

Predictors of Health-Related Quality of Life Among Lecturers in Selected Universities in South West Nigeria

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Abstract:

Health-Related Quality of Life (HRQoL) is an important indicator of physical, emotional and psychological wellness. This study examined the predictors of HRQoL among lecturers in selected universities in South West Nigeria. Specifically, the study assessed lecturers' eating habit and workload as they affect HRQoL. The study adopted mix-methods approach which involved the use of qualitative method to complement data obtained through quantitative source. Lecturers were selected from both public and private Universities in three south-western states. A multi-stage sampling approach was used to reach a calculated sample of 343 lecturers across the selected universities. Structured questionnaires were used for the quantitative data collection while Key Informant Interview (KII) was conducted among the selected universities' senior staff. Quantitative data analysis was done using Statistical Package for Social Scientists, while qualitative analysis was done using Atlas-ti. The results show that 52.8% of the respondents had medium-level HRQoL. About 40% had low HRQoL while only few (7.3%) had high HRQoL. About 64% had irregular eating habit and half (49.6%) of the respondents had mild workload. Socio-demographic variables that had significant influence on lecturers' HRQoL were marital status ($\chi^2 = 89.75$; $p=0.00$) and highest educational qualifications ($\chi^2 = 74.65$; $p=0.00$). While eating habit ($B=0.125$; $p=0.001$) had significant positive effects on HRQoL, workload ($t=-0.256$; $p=0.001$) had significant negative effects. HRQoL is low among University Lecturers in Southwestern Nigeria. Personal socio-demographic characteristics play roles in the level of

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HRQoL though; the significant predictors of their HRQoL were eating habit and workload. In other words, with low/mild workload and regular eating habit, lecturers would have high HRQoL. It is also recommended that universities in South West Nigeria should recruit additional lecturers to ease workload.

Keywords: Health-Related, Quality of Life, Workload, Eating Habit, Lecturers,

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Introduction

University lecturers play a crucial role in society as they bear vital tasks of cultivating highly qualified special talents and developing science and culture. They also play a vital role in educating human capital. The productivity and output of the education sector rely on these educationists directly because, in contrast with other sectors, facilities and technologies are barely available. Operating as a faculty member in the university may have positive experiences; but at the same time, being a lecturer can be exhausting and affect the quality of life of an individual. Members of the faculty face common work pressures (Akeredolu & Adefuye, 2018). Different demands are however, particularly linked to faculty activities, such as research, outreach programs, and management. They are subjected to different kinds of stressors, such as academic pressures and social issues (Alamgir et al., 2018). As such, they are prone to the development of physical and psychological problems, which can affect their job performance and quality of life (Cai & Lin, 2018).

In the last two decades Quality of Life (QoL) has become topical worldwide. This has drawn employees and employers' interest, particularly due to the positions and responsibilities shouldered by adequately trained and skilled workers. Employers used QoL considerations to recruit and maintain skilled staff. Institutions of higher education are no exceptions to this increasing phenomenon. Modern nursing practice is focused on achieving a high Quality of Life; as this has a great impact on health outcomes (Eyre et al., 2019; Adeogun & Dansu, 2016). Efforts are therefore needed to preserve the health and quality of life of faculty members in universities.

In recent years, HRQoL has been addressed as an important index to assess personal health, decision making and judgment of the overall health of the society; and to appraise major problems in various aspects of people's lives. The significance of HRQoL and health status is to the extent that the present century has been given the title of 'improving Quality of Life (not just survival) and health status' (Warburton, et al., 2016). It is believed that measuring health should include assessments of well-being and welfare in addition to mortality and life expectancy, which are embedded in the concept of Health-Related Quality of Life (Pierce, 2018).

Accordingly, paying attention to factors that are associated with HRQoL and its improvement is of essence to health care services available to university lecturers. HRQoL of university workers has been described as low, especially when compared with non-university workers (Vaez, et. al., 2016). The reason adduced for this was that the reported workload of university workers was very high. University lecturers feature prominently as the most affected members of the university work force. Lecturers are actively involved in academic activities; which comprise of teaching, research, administration and community services. They are not only involved in transmitting knowledge through rigorous talks in the lecture rooms and marking of students' scripts, but they also engage in research, frequent write-ups such as lesson notes, articles for publications and presentation at conferences.

According to Etuk (2017), academic activities are brain-stressing and emotion-sapping engagements that demand quality time and energy. They supervise students' research projects – both undergraduate and postgraduate – and many times, these students pay unscheduled visits to the lecturers who are their academic advisors. Most often, these additional responsibilities tend to enlarge the workload of lecturers and make the load excessive. Excess workload and the accompanying stress resultant effects are its attendant health problems, thus affecting Health Related Quality of Life (Eshragi et al, 2012).

A study by Graham (2009) on 60 academic staff (lecturers, assistant professors, associate professors, and professors) found that security, promotion, and co-workers are important factors for university academics' job satisfaction and health-related quality of life. Another study by Gunnar *et al* (2009) indicates that job satisfaction is usually experienced and health-related quality of life enhanced when academics have proficiency, value, and recognition. Joshua *et al.* (2012) find a strong association between health-related quality of life and promotion. Similarly, several studies have been conducted by many researchers, with the conclusion that there is a correlation between health-related quality of life and several variables. These include achievement, recognition, the work itself, responsibility, advancement, policy and administration, supervision, salary, interpersonal relations, working conditions, age, tenure, educational level, teaching experience, job activities, and gender (Keating *et al*, 2017).

