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Barriers to Healthy Lifestyle Behaviors Perceived by Nurses Working in Hospitals

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ABSTRACT

In Turkey, nurses' health is threatened by risks related to lifestyle as well as risks at the workplace, and they cannot exhibit enough healthy lifestyle behaviors. This study was conducted to determine barriers to healthy lifestyle behaviors perceived by nurses working in hospitals. In this qualitative study, in which five face-to-face focus-group interviews were held, 31 nurses working in a hospital selected by purposive sampling method were interviewed. The data were analyzed using the inductive content analysis technique. Three main themes, namely, work-related barriers (working hard, shift work, and lack of institutional support), individual barriers (lack of knowledge and failure to take care of health), and social barriers (family responsibilities and cultural habits), were identified and described. This study highlighted the barriers to healthy lifestyle behaviors perceived by nurses working in hospitals in Turkey. Deep knowledge of the barriers nurses perceive to initiating and maintaining healthy lifestyle behaviors can guide the development of workplace health promotion programs to reduce risk factors related to nurses' lifestyles.

Key words: Focus groups, Healthy lifestyle, Hospital, Nurse.

Hastanede Çalışan Hemşirelerin Sağlıklı Yaşam Biçimi Davranışlarına Yönelik Algıladıkları Engeller

ÖZ

Türkiye'de hemşirelerin sağlığını işyeri risklerinin yanı sıra yaşam biçimiyle ilişkili riskler tehdit etmekte, hemşireler yeterli düzeyde sağlıklı yaşam biçimi davranışlarını sergileyememektedir. Bu çalışmanın amacı, hastanede çalışan hemşirelerin sağlıklı yaşam biçimi davranışlarına yönelik algıladıkları engelleri belirlemektir. Beş odak grup görüşmesi yapılan bu nitel çalışmada, amaçlı örnekleme yöntemiyle seçilmiş hastanede çalışan 31 hemşireyle yüz yüze görüşülmüştür. Veri, tümevarımsal içerik analizi tekniği kullanılarak analiz edilmiştir. İş ile ilgili engeller (yoğun çalışma, nöbetli çalışma ve kurumsal destek eksikliği), bireysel engeller (bilgi eksikliği ve sağlığa özen göstermeme) ve sosyal engeller (ailevi sorumluluklar ve kültürel alışkanlıklar) olarak üç ana tema belirlenmiş ve tanımlanmıştır. Çalışmanın sonuçları, Türkiye'de hastanelerde çalışan hemşirelerin sağlıklı yaşam biçimi davranışlarının önündeki engelleri vurgulamıştır. Hemşirelerin sağlıklı yaşam biçimi davranışlarını başlatma ve sürdürme konusunda algıladıkları engellere dair derin bilgi, hemşirelerin yaşam biçimiyle ilgili risk faktörlerini azaltmak için işyeri sağlığı geliştirme programlarının geliştirilmesine rehberlik edebilir.

Anahtar kelimeler: Hastane, Hemşire, Odak grup, Sağlıklı yaşam biçimi.

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INTRODUCTION

Nurses provide patient care services as an important component of the health system. The number of nurses who are working in Turkey is 198.103 and 60% of these nurses are employed in hospitals (Republic of Turkey Ministry of Health, 2019a). The health of nurses working in shifts or on duty is affected physiologically (gastrointestinal, neuropsychological, cardiovascular, and musculoskeletal disorders); psychologically (depersonalization, cynicism, aggression and frustration) and socially (deterioration in family relationships and social life) (Reisinho et al., 2021). Nurses' health is also threatened by the integrated effect of risks related to lifestyle as well as workplace risks.

A healthy lifestyle is individuals' ability to control their behaviors that may affect their health and regulate their daily activities by choosing behaviors suitable for their own health status (Pender et al., 1992). According to Pender, Healthy Lifestyle Behaviors (HLBs) include health responsibility, physical activity, nutrition, interpersonal relationships, spiritual development, and stress management (Pender et al, 2006). Nurses, who are educated to provide healthcare, education, and consultancy services to individuals, are expected to have enough knowledge and practices about these behaviors. However, nurses in Turkey exhibit unhealthy eating habits, such as skipping meals (Daş Geçim & Esin, 2019) and behaviors that negatively affect health, such as inadequate physical activity (Bostan & Beşer, 2017). According to the Health Promotion Model, barriers perceived by individuals are directly or indirectly important in maintaining health behaviors, and 79% of the behavior change is explained by perceived barriers (Pender et al., 2006). Phiri et al., (2014) nurses' perceived barriers to healthy living were found to include lack of time to prepare healthy meals due to long working hours, being tired after work, and the presence of food vendors selling unhealthy foods around the hospital. Kolbe-Alexander et al., (2014) the main barrier perceived by nurses to healthy nutrition and regular physical activity was the lack of time and healthy food options in the cafes around the hospital.

