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## Contents

### Vol. 15, 1, 2013

- Role of organizational learning culture and interpersonal skills in the receipt of mentoring support: a comparative analysis  
- David E. Okurame.....1

- Low teacher efficacy, poor parental involvement, truancy and gender as indices of students' mathematics underachievement in Osun state, Nigeria  
- Adewuyi H.O. and Dr. D. A. Oluwole.....29

- Path analytical study of the influence of some psycho-democratic factors on aggressive behaviour among out-of-school adolescents in Lagos state, Nigeria  
- Hammed Teslim Ayobami and Adebawo Oladayo Charles .....51

### Vol. 15, 2, 2013

- Psychological variables influencing academic achievement in a Nigerian university  
- David E. Okurame.....71

- Psychosocial predictors of quality of life among shift-work employees in three selected hospitals in Ibadan, Nigeria  
- Owodunni, Abdulfatai Adekunle.....94

- Influence of psychological work climate, social support and work stress on job performance among selected non-teaching university staff in Nigeria.  
- Awoyemi A.E Ph.D & Akinwande M. S. ....115

### Vol. 16, 2014

- Paternal deprivation, self-efficacy and demographic factors on goal setting behavior of adolescents in Ibadan  
- Jimoh, A. M.....137

- Socio-cultural factors as correlates of well-being of patients with sickle cell anaemia in selected hospitals in Ibadan, Nigeria  
 - James A. Ayangunna, Ph.D & Prisca C. Eke.....164
- Predictive influence of school location, student engagement and teachers' choice of pedagogy on students' academic achievement in Ibadan metropolis  
 - Awoyemi, A.E. Ph.D and Sanda, A. A. ....182
- Stakeholders involvement in cooperative societies for social innovation in Nigeria  
 - Olajide, O. E. PhD.....199
- Health disparity: implication for coping strategy and perceived stress among women in Gbagi multi-ethnic market – Ibadan, metropolis  
 - Okhakhume, Aide Sylvester .....214
- Social dominance, peer pressure and unemployment as predictors of involvement in electoral violence among youth street urchins in Oyo town  
 Owodunni, Abdulfatai Adekunle Ph.D. & Asiyambi, Mutiat Sola...239
- Perceived quality of life among residents of an established settlement in Ogun state, Nigeria  
 - Peter O. Olapegba & Emmanuel E. Uye.....267



## Health Disparity: Implication for Coping Strategy and Perceived Stress among Women in Gbagi Multi-Ethnic Market – Ibadan, Metropolis

Okhakhume, Aide Sylvester

### Abstract

Market women are low income earners and therefore majority of them are often unable to afford medical expenses. Yet, most government healthcare interventions schemes have failed to address the health concern of this group leading to high disparity in their health status and their counterparts who are high income earners. In view of this, the current study investigated Health disparity: Implication for Coping Strategy and Perceived Stress among women in Gbagi multi-ethnic market in Ibadan Metropolis, Oyo State, Nigeria.

Market women who were 249 were conveniently sampled. Their age ranged from 31 to 51 years. A structured questionnaire comprising of socio-demographic variables and measures of perceived stress, coping and health disparity was used to collect data. The hypotheses were tested using independent t-test, multiple regression analysis and one-way analysis of variance.

There was significant influence of coping on health disparity of market women ( $t(247)=-2.27, p<.05$ ) among participants with high coping ( $\bar{X}=25.85$ ) reporting higher level of health disparity than those with low coping ( $\bar{X}=24.53$ ). Perceived stress and coping influenced 33% of health disparity. However, only coping ( $\beta=0.31; t=5.06, p<.001$ ) showed significant independent influence on health disparity. There was also significant influence of family type on health disparity ( $t(236)=-2.10, p<.05$ ). Participants from nuclear families ( $\bar{X}=25.87$ ) significantly reported higher level of health disparity than those from extended families ( $\bar{X}=24.63$ ). There was significant influence of education status on health disparity  $F(6,248)=7.22; p<.001$ ). Age also had significant influence on health disparity  $F(3,248)=7.77; p<.001$ .

*It was concluded that perceived stress and coping strategy had significant influence on health disparity. This finding has implications for well-being and community health. It was suggested to health administrators to include market women in their health promotion policy.*

**Keywords:** *Health disparity, perceived stress; coping strategy*

### **Introduction**

As market women pursue their businesses with the goal of satisfying the consumption needs of their household members, the interaction between market and household appears to be important. Market women tend to participate and being equally responsible for (household) food security and basic medical care, in addition to coping with typical domestic responsibilities such as child-rearing and running the household. In addition to this, market women are vulnerable to stress as their average income from trade is low, most market women do not have access to the formal financial sector. In short experience has shown the decline of their trading business during their professional history at some point in time. Because the goal of their economic enterprise is to fulfil the needs of their households in both short term and long-term respects, market women may not allow their enterprise to go bankrupt at times when the total revenue is negative.