Findings from research done by Kline (2013) indicate that a positive and healthy university structure increases the university academics' health-related quality of life. Furthermore, Kocella W. & Kygzip (2010) also show that it not only increases the health-related quality of life but at the same time, improves the learning environment as well as increases university productivity. However, their study concludes that private university academics are more satisfied in terms of pay, supervision, and promotional opportunities, compared to public universities, while public university academics are more satisfied in terms of co-workers' behaviour and job security.

A study by Akeredolu and Adefuye (2018) finds that the set of predictors of health-related quality of life includes pay, work, promotion, supervision, environment, and co-workers. Another study by Demerout, *et al.*, (2011) concludes that health-related quality of life factors of any officers or any employees include pay, work, co-workers, and environment. Studies by DeVane & Sandy (2013) indicate that health-related quality of life of employees or workers is reflective in attitude to the job, relations with co-workers, supervision, company policy and support, promotion, and pay.

Results from Mirkamali and Thanni (2011) show that pay, promotion, work, supervision, and fellow workers are the main factors for university academics, in terms of work-life quality. Studies conducted by Olatunji and Akinlabi (2012) revealed that health-related quality of life is induced by compensation, an opportunity for advancement, leadership style, work environment, organizational structure, and climate. In Malaysia, conducted a study and found that private university academics' health-related quality of life includes salary, promotion, fringe benefits, and working conditions (Ahsan, *et al.*, 2011).

In the United Kingdom (UK), a study was conducted by Orleans, *et al.*, (2013), which indicates that job rank level and occupational level are the factors that are usually considered as contributing to health-related quality of life. Research conducted by Bulugbe and Oloyede (2014) delivered a response rate of 72.9 percent and the results show that work-life quality factors include authority, supervision, policies and facilities, the work itself, interpersonal relationships, commitment, salary, and workload. Similarly, another study by Brush (2013) finds that work-life quality factors are co-workers and working as a team, while sharing also rated as important

Munyewende, *et al.*, (2014) maintain that work-life quality was highest among employees who received the most reward. However, the relationship behaviour of supervisory staff affects academic job satisfaction (Graham, 2010). Furthermore, Blaauw (2013) study also indicates that supervisors can increase the employees' health-related quality of life. Similarly,

results from Hanif (2010) conclude that promotional opportunities have a positive impact on the employees' health-related quality of life. Research by Beehr and Newman (2018) finds that positive relationships with fellow workers increase with the health-related quality of life. Similar findings by Tarris and Van (2011) support the findings that relationships with co-workers are improved when employees experience work-life balance.

According to Damte and Tefarra (2003), pay has a positive impact on determining the health-related quality of life and job satisfaction. The study further reveals that promotion and flexible work overload also influence job satisfaction, when compared to recognition, and achievement. Findings from the research were done by Elendu and Akpan (2012) indicate that when employees observe that their supervisors are fair, competent, and sincere, their level of job satisfaction increases and this in turn positively influences their health-related quality of life. Results from a study done by Yusoff, et al., (2018) indicate that the working environment increases employees' health-related quality of life very positively.

Alamgir, et al., (2018) conducted a study on the associated factors health-related quality of life in Malaysia on 173 academics of a private university. The results show that there is a relation between health-related quality of life and pay, promotion, fringe benefits, working conditions, support for research, support of teaching, and gender. Furthermore, they also indicate that pay, promotion, working conditions and support of research have a positive and significant effect on the university academics' job satisfaction. According to Osaat and Ekechuckwu (2017), an employee's health-related quality of life usually depends on the individual's characteristics and characteristics of the job itself. However, age, gender, education status, hours of work, and the earning figure are the factors that affect university academics' job satisfaction.

Mostly, the rigors expended by lecturers into academic activities make them pay little attention to their health and Quality of Life. Paradoxically, good academic works are hardly possible without sound mental stability and good health (Joshua, et al., 2012). More so, the making of professionals, such as doctors and nurses are at the instance of university lecturers. To this end, provision of effective modern nursing care and services should have in focus, Health-Related Quality of Life (HRQoL) of university lecturers.

Poor dietary habit includes under or over-eating, lack of sufficiently nutritious foods per day or taking too many food and drink forms that are poor in fibre or high in calories, salt or sugar. Good diet may also be one of life's greatest psychological pleasures (Alamgir, et al., 2018). So if diet is insufficient or unnecessary, the body has difficulties quantitatively controlling the absorption and accumulation of nutrients, bad dietary habits such as insufficient diets or heavy consumption can have negative health consequences. Those involved are at risk of hypertension, elevated cholesterol, heart disease and stroke, type-2 diabetes, osteoporosis, etc. Bad diet causes a person to become sick or to suffer from headaches and stomach problem (Alamgir, et al., 2018).

Since there is paucity of studies addressing the afore mentioned, which the researcher considers as essential for optimum health with subsequent effectiveness and productivity in higher institutions, the need emerges to conduct a study to explore the current status of those variables and how they are related. This study was set out to identify the predictors of Health-Related Quality of Life among lecturers in selected tertiary institutions in South West Nigeria. The specific objectives of this study were to:

1. assess the HRQoL of participants in selected universities in South West Nigeria;

2. determine the eating habit that affect HRQoL of participants in selected universities in South West Nigeria; and
3. determine the nature of workload and schedule that affect the HRQoL of participants in selected universities in South West Nigeria.

Research Hypotheses

Ho1: There is no significant relationship between the respondents' HRQoL and their socio-demographic characteristics.