Workplaces are suitable places to implement health promotion programs that include health promotion initiatives to improve employees' lifestyle-related health behaviors. Key elements in Workplace Health Promotion Programs (WHPP), which provides evidence that nurses have positive effects on HLBs, cover the implementation of measures related to healthy working conditions and healthy lifestyle with the direct participation of employees (European Network for Workplace Health Promotion [ENWHP], 2018). It is important to reveal barriers to these behaviors perceived by nurses in the design and implementation of effective WHPPs to improve HLBs. Qualitative research on the perceived barriers to HLBs by nurses working in the hospitals is limited. This study was conducted to determine barriers to HLBs perceived by nurses working in hospitals in Turkey. Within the scope of the research, we sought answers to the following question: What are the barriers to practicing healthy lifestyle behaviors perceived by nurses working in hospitals?

MATERIAL AND METHOD

Design and participants

This is a descriptive qualitative study conducted using face-to-face focus groups consisting of 31 nurses who were determined by the purposive sampling method. Focus groups (Krueger & Casey, 2000) were carried out to determine the perceived barriers of nurses working in a hospital toward HLBs by making use of group interactions.

According to the inclusion criteria, the participants who worked in a medium-size hospital located in the Central Anatolia region of Turkey, where the research was conducted, and who volunteered to participate in the research were included in the study. Since the subject of the study did not include sensitive issues, nurses who took part in the management of nursing services were also included in the focus groups. The size of focus groups was determined according to the depth of the data collected in the interviews (Krueger and Casey, 2000), and a new focus group meeting was not planned when the data reached a saturation point. A total of five focus groups, which included 5 to 8 participants, were carried out between January and June 2015 in the meeting room of the hospital where the research was conducted, and a total of 31 nurses participated in the interviews (see Table 1).

Table 1. Demographic data of nurses who participated in focus group interviews

Variables	Frequency	Percentage (%)
Age		
24-30	2	6
31-37	8	26
38-44	13	42
45-51	8	26
Education level		
High school	1	3
Associate	7	23
Undergraduate	19	61
Graduate	4	13
Work experience (years)		
5-10	5	16
11-20	14	45
21+	12	39
Shift		
Day (08-16)	12	39
Night (16-08)	1	3
Rotating	18	58
Status of smoking		
Not at all	19	61
Less than a pack	8	26
A pack a day	4	13
Total	31	100

Ethical clearance for this study was obtained from the Dokuz Eylul University Clinical Research Ethics Committee (Number: 209SBKAEK). Institutional permission was obtained from the management of Yenimahalle State Hospital, where the research was conducted. Oral and written informed consent was obtained from all participants, and a copy of the written informed consent was given to the participants.

Data collection

Data were collected using a Personal Information Form and a Focus Group Interview Guide. The Personal Information Form developed by the researchers consists of questions about nurses' age, gender, marital status, education level, work experience and shift work, smoking, alcohol use, chronic diseases, and doing sports. Information about the purpose and rules of focus groups and focus group interview questions were included in The Focus Group Interview Guide. Interview questions were developed by using the question preparation format suggested by Krueger and Casey (2000) (see Table 2). The questions were revised according to the recommendations made by five experts specialized in qualitative research. The preliminary study was conducted by holding a focus group interview with five nurses working in the hospital where the research was conducted, the questions were modified according to the results of the preliminary study, and they were rearranged according to the feedback received from three experts specialized in qualitative research.

