiple sex partners	231(91.5)	21(8.5)
Multiparty	91(57.6)	67(42.4)
Low socioeconomic status	60(26.1)	170(73.9)
Smoking	122(52.1)	112(47.9)
Previous history of STD	124(61.4)	78(38.6)
No symptom in early stages	155(75.2)	51(24.8)

Majority of the respondents (85.3%) have heard about cervical cancer and their most important sources are Radio/TV, seminar and hospital (53%, 21%, 15%). Out of the five (5) statements about cervical cancer, majority of the respondents (95%, 77%, 84%, 75%) indicated correctly four except for the mortality burden of the cervical cancer where only 43% got right. Majority indicated correctly six risk factors out of the seven stated. This shows they have a relatively good knowledge of cervical cancer.

Table 3: Knowledge of cervical cancer screening

Items	Pre	
	Number	**%**
Heard about cervical cancer screening		
Yes	221	58.9
No	154	41.1
Total	**375**	**100**
Source of information		
Hospital	74	33.5
Seminar	53	24.0
Journal	8	3.6
Radio /TV	86	38.9
Total	**221**	**100**
Statements about cervical cancer screening		
Relatively cheap test that allows for identification	176(67.7)	84(32.3)
Painless investigatio n in which cervix is visualized	1.89(84.8)	34(15.2)
Can stop cancer from developing	307(97.3)	8(2.7)
Age group for testing ranges from 18 64yrs	256(87.4)	37(9.7)
Screening interval in Nigeria is 1 3 yrs	157(71.7)	62(28.3)
Test is done in the middle of menstrual cycle	155(75.2)	51(24.8)
Test is done by a doctor or trained nurse	222(94.9)	12(5.1)

The data in table 3 indicates that about 59% of the respondents have heard about cervical cancer screening. The important sources of information include radio/ TV, hospital and seminar (39%, 34%, 24% respectively).

Also for the seven statements about cervical cancer screening, majority of the respondents (68%, 85%, 97%, 87%, 72%, 75% and 95%) indicated correctly the truthfulness of all the statements. All these data shows that the respondents have relative good knowledge of cervical cancer screening.

To determine the attitude of the respondents, they were required to agree or disagree to ten (10) statements of opinion in the item 10 of the questionnaire. Their responses are found in this table 4.

Table 4: Statements of opinion on cervical cancer screening

Statements	Pre	
	Number	**%**
List interest I the test		
SA	48	14.6
A	40	12.2
D	130	39.6
SD	110	33.5
TOTAL	**328**	**100**
Go to test with adequate knowledge or referral by a doctor		
SA	193	51.2
A	111	29.4
D	56	14.7
SD	17	4.5
TOTAL	**377**	**100**
Not susceptible to cervical cancer		
SA	98	28.7
A	84	24.6
D	101	29.6
SD	58	17.0
TOTAL	**341**	**100**
Afraid of the result		
SA	40	11.1
A	70	19.5
D	193	53.8
SD	56	15.6
TOTAL	**359**	**100**
Need the consent of husband		
SA	53	14.8
A	111	30.9
D	122	34.0
SD	73	20.3
TOTAL	**359**	**100**
Cost is unaffordable		
SA	30	9.3
A	39	12.1
D	169	51.2
SD	88	27.3
TOTAL	**322**	**100**
Symptom is the only reason for the test		
SA	90	27.7
A	88	27.1
D	71	21.8
SD	76	23.4
TOTAL	**325**	**100**
No knowledge of where to go for test		
SA	82	25.8
A	73	23.0
D	68	21.4
SD	95	29.9
TOTAL	**318**	**100**
Dont believe in outcome		

The data in the table 4 shows that a good number of the respondents (73%, 80%, 69%, 79%, 51%, 87% and 64%) correctly indicated agreement or disagreement to 7 out of 10 statements of opinion in the item 10 of questionnaire, with only 47% and 45% correctly agreeing or disagreeing with the remaining two statements. This implies a positive attitude of the majority of the respondents towards cervical cancer screening.

To ascertain practice of cervical cancer screening. The responses to these items are shown in this table 5.

Table 5: Practice of cervical cancer screening

Items		
	Number	**%**
Ever gone for cervical cancer screening		
Yes	42	12.9
No	284	87.1
TOTAL	**326**	**100**
Frequency of screening		
Just once	21	50.0
Yearly	15	35.7
Every 2 5 yrs	6	14.3
TOTAL	**42**	**100**
Reasons for non - participation in screening:		
Busy schedule	5	1.3
No symptom	65	17.1
Take care how I live	4	1.1
Ignorance	29	7.6
Hereditary	5	1.3
No awareness	66	17.4
No reason	101	26.6
Not yet prepared	10	2.6
TOTAL		**100**

The data in the table 5 show that greater percentage of the respondents (87%) have never gone for the cervical cancer screening. Out of the 42 respondents (12.9%) that have gone for the test, 50% have done the test just once presumably on opportunistic basis while only 15 (about 36%) go for the test regularly on a yearly basis. The most important reasons for non-participation include no awareness/ ignorance (25%), and no symptom (17%).

These imply that the majority of the respondents do not practice cervical cancer screening.

Discussion

The findings revealed that secondary school teachers in Enugu State have relative good knowledge of cervical cancer screening. This can be appreciated from the data in table 3 of which showed that about 59% of the respondents have heard about cervical cancer screening, and about 68%, 85%, 97%, 87%, 72%, 75% and 95% that respectively identified all the correct statements about cervical cancer screening. This finding may be related to the educational status of these secondary school teachers, for according to a study among women attending antenatal clinic by Loxton, Powers, Schofield, Hussain, and Hosking (2009), knowledge of cervical cancer and cervical cancer screening was inadequate in less educated patients.

Majority of these teachers have positive attitudes towards cervical cancer screening. This is evident in data of table 4 which showed that a greater percentage of them (73%, 80%, 69%, 54%, 79%, 51%, 87% and 64%) correctly indicated agreement or disagreement to 8 out of 10 statements of opinion in the instrument. This finding could be related to their relative knowledge of the concept under study for, according to KAP model of health education[9], knowledge precedes attitude.

The finding is also in line with a study among ever married Jordanian women which showed negative attitude with inadequate knowledge in less educated patients (Loxton, Powers, Schofield, Hussain, & Hosking, 2009).

The findings of the study further revealed a poor practice as majority of the respondents (87%) have never gone for cervical cancer screening as shown in table 5. Out of 42 respondents (12.9%) that have gone for the test, 64% have done it presumably on opportunistic basis.

This study is in line with a study Loxton, Powers, Schofield, Hussain, & Hosking (2009), where only 109 (14%) of the participants had previously had the test and 92% of these had opportunistic testing.

The finding also agrees to an observation that a significant proportion of our screening is on opportunistic basis rather than systematic (Mutyaba, Mmiro, & Weiderpas, 2006). It is however surprising that despite the good knowledge and positive attitudes of majority of the participants, their practice of testing is poor. The findings therefore is contrary to WHO's observationin Akinsola (2006), which stated that lack of knowledge/ignorance among women about the screening is the major contributory factor. The poor practice of cervical cancer screening among these teachers despite their relative good knowledge and positive attitude may be because of few health facilities that offer the screening services as to compare with other health services readily offered in most health facilities e.g. antenatal services. This reason is in line with an observation of Tebeu,et al (2008), which blame the location of facilities and logistics for the cervical screening services in the hospital setting (tertiary as in the case of Enugu) a place where one goes when sick, and the shortage of the hospitals offering screening services.

The finding is in line with the KAP model of health education (Nganwai, et al 2007), which assumes that if knowledge of cervical cancer screening is increased among these participants, it will positively influence their attitude. However, the fact that good knowledge and positive attitude did not influence practice contrasts the assumption of KAP

model. The finding rather can be related to the observations of some critiques of this model that the relationship between knowledge, attitude and practice is complex.

Conclusion

On the basis of the findings, the researcher concludes that secondary school teachers in Enugu State have relatively good knowledge of cervical cancer screening and they have positive attitudes towards cervical cancer screening. However, their practice of cervical cancer screening is poor.

Recommendations

In view of the findings, the following recommendations are made:

1. More health facilities offering cervical cancer screening services should be established in Enugu State.
2. Mobile clinics should also be encouraged to capture missed cases in the State.

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IMPACT OF SOCIO-ECONOMIC BACKGROUND ON ACADEMIC PERFORMANCE OF NURSING STUDENTS IN NIGER DELTA UNIVERSITY, BAYELSA STATE, NIGERIA.

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Abstract

The study examined the impact of socio-economic background of nursing students on their academic performance. Findings revealed there was significant relationship between parental occupation and student academic performance, there was also significant relationship between socio-economic background and the students' academic performance including their parental educational background and income and it was discovered that a better socio-economic, educational status, level of income and enhanced parental occupation impact on their children academic performance. Based on the findings, it was recommended that efforts should be made by parents to improve on their level of socio-economic and education level as these will aid their children's academic performance.

Keywords: educational level, parental income, parental occupation. socio-economic background,

Introduction

Education is the best legacy a nation can give to her citizens especially the youths. This is because the development of any nation depends largely on the quality of education of such a nation. It is generally believed that the basis for any development must commence with the development of human resources. Formal education remains the vehicle of socio-economic development and social mobilization in any society.

High level of illiteracy, poverty and low socio-economic status or background coupled with high rate of paternal and / or maternal deprivation of student academic needs, which is necessitated by poor socio-economic situation of the country has thrown many farmers and old rural dwellers into untold financial hardship such as lack of money to buy necessary textbook and working materials for their wards and many cannot afford to pay the school fees which has led many students to dropout of schools, engaged in subsistent farming, becoming maids or engaged in other menial jobs to support their academic pursuit. Hence, many students have since taken school attendance on rational basis. The resultant problems posed by this, is poor academic performance in school examination like semester and professional examinations.

Battle and Lewis (2002) were of the view that a person's academic achievement is closely linked to his/her life chances, incomes and wellbeing. Therefore, it is important to have a clear understanding of what benefits or hinders one's educational attainment.

Heather and Weller (2005) identified income as a factor that affect socio-economic background of an individual, and that low income families focus on meeting immediate needs and families with higher and expendable income can accumulate wealth and focus on meeting immediate needs while being able to consume and enjoy luxuries. Education is another factor that plays a role in income level, income earnings increase with level of education (Lareau, 2003). Occupational status reflects the educational attainment, this also shows achievement in skills required for a particular job. Occupational status measures social position by describing job characteristics, decision making ability and control and psychological demands on the job. Jobs that are less valued also paid significantly less and are more laborious, very hazardous and provide less autonomy (Bureau of Labour Statistics, 2008).

Kraus and Kettner (2008) found out that children of parents with high socio-economic background tend to express more disengagement behaviours than the less fortunate peers. Chambers and Schreiber (2004) and Eitle (2005) asserted that an academic achievement gap exists between the sexes, with boys ahead of girls. However, they further stated that more recent researches have shown that the achievement gap has been narrowing and that in some instances, girls have higher academic achievement than their boys counterpart.

Programmes International Student Assessment (2000) opined that home front influences academic and educational success of students and school work while socio-economic status reinforces the activities and functioning of the teachers and students. This shows that the quality of parents and home backgrounds of a student go a long way to predict the quality and regularity of the satisfaction and provision of a child's functional survival and academic needs. Poor parental care with gross deprivation of social and economic needs of a child, usually yield poor academic performance of the child. In another way, where a child suffers parental and material deprivation and care due to divorce or death or abscondence of the father, the child's schooling may be affected as the mother alone may not be financially buoyant to pay school fee, purchase needed books and uniforms, such child may play truant, thus his performances in school may be adversely affected (Shittu, 2004).

Danesty and Okediran (2002) lamented that

street hawking among young school students has psychologically imposed other problems, like sex networking behaviour, juvenile delinquency which takes much of the student school time that necessitated the poor academic performance and dropout syndrome noticed among students.

The United States Department of Education (2000) found out relationship between poverty and students performance is not simple and direct but concluded that poverty is an important factor accounting for differences in performance and achievement across rural, sub-urban and urban districts. However, the study was of the view that poverty alone does not account for all the differences in the performance of students. Although, Johnson (1999) said that poverty of parents has elastic effects on their children academic work as they lack enough resources and funds to sponsor their education and good school, good housing facilities, medicare and social welfare services.

To Jimoh (2006), lack of funds, materials and priority attention being paid to the schools and education of the students with disabilities in the past constituted reasons for their poor academic performance.

Hypotheses

Studying the impact of socio-economic background on academic performance of these students, the following hypotheses were tested at significance level of 0.05.

1. There is a relationship between parents' occupation and students' academic performance.
2. Socio-economic background is related to students' academic performance.
3. A significant relationship between parental education and students' academic performance exists.
4. Parental income is related with students' academic performance.

Materials and Methods

The study was conducted among the Clinical Students of the Faculty of Nursing. A sample size of 60 participants was used for the study i.e. 15 participants in each of 200 500 levels (15 × 4 = 60). A balloting system was adopted to arrive at the participants as a "Yes" or "No" paper was passed out in each level (class) and where "Yes" of 15 was picked in each set to avoid any bias whatsoever. Any balloter that picked "Yes" automatically became a participant while whosoever picked "No" was not qualified as a participant.

A self-administered questionnaire was prepared by the researchers for the study. The instrument had two sections, i.e. Section A was on biodata of the participants while Section B was of a Likert Scale designed to elicit their responses which was tabulated on a four scale basis of Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD). Section A had nine questions while Section B had 45 items sub-divided into Parents' Socio-economic Background Inventory (PaSeBI) with 15 items. Parents Education Background Inventory (PEBI) with 10 items, Parents Income Level Inventory (PILI) with 10 items and Family Size Inventory (FSI) with 10 items respectively.

In order to establish the content and face validity of the instrument, the questionnaire was given to senior researchers in the Faculty for assessment, correction and critique. All suggestions were adopted to enhance the quality of the instrument. For reliability, this was established through the measure of stability, test re-test was used. Five participants from each level (5 × 4 =20) were conveniently selected from the population; the instrument was administered to these 20 participants and then analyzed with reliability co-efficient of 0.74 attained.

The data collected was analyzed by simple percentages, chi-square and t-test statistical techniques.

Hypotheses Testing

Hypothesis One: Socio-economic background is related to students' academic performance

Table 1: Chi-square of relationship between socio-economic background and students' academic performance

	Academic Performance							
Socio-economic	Low	Average	High	Total	df	Cal. ÿ ^{2}	Critical ÿ^2	p
High	2.00	20.00	12.00	34.00				
Low	4.00	16.00	6.00	18.00	2.00	11.07	5.99	0.05
Total	6.00	36.00	18.00	60.00				

Table above showed a calculated chi-square of 11.07 higher than table value of 5.99 at degree of freedom of 2 and significance level of 0.05 indicating that socio-economic background of the participants was significantly related to the students' performance.

Hypothesis Two:

There is a significant relationship between parental occupation of the participants and their academic performance.

Table 2: Chi-square of the relationship between participants' parental occupation and their academic performance.

	Academic Performance							
Occupation	Low	Average	High	Total	df	Cal. ÿ ^{2}	Critical ÿ ^{2}	p
High	2.30	0.26	13.00	42.00				
Low	4.30	10.00	5.00	18.00	2.00	15.72	5.99	0.05
Total	6.00	36.00	18.00	60.00				

From table 2 above, it showed 15.72 calculated **chi-square higher critical** ÷^{2} of 5.99, df=2 at significance level of 0.05. this showed that parental occupation had relationship with participants' academic performance.

Hypothesis three: A significant relationship between parental level of education and participants' academic performance does exist.

Table 3: Parental educational background and academic performance. (t-test result).

Educational background	Sample	Mean	df	t-cal	t-table	p
High	30	3.4				
Low	30	3.5	58	6.324	2.00	0.05

t-calculated was 6.324 which was higher that t-table of 2.00 at significance level of 0.05. Hence, parental income was significantly related with the participants academic performance.

Hypothesis four: There is a significant relationship between parental income of the participants and their academic performance.

Table 4: t-test summary of parental income and participants' academic performance.

Parental income	Sample	Mean	df	t-cal	t-table	p
High	32	3.3				
Low	28	3.2	58	14.251	2.00	0.05

Table above showed a t-cal of 14.251 which was higher than t-table of 2.00 at significance level of 0.05 which means that parental income had a relationship with participants' academic performance.

Discussion

Parental occupation, as revealed by the findings of the study affects the students' academic performance. Although, the finding is contrary to the study of Peter (2008), on the relationship between parents' socio-economic status and academic performance of secondary school students in Rivers State, Nigeria. His study revealed that the students' academic performance was not been affected by their parents' occupation. Although, Johnson (1996), in his study of theoretical model of economic nationalism in developing states in Nigeria stated that parents become poor due to hard measures, such that they can no longer provide adequately for good education of their children as these ugly situations have promoted school children to drop out of schools to engage in menial jobs to support their academic pursuit.

The study further revealed that socio-economic background influenced greatly academic performance. Olatunde (2010), in his study of socio-economic background and mathematics achievement of students in some selected senior secondary schools in South-West Nigeria, the result showed that majority of the students were of average academic ability in mathematics with a conducive environment given to them. Goleman (1988) also found out that high socio-economic students of all ethnic groups display higher average levels of achievement and also stay in schools longer than low socio-economic students. Although, it may not really matter the socio-economic background a student comes from to make academic achievements as it depends on the student if he has the strive to succeed in life as he will perform well no matter his background. But in another dimension, poor socio-economic background can affect the students' performance negatively as basic educational needs will not be met which may make him or her to drop out of school and not able to achieve his academic prowess.

On parental educational level, the study revealed that this can affect the academic performance of the students. Ogoina (1985) in her study on parental educational level and academic achievement, she found out that parental education itself had no direct positive effect in grades but generally, the more highly parents value education, the more they will likely support their children's educational endeavor and more likely they will succeed as they will provide enabling environment for their children sacrificially.

Parental level of income also had impact on academic performance of the students. Jerkins and Schluter (2002) studied the effect of family income during childhood and later life attainment then found out that later income is more important than early income but that income effects were relatively small to education effects. Although, Ogbugo-Olalube (2008) asserted that parental income level does not make a significant relationship with the students' performance.

Conclusion

A stable socio-economic background is an impetus for better academic performance as enhanced environment is a pivot for excellence. Hence, a better socio-economic background will assist the students greatly for better academic performance.

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ENHANCING RAPID RECOVERY OF PATIENTS DURING HOSPITALIZATION THROUGH PASSIVE EXERCISES AND EARLY AMBULATION

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Introduction

Exercise according to Ekerrette (2006) is any physical activity consciously engaged in by an individual in a bid to achieve physical fitness and health. Exercise could be passive or active. Passive exercise is that form of exercise that requires minimal physical activities and effort (Ekerrette 2006).

Early Ambulation on the other hand is defined as physical activity mostly involving movement especially walking; usually encouraged quite on time to aid patients' recovery (Ukpong 2006).

During hospitalization, the patient is confined to bed and performs little or no activity. Some patients depending on the severity of illness stay for longer periods confined to bed. Confinement to bed, Ukpong (2006) said can result in weakness of muscles, bone pains, reduced physiological response to body organs like poor digestion, poor appetite resulting in Anaemia if not addressed, sluggish pumping capacity of the heart, poor mental functioning and so on. In view of the above recognized problems and others not mentioned in this work, involving the patient in some level of physical exercise is important to keep body parts alive, healthy and functioning well.

Hospitalization in this work refers to a period of being confined in a health facility to receive therapy while a patient is an individual obtaining therapy in a health facility from a health personnel (Kasner and Tindal 1983).

Passive exercises and early ambulation are of immense benefit to the body in the following ways:

Revitalization of the body bones and muscles, provision of energy to the body, rapid body development especially in young children, improvement of body metabolism, stimulation of endocrine functioning towards effective production of hormones, promotion of blood flow to various body tissues and organs, promotion of metabolic activities in the gastro intestinal tract, prevention of hypertension, prevention of deep vein thrombosis and respiratory complications (Akintunde 2005).

As important as passive exercises and early ambulation are to the body, some patients during hospitalization turn down participation in passive excercises for some unfounded or baseless reasons like; the drugs administered will not function properly if one exercises, the illness/pain will increase, site of surgery will break down, doctors and nurses will think they are well hence may not be given medications again, their relations may think they are well and hurry to take them home (especially those patients who are enjoying the care in the hospital and would want to rest some more (Ukpong 2006). It is therefore the place of the health personnel (doctors, nurses etc) to dispel these fears through proper counseling and education of patients on the benefits of passive exercises and early ambulation.

Passive Exercise:

Definition:

Passive Exercise is defined by Ekerrette (2006) as that form of exercise that requires minimal physical activities and effort.

Indications for passive exercise: all health conditions whether medical, or surgical.

Composition of passive exercise:

Akintunde, (2005) said excercise places demands on all body systems, beginning with conscious or subconscious thought processes and involves impulses from the Central nervous system (C.N.S) which initiate coordinated muscle, Cardio Vascular, pulmonary and other systems activities. For this reason, there is a difference in the load, duration and intensity of exercise prescribed for individual patients during hospitalization.

Passive exercise as the name implies is different in composition from active exercise because it is prescribed for the sick who are trying to recover to assist them recover rapidly. In view of this, it does not require vigorous use of muscles, muscular endurance, reaction time and so on. It is very mild and only intended to enhance recovery (Watson 2002).

Styles of passive exercises:

According to Procedure Manual (2005)

Passive Exercise carried out by patients during hospitalization include:

- Turning side to side: That is, turning the patient from the left side of the bed to right and vice versa.
- Lifting Top to bottom: That is, lifting the patient from the top part of the bed to the bottom.
- Gentle flexion of the legs at the knee region
- Deep breathing exercise to expand the lungs
- Extension and flexion of the arms
- Flexion and extension of fingers and toes

Duration/time:

Above listed exercises are Usually carried out during the day, where the patient's reaction can be observed and the duration of passive exercise is nothing longer than the patient can tolerate. Even if the patient intends to go further mile, the health personnel should use his/her discretion to know when the exercise is enough in order not to be injurious to the patient (Ekerrette 2006).

Benefits of passive exercise:

- To promote blood circulation to all body parts,
- Ease muscular and bone pain,
- Keep bones and joints flexible,
- Prevent respiratory complications especially through deep breathing exercises,
- Prevent deep vein thrombosis,
- Give patient a sense of belonging.

Supervision:

The Nurse or the physiotherapist supervises passive exercises; demonstrating it first, then encouraging and making sure the patient does same (procedure manual 2005).

Hindrances to patients'participation:

Amanso, (2007) said apart from general misconceptions people have concerning exercises, a patient in a health facility may turn down participation in a passive exercise session for reasons like:

- Pain at site of injury or nature of disease; sometimes pain experienced may be unbearable for the patient to even consider taking instructions like flex your legs, raise your hands etc.
- Patient's psychological state: a worried, anxious and depressed patient may not see any reason to comply to treatment regimen like exercise.
- Health personnel/patient relationship: A cordial relationship is all it takes to handle stubborn patients. A stubborn patient will naturally given-in to and be willing to cooperate with a kind, caring concerned, humble and cheerful health personnel.
- Lack of confidence on the health personnel: No patient will want to take instructions from nor cooperate with a health personnel who is always wrong in her patients care and treatment; as made obvious through negative compliments and complaints by other colleagues.
- Inadequate patient education on the procedure: In this era of patients' bill of right, the patient Amanso (2007) said has a right to know everything concerning his/her care ranging from drugs, type of food prescribed, type of clothing prescribed, life modifications prescribed to participation in exercises. The patient has to be adequately informed about the type, duration and benefit of passive exercise if he/she has to participate.

How to gain patients' cooperation to take part in passive excercises:

According to Ukpong (2006) the following steps are necessary:

1. As patients come to your health facility, treat them nicely and respectfully. Every patient has self esteem hence should be treated as such regardless of their temporary incapability.
2. Be kind, cheerful to patients, go close to them, answer their questions promptly and intelligently.
3. Take pain to explain to patients every detail concerning procedures and treatment.
4. Reassure patients by assuring them of rapid recovery and health.

Early Ambulation

Definition:

According to Ukpong (2006) early ambulation refers to physical activity mostly involving movement. Movement especially walking, is usually encouraged quite early for patients during hospitalization especially surgical cases to aid rapid recovery.

Indications for early ambulation:

- Mostly surgical cases like appendicectomy, laparotomy to promote rapid would healing.
- Patients with chronic conditions e.g. tuberculosis, are also encouraged to walk around as their conditions permit.

Composition of early ambulation:
(Procedure manual 2005)

- Early ambulation principally follows the "fitness pyramid or climb up principle". This is so because the patient will have to start with coming down and going back to bed, then slow movement round the bed, to graduated walk in and around the hospital ward.
- It is not hurried over,
- It is not muscle tasking

Style/pattern of early ambulation:

Soon after surgery, precisely the 2nd day post operation, the patient should be encouraged to come down from bed assisted, sit on the chair by the side of the bed for a while, then go back to the bed assisted.

From the 3rd day post operation, the patient should be able to come down from and back to bed

alone (procedure manual 2005).

In addition to this, the patient should take gentle walk round his/her bed.

On the 4th day post operation it is expected that the patient should be able to walk the length of the ward slowly and back to bed.

From the 5th day post operation, patient should be able to sit out of the ward for fresh air. This also depends on patient's condition.

Early ambulation just like passive exercise is encouraged during the day where the patient's reaction can be observed and also to prevent injuries to the patient in the event of walking out in the dark.

The duration is also nothing longer than the patient can tolerate. The health personnel should use his/her discretion so as to avoid pain usually experienced after long treks. (Ekerrette 2006).

Benefits of early ambulation:

1. Strengthening of bones, muscles and joints,
2. Improvement of blood flow to surgical operation site,
3. Promotion of wound healing,
4. Stimulation of peristaltic movement,
5. Assessment of patients' progress after surgery.

Supervision of early ambulation:

The Nurse particularly supervises early ambulation because the procedure (early ambulation) is part of routine nursing care after surgery for all patients.

Hindrances to patient's participation:

- Pain at operation site
- Weakness
- Inadequate education of patient on benefits of early ambulation.
- Poor Nurse-patient relationship
- Lack of confidence in the nurse or health personnel (Amanso 2007)

How to gain patients' co-operation on early ambulation

According to Ukpong, (2006) the following steps should be taken to gain the patients co-operation and willingness on early ambulation.

1. From onset (admission of patient), the health personnel should be nice to patient, show warm and receptive attitude
2. Involve patient in his/her care
3. Be cheerful, kind, tolerant and go close to patient
4. Give patient a sense of belonging and give reasons to stay alive
5. Reassure patient on rapid recovery and health
6. Answer patients' questions promptly and intelligently.
7. Adequate explanation of every procedure and treatment to patient

Conclusion

Passive exercises and early ambulation actually enhance patients' rapid recovery during hospitalization. All health personnel should encourage patients in their care to take passive excercises and early ambulation seriously in order to get well quickly and return to loved ones at home.

Recommendations

1. Health personnel should treat all patients as fellow human beings, by showing them love and respect.
2. Health workers should take out time to adequately explain benefits of passive exercise and early ambulation to their patients.
3. Health personnel should not only encourage passive exercise and early ambulation but should also supervise the procedure effectively.
4. Positive reinforcement of complying patients like a smile, clap and so on for activity well done.
5. Education of patients on how to stay healthy at home when they are discharged.

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RESIDENCE AS PREDICTOR OF USE OF MATERNAL HEALTH SERVICES IN RURAL AND URBAN COMMUNITIES OF ENUGU STATE.

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Abstract

The study examined residence as a predictor of utilization of maternal health services in rural and urban communities of Enugu state. A survey research design was adopted for the study. A total of 620 mothers was randomly selected from rural areas. Questionnaire and interview schedule were used for data collection. The reliability coefficient of the instrument was 0.9 using co relational analysis while two experts carried out face and content validations. Three research objectives and one hypothesis tested at 0.05 level of significance guided the study. Percentages and mean were used to achieve the objectives while chi-square (x2) was used to test the hypothesis. The study revealed that maternal health services are significantly dependent on distance and residence of respondents. As such, it was recommended that health facilities with delivery amenities should be sited centrally in urban and rural areas.