Ho2: There is no significant relationship between the respondents' HRQoL and their life-work variables

Materials and Methods

The study adopted a mixed method approach. The mixed method approach involved the use of qualitative method to complement data obtained through the quantitative source and that provided robust information for achieving the research objectives. The target population for the study was academic lecturers in both public and private Universities of South-West Nigeria. The study focused on academic staff (lecturers) of University of Ibadan, Ekiti State University and Achievers University.

The sample size was determined using (Yamane, 1967) formula for known population.

University of Ibadan

$$n = \frac{N}{1 + [Ne^2]}$$

Where: n is the sample size; N is the target population; e is the precision level/sampling error (5%).

Applying this formula, n takes the form:

For UI where N=731,

$$= \frac{731}{1 + [731(0.05)^2]}$$

$$n = \frac{731}{1 + [2.8275]}$$

$$n = \frac{731}{3.8275}$$

$$n = 191$$

The sample size for UI is 191 lecturers;

Ekiti State University

Where N=432 (for EKSU)

$$n = \frac{432}{1 + [432(0.05)^2]}$$

$$n = \frac{432}{1 + [3.08]}$$

$$n = \frac{432}{4.08}$$

$$n = 106$$

Achievers University

Where N=103 (for Achiever)

$$n = \frac{103}{1 + [103(0.05)^2]}$$

$$n = \frac{103}{1 + [1.2575]}$$

$$n = \frac{103}{2.2575}$$

$$n = 46$$

The total sample will be $191 + 106 + 46 = 343$

The proportionate sample that will be drawn from each faculty is calculated using the formula:

$$\frac{N(Ed)}{N(d)} \times n$$

Where: $N(Ed)$ = Total population of staff in each selected faculties

$N(d)$ = Total population of staff in all the selected faculties

n = the calculated sample

A multi-stage sampling was adopted for the selection of study participants in this study.

The study adopted mixed methods using both qualitative (In-depth Interview) and quantitative (questionnaire) in eliciting information from the study participants. For the qualitative data collection, In-depth interviews were conducted. One lecturer with at least 10 years work experience was purposefully selected per faculty in each of the settings, and they provided informed and robust information on the subject matter of the study.

The instrument for data collection was adapted from the 2017 WHO-developed checklist for the measurement of HRQoL. The adaptation of the WHO checklists was to ensure that they were able to provide data to address the study objectives. The questionnaire was divided into four sections. Section A contains the respondents' sex, age, marital status, religion, qualification, living arrangement, etc. Section B has 14 items that gives a complete overview of a person's health and wellbeing. The scoring of HRQoL was done by the responses obtained. The minimum score obtainable was scores ≤ 34 , median score was 34 to 50 while maximum score was >50 . However, the minimum score was categorized as "low HRQoL" median score was categorized as "moderate HRQoL" while maximum score was categorized as "high HRQoL".

Section C has 15 items which measure eating habits; Eating habit will be evaluated using the eating habit score (EHS). Total maximum points on the scoring system was 62 when eating habit was evaluated (highest quality of eating habits). Scoring over 48 was classified as good eating habits while scoring in the 35–48 range was considered medium. A score value below 35 denotes poor eating habit from a health standpoint.

Section D consists of 15 question items which covered Work load (WL), Student Related Issues (SI), Research and Career Development (RC), Administrative Related Issues (AI). Respondents were asked to rate how all these constitute to excess work load based on 3-points Likert scale, Usually, Rarely and Never. Total maximum mark obtainable is 45, a score value above 40 denotes excess workload, while a score value 35-40 is medium and below 35 was normal.

Standardized instruments were adapted. However, the adapted version was validated using face and content validity. This was assessed by experts in the field of Psychology and HRQoL and other researchers who read the questionnaire and ensured the content was relevant to the topic, met the research objectives, and answered the research questions.

Data obtained was screened for errors and completeness. Analysis was done using IBM SPSS version 27 for windows. Results were presented in frequencies, percentages, while level of HRQoL among Lecturers and eating habits of lectures in selected Universities on HRQoL were presented in frequency counts and percentages. Inferential statistics was employed to



investigate whether life-style variables (eating habit and work load) will not significantly influence HRQoL. Qualitative data was analyzed thematically.

Results

Results as presented in Table 1 show that 51.3% of the respondents were male while 48.7% were female. The highest proportion of female (60.9%) was among respondents from Achievers University. Most (78.1%) of the respondents were married while 7.6% were single. 14.3% were divorced, widowed or separated. Educational attainments of the respondents show that more than half (51.3%) had PhD Degrees while 38.5% had Master's Degrees. On the respondents' designations, results show that about 40% (39.9) were Lecturer I or II, 35.6% were Senior Lecturers, while 17.2% were Assistant Lecturers. Few (7.3%) were Professors/Readers. Furthermore, on years of work experience, about two-thirds (64.1%) of the respondents had spent between 5 and 10 years while 20.1% had spent more than 10 years. Results on place of residence show that majority (69.4%) lived off-campus while 30.6% lived on University Staff Quarters. About 41% of the respondents had not more than six as their household size.