Table 2. Focus group interview questions

Type of questions	Questions
Opening question	Could you briefly introduce yourself?
Introductory question	What do you think about being healthy?
Transition question	What do health behaviors mean to you?
Key question	What did you do for healthy living in the past?
Key question	(Probes: Any examples you can think of? Could you give us a little more details about what happened?)
Key question	What were the factors underlying your efforts to lead a healthy life? (Probes: Any examples you can think of? Could you give us a little more details about what happened?)
Closing question	What barriers did you encounter during your efforts to lead a healthy life?

Focus groups conducted by the first researcher were held during the nurses' lunch break and lasted an average of 55 minutes. A voice recorder and camera were used to record the interviews equally and with the same sensitivity. The participants were asked the questions in the guide respectively, and an observer took notes. After the interview questions, the researcher summarized the topics discussed, and the interview was ended with a general question: "Is there anything we missed?"

Data analysis

The data were subjected to inductive content analysis, which included coding the data, eliciting the themes, organizing the codes and themes, and describing and interpreting the findings, respectively. The data recorded during the interviews were transcribed by the first researcher within a week, and the records were listened to for the second time to confirm that the data were complete. The whole data set was read several times, and before breaking it into parts, meaningful expressions were elicited and coded by making an overall sense out of the interviews. After the data were coded, a codebook was created. This process was carried out independently by two researchers. Then, the codes, their names, and the coded text parts were compared and discussed. Miles and Huberman (1994) recommended 80% intercoder agreement, and a 100% agreement was achieved in this study. As a result of the agreement, the code list was revised and the themes were determined. The first analyses including the themes were presented to five participants, and they were validated by taking their opinions. The findings were interpreted by making direct quotations from the focus group interviews in the theme titles. Since it was not suitable for the research, situational factors such as group interaction and group dynamics in focus groups were not taken into account, and questions other than the key questions in Table 2 were not included in the analysis.

The terms and strategies recommended by Lincoln and Guba (1985) were taken into account to establish the validity and reliability of the study. Lincoln and Guba (1985) suggested using the concepts of credibility instead of internal validity, transferability instead of external validity, dependability instead of internal reliability, and confirmability instead of external reliability. (a) Credibility: All interviews were recorded separately with a voice recorder and camera, and the observer took notes during the interviews. The notes taken were discussed with the observer immediately after the meeting. Data were collected through questions that required detailed answers, and focus groups were terminated when new data could not be obtained. The findings obtained for data triangulation were compared with other research findings in the literature. At the end of the interview, the participants' statements were summarized for their control, and they were asked to state their thoughts on the accuracy of the summary. At the same time, the first analyses containing the themes were presented to the participants, and their opinions on the findings were requested, and the results obtained in this context were made more detailed. (b) Transferability: The sample, environment, and processes of the research were explained in detail. The data were defined in detail, reorganized according to the emerging codes and themes, the themes obtained were exemplified by quoting directly from the statements of the participants, and the data were defined as expressed by the interviewees as much as possible. The names of the participants were kept confidential and the codes were given as N1, N2, N3 to refer to the statements of the participants. (c) Dependability: All interviews were conducted by the same researcher and recorded with the same recording devices. The same interview guide was used in all focus groups. Intercoder agreement was employed, and the analysis was evaluated by two researchers. To control the research process from outside, peer review was employed, and the inquiries were kept as written notes. (d) Confirmability: A consultant out of the research team assessed both the research process and whether the findings, interpretations, and results were supported by the data, and confirmed the study results reflecting the raw data. Data collection tools, raw data, code lists, and interview notes were kept by the researcher.

RESULTS

Table 3. Barriers to healthy lifestyle behaviors, which were divided into three themes and sub-themes, perceived by nurses working in a hospital

Themes	Sub-themes
Theme 1: Work-related barriers	- Working hard - Shift work - Lack of institutional support
Theme 2: Individual barriers	- Lack of knowledge - Failure to take care of health
Theme 3: Social barriers	- Family responsibilities - Cultural habits

Three main themes were identified and defined: work-related barriers (working hard, shift work, and lack of institutional support); individual barriers (lack of knowledge and failure to take care of health); and social barriers (family responsibilities and cultural habits) (See Table 3).