They have to develop coping strategies that minimize risk and facilitate the reconstruction of their enterprise after a total loss. Coping strategies of market women to handle risk include the diversification of goods offered in the market in order to realize predictable everyday cash-flows and the investment in the education of their children as a long-term security for their old-age. Market women also employ informal lending as their main coping strategy. Like other informal sector entrepreneurs, they have limited or no access to the formal financial sector, including commercial banks and formal micro-finance programs.

Health disparities refer to difference in health status amongst different group of people. These differences are categorized by gender, race or ethnicity, education or income, disability,



geographical location and sometimes sexual orientation (Resource centre for adolescent pregnancy prevention, ETR Association) which confers economic advantage to some people while disadvantaging others. Health disparities is a particular type of difference in which disadvantaged social group, such as poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination, systematically experience worse health or greater health risks than more advantaged social groups. Health disparities are prevalent and many psychological and social factors influence health disparities. For example, Low socio-economic status, environment, gender, ethnic background etc have been noted as causative agents in health disparity.

Health disparities research seeks to measure and reduce or eliminate avoidable differences in health of necessity; such efforts require judgment as to whether people chose the situation that caused ill health, or whether it was out of their control (Whitehead, 1992). In this context, the absence of control may occur through a lack of resources, whereby many families are going through financial difficulties as men lose their jobs, women's income now go into such expenses as house rents and school fees that used to be the responsibilities of their husbands.

This study also identifies perceived stress as a natural reaction that occurs when humans encounter a threatening physical or emotional situation, which can have so many harmful health effects on women especially continuous unresolved stress. Here, perceived stress is aptly defined as experiences that persons have which threatens their ability to cope with life challenges. Although studies indicated that there are two types of stress: eustress and distress. Eustress refers to positive stress such challenging work, the birth of the first baby in a family, or even when getting married. These activities or stressors as the case may be are stressors but they are perceived as pleasant. However, distress is usually the focus of research because of deleterious effects on the health of individuals. Distress is a negative stressor because when it takes its toll on the well-being of people, it could cause many damage even death.

However, the effect of stress is directly linked to coping, defined as an active efforts to manage or control aspects of the stressful event such as problem solving, cognitive restructuring, and seeking social support. This addresses the strain on Nigerian market women's mental health as they struggle to balance the multiple competing demands on their time and energy, it also enhances their well-being. This is because ability to cope has been noted to contribute a dose to well-being (Goldberg, 1990). People cope with stress in different ways. Some people cope by tackling the problem; some cope by avoiding, while some cope through the use of emotion focused coping. Although researchers have identified the coping style that is effective but this is not the focus of the current study.

Research evidence suggested that perceived stress and coping substantially determine the well-being of individuals (Lazarus & Folkman, 1984). Market women who experience high level of stress are likely to engage in behaviours and attitudes which will support the seeking of optimal health. Therefore, high level of stress and coping are likely to determine the extent to which an individual will cope with stress. People who are high in stress will strive to restore optimal health by engaging in well-being induced strategies such as exercise, stress management and other activities that are in support of optimal health state. However, people who suffer poor health are those who are unable to cope effectively. At any rate, perceived stress and coping are two factors that have salient effects on ability to cope with life challenges.

### **Statement of Problem**

Market women are one of the disadvantaged groups in the Nigeria society due to their low socio-economic condition as well as gender. Of course, majority of professions where women dominate are low paid jobs. For instance, many market women suffer untold hardship which puts them in disadvantageous position resulting in high disparity between this group and other groups are relatively better. Many market women who cannot pay for their medical expenses and had to patronize traditional healers which more often result to premature death. Yet, the market these women sell their wares, lack



good toilet, the environment is often unhygienic, while there is hardly any medical facility in these markets. They also have to contend with the stress of taking their children to schools on a daily basis because there are no schools in the market. All these are stressors resulting in both physiological and psychological strains.