Introduction

Everyday, at least 1600 women die from complications of pregnancy and childbirth. In addition to these is 585,000 maternal deaths each year, (WHO 1998, WHO, 2011), further 50 million women suffer acute complication. According to Murray (1997), the high level of maternal mortality and morbidity in developing countries have been attributed partly to the non-availability of services and partly to poor utilization of services even when they are available (Nwakoby,1994). In contrast, the estimated percentage ante-natal care coverage, deliveries in health facilities and skilled attendant at delivery in developed countries are 97%, 98% and 99% respectively (WHO 1997), while the estimate for developing world shows that approximately 65% of pregnant women received at least one ante-natal care, (WHO (1997, WHO 1998), 40% of deliveries take place in health facilities and a only 53% of all deliveries are attended to by skilled personnel (WHO 1997). This goes to show that the developing world contributed more to the poor estimated world total. Furthermore, the regional estimates show that countries in Africa have the lowest rates of maternity care coverage in the developing world. In this region, about 63% of women received ante-natal care, 42% have a skilled personnel attending at delivery and 36% give birth in a hospital or other health facilities5. Within the region, the coverage figures for West Africa show that 60% of women receive ante-natal care, 32% deliver their babies in health facilities and 34% have skilled personnel in attendance during delivery. This lack of or inadequate care of mothers during pregnancy and delivery has been noted to be the immediate causes of pregnancy-related complications, ill-health and death (WHO 1997). As reported by some researchers, in developing countries as a whole, the risk of death during pregnancy or childbirth (maternal mortality ratio) ranges from 200 per 100,000 live births in Latin America and the Caribbena to 870 per 100,000 in Africa (WHO 1995). Extremely high ratios of over 1000 per 1000,000 live births are found in Eastern and Western Africa (WHO 1995). To the extent that Africa, which has 20% of the world's births, accounts for 40% of all maternal deaths ((WHO 1995). By contracts developed countries, with 11% of all birth, have less than 1% of total maternal deaths. This implies that death of mothers can be greatly reduced with attainable skills and resources.

The reduction of maternal deaths to almost non-existent in the developed world has been attributed to adequate coverage of ante-natal care (7%) deliveries in health facilities (98%) and skilled attendants at delivery (99%) (WHO 1995). Thus, use of certain maternal health services, such as effective ante-natal care, institutional delivery and skilled attendant at labour and delivery improve the fate and health status of pregnant women. Nevertheless, some demographic factors have been found to have implications for use of maternal health services by women. Thus, the present study therefore seeks to look into the residence and utilization of maternal health services.

Statement of the Problem

Maternal mortality rates in Nigeria are among the highest in the world, ranging room 800 to over 1000 per 100,000 live births (WHO 1997, Russels 1993). Nigerian women run a risk of dying during pregnancy or childbirth that is 100 times greater than that faced by women in Western Europe WHO 1997) and 7.4 in the United States (Russel 1993). However, data on the percentage of Nigerian women that use Maternal Health Services show that the high risk of dying and high mortality rates may be due partly to low maternity care coverage. Sixty percent of Nigerian women received ante-natal care, 31% in a health facility and 31% have skilled attendant at delivery ((WHO 1997). Data from the Nigerian Demographic and Health Survey (DHS) 1985-90 show that the national (urban) coverage of maternity care stood at ante-natal care 87%, deliveries in health facilities 58% and skilled attendant at delivery 59%, (WHO 1995). The national (rural) coverage by the same survey for the same period were 53% ante-natal care, 24% institutional deliveries and 23% skilled

attendant at delivery. While the picture of coverage on the average is poor itself, a striking features worthy of note is the fact that the proportion of women receiving ante-natal care is distinctly higher than the proportion that deliver in a health institution and/or receive care by skilled personnel at delivery. The implication is that most women after receiving antennal care default from coming to a health facility to deliver their babies and as such fail to have a trained attendant at delivery. Considering the enormity of the mortality and morbidity problems, one wonders whether residence factor is key to the underutilization of maternal health services. Thus, the present study looked into the relationship between residence and use of maternal health services.

Objectives

- To establish whether a difference exists in the utilization of antenatal services among women residing in the urban and rural areas.
- To assess the utilization of skilled attendant during labour amongst women from the two areas of study.
- To find out whether institutional delivery is dependent on residence of the respondents.

Hypothesis

The use of maternal health services is significantly independent of residence.

Literature Review

Residence and Utilisation of Services:

As shown by previous studies, residence invariably influences use of MIIS (Cayemittes, Zeif and Smith 1996, Remez 1997). In a study on utilization of maternity services by Black women in rural and urban areas of the damage Free State, it was found that antenatal care was received by 71% of the rural women and 87% of the urban women. Rural women delivered at home in 60% of cases, while 37% delivered in hospitals.

Only 23% of urban women delivered at home, while 67% of the deliveries were conducted in hospitals. Nurses supervised deliveries in both instances in more than 60% of cases, but in rural areas traditional midwives managed 26% of the confinements. In this epidemiological survey, which was undertaken to evaluate utilisation of maternal health services, 240 clusters were selected from the urban and rural populations and 8 households were interviewed in each cluster. Information was gathered from 237 rural women and 168 urban women who had delivered a baby or aborted during the preceding year (Cronje,Joubert, Chapman, de Winnaar and Ban 1995). In addition, the 1993 Ghana DHS showed that the likelihood of having received prenatal care varied notably by residence. In the survey, the proportion of infants whose mothers had obtained pre-natal care was 97% in urban areas and 84% in rural areas (Ghana Statistical Services Micro International 1994). Births to urban women were almost twice as likely as births to rural women to have received prenatal care (56% vs. 24%), and 20% of urban births took place in a health facility compared with 2% of rural births (Donoran, 1995). Again, births to urban women were about 5times as likely as births to rural women to have been overseen by a doctor or a trained nurse or midwife (Donoran, 1995). Moreover, the findings of the 1994 Haitian survey indicated that women living in urban areas were more likely to have received care from a trained provider than were those in rural areas (83% vs. 61 %), and urban births were almost 5 times as likely as rural births to occur in a health facility (42% vs. 9%) (Cayemittes, Zeif and Smith 1996).

The trend is same with the findings of the 1995-96 Mali DHS where the proportion of women who obtained no prenatal care was 6 times as high as the proportion in Bamako and more than twice as high as in other urban areas (62% vs. 10% and 24%). In the study, the majority of recent births took place at the mothers' home (63%). Births in rural areas being 7 times as likely as those in Bamako to occur at home (77% vs. 11%). According to 1995 DHS Guatemala, in 1990-95, 65% of births occurred at home. Births to indigenous rural women were especially likely to take place at home (78 - 90%) (Remez, 1997). In all, deliveries were more likely to be attended by trained midwives than by doctors (46% vs. 10%). Though, doctors were more likely to attend births to urban women (Remez, 1997). In Zimbabwe, only 9% of urban women gave birth at home in the three years preceding their 1994 DHS, compared with 38% of rural women (Edward, 1996). As reported by the National Family Health Survey conducted in India between April 1992 and September, 1993, urban women were more than twice as likely as rural women to receive prenatal care from a doctor (70% vs 31%).[62] Only one-quarter of all deliveries took place in a health facility (15% in a public institution and 11 % in a private facility). Among the deliveries, there was a wide disparity in institutional births by urban-rural status. Fifty-eight percent of urban births occurred in a health facility compared with just 16% rural deliveries (Donovan, 1995). The proportion of births attended by a doctor was 3 times as high in urban areas as in rural areas (48% vs. I4%) (Donovan, 1995).

Methods And Materials

Research Design

Cross sectional survey design was used for the study. This was an examination of how the existing health is used by women of childbearing age (15-49 years). The decision to use the survey of women (instead of data from DHS hospital records or vital statistics) is deemed appropriate because for data sources and means of data collection for process indicators at the population level, community-based information has been identified as being the best source of information.

Study Areas

Enugu North Local Government Area is an urban area and Obinagu is a rural community selected for this study. There are many health facilities of' varied ownership.

Population of the Study

The population of the study consisted of all married women of childbearing age (15-49 years) who had at least one live birth in the last three years in Enugu North Local Government Area and Obinagu, Udi Local Government Area. The study excluded primi-gravidae. This group has not had deliveries nor had the presence of trained personnel at delivery and as such cannot supply needed information on these. The decision to study those women that had births within the last three years is to control for recall especially among the illiterate group.

Sample and Sample Size Determination

The sample composed of 648 women of childbearing age (15-49 years) irrespective of educational attainment, parity, occupation and religion. Out of this number, 50% (324) was from urban (Enugu North Local Government Area) and 50% (324) from rural (Obinagu Udi Local Government Area).

This sample size was determined using the WHO's (1997) national estimate of the proportion of women that receive ante-natal care which is 60%, and the formula for determining the required sample size for estimated proportion.

$$n = \frac{Z^2\pi(1-\pi)}{E^2}$$

Sampling Procedure

Multistage sampling technique was used for the study. For the urban sample, Enugu North Local Government Area was stratified into high, medium and low density residential areas. For the rural area, the existing three villages in Obinagu were used as strata. Women of childbearing age who had given birth in the last three years participated in the study.

Instruments for Data Collection

The data used for this study were mainly from primary sources using questionnaire and interview schedule. The two instruments contained both open and closed - ended questions aimed at identifying the residence of the respondents and MHS utilization.

Table I: Percentage of women who utilize ANC, I.D. and S.A. Services by selected Characteristics. N=620

	Utilization of maternal health services				
Age (In years)	**N**	**%**	**ANC = 45 (72.9%)**	**I.D. = 462 (74.5%)**	**S.A=390 (62.9%)**
15-24	82	13.2	64.6	69.5	62.2
25-34	247	39.8	76.1	71.3	59.9
35-44	196	31.6	75	78.1	64.8
45-49	95	15.3	67.4	80	67.4
Educational Attainment					
No Formal Education	23.7	147	75.5	74.8	59.9
Primary Education	160	25.8	66.9	75.6	72.1
Secondary Education	155	25	78.7	72.3	62.6
Tertiary Education	117	18.9	70.9	77.8	65.8
Others	41	6.6	70.7	68.3	65.9
Occupation					
Cleaner, labourer	152	24.5	75	70.4	60.5
Subsistence Farmer	159	25.6	71.1	78	60.4
Manager, Nurse	117	18.9	77.8	76.1	65.8
Accountant, Doctors, Lawyers	65	10.5	70.8	56.9	67.7
Religion					
No Religion	55	8.9	80	74.5	58.2
Traditional	59	9.5	74.6	71.2	44.1
Protestant	170	27.4	70	76.5	68.8
Catholics	290	46.8	74.5	74.5	63.1
Islam	19	3.1	68.4	78.9	78.9
Others	27	4.4	59.3	66.7	63.0
Numbers of Time Pregnant					
Once	63	10.2	71.4	73.0	58.7
Twice	83	13.4	74.		
Three Times	134	21.6	70.2	71.6	61.9
Five Times and above	137	22.1	72.9	85.4	72.3
Number of Living Children					
One child	60	9.7	68.3		
Two children	160	25.8	83.1	77.5	66.3
Three children	110	17.7	63.6	63.6	60
Four children	143	23.1	66.4	78.3	60.8
Husbands Education Attainment					
No Form Education	149	24	7.11	75.2	61.7
Primary Education	154				
Secondary Education	121	19.5	74.4	67.8	55.4
Post Secondary	140	22.6	81.4	76.4	67.9
University Education	47	7.6	66.0	78.7	74.5
Others	9	1.5	55.6	77.8	55.6

The table shows that greater proportion of the rural women utilize antenatal services during pregnancy when compared with the proportion of their urban counterparts that utilize the services (77.5% vs. 68.5%). On the other hand, the proportion of urban women that utilize the services of skilled personnel at delivery was more than of the rural women (65.9 vs. 59.8%). Nevertheless, it is worthy of note that equal proportion of both urban and rural women utilize institutional delivery services (74.5% each). It may then be said that there is no defined pattern of utilization of services among the urban and rural women that were studied.

Hypothesis Testing: The use of maternal health services is significantly independent of the residence of the women.

Chi-square analysis of the descriptive data presented in Table above was done and the results show that utilization of antenatal services was significantly dependent on the residence of the women (X2=6.33, df =1=S, p < 0.05)

Nevertheless, institutional delivery and skilled attendant services were significantly independent of their residence (X20.0000l, d1l=NS, p > 0.05 and =2.49, df=l=NS, p>0.05) respectively.

Discussion

Residence and Utilization of Services

Antenatal service utilization was found to be dependent on the residence of' the women while utilization of' institutional delivery and skilled attendant services were shown to be independent of their residence. The proportions of women that deliver in health institutions were the same for the urban and rural areas (74.5% each). For skilled Personnel services more than rural women (65.9%). These findings on utilization of MHS are similar to be Findings of studies carried out in Orange Free State (Gronje, Joubert, Chapman, de

Winnar, Ban 1995). Ghana (Ghana Statistical Services and Micro International 1994) (Donoran, 1995) and in India (Donovan, 1995). In these studies, urban women were at least twice as likely as rural women to receive prenatal care and urban births more likely to take place in a health facility than rural births. Births to urban women were more likely to have been overseen by a doctor or a trained nurse or midwife (Cayemittes, Zeth, and Smith 1996). According to Donovan, (1995) the similarity in the findings is expected and the urban-rural variance is utilization of services may be attributed to variations in accessibility of services.

Conclusion/ Recommendations

The present study of influence of residence on use of maternal health services in rural and urban communities of Enugu state revealed that maternal health services are significantly dependent distance and residence of respondents . As such, the following recommendations are made:

1. Health education on the importance of strategizing to effectively access MHS irrespective of residence should be intensified.
2. Health facilities with delivery amenities should be sited centrally in urban and rural areas. This is because residence and distance were revealed to be significant determinants of use of MHS.

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"PROFESSIONALISM IN NURSING"

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Introduction

I feel very humbled and honoured for this singular opportunity given to me to present the Keynote address to this occasion of the 2nd National Nurse Scientist Conference. By way of introduction I wish to highlight the issues to be addressed in this year's Theme of Professional Nursing: Issues and Challenges: The Nigeria Perspective.

Keynote address presented at the 2nd National Nurse Scientists Conference held at Uyo from 12-16th, March 2012

Highlights

- The Focus of the Keynote address (Professionalism in Nursing)
- Definition of key issues involved.
- The issues of Professionalism and Competency
  (a) Professional competencies
  (b) The foundation of Nursing Competency
- What we can do to promote Professionalism
- Evidence-Based Care delivery
- Barriers to Promoting Evidence-Based Practice
- Nurses becoming more Professional
- The Power of Professional Nursing Practice
- Challenges posed by the Declining Nursing Services and the Image of Nursing in Nigeria
- Challenges in Nursing Professionalism in Nigeria
- Some Elements of Nursing Services Delivery in Nigeria
- The General Overview of declining Nursing Services in Nigeria
- Summary and Conclusion.

Definition Of Key Issues

Professionalism:

The conduct, aims or qualities that characterize or make a Profession or Professional person.

Professional: Is characterized by or conforming to, the technical or ethnical standards of a Profession.

Profession therefore is a calling requiring specialized knowledge and often long and extensive academic preparation OR the whole body of persons engaged in a calling or vocation.

The question then is what makes Nursing a Profession?, what is a Nursing Professional? What is Nursing Professionalism? A look at the criteria for Nursing Profession should help to answer these questions. The criteria include the following:-

- There is an Educational background required to ensure safe and effective practice
- All Professional Nursing providers must complete an Educational Programme or meet minimum criteria to be eligible for a licence.
- Members of the profession must adhere to a code of ethics
- Nursing Profession is expected to develop and members accountable to general ethical standards.
- Members participate in professional organizations
- Members participate in organizations which aim to support and advance the profession e.g the Nurse Scientists Union.
- Members are accountable for Continuing Education and Competency
- Licenced Nurses must keep their knowledge base current by formal and informal on-going Education, and demonstrate competency when required.
- Professionals publish and communicate their knowledge and advances in their profession.
- Professionals further the Education of Peers by sharing their knowledge through published works, communication and or training.
- Members of the Profession are Autonomous and self-regulating.
- Nursing Professional makes independent decisions within their scope of practice and are responsible for the results and consequences of those decisions
- Professionals are involved in Community Service.
- Nursing Professionals formally and informally share health care information in their communities.
- A Professional develops, evaluates and uses theory as a basis for practice as Nursing has been based on theory since the days of Nightingale
- Members of the Profession are involved in Research
- Nursing as a Profession and individual Nursing providers are integrally involved in Research and expanding their knowledge base.
- The Conduct and Responsibilities require each Profession to participate in determining individual members and the group responsibilities and conduct.
- Each Profession participates in the regulation of its members adherence to its own Professional Standards.

Professional Nursing

This is the process in which substantial specialized knowledge derived from the biological, physical, and Behavioural Sciences is applied to: the care, diagnosis, treatment, counsel and health teaching of persons who are experiencing changes in

the normal health processes or who require assistance in the maintenance of health or the prevention or management of illness, injury or infirmity (Dale, A.E. 2005).

Having looked at the Criteria that makes Nursing a Profession, the question is, do we meet these Criteria? Do we have in the Nigeria Perspective the Criteria of Professional Nursing Values, and behaviours. Professional Values are those of Altrusism (humanity) Equality, Aesthetic, freedom/Autonomy, Human, Dignity, Justice and Truth.

While Professional behaviour is looking at Dependability, Professional Presentation, Initiative, Cooperation, Organization, Reasoning, Clinical Supervisory process, Verbal and written communication (French, P. 2002).

The Issues Of Professionalism And Competency:

Professional Competencies:

This refers to the Values, Attributes and Practices that Nurses embody and may share with members of other Professions. Nursing Care Competency is the relationship of capabilities that Nurses need to work with Clients and Colleagues, the knowledge and skills of practicing the discipline that encompass understanding of the broader health care system.

The Foundation Of Nursing Competency

Would require the development of insight through Reflection, Self-analysis, and Self-care through the understanding that using ongoing reflection, critical examination and evaluation of one's professional and personal life improves nursing practice. Nurses must engage in ongoing self directed learning with the understanding that knowledge and skills are dynamic and evolving. In order to maintain competency one must continuously update the knowledge. We need to demonstrate leadership in Nursing and Health care through the understanding that effective Nurse is able to take a Leadership role to meet client needs, improve the health care system and facilitate community problem solving. Nurses must collaborate as part of a Health Care team through the understanding that successful Health Care depends on a team effort, and that collaboration with others in the team is essential for success in serving clients. Each Nurse must practice within, utilize and contribute to the broader health care system through the understanding that Professional Nursing has a Legally defined Standard of Practice. Nurses must take the responsibility of efficient management and utilization of health care resources.

They should practice Relationship-Centered Care through the understanding that the effectiveness of nursing interventions and treatment plans depends on the attitudes, beliefs and values of clients and these are both by how Professionals interact with clients and by the intervention. Nurses need to communicate effectively through the understanding that effective use of therapeutic communication, to establish a caring relationship, to create a positive environment, to inform clients and to advocate is an essential part of all interventions. The need to make sound Clinical Judgment is not a single event, but concurrent and recurrent processes that include Assessment (data collection, analysis and diagnosis), community and client participation in planning, implementation, treatment, ongoing evaluation and reflection. Nurses need to realize that there are many sources of knowledge, including research evidence, standards of care, community perspective, practical wisdom gained from experience, which are legitimate source of evidence for decision-making.

What We Can Do To Promote Professionalism:

* Provide Strategic directions and Programmes that enhance the competencies of nurses to be globally competitive.
* Passionately sustain the quality work life and interactions with and among nurses.
* Encourage staff to develop their knowledge and skills by participating in a wide variety of both formal and informal activities.
* Enthusiastically explore possibilities of collaboration.
* Maintain Nursing educational standards.
* Promote Professional behaviour in the professional nurse.
* Practice Evidence-Based Care delivery.

Evidence Based Care Delivery

Nursing is a caring Profession. It is also a Profession that is increasingly highlighting Evidence-based Practice regarding the Scientific aspects of Nursing. In as much as a complex technological advances in Medicine and Machines have been used with patients in bed, however, the Nurse is the first person who touches the customer generally in any emergency or hospital.

Mitchell (1999) opined that "Good Health and Good Sense are two of life's greatest blessing and that times have changed. Today, the Philosophy of Professionals have to show evidence in their practice. The five keys to being a true Professional are Character, Attitude, Excellence, Competency and Conduct. They relate, and influence your Values, Ethics and Performance Standard. Getting involved in Organizations, reading Journals and continually seeking out new information will keep one current on the Nursing Profession.

Evidence-Based Nursing therefore is a type of healthcare, drawing on some of the traditions of Evidence-Based Medicine. It involves identifying Research findings and implementing them in nursing practices, in order to increase the quality of patient care.

The Goal of Evidence-Based Nursing is to provide the highest quality and most cost-effective nursing care possible. Evidence-based Nursing is founded on the collection, interpretation, and integration of valid, important, and applicable Research. In order to practice Evidence-Based Nursing, practitioners must understand the concept of Research and know how to accurately evaluate this Research. These skills must be taught in Modern Nursing

Education and also as part of Professional training.

Barriers To Promoting Evidence-based Practice

There are many barriers to promoting Evidence-Based Practice. The first of which would be the practitioner's ability to critically appraise Research. Time, workload pressures, and competing priorities can impede Research and development. The causes of these barriers include nurses and other professional practitioners' lack of knowledge of Research Methods, lack of support from professional colleagues and organizations, lack of confidence and authority in the Research Arena.

Another barrier is that the practice environment can be resistant to change, sticking to conventional methods. A good example is the adoption of and implementation of the Nursing Process in Nigerian hospitals. It is important to show nurses who may be resistant to changes in nursing practice the benefits that nurses, their patients, and their institutions can reap from the implementation of Evidence-Based Nursing practice, which is to provide better nursing care. Values, Resources and Evidence are the three factors that influence Decision-making with regard to Health Care. Nurses should be taught to read and critically interpret which relate to their field of Care. In addition, nurses need to be more aware of how to assess the information and determine its applicability to their practice.

Another barrier to implementing Evidence-Based Nursing into practice is lack of Continuing Education Programmes. Practitioners do not have the means to provide workshops to teach new skills due to lack of funding, staff and time, therefore, the Research component may be dismissed. If this occurs, valuable treatments may never be utilized in patient care. Not only will the patients suffer but staff will not have the opportunity to learn a new skill. Also, the practitioners may not be willing to implement changes regardless of the benefits to patient care.

The barrier to introducing newly learned methods for improving treatments or patients' health is the fear of "stepping on one's toes'. New Nurses might feel it is not their place to suggest or even tell a superior nurse that newer, more efficient methods and/or practices are available. The perceived threat to clinical freedom offered by evidence-based practice is neither logical nor surprising. Resistance to change is part of human nature. Human nature offers many challenges to Evidence-Based Practice. The question then is can we do a better job of promoting Evidence-Based Practice? And even if we find and use the evidence, will we make consistent un-biased decisions?

Nurses Becoming More Professional

A look at what a Professional looks like, acts like, behaves like, and how can we as nurses become more Professional no matter what or how many letters come after our name.

A Professional look in the way of dressing is important. Professionals treat everyone (Colleagues, patients, residents, clients) with dignity and respect. They see value in each person, no matter how high or low.

Professionals are committed to life-long learning. School is never out for us, always having a book on the go, keeping up to date with Professional Magazines, or Websites, attending Personal or Professional Conferences, or simply by listening and learning from others.

Professional does their best at what they are being paid to do. They are committed to Excellence whether they "feel like it or not".

DiCenso, A et al (1998) gave a preview of the following questions begging nurses for answers and they include: Are you a professional? What could you do to act more Professionally? Do you treat others Professionally? What could you do differently to improve Professionalism in your workplace? How would things be better in your workplace if you treated others more Professionally?

The Power Of Professional Nursing Practice

Understanding Power and learning how to use it is crucial if nurses efforts to shape their practice and work environments are to be successful. Mason et al (2002) studied Nurse Leaders from six Organizations to explore what Power means, how nurses acquire it and how they demonstrate it in their practice.

Through these discussion, eight characteristics of powerful Nursing Practice was identified, which together, formed a framework that can guide nurses efforts to develop a powerful practice and shape the health care delivery settings and academic institutions in which they work. Studies of Organization Power can help us better understand Nursing Power and the ways in which it is manifested. This has accorded us the opportunity of reflecting on what Power means for individual Nurses and the Profession. An example is the Labour Union during Comrade Adams Oshiomole's times and the present dispensation with the crisis that arose from the removal of Oil Subsidy.

Challenges Posed By The Declining Nursing Services And The Image Of Nursing In Nigeria:

The trust of the discussion on Professionalism lies on the Nursing Challenges posed by declining Nursing Services and the Image of Nursing in Nigeria: Challenge is defined by Oxford Advanced Learners' Dictionary as "A new or difficult task that test somebody's ability and skill", While Nursing was defined by Virginia Henderson as "A humanistic and Scientific discipline whereby a Nurse assist the patient sick or well in the performance of those activities contributing to his/her recovery or to a peaceful death that he or she would have performed unaided if he had the necessary strength, will or knowledge and to do those things in such a way to help him or her gain independence as rapidly as possible.

Ogbuokiri, C.U. (2007) identified the following challenges that plaque the Nursing Profession in Nigeria and they include: The attitude of the nurse herself, the advancement in Science and Technology, lack of input on Policy-Making on health issues, Shortage of Nurses, Un-conducive work environment, Non-supportive staff, Lack of sufficient facilities and equipment to work with. Also are; lack of motivational

input such as Housing, Transportation, incompetent Clinical Supervision, poor working relationship, general moral laxity in the society, undue familiarity with the subordinates with a weakness in disciplining erring staff. Nurses are no longer in control of the immediate environment in which patients are nursed. If quality health care, the corner stone of Professionalism trust be provided, then we have to look critically into some of these problems of the physical, social and mental environments.

The patronage of Traditional Healers and Traditional Birth Attendants continue to flourish, especially now that they have to pay for health services in orthodox health care facilities. These challenges indeed have a lot of effects, among which are relapses and complications which are further challenges to Nursing. In addition, most Government Policies do not focus on meeting the needs of the Profession because nurses do not fully participate in Policy- Making.

The solution to these challenges lie in the hands of the Nurses and Policy Makers. There is no gain saying that Nursing Profession must remain dynamic, scientific and professional in its attempt to meet healthcare needs of the society.

The Challenges In Nursing Professionalism In Nigeria Are:

* Membership issues
* Communication
* Changes in Nursing Practice
* Diversity in the population
* Lack of Autonomy
* Lack of Leadership skills
* Nature of the job: Long hours, health care risk, emotional load and undervalue by society
* Shortage of Nurses
* Limited Opportunities

Some Elements Of Nursing Services Delivery In Nigeria Are:

* Mentorship in Nursing Clinical practice.
* Educational Guide of Nurses.
* Image of the Nurse.
* Nursing procedures/Quality Assurance.
* Role of different Cadres of Nurses.
* Record keeping and documentation in Nursing.

The Causes Of General Overview Of Declining Nursing Service In Nigeria

* Lack of equipment
* Lack of continuous training and re-orientation on the job by some employers
* Lack of commitment on the part of Nurse Professionals
* Nurses seeing their Professional training as just the necessity for Registration and obtaining Licence.
* Nurses idea about improvisation Nurses and rural care and delegation of this care to untrained persons.
* Leadership problems/Brain drain issues
* Inter/Intra Professional rivalry among health Professionals.
* The Educational goal of the Nurse/lack of proper training and status egocentrism
* Financial problem in health institutions
* Poor information dissemination system such as (HIFA2015) which is Healthcare Information for All by 2015 and other Forums like (CHILD 2015) - Child Healthcare Information And Learning Discussion Group.

Summary And Conclusion

In order for Nurses to be seen as Science-Based Professionals, there is need to change the way the public view nurses. There are still large numbers of people out there who are completely clueless as to what nurses actually do and therefore, they view us as the 'hand-maids of the Medical Profession'. Education of the Public about the actual Roles and Duties of Nurses is vital to the transformation of the Profession. Once the public is made aware of the Education and Training that goes into becoming a Nurse, as well as seeing that Nurses don't simply wipe bottoms and run errands, then the situation might improve. It is equally important that our responsibilities are spelt out at every level of Nursing and assistance to both new and old members of staff which would be indicative of the growth, maturity and Professionalism. Respectful mentoring, support, clinical supervision and constructive criticism are the Hallmarks of Professionals.

Once again Ladies and Gentlemen, I wish to remind us that Good Health and Good Sense are two of life's greatest blessings and that Times have changed. This is a wake-up call for us to exhibit our Scientific and Professional attributes.

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NURSE SCIENTISTS UNION, A PROFESSIONAL NURSING ORGANISATION

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Introduction

The progress of nursing issues, practice, education, administration and research has been painfully slow, inefficient, ineffective and disappointing in Nigeria. The state of affairs of professional nursing services in progressing too slowly, while resolution of many issues relating to nursing and midwifery services are far below expectation.