Table 1: Respondents' Socio-demographic Characteristics

		Federal University (n=191)		State University (n=106)		Private University (n=46)		Total (N=343)	
		Freq.	%	Freq.	%	Freq.	%	Freq.	%
Gender	Male	89	46.6	59	55.7	28	60.9	176	51.3
	Female	102	53.4	47	44.3	18	39.1	167	48.7
Marital Status	Single	5	2.6	12	11.3	9	19.6	26	7.6
	Married	157	82.2	79	74.5	32	69.6	268	78.1
	Others	29	15.2	15	14.2	5	10.9	49	14.3
Highest Educational Qualifications	Bachelor	13	6.8	19	17.9	3	6.5	35	10.2
	Master	63	33.0	39	36.8	30	65.2	132	38.5
	Doctoral	115	60.2	48	45.3	13	28.3	176	51.3
Designation	Assistant Lecturer	30	15.7	11	10.4	18	39.1	59	17.2
	Lecturer I & II	77	40.3	45	42.5	15	32.6	137	39.9
	Senior Lecturer	68	35.6	43	40.6	11	23.9	122	35.6
	Reader/Prof.	16	8.4	7	6.6	2	4.3	25	7.3
Years of Working Experience	Less than 5	4	2.1	21	19.8	29	63.0	54	15.7
	5-10	159	83.2	46	43.4	15	32.6	220	64.1
	Higher than 10	28	14.7	39	36.8	2	4.3	69	20.1

Place of Residence	University Quarters	71	37.2	27	25.5	7	15.2	105	30.6
	Off-campus	120	62.8	79	74.5	39	84.8	238	69.4
Household Size	Max. of 6	89	46.6	13	12.3	40	87.0	142	41.4
	7-10	66	34.6	59	55.7	5	10.9	130	37.9
	More than 10	36	18.8	34	32.1	1	2.2	71	20.7
Total %			55.7%		30.9%		13.4%		100.0%

Objective 1: Health-Related Quality of Life

Table 2 shows result on the respondents' Health-Related Quality of Life (HRQoL). Asked whether there was any major impairment or health problem that limited their daily activities in the previous one month, 45.8% responded in the affirmative. Within the previous one month, almost half of the respondents (47.8%) indicated that their health was good for 1-2 days while 54.5% expressed that their mental health was not good for 1-2 days. Similar report was obtained from 51.9% of the respondents who indicated that poor physical and mental health kept them from physical activities for about 2 days within the previous one month. Furthermore, still within the reference period, about 61% were worried, tensed and anxious for a minimum of 3 days while 62.4% reported that they lacked energy. In addition, 45.3% needed the help of someone for 1-2 days because of health problem within the previous 30 days.

Table 2 Respondents' Health-related Quality of Life

<i>Variables</i>	Frequency (N=343)	Percentage
Daily activities ever limited because of major impairment or health problem during the previous one month?		
Yes	157	45.8
No	186	54.2
Number of days physical health not good		
None	99	28.9
1-2	164	47.8
More than twice	80	23.3
Number of days mental health not good		
None	89	25.9
1-2	187	54.5
More than twice	67	19.5
Number of days poor physical and mental health kept respondents from physical activities		
None	74	21.6
1-2	178	51.9
More than twice	91	26.5
Number of days pain made it hard to do usual activities		
None	38	11.1
1-2	241	70.3

More than twice	64	18.7
Number of days felt sad, blue or depressed		
None	36	10.5
1-2	167	48.7
More than twice	140	40.8
Number of days worried, tense or anxious		
None	19	5.5
1-2	115	33.5
More than twice	209	60.9
Number of days with no enough rest or sleep		
None	7	2.0
1-2	198	57.7
More than twice	138	40.2
Number of days lacked energy		
None	88	25.7
1-2	214	62.4
More than twice	41	12.0
Number of days the help of someone was needed because of health problem		
None	78	22.7
1-2	157	45.8
More than twice	108	31.5

Results as presented in Table 3 show major impairments or health problems that limited the activities of the respondents within the previous 30 days. About 44% indicated that arthritis/rheumatism limited them a little just as 81% also indicated that back/neck pain and joint injury impaired them a little. About 34% pointed that eye/vision problem limited them a lot just as 72.9% also indicated that high blood pressure limited them a lot. Other health problems that impaired daily activities of the respondents a lot were depression/anxiety/emotional problems (56.9%) and eye/vision problem (34.1%).

Table 3 Responses on Major Impairments that limited Activities

<i>Major impairments or health problems that limited activities?</i>	<i>Responses (N=343)</i>		
	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>
	<i>Yes, limited a lot</i>	<i>Yes, limited a little</i>	<i>No, not limited at all</i>
Arthritis/Rheumatism	7 (2.0)	150 (43.7)	186 (54.2)
Back or neck problem	17 (5.0)	278 (81.0)	48 (14.0)
Fractures, bone or joint injury	29 (8.5)	141 (41.1)	173 (50.4)
Walking problem	32 (9.3)	179 (52.2)	132 (38.5)
Lung/breathing problem	15 (4.4)	31 (9.0)	297 (86.6)
Hearing problem	22 (6.4)	25 (7.3)	296 (86.3)

Eye/vision problem	117 (34.1)	25 (7.3)	201 (58.6)
Heart problem	20 (5.8)	79 (23.0)	244 (71.3)
Stroke	14 (4.1)	15 (4.4)	314 (91.5)
High blood pressure	250 (72.9)	45 (13.1)	48 (14.0)
Diabetes	64 (18.7)	111 (32.4)	168 (49.0)
Cancer	19 (5.5)	33 (9.6)	291 (84.8)
Depression /anxiety/emotional problem	195 (56.9)	163 (47.5)	15 (4.4)
Other impairment/problem	18 (5.2)	147 (42.9)	178 (51.9)

Table 4 presents the summary of responses on the respondents' HRQoL. Responses in Table 3 were coded such that 'Yes' had code '1' and 'No' had '2'; 'None' had '3', '1-2' had '2' and 'more than twice' had '1'. Also, those in Table 4.2.2 were coded with 'Yes, limited a lot' as '1', 'Yes, limited a little' as '2' and 'No, not limited at all' as '3'. These weights were applied and composite HRQoL scores were derived. The resultant scores had a mean of 42.5 ± 8.5 with minimum as 24 and maximum as 71. The mean and the standard deviation were used to divide the scores into three: high, medium, low. In other words, scores from the minimum (24) to $42.5 - 8.5$ (which gives 34) were grouped as low HRQoL. Scores from $42.5 + 8.5$ (which equals 51.0) to the maximum (71) were grouped as high HRQoL. Scores within the range 42.5 ± 8.5 , i.e. 34.0 – 51.0 were grouped as medium HRQoL. Then, results as presented in Table 4 show that 52.8% of the respondents had medium-level HRQoL. About 40% had low HRQoL while only few (7.3%) reported high HRQoL.