Furthermore, research on health disparity so far has not been carried out intensively among market women in Nigeria. Extant studies relating to health disparity have been carried out among women in general with no specific reference to market women. Moreover, prior studies mainly examined demographic variables such as socio-economic status, gender, education etc as they relate to health disparity and not psychological variables. Therefore, there is paucity of research linking psychological factors such as job stress and coping to health disparity in the Nigerian context. Such lack of adequate investigation relating to stress, coping, and health disparity has led to proliferation of the health disparity literature with different antecedents.

In view of these shortfalls, the current study seeks to provide answers to the following research questions:

- What is the independent influence of perceived stress on health disparity?
- What is the influence of coping strategy on health disparity of women?
- To what extent will age of women influence health disparity?
- Will educational status influence health disparity among market women?
- Will marital status influence health disparity?

### **Purpose of Study**

This study was designed to investigate the influence of perceived stress and coping on health disparities among market women in Ibadan, Oyo State, Nigeria. However, the study specifically focused on the following objectives:

- To investigate the influence of perceived stress on health disparity among market women.
- To identify the influence of coping strategy on health disparity among market women.

- To ascertain the influence of education on health disparities among market women.
- To test the influence of age on health disparity among market women.
- To assess the influence of marital status on health disparity among market women.

### **Relevance of Study**

The Ministry of Women Affairs will derive benefit from the findings of this study through enlightening it on the way it can contribute to reducing health disparity among women. In the Nigerian society so much is said about gender inequality, but nothing has virtually been done in the area of reducing health disparity among women. The rich could afford the best medical facilities the world can offer but for the downtrodden this is very difficult. Yet the Nigerian government harps on meeting the 220 millennium goal of health and education for all. Therefore, the findings of this study can be used by the Ministry of Women Affairs to improve the health of market women who seem to be one of the most disadvantaged groups even among women.

State and local governments in Nigerian may also derive some benefits from the outcomes of the current study through the understanding of their roles in diminishing the rate of unhealthy condition of market women in their various domains. Market women are found in every state of the federation and the local governments. They are usually used during election by different political parties but yet they have never been deemed fit or worthy of their attention after their political victories. Therefore, the various local governments can now see the benefits in giving market women the ideal condition of life through the understanding of the facilities they can provide to them to improve their health condition thereby reducing the gap between the less privileged and the so called rich women. The findings of this study will also benefit market women themselves through their being enlightened on the various strategies they could adopt to cope with stress in order to reduce the health disparity between them and their counterparts who work in paid employment.



The outcomes of this study will also contribute to knowledge by reducing the gap in extant knowledge of the influence of perceived stress and coping on health disparity which can be used to develop more valid theories on women's health and health promotion by health psychologists, sociologists, epidemiologists, public health practitioners and rehabilitation experts in psychological domains.

## **Method**

### **Design**

The study adopted the ex-post facto research design because the events of interest had occurred prior to conducting the study. Also, some of the variables of interest cannot be actively or directly manipulated. The independent variables of the study were: perceived stress and active coping, while age, education, marital status, and family type were the socio-demographic variables of interest. The dependent variable was health disparity and only the composite scores of the respondents on the criterion variable was the focus of interest.

### **Setting**

The study took place in Ibadan precisely at Gbagi market in outskirts of Ibadan metropolis. Ibadan is the capital of Oyo State and it is historically important place among the southwestern people of Nigeria having been the seat of government during the practice of regionalism in southwest Nigeria. It is also a highly important place politically in the southwest and indeed Nigeria at large.

### **Participants**

Two hundred and forty-nine ( $n = 249$ ) market women conveniently sampled at Gbagi market constituted the sample of the study. The sample cut across different age, level of education, marital status, family types, and market wares. The ages of the participants ranged from 19 to 51 years and above. Sixty-five (26.1%) were less than thirty-years of age. Forty-seven (18.9%) were between the age range of 31-40 years, ninety-one (36.5%) were within age range of 41-50 years, while forty-six (18.5%) were 51 years and above. The

level of education of these individuals ranged from no formal education to Bsc/BA/B.Ed. five (2.0%) had no formal education, thirty-one (12.4%) had primary school education, twenty-six (10.4%) had junior secondary school, eighty-nine (35.7%) completed secondary school, twenty-five (10.0%) had OND, thirty-nine (15.7%) were holders of HND certificates, while thirty-four (13.7%) were B.sc/BA/B.Ed degree holders. Fifty-two (20.9%) were single, one hundred and fourteen (45.8%) were married, sixty-four (25.7%) were divorced, seven (2.8%) were separated, while twelve (4.8%) were widowed. One hundred and twenty-five (50.2%) had nuclear family, while one hundred and twenty-four (49.8%) were from nuclear family. On ethnicity, six (2.4%) were Hausa, sixty-two (24.9%) were Ibo, while Yoruba were one hundred and eighty-one (72.7%). One hundred and twenty-six (50.6%) were Christians, eighty-eight (35.3%) were Muslims, thirty-three (13.3%) were traditionalists, while those of other religions were two (0.8%).