Nurse Scientists have had to contend with myriads of hydra-headed problems which in many cases keep cycling in crisis and trauma. These are issues of serious concern demanding urgent and genuine commitment by every nurse scientist. Motivated by values, principles, ideas, professional norms and ethics we do hereby to provide a strong based forum for superior intellectual interaction, networking skills, dialogue, concept articulation and sophisticated inter-professional skills mix; co-operation and collaboration towards Refocusing, Redefining, Reviving, Reshaping, Redirecting and Revitalizing Nursing in Nigeria in particular and the world all over.

The NSU is a specialized body with restricted membership committed primarily to scientific professional nursing. It is a group of nurses genuinely interested in the course of scientific professional nursing service Provision. Directed at global nursing problems. It Directs the diverse and highly specialized scientific nursing to the benefiting customers of nursing cares. It provides information, advice and guidelines while bringing together nurse scientists in the international scientific nursing endeavor.

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The NSU provides the following benefits to members

* Meeting others in the nursing professions (Networking)
* Staying up-to-date with professional changes.
* Making connection leading to possible job or promotion opportunities
* Continue Educational Services
* Scholarships, grants, studies assistance.
* Legal/professional assistance

The union is composed of Persons with superior intellectual distinction and qualitative experience, who are vested with knowledge of meaningful actions that will uplift the scientific professional nursing service in all aspects of life to the consumers of nursing services in general and the professional nurse in particular"

Activities include:

* Capacity Development of members
* Regular Continuing Nursing Education Programs (CNES) and certification courses for all levels of nursing professionals
* Development of Post Graduate specialization programmes for members
* Researches Programmes, conferences and tutorials.
* Scholarships, Research Grants, Funds and Loans-Provision for professional nurses who are members for educational purpose at all levels, Nationally and internationally (researches in clinical, educational and Academic purpose).
* Provision of a forum of persons with superior intellectual distinction and qualitative experience that are not for the fulfillment of scientific fantasy, but for serious discussion, suggestions and implementation of meaning full actions that will redefine nursing professional practice.
* The Union motivate by values, ideas and professional norm, it focuses more on Refinement and Development of Nursing Professionals by provision of a strong intellectual base, and a forum for intellectual interaction,

The union also focuses on:

Provision of professional assessment of major nursing issues with a view towards:

* Identifying key actions necessary for moving nursing forward.
* Broadening areas of concentration in clinical nursing practice and research.
* Developing Strategies for Scientific nursing improvements
* Facilitating networking and promotion of co-operation both in the intra and inter nursing Professions and Associations.
* Fostering Collaboration and Co-operation among all nurse scientists individually and collectively.
* Promotion of Excellence in clinical nursing, education, administration and research practices.
* Shaping health care policies in particular nursing issues.
* Advancing the nursing profession by fostering high standards as well as ethical inculcation in nursing pratice

Membership:

The membership is composed of registered nurses and other persons of proven characters: A person may be registered as a member of the union under the following category:

* Fellow
* Full member
* Associate
* Graduates or
* Students

"Few will have the greatness to bend history itself, but each of us can work to change a small portion of events, and in the total of all those acts will be written the history of this generation-(of nurses).

The Union is Designed to meet specific professional goals common to all nurses with verify technical contents and evaluative of every members opinion which are most often empirically tested and accepted with full understanding of present and future trends.

We, being much familiar with past events and circumstances, must examine current and relevant issues facing all nurses today, with the context of the historical developments of organized nursing Unions as well searching into the practical, technical and professional nursing display, especially in issues of Similarity, Rapidity, technicality and responsibilities (moral legal, interprofessional, Educational, Clinical, legislates, and Controversies).

I admits being one of the nostalgic nurses who finds identity in remembering the accomplishment of the pioneers in nursing as well enjoy being an active participant in the turmoil of the present predicament of the noble profession. I am enthusiastically attuned to the contributions this particular conference will display in meeting the professional needs of nurses as well as the health care needs of all people who consume nursing services.

The burden of bringing about the desired change in nursing rest primarily with the nurse. For all to recognize that nurses are capable of making sound professional judgments, able to provide comprehensive health care which will lead to a better relationship, an interdependent, collaborative, or peer relationship, Self-Confidence and Competencies must also be demonstrated. Subservient roles must be a thing of the past.

Philosophical orientation which recognizes the practice of doctors and nurses as different, but equal is a necessity. There must be a sharing of power and the elimination of unilateral decision making by doctors. Nursing must be viewed as a team. The nursing team is therefore made up of all the individuals who are involved in the nursing care. The composition of this team varies according to available programms, patient census, type of unit, and affiliated nursing education programs. Each member of the team makes a unique contribution and plays an important part in the total health care team. Here it is necessary to keep in mind that the patient is the focal point of all team effort. This therefore necessitates cooperative planning, good communication and good interpersonal relationships which is sin-qua-non in the Union. The patient today is the Nigerian nurse and the team different nursing unions, Committees, associations, agencies etc.

The value of belonging to a group and the advantages of Cooperative endeavor has long been recognized by humanity. Much is achievable through group effort and unselfish cooperation. Much will be accomplished when we direct our efforts toward a common goal. The NSUN is conceived as the official spokesman of individual nurses at the local, state, national and international level. The union can be no better than the members which constitute it, therefore all nurses, should join and participate in one or the other way to facilitate the achievement of the conceived goals.

In like comparison, all professional nursing unions, committees, associations, agencies, parastatals and bodies must work as a team to better nursing with Nurses responsible for nursing practice, accountable to their patients with traditional nursing judgments as well as collaboration with other member of the health care professionals, in many cases nurses are performing tasks, usually associated with the practice of medicine which are not nursing responsibility as defined by the nurse practice acts. Those who do not understand the role of nurse professionals or who feel threatened by it, tend to emphasis legal restrictions of nursing practice or placement of that practice under the direct supervision of the associated professionals as well as illegal suppression.

Improving the abilities of the nursing organizations to respond to the multipurpose interests and needs of the members as well as responding to nurses representation in gaining authority for practice and for determination of employment conditions, they are necessary because of the following reasons:-

* Due to complexity of modern diagnostic and therapeutic procedures there is corresponding demand for nurses with specialized scientific skills and knowledge. Such expertise knowledge necessary to make sound judgments concerning nursing intervention in the care of Patients in clinical care areas of the hospital (coronary unit, intensive care units, haemodialysis units etc) is dependent on the nurse's awareness, enhanced by appropriate education.
* To positively affect the facilitation of healing, prevention of complication, promotion of health and prevention of recurrences and new illness totally depends on provision of continues quality nursing care which in turn directly and indirectly revolves around the knowledge base of the professional nurse practitioner.
* To create greater Clinical specialization with relative autonomy and freedom of movement which allows the development of roles as necessarily meeting her expertise of a clinical specialist which may vary considerably with the nature of case loads of Patients referred to him where the nurse is practicing nursing with new dimensions.

Priorities of the Union:-

* Participating and contributing to health planning at the local state, national, and international level

* Implementing a coherent manpower policy for nursing resources
* Evolving a coherent system of credentialing including accreditation of educational programs and service agencies, certification and co licensure
* Developing systems to ensure the professions accountability to practice. Delivery of services education, economic and general welfare of nurses.
* Expanding public relations endeavour within and without the profession; Improving relationships with local and international organizations, (professional, consumers and government.)
* Fostering organizational arrangements to protect rights of all members of the profession
* Unifying the professional nursing occupation.
* Providing the consultation and information system necessary to assist other nursing associations in collective bargaining Improving and maintaining information base about the profession.
* Studying and evaluating the economics of health care in Nigeria and the world over. and its impacts on nursing with the view of making positive inputs.
* Expanding knowledge base of professional nursing practice. Promoting a stable financial base on the conduct of research Organizing national conferences/conventions for exchange of ideas and information of interest to nurses (clinical conferences and research forums) for the promotion of professional growth.
* Searching of professional employee.
* Employment reference and verification of education.
* Reviewing, supporting or lobbying against legislation actions which affect member nurses.
* Emphasizing greater understanding of the Nurse Practice Acts.

The Nurses Practice Acts of Professional Nurses Includes

* The qualification to practice nursing
* The mechanics of licensure and registration
* The definition of misconduct and unlawful acts, disciplinary actions
* Agencies which shall administer the laws and
* The function of the body.

Who is a professional nurse?

A professional has control over the scope and exercise of duties. How many staff nurses have the power to order new equipment for their unit because the old one has broken down or are unsafe? How many nurses can take a personal day off without pretending to be sick? Does your salary match your professional responsibilities?

Believed in truth, we have not yet fulfilled our potentials as Professionals-Doctors have known for so long that "it is not in the financial interest of hospitals to volunteer to pay nurses more, or to hire more staff, nor to grant them seniority or time off, or any other privileges. Again what control do we have in selecting work hours, how is our ability to decide what" "safe" working condition" are, based on training and, is our compensation in line with our education and responsibility?

But if nurses unify themselves, set reasonable goals for a collectively bargained contract and are determined here I stand," they have the ability to exert financial and moral pressure thereby wining some changes, thus the union.

For Doctors to see us as valued colleagues, they must see and hear as well listen and interact with their equals which we have in nursing but who do not join hands in helping the profession. That there are professors in nursing profession, there are doctorate degree holders, masters degree holders, 'wonder how often in an organized body that these important professional colleagues of ours have spoken as a voice and in unison for moving the profession forward. I believe God on our side we will provide the forum for this and even more.

Whatever position we adopt in respect to above, it is clear that as professional nurses we should continually strive to enhance our contribution to the development of nursing practice and deliver excellent nursing care. In order to develop practice nurses require the skills that encompass both clinical, educational and research domains

On the theory-practice interface, and in addition to the individual nurses responsibility to develope-practice, the organization within which nurses work both clinical and educational, social and economical, have an important role to play in supporting the development of practice. They need to foster and environment which is conducive. The creation of such an environment involves institutional demonstration of commitments to nursing and not only the provision of educational opportunities (for example research workshops, scientific conference, seminars, study days mentorship, preceptor ship and clinical supervision) but also the capacity to allow for promotion and professional development innovatives

In addition to the individual and organizational activities to support professional practice development, the national and international area also have an important port to play. Does what we were taught in school of nursing relate to what we experienced in practice?

Let me state herein that this conference is an attempt for us all as professional nurses to critically examined the development of professional nursing practice in Nigeria vis-a-vis individually, institutionally/ nationally and internationally.

Generalizing our conception in relation to our theme, Nigerian nurse over the past decades has been confronted by multifaceted demographic, economic, political and social transformational problems. These have had significant impact on the patterns and dynamics of nursing practice. Increased service demands, little available resource, patient safely,

quality of care, governmental policies are all environmental confrontations on professional nursing practice. There is therefore a need to

i. Define existing local and national policies focused on professional nursing practice
ii. Establish the link for policy-markers between patient safety, quality of care and the professional nurse
iii. Collect all relevant fact sheets and position statements that exist at international level
iv. Encourage the mobilization of nurses and survey them to determine priority issues and action
v. Develop guidelines that address specific work condition
vi. Disseminate evidence on best practices and prepare communication plan on professionally centered issues
vii. Establish committees at the organizational level that focuses in professional nursing issues.
viii. Promote affective arguments for the purchase and maintenance of safe and positive professional practice environment. Particularly hostile working environment (in speech conduct-both severe and pervasive).

However, there is an important issue worthy of inclusion in this paper. It is control over professional practice Here determination of competencies should be by nurses with professional authority, responsibility and accountability in an atmosphere of participatory decision making at all levels regarding policies and work institutions/organization. Availability of appropriate resources, collaborative and cooperative decision making with adequate support in the absolute control of the practice of nursing.

Empirical facts and the experience of other nations has revealed some common factors and process, unique experience, peculiar circumstance including both comparative and competitive and advantages in professional nursing practice, in the final analysis, the motive force of successful professional nursing practice is the end result of complex interaction of many factors peculiar to each professional history, culture and successful factors much of which are basically endogenics. This truism is amply illustrated in the experience of America and Europe.

If we apply three classifications of professional development, of factor driven, efficiency driven and innovation driven profession to nursing, we may be able to dependably rely on some requirements such as:-

Functional institution, infrastructure, macro economic stability, health, and education as a yard stick in factor driven while

Higher education and training, service product efficiency, labour market efficiency, financial market availability/sophistication, technological applicability, and customer size in the efficiency driven professions and, Innovative and sophisticative concerns such as professional sophistication and innovations in the innovative professions. For assessment, these are the major pillars upon which we should asses the nursing professional practice. The three represents an evolutionary progression in complexity, productivity and prosperity of the evolving professions with innovative professionals being the mostly favoured.

Within the past decade, the nursing shortage has presented many faces: fewer persons are interested in nursing; few students are enrolled in schools of nursing. This can be viewed as "trouble in the pipeline"; and fewer nurses are employed by hospitals. Another component of the shortage is that nurses, especially hospital nurses, express dissatisfaction with their practices

This lack of satisfaction has several causes but similar outcomes: decreased retention, especially among specialty practice nurses: frequent turnover; early retirement; or departure from nursing. In some hospitals, a significant component specialty nurse workforce is outsourced. Active international recruiting has increased the number of foreign-born nurse in the workforce. In some countries Nurses over 50 year, of age have been lured back to work or encouraged to increase their participation in the workforce. Hospitals employ more agency nurses, foreign-born nurses, are not common in Nigeria. The changing composition of the complexity of the nursing workforce and the practicing nurses contribute to the complexity of the nursing shortage.

Looking at the nurse workforce, you might wonder why the profession is challenged by a shortage. There are approximately 2.8 million registered nurses in the United State; and 80% practice nursing. Ninety-five percent of these nurses are female; 12% come from minority backgrounds; 59% work in the hospitals; 32.3% have baccalaureate degrees, 7.3% have master degrees, and 0.6% hold doctorates. Most nurses have associate degrees (40%) and the majority of new graduates come from associate degrees programs (55.4%) the average age of the RN was estimated to be 45.2 years in the year 2000 Teachers with master's level preparation have a mean age of 48.8, while doctorally prepared teachers have a mean age of 53.3 (American Association of Colleges of Nursing [AACN], (2003). Do we have a similar records in Nigeria?

Nurse leaders face a myriad of challenges in the 21st century such as nursing workforce shortage, negative affectivity, generation workforce concerns, changing delivery systems, and increasing clinical practice complexity, to name but few. Visionary and strategic thinking centered on practitioners well being are needed to tackle these challenges and shape a more human and compassionate profession. Hostility within and without must be put to an end.

The professional nurses practice environment is hostile and provocative. Nursing representatives in most of the environment are not useful in defending the profession. Some even take side with others to victimize and frustrate fellow professionals. These are the real enemies of the profession, the satanic principalities and powers in high places and position talked about in the Bible.

The political social, economics, demographic

trends and technology are recalled to be exercising a deleterious influence on professional scientific practice of nursing. The turbulence and uncertainty of the external forces and the internal context which includes culture, ethnicity, tribalism health care settings and discriminatory roles and responsibilities all weigh on the professional nursing practice, leaving it with both positive and negative influences as well as affecting quality of the professional nurse's services.

Nursing is intellectual, emotional and social work. It is an organizational and social intervention. There is a lot talked about needs of Nigerians, and Hospital Institutions, yet there is little talked however about the "NURSE" that is giving the quality care. It is a pressing reality that nurses are little considered as professionals. There is an increase professional nursing challenges faced with even outright and great suppression condemnation by other health care team members. Financial constraints, low financially independent practice output, low self exteem arising from preparatory foundation, personal financial constraints that limits achievement potentials to strengthen personal infrastructures and achievement forces; lack of strong professionally concerned union, unhealthy work environments that weakens performance or alienates Nurse and which often drive them away from specific work settings or from the profession itself.

The nurse is first, a person with life experiences, human needs and a personal lifestyle and value system. She is also into helping persons. Applying skills and interacting with individuals as well as groups while developing relationships. He/She employ her knowledge base that provides understanding about self and situation; methods and values. Some nurses are practical others are sympathetic and friendly, others still are enthusiastic and insightful, some are logical and well organized; some nurses prefer to deal with technical facts and objects, others prefer to give practical help and service to people

Improvements, change and innovations are overtaking nursing and nurses, some changes are subtle and emerge slowly while others are obvious and seem to surface quickly. Some in conflict, some complementary to one another while others are uncomplimentary; some aspects will become prevailing trends while others may be modified by social or professional forces or disappear altogether.

The broadening focus of nursing practice, the increasing scientific bases, the increasing use of the technology, the drive for more education, greater collaboration between nurse and other members of the health care team, the push for greater autonomy in professional scientific nursing practice, the increasing awareness for the need of high touch skills, great participation by nurses in making of health policy and intensified collective bargaining requirements all combine to impact professional scientific nursing practice as well as the practitioners demanding a capable professional body "the union"

In Nigeria as in most every country, nurses provide majority of health services. They are committed professionals who embrace holistic philosophy of care. They need acknowledgements of their social professional functioning mandate with creativity and innovation being encouraged. The profession should certainly be more than a source of pure economic livelihood; it should as well be a source of personal satisfaction.

No nurse escapes the impact of change and flux in her professional unionism. However, she must influence its direction. She must be inextricably tied to the process of change and interacts as well with co-professionals. However we must employ our intelligence to act in our professional union in such a way that will bring about adjustments favorable to our own interests. Intelligent action is guided by anticipated consequences. Anticipated Consequences is a product of empirically developed and tested guidelines, systematically developed evidences, appropriate decisions making as well as joint responsibilities. Nurses in clinical settings, Educational Institutions, Administrative Citadels including regulating bodies, employers both Governmental, private and Non-government, must all be united in the NSUN to create a sustainable professionally scientific nursing care endeavor.

These has necessitated putting certain key elements in this union to directs its focus on: A comprehensive understanding is a product of a comprehensive knowledge base.

Conclusively, the professional disciplines of nursing now have a union that is unique, coherent and seamless as possible, a unified body for all nurses irrespective of additional academic acquirements or other professional associations. A body that is organized based on research, theoretically identified concepts, patterns and organized relationships. A union that will further enhanced the systematic knowledge generation from this conference with full connectedness to ongoing necessities in professional nursing practice. I am grateful to all of the members/intending members and every person here present who have contributed in oneway or the other to hosting this conference which may referred to as "the professional nursing retreat'.

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ACCESSIBILITY OF MATERNAL HEALTH SERVICES IN TWO COMMUNITIES WITHIN ENUGU STATE

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Abstract

The study investigated accessibility of maternal health services in two communities within Enugu state using survey design. A structured and unstructured questionnaire was used in collecting data from 620 women randomly sampled. The study was directed with five objectives and a hypothesis, tested at 0.05 level of significance. Frequencies, percentages and mean were used to calculate the objectives while one factor analysis of variance was used to test the hypothesis. Results show that antenatal services were found to be significantly dependent on distance and cost, but significantly independent of awareness, staff attitude and community perception. Therefore, in conclusion, utilization of maternal health services is dependent on residence and distance to the health facility. It was therefore recommended that health facilities with, delivery amenities, should be sited in the rural areas bearing in mind the centrality of the location.

Introduction

Background to the Study

Maternal mortality rates in Nigeria are among the highest in the world, ranging from 800 to over 1000 per 100,000 live births (WHO 2007; Zuzulya, 2011). Nigerian women run the risk of dying during pregnancy or childbirth, that is, 100 times greater than that faced by women in Western Europe (WHO 2007). However, data on the percentage of Nigerian women that use Maternal Health Services show that the high risk of dying and high mortality rates may be due partly, to low maternity care coverage. Sixty percent of Nigerian women received ante-natal care, 31% in a health facility and 31% have skilled attendant at delivery. In southern India, according to Dharmalingam (2002), in a study to assess the utilization of maternal health care services, result shows that utilization variations exists between the states. Data from the Nigerian Demographic and Health Survey (DHS) 1985-90 show that the national (urban) coverage of maternity care stood at ante-natal care 87%, deliveries in health facilities 58% and skilled attendant at delivery 59%,[5]. The national (rural) coverage by the same survey for the same period was 53% ante-natal care, 24% institutional deliveries and 23% skilled attendant at delivery. Much more local situations reveal that in the same period (1985-90), the picture of coverage of maternity care in South-eastern region was 72% ante-natal care, with 46% of the women delivering in a health facility and 46% having skilled attendant at delivery. Similarly, the coverage for Udi Local Government Area showed that for the period 1986-88, 68% of women received, ante-natal care and 38% had skilled attendant at delivery (WHO 2007 and Okafor, 1991). However, in a rural community study in the former Anambra State in 1989, it was found that 97% of women in Obukpa town received ante-natal care, 62% had their deliveries in health facilities and 62% were attended by skilled personnel at delivery (Nwakoby, 1992).

While the picture of coverage on the average is poor, a striking feature worthy of note is the fact that the proportion of women receiving ante-natal care is distinctly higher than the proportion that deliver in a health institution and/or receive care by skilled personnel at delivery. The implication is that most women, after receiving antennal care default from coming to a health facility to deliver their babies and as such fail to have a trained attendant at delivery. As found in a study in 1994, mortality estimate in Nigeria continue to be high, primarily because maternal health services especially in the rural areas are often deficient and inappropriate to women's situation(Okafor,1994).

Thus, utilization of certain maternal health services, such as effective ante-natal care, institutional delivery and skilled attendant at labor and delivery improve the fate and health status of pregnant women. Nevertheless, some factors have been found to have implications for use of maternal health services by women. Thus, the present study therefore seeks to look into the factors of access that may affect the use of maternal health services.

Statement of the Problem

Every year, more than 200 million women become pregnant (WHO 2008, Murray, 1997) with 15% of them likely to develop complications that will need skilled obstetric care to avoid death or serious ill-health. This is the extent of the risks associated with pregnancy which, though, has been seen as a normal physiological process. These risks are present in every society and in every setting (Nakajima, 1998). Every day, at least 1600 women die from complications of pregnancy and childbirth. In addition to these, 585,000 maternal deaths all recorded each year (WHO, 2008); and (WHO, 2005), a further 50 million women suffer acute complication (WHO, 2008, Murray, 1997). For 18 million of these women, the result is long-term disability (WHO 2008). Most of these mishaps occur during or soon after delivery. Similarly, every year 60 million deliveries take place with only a relative or an untrained birth attendant present (WHO,2008). Far too

many women give birth completely untended to (WHO, 2008) contributing to the risk women face. In developed countries, these risks have been largely overcome because every pregnant woman has access to special care during pregnancy and childbirth. However, such is not the case in many developing countries. The high level of maternal mortality and morbidity in developing countries have been attributed, partly to the non-availability of services and partly to poor utilization of services even when they are available (Nwakoby, 1994). Therefore, the present study seeks to determine the accessibility of maternal health services in two communities within Enugu state.

Objectives

- To ascertain whether distance influences utilization of maternal health services;
- To determine whether cost influence utilization of maternal health services;
- To determine whether the awareness of maternal health services influence utilization;
- To find out whether community perception of maternal health services influence utilization, and
- To find out whether staff attitude influence utilization of maternal health services.

Literature Review

Access is viewed as a multidimensional construct consisting of five key elements -geographical (physical), economic, administrative, cognitive and psycho-social accessibility (Eregie,1993). Accessibility is defined as the degree to which services and supplies may be obtained at a level of effort and cost that is both acceptable to and within the means of a large majority of the population (Bertrand 1995).

Geographical (physical) accessibility is the extent to which service delivery and supply points are located so that a large proportion of people can reach them with an acceptable level of effort. As the geographic density of clinics and other service sites increase, the trip for health service becomes shorter and quicker for most people and this affects the use of the services (Ross,1989). For instance, contraceptive prevalence was higher where services were closer, as measured by travel time and distance (Ross,1989). In Thailand, the mean travel time to the nearest family planning facility was short, (15minutes) and the mean distance was only 3kilometres. Contraceptive use was thus high, at 68%. In Zimbabwe, service were not as convenient. Median travel time was 31 minutes and the median distance was 5kilomtres. Prevalence was 45%. In Uganda, most people have little access. The average person lives 60minutes and 19kilometres from the nearest family planning Facility. Contraceptive use was 5%. In Uganda, a study nevertheless involving a total of 149 women between the ages of 14 and 38 years with a mean age of 23years was conducted to analyses reasons for use or non-use of ante-natal care services and malaria treatment among pregnant women living in rural areas. The findings showed among other things that few pregnant women (9%) mentioned long distance to the service place as one of the factors that hinder their use of formal ante-natal services (Ndyomugyenyi, 1998). Cost is another access factor that can affect the use of services. The extent to which the cost of reaching service delivery (or supply points) are within the economic means of a large majority of the target population is referred to as economic accessibility. Cost of the services being delivered was one of the reasons for non-attendance at formal ante-natal clinic among Ugandan women resident in women areas (Ndyomugyenyi, 1998). These women compared the fees charged at the formal health delivery system with that charged by the traditional birth attendants and thought that the fee at the Formal health delivery system was too high. Although most women in that study indicated that they attend ante-natal clinic (54%), most mothers did not utilize the system for delivery due to perceived high fees. They commented that at delivery, a mother is required to bring with her a pair of gloves, cotton wool, a polythene sheet to cover the delivery bed and a vial of ergometrine. They, therefore, opted to visit the trained or untrained traditional birth attendants or deliver at their homes assisted by neighbours. They however suggested that improvement in the delivery of antenatal services in the area could be achieved if antenatal care fee was abolished or reduced. A similar observation of perceived high cost of antenatal care services as a hindrance to attendance was made among unmarried pregnant girls in Nigeria (Okonofua,1992).

Cognitive accessibility refers to the extent to which potential clients are aware of the locations of services or supply points and of the services available at these locations. Awareness about availability and importance of healthcare services have been implicated in many studies on utilization of health services (Ndyomugyenyi, 1998, Okonofua,1992 & Islam and Nielsen, 1993). Lack of awareness about the importance of ante-natal care was among the factors shown to hinder the utilization of the formal health system delivery and ante-natal care among rural Ugandan women (Ndyomugyenyi,1998). Similarly, an analysis of two Bolivian Demographic and Health Surveys revealed that increase in contraceptive knowledge among Bolivian women was accompanied by an even greater increase in method use. The proportion of women in union who were then using a method increased by 50% in the five years between the two surveys from 30% in 1989 to 45% in 1994.

Psychosocial accessibility implies the extent to which potential clients are constrained by psychological, attitudinal or social factors in seeking health care Services. In a Ugandan study (Ndyomugyenyi, 1998), the "Alurs" do not usually attend ante-natal clinic nor deliver in the health unit because they get embarrassed in front of other community members who would think that they were not brave enough to deliver on their own without the assistance of a midwife. Another factor included sell-confidence among women who had delivered several times in the villages. Similarly, a Bolivian Non-Governmental Organization working with Quechua-

speaking populations reported widespread concern among rural women concerning the use of family planning (Terbourgh, Rosen,Galvez, Terceros, Bertrand, Bull 1995). In the report, Bolivian women indicated that they will be criticized and ostracized when neighbors realize that they are not getting pregnant with the accustomed regularity. In the same vein, in Ecuador, the Medical Centre for counseling and family planning found that to shield themselves from negative comments, many women in indigenous communities preferred to receive contraceptives from the non-indigenous supervisors (who made sporadic visits to the community) rather than from the volunteer distributors (who lived in the same town) (Terbourgh, Rosen,Galvez, Terceros, Bertrand, Bull 1995).

Administrative accessibility means the extent to which unnecessary rules and regulations that inhibit choice and use of health services are eliminated. Examples of administrative access type include restricted clinic hours, process or scheduling hurdles (official Protocols) and staff attitude. In this study, administrative access will be defined as staff attitude. Care providers who do not treat clients with respect or are judgmental, for instance, are likely to discourage people from seeking health care. Thus, the attitudes of health workers towards their clients are very important. Respecting clients' sensibilities means treating them with courtesy and consideration. In the study carried out in Bangladeshamong mothers, it was revealed that under-utilization of maternal and child health clinics was mostly due to misbehavior of staff, and partly because the clinics open only during the busy hours of family work. A study of the quality of maternal and neonatal health services in Yemen, as seen through women's eyes was carried out by Radda Barnen, Swedish Save the Children, which supports a number of maternal and child health clinics in Yemen (WHO, 1996). Interviews were conducted with 250 mothers in five of the 11 districts where Radda Barnen has programmes. The interviews revealed that social, cultural and emotional factors have a strong influence on whether women seek professional assistance with pregnancy and delivery. The midwives did not receive most rural women and health personnel in a way that made them feel equal and welcome. Many women in this study preferred to give birth at home because they like the friendship and support of female relatives and neighbours. Rural women, in particular often feel that health care facilities are un-welcoming and that staff treats them with little respect (WHO, 2006).