Table 4 Summary Response on Health-related Quality of Life

Health-related Quality of Life (HRQoL)				Mean	S.D.	Min.	Max.
HRQoL	Range Scores	Frequency	Percentage				
High	51.1 – 71.0	25	7.3	42.5	8.5	24	71
Medium	34.1 – 51.0	181	52.8				
Low	24.0 – 34.0	137	39.9				
Total		343	100.0				

Responses from In-depth Interview

Lecturers were asked to describe their Health-Related Quality of Life. A 58-year old interview participant who was an Associate Professor in a Federal University, living on University Quarters in a household of 6 had these to say:

"To me, health-related quality of life refers to overall wellbeing. The type of food we eat – balanced diet – the housing quality, the sleep patterns, how we exercise, how we rest, vacation and the frequency at which we take time to enjoy with our family. The nature of our work is such that if you do not know

how to balance work with personal life, the health-related quality of life will suffer. We hear of lecturers collapsing and dying at home and in offices. We hear of those who have terminal diseases. All these are products of stress and inability to take time to rest. Although some of these problems are influenced by our hereditary make-up, we as individuals have roles to play. So back to your question, health-related quality of life refers to our ability to separate work demands from sleep time, rest time, leisure time, family time and then eating good food, fruits and taking time to do physical exercise."

Another participant, a State University Lecturer I, 49, living off-campus expressed thus:

"It means our overall health and standard of living. We can have money but have poor health-related quality of life. Why do I say this? Some have money and all they think about is to increase the money. They never take time to rest nor do physical exercise. They sit inside Air Condition from morning to night without exposure to fresh air. That is a high standard of living but it does not represent any good health-related. Personally, I would rate myself above average in health-related quality of life. This is because I don't joke with my health. I eat well, I spend time with my family, I do physical exercise, in fact, I play Table Tennis a lot. Our work is demanding but I ensure it does not take any negative toll on my health. A way I handle this is never to allow my work to pile up and I get a lot of help from my wife at home."

However, the views expressed about Health-Related Quality of Life differed in the expressions of another participant, a Lecturer II in a Private University. According to him:

"We all know what health-related quality of life is but how many of us can actually achieve it. Look at me, how much do they pay me here? It cannot cater for my family needs so I have to look for alternatives. Despite the huge workloads here, I still burden myself to look for money through other means. So in a lot of times that I am supposed to be resting, I go all out to make ends meet. Who does not know that physical exercise is good for body? But how would you have strength for physical exercise when your daily work routine is already energy-sapping. All we can do is try. Even fruits are expensive now. Imagine a bunch of banana that we used to buy for #500 is not about #3,000. How can I afford that?. Even if I squeeze myself to buy it, can we eat it as we are supposed to? The whole thing is tiring. We are merely surviving. Health-related quality of life is already becoming an illusion. All we do now is survive and stay away from diseases ... personally, my health-related quality of life is very low. This is because I have not done any deliberate physical exercise this year. I have hardly slept up to 6 hours at time in the last two months. We now eat more of semo and rice, unlike before that we used to eat banana flour and beans a lot."

Objective 2: Eating Habit of the Lecturers in Selected Universities

Results as presented in Table 5 show respondents' eating habit. The results show that in a typical week, 58.3% rarely took home meal to work. Meanwhile, 13.1% usually took it but 28.6% indicated that they never did. About 41% indicated that they usually skipped meals while 51.9% also pointed that they often ate from roadside junk stores. About 59% rarely ate with members of their families just as 55.1% rarely took breakfast before leaving home daily. However, more than half (57.4%) did take lunch regularly just as 62.7% did take dinner

regularly. Results also show that usually, 51% did eat fruits early in the morning while 62% regularly took dinner latest by 7pm daily.

Table 5: Eating Habit of Lecturers

<i>Questions on Eating Habits</i>	Response (N=343)		
	Usually	Rarely	Never
	n (%)	n (%)	n (%)
In a typical week, how often do you take home meal	45 (13.1)	200 (58.3)	98 (28.6)
How often do you skip meals?	142 (41.4)	123 (35.9)	78 (22.7)
Do you take responsibility for your meals	90 (26.2)	156 (45.5)	97 (28.3)
How often do you eat from roadside junk stores?	178 (51.9)	105 (30.6)	60 (17.5)
Do you take breakfast before leaving home daily?	54 (15.7)	189 (55.1)	100 (29.2)
Do you take lunch daily	197 (57.4)	124 (36.2)	22 (6.4)
Do you take dinner daily	215 (62.7)	111 (32.4)	17 (5.0)
Do you eat with members of your family	99 (28.9)	203 (59.2)	41 (12.0)
I take carbonated drinks	162 (47.2)	111 (32.4)	70 (20.4)
I go snacking	167 (48.7)	97 (28.3)	79 (23.0)
I eat my choice food	99 (28.9)	120 (35.0)	124 (36.2)
I eat fruits early in the morning	175 (51.0)	86 (25.1)	82 (23.9)
I eat vegetables	136 (39.7)	111 (32.4)	96 (28.0)
I take my dinner latest 7pm	213 (62.1)	89 (25.9)	41 (12.0)
Would you say you eat balanced diets?	88 (25.7)	94 (27.4)	161 (46.9)