### **Instruments**

A structured questionnaire was used to collect relevant information from the participants of the study. The questionnaire was made up of four sections with each of the sections tapping information on the variables of interest and was divided into sections A, B, C, and D. Full description of the questionnaire is outlined below:

### **Socio-demographic Characteristics**

This section consisted of the socio-demographic characteristics of the participants (i.e., the market women). These comprised their age, marital status, levels of education, religion, and ethnicity. It was precoded such that levels of the demographic variables are clearly depicted in the questionnaire and were therefore measured accordingly. For instance, their age was divided into four categories viz: <30 years, 31-40 years, 41-50 years, and 51 years and above. This same procedure was employed for other socio-demographic variables having more than one level such as marital status, family type, religion, and ethnicity.



### **Perceived Stress Scale**

This scale was used to measure level of stress perceived by the respondents. It was developed and validated by Cohen (1988). The *Perceived Stress Scale* (PSS) is the most widely used psychological instrument for measuring the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. Items were designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. The scale also includes a number of direct queries about current levels of experienced stress. The PSS was designed for use in community samples with at least a junior high school education.

### **Coping Scale**

This scale was used to measure active coping among the study's respondents. The scale is a subscale from the Coping scale developed by Sherman (1983). It comprised of 11 items anchored on Likert type rating scale with degree of response ranging from completely false = 1 to completely true = 5. The scoring manner of the scale is such that higher scores imply higher level of active coping, while lower scores reflect lower active coping. The reliability alpha coefficient for the remaining 9 standardized items was 0.88.

### **Health Disparity Scale**

The health disparity scale developed by Sherman and Ware (1997) was used to measure health disparity among respondents. It consisted of 8 items formatted in Likert manner with three different indicants ranging from yes limited a lot = 1 to no, not limited at all = 3, not at all = 1 to extremely = 5, and all of the time = 1 to none of the time = 5. The scale was revalidated in this study and the items were reduced to 8 due to low inter item correlation exhibited by 1 item. The remaining 8 items yielded reliability alpha coefficient of 0.88.

### **Sampling Procedure**

The researcher visited Gbagi market situated at Gbagi in Ibadan. The choice of this market for the study is justified on the basis of

the large nature of the market and the fact that it accommodates variety of wares. Although Gbagi market is popularly known for sales of clothes but it also accommodates women and men who sell house hold items including stationery. The researcher visited the officials of the market where administrative functions are handled. They were informed the intention of the researcher to carry out research using the women who sell things in the market. This was verbally given as there was no provision for such request in the market.

The researcher met with the Head of the market women and informed her of the purpose of coming to select the market women for the study. It was necessary to meet with the women head of the market so that the researcher could solicit for her support which she accepted without any form of reluctance. This overture really helped the researcher as the woman introduced her to the market women around her wing and other wings of the market. The researcher introduced herself to them and informed them that she intended to sample their opinions on health-related matters. Those who found it convenient to participate in the study gave their consent. Although some of them requested for incentives such as drinks and other consumable items. They were told that there was no provision for that since the research was only for academic purposes.

The researcher distributed the questionnaires to the participants going from one shop to the other. Although there were some of them who are barely literate but the researcher used some of them as research assistants. It was the researcher assistants who helped to communicate with those who are not literate. The meaning of the statements in the questionnaires was interpreted to those who could not read and write and their responses were taken as they were responding to the items in their own language. Pigeon English was also used for those of Ibo extraction who did not understand the statements in the questionnaire. The researcher got back some of the questionnaires on the spot while she had to come back to retrieve those that were not able to fill theirs immediately. A total of three hundred questionnaires were distributed to the



participants. However, two hundred and forty-nine were validly returned.

### Results

The results presented in this chapter are based on the 249 questionnaires collected from market women to examine the influence of stress and active coping on health disparity.

Hypothesis one which stated that there would be significant influence of perceived stress on health disparity among market women was tested using independent t-test. The result is presented in Table 1.