In testing the third hypothesis, access was measured against utilization of the three maternal health services with the sub-elements of distance, awareness, and cost. Community perception and health staff attitude using one- factor analysis of variance. Respondents rated the influence of the access types on utilization of services on a 5- point Likert scale. The respondents' mean ratings of the influence of the access types against the use of the three services were tested.

Methods And Materials

Introduction: Method and material section of this study discusses the research design, the study areas, population of the study, sample and sample size determination and sampling procedure. Instruments used for the study, the validation of the instrument, methods of data collection and analysis are also discussed.

Research Design: The cross sectional survey design was used for the study. This was an examination of how the existing maternal health services are used by women of childbearing age (15-49 years).

Study Areas: Enugu North Local Government Area and Obinagu, a rural community in Enugu state.

Population of the Study: The population of the study consisted of all married women of childbearing age (15-49 years) who had at least one live birth in the last three years in Enugu North Local Government Area and Obinagu, Udi Local Government Area.

Sample and Sample Size Determination The sample composed of 648 women of childbearing age (15-49 years). Out of this number, 50% (324) was from urban (Enugu North Local Government Area) and 50% (324) from rural (Obinagu Udi Local Government Area).

This sample size was determined using the WHO's national estimate or the proportion of women that receive ante-natal care which is 60% giving approximation of 364 person but 648 persons were involved.

Sampling Procedure Multistage sampling technique was used for the study. For the urban sample, Enugu North Local Government Area was stratified into high, medium and low density residential areas. From each residential area, 108 respondents were involved. To do this, 18 streets were picked from each residential area. From the selected streets, 6 houses per street were chosen. One married woman of' childbearing age (who had given birth in the past three years) from each house participated in the study. In a situation where more than one woman qualifies for the study in each house, balloting was done to pick one out of the lot. Thus, the actual selection of subjects from each house was at random.

For the rural area, the existing three villages in Obinagu were used as strata. From each stratum, 27 compounds were picked at random. Then, from each of the selected compounds, four women of childbearing age who had given birth in the last three years participated in the study.

Instruments for Data Collection: The data used for this study were mainly from primary sources using questionnaire and interview schedule. The two instruments contained open and closed - ended questions.

Validation of Instrument: The validity of the instrument was established by examining the questionnaire critically for content relevance and clarity of statement. As such, three experts were requested to rate the content relevance of the items and the entire instrument using a four point ordinal rating scale.

Method of Data Collection: Permission was obtained to carry out the study in the two localities. To ensure the cooperation of the selected respondents, clarification as regards the purpose of the study was given clearly from the onset, at the beginning of the questionnaire. Three research assistants were involved in the distribution and collection of questionnaire, and

interview of the illiterate respondents using the questionnaire as a guide.

Method of Data Analysis: Data collected were presented with frequency distribution tables and analyzed in percentages to answer the research questions. For the formulated hypothesis, inferential statistics were applied to test for their significance at 0.05 levels. In testing the hypothesis, access was measured against utilization of the three maternal health services with the sub-elements of distance, awareness, and cost. Community perception and health staff attitude using one- factor analysis of variance. Respondents rated the influence of the access types on utilization of services on a 5- point Likert scale. The respondents' mean ratings of the influence of the access types against the use of the three services were tested.

Results:

Table 1: Number and Percentage of Women Reporting on whether Access to Maternal Health Services Influences Utilization of Such Services. N =620

Access Type		Influence On Utilisation Of Services				
	Yes		Undecided		No	
Antenatal Care	**N**	**%**	**N**	**N %**	**N**	**%**
Distance	382	61.6	46	7.4	192	30.9
Awareness	387	62.5	54	8.7	179	28.8
Cost	380	61.2	52	8.4	188	30.4
Community perception	337	54.4	63	10.2	220	35.4
Staff Attitude	356	57.4	37	6.0	226	36.5
Institutional Delivery						
Distance	364	58.7	30	4.8	226	36.5
Awareness	374	60.3	59	9.5	187	30.2
Cost	374	60.3	50	8.1	196	31.6
Community Perception	385	62.1	52	8.4	183	29.5
Staff Attitude	378	60.8	39	6.3	204	32.9
Skilled Attendant At Delivery						
Distance	382	61.5	39	6.3	199	32.2
Awareness	369	59.5	46	7.4	205	33.1
Cost	400	64.5	59	9.5	161	26.0
Community Perception	367	59.2	45	7.3	208	33.5
Staff Attitude	359	57.9	55	8.9	206	33.2

The data in the Table 1 above reveals that the greatest majority of the women were of the opinion that access to maternal health services affects utilization of the services (ranging from 54.4% - 64.5%). Less than half of the women (35.5% - 45.6%) do not think access affect utilization of services. Of this proportion, 4.8% - 10.2% were of no opinion while 25%-36.5% clearly disagreed that any of the access types affects utilization of services.

On the utilization of antenatal services, awareness of availability of the services was shown to be a major factor that determines use by majority of the women (62.5%). followed closely by distance and cost (6 1.6%, vs. 6 1.2% respectively). Services staff attitude and community perception about the service also determined use of services as indicated by 57.4% and 54.4% of the women respectively.

On whether the women go to health institutions to deliver their babies, majority of the women (62.1%) said that community perception was the most important factor that influenced access. This was followed by the attitude of staff providing the services (60.8%). The proportion of women that indicated that awareness of availability of services and cost of the services affect institutional delivery was 60.3% each. Distance was shown by a lesser proportion of the women (58.7%) as a factor that determines whether a woman delivers in a hospital or health centre.

Cost has been shown to be the most important factor that determines whether a woman seeks the services of skilled personnel during delivery. The majority of the women (644%) supported this fact, distance to the health facility where skilled personnel provides care was indicated by 61.5% as a determinant. This was closely followed by awareness of availability of institution with skilled personnel and community perception. (59.5% vs. 59.2% respectively). Staff attitude ranked the least as indicated by 57.9% of the women.

Hypothesis Testing: Utilization of maternal health services is significantly independent of accessibility of the services.

To analyze this hypothesis, one-way analysis of variance (ANOVA) was used as shown below.

Table : ANOVA Result for rating of Influence of Access Types on Utilization of Maternal Health Services

Access Type	Source	DF	Sum of Squares	Mean Squares	F-Ratio	F-Probs.
ANTENATAL						
Distance	Between Groups	1	7.0976	7.0976	4.7436	0.0298
	Within Groups	618	924.6766	1.496		
	TOTAL	619	931.7742			
Awareness	Between Groups	1	0.6896	0.6896	.4381	0.5083
	Within Groups	618	969.6292	1.5741		
	TOTAL	619	970.3188			
Cost	Between Groups	1	7.0120	7.0120	4.5258	0.0338
	Within Groups	618	954.3860	1.5493		
	TOTAL	619	961.3981			
Community Perception	Between Groups	1	0.5407	0.5407	.3189	0.5725
	Within Groups	618	1046.2088	1.6956		
	TOTAL	619	1046.7496			
Staff Attitude	Between Groups	1	3.9101	3.9101	2.8023	0.0946
	Within Groups	618	862.3141	1.3953		
	TOTAL	619	866.2242			
Institutional Delivery						
Distance	Between Groups	1	0.6113	6113	0.4733	0.4917
	Within Groups	618	798.2596	1.2917		
	TOTAL	619	798.8710			
Awareness	Between Groups	1	1.0115	1.0115	0.6211	0.4309
	Within Groups	618	1004.8076	1.6285		
	TOTAL	619	1005.8191			
Cost	Between Groups	1	1.0398	1.0398	0.7070	0.4008
	Within Groups	618	908.8957	1.4707		
	TOTAL	619	909.9355			
Community Perception	Between Groups	1	1.9832	1.9832	1.3069	0.2534
	Within Groups	618	937.8410	1.5175		
	TOTAL	619	939.8242			
Staff Attitude	Between Groups	1	3.9917	3.9917	2.8680	0.0909
	Within Groups	618	857.3416	1.3918		
	TOTAL	619	861.3333			
SKILLED ATTENDANT						
Distance	Between Groups	1	0.0370	0.0370	0.0267	0.8702
	Within Groups	618	855.3426	1.3863		
	TOTAL	619	855.3796			
Awareness	Between Groups	1	0.2928	0.2928	0.1909	0.6623
	Within Groups	618	946.3696	1.5338		
	TOTAL	619	946.6624			
Cost	Between Groups	1	0.1253	0.1253	0.0780	0.7801
	Within Groups	618	992.8682	1.6066		
	TOTAL	619	992.9935			
Community Perception	Between Groups	1	0.4918	0.4918	0.3337	0.5637
	Within Groups	618	910.9453	1.4740		
	TOTAL	619	992.9935			
Staff Attitude	Between Groups	1	0.4365	0.4365	0.2742	0.6007
	Within Groups	618	977.5748	1.5921		
	TOTAL	619	978.0114			

This ANOVA table shows that utilization of antenatal services was found to be significantly dependent on distance and cost ($p < 0.05$) but significantly independent of awareness, community perception and staff attitude ($p > 0.05$). However, institutional delivery and skilled attendant services were shown to be significantly independent ($p > 0.05$) of any of the access type (distance, awareness, cost, community perception and staff attitude).

Access and Utilization of Services

Utilization of antenatal services was found to be dependent on distance.

This disagrees with the finding of a study carried out in Uganda ", where few women (9%) mentioned long distance to the service sites as one of the factors that hindred their use of formal antenatal services. However, use of institutional delivery and skilled attendant services were found not to be dependent on distance. These findings agree with the studies carried out in Thailand and Zimbabwe (Ross, Rich, & Molzan, 1989), where it was found that contraceptive prevalence was higher where services were closer. The difference observed in the findings on utilization of antenatal services may be attributed to ignorance about the importance of antenatal care among the women in the present study or to a laisely faire attitude towards antenatal care. Lack of awareness about the importance of antenatal care was among the factors shown to hinder the utilization of formal health system for delivery and antenatal care among rural Uganda women (Ndyomugyenyi, Neema, and Magnussen, 1998).

The use of the three maternal health services was found to be significantly independent of awareness about the services. These findings are not in line with the findings of studies done in Ugandan and Bolivia (Remez, 1995). In the Ugandan study, lack of awareness about the importance of antenatal care hindered utilization of delivery and antenatal services while in the Bolivian study, increase in contraceptive knowledge was accompanied by an even greater increase in method use. The observed difference may be due to increasing level of knowledge about the importance of health care especially during pregnancy and delivery. Secondly, the difference may be attributed to the fact that the studies were conducted at different times.

Antenatal, institutional delivery and skilled attendant services utilization were shown to the significantly independent of cost of the services. These findings were at variance with the findings in Uganda (Ndyomugyenyi, Neema, and Magnussen, 1998) and Nigeria (Okonofua, Feyiseteam, Davis-adetugbo and Sanusi, 1992). In the Uganda study, one of the reasons for non-attendance at formal antenatal clinic by the women studied was high cost of services. These women compared the fees charged by the traditional birth attendants and thought that the fees at the formal instruction with delivery system were too high. A similar observation of perceived high cost antenatal care services as a hindrance to attendance was found among unmarried pregnant girls in Nigeria. The difference in the findings may be due to location of the study and probably, marital status (Okonofua, Feyiseteam, Davis-Adetugbo and Sanusi,1992) of the respondents. The Ugandan study involved only rural women who as reported preferred to visit trained or trained traditional birth attendants to deliver at their homes assisted by neighbors. On the other hand, the Nigeria study involved single, unmarried girls who may be entirely dependent on self for sustenance.

Utilization of maternal health services was shown to be independent of community perception. This finding disagrees with the findings of other studies conducted in Ugandan Bolivia and Ecuador. In the Uganda study, the "Alurs" do not usually attend antenatal clinic nor deliver in the health unit because they get embarrassed in front of other community members who would think that they were not brave enough to deliver on their own without the assistance of a midwife. In Bolivia and Ecuador, community perception affected the use of Family planning services. The variance in the findings of the study may be attributed to the location of the study. The Ugandan study was among rural women who could easily be influenced by the feeling of lack of self-confidence or perception by neighbors about inability to deliver at home. The studies in Bolivia and Ecuador were on utilization of family planning services. As reported in these studies, the women studied feared being criticized and ostracized for practicing Family planning. This is not surprising as culture plays an important role in health-seeking behavior of a people.

Utilization of antenatal institutional delivery and skilled attendant services were found to be independent of staff' attitude ($p>0.05$). These findings are at variance with the results of studies carried out in Bangladesh and Yemen (WHO, 2006). In these studies, it was reported that under utilization of maternal and child health services was mostly due to misbehavior of the staff. Many women in Yemen study gave birth at home because they liked the friendship and support of female relatives and neighbors. The difference observed may be due to time gap. The Bangladesh and Yemen studies were conducted in the 1990s while the present study was carried out in the year 2000. It was also being attributed to be location of the study. The Yemen study in particular involved rural women only who often feel that health Facilities are unwelcoming and that staff treat them with little respect (WHO, 1996). This study involved both urban and rural women.

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"FATIGUE AS THE SIXTH VITAL SIGNS:"

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Abstract

Despite the high prevalence of chronic fatigue syndrome and its documented negative effects on patient's quality of life, limited evidence is available to support interventions to prevent or treat chronic fatigue syndrome. Therefore fatigue being approved as the sixth vital signs has both pharmacologic and non pharmacologic interventions that have been tested, with aerobic exercise programmes and adequate nutrition demonstrates greater effectiveness. This paper discusses the gap in knowledge and make recommendations for interventions for fatigue as the sixth vital signs after having analyzed its implications for nursing care.

Introduction

In the nursing/medical practice vital signs are regarded as very important health indicator. (Smeltzer, Bare, Hinkle and Cheever 2008). The health professionals morally carry out routine checks in vital signs to ascertain the true health of the patients. It is a baseline indicator of the patients' health condition. If it deviates from the normal then assistance is called for. Vital signs are the essential part of patient's presentation during the routine health meetings of health professionals. It is the first question that will be asked "what was his /her vital sign? The vital signs include: Body temperature, pulse, respiration and Blood pressure.

In 1999 due to palliative care services pain was endorsed as the fifth vital signs and fatigue was the sixth.(Doyle and Benson 2001)
. The concept of naming fatigue as the sixth vital signs has gained much support and has been published in many journals. At the 2009 board meeting in Vienna, members unanimously endorsed the concept that fatigue be named the sixth vital sign in Oncology (Butz. 2009).

This raises awareness as an essential component of the patient experience and will act as a call to action for health providers and health care system as a whole.

Naming fatigue as the sixth vital sign is a major breakthrough in the move towards a more holistic understanding of the experiences of cancer.
According to Hornsby (2005) fatigue is defined as feeling of being extremely tired. It is normal for all patients and their love ones to experience feeling of fatigue in the hospital setting due to cancer. However like pain, the fact that fatigue is normal, does not mean that nothing can be done to reduce its symptoms. The unfortunate aspect of this fatigue is that it is not only present in chronic disease conditions but also with their pharmacologic treatments and some acute conditions too.

Objective Of The Presentation

At the end of this presentation, the following will be addressed:

1. The concept of fatigue
2. Types of fatigue
3. Causes of fatigue
4. Signs and symptoms of fatigue
5. Management of fatigue and
6. Implication to the nursing care.

The Concept Of Fatigue

Fatigue can be described as a state of affliction varying from a general state of lethargy to a specified work induced burning sensation within ones muscles (Griggs,Aminoff Jozefowicz 2007).

Hornsby (2005) defines fatigue as a feeling of being extremely tired, usually because of hard work or exercise which can be mental or physical fatigue. Fatigue is also described by this author as loose clothes worn by solders especially when they want to do punishment. Fatigue can also be described as exhaustion, lethargy, languidness, lassitude and listlessness (Butz 2009).

It can be both mental and physical, physical fatigue is inability to continue functioning at the level of one's normal abilities. It is ubiquitous in everyday life particularly noticeable during somnolence (sleepiness) (Griggs, Anmioff and Jozefowicz 2007).

Fatigue can be normal and important response to physical exertion, emotional stress, boredom or lack of sleep. However it can be non-specific sign of more psychological or physical disorder. When fatigue is not relieved by sleep good nutrition or low stress environment here, it is common symptom and is usually due to a disease. (Gonzalec 2010).

Fatigue And Cancer

Fatigue is one of the most common symptoms in patients with advanced cancers. Despite its high prevalence it is often unrecognized and undetected. Cancer related fatigue differs from fatigue experienced by healthy people, this is because this type of fatigue is unrelieved by rest or sleep. The national comprehensive cancer network defines cancer related fatigue as persistent, subjective sense of tiredness related to cancer or cancer treatment that interferes with usual functioning (Barrios' 2005) .

Fatigue And Chemotherapy And Radiation

Although fatigue is prevalence during cancer diagnosis but it increases its intensity during chemotherapy and drugs and radiation. Fatigues go hand in hand with pain in cancer.

Cancer related fatigue is distressing to patients as it interferes with their ability to remain functionally independent and active. Fatigues negatively affect enjoyments and quality of life. Even cancer survivors experience fatigue while taking chemotherapy. Fatigues prevent them from experiencing normal life and cause them to alter their daily routine. Fatigue is one of the most side effects that affect them more than nausea, hair loss and pain during therapy (Temel, pirl, Recklitis and cashavelly 2010) .

Cancer Related Fatigue And Clinical Nursing Practice

Despite the prevalence of fatigue and its impact on patients, cancer related fatigue and chronic fatigue

of other chronic and acute conditions are always over looked in clinical practice; instead more energy is spent on the discussion and implementation of anti-cancer therapy with patients. This then act as a barrier to effective communication about fatigue. The cancer patients or other chronic or acute condition patients often withdraw from communicating symptoms of fatigue to their clinicians.

The steps toward improving management of cancer related fatigue and other chronic or acute fatigue are to recommend screening of patients at regular intervals for fatigue as part of vital signs. The recommended screenings should start from questions such as: how would you rate your worst fatigue on a scale O to 10? Scores on the scale are given categorical considerations such as: no fatigue= O, mild fatigue= 1 3, moderate fatigue= 4 6, and severe fatigue= 7-10. Scores of seven or greater fatigue during the past 24 hours shows the worst level of fatigue and this may be associated with greater interference in therapy and increased symptom of fatigue and decreased quality of life which finally emanates in poor functioning within the period (Kelso, scott 2006).

Types Of Fatigue

Fatigue can be described as a range of afflictions varying from general state of lethargy to a specific work induced burning sensation within one's muscle. It can be both physical and mental. Physical fatigue is the inability to continue functioning at the level of ones normal abilities. It is ubiquitous to everyday life. (Hawley 2008) But usually noticeable during exercise, mental fatigue on the other hand rather manifest itself in somnolence (sleepiness).

Physical Fatigue

This is mostly muscle weakness, physical fatigue or muscle weakness or "lack of strength" is a direct term for the inability to exert force with ones muscle to the degree that would be expected, given the individual general fitness.

Diagnosis Of Physical Fatigue

A test of strength is often used during a diagnosis of a muscular disorder before the aetiology can be identified. Such aetiology depends on the types of muscle weakness, which can be true or perceived as well as central or peripheral. True weakness is substantial while perceived rather is a sensation of having to put more effort to do the same task. On the other hand, central muscle weakness is as overall exhaustion of the whole body while peripheral weakness is the exhaustion of individual muscles

Physical Causes Of Fatigue

Fatigue can be normal and important response to physical exertion, emotional stress, boredom or lack of sleep. However it can be non specific sign of a more serious psychological physical disorder. When fatigue is not relieved by enough sleep, good nutrition or a low stress environment, it should be evaluated by the health professionals (Edelman 2006). Fatigue is a common symptom, and is usually due to a serious disease.

There are many possible physical or psychological causes of fatigue. Some of the more common ones are:

* An allergy that leads to hay fever or asthma.
* Anemia which includes iron deficiency anemia.
* Depression or grief.
* Persistent pain.
* Sleep disorders such as ongoing insomnia, obstructive sleep apnoea.
* Under active or overactive thyroid gland.

Mental Fatigue

This is mostly somnolence, in addition to physical fatigue; not necessarily including any muscle weakness such a mental fatigue can manifest itself both as somnolence (decreased weakness) or first general decrease in attention not necessarily including sleepiness it may be described as a decrease in attention. At times an individual may feel like sleeping but when lying drown the person cannot really sleep in any case, decrease in attention may be dangerous when performing a task such as driving which require constant concentration such as driving a vehicle .Such a person may experience micro sleeps while driving.

Diagnosis

Cognitive testing is necessary to rule out micro cognitive deficit of brain disease from those attributable to tiredness. Certain medications also cause fatigue which include anti-histamines, blood pressure medications, sleeping pills, steroid and diuretics

* Some poisoning also cause fatigue.
* Some vitamin or mineral deficiencies.
* Some problems at place of work or at home might cause fatigue.

Fatigue Also Has Physical Causes

Chronic tiredness can become a vicious cycle, if a person feels tired he may avoid most forms of physical activities. He then becomes physically unfit but will be more tired when trying to do something physical. If your body weight is too high or too low for your height, you may feel tired because of this (kelson 2007). An overweight person's body has to work harder to do everything. Compared to persons whose body weights are normal? A person who has less body weight might have less muscle strength and will become tired more easily.

Use of alcohol or drugs such as cocaine or narcotics on regular basis.

Fatigue can also accompany the following sicknesses.

* Addison diseases.
* Anorexia or any other eating disorders.
* Arthritis, including rheumatoid arthritis.
* Autoimmune diseases such as lupus erythematosus.
* Cancer
* Fibromyalgia
* Infection, especially one that takes a long time to recover
* Parasitic infections
* HIV/AIDS and tuberculosis.
* Kidney diseases
* Liver disease
* Malnutrition
* Sickle cell disease
* And any other chronic ailments.

Fatigue May Have Emotional Or Mental Causes

Some stress can be invigorating. Infact many of us need some kind of mental pressure to get going. However when stress level are so high they commonly trigger fatigue.

* Stress and worry are two emotions that most frequently cause tiredness.
* Some people when they do not have control over a situation they feel frustrated, irritable and tired.
* Depression can also lead to fatigue
* Fatigue can also occur as a result of depression itself and can be that the patient is not sleeping properly.

Lifestyle Also Can Cause Fatigue

Nurses, firefighters, doctors, police and all other shift duty workers may have an irregular sleep pattern which culminates in fatigue.

Also caffeinated drinks consume close to bed time can reduce sleep and bring about fatigue.

Sedatives also worsen fatigue. Divorce can also cause fatigue.

Symptoms Of Fatigue

People who experience fatigue say:

* They feel discomfort.
* They feel unwell, they feel sleepy
* They have lost motivation
* Their concentration is poor; they find it hard to take decisions.
* They find daily task difficult to carry out.
* They feel depressed
* They have ongoing, unexplained weakness or fatigue especially when accompanied with fever or unintentional weight loss.
* They feel confused or dizzy
* They have blurred vision.
* They have little or no urine or recent weight gain.
* They have constipation dry skin, weight gain or intolerance to cold.
* They wake up and fall back to sleep multiple times throughout the night.
* They have insomnia
* They are sad or sometimes their emotion swings from sadness to joy and vice versa.

Assessment

The nurse must perform a complete physical examination, paying special attention to lymph nodes, heart, thyroid and nervous system. According to Gonzalec (2010), he says that nurses should ask the patient about medical history, symptoms and lifestyle, habits and feelings.

To make accurate assessment, the nurse must distinguish between acute fatigue which occurs after an energy demanding experience and chronic fatigue which is often overwhelming, excessive and not responding to rest.

Acute fatigue serves as a protective function where as chronic fatigue does not. The nurse assesses feelings of weariness, weakness, lack of energy, inability to carry out necessary and valued daily functions lack of motivation and inability to concentrate.

The patient may become less verbal and pale with relaxed facial musculature. The nurse assess physiologic and psychological stressors that can contribute to fatigue, including pain, nausea, dyspnoea, constipation, fear, anxiety (Smeltzer, Bare, Hinkle and Cheever 2008).

The following questions can be asked by the nurse:

* How long have you had fatigue?
* Did it develop recently or a while ago?
* Do you have fatigue at all?
* It so does it tend to occur at regular interval?
* How many hours do you sleep in the night?
* Do you have problem falling asleep?
* Do you wake up in the night at all?
* Do you wake up in the morning and still feel like sleeping again?
* Do you snore or do someone who sleeps nearby told you that you snored in the night?
* Has any body told you that you stopped breathing intermittently while sleeping at night?
* Do you feel tired throughout the day?
* Does it tend to get worst as the day goes on or stay about the same?
* Do you feel bored, stressed or unhappy or disappointed
* How are your relationships
* Has any one in your life recently passed away
* Have you had more activities (mental or physical) lately?
* What is your diet like?
* Do you get regular exercise?
* Do you have any symptom like pain, headache or nausea
* Have you any recent change in appetite (up or down) or weight (up or down).
* Do you take any prescribed or non prescribed medications, which one?

Laboratory Investigations

Laboratory investigations that should be carried out include:

* Blood test to check anaemia, diabetes and possible infection
* Thyroid, kidney and liver function test
* Urinalysis

Management

Encourage client/patient to get decent sleep. The sleep pattern should be a regular one. This means that the patient should get to bed and get up at regular times daily.

* The bed room should neither be too hot or too cold.
* Encourage not to eat too close to bed time
* The clients should make sure he/she relaxes his/her thought and activities ones bed time draws near.
* Listen to soothing music, have warmth bath and catch calm movie
* Do everything possible to remove worries whatever you want to maintain thinking about, write it down in a jotter.
* Encourage him to eat and drink in a way that helps him to sleep better.
* There is need for adequate balanced diet consumption. People who take well

balanced/adequate diet tend to sleep better than those who do not.

* If one is too thin then he/she should eat more.

Crash diet can make you have sleeping problems.

* Do not consume alcohol or caffeine
* Encourage patient to be more physically active.
* Remember that people who are unfit feel tired more easily meaning that they do not exercise enough, make sure your physical activities increase gradually.
* Studies shows that those who exercise regularly have adequate sleep than those who do not (Griggs 2007).
* Changing your lifestyle behaviours necessary to have adequate sleep
* Where there is chronic tiredness, underlying problem should be solved. If patient has any disease condition this should be treated to enable the patient be free.
* Do not take or change medication without the knowledge of a health professional.

Implication Of Fatigue To Nursing Profession

According to Piper et al (2008) who says that fatigue must be considered within the context of the patient daily lives and environment, disease process, and treatment modalities and that nurses must listen carefully to patients own descriptions of being tired and respond positively otherwise it may spell doom for the patient.

Also Piper et al (2008) in his study acknowledged accurate measurement and assessment as being essential to advance not only the science of fatigue but most importantly to evaluate the efficacy of intervention strategies on patient and family outcomes.

Berger (2008) opined that nurses should be instructed to monitor the intensity of fatigue level and encourage them to maintain activity levels balanced with efficient rest periods and diet.

Mock, Dow, Meares and Dienaman (2007) says that nurse prescribed and monitored therapy and exercise are effective, convenient and low cost self care activity that reduces symptoms and facilitates adaptation for fatigue treatment.

Chang, Cheng, Lin, Gau and Chao (2011) say that exercise during chronic illness does not cost patient extra time and is effective in reducing fatigue and increasing physical activity potential as demonstrated by the nurse.

According to Sonya et al (2011), says another implication is that it is the nurse that integrates the patient and the entire family needed for optimal care of each patient that has fatigue and so restricted hours that were thought to promote rest and healing were never substantiated with empirical data. More recent study supports the trend toward family visits being beneficial to patients who are critically ill and with fatigue.

Nurses play a key role in providing patient education and support tailoring education programmes may better target needs and improve the quality of fatigue care.

Summary And Conclusion

Fatigue as the sixth vital signs deserve routine checks just like any other vital signs. This is in order to ascertain the diagnosis and appropriate treatment. Fatigues have types such as physical and mental fatigue and can be treated physically, psychologically, cognitively and pharmacologically. The causes are enormous and fatigue can be harmful and fatal and so there is need for change in lifestyle and adequate management.

Recommendation

For a quality nursing care: Nurses must accept fatigue as the sixth vital signs and treat it accordingly:

* Nurses must asses all disease conditions and sort out fatigue and treat with other conditions.
* Nurses must educate the public on the importance of living a healthy life thereby refraining from smoking and alcoholism which is one sure cause of fatigue.
* Nurses should encourage patients to come to the hospital during the early period when the disease starts newly so as to prevent chronic fatigue syndrome.
* They should encourage early treatment of diseases so that healing can be achieved.
* Health workers should know that fatigue is a problem in all disease conditions mostly the chronic ones and should not relent their efforts in treating it in addition to the disease condition.