Table 6 presents summary of responses on the respondents' eating habit (as earlier reported in Tables 5). Responses in Table 5 were coded such that 'usually' had code '2', 'rarely' had '1' and 'never' had '0'. These weights were applied to derive a set of composite scores. The mean of the scores was 15.0 ± 5.0 with minimum and maximum scores as 0 and 30 respectively. The mean was used to divide the scores into two groups: regular and irregular eating habits. Scores above the mean (16-30) were grouped as regular while scores from the minimum up until mean were grouped as irregular eating habits. Therefore, results as presented in Table 6 show that 64.1% of the respondents had irregular eating habits while 35.9% had regular eating habits.

Table 6 Summary Response on Eating Habit of Lecturers

Eating Habits				Mean	S.D.	Min.	Max.
Result	Range Scores	Frequency	Percentage				
Regular	16.0 - 30	123	35.9	15.0	5.0	0	30
Irregular	0 - 15.0	220	64.1				
Total		343	100.0				

Objective 3: Workload of Lecturers in Selected Universities

Table 7 presents results on the respondents' workloads. The results show that very many (71.7%) usually had time tables for their lectures but only 36.4% of them usually followed the lecture time tables. About 65% indicated that it was rare for courses outside their timetable to be routinely assigned to them just as 71.1% noted that ad hoc activities were more given to them. Some 48.1% of the respondents indicated that they often had to make up for colleagues with whom they took certain courses while 46.4% rarely had specified time they have allotted to research activities. Furthermore, 42.6% reported that they usually spent more than normal official hours at work and huge majority (87.8%) of them rarely had specified time allotted to the University community development activities. Similarly, 77.6% often had their academic activities conflicting with one another while 57.4% usually had their academic work schedules conflict with the time they have reserved for personal leisure. About 46% of the respondents reported that they did have excess workload on regular basis.

Table 7 Responses on Lecturers' Workload

Questions	Response (N=343)		
	Usually	Rarely	Never
	n (%)	n (%)	n (%)
I have a time table for my lectures	246 (71.7)	65 (19.0)	32 (9.3)
I follow the time table for my lectures	125 (36.4)	85 (24.8)	133 (38.8)
Courses outside my timetable are routinely assigned to me	74 (21.6)	222 (64.7)	47 (13.7)
Senior colleagues ask me to help take their classes	88 (25.7)	104 (30.3)	151 (44.0)
How often do you have to make up for colleagues with whom you take certain courses?	165 (48.1)	145 (42.3)	33 (9.9)
Do you have specified time you have allotted to research activities	69 (20.1)	159 (46.4)	115 (33.5)
I don't follow any time table for my lectures	47 (13.7)	212 (61.8)	84 (24.5)
Ad hoc activities are more given to me	78 (22.7)	244 (71.1)	21 (6.1)
I spend more than normal official hours at work	146 (42.6)	79 (23.0)	118 (34.4)
I have a to-do-list which I follow	63 (18.4)	198 (57.7)	82 (23.9)
Do you have specified time you have allotted to research activities	189 (55.1)	122 (35.6)	32 (9.3)

Do you have specified time you have allotted to the University community development activities?	11 (3.2)	301 (87.8)	31 (9.1)
How often do your academic activities conflict with one another?	266 (77.6)	56 (16.3)	21 (5.2)
How often do your academic work schedules conflict with the time you have reserved for your personal leisure?	197 (57.4)	74 (21.6)	72 (21.0)
I have excess workload on regular basis	156 (45.5)	99 (28.9)	88 (25.7)

Table 8 presents the summary of responses on the respondents' workloads (as earlier reported in Table 7). Responses in Table 7 were coded such that 'usually' had code '2'; 'rarely' had '1' and 'never' had '0'. These weights were applied to derive composite workload scores. The scores derived had a mean of 15.0 ± 5.0 with minimum and maximum values as 0 and 30 respectively. The mean and the standard deviation were used to divide the scores into three: heavy, mild, low. In other words, scores from the minimum (0) to $15.0-5.0$ (which gives 10) were grouped as low workloads. Scores from $15.0+5.0$ (which equals 20.0) to the maximum (30) were grouped as heavy workloads. Scores within the range 15.0 ± 5.0 , i.e. 10.0 – 20.0 were grouped as mild workloads. Furthermore, results as presented in Table 8 show that 49.6% of the respondents had mild workloads. About 30% had heavy workloads while 20.7% had low workloads.

Table 8 Summary Responses on Lecturers' Workload

Workload				Mean	S.D.	Min.	Max.
Result	Range Scores	Frequency	Percentage	15.0	5.0	0	30
Heavy	20.1 – 30.0	102	29.7				
Mild	10.1 – 20.0	170	49.6				
Low	0 – 10.0	71	20.7				
Total		343	100.0				

Test of Hypotheses

H₀₁: There is no significant relationship between the respondents' HRQoL and their socio-demographic characteristics.