**Table 1: T-test for Independent Groups Showing the Influence of Stress on Health Disparity among Market Women.**

Variables	Stress	N	$\bar{X}$	SD	df	t	P
Health disparity	Low	126	24.99	4.07	247	-1.11	>.05
	High	123	25.63	5.01			

The result in Table 1 shows that there was no significant influence of perceived stress on health disparity of market women ( $t = -1.11$ ;  $df = 247$ ;  $p > .05$ ). This result implies that market women who perceived high stress ( $\bar{X} = 25.63$ ) reported similar health disparity as those who perceived low job stress ( $\bar{X} = 24.99$ ). The result did not support hypothesis one and therefore it was rejected.

Hypothesis two which stated that there would be significant influence of active coping on health disparity of market women was tested using independent t-test. The result is presented in Table 2.

**Table 2: T-test for Independent Groups Showing the Influence of Active Coping on Health Disparity among Market Women.**

Variables	Coping	N	$\bar{X}$	SD	Df	t	P
Health disparity	Low	103	24.53	4.32	247	-2.27	<.05
	High	146	25.85	4.66			

The result in Table 2 shows that there was significant influence of active coping on health disparity of market women ( $t = -2.27$ ;  $df = 247$ ;  $p < .05$ ). This result implies that market women who were high in active coping ( $\bar{X} = 25.85$ ) reported higher level of health disparity than those who were low in active coping ( $\bar{X} = 24.53$ ). The result supported hypothesis two.

Hypothesis three which stated that perceived job stress and active coping would independently and jointly influence health disparity among market women was tested using multiple regression analysis. The result is presented in Table 3.

**Table 3: Multiple Regression Analysis of Health Disparity on Perceived Stress, and Active Coping among Market Women.**

Variables	$\beta$	T	P	F	$R^2$	R	P
Stress	0.06	0.96	ns	14.64	0.11	0.33	<.001
Active coping	0.31	5.06	<.001				

The result in Table 3 shows that the independent variables (i.e., perceived stress and active coping) showed significant joint influence on health disparity of market women  $F(2, 248) = 14.64$ ;  $R^2 = 0.11$ ;  $p < .001$ ). The independent variables accounted for 11%



of the variance in health disparity. However, only active coping ( $\beta = 0.31$ ;  $t = 5.06$ ;  $p < .001$ ) showed significant independent influence on health disparity. Perceived stress ( $\beta = 0.06$ ;  $t = 0.96$ ;  $p > .05$ ). The result partially supported hypothesis three.

Hypothesis four which stated that there would be significant influence of family type on health disparity among market women was tested using independent t-test. The result is presented in Table 4.

**Table 4: T-test for Independent Groups Showing the Influence of Family Type on Health Disparity among Market Women.**

Variables	Family type	N	$\bar{X}$	SD	Df	t	P
Health disparity	Nuclear	115	25.87	4.11	236	2.10	<.05
	Extended	123	24.63	4.95			

The result in Table 4 shows that there was significant influence of family type on health disparity of market women ( $t = 2.10$ ;  $df = 236$ ;  $p < .05$ ). This result implies that market women who from nuclear families ( $\bar{X} = 25.87$ ) significantly reported higher level of health disparity than those from extended families ( $\bar{X} = 24.63$ ). The result supported hypothesis four.

Hypothesis five which stated that there would be significant influence of education on health disparity among market women was tested using one-way ANOVA. The result is presented in Table 5.

**Table 5: One-Way ANOVA Showing the Influence of Education on Health Disparity among Market Women.**

Source	SS	Df	MS	F	P
Between groups	783.23	6	130.54	7.22	<.001
Within groups	4377.96	242	18.09		
Total	5161.19	248			

The result in Table 5 shows that there was significant influence of education on health disparity of market women  $F(6, 248) = 7.22; p < .001$ . The result supported hypothesis five.

**Table 6: Least Significant Difference (LSD) of Multiple Comparison of Respondents' Levels of Education on Health Disparity.**

S / N	Groups	N	$\bar{X}$	1	2	3	4	5	6	7
1	No formal education	5	25.20	-	1.55	-0.57	0.22	-1.96	-3.08	2.61
2	Primary school	31	23.65	-	-	-2.12	-1.33	-3.52*	4.63*	1.06
3	Junior sec sch.	26	25.77	-	-	-	0.79	-1.39	-2.51	3.18*
4	Senior sec sch.	89	24.98	-	-	-	-	-2.18*	3.31*	2.38*
5	OND	25	27.16	-	-	-	-	-	-1.12	4.57*
6	HND	39	28.28	-	-	-	-	-	-	-
7	BSC/BA/ B.ED	34	22.59 25.31	-	-	-	-	-	-	5.69*
	Total	249								