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AWARENESS AND KNOWLEDGE OF HIV/AIDS AMONG UNDERGRADUATE IN SELECTED TERTIARY UNIVERSITY IN EDO STATE NIGERIA.

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Abstract

The Acquired Immunodeficiency Syndrome is an unprecedented public health problem facing the entire world and has remained the most devastating disease human kind has ever faced with more than 60million people having been infected with the virus and killed millions of people including children since it was first recognized in 1981. Making it one of the most destructive epidemics in recorded history.. This study was designed to assess the awareness and knowledge about HIV/AIDS among undergraduate in a selected tertiary university in Edo State Nigeria. A multi-stage sampling technique was used to select the sample of 100 respondents. Data were collected using a questionnaire. Descriptive and inferential statistics were used to analyze the data generated.

The finding also reveals that majority of the study population had high awareness and moderate knowledge of HIV/AIDS. The findings of this study also further revealed that there was significant association between marital status, tribe, religion, college, course of study, and level of knowledge of HIV/AIDS of the respondents under study with p<0.05.and no significant association being found between sex and level of awareness of HIV/AIDS of the respondents under study with (p>0.05)

It is recommended that Government should provide funding for youth friendly services and HIV/AIDS enlightenment programmes in order to educate adolescents on HIV/AIDS. It is the first step in reducing the impact of the HIV/AIDS epidemic.

Keywords: *Awareness, HIV/AIDS, Undergraduate University, Nigeria.*

Introduction

HIV/AIDS is one of the most urgent public health challenges facing both developing and developed nations. Even though it affects all the social sectors of the population, the epidemic among adolescents is the fastest growing, partly because of young people's vulnerability and because of low use of preventive services. In spite of this, adolescents are also seen as a 'window of hope' because they have great potential for positive change of attitudes and behaviors. Focusing on young people is likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries (UNAIDS, 2008).

It is estimated that there are 1.2 billion adolescents in the world. Near about eighty-seven percent of these adolescents live in the developing countries and It is believed that adolescence is the time when the majority of people become sexually active and they get the knowledge regarding sex from their peer group, and books., These do not give them, correct information and some-times mislead them. Furthermore, undergraduates are the most vulnerable group, because of their natural explorative behavior and peer pressure, and this result in the highest rate of infection among them. They are at the prime of working life, between adulthood. They prime of their working life (between 15 years -49 years), between adolescent and adulthood. The economic and social impact of the epidemic is distrastrous on individual, family and the nation. It is believed that if adolescents have qualitative reproductive health literacy ultimately, HIV/AIDS prevention will be successful.

United Nations report released in 2002 revealed that the vast majority of the world's young people have no idea about the transmission of HIV/AIDS and how to protect themselves from the disease. The younger age group has been identified as bearing half of the burden of HIV worldwide and this is because of their sexual behavior of the youths. They are more prone to unsafe sex practices and have poor access to contraceptives.

Since it was first reported among homosexuals in the United States in 1981, HIV/AIDS has had its most profound effect on people of sub Saharan Africa. The HIV/AIDS pandemic has not only been the worst tragedy in contemporary history, but has also posed serious demographic, humanitarian, economic and developmental crisis (Ogunbodede, 2004). According to UNAIDS (2009) about 2.7 million people became infected with HIV in 2008. Sub-Saharan Africa has been hardest hit by the epidemic; in 2008 over two-thirds of AIDS deaths were in this region.

In Nigeria, Approximately 170,000 people died

from AIDS in 2007 alone with an estimated 3.1 percent of adults between ages 15-49 living with HIV and AIDS. Although the HIV prevalence is much lower in Nigeria than in other African countries such as South Africa and Zambia (UNAIDS, 2008). With AIDS claiming so many lives, Nigeria's life expectancy has declined significantly. In 1991 the average life expectancy was 53.8 years for women and 52.6 years for men. In 2007 these figures had fallen to 46 for women and 47 for men (UNAIDS, 2008). Nigeria has the third-largest number of people living with HIV. The HIV epidemic in Nigeria is complex and varies widely by region. In some states, the epidemic is more concentrated and driven by high-risk behaviors, while other states have more generalized epidemics that are sustained primarily by multiple sexual partnerships in the general population. Youth and young adults in Nigeria are particularly vulnerable to HIV, with young women at higher risk than young men. There are many risk factors that contribute to the spread of HIV, including prostitution, high-risk practices among itinerant workers, high prevalence of sexually transmitted infections, clandestine high-risk heterosexual and homosexual practices, international trafficking of women, and irregular blood screening(Country Profile Nigeria,2008.)

It was reported that the chance of underestimation of the real extent of HIV/AIDS in Nigeria cannot be barred due to underreporting and inadequate facilities for HIV testing and missed diagnosis (Alubo, 2002). Also, for some reasons, the rates of female-to-male transmission are 4 to 10 times higher in low-income countries than high-income countries (Boily, Baggaley, & Wang, 2009). According to Owolabi et al., (2005); Lau and Muula, (2004) cited by Saleh(2011), the factors that have contributed to the spread of HIV in Nigeria and indeed in other parts of Africa include poverty, poor health status, low literacy level, high number of young people, inadequate knowledge about the disease, cultural paradigm that encourage promiscuity such as polygamy, violence and the cultural pressure to present ones premarital relationship as moral thus preventing young girls from negotiating safer sex. Also sex is traditionally a very private subject in Nigeria and the discussion of sex with teenagers is often seen as inappropriate. Up until recently there was little or no sexual health education for young people. This has been a major barrier to reducing rates of HIV and other STDs. Around 20 percent of women and 25 percent of men between the ages of 15 and 24 correctly identify ways to prevent sexual transmission of HIV. Also rejectes two misconceptions about HIV transmission. Lack of accurate information about sexual health myths and misconceptions about sex and HIV, which contributes to increasing transmission rates as well as stigma and discrimination towards people living with the virus WHO, UNAIDS & UNICEF (2008).

Presently, no cure has been found for HIV/AIDS, and until a vaccine is found, provision of correct information will remain one of the key prevention strategies recommended against HIV/AIDS. It is for this reason that this study aimed to assessing the level of awareness and knowledge of HIV/AIDS among undergraduate, in a selected tertiary university in Edo State Nigeria.

Objectives of the study

- To assess the level of **awareness** of HIV/AIDS among undergraduate in selected tertiary university in Edo State Nigeria.
- To assess the **level of knowledge** of HIV/AIDS among undergraduate in selected tertiary university in Edo State Nigeria.
- To find out the **relationship between the course** of study and the level of knowledge about HIV/AIDS among undergraduate in selected tertiary university in Edo State Nigeria.

Hypothesis

There is no significant association between selected socio-demographic characteristics (such as sex, marital status, religion, and course of study) of the respondents under study and level of knowledge about HIV/AIDS.

Significance of the Study

There are individuals whose life circumstances or personal characteristics, or combinations of these create particular vulnerabilities to social and medical problems. In our society, the undergraduates are examples. Because they are more at risk of taking sexual action. The awareness and knowledge about HIV/AIDS among undergraduate is, therefore essential in identifying the area of health education and reinforcement needs. It is also envisaged that the results of this study will be useful for social monitoring and planning of preventive strategies for HIV/AIDS among undergraduate. Consequently, results of the study may be used to project into the future, as to the socio-economic consequences of lack of awareness of HIV/AIDS among undergraduate in the society. The results of the study will also assist government and voluntary organizations to organize continuing public enlightenment campaigns and programmes on HIV/AIDS. And to the respondents in the study area, the results of the study may spur them to acquire more knowledge about HIV/AIDS.

Methodology

A descriptive research design was used and the setting was selected because it has undergraduate students who are predispose to HIV/AIDS due to their increase sexual risk. A multistage sampling was used to obtain a representative sample of the population.

First stage: Random sampling technique was used to select five colleges from the six colleges in the university. The college of health sciences was excluded because it is assumed that they have basic knowledge of HIV/AIDS

Second stage: A list of various departments in each of the colleges selected was obtained and some of these departments were selected using disproportionate stratified sampling

Third stage: 100 respondents were randomly selected from the selected departments.

Questionnaires were administered to these respondents. These respondents were met in their classrooms between 9.00am and 2.00pm daily from Monday to Friday. The data collection took two weeks.
The data for the study was collected using a questionnaire developed by the researcher after extensive literature review. The questionnaire consists of 3 sections with a total of 29 question items. Section A contains demographic information of the respondents; section B contains information on the level awareness and knowledge of HIV/AIDS while section C contains information on factors influencing knowledge of HIV/AIDS. The instrument was given to experts in the field of study for content validity and the instrument was modified according to the recommendations of the experts. Data was collected by obtaining permission from the heads of department of various colleges where this study was carried out. Informed consent of the respondents was sought and the purpose of the study was explained to the respondents. Information provided by the respondents was treated confidentially and respondents' anonymity was maintained. The researcher ensured that participants were not harmed in any manner be it physically, psychologically and emotionally.
Both descriptive and inferential statistics were used to analyze the data collected. Descriptive statistics in the form of frequencies, percentages, and Pearson's Chi square (X^2) was used to establish associations between the course of study and the level of knowledge about HIV/AIDS among undergraduates.

Results:

Table 1: Demographic characteristics of the respondents (n=98)

Variables		Frequency	Percent
Sex	Female	70	71.4
	Male	28	28.6
Religion	Christian	62	63.3
	Islam	29	29.6
	Traditional	7	7.1
Marital Status	Single	90	91.8
	Married	8	8.2
Level	100	15	15.3
	200	20	20.4
	300	22	22.4
	400	33	33.7
	500	8	8.2
Colleges	ASS	30	30.6
	BMS	14	14.3
	Engineering	12	12.2
	Law	33	33.7
	NAS	9	9.2
	Total	98	100.0

Table 1 shows that majority of the respondents 70(71.4%) were females while 28 (28.6%) were males. 62(63.3%) were Christian, 29(29.6%) were Muslims and 7 (7.1%) were Traditionalist. Majority of the respondents 90 (91.8%) were single and 8 (8.2%) were married. 33(33.7%) of the respondents were in 400level, 22 (22.4%) in 300level, 20 (20.4%) in 200level, 15(15.3%) in 100level and 8 (8.2%) in 500level. Majority of the respondents 33 (33.7%) were from faculty of Law and 30 (30.6%) from Art and social science while the lowest 9 (9.2%) were from Natural and applied science

Age of respondent	Frequency	Range	Minimum	Maximum	Mean	Std. Deviation
	98	14	15	29	21.84	3.360

Table 2 shows that the minimum age of the respondents was 15years and the maximum age was 29, with a mean age of 21.84and standard deviation of 3.360

Table 3 Awareness of the respondent about HIV/AIDS (n=98)

Variables		Frequency	Percent
have you heard of HIV/AIDS before	no	3	3.1
	yes	95	96.9
are you aware that HIV/AIDS is real	no	6	6.1
	yes	92	93.9
have you seen a person with HIV/AIDS before	no	48	49.0
	yes	50	51.0
can healthy looking person have HIV/AIDS	no	11	11.2
	yes	87	88.8
	Total	**98**	**100.0**

Table 3 shows that majority of the respondents 95 (96.9%) have heard about HIV/AIDS while 3 (3.1%) have not. Most of the respondents 92 (93.9%) were aware that HIV/AIDS is real while 6 (6.1%) were not. More than half 50 (51%) of the respondents have seen a person with HIV/AIDS before while 48 (49%) have not. Majority of the respondents 87 (88.8%) were aware that a health looking person can have HIV/AIDS while 11 (11.2%) were not.

Table 4: Knowledge of the respondent about HIV/AIDS (n=98)

Variables		Frequency	Percent
I know that HIV is the organism that causes AIDS	no	16	16.3
	yes	82	83.7
HIV/AIDS has no cure	no	37	37.8
	yes	61	62.2
Multiple sexual partner can put one at risk of contracting HIV/AIDS	no	8	8.2
	yes	90	91.8
HIV/AIDS can only affect sexually active individual	no	78	79.6
	yes	20	20.4

HIV/AIDS is caused by witchcraft	no	88	89.8
	yes	10	10.2
HIV/AIDS is a punishment from God for immortal people	no	80	81.6
	yes	18	18.4
	Total	98	100.0

Table 4 shows that majority of the respondents 82 (83.7%) knew the causative organism of AIDS while 16 (16.3%) did not. Most of the respondents 61 (62.2%) said that HIV/AIDS does not have cure while 37 (37.8%) said that there is cure. Majority of the respondents90 (91.8%) were aware that multiple sexual partner can put one at risk of contracting HIV/AIDS while the remaining 8 (8.2%) were not. Majority of the respondents 78 (79.6%) believed that HIV/AIDS can affect any body while 20 (20.4%) said that HIV/AIDS can only affect sexually active individual. 88 (89.8%) knew that HIV/AIDS is not caused by witchcraft while 10 (10.2%) think otherwise. Majority of the respondents 80 (81.6%) were aware that HIV/AIDS is not a punishment from God. 18 (18.4%) said that it is a punishment from God.

Table 5: Knowledge of HIV/AIDS Transmission and Prevention (n=98)

Variables		Frequency	Percent
HIV/AIDS can exist spread through shaking hands with an infected person	no	86	87.8
	yes	12	12.2
HIV/AIDS can be spread through transfusion of infected blood to a person	no	8	8.2
	yes	90	91.8
HIV/AIDS can be spread through sexual intercourse with infected person	no	9	9.2
	yes	89	90.8
HIV/AIDS can be spread through sharing toilet with an infected person	no	91	92.9
	yes	7	7.1
HIV/AIDS can be spread through eating with an infected person	no	91	92.9
	yes	7	7.1
HIV/AIDS can be spread through hugging of an infected person	no	92	93.9
	yes	6	6.1
HIV/AIDS can be spread through mosquito and other insec	no	86	87.8 t bites
	yes	12	12.2
HIV/AIDS can be spread through sharing of sharp instrument like needle, blade, with an infected person	no	7	7.1
	yes	91	92.9
HIV/AIDS can be spread from infected mother to an unborn child	no	74	75.5
	yes	24	24.5
HIV/AIDS is infectious	no	19	19.4
	yes	79	80.6
HIV/AIDS can be prevented through the use of drugs	no	52	53.1
	yes	46	46.9
Can HIV/AIDS be prevented by immunization	no	82	83.7
	yes	16	16.3
	Total	**98**	**100.0**

Table 5 shows that majority of the respondents (more than 85%) knew the modes of transmissions of HIV/AIDS while very few do not. Majority of the respondents 79 (80.6%) said that HIV/AIDS is not infectious while 19 (19.4%) said that it is infectious. Majority of the respondents 74 (75.5%) said that HIV/AIDS cannot be spread from infected mother to an unborn child while 24 (24.5%) said that it can. 52(53.1%) of respondents opined that HIV/AIDS cannot be prevented through the use of drugs immunization while 46 (46.9%) said that HIV/AIDS can be prevented by the use of drugs. Majority of the respondents 82 (83.7%) said that HIV/AIDS cannot be prevented by immunization while 16 (16.3%) said that HIV/AIDS can be prevented by immunization.

Table 6 shows significant associations between level of knowledge about HIV/AIDS and selected demographic variables of the respondents under study.

variables	Pearson chi-square X^2 (P-Value)	Df	Remarks
Sex	1.14 (0.284)	1	No Significant Association
Religion	37.87(0.000)	2	Significant Association
Marital status	45.91(0.000)	1	Significant Association
College	9.49(0. .050)	5	Significant Association
Department(Course of study)	72.474(0.000)	24	Significant Association

Table 6 above reveals that there was significant association between marital status(0.000), religion(0.000), college(0.050), course of study(0.000), and level of knowledge of HIV/AIDS of the respondents under study with $p<0.05$. On the other hand no significant association was found between sex(0.284) and level of knowledge of HIV/AIDS of the respondents under study with $p>0.05$.

Discussion

Table 2 shows that the minimum age of the respondents was 15years and the maximum age was 29, with a mean age of 22.This indicates that the respondents are in their prime age and were adolescents. Respondents were predominately females 70(71.4%) and were Christian 62(63.3%). This is an indication that female and Christian predominates in this study area. Most of the respondents 90 (91.8%) were single. this is not surprising since all of the respondents were undergraduates.

Majority of the respondents (96.9%) have heard about HIV/AIDS and were aware that it is real and more than half have seen a person with AIDS before. This shows that the awareness of the respondents is high. This is in line with a survey result from Rwanda which showed that though awareness about HIV/AIDS is almost universal, only 6% of both males and

females cite HIV testing as the only means through which people can know their HIV status (Malindwa, 2003).

Majority of the respondents 74 (75.5%) said that HIV/AIDS cannot be spread from infected mother to an unborn child and 46 (46.9%) said that HIV/AIDS can be prevented by the use of drugs while 16 (16.3%) said that HIV/AIDS can be prevented by immunization. This also reflects the fact that despite the high level of HIV/AIDS awareness, there are still some fractions with poor knowledge of HIV/AIDS prevention and transmission. According to Demographic Health Survey (EDHS) report discloses a high level of awareness among both sexes aged 15-49 (90% for women and 97% for men). However, relatively lower percentages of both sexes believe that there is a way to avoid HIV/AIDS. However, according to WHO, UNAIDS & UNICEF (2008), sex is traditionally a very private subject in Nigeria and the discussion of sex with teenagers is often seen as inappropriate.

The findings of this study revealed that there was significant association between marital status(0.000), religion(0.000), college(0.050), course of study(0.000), and level of knowledge of HIV/AIDS of the respondents under study with $p<0.05$. Since the association is positive, it shows that they are moving in the same direction and there is significant association between the two variables. On the other hand no significant association was found between sex(0.284) and level of knowledge of HIV/AIDS of the respondents under study with $p>0.05$.

Conclusion

The study revealed that the respondents have high awareness and adequate knowledge of HIV/AIDS but there are still some fractions with poor knowledge of HIV/AIDS prevention and transmission. Also the study revealed that there was significant association between marital status(0.000), religion(0.000), college(0.050), course of study(0.000), and level of knowledge of HIV/AIDS of the respondents under study with $p<0.05$. On the other hand no significant association was found between sex(0.284) and level of knowledge of HIV/AIDS of the respondents under study with $p>0.05$.

Recommendations

Based on the findings, the following recommended were made

- Health care provider especially nurses should organize Public education & awareness on HIV/AIDS
- Government should provided funding for HIV/AIDS enlightenment programmes to health educate adolescents on HIV/AIDS
- Provision of youth friendly services by the government and nongovernmental organizations

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PERCEPTION ABOUT THE CARE OF THE ELDERLY - A SURVEY AMONG ELDERLY TEACHERS IN OYO STATE

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Abstract

Traditionally, elderly care is considered the responsibility of family members; however the trend is changing for various reasons such as changing family structure, greater life expectancy, urbanization, global travels and increasingly educated elderly population. In the light of these changes, this study assessed the opinion of prospective elderly population's perception of ideal care, with the aim of providing information for health care providers to meet these demands. Majority of respondents (70.8%) preferred care by immediate family members. There were no significant relationship between sociodemographic characteristics and perception of ideal care.. Conclusively the study revealed elderly perception of ideals in terms of care within the context of physical, mental and social domain. Understanding of these will ultimately influence the response of the policy makers, health care providers and the entire community who are saddled with the responsibility of caring for the elderly.

Keywords: Perception of Care, Care in Old Age, Care of the Elderly, Elderly Teachers Oyo State

Introduction

The elderly group is one that is vulnerable and a major concern to the community health nurse. Planning for effective care, good health and well being of the elderly requires exploring the opinion and perception of this group. The population of elderly is increasing in all countries of the world with greater majority, two-thirds of those over 60 years in the developing world and the population is increasing steadily and will reach nearly three- quarters by the year 2030 (Asiyanbola 2005)[1] . Globally, the nations of the world are struggling with how best to deliver care within the changes and structure of economic costs (Kennard 2006) [2].

In the United States, and in some European countries, institutional care is popular whereas, countries like Sweden, Norway, Denmark, the UK and Australia have attempted to balance the cost of state care with a broader mix of private and community based care, (Kennard, 2006) [2]. However in Japan, family commitment to older adult remains a strong tradition, some elderly live alone whereas there is increasing supportive health care services and institutional care. In China, elderly are bound to family while their local formalized community provides care. Short term care is provided by Hospitals (Kennard, 2006)[2].

The story is different in developing countries as care of the elderly is the responsibility of the family, institutional care is just evolving and Non - Governmental Organization, religious organization as well as private homes are in the fore front (Free Encyclopedia on aging and elderly 2010) [3]. This changing trend may be due to various reasons such as changing family structure, greater life expectancy, urbanization, global travels and increasingly educated elderly population. The increasing number of women taking up employment outside the home due to increase in level of education of women, as well as economic recession may also explain evolution of institutionalized care in the developing nations. body, Johnsen, Fulcomer & Lang (1983)[4].

Health and well-being encompasses a state of complete physical, mental, social and emotional well-being, happiness and prosperity not necessarily the absence of diseases or infirmity. In a country where there is no focused structured social welfare for the elderly, in the face of changing traditional pattern of elderly care, it is pertinent to explore what prospective elderly considered ideal in terms of care.

Statement of Problem

It is a known fact that the care of the elderly is at its lowest rate especially in developing countries where most of them are neglected. This might be due to many reasons. Some of which include, busy schedules of immediate families, improved level of education of women and immediate families who are carers of the elderly, industrialization, urbanization and technological advancement among other things.

To worsen matter, the population of the elderly is increasing in all countries of the world with greater majority, two - thirds of those over 60 years in the developing world. In Nigeria the elderly constitute 3% of the total population elderly are vulnerable to diseases such as Arthritis, Cardio vascular diseases, diabetes among others.

The Cost of treating these diseases and the burden of caring for the elderly could be very enormous and quite challenging.

This study therefore explores the opinions of teachers who are prospective retirees about care of the elderly.

Objectives of the Study

- To identify participants' preference for care.
- To explore teachers perception of ideal place of care in old age.

- To identify relationship between preference for care and socio demographic factors.

Significance of the Study

Currently the population of the elderly in Nigeria is low compared to other parts of the world, however a steady increase is also observed. It has been assumed over the years that institutional care is not acceptable culturally as Intergenerational care approach, that is, care within the children's family is quite a popular care option. This is similar in developed countries. Brody, Johnsen, Fulcomer & Lang (1983)[4]. Considering the changes in family structure, increasing literacy levels among the elderly and technological advancement it is necessary to seek the opinions/ perceptions of prospective elderly about what the type of care they prefer in old age. This study accessed the opinions of teachers who are prospective retirees (who will soon step into old age) about care of the elderly. Such data could provide information for policy makers and community nurses to plan adequately for the elderly. The perception of this group in relation to health and well- being and preference for care option were explored.

Literature Review

The ageing population is an obvious challenge to most countries. It is expected that in the next 50 years, the population of the elderly will increase to about 21% in the developing world. The elderly population is expected to increase to one and half billion by the year 2050 (Rasheed and Rahmah 2010)[5].

Providing appropriate health services to the elderly is emerging as one of the major challenges of 21st century just as the medical care of elderly represent a significant unmet health need (Agbogidi and Azodo 2010)[6]. Coupled with this is the fact that older people experience a greater level of morbidity and are relatively more frequent users of health services (Agbogidi and Azodo 2010)[6].

Troisi (2004)[7] observed that almost one in ten people are over 60years. By 2050 nearly one in five people in developing countries will be over the age of 60years and by 2150, one out of three persons will be 60years or older. People aged over 60 will outnumber children aged 0 to 14. Troisi (2004)[7] also observed that older population is ageing, that is, the oldest old (80years) is the fastest growing segment constituting 11percent of the 60years or older age group., It is projected that this group (80 years) will grow to 19 percent by 2050.

Furthermore, the ratio of the elderly men and women across the region is as follows;

Elderly that are 60+ years old in the world is ratio 84/100, whereas in developed nations it is 74/100 and less developed 89/100, the least developed is 85/100. Whereas the elderly that are 80 years and above in the world are 59/100, developed nations 49/100, less developed nations 70/100 and least developed 73/100. It is also reported that the survival rate of women is higher than that of men,. However in Nigeria the elderly constitute only 3% of the total population, this may be due to the fact that life expectancy is very low (57years) (National bureau of population statistic 2011)[8].

In the developed nations institutional care is the norm (free Encyclopedia on elderly 2010)[3]. However, countries like Sweden, Norway, Denmark, UK and Australia have attempted to balance the cost of state care with a broader mix of private and community based care. (Kennard, 2006)[2].

In contrast, institutional care for the elderly is rare in the developing nations of Asia, Africa and Latin America. The family is expected to be in the forefront of care in these nations (Uwakwe and Modebe, 2007[9], Fantahun, Berhane and Hogberg et al, 2009)[10].

Specifically, in Japan family commitment to older adult remains a strong tradition. In China, an average Chinese is bound to the families whereas, local formalized community provide care within the limited health and medical facilities (Kennard 2006[2], Papalia et al 2006[11]).

The trend of care of the elderly follows the same pattern in Nigeria, that is, care provided by the extended family. However, some researchers (Aboderin 2006, Ajomale 2007) [12,13] have identified this as a wrong assumption because of the following reasons;

- at the family level, care services provided do not adequately meet the needs of the old person in Nigeria.
- Diminishing economic power has hindered the willing family member's capability to give.
- Priorities are given to the needs of the members of the nuclear family - spouse and children - at the expense of older family members: parents or grandparents Current observations show that care provided by the family only attempts to satisfy the needs of older persons. Due to changing social and economic configurations, older persons are most of the time left in the care of strangers i.e. people who are not properly trained to be caregivers, many of them uneducated, young and frustrated (Aboderin 2006, Ajomale 2007) [12,13].

Method

This is a descriptive cross sectional study conducted in one of the southwestern state in Nigeria.

Research Setting

The study area is Oyo state. The state is an inland state located in south-western Nigeria founded in February 3, 1976 (Galleria Media Limited 2004)[14]. It has 33 local government areas and lies between latitude 8 and 4 degree north of the Equator and longitude 4 and 10 degrees east of the Meridian. It is bounded in the north by Kwara state, in the South by Ogun state, in the East by Osun state, in the West partly by Ogun state and partly by republic of Benin. The state is homogenous, though a Yoruba speaking state comprising majorly the Oyos, Ibadans, Ibarapas and Oke-Oguns. Two towns, Oyo and Ibadan were chosen for the study.

Sample

It was a purposive sample of teachers who were about to retire from public service. The sample consisted of 226 respondents who consented to participate in the study after due information was given about the study.

Method of Data Collection

A 52 item questionnaire developed after literature review was utilized to collect the relevant data. It consisted of two sections. Section I assessed the socio demographic characteristics of the respondents while section II consisted of 26 item questions which assessed the concept of care spanning through physical care, mental and social care. Sixteen likert scale questions were used to elicit information from the respondents about preferences in terms of care options in old age. It's also considered the presume attitudinal concerns of respondents in old age.

Technique of Data Analysis

The statistical package utilized for processing the data was SPSS version 16.0. Only 195 (84.7%) of the 226 questionnaires distributed were suitable for analysis. Categorical variables were summarized using frequencies and percentages while quantitative variables were summarized using mean and standard deviation.

Ethical Issues

Permission was obtained to access the group from executive members of the group. during one of the meetings the from the prospective retirees and voluntary consent solicited from each respondents before data collection. Explanation was also given on how questions should be answered. Respondents were free to opt out of the study at any stage without criticism of any kind. Principle of confidentiality was strictly adhered to.

Result

The mean age range of participants was 54.7 (SD = 4.5). Majority (91.8%) were married with about a quarter (27.7%) having had has 4 children. Table 1 shows details of socio demographic characteristics.

Table 1: Socio demographic characteristics of participants (n=195)

Variable	freq	percent
Age group		
45-50	48	24.6
51-55	48	24.6
56- 60	99	50.8
Total	195	100
Sex		
Male	109	55.9
Female	78	40.0
Missing	8	4.1
Total	195	100
Marital status		
Married	179	91.8
Widowed	10	5.1
Separated	2	1.0
Missing	4	2.1
Total	195	100
Religion		
Christianity	172	88.2
Islamic	23	11.8
Total	195	100
Educational status		
University	49	25.1
Higher degree	102	52.3
Higher degree	29	14.9
Teaching area		
Secondary		62.1
Primary		26.2

Perception of care in old age

One hundred and thirty eight (70.8%) participants will feel cared for when care is given by member of immediate family member. When sick, Fifty one (26.1%) will use home remedy, 43(22.1%) will use anointing oil and prayer, while 46 (23.6%) will use only analgesics (paracetamol). About half of the participant (50.3%) patronizes state hospital, 26.3% patronizes private while only 6.7% patronizes tertiary hospitals. Participant had various reasons for their choice; the significant ones being trained personnel (26.5%), appropriate effective medical care (16.9%), and negligible percentage 8.2 gave the reason that it is timely and easily accessible.