Table 9 shows results on the relationship between the respondents' HRQoL and their socio-demographic characteristics. The results show that more of married respondents (56.7%) than single (38.7%) had medium-level HRQoL and the relationship was significant at $p=0.00$. Also, the proportion of the respondents with medium HRQoL increased consistently with higher education. Stated specifically, 51.4% of those with Bachelor's Degrees, compared with 88.6% of those with Master's Degrees, had medium-level HRQoL. Although the proportion declined to 26.1% among those with Doctoral Degrees, the relationship between education and HRQoL was significant at $p=0.00$. Furthermore, the respondents' place of residence had significant relationship with HRQoL ($\chi^2=100.1; p=0.00$). That is, much more of those living on University Quarters (71.4%) than those living off-campus (44.5) had medium-level HRQoL. Also, while only 28.9% of the respondents who had a maximum of 6 household members had medium-level HRQoL, about 70% of those who had more than 6 household members had medium-level HRQoL.

Table 9 Cross-tabulation of Health-related Quality of Life by Respondents' Socio-demographic Characteristics

<i>Socio-demographic Factors</i>		Health-related Quality of Life				χ^2	P
		High	Medium	Low	Total		
Gender	Male	14 (8.0)	81 (46.0)	81 (46.0)	176	45.21	0.19
	Female	11 (6.6)	100 (59.9)	56 (33.5)	167		
Marital Status	Married	19 (7.1)	152 (56.7)	97 (36.2)	268	89.75	0.00*
	Not Married	6 (8.0)	29 (38.7)	40 (53.3)	75		
Highest Educational Qualifications	Bachelor	10 (28.6)	18 (51.4)	7 (20.0)	35	74.65	0.00*
	Master	7 (5.3)	117 (88.6)	8 (6.1)	132		
	Doctoral	8 (4.5)	46 (26.1)	122 (69.3)	176		
Designation	Assistant Lecturer	7 (11.9)	18 (30.5)	34 (57.6)	59	69.10	0.02
	Lecturer I or II	6 (4.4)	98 (71.5)	33 (24.1)	137		
	Senior Lecturer	10 (8.2)	59 (48.4)	53 (43.4)	122		
	Reader/Prof.	2 (8.0)	6 (24.0)	17 (68.0)	25		
Years of Working Experience	Less than 5	11 (20.4)	35 (64.8)	8 (14.8)	54	42.84	0.21
	5-10	7 (3.2)	140 (63.6)	73 (33.2)	220		
	Higher than 10	7 (10.1)	6 (8.7)	56 (81.2)	69		
Place of Residence	University Quarters	15 (14.3)	75 (71.4)	15 (14.3)	105	100.4	0.00*
	Off-campus	10 (8.2)	106 (44.5)	122 (51.3)	238		
	Total	25 (10.1)	181 (69.0)	137 (16.9)	343		

*significant at 5%

Ho2: There is no significant relationship between the respondents' HRQoL and their life-work variables

Results as presented in Table 10 show that 13.8% of the respondents with regular eating habits versus only 3.6% of those with irregular eating habits had high HRQoL. Similarly, while 80.5% of those with regular eating habits had medium-level HRQoL, only 37.3% of those with irregular eating habits had medium-level HRQoL. Chi-square test shows a significant relationship between the variables ($\chi^2=114.3$; $p=0.00$). Similar results were shown in the relationship between HRQoL and workloads. That is, highest proportion (81.4%) of the respondents with low HRQoL were found among those with heavy workloads. The relationship between workloads and HRQoL was also significant at $p=0.01$.

Table 10 Cross-tabulation of Health-related Quality of Life by Life-work Variables

Life-work Variables		Health-related Quality of Life				χ^2	p
		High	Medium	Low	Total		
Eating Habits	Regular	17 (13.8)	99 (80.5)	7 (5.7)	123	114.3	0.00*
	Irregular	8 (3.6)	82 (37.3)	130 (59.1)	220		
Workloads	Heavy	13 (12.7)	6 (5.9)	83 (81.4)	102	97.15	0.00*
	Mild	7 (4.1)	125 (73.5)	38 (22.4)	170		
	Low	5 (7.0)	50 (70.4)	16 (22.5)	71		

*significant at 5%

The influence of eating habit on HRQoL was examined using Independent T-test (because eating habit had two levels) while the influence of workloads, on HRQoL was examined using Analysis of Variance (ANOVA). The results are presented in Table 11. This statistic examines the relationship between two variables, one of which has group response levels (such as regular or irregular; severe, mild or low) and the other quantitative (HRQoL scores). The statistic is used to compare the mean HRQoL scores between the groups. Results show that the respondents with regular eating habit had mean HRQoL score of 17.1 while those with irregular eating habit had HRQoL score of 10.8. With $F=27.256$ at $p=0.00$, it is concluded that there is significant difference in the means between the two groups. Hence, respondents with regular eating habit had significantly higher HRQoL than those with irregular eating habit. Respondents with heavy workloads had mean HRQoL of 9.4, mild workload had 17.2 and low workload had 19.2. This shows a trend where HRQoL is inversely related with workload.

Table 11 Analysis of the Predictors of Health-related Quality of Life

Variables		N	Mean HRQoL	F	Sig.
Eating Habit	Regular	123	17.1	27.256+	0.000*
	Irregular	220	10.8		
Workload	Heavy	102	9.4	35.148++	0.001*
	Mild	170	17.2		
	Low	71	19.7		

+Independent T-test

++ANOVA

*significant at 5%

Discussion of Findings

This study shows that majority of lecturers in South-western University had medium-level health-related quality of life and this is in tandem with the study by Etuk, (2017) who reported that about two-thirds of University lecturers were on average level as regards health-related quality of life. Furthermore, Etuk, (2017) also show that it not only increases the health-related quality of life but at the same time, improves the learning environment as well as increases university productivity. However, their study concludes that private university academics are more satisfied in terms of pay, supervision, and promotional opportunities, compared to public universities, while public university academics are more satisfied in terms of co-workers' behaviour and job security. A study by Akinwale (2019) finds that the set of predictors of health-related quality of life includes pay, work, promotion, supervision, environment, and co-workers. Another study by Demerout, *et al.*, (2011) concludes that health-related quality of life factors of any officers or any employees include pay, work, co-workers, and environment. Studies by Ding, *et al.*, (2015) indicate that health-related quality of life of employees or workers is reflective in attitude to the job, relations with co-workers, supervision, company policy and support, promotion, and pay.