The result in Table 6 shows that respondents who had OND ( $\bar{X} = 27.16$ ) and those with HND ( $\bar{X} = 28.28$ ) significantly reported higher level of health disparity than those who had primary school ( $\bar{X} = 23.65$ ). Also, respondents who had junior secondary school ( $\bar{X} = 25.77$ ) significantly reported higher health disparity than those with Bsc ( $\bar{X} = 22.59$ ), while those with OND ( $\bar{X} = 27.16$ ) also significantly reported higher health disparity than those who had senior secondary school ( $\bar{X} = 24.98$ ). Further, respondents with HND ( $\bar{X} = 28.28$ ) significantly reported higher health disparity than those with senior secondary school ( $\bar{X} = 24.98$ ).



However, those with senior secondary school education ( $\bar{X} = 24.98$ ) significantly reported higher health disparity than those who had B.SC ( $\bar{X} = 22.59$ ). Respondents with OND ( $\bar{X} = 27.16$ ) and those with HND ( $\bar{X} = 28.28$ ) significantly reported higher health disparity than those who had BSc ( $\bar{X} = 22.59$ ).

Hypothesis six which stated that there would be significant influence of age on health disparity among market women was tested using one-way ANOVA. The result is presented in Table 7.

**Table 7: One-Way ANOVA Showing the Influence of Age on Health Disparity among Market Women.**

Source	SS	Df	MS	F	P
Between groups	448.19	3	149.40	7.77	<.001
Within groups	4713.00	245	19.24		
Total	5161.19	248			

The result in Table 7 shows that there was significant influence of age on health disparity of market women  $F(3, 248) = 7.77; p < .001$ . The result supported hypothesis six.

**Table 8: Least Significant Difference (LSD) of Multiple Comparison of Respondents' Age on Health Disparity.**

S/N	Groups	N	$\bar{X}$	1	2	3	4
1	<30	66	26.06	-	0.02	0.25	3.56*
2	31-40 yrs	46	26.04		-	0.23	3.54*
3	41-50 yrs	91	25.81			-	3.31*
4	51 yrs +	46	22.50				-
	Total	249	25.31				

The result in Table 8 shows that respondents who were less than 30 years ( $\bar{X} = 26.06$ ) significantly reported higher health disparity than those who were 51 years and above ( $\bar{X} = 22.50$ ). It was also shown that those who were 31-40 years ( $\bar{X} = 26.04$ ) also reported significantly higher health disparity than those who were 51 years and above ( $\bar{X} = 22.50$ ). Those who were 41-50 years also significantly reported higher level of health disparity than those who were 51 years and above.

### Discussion

The current study investigated "Health Disparity: Implication for coping strategy and perceived stress women in multi-Ethnic Market-Ibadan-Metropolis" Six hypotheses were tested from which four were fully supported, one was partially accepted, while one was also completely rejected. Based on these outcomes, the following discussion was made:

Hypothesis one tested job stress influence on health disparity of market women. The result obtained showed that there was no significant influence of job stress on health disparity. This result implies that respondents (i.e., market women) who reported low stress did not significantly have better health than those who reported high stress. Therefore, from this study it is found that market women low in job stress reported similar level of health as those who reported high stress. This result is not in congruence with those of previous studies which reported significantly health disparity between women (Denollet, (2005), Denollet, Sys, and Brutsaert (1995), Kupper and Denollet, (2007). Pedersen and



Denollet (2006) who reported the significant influence of job stress on health outcomes. Kupper and Denollet (2007) reported the salience effect of stress on health-related outcomes and this has been found to be a strong predictor of longevity. Also, Friedman et al. (1993) revealed that students who had been higher in job stress in childhood were more likely to be alive when mortality was assessed 64 years later. In addition to stress and contrary to expectations, cheerfulness was related to greater mortality risk (Friedman et al., 1993). A review of studies on 20 independent samples by Kern and Friedman (2008) showed that stress was a clear predictor of mortality across samples and held even when controlling for traditional risk factors.

There was significant influence of coping on health disparity among market women with those high in coping reporting higher level of health disparity than those who were low in coping. Therefore, coping level is an indicator of health disparity for market women. This finding is consistent with finding from prior studies (Suiton et al, 2010; Schnall, Landsbergis & Baker 1994). These authors aver that the extent to which women cope with daily life hassles predict health disparity. For instance, women with better coping ability will engage in behaviours that make them less vulnerable to the ill effects of stress, whereas those who can only moderately or lowly will tend to experience more ill health due to a higher level of vulnerability.