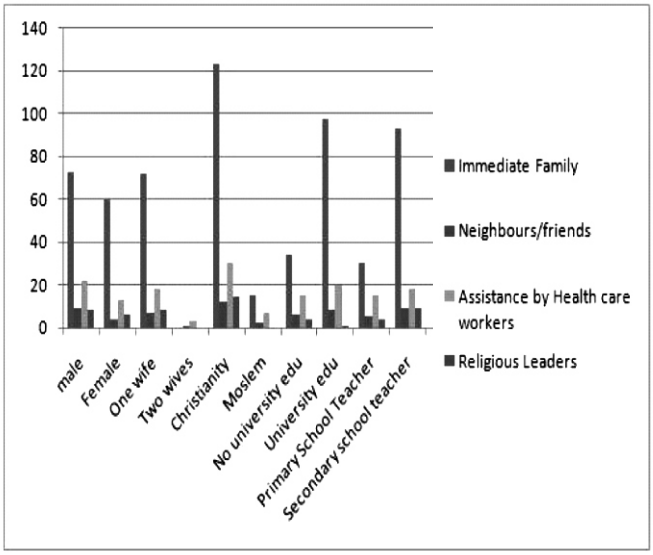

Figure 1: details of when participants will feel cared for across sociodemographic data

Figure 1 shows details of when participants will feel cared for across sociodemographic data.

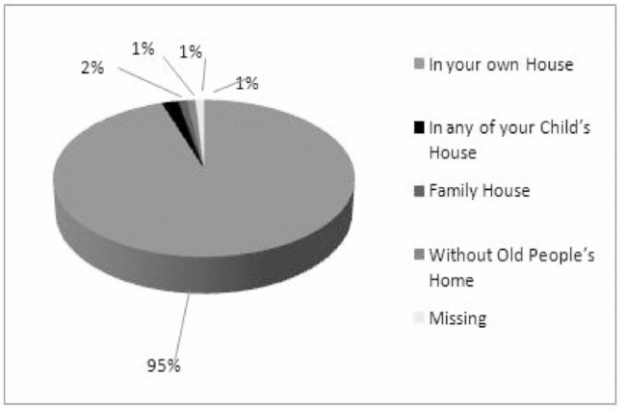

Figure 2: Prefered place to live in old age.

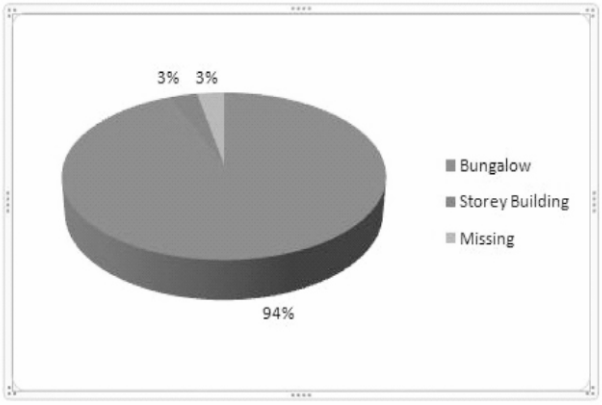

Figure 3 : Prefered building in old age

S/N	PREFER BATHROOM	FREQUENCY	PERCENTAGE
1	Bathtub	20	10.3%
2	Floored Bathroom	134	68.7%
3	Others	4	2.1%
4	Missing	4	2.1%

TOTAL = 195

Table 2: Preferred Bathroom

S/N	PREFER FLOOR	FREQUENCY	PERCENTAGE
1	Tiled Floor	29	14.9%
2	Rugged	105	53.8%
3	Cement Flooring	52	27.2%
4	Others	1	0.5%
5	Missing	6	3.1%

Table 3: Preferred Flooring

S/N	WIRING	FREQUENCY	PERCENTAGE
1	Conduct	84	43.1%
2	Open Wiring	87	44.6%
3	Others	23	11.8%

Table 4: Prefer Wiring

Tables 2, 3 and 4 reveal the participant safety measures in prevention of fall in old age.

Majority 178 (91.3%) prefer garden in their in old age.

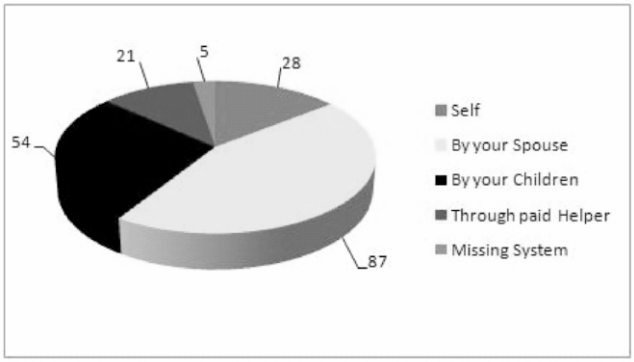

Figure 4: Prefered person to purchase food items

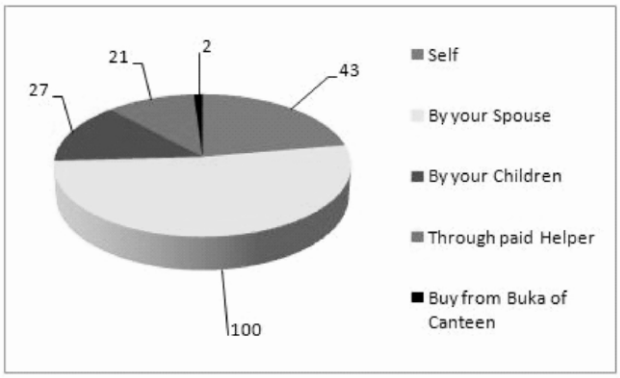

Figure 5: Who prepares food in old age

Majority of participants 149 (76.4%) will prefer semi - solid in old age whereas 16 (8.2%) and 12 (6.2%) will prefer solid and liquids respectively.

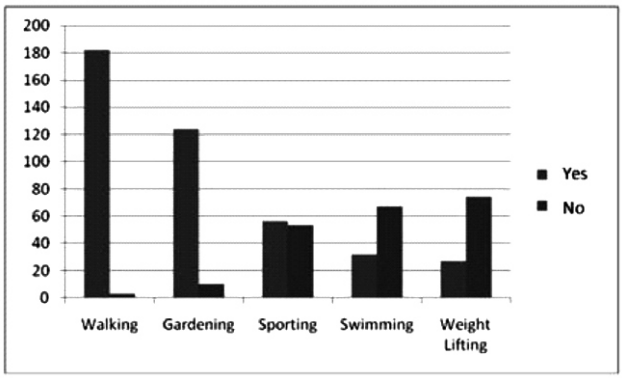

Figure 6: Respondents' prefered exercise

S/N	EXERCISE	DAILY	WEEKLY	MONTHLY	ONCE A WHILE
1	Walking	164(84.1%)	12(6.2%)	1(0.5%)	4(2%)
2	Gardening	48(24.6%)	57(29.2%)	4(2.1%)	15(7.7%)
	Sporting	21(10.8%)	27(13.8%)	7(3.6%)	28(14.4%)
4	Swimming	7(3.6%)	16(8.2%)	9(4.6%)	23(11.8%)
5	Weight Lifting	5(2.6%)	12(6.2%)	6(3.1%)	27(13.8%)

Table 5: duration of exercise

Majority 147(75.4%) will prefer to purchase clothes themselves while 28(14.4%) by Spouse whereas 26(13.3%) by Children while only 14(7.2%) by others.

S/N	GREATEST MOMENT OF STRESS	YES	NO	VALID MISSING
1	Loss of Spouse	52(26.7%)	110(56.4%)	33(16.9%)
2	Retirement without Pensioner Gratuity	62(31.8%)	99(50.8%)	34(17.0%)
3	Loss of close friend	15(7.7%)	146(74.9%)	34(17.4%)
4	Loss of close relatives	23(11.8%)	138(70.8%)	34(17.4%)
5	Others	16(8.2%)	89(45.6%)	90(46.2%)

Table 6: Participants perception of causes of mental stress in the elderly

Stress of life e.g. Partial deafness, decrease usual acuity diabetes extension contribute to mental stability

The Social activities the elderly engage in is as follow; family meeting, visiting children and traditional in - door games e.g. Ayo/Drafts. 28.2%, 46.2% and 47.2% of the elderly engaged in these activities Majority (79.9%) of the elderly goes for social outing occasionally. On preference of outing, wedding ceremony is the most well attended, 67.7% of the elderly engages in this whereas 21.5%, 21% and 15.4% consider Burial, Birthday and Housing Warming ceremonies respectively.

Discussion

There are only a few studies which have been conducted among the elderly to elicit information about opinion and perception of teachers about care of the elderly. The discussion in this segment will compare the findings of this study with other studies which have been carried out on general care of the elderly.

The results of findings revealed that about half are within 55-60years, the mean age of respondents is taken to be 54.6% hence the population are prospective elderly as they will soon attain the 60years mark, which is accepted globally as a lower chronological age threshold for older persons (Agbogidi & Azodo 2010)[6]. higher percentage of the respondents are male (55.9%) this is similar to the study of (Agbogidi & Azodo 2010)[6] who discovered there were more males (56.5%) than females in their study population. As there are cultural variations across the country it is pertinent to note that majority of the respondents were Yoruba the most popular ethnic group in the southwestern region.

Majority of the study population preferred care by immediate family, although there were no significant relationships between preferences for care within the various age groups. It is evident that care by immediate family members is the best option from the elderly perspective. This is similar to the findings (Uwakwe & Modebe 2007)[9] who opined that world over, it is generally agreed that family members are the main carers. In the same vein Papalia et al 2006 also confirm same. Studies in the Nigerian setting by (Aboderin 2006, Ajomale 2007) [12,13] also affirmed that care for older people has always been provided by the family and that such care is considered adequate. The same trend was observed in the participants response in relation to food purchase and preparation, as spouses followed by children were the preferred options mostly selected.

In conformity with the assumption that in the Nigerian setting institutional care is not an acceptable option, findings of this study indicated that most participants desire to live in their own homes while only very minute proportion selected children's home or family house. This trend may be explained by the fact that the population for this study are educated, which may therefore be expected in the more educated aging population. Similarly, Abdulraheem 2005[15] reported that 90.7% choose home as place of care while only 9.3% opted for institutional care. Asiyanbola (2005)[1] also reported that 64.4% of the study population is living in their own houses. Furthermore, Abdulraheem (2005)[15] opined that there is no statistically significant difference between respondents with or without formal education concerning where to care for the elderly among the study participants. Moreover, as much as the elderly want to be cared for by family they still preferred to live in their own house.

The participants in this study were safety conscious judging from their choices of type of building, preference for flooring, as well as preference for various treatment options if taken ill. Previous study by (Asiyanbola 2005)[1] however has reported that the elderly in their study were living in a deplorable condition. It is one thing to desire a good thing and another thing to get that desire when you have to be dependent on others to do it.

Majority of the current study population demonstrated preference for healthy life style as depicted in respect to food choices and exercise choice and duration. The study population revealed that majority of respondents know that semi solid balanced diet is most suitable in old age, this is in consonant with Kovatch & Kemps (2011)[16] opinion that eating well balanced diet can be key to a positive outlook and emotional stability. diabetes, arthritis, hypertension were identified to contribute to emotional instability in old age. this is in consonant with Onwuchekwa & Asekomeh 2009[17] and Agbogidi & Azodo 2010[6].

Walking followed by gardening were preferred exercises engaged in by participants and these were done by most of the participants on a daily basis, this will ensure longevity as opined by Richard (2007)[18].

It is surprising that most of the participants did not consider the loss of a spouse to be the greatest moment of stress rather retirement without pensioner's gratuity was rated more stressful than death of a spouse. This finding is very significant and should be explored in other studies and it has implications for government functionary in charge of retirement benefits as this is in line with Maslow's Hierarchy of need.

Conclusion

Conclusively, the study revealed elderly perception of ideals in terms of care within the context of physical, mental, social domain as well as happiness and prosperity enhancing a state of healthiness and well - being to the optimal.

Recommendation: Nursing Practice, Education and Research

In community health nursing where the core functions align with that of public health involving assessment, policy development and assurance, it is imperative that community health nurses should explore similar population to assess need of the elderly population. Advocacy should be explored to drive home policy issue especially the need to provide assistance for care in the home of the elderly. Also the issue of nonpayment of gratuity being considered as greater source of stress than loss of a spouse should be an advocacy issue. Assurance is the role of public health in ensuring the provision of community oriented health services for all that need such, it also involve provision of competent human resources as well as adequate resources. Every effort should be directed towards assurance on the issue of elderly care.

Nurse educators will be able to identify missing gap in terms of appropriate, specific care option with the aim of including this in curriculum of Nurses.

There are equally, opportunities of further research on a large scale so that findings of such future research (on a large scale) will be true representation of the elderly opinions of care expected from all nurses. The study can equally be replicated in various setting to cater for the cultural diversity of population.

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PERCEPTION ABOUT DYSMENORRHOEA AMONG ADOLESCENT GIRLS IN SELECTED SECONDARY SCHOOLS IN NSUKKA LOCAL GOVERNMENT AREA OF ENUGU STATE, NIGERIA.

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Abstract

The study examined the perception of adolescent girls about dysmenorrhoea in selected secondary schools in Nsuka local government area of Enugu state. It also determines the causes and the likely signs of dysmenorrhoea and ascertained if dysmenorrhoea is viewed as an illness among the girls with the view to finding remedies in managing dysmenorrhoea. The study employed a descriptive survey design. Two (2) secondary schools were purposively selected for the study. One hundred and twenty-eight adolescent girls were recruited for the study from the two schools. The instrument used for data collection was a questionnaire and data was analyzed using descriptive statistic. Findings showed that, adolescents perceive dysmenorrhoea as physiological changes occurring within the body system (36.7%) and not an illness state (57.8%) and that the likely signs of drugs dysmenorrhoea is pelvic pain (36.7%) and dysmenorrhoea can be remedied by the use of (especially analgesic drugs such as aspirin and feldene). The study concluded that adolescent girl in Nsuka local government area secondary schools do not perceive dysmenorrhoea as an illness state, but rather a result of physiological changes within the body and that it can be remedied by the use of analgesic drugs to alleviate the pelvic pain and other signs.

Key words: perception, adolescent, girls, dysmenorrhoea.

Introduction

The period of life between childhood and adulthood is termed adolescence. Biologically, it extends from the age of 10 to the age of 19. The most important event in adolescence, as far as the girl and her mother are concerned is the onset of menstruation, which may occur between the age of 10 to 16 years. In some individuals it could start as early as 9 years. The normal period of menstruation comes ones in every 28 days and last about 3 to 6 days. However this varies a lot in different girls. During this period, some girls do not experience any discomfort while some experience excruciating pain in the process. "this pain associated with menstruation is what is termed dysmenorrhoea"

Research has proven that daughters of women who have suffered dysmenorrhoea are more frequently dysmenorrheic, but whether this is inherited is unclear. Some believe that dysmenorrhoea stops when the individual conceives at least a pregnancy or has evacuation done, while some believe it is as a result of not engaging in sexual intercourse. A woman's personal tolerance to discomfort undoubtedly affects her response to any pain in school, at home, and working places. girls who suffer from dysmenorrhoea are given special attention (Derek 1998). Dysmenorrhoea is the most common gynaecological problem that occurs during adolescence. It is estimated that 75 % of menstruating women experience dysmenorrhoea, making it the leading cause of incapacitation in adolescents.(Fraser and cooper, 2003). Govan et al (1998) posited that dysmenorrhoea implies pain during menstruation and most girls experience some degree of pain at least on the first day of the period, when the blood loss is heaviest. Many girls will also describe varying degrees of discomfort before the period start, but these symptoms should be regarded as manifestation of pre-menstrual tension syndrome. This pain may be secondary to-organic diseases such as endometriosis (presence of endometrium in abnormal sites) .or infection, but primary dysmenorrhoea occurs in the presence of a normal genital tract. Vasopressin may playa role by increasing uterine contractility and causing ischemic pain as a result of vasoconstriction. Elevated vasopressin levels have been reported in adolescent girls with dysmenorrhoea.

Evaluation of the adolescent girl~who have dysmenorrhoea begins with questioning about timing, character and location of the pain as well as presence of associated systemic symptoms. A history of pelvic infections, menorrhagia (excessive regular menstrual flow) or intermenstual bleeding suggests that the dysmenorrhoea is secondary to pelvic pathology. The onset of dysmenorrhoea soon after menarche (commencement of menstrual period and other body changes) worsening over several cycles suggest an outlet obstruction which may result from a partially imperforate hymen or uterine malformation (Fraser and cooper, 2003).

Goven et al (1998) posited that there is

increased myometrial activity in women with dysmenorrhoea during the period while the uterine blood flow is also reduced, especially during intense contraction. It is thought that this hyperactivity is as a result of excessive quantity of prostaglandins synthesized during the break down of the pre-menstrual endometrium. Retrograde menstruation has also been regarded as a cause. This phenomenon is most common in the presence of severe dysmenorrhoea.

In providing remedies and/or managing dysmenorrhoea, adolescent girls must be properly educated on the physiologic changes occurring during this period with proper examination. Fraser and Cooper, (2003) opined that, a pelvic examination should be done before initiating treatment for dysmenorrhoea. Abnormal uterine size, position or shape suggests uterine malformation rather than fibroids. Girls suffering from severe dysmenorrhoea needs sympathy and support.

Malcon (1997) suggest that dysmenorrhoea can be effectively managed with drugs that inhibit prostaglandins synthesis and hence uterine contraction. Also non-steroidal antiinflammatory drugs which are usually use the initial drugs of choice in girls with presumptive primary dysmenorrhoea can be considered. These drugs include aspirin, mefenamic acid, naproxen or ibuprofen, indomethacin and piroxicam. Some girls may benefit from the use of oral contraceptives and depo-medroxyprogesterone acetate.

Materials and Methods

The study was conducted in Nsukka local Government of Enugu State, and a descriptive survey design was adopted for the study. The target population comprises adolescent girls between the ages of 10-19 years from two selected secondary schools (St Catherine Girls Secondary School, Nsukka and community secondary, School Uabor-Eha-alumona, Nsukka) which were purposively selected for the study. The total population of the adolescent girls was 640; St cathrine girls Secondary school, Nsukka had 268, while community secondary school, umabor had 372.

The sampling technique employed was the stratified random sampling technique and 128 students were drawn from the total population of 640, that is, 54 students sampled from St Catherine girls secondary school and 74 students sampled from community secondary school, Umabor-considering weighting in the population sample size.

Sample inclusion criteria include:

- The student must be an adolescent between ages 10-19years old.
- The student must be able to read and write in order to answer the questions correctly.
- The adolescent girl must have experienced menstrual pain prior to this study.

A structured questionnaire was used as an instrument for data collection which lasted for two months. Questionnaire return rate was 70.3% (90) and data collected was analysed with the use of descriptive statistical procedure (frequencies, percentages were then used to present summary tables for relevant variables).

Results

The result of the study showed that majority of the respondents (37.8%) asserted that dysmenorrhoea is caused by physiological changes in the body, 31% said, it is due to curses from the gods and/or ancestors, while 16.7% asserted, that it is due to infection and 14.4% said poor hygiene causes dysmenorrhoea (table 2).

In determining the likely signs of dysmenorrhoea, majority of the adolescent girls (36.7%) agreed that pelvic pain is the most likely sign, of dysmenorrhoea, 28.9% said back ache is a likely sign, while 21.1% said, the likely sign is vomiting and 13.3% asserted that the most likely sign is nausea. (Table 3).

Ascertaining the fact whether the adolescent girl views dysmenorrhoea as an illness state, majority ofthe respondents (S7.8%) did not view dysmenorrhoea as an illness state but 42.2% of the view it as an illness (Table 4).

Table 5 shows that majority of the respondents (37.8%) use drugs to combat their menstrual pain, 24.4% engages in one activity or the other as walking about in order to take their minds off the pain, while 21.1% uses cold compress at the pelvic region to reduce the pain and 16.7% embark on complete bed res during the period ofthe pain.

The findings of the study revealed that majority of the adolescent girls (37.8%) asserted that what causes dysmenorrhoea is the physiological changes occurring during the period of menstruation as in hormonal changes. This agrees with Govan et al (1998) who posited that dysmenorrhoea implies pain during menstruation and that, most women experience some degree of pain at least on the first day of the period when the blood flow is heaviest which is most likely associated with changes occurring at that time.

Discussion

The finding also revealed that, majority of the respondents (36.7%) agree that, the most likely sign of dysmenorrhoea is pelvic pain. This supports El-Gilany (200S) which stated that pelvic pain is one of the commonest symptoms of dysmenorrhoea among secondary school adolescent girls.

Another finding from the study also showed that, majority of the respondents (S7.8%) did not view dysmenorrhoea as an illness state, but that it was due to changes in the body and/other factors. This agrees partially with Derek (1998) who posited that some adolescent girls believe that dysmenorrhoea is a curse or punishment from the gods/ancestors for any evil committed by the woman but they take drugs to combat the excruciating pain for a temporary relief.

Further analysis showed that, greater number of students (37.8%) use drugs especially pain relieving drugs such as aspirin and feldene as remedies for the menstrual pain. This corroborates Malcom (1997) who stated that dysmenorrhoea can be effectively managed with drugs that inhibits prostaglandins synthesis and hence uterine contractility.

Conclusion

The study concluded that, most of the adolescent girls in our secondary schools in Nsukka local Government area of Enugu state do not perceive dysmenorrhoea (menstrual pain) as an illness state but that the physiological and other changes within the system causes dysmenorrhoea and that they engage in drug remedy such as analgesics (aspirin, feldene) when they experience the most commonest excruciating pelvic pain in order to alleviate the pain during this period.

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Table 1 Demographic Characteristic Of Respondents.

Age	**Frequency**	**Percentage**
10-13	33	37%
14-19	57	63%
Total	**90**	**100%**
Marital status		
Single	83	92%
Married	7	8%
Total	**90**	**100%**
Religion		
Christianity	51	57%
Islam	22	24%
Traditional	17	19%
Total	**90**	**100%**

Table 2: Distribution Of Respondents On The Causes Of Dysmenorrhoea.

Variable	**Frequency**	**Percentage**
Physiological	34	37.8%
Curses from gods/ancestors	28	31.1%
Infection	15	16.7%
Poor hygiene	13	14.4%
Total	**90**	**100%**

Table 3: Distribution Of Respondents On The Most Likely Sign Of Dysmonorrhea.

Variable	**Frequency**	**Percentage**
Nausea	12	13.3%
Vomiting	19	21.1%
Pelvic	33	36.7%
Backache	26	28.9
Total	[illegible]	[illegible]

Table 4: Distribution Of Respondents On Whether They View Dysmenorrhoea As An Illness State.

Variable	**Frequency**	**Percentage**
Yes	38	42.2%
No	52	57.8%
Total	**90**	**100%**

Table 5: Distribution Of Respondent On The Remedies Used For Dysmenorrhoea.

Variable	**Frequency**	**Percentage**
Use of drugs (aspirin, feldene)	34	37.8%
Complete bed rest	15	16.7%
Exercise like walking	22	24.4%
Use of cold compress on the abdomen	19	21.1%
Total	90	100%

THE ATTITUDE AND PRACTICE OF WEANING DIET AMONG WOMEN OF REPRODUCTIVE AGE IN NGWO, UDI LOCAL GOVERNMENT AREA OF ENUGU STATE, NIGERIA

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Abstract
The study was carried out to determine the attitude and practice of weaning diet among women of reproductive age in Ngwo, Udi Local Government Area of Enugu State. It also ascertained the effect of early weaning on children with the view to educating mothers on the importance of weaning and the appropriate time to start it. The study utilized a descriptive survey design as a community based study and one hundred (100) women of reproductive age were randomly selected on a simple basis for the study. Questionnaire was used to elicit the needed information. The finding of the study showed that majority of the respondents (73%) engaged in weaning their children between four to six months (4-6 months). Majority of them (37%) gave reasons for the early weaning as per helping them to return back to their work quickly. Also a greater percentage (57%) practiced weaning by using pap with Soya milk as the weaning diet. A good number (45%) said early weaning can lead to diarrheal diseases. The study concluded that women of Ngwo, Udi L.G.A of Enugu State displayed a good attitude about weaning but their practice of weaning diet was marginal. Therefore, efforts should be made to educate these women on the types of diet to incorporate during the weaning period.

Key Words: Attitude, Practice, Weaning diet, Women of reproductive age, Multimixes.

Introduction

Weaning has been in existence right from the origin of man, though not practice as it is supposed. The term weaning was derived from the Greek work "wenian" which means to accustom. Weaning starts from the time supplementary food is given till the child is taken off the breast completely. When a mother decides to stop breastfeeding a baby, feeds should be tailed off gradually. Breast feeding may be omitted one at a time and spaced further apart. (Cooper, 2003)

Weaning is the gradual substitution of the human breast milk with cow milk or any other cooked food. Naturally, all babies start life on breast milk produced by their mothers except otherwise indicated. But as the child grows, the breast milk becomes inadequate for him and he will need semi-solid or solid but rich nutritious food to assist in the growth process and also to maintain other physiological activities in the body. (Ujiri, 2001)

Traditional child weaning has proved difficult and dangerous to most children in Africa. The reason is that, most African mothers, both educated and illiterate, do not cook special meals for the child who is being weaned. Adult foods which are usually too peppery and difficult for the child to digest are given to the child. (Idusogie, 2003).

Statement of Problem

Weaning as an act of introducing other diets than the breast milk should not have any effect on the child, if properly adopted and done when the child is physiologically mature to handle solid foods, but African mothers do not make or prepare any particular weaning food for their babies, rather, when they decide to wean, the infants are immediately introduced to adult foods, not realizing that the intestines of these infants cannot withstand adult foods. All these make, the child's immunity depressed thereby predisposing them to many childhood illnesses including diarrhea, and anaemia. Which contributes to infants' morbidity and mortality.

Objectives of the Study

The specific objectives of the study were to:

- Ascertain the attitude of weaning diet among women of reproductive age.
- Determine the practice of the women weaning diet.
- Identify the effect of early weaning on the children.
- Educate mothers on the importance and the appropriate time to start the weaning.

Significance of the Study

The findings from this study will serve as a guideline for feeding regimen on the weaning diet for mothers. The findings will also serve as a baseline information for other research in human health and nutrition in relation with maternal and child health.

Furthermore, this research will serve as a reference material for health workers in educating mothers, on the weaning diet to adopt and also on the importance and appropriate time to start weaning.

Literature Review

Weaning is the gradual introduction of other diet besides breast milk to an infant in order to accustom him to the family diet before taking off breast completely. The diet should be made from locally available food increments that are acceptable to the parents' cultural beliefs and practices, low in cost, low in bulk, digestible, easily prepared and contain all the nutrients required for growth during the period. (Jellifie, 2001).

Some mothers think weaning should start when they are expecting another baby, which should not be. It is important to start introducing weaning diet to a child as early as possible especially when the child weighs 6kg or more at about 4-6 months because by then, the child is physiologically mature to handle semi-solid food. Weaning diet should be rich in body building materials essential for growth, physical development and good health. (Ujiri, 2001)

Ujiri, (2001) posited that infants in our community thrive on breast milk alone up to six months of life and their growth rate during this period is satisfactory. Breast milk alone is not able to provide sufficient amounts of all the nutrients needed to maintain growth after the first six months. Increasing needs for calories and protein of growing children cannot be met by the diminishing output of mother's milk. Milk is also a poor source of vitamin C and supplement with fruit juice is essential. Iron stores in liver of the infant would last only for up to 4-6 months. Hence iron rich foods should be given at least from six months on wards, milk is also deficient in vitamin D. if the baby is to main the expected rate of growth and remain healthy and well nourished, supplementary feeding has to be restored to about the 6^{th} month of life. But then, introduction of weaning food too late can lead to under nutrition and increase diarrheal morbidity.

Shubhangini (2005) commenting on sources of weaning diet asserted that home made or commercially processed food can be given as weaning foods. These can be prepared by using cereals, pulses, nuts and Jiggery with or without milk products. Processed food like pasta, rusks and biscuits can also be given. Commercially available weaning foods (predigests) like vegetable soups and fruit deserts, puddings and vegetable juice can also be given as part of weaning diet. These processed foods are standardized, convenient and suitable to the infant. A spray-dried milk based infant formula containing 0.5% lacunose or carrot juice stimulated are available in the market-these are more energy dense than milk.