Results from Mirkamali *et al* (2011) show that pay, promotion, work, supervision, and fellow workers are the main factors for university academics, in terms of work-life quality. Studies conducted by Tester and Simptison (2011) revealed that health-related quality of life is induced by compensation, an opportunity for advancement, leadership style, work environment, organizational structure, and climate. In Malaysia, Rapheal *et al* (2019) conducted a study and found that private university academics' health-related quality of life includes salary, promotion, fringe benefits, and working conditions.

In a study conducted by Beehr *et al* (2008), which indicates that job rank level and occupational level are the factors that are usually considered as contributing to health-related quality of life. Research conducted by Ahsan *et al.* (2011) delivered a response rate of 72.9 percent and the results show that work-life quality factors include authority, supervision, policies and facilities, the work itself, interpersonal relationships, commitment, salary, and workload. Similarly, another study by Brush (2013) finds that work-life quality factors are co-workers and working as a team, while sharing also rated as important. Studies from Taris and Van (2011) reveal that appropriate compensation, equivalent promotion opportunities, job security, suitable working conditions and the work itself have an impact on public and private university academics' health-related quality of life in Pakistan.

Eshragi, *et al.*, (2012) and Marcus (2020) maintain that work-life quality was highest among employees who received the most reward. Another study at a Massachusetts higher education institution, conducted by Graham (2016), concludes that professional development and salary packages are the most important factors in work health-life quality. However, the relationship behaviour of supervisory staff affects academic job satisfaction (Graham, 2016). Furthermore, Brush (2013) study also indicates that supervisors can increase the employees' health-related quality of life. Similarly, results from Elendu & Akpan (2012) conclude that promotional opportunities have a positive impact on the employees' health-related quality of life. Research by Beehr (2008) finds that positive relationships with fellow workers increase with the health-related quality of life. Similar findings by Tahir (2019) support the findings that relationships with co-workers are improved when employees experience work-life balance.



According to Edward, (2011), pay has a positive impact on determining the health-related quality of life and job satisfaction. The study further reveals that promotion and flexible work overload also influence job satisfaction, when compared to recognition, and achievement. Findings from the research conducted by Brush (2013) indicate that when employees observe that their supervisors are fair, competent, and sincere, their level of job satisfaction increases and this in turn positively influences their health-related quality of life. Results from a study done by Robert (2017) indicate that the working environment increases employees' health-related quality of life very positively. In a study by Demerout *et al* (2011), it is concluded that rewards increase and decrease the satisfaction of employees.

Taris & Van (2018) conducted a study on the associated factors health-related quality of life in Dutch on 173 academic of a private university. The results show that there is a relation between health-related quality of life and pay, promotion, fringe benefits, working conditions, support for research, support of teaching, and gender. Furthermore, they also indicate that pay, promotion, working conditions and support of research have a positive and significant effect on the university academics' job satisfaction. According to Yusoff, (2018), Fields & Blum (2007), an employee's health-related quality of life usually depends on the individual's characteristics and characteristics of the job itself. However, age, gender, education status, hours of work, and the earning figure are the factors that affect university academics' job satisfaction. Osaat & Ekechukwu, (2017) show that job security affects university academics' health-related quality of life while fringe benefits have a low effect. Akinwale (2019) identify that an employee's salary is a forecaster of job satisfaction and largely, of health-related quality of life.

Nursing Implication

Health-related quality of life of lecturers needs to be high/good in order to keep them away as much as possible from congesting the already strained hospital beds in respective campuses. HRQoL of lecturers is closely related to their productivity and the nursing professional relies on Universities to produce professional nurses who will provide solutions to societal health needs and problems. Lecturers who have good HRQoL would be wholly satisfied with their jobs and are more likely to have positive energy, vigor and self-confidence with which they will run their daily activities devoid of diseases and activities.

Therefore, nurses should focus on university lecturers to discharge both preventive and primitive healthcare services by mass sensitization on the need for lecturers to pay more attention to their eating habit and sleep quality.

Conclusion

Health-Related Quality of Life is low among university lecturers in South-western Nigeria. Lecturers' marital status, educational attainments, designations, place of residence and household size, played roles in the low-level Health-Related Quality of Life though, the significant predictors of Health-Related Quality of Life of the lecturers were their eating habits and workloads. In other words, low/mild workloads and regular eating habits, lecturers would have high Health-Related Quality of Life.

Recommendations

Based on the results of this study, the following recommendations were made;

1. Shortage of lecturers was a factor identified as source of excessive workload which negatively impacted HRQoL. It is therefore recommended that Universities in south-west Nigeria should recruit additional lectures so as to ease their workload

2. University authority should devise inclusive orientation programme for lecturers family members; who though are not university employees, but are key to the HRQoL of lecturers. The key objective of this programme is to enlighten them on the need to understand the challenges of lecturers' workload and that they need their support for emotional, psychological and mental stability in order to function effectively, while still maintaining a high HRQoL.

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