Hypothesis three revealed that both coping and stress had significant joint influence on health disparity. This result is a confirmation of the findings of previous studies which reported the benefit of coping and low job stress on health outcomes (Alder & Ostrove, 1999; Marmot et al., 1997b; Mulatu & Schooler 2002; Wilson 2001; WHO, 1997; Nash Ojanuga & Gilbert, 1992). It was reported that women who have better coping techniques with stress would report better health because they can effectively cope with ill effect of stressors that daily contend with. Moreover, accumulating research evidence suggest that both coping and stress are major important factors in health of women with studies indicating positive relationship between coping and health, while the opposite is for stress and health.

On the independent influence of stress on health disparity, it was although found in the current study that stress did not have significant independent influence on health disparity. This result implies that market women who reported high level of stress and those who had low stress level had similar level of health disparity. However, extant research showed that stress was particularly a salient factor in health of women (Alder & Ostrove, 1999; Marmot et al., 1997b; Mulatu & Schooler 2002; Wilson 2001; WHO, 1997; Nash Ojanuga & Gilbert, 1992). The probably reason for the result obtained in the current study might be due to the differences in the environments where these studies were carried out. For instance, it was expected that market women in Nigeria may possibly report higher level of stress and expression of lower wellness when compared to their counterparts in developed countries where prior studies were conducted.

It was shown that coping had significant independent influence on health disparity of market women. This result implies that respondents with better coping skill reported significantly better health disparity than those who have less effective coping skill. This finding is in agreement with those of previous studies which reported positive relationship between coping health disparity (Linzer, Spitzer, Kroenke, 1996). For instance, women had a higher prevalence of most affective disorders and non-affective psychosis, and men had higher rates of substance use disorders and antisocial personality disorder (Linzer, Spitzer, Kroenke, 1996). Yet, studies have shown that women who are able to cope effectively tend to have better health status than those who are not able to cope effectively. It is suffice to say that women who do not suffer from affective disorders are those who cope better than those who have such psychological disorders.

Hypothesis four tested the influence of family type on health disparity. The result revealed that there was significant influence of family type on health disparity. This result implies that respondents in nuclear family reported significantly higher level of health disparity than those in extended family. This result has a strong support in literature with empirical findings in prior studies indicating a salient link between family factors and health disparity



(Schnall, Landsbergis & Baker 1994). For instance, Suiton et al, (2010). These authors aver that women who are high in marital satisfaction and have their spouses' support tend to be more health seeking than those who are low in marital satisfaction and do not have their spouses' support. The probable reason why those in nuclear family reported higher health disparity is because of the difference in the number of family members. The extended family type might be more finance consuming due to the number of family members as well as responsibilities. Although this is not to say that the extended family membership does not have its merits or advantages. However, the disadvantages may outweigh the benefits.

Hypothesis four tested the influence of education on health disparity of market women. The result showed that there was significant influence of education on health disparity. The result from the post hoc analysis (i.e., multiple comparisons) showed that respondents who had OND and those with HND significantly reported higher level of health disparity than those who had primary school. Also, respondents who had junior secondary school, significantly reported higher health disparity than those with B.sc, while those with OND also significantly reported higher health disparity than those who had senior secondary school.

Further, respondents with HND significantly reported higher health disparity than those with senior secondary school. However, those with senior secondary school education significantly reported higher health disparity than those who had B.sc. Respondents with OND and those with HND significantly reported higher health disparity than those who had B.Sc. Consistent with this finding, studies have demonstrated that education plays a significant role in health-related outcomes (Mackenbach, 2002). For example, Wilson (2001) found very strong associations between overall, self-assessed health and education and income; in his study, Wilson (2001) found that men and women in the lowest income quintile were about six times as likely as their counterparts in the highest income quintile to report that their health was generally fair or poor.

Likewise, Marmot et al. (1997b) found in their analyses of NSFH data that people with less than a high school degree were four or five times as likely as people with a four year college degree

to say that their health was less than good. Miech and Hauser (2001) came to similar conclusions regarding the strong relationship between education and self-assessed overall health. The probable reason for this result might be that people with higher level of education tend to have access to more funds than those with low level of education to take care of their health.

Hypothesis five tested the influence of age on health disparity of market women. The result obtained through "multiple comparisons revealed that respondents who were less than 30 years significantly reported higher health disparity than those who were 51 years and above. It was also shown that those who were 31-40 years also reported significantly higher health disparity than those who were 51 years and above. Those who were 41-50 years also significantly reported higher level of health disparity than those who were 51 years and above. This result implies that younger market women reported higher level of health disparity than older market women. This finding is in tandem with those of In congruence with this result, literature suggests demographic variables are salient in the prediction of health outcomes (WHO, 2001).