He also asserted that when planning a weaning diet, one should consider introducing one food at a time, allow the infant to become familiar with the food before trying to give another, small amounts of new food should be given at the beginning, food should be only slightly seasoned, at first-strained fruits, vegetables and cereals are given and when the baby is able to chew, gradually substitute finely chopped fruits and vegetables which is usually given at 8-9 months. Also variety in the choice of food is very important. (Shubhangini 2005)

Methodology

The Study Area

The geographical area which the study covers is Etiti village in Ngwo (Central village in Ngwo) in Udi Local Government Area of Enugu State.

Research Design

The study adopted a descriptive survey research design in a bid to study the attitude and practice of weaning diet among women of reproductive age in Ngwo, Udi Local Government Area in Enugu State.

Sample and Sampling Procedure

One hundred (100) women of reproductive age were randomly selected on a simple basis from the target population of two hundred (200) women.

Instrumentation

The data for this study were collected by means of structured questionnaire. The questionnaire consists of two parts. The first section sought for socio-demographic background of age, marital status, educational status, occupation and religion of respondents. The second section relates to the information on the attitude and practice of weaning diet among the women.

Procedure for Data Collection

The questionnaire were administered on the spot by the researcher to the women in their monthly meetings and collected immediately. This procedure greatly increased the rate of return of the questionnaire and allowed the respondents to ask questions on grey issues.

Data Analysis

The data collected were organized and analyzed using descriptive statistics and presented in tables with frequencies and percentages.

Results

As shown in Table 1, 46% of the respondents were aged 25-29 years old, 26% were aged 20-24 years old, 18% were aged 30-34 years, and 10% were aged 35-39 years. The findings in Table 1 showed that 57% of the respondents were married, 23% were widowed, 11% were divorced and 9% were singles. Also, 82% were Christians, 17% were of the traditional religion and 1% of Islamic religion.

It is also seen in Table 1, that 75% attained tertiary education, 18% with secondary education and 13% with primary education, majority of the respondents (48%) were civil servants, 20% were business women, 15% were students, 12% were full time housewives and 5% were farmers.

From Table 2, it is shown that majority of the respondents (73%) engaged in weaning their children between 4-6 months, 17% weans between 1-2 months, 7% between 1-2 years and 3% immediately after birth.

Table 3 reveals that 37% of the respondents practice early weaning because it helps them to return back to their work quickly, 29% said, weaning is more nutritious than breast milk, 19% said they want to show up that they are wealthy and 15% said it is more economical. While Table 4 shows that majority of respondents (57%) practice weaning by using pap with Soya milk; 12% with matched yam and meat; 7% respectively with canned foods and soaked garri with beans. 5% with Akpu and 3% with boiled eggs. From Table 5 it is shown that majority of the respondents (45%) asserted that the effect of early weaning can lead to diarrheal diseases; 20% said it can lead to malnutrition; 15% to lack of physical attachment between mother and child and 10% respectively said it can lead to low intelligent quotient and dehydration.

Table 1: Socio-demographic Characteristics of Respondents

Age	No. of Respondents	Percentage
20 - 24 years	26	26%
25 - 29 years	46	46%
30 - 34 years	18	18%
35 - 39 years	10	10%
Total	**100**	**100%**
Marital Status		
Married	57	57%
Single	9	9%
Widowed	23	23%
Divorced	11	11%
Total	**100**	**100%**
Educational Level		
Primary	13	13%
Secondary	18	18%
Tertiary	75	75%
Total	**100**	**100%**
Religion		
Christianity	82	82%
Traditional	17	17%
Islamic	1	1%
Total	**100**	**100%**
Occupation		
Civil Servants	48	48%
Business women	20	20%
Students	15	15%
House wives	12	12%
Farmers	5	5%
Total	**100**	**100%**

Table 2: The Attitude of Respondents as per the Time of Weaning of the Children

Womens attitude about the time of weaning	No. of Respondents	Percentage
Immediately after birth	3	3%
From 1 - 2 months	17	17%
From 4 - 6 months	73	73%
From 1 - 2 years	7	7%
Total	**100**	**100%**

Table 3: Respondents' Reason for the Early Weaning

Reasons	No. of Respondents	Percentage
Weaning is more nutritious than breast milk	29	29%
More economical	15	15%
Help them to return back to their work quickly	37	37%
Showing up of wealth	19	19%
Total	**100**	**100%**

Table 4: Practice of the Weaning Diet by the Respondents

Diet Used	No. of Respondents	Percentage
Akpu	5	5%
Soaked garri & beans	7	7%
Mashed yam & meat	21	21%
Boiled egg	3	3%
Pap with Soya milk	57	57
Canned foods	7	7%
Total	**100**	**100%**

Table 5: Respondents' responses about the Effect of Early Weaning

Effect of early weaning	No. of Respondents	Percentage
Lack of physical attachment between mother and child.	15	15%
Diarrhea	45%	45%
Malnutrition	20	20%
Dehydration	10	10%
Total	**100**	**100%**

Discussion and Conclusion

The findings of this study revealed that majority of respondents (73%) displayed a good attitude about when to start the weaning of their children as they asserted that it is good to start weaning between 4-6 months. This supports Onigbinde (2005) who asserted that, weaning should commence within 4-6 months of life when babies are physiologically mature to handle solid food. Moreover, the age of introduction of supplementation is 3-5 months in the urban elite and middle income group. The supple mutation is delayed in urban poor by 7-9 months and rural poor by 9-11 months.(Ujiri, 2001)

Further findings revealed that majority of the women (57%) used pap with Soya milk as the means of their weaning diet. The finding agrees with Ubanduma(2005) who posited that in the weaning of children, the preferable diet is pap and Soya milk, though he said matched beans with eggs could also be used by mothers who can afford it. The findings did not totally agree with Shubhangini (2005) who asserted that home made or commercially processed foods can be given as part of the weaning diet. The asserted that commercially available weaning foods (predigests) like vegetable soups and fruits deserts, pudding and vegetable juices/fruit juices can also be given as part of the weaning diet. The reason for the inconsistency in the finding of the rural poor may be due to the fact that, they may not be able to purchase available commercial processed foods. .(Ujiri, 2001)

Analysis also revealed that majority of the respondents (37%) wean their children early because they would like to return back to their work as early as possible and also a greater percentage of the women (45%) asserted that the effect of early weaning can lead to diarrheal disease and 20% said it can lead of malnutrition (protein calorie malnutrition). Paul (2005) asserted that, a single but important problem that caused malnutrition was premature weaning of children. Also children who were admitted to the hospital for protein calorie malnutrition diarrheal diseases had been weaned earlier than 6 months of age. (Jellifie, 2001)

The study therefore, concluded that the women of reproductive age at Ngwo, Udi Local Government Area of Enugu State displayed a good attitude about weaning but their practice of weaning diet is marginal, therefore efforts should be made to help educate these women on the type of diet to incorporate during the weaning period.

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DETERMINANTS OF NURSES JOB STRESS IN CRITICAL CARE WORK PLACE. A STUDY OF NURSES IN THE UNIVERSITY OF CALABAR TEACHING HOSPITAL, CALABAR, CROSS RIVER STATE, NIGERIA.

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Abstract

Stress is a universal phenomenon experienced by all humans in the course of life on earth and pervades all human endeavors. Job-stress is mostly experience by professions that interact with humans when in distress, and nursing, is foremost in the line of professions. It is a factor that affects job performance therefore detrimental to productivity. This study was carried out in the University of Calabar teaching hospital with the purpose of identifying determinants of Nurses Job-Stress in critical workplaces of the hospital. A survey design was adopted for the study. Nurses working in critical care settings of the hospital such as intensive care unit, recovery room, special care baby unit, sick baby unit and Adult Accident and Emergency unit were purposively used for the study. It was a census study since the entire populations of nurses in these wards were used due to the small size of available nurses. Data was obtained from a sample size of 58 nurses using a self structured questionnaire and was presented in tables and analyzed in percentages and chi square. Findings revealed that there was shortage of nursing manpower at the ratio of 1:6 (one nurse to six patients) per shift in critical care units. Also, the result showed that shortage of nursing manpower and lack of training/ skills were the major determinants of nurses' job-stress in the critical care units of teaching hospital Calabar. It was recommended that the management of the hospital should employ more nurse and increase in-service training scheme for nurses in specialty areas so as to reduce the identified stress inducers in critical care units.

Key Words: Determinants, Nurses, Job-stress, Critical care workplace.

Introduction

The word stress has become such an ingrained part of our vocabulary and daily existence. It is a universal phenomenon experienced by all humans in the course of life on earth. Selye (1976) asserts that without stress there would be no life. However stress is a coin with two sides, a negative and a positive side. Positive stress (eustress) which may be mild to moderate and intermittent, increase performance, while negative stress (distress) which is high and unremitted reduces performance.

Workers everyday experiences varied levels of stress as they come in contact with factors in their workplace that induce stress. Job-stress according to Mojdeh et al (2007) is mostly experienced by professions that interact with humans when in distress and nursing is foremost in this line of professions. The international Association of safety professions in Lelanie, 2008 identified nursing as the first most stressful professions. This stressful experience is more intense when the nurse is exposed to patients who are in constant pain, unstable and require greater levels of care such as characterize patients in critical care workplaces. Also, patients in these units require urgency of attention, are placed on highly technical equipment requiring high level of skills and their condition can take a turn for the worse in a heartbeat. Such is the situation in critical care units such as Accident and Emergency departments, intensive care units, recovery room, special care baby unit and sick baby unit of the university of Calabar teaching hospital. A stressed nurse may transmit stress indirectly to his/her patients through poor quality nursing care, thus the need to investigate stress inducers in critical care nursing care.

Statement of problem

The Teaching Hospital Calabar is the only tertiary health institution in the state and from all indications the best equipped in terms of specialize personnel and equipment to meet the needs of critically ill patients. Thus, the hospital experiences high influx of patients referred from all parts of the state and some who though not referred, see the teaching hospital as the only place they can get more detailed and expert services. Most referred cases, come to the hospital at critical state that demand or require a high level of care, urgency in attention and decision making. These patients are admitted in critical care units until their conditions become stable. Nurses in these units are in constant contact with these patients, they monitor their progress closely through highly technical equipment and sometimes, abandon some procedures to attend to alarms from monitors that require urgent attention. This makes nurses indispensible members of the critical care health team, with a high tendency of exposure to job-stress. They also determine patient satisfaction with health care

services; therefore, any factor that causes poor performance affects not only the patients but the entire system. Job stress among nurses has a detrimental effect on the quality of nursing care rendered, therefore, the need to investigate possible stress inducing factors among nurses, working in critical care settings of University of Calabar Teaching Hospital, Calabar, to enable stake holders intervene appropriately.

Specifically, the study sought to;

1. Determine the level of nursing manpower in critical care work places of teaching hospital Calabar.
2. Find out the extent to which shortage of nursing manpower cause job stress among nurses working in critical care units of the hospital.
3. Determine if lack of specialty training/skills in critical care nursing is a source of job stress in critical care units.
4. Ascertain if inadequate work equipments /materials is a source of nurses job stress in critical care units of Teaching Hospital Calabar.
5. Investigate the extent to which poor reward/lack of special incentives cause job-stress in critical care units of teaching hospital Calabar.

Hypothesis

There is no significant relationship between shortage of nursing manpower and nurses' job stress in critical care units of Teaching Hospital Calabar.

The following research questions were raised to guide the study:

1. What is the level of nursing manpower in the critical care units of the hospital?
2. To what extent does shortage of nursing manpower cause job-stress among nurses working in critical care units?
3. Does lack of training/skills in critical care nursing induce job-stress in critical care units?
4. Is there any relationship between inadequate work equipments/materials and nurses job-stress?
5. Does poor reward/lack of special incentives for nurses working in critical care units induce job-stress?

Significance of study

The result of this study will assist and guide the management of UCTH to identify stress inducers that are relevant to the hospital, reveal the ratio of patients to nurse per shift so as to review policies on nursing manpower recruitment based on the needs of the various nursing specialty areas and in-service training. Also, nurses in these units would know major stress-inducers so as to generate a work plan that would reduce the impact of these factors. If nurses are able to identify stress inducer in the work place, they may better be able to handle problems when and even before they arise. Knowledge of job-stress determinants in critical care units would benefit the profession as nurse leaders would initiate better policies on motivation of these nurses so as to cushion the effect of the stress factors and make the job more interesting.

Review of related Literature.

Theoretical framework

Various theories and models have been used by writers and researchers to explain the phenomenon of stress and job-stress specifically. The theoretical frame work for this study was embedded in transaction/cognitive theory of Lazarus and Folkman (1984). Lazarus and Folk man, view job-stress as a particular relationship between the person (worker) and his/her work environment which the worker appraises. The theory proposes that, an individual stress reaction is determined by his/her interpretation or appraisal of work situation either as harm, threat or challenge. This is the primary appraisal. The secondary appraisal involves a self assessment of the worker's copying resources. That is his/her ability to cope with the harmful, threatening or challenging work-situation. This implies that if the nurses working in critical care units of UCTH appraise the high-work load related to shortage of nursing manpower, inadequate work equipment/material, lack of incentives or lack of specialty training/skills as a harm or threat, negative stress (distress) results which reduces job performance but if the nurse perceive this as a challenge and appraises her copying ability as adequate, it results in positive stress (eustress) and increase performance.

Some researchers have studied job stress and critical care units of various hospitals over time. Meltzer and Huckabay (2004) opined that critical care workplaces are the most stressful areas both for the patients and the nursing staff. Karen (2003) wrote that, critical care nursing is an aspect of nursing care that deals specifically with human responses to life threatening problem. It is concerned with patients who are at high risk for actual or potential life threatening conditions. The more critically ill the patient, the more likely he/she is to be vulnerable, unstable and complex thereby requiring intense and vigilant nursing care.

Factors identified as stress inducers include communication and relationship with patients and relatives, high level of knowledge and skill required, the necessity to respond immediately in an emergency, the very high work load and understaffing, lack of support and inability to escape for break. (Meltzer and Huckabay, 2004)

WHO in Obadiya (2011), observed that some advance countries have approximately 1,000 nurses per 100,000 population while many developing countries including Nigeria have 10 (ten) nurses per 100,000 population or even less, increasing the stress level of nurses in Nigerian hospitals. Makie [2006] assert that 70% of nurses surveyed by the American Nursing Association cited over work due to shortage of nursing manpower as one of their top three health's and safety concerns. The specialized skills, experience and training it takes to cope and be qualified to work in critical care units preclude these settings. From having

sufficient nurses to work here, Karen [2003] propose that critical care units generally require one nurse per every one or two patients but nurses sometimes handle six to 10 patients per nurse in a shift. This ward situation causes high level of work stress experienced by Nurses.

According to Karen (2003), training and experience are key to critical care nursing. The orientation is longer because there is a lot more technical responsibility. Also, Budassi., Shehy and Leduc[2002] observed that the critical care units is a specially equipped hospital area that has special resuscitation and monitoring equipment and are staff by personnel specially trained and skilled in recognizing and immediately responding to clients' change in condition. Mcvicar [2003] reported that nurses who were not trained, lack skills and are inexperience in critical care nursing, reported low level of confidence in responding to patients' needs, operation of high technical equipment and reporting observations as interpreted by the monitoring equipment. They perceived lack of skill as a strong and vital source of job stress. Supporting the issue of lack of skills and experience as a cause of job- stress, Lelanie [2008] stated that, sources of stress in emergency and critical nursing environment include staff shortages, compassion fatigue, training and qualification and years of experience in clinical settings. Lau, Chan and Chan [2005] observed that stress is inherent in critical care environment because of the highly technical equipments and monitoring gadgets which require specialized skills to operate them.

Inadequate provision of work-equipment in Nigeria hospitals has been identified as a source of Job stress. The FMOH in Obadiya [2011] assert that the delivery of health care in the health system involves three lines of actions; system input, health production and system output. System input include facilities, equipment, supplies that are required for health production by health providers who supply the output for patients. Akah, Chukwurah and Ihejiamaizu [2005] also observed that factors such as Shortage of nursing power, inadequate provision of equipment, unconducive work environment among others adversely lowers the morale of nurses. This trend is evident in situations where patients cannot be attended to except they provide materials even as insignificant as hand gloves, razor blades, disinfectants and bandages and some, because of poor condition of bed linen, provide their own bed sheets, such situations result in undue delay in attending to patients, lowers the morale of nurses and, cause job stress as nurses tend to improvise in attempt to render care required.(Castle, 2006 and Akah,et al, 2005)

Afolayan, Adebanjo and Olubiyi (2010) in their book on critical care nursing attributed stress broadly to two factors; environment and relationship. Environmental factors identified include crowded work place, noise, shift rotation, inadequate equipments, inadequate drugs and personnel. While inter personal relationship factors include communication barriers, lack of decision making authority, lack of rewards, and working with inexperienced peers among others. McGowan (2003) observed that stress is having a greater impact in today's Nursing work-force particularly the critical care nurses with higher stress experience due to the emergence of new issues. He asserts that lack of reward and terms of employments are becoming more prominent displacing some other issues in other of ranking. Also, lack of reward, inadequate protection and working equipments and increase exposure to infection and litigation are becoming an increasing source of frustration and disengagement which is a major component of a burnout. Lau,Chan and Chan (2005) in a study of Nurses working in intensive care units in Hong Kong revealed that 80% of intensive care nurses identified poor incentives, poor pay, and no opportunities for advancement as sources of stress. In line with the study, Madu and Mamomane (2003) in a study of 780 black nurses working in critical care units in South Africa identified three top world stressors, as; poor working conditions (shortage of staff, equipments, medicines, poor salaries and limited scope for vertical mobility e.g. promotion) work environment and managerial styles. This observation was also affirmed by FMOH (2004) stating that lack of motivation in terms of inadequate reward for hard work, poor salaries, delay in payment of salaries, nonpayment of fringe benefits has adverse effects on the morale of workers causing stress and tension in work place.

Methodology

Design and Setting: The study adopted a descriptive survey designed to elicit information on determinants of nurses job-stress in critical care nursing workplace. The study was carried out in the University of Calabar teaching hospital, Calabar, Cross River State. The teaching hospital is made up of three annexes and a permanent site located in Calabar municipal council, It became a teaching hospital in 1979 and has a bed capacity of 600 beds with the following wards;2 male wards, 2 female wards, 2 children ward, 2 amenity ward, sick baby unit, special care baby unit, labor ward, postnatal ward, eye ward, ENT section, adult and children accident and emergency unit, operation theater, an intensive care unit and a recovery room (copy right, 2010).

The study population consisted of all registered nurses working in critical care units of the hospital. Nurses were used because there are in a better position to identify stressors related to professional practice of critical care nursing. The critical care units used for this study were Accident and Emergency department, sick baby unit, Special care baby units, intensive care and recovery room. These units were the focus of the study due to the highly technical equipment and nature of patient found in these units.

Sample and Sampling technique. Nurses were purposively selected for this study. The entire population of nurses working in the selected units as at time of study was 69 but 58 nurses was available for the study while others were on annual leave. Due to the small population available for study, the entire population of 58 nurses were used, therefore, according to Denga and Ali (1998) it could be said to

be a "census study".

Method of data collection: The instrument for data collection was tested for validity by research statisticians and lecturers in the college of health technology Calabar. It was also tested for reliability. A 19 item self structured questionnaire with close ended questions was used to elicit information on identified variables. The items covered socio Demographic data, nursing manpower level, shortage of nursing manpower, lack of special training/skills, inadequate work equipment/materials, and poor reward/lack of special incentives and job stress in critical care nursing units.

Ethical consideration: A written application for permission and proposal was sent to the nursing management and approval was given and duplicates of approval sent to the nursing heads of the selected units before the distribution of the questionnaires. The questionnaires were distributed individually to the respondents after a verbal consent with the aid of an assistant. Confidentiality was assured verbally, written and by using numbers on the questionnaires.

Data collection: Data for the study was collected using a self structured questionnaire. The Questionnaires were distributed to the respondents and allowed to respond independently. The distribution and collection lasted for three weeks covering the three shifts.

Methods of data analysis

The data generated was prepared and coded. Results were presented in tables, bar chart and percentages. Chi square at .05 significance level was used to test statistical relationship between independent and dependent variables respectively.

Data presentation

Table 1: Socio-demographic characteristics of respondent

1. Age :	**Respondents**	**Percentage**
12-30 Years	8	14%
31- 40 Years	17	29%
41- 50 Years	21	36%
51- 60 Years	12	21%
Total	**58**	**100%**
2. Sex -Female	58	100%
Male	-	
	58	**100%**
3. Rank - Nursing Office	12	21%
Senior Nursing Office	10	17%
Principal Nursing Office	15	26%
Assistant Chief Nursing Office	13	22%
Chief Nursing Office	8	14%
	58	**100%**
4. Years Of Practice		
1-10 Years	16	28%
11- 20 Years	14	41%
21 -Above	18	31
	58	**100%**
5 Ward Placement		
Accident And Emergency Unit	17	29%
Special Care Baby Unit	14	24%
Sick Baby Unit	10	17%
Recovery Room	8	14%
Intensive Care Unit	9	16%
	58	100%

Table 1: Present the socio-demographic characteristic of respondent. It showed that, of the 58 respondents 12 (21%) were nursing officers, 10(17%) senior Nursing officers, 15(26%) principal nursing officers, 13 (22%) were Assistant chief nursing officers and chief nursing officers accounted for 8(14%) of the respondents. The respondents were all females 58(100%) with no male respondent. 16(28%) had 1-10 years of practice, 24(41%) had practiced for about11-20 while 18(31%) had practice years ranging 21 years and above. Nurses working in the Accident and Emergency unit of the critical care setting accounted for 17(29%) of the respondents, special care baby unit 14(24%), sick baby unit 10 (17%), recovery room 8(14) while 9(16%) respondents work in the intensive care unit.

Table 2: Level of nursing manpower in critical care workplace

Ratio of nurse to patient per shift	**Respondents**	**Percentage**
1:4	18	31%
1:6	30	52%
1:8	10	17%
	58	**100%**
Nursing staff strength in the unit		
Low	39	67%
Moderate	14	24%
High	5	9%
	58	**100%**

Table 2 Indicate that the response for nurse - patient ratio of one nurse to six patients (1:6) was 30(52%), 18(31%) gave the nurse-patient ratio in their unit as 1:4 while 10 (17%) of nurses indicated a nurse to patient ratio of 1.8 per shift. Majority of the respondents 39(67%) indicated that their unit had low level of Nursing manpower, 14(24%) had moderate Nursing staff strength while 5(9%) of respondents accepted that the nursing staff strength in their unit was high.

Table 3: Response on shortage of nursing manpower and nurses Job-stress

Variable	**Response**	**Frequency**
With the nursing staff strength in your unit, are you able to complete your job schedule	Yes No	23 (40%) 35 (60%)
Total		58 (100%)
How will you describe the impact of shortage of nursing manpower on you	Discouraging Stressful Normal experience	11 (19%) 34 (59%) 13 (22%)
Total		58 (100%)

Table 3 shows Nurses response on shortage of nursing manpower as a determinant of job stress in critical care units. On ability to complete job schedule per shift with shortage of nursing manpower, 35(60%) of the nurses response was negative while 23(40%) accepted that they completed their duties. Responding on the impact of shortage of nursing manpower, 11(19%) of the respondents said it was discouraging, 13(22%) saw it as a normal experience while 34 (59%) accepted it was stressful.

Table 4: Response on Lack of specialty training/ skill in critical care nursing and job stress.

Variable	Yes	No	Total
Have you received any specialty training related to the unit you are working?	25(43%)	33(57)	58 (100%)
Does it affect your ability to render care?	31 (53%)	27 (47%)	58 (100)
Is lack of specialty training/ skill a source Of nurses job stress?	36(62%)	22 (38%)	58 (100%)

Table 4 Reveal that 33 (57%) of nurses working in critical care units of the hospital have not received specialty training and lack special skills related to the unit they are working while 25 (43%) have been trained. Also, 31 (53%) 0f nurses agreed that lack of training/skill affect their ability to render care while 27 (47%) of nurses indicated that lack of training/ skill does not affect their ability to render care and operate equipment found in their units.

In response to whether lack of specialty training/skills is a source of nurses' job-stress, 36 (62%) affirmed that it is a source of job stress while 22 (38%) respondents gave a negative response.

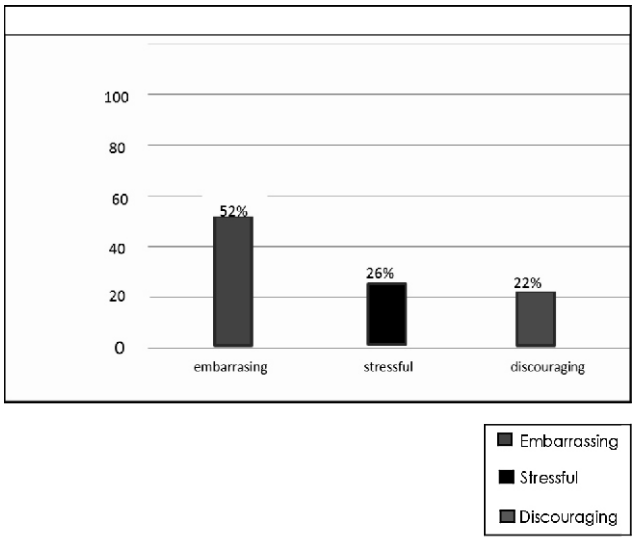

Fig 1. Inadequate materials and nurses job stress in critical care work place.

Figure 1 Reveal that 30 [52%] perceive the inadequacy of work materials as embarrassing, 15 [26%] saw it as a cause of stress while 13 [22%] saw it as discouraging.

Table 5: Poor reward/ lack of special incentive for nurses in critical units and nurses job stress

Variable	Yes	no	Total
Is there any special incentive for nurses Working in critical care units?	9(16%)	49(84%)	58(100%)
Does the hospital have any way of rewarding hard Work?	15(26%)	43(74%)	58(100%)
Is poor/lack of special incentive for nurses Working in critical care units a source of Nurses job-stress?	23(40%)	35(60%)	58(100%)

Response as shown on the table 5 revealed that 49(84%) of respondents responded negatively indicating that there was no special incentives for nurses working in critical care while 9(16%) gave a positive response,15(26%) accepted that the hospital have a way of rewarding hard work while 43(74%) revealed that the hospital has no special way of rewarding hard work. 35(60%) of the respondents did not see it as a source of job stress while 23(40%) saw it as a source of stress.

Hypothesis: There is no significant relationship between shortage of nursing manpower and Nurses Job stress in critical care workplace.

Chi square statistical technique was employed as shown below.

Table 6: Relationship between shortage of nursing manpower and Nurses Job stress.

Variable	(O)	(%)	(E)	X^2
Discouraging	11	19	19.3	
Stressful	34	19	19.3	16.1
Motivating	13	22	19.3	

The result of chi square analysis revealed that the calculated x2 value of 16.1 was greater than the critical value 3.84 at .05 level of significance. With this result the null hypothesis is rejected. This shows that there is a significant relationship between shortage of nursing manpower and nurses Job-stress in critical care workplaces of teaching hospital Calabar.

Discussion

The low staffing level of nursing manpower is a

problem in health facilities. Table 2 shows that 30(52%) of respondents affirm that the ratio of nurse to patient is about 1.6 and 39(67%) of the respondents concluded that the staffing level in their units are low. This result supports the findings by Obadiya (2011) and Makie (2006) that many developing countries including Nigeria have 10(ten) nurses per 100,000 patients population increasing the stress level of nurses' job stress.

The chi square analysis of the relationship between level of nursing staff strength and nurses job stress revealed that there is a significant relationship between low level of nursing manpower and nurses job stress. This finding collaborates the report by Karen (2003) that critical care units generally require one nurse per every one or two patients but nurses sometimes handle six to ten patients per nurse in a shift. This ward situation causes high level of work stress experienced by nurses working in critical care units.

The findings on lack of specialty training/skills showed that 33 (57%) of the nurses working in the various critical care units have not received any specialty training related to the units they are working and this is a source of job-stress as affirmed by 35(60%) of the respondent. These findings agree with Mcvicar (2003) reports that nurses who were not trained lack skills and are inexperience in critical care nursing reported low level of confidence in responding to patients' needs, operation of highly technical equipment and reporting observations as interpreted by the monitoring equipment. They perceived lack of training and skills as a strong and vital source of job-stress.