For instance, Campbell (1981) stated that "the literary image of the crotchety old person, dissatisfied with everything, is not a very realistic picture of older people" (p. 203). This pleasant finding may be due to older people being healthier and staying involved in more life domains compared to past generations (Bass, 1995). Current studies agree that life satisfaction often increases, or at least does not drop with age (Herzog & Rodgers, 1981). International studies of representative samples from multiple countries also indicate that life satisfaction does not decline with age (Kennedy, 2005). Diener and Suh (1998) surveyed 60,000 adults from 40 nations and discovered a slight upward trend in life satisfaction from the 20s to the 80s in age, and little change across age cohorts with respect to the experience of negative affect. In contrast, pleasant affect declined with age.

Above all, the study found significant influence of coping on health disparity. Also, there was significant joint influence of perceived stress and coping on health disparity. There was significant independent influence of coping on health



disparity. Respondents with nuclear family had significantly higher level of health disparity than those with extended family. Respondents with higher education had significantly higher level of health disparity than those with lower education. Younger respondents scored significantly higher on health disparity than older respondents. There was no significant independent influence of perceived stress on health disparity.

### **Implication of the study**

The study found that there was no significant influence of perceived stress on health disparity. This result has implications for health promotion among market women. Therefore, public health administrators, and their counterparts in the private sector should use this information to improve the wellness of market women in the country. The provision of health market environment with good clinic facilities and well as health psychologists to give advice to these women will help to improve the well-being of these women.

It was found that coping had significant influence on health disparity of market women. This result implies that coping plays a significant role in wellness. In view of this evidence, local government who is charged with the responsibility of provision for health facilities at the grass root level should endeavour to provide medical experts to market women where they sell their wares. Most market places including the one sampled in this study do not have health clinics. Ill health reported by these women has not been looked into several years in this country due to absence of health programmes. Health experts should give medical advice to market women based on psychological outcomes.

Majority of the ill health reported by these women do not usually have physical basis. Therefore, advice on health issues concerning market women should focus on positive coping skill that can be adopted by them. This may be in form of exercise, eating the right food, associating with family members and significant others in order to receive social support from the networks they have.

The study found that perceived stress and coping had significant joint influence on health disparity. This result has implications for wellness programmes, weekly inspection of market

in order to upgrade their health status, and provision of facilities that will aid the well-being of market women. To this end, NGOs, government bodies, and the private sector should look into the health needs of market women. This is a group that is neglected in Nigeria except during election. Market women themselves should vote for those who promise to clean up their environment and cater for their health needs. There is nothing bad in situating a good clinic in all public markets and neither will it be considered bad to have qualified doctors checking the blood pressure of market women on a weekly basis with them paying a kobo.

The study found that there was independent influence of coping on health disparity of market women. This result implies that health managers in the country especially psychologist should give effective psychological interventions to market women. Thus, it is suggested that psychologists should be recommended to market women for psychological advice relating to how they cope with stress. Many market women have died as a result of high level of stress and inability to go for medical check up. Therefore, having qualified psychologists to give advice to these women on best health practices can help to put them in optimal health status.

The study found that there was significant influence of education on health disparity among market women. This result has implications for health training. Therefore, market women should be provided with effective training that relate to psychological health such as relaxation technique, the use of hydrotherapy, and avoidance of fatty foods in order to cope effectively well with the stress prone environment they work. This can be done by assigning psychologists to every market to check the health status and give quality training relating to safe health practices to market women. Such psychological intervention will not take into consideration the level of education of the majority of these market women such that individuals who are posted to these markets are those who understand their languages and their culture in order to have effective outcomes from exercise.

It was also found that there was significant influence of age on health disparity with younger market women reporting higher level of health disparity than older women. This result has



implications for geriatric, health within the market women segment. Therefore, government needs to make effort to direct their health programmes within the market women segment more towards the older market women. Facilities such as drugs, exercise equipment, medical doctors, and health psychologists should be provided within the traditional market system in order to improve the health of older market women.

### **Recommendation and Suggestions for Further Studies**

Researchers who wish to replicate the findings of this study should endeavour to sample more market rather than one market as was used in the current study, it is also important to control for extraneous variables. This can be done by adopting a quasi experimental research design. The use of key informant interview may also be useful to complement the use of self-report questionnaire.

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