Results on inadequacy of work materials such as gauze, cotton wool, catheters, plaster, razor, blades disinfectants' and catheters among other consumables showed that they were inadequate in the ward stock but contrary to the findings of Castle (2006) and Akah,Chukwurah and Ihejiamaizu (2005), the nurses in critical care units of teaching hospital Calabar did not perceive inadequate work materials as a source of stress rather, they saw it as embarrassing as revealed in figure 1. Castle (2006) and Akah, Chukwurah and Ihejiamaizu (2005) observed that situations where patients cannot be attended to except they provide materials even as insignificants as hand gloves, razor blades, disinfectants, bandages and some patients because of the poor condition of bed linen provide their own bed sheet result in undue delay in attending to patients, low morale of nurses and job-stress as nurses tend to improvise in attempt on render care.

Analysis of response on poor rewards/lack of special incentives for nurses working in critical care units and job stress as revealed table 5: indicates that there are no specials incentives for nurses working in critical care work place of teaching hospital Calabar neither is there any way of appreciating hard working nurses in critical care units. This was not a source of nurses job-stress as shown by their negative response. This contradicts the report by Lau, Chan and Chan (2005) that 80% of nurses working in intensive care units in Hong Kong identified poor incentives, poor pay and no opportunities for advancement as a source of stress. This finding also differs from the observation by the Federal Ministry of Health which asserts that lack of motivation in terms of inadequate reward for handwork, delay in payment of salaries, nonpayment of fringe payments affect the morale of workers causing job stress and tension in the workplace. Drawing from the findings of this study it implies that poor reward/lack of incentive was not a problem or stress inducer among nurses working in critical care units of university of Calabar teaching hospital for reasons beyond the scope of this study.

Implication Of The Study To Nursing Practice

Care is the very reason why nursing exist and rendering quality nursing care to the consumers of nursing services is the ultimate goal of the profession. The achievement of this goal may be a mirage if nurses' job stress inducers pervade the nurses' workplace particularly the critical care

Workplace where job stress is inherent in view of the peculiar nature of patients found in these units.

Nurses by the nature of their services determine health care consumer's satisfaction with the entire health care delivery system thus any situation that induce nurses stress affects consumers satisfaction with care. This is inevitable because a stress nurse may indirectly transmit stress to the clients through client neglect and abandonment, hostility and medication errors. Such situations jeopardize the goal of nursing care, the image of nursing as a noble profession and becomes very dangerous In units like the critical care settings where the patients are critically ill, unstable and need constant attention.

This study exposes determinants of job stress in critical care workplaces of teaching hospital calabar. This would facilitate formulation of policies that would reduce nurses' stressors in the workplace so as to enhance maximum performance and output in terms of nursing care.

Conclusion and Recommendation

Base on the findings of this study, it was concluded that nurses working in critical care units of Teaching hospital Calabar experience job stress related to shortage of nursing manpower and Lack of specialty training/skills related to their units.

In view of the findings, the following recommendations were made;

1. Nurses posted to critical care units who have not attended any specialty course related to the unit should see it as an opportunity to learn and gain new skills by watching the skilled nurses perform activities and asking questions where necessary.
2. Nursing management should organize in -door training sections and seminars for newly Qualified/posted Nurses and those who have not been trained in critical care nursing. This prepares the nurses to face challenges commonly encountered in the ward.
3. The skilled nurses in the units should understand

the importance of sharing Knowledge and team work but not an avenue to scold and expose the weaknesses of the unskilled and new Nurses.

4. The university of Calabar teaching hospital management should employ more nurses so as to reduce the number of patients per nurse in a shift. This would reduce the job-stress experienced by nurses working in critical care units of the hospital.
5. Policies regarding in-service training of nurses should be reviewed to accommodate more number of nurses trained per year in different areas of nursing specialties so as to enhance job performance and reduce job-stress.

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KNOWLEDGE AND PRACTICE OF HAND WASHING AMONG NURSES IN THE MATERNITY ANNEX, UNIVERSITY OF CALABAR TEACHING HOSPITAL

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Abstract

A descriptive survey was designed to assess knowledge and practice of hand washing among nurses in the Maternity Annex, University of Calabar Teaching Hospital Calabar. Four objectives, four research questions and two hypotheses were used to guide the study. A sample size of 120 nurses was used for the study. Data collection was through a self reporting questionnaire and check list. Data was analysed using frequencies, percentages Pearson Product Moment Correlation Coefficient to test hypothesis. The result revealed that they were more female 117 (97.5%) than male 3 (2.5%) majority of the respondents were within the age range of (31-34 years). Responds with years of nursing experience were 15-20years. The hypotheses was tested. The result shows nurses knowledge of hand washing and practice of standard hand washing technique. A positive and insignificant relationship was observed (r = 0. 124, d.f = 118, (p >.05) null hypotheses is retained. Based on the finding it was recommended that the hospital management should conducts seminar and conference every 3 month to enlighten nurses on proper hand washing technique practice in the hospital till perfection. However for quick decontamination alcohol- based hand rubs should be provided in hospitals. Frequent supervision of proper hand washing should be conducted or inspected by the ward charges so as to correct where and when applicable.

Introduction

The hands of staff are thought to be the most common route by which microorganisms are spread between patients. These microbes are acquired on the skin by contact with people or the environment. They do not remain on the skin for long but are readily transferred to the next person or object touched. They are also easily removed by hand-washing with soap and water. Even a brief 10 seconds hand wash is effective, but attention should be paid to exposing all parts of the skin to soap and water to ensure complete removal of transient contaminants. (Hoffman and Wilson 2000). Unfortunately, many studies have shown that hands are frequently not washed appropriately and such omissions are commonly considered responsible for outbreaks of hospital-acquired infection (Ward 2000).

According to Smelter and Bare (2000), hand-washing is important because transient bacteria can be easily removed before transfer to other patients. Effective hand-washing calls for at least 10-15 seconds of vigorous scrubbing with special attention to the areas around nails beds and between fingers where there is high bacterial burden. Hands should be thoroughly rinsed after washing and dried. Hand-washing is an act of cleansing the hands with water or another liquid with or without the use of soap or detergents for the sanitary purpose of removing soil or micro-organism. The purpose of washing hands is for cleansing the hands of pathogens (including bacteria or viruses and chemical) which can cause personal harm or disease. This is especially important for people who handle food or work in medical field. The centre for disease control and prevention (CDC) (2000) has stated "it is well documented that the most important measure for preventing the spread of pathogen is effective hand-washing.

Nosocromial infection (NI) now hospital-acquired infection are infection that the patient was not suffering from, or incubating at the time of admission to hospital. Infection may be endogenous that is caused by microorganisms that colonize the body, entering another site to establish infection (example Gram negative bacilli in the intestine may cause wound infection after abdominal surgery) or exogenous caused by the transmission of microorganism from the environment or another person. NI may prolong hospital stay, increasing the cost of treatment as well as causing discomfort and inconvenience to the patient. The principal types of infection acquired in hospital involve surgical wounds, urinary and respiratory infections. To prevent the transmission of infection between patients, from patient to staff, and from staff to patients. Nurses have the responsibility to practice and promote measures (hand washing) that will confine microorganisms (Walsh 2002).

Therefore the knowledge and practice of hand washing among nurses in maternity annex, will help in minimizing contamination and preventing the transferring of pathogenic micro-organism to other individuals as well as reducing the rate of morbidity and mortality among hospitalized patient in maternity annex of University of Calabar Teaching Hospital, Calabar.

Statement of Problem

As a new nursing student, experience during my clinicals, exposed me to a lot incidence of diarrhorea among babies in Peadiatric ward. The

condition always persisted for sometime before discharged. While in the surgical unit both male and female ward as well as Maternity Annex mostly Gynae ward, Upperblock and Post-natal as well as Sick baby's unit. I also observed that wound do not heal by first intention. However, in recent years even as a nursing science student of University of Calabar, it was found out that, the same condition persisted mostly with unbooked cases but in a more limited way. Mothers used to suffer changing their beds cloths with their own wrappers because the hospital bed clothes could not circulate to reach the number of women, their children suffered from diarrhoea and vomiting.

This result in social stigma, embarrassment as well as depression and psychological influences on the part of the patient, mothers of the children as well as patients relations. Apart from psychological impact, prolonged wound drainage and persistent diarrhoea and vomiting result in fluid and electrolyte imbalance. Continuous wound drainage soiled bed cloths requiring a lot of materials and other consumable items, thereby increased the cost of care to the patient. This has even cause a tremendous loss to the hospital. Patients family also suffer financial and psychological stress, due to the fact that nurses do not seem to maintain the principles of hand-washing before and after caring for the patients.

Having encountered several of the above problems, I was motivated to carry out this study to access the knowledge and practice of hand-washing among nurses in Maternity Annex of (UCTH) Calabar.

Purpose / Aim of the Study

The purpose of the study is to assess the knowledge and practice of hand-washing among nurses in the Maternity Annex of the (UCTH) Calabar.

Specific Objective

- To identify the knowledge of standard hand-washing among nurses in Maternity Annex.
- To ascertain, if nurses in Maternity Annex practice standard hand-washing technique in the care of the patients.

Research Questions

- What is the level of knowledge of hand-washing among nurses in Maternity Annex of (UCTH) Calabar?
- Do nurses in the Maternity Annex actually practice standard hand-washing technique.

Hypothesis

- There is no significant relationship between knowledge of hand-washing and the practice of standard hand-washing techniques by the nurses in the Maternity Annex.

Scope of Study

The study involved all cadre of nurses in the profession in ten units/wards.

Significance of the Study

To the Nursing Administrator

This study will reveal factor influencing Nursing practice to hand-washing on information that will help Nurses manage to boost this practice amongst them, and to identify appropriate hand-washing technique in the care of patient in nursing practice.

To the Patient

This study will reduce prolong stay in the hospital caused by Nosocromial infection as well as reducing hospital bills and other expenses.

To the Researchers

The study will also provide reliable literature for further researchers in this area.

Operational Definition of Terms

Knowledge of hand washing: understanding of the guidelines for effective hand washing practice.

Practice of hand washing: Act of adequate friction and thorough cleaning of hand surface with soap and water for at least 15 seconds before and after attending to patient.

Literature Review

Knowledge of Hand-Washing

From time immemorial, man is trying to control diseases. The medicine man, the priest, the herbalist and the magician; all tried to bring relief to the sick in an almost complete absence of scientific medical knowledge. One of the most important tasks in health care is providing healthy environment for patients and oneself, whereas significant method to prevent the spread of disease and germs is hand-washing. It is a safety skill required not only for patients but also for health personnel and patients relatives. The hands of health care workers are often responsible for the transmission of various infections but unfortunately, hand-washing practices, often appear more ritualistic than realistic (Bedi, 2000).

Normally transient and resident bacteria are found in hands, and are found in greater number under the finger nails. Transient bacteria can be removed by washing the hands thoroughly and frequently, whereas resident bacteria, normally found cling to the skin by adhesion and absorption and considerably friction with brush is required to remove them. If transient bacteria become resident bacteria the hands are carriers of the particular organisms. Hand-washing with the soap and water is the simple and cost-effective measures for infection control (Seyder, 2000).

Practice of Hand-Washing

When identifying factors that promote hand-washing with soap, different elements or conditions come to play. These are associated with preventing the contamination apparent in the environment and with avoiding negative social control. In a context in which water, soap and hand-washing location are available, the nurse becomes the main actor responsible for associating hand-washing practices with the concepts that promote the practice in an

effort to achieve a sense of cleanliness and to establish the link between health status and dirtiness. Mass and interpersonal media also play a role in promoting the practice, especially in reinforcing the ideal of cleanliness and the nurses role in achieving it (Glanz, Rimer, Lewis, 2002).

More recently, Pittet, Hugonnet and Harbarth (2000) produced evidence to show that residual moisture left on hands after washing allow translocation of micro-organisms from fingers to solid surfaces during touch contact. The authors then went on the show that the translocation of bacteria following touch contact, is also related to the time spent in drying, in order to remove sufficient micro-organisms.

Given these findings, Gould underlined, the importance of drying hands following hand-washing in her 2000 review of hand-washing facilities in the clinical area, and she raised the issue of the best method for drying hands which has been the subject of much research and debate in recent years.

Comparative studies of paper towels and cloth towels have revealed paper towels to be the most effective hand drying method (Gould 2000).

Techniques of Hand-Washing

- Make sure sleeves are rolled up and do not get wet during washing
- Wet hands and forearms thoroughly in running water,.
- Apply 5mls of the appropriate product.
- Rub palm to palm
- Right palm over left dorsum and left palm over right dorsum
- Palm to palm fingers interlace
- Backs of fingers to opposing palm fingers interlocked
- Rotational rubbing of right thumb clasped in left palm and vice versa
- Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
- Rinse and dry hands and forearms thoroughly

N/B: Ensure that each step consists of 5 strike backwards and 5 forwards.

For surgical hand decontamination forearms is included in the procedure.

This hand washing technique is based on a method first described by Aylife et.al. (1998).

Concept /Theory Health Belief Model Explaining Health Behaviours

The Health Belief Model (HBM) is a psychological model that attempts to explain health and predict health behaviours. This is done by focusing on the attitudes and beliefs of individuals.

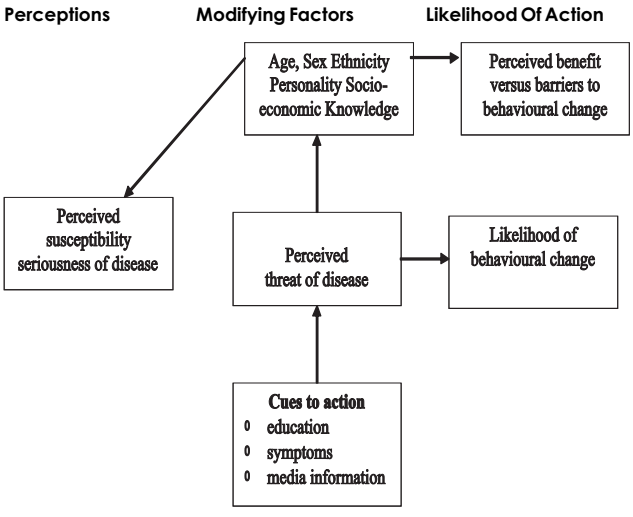
Core Assumptions and Statements

The HBM was spelled out in terms of four concepts representing the perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. These concepts were proposed as accounting for peoples "readiness to act". An added concept, cues to action activate that readiness and stimulates overt behaviour. The recent addition to the HBM is the concept of self-efficacy, or one's confidence in the ability to successfully perform an action.

Theory at a Glance: A Guide for Health Promotion Practice (1997)

Concept	Definition	Application
Perceived susceptibility.	This gave chances of getting a condition.	It defines population(s) at risk, to heighten perceived susceptibility if too low.
Perceived seVerity.	How serious a condition and its consequences are.	It specifies consequences of the risk and the condition.
Perceived benefit.	Efficacy of the advised action with reduce risk or seriousness of impact.	It defines action to take; how, where and when; clarify the positive effects to be expected.
Perceived barriers.	To get tangible and psychological costs of the advised action	It identifies and reduce barriers through reassurance, incentives, assistance.
Cue to action.	Give strategies to activate readines.	It provides information to promote awareness, reminders.
Self efficacy.	Gives confidence in ones ability to take action.	It provides training, guidance in performing action.

Glanz, Rimer, Lewis (2002).



Source:Glanz et.al., 2002, p.52

Application of the Model to the Study

The knowledge and practice of hand-washing among nurses is related to the theory of Health Belief Model in the sense that, if a person have belief and trust for something. There is no where he or she will not adhere to it.

In the practice of hand-washing a nurse who have the knowledge that non-compliance will cause infection will adhere to it so as to avoid its occurrence. Likewise the patient. By so doing the hospital acquire infection will be reduced. Prolonged stay of the patient in the hospital will not come on at all. Wound breakdown will not even occur but wound healing by first intention will come to stay. No more stress, no more pain on the part of the patients. Their relations will not have much expenses to make. Nurses will be happy in rendering these service to the patient. The management will spent less in buying consumable materials.

Methodology

Research Design

A descriptive design was adopted for this study.

Research Setting

The research setting is the maternity annex of University of Calabar Teaching Hospital, Calabar. (UCTH) The hospital has 4 sites (St. Margaret's Annex, Maternity annex, the permanent site and Comprehensive Health Centre Okoyong. The maternity annex is composed of 99 beds / 97 cots and 8 wards / 5 units including specialty areas like theatre, family planning, public health and intensive care unit for babies with 152 nurses. It is an institution for safe-motherhood where mother comes in, have their babies and go back home happily.

The site being the researchers place of work, she observed a lot of relapses pertaining to hand washing and even during scrubbing for surgery.

Target Population

The target population consist of one hundred and fifty-two nurses (152) working in various unit of the maternity annex.

Sample and Sampling Technique

The simple sampling technique of stratified random sampling was used to select the subjects. The size was one hundred and twenty (120) respondents.

Instrument for Data Collection : This was questionnaire and observation checklist with yes and no remark made. It was divided into three sections socio-demographic data, knowledge and practice of hand washing.

Validity of the Instrument: The instructions given was adhered to accordingly.

Reliability of the Instrument: The reliability of the instrument was determined through a test retest reliability co-efficient, the value of 0.75 obtained. This was considered high enough for the study.

Ethical Consideration

The information obtained was confidentially.

Procedure for Data Analysis

Data was analysed using frequency and percentages. Pearson Product Moment Correlation Coefficient, was used to test the statistic for the hypothesis. The result was presented in tables.

Results

This deals with the socio demographic data of respondents, research questions and research hypothesis.

Socio Demographic Data

Age indicates that 11 (9.2%) of the respondents were aged 20-24 years, 17 (14.2%) were 25-30 years, 27 (22.5%) were 31-34 years old, 25 (20.8%) were 35-40 years old 15 (12.5%) were 41-44 years old, 15 (12.5%) were 45-50 years old while 10 (8.3%) were 51 years and above. On their **sex** 3 (2.5%) were male while 117 (97.5%) were female. Their **marital status** showed that 94 (78.3%) were married 15 (12.5%) were single while 11 (9.2%) were divorced. Their **educational qualification** showed that 64 (53.3%) had OND/HND, 32 (26.7%) had B.Sc / B. N.Sc, 15 (12.5%) had BA/B-ED, 6 (5.0%) had post Graduate degrees, and 3 (2.5%) The **professional qualifications.** 31 (25.8%) were RN, 41 (34.2%) were RN/MW, 21 (17.5%) were RN/RM/RPHN, 16 (13.3%) were RN/RM/RPN, 11 (9.2%) had others. On their **professional rank** 27(22.5%) were No II, 11 (9.2%) were No I, 17 (14.2%) were SNO, 12(10%) were PNO, 22 (18.3%) were ACNO, while 31 (25.8%) were CNO. Their **years of nursing experience** showed that 21(17.5%) were 1-4 years, 17(14.2%) were 5-9 years 19(15.8%) were 10-14 years 32(26.7%) were 15-20 years, 31(25.8%) were 21 years and above. Their **current ward and unit of practice** showed that 12(10%) were selected from each of the 10 wards. Their **religious affiliation** showed that 106(88.3%) were Christians, 11(9.2%) were muslins while 3(2.5%) belonged to other religions. (see Table 1).

Table 1: Socio-demographic Data of Respondents.

Item	Frequency	Percentage
Age		
20-24 years	11	9.2%
25-30 years	17	14.2%
31-34 years	27	22.5%
35-40 years	25	20.8%
41-44 years	15	12.5%
45-50 years	15	12.5%
51-above	10	8.3%
Total	**120**	**100%**

Sex		
Male	3	2.5%
Female	117	97.5%
Total	**120**	**100%**

Marital Status		
Married	94	78.3%
Single	15	12.5%
Divorced / Separated	11	9.2%
Total	**120**	**100%**

Item	**Frequency**	**Percentage**
Educational Qualification		
OND/HND	64	53.3%
B. SC/B. NSC	32	26.7%
B. A /B. ED.	15	12.5%
Post Graduate Degree	6	5.0%
Others	3	2.5%
Total	**120**	**100%**
Professional Qualification		
RN.	31	25.8%
RN/MW	41	34.2%
RN/RM/RPHN	21	17.5%
RN/RM/RPN/	16	13.3%
Others	11	9.2%
Total	**120**	**100%**

Professional Rank		
NO II	31	25.8%
NO I	11	9.2%
SNO	17	14.2%
PNO	12	10.0%
ACNO	22	18.3%
CNO	27	22.5%
Total	**120**	**100%**

Years of Nursing Experience		
1-4 years	21	17.5%
5-9 years	17	14.2%
10-4 years	19	15.8%
15-20 years	32	26.7%
21-above	31	25.8%
Total	**120**	**100%**

Current ward /unit of practice		
SCBU	12	10%
SBU	12	10%
Upper Block	12	10%
Amenity	12	10%
Gynea	12	10%
ANW	12	10%
Post-natal WD	12	10%
Labour WD	12	10%
Obs and Gyneatheak	12	10%
ANC	12	10%
Total	**120**	**100%**
Religion		
Christianity	106	88.3%
Islain	11	9.2%
Others	3	2.5%
Total	**120**	**100%**

Specific Objective

Objective 1: What is the level of knowledge of hand washing among nurses in maternity annex of the University of Calabar Teaching Hospital?

On the respondents view of knowledge, it showed that 92(76.7%) of the respondents agreed that washing of hands under continuous running water with soap is important while 28(23.3%) disagreed. 97(80.8%) agreed that scrubbing of hands vigorously paying attention to nails bed is ideal while 23 (19.2%) disagreed. 87(72.5%) agreed that washing of hands with tepid water in a basin where there is no running tap is ideal while 33(27.5%) disagreed. 94(78.3%) agreed that washing of hands with warm water without soap 15 seconds is not proper while 26(21.7%) disagreed. 98(81.7%) agreed that hands are washed before and after each clinical procedure while 22(18.3%) disagreed. 55(45.8%) agreed that the limited time used in hand-washing should be 1 to 2 seconds while 65(54.21%) disagreed. 100(83.3%) agreed that routine washing of hands after removing gloves is proper while 20(16.7%) disagreed. 97(80.8%) agreed that wetting of hands before applying soap with rotational rubbing of wrist is effective while 23(19.2%) disagreed. 96(80%) agreed that proper hand hygiene is a single most important method for preventing infection while 24(20%) disagreed. 89(74.2%) agreed that hands are washed before and after caring for the patience while 31(25.8%) disagreed. From the above results it is concluded that nurses in maternity annex of the University of Calabar Teaching Hospital have knowledge of hand washing. (see table 2).

Table 2: Knowledge of Hand-Washing Among Nurses in Maternity Annex

Items	Agree Frequency	Percentage %	Disagree Frequency	Percentage %
Washing of hands under continuous running water with soap is important.	92	76.7%	28	23.3%
Scrubbing of hands vigorously paying attention to nails bed is ideal.	97	80.8%	23	19.2%
Washing of hands with tepid water in a basin where there is no running tap is ideal.	87	72.5%	33	27.5%
Washing of hands with warm water without soap for 15 seconds is not proper.	94	78.3%	26	21.7%
Hands are washed before and after each medical procedure.	98	81.7%	22	18.3%
The limited time used in hands-washing should be 1 to 2 second.	55	45.8%	65	54.2%
Routine washing of hands after removing gloves is proper.	100	83.3%	20	16.7%
Wetting of hands before applying soap with rotational rubbing of wrist is effective.	97	80.8%	23	19.2%
Proper hand hygiene is a single most important method for preventing infection.	96	80%	24	20%
Hands are washed before and after caring for the patient.	89	74.2%	31	25.8%

Objective 2

Do nurses in the maternity annex actually practice standard hand washing technique? This research question is answered using the observation check list as below:

Results indicates that 76(63.3%) of the nurses make sure that sleeves are rolled up and did not get wet during washing while 44(36.7%) did not 38(31.7%) wet their hands and fore arms thoroughly in running water while 82(68.3%) did not. 29(24.2%) applied 5ml of the appropriate product while 91(75.8%) did not 69(57.5%) rub palm to palm during hand washing while 51(42.5%) did not. 42(35%) placed right palm over left, dorsum and left palm over right dorsum during hand washing while 78(65%) did not. 58(48.3%) practiced palm to palm fingers interlace while 62(51.7%) did not. 44(36.7%) practiced rotational rubbing of right thumb clasped in left palm and Vice versa while 76(63.3%) did not. 48(40%) practiced rotational rubbing backward and forward with clasped fingers of right hand in left palm and Vice versa. 61(50.8%) rinse and dry their hands and forearms thoroughly while 59(49.2%) did not. From the above result is concluded that nurse in the maternity annex do not practice standard hand washing techniques. (see Table 3).

Table 3: Practice of Standard Hand Washing Technique

Observation	Practice			
	Yes	Percentage	No	Percentage
Make sure that sleevesare rolled up and do not get wet during washing.	76	63.3%	44	36.7%
Wet han ds and fore arms through in running water.	38	31.7%	82	68.3%
Apply 5ml. of the appropriate product.	29	24.2%	91	75.8 %
Rub palm to palm.	69	57.5%	51	42.5%
Right palm over left dorsum and left palm over right dorsum.	42	35%	78	65%
Palm to palm fingers interlace.	58	48.3%	62	51.7%
Back of fingers to opposing palm fingers interlocked.	55	45.8%	65	54.2%
Rotational rubbing of right thumb closed in left palm and vice versa.	44	36.7%	76	63.3%
Rotational rubbing backwards and forwards w ith clasped fingers of right hand in left palm and vice versa.	48	40%	72	60%
Rinse and dry hands and fore arms thoroughly.	61	50.8%	59	49.2%

Hypothesis

There is no significant relationship between nurse knowledge of hand washing and practice of standard hand washing techniques by nurses in maternity annex of UCTH Calabar. To test for this hypothesis Pearson Product Moment Correlation Coefficient is used. (see table 4).

Table 4 Pearson Product Moment Correlation Coefficient Analysis of the relationship between nurse knowledge of hand washing and practice of standard hand washing techniques by nurses in maternity annex UCTH Calabar.

Variable	Mean	SD	n	r-cal	r-crit	d.f.	p-value
Knowledge of hand washing by nurses	27.98	3.76	120	0.124	0.2	118	0.05
Practice of hand washing techniques	14.56	2.22					

The result shows the relationship between nurse knowledge of hand washing and practice of standard hand washing techniques. A positive and insignificant relationship was observed ($r=0.124$, $d.f. = 118$, $(p > 0.05)$. With this result the null hypothesis is retained. It therefore implies that there is no significant relationship between nurse knowledge of hand washing and practice of standard hand washing techniques in maternity annex of University of Calabar Teaching Hospital.

Discussion Of Findings

The Finding revealed that there was no significant relationship between nurses' knowledge of hand washing and practice of standard hand washing technique.

Here, the result showed that inspite of the fact that the nurses had knowledge of standard hand washing techniques they did not practice it in their daily activities.

Findings from socio demographic data, revealed that female respondents were 117 (97.5%) males 3 (2.5%). The age range shows that majority of respondent were age 31 34 year. This revealed that most of them were matured. Professional rank shows that majority of respondents were nursing officer II by implication Nursing officer II form the work force in the hospital.

Findings revealed that, nurses in maternity annex, have knowledge of hand washing. As shown in table two (2) that 100% (83.3%) has adequate knowledge. This is in line with the findings of Bedi (2000) and Seyder (2000).

The result of findings also showed that nurses in the maternity annex do not practice standard hand washing techniques. As shown in the table three (3) 91% (75.8%) do not practice because of heavy work load (too busy) as supported by Pittet et al., (2000).

The result is also supported by Rudnick (2004) as he identifies water less alcohol based hand rubs with antiseptic and emollient gel and alcohol swabs which can be applied to clean hand to promote effective hand hygiene practice.

Summary

After carrying out a the study, it reveals the following:

1. Nurses in maternity annex of the UCTH Calabar, have knowledge of hand washing.
2. Nurses in the maternity annex do not practice standard hand washing techniques.
3. There was no significant relationship between knowledge of hand washing and the practice of standard hand washing techniques by nurses in the maternity annex of (UCTH).

Conclusion

It was concluded that even though the nurses in maternity annex of (UCTH) Calabar, have knowledge of standard hand washing techniques, they do not practice as supposed.

Recommendations

Based on the finding of the study, the following recommendations were made:

1. Nurses should always wash hand with soap under continuous running water before and after each shift and in between procedures, pay special attention to nail bed, between fingers and wrist.
2. Frequent supervision of proper hand washing should be conducted or inspected by the ward charges so as to correct where and when applicable.
3. To the hospital management, seminars and conference should be conducted once every 3 month to enlighten nurses on the proper hand washing techniques practice among nurses in the hospital.
4. Posters and pamphlets should be used for constant reminder in each wards.
5. Regular provision of articles like soap and towels is important.
6. They should also provide alcoholbased hand rubs in hospitals as this has been proven to improve compliance to the hand hygiene.

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