Work-related barriers

Working hard: Working hard was among the prominent barriers to implementing HLBs in focus groups. In most focus groups, nurses stated that their working hours were long, therefore they could not spare time for healthy eating and physical activity practices, and even if they did, they could not practice these behaviors regularly: "You leave the shift, and you sleep at home... You go back to the shift the next day... This is our cycle. We have nothing else... I have no weekends. I'm on duty almost every other day. I'm looking forward to spending my time at home in my bed (N14)". Depending on the intensity they experienced during work, some nurses stated that they sometimes preferred not to eat lunch, they had to finish their meals quickly, and that they ate snacks when they skipped lunch: "You are in a rush for hours... You will sit and eat your food. When it is time for lunch, you should meet your basic need of eating. Your food has become cold; you try to eat in a hurry (N20)." In many focus groups, nurses emphasized that working hours needed reducing so that they could practice health behaviors: "Working conditions are very hard... We do not have time to rest, and we have a family life on the other hand... We need time for ourselves and healthy living. While we are protecting others' health, we are losing ours ... So, working hours will need to be reduced so that everyone can maintain and improve this (health) condition (N26)."

Shift work: Another prominent barrier in focus groups to implementing HLBs was shift work. In some focus groups, the nurses stated that they worked on shift, they led an irregular life due to working on shifts, and that this was an important barrier to practicing health behaviors: "... When I work on shift, the next day, I am sleepless and tired. I go home, I sleep, I rest... I can't make myself a healthy meal and eat it. I'm just eating to feel full. After all, I want to eat and sleep or rest as soon as possible... It is difficult to maintain a healthy and balanced diet ...(N11)"; "When I finish working on duty, I feel exhausted; my body cannot rest. I just want to sleep. Today, for example, I worked the day shift ... I will work on duty the next day. I will come back to the day shift the following day. Now, with this working order, I can't spare time for sports regularly even if I want it...(N2)" In all focus groups, nurses stated that the way they worked on shifts affected their health negatively and that they experienced health problems after the shift: "... I feel tired all the time. There are always people with mental disorders; you know, they are always in a lying position. I can't sleep due to pain after finishing shift work. It's a close distance from my home to work. Even for this short distance, my husband comes and picks me up by car. I don't want to get tired...(N9)" A few nurses said that they could not follow the diet recommended by the dietician regularly due to shift work, and gained weight due to their tendency to snack during the shift.

Lack of institutional support: In some of the focus groups, nurses stated that they did not have the opportunity to do physical activity in the hospital environment: "Actually, if we had the opportunity here (at the workplace), like a walking path, we could walk for half an hour after work or during lunch breaks (N7)."; "... I have always dreamed of something smaller at the workplace, not as a sports center. There will be a small social facility where I work. I'll go there during lunch break. I will run for half an hour. I'll take my shower. There will be a hairdresser, and she will blow-dry my hair. I'll come back to work (N30)." A few nurses emphasized that physical activity would positively affect their mental health if provided by the hospital administration: "... In some workplaces, there are gyms for the employees... The staff go there and do activities for half an hour. We don't have such a place, which we need very much... They can give us a small room. I'll go to that room... Why don't I go down to the hall and ride a bike? Why not run on a treadmill? Why don't I go and relax my muscles? (N12)"

Individual barriers

Failure to take care of health: In a few focus groups, nurses stated that they smoked, they wanted to quit, but they could not: "... There are no smokers in the house. My husband used to smoke, but he quit it. I think I give a lot of disturbance to them because I always smell bad. I have thought I need to quit after hearing I smell very bad, like an ashtray. Of course, I want to quit mostly for my health...(N6)" In several focus groups, nurses said that they could not quit smoking and did

not even think about quitting: "The worst thing I could not do was not being able to quit smoking ... I would quit if I wanted. I believe it. I've never seen it stronger than me ... There are times when I smoke less than half a pack of cigarettes a week. Sometimes, I forget my cigarette pack in my bag for a month. There are also times when I smoke a pack a day. But for some reason, I haven't been able to make the decision and say seriously, 'I am going to quit it now.' Have I encountered any difficulties? No, in fact, there is no other smoker at home (N19)." In some of the focus groups, the nurses stated that they did not pay attention to their own health: "We can't find the opportunity to cope with our own health problems and have check-ups. Twenty days ago, I had an abscess in my breast. It was emptied. I'm going to have an ultrasound. I have not got it done, yet... We are postponing, delaying. We put ourselves in the second place (N5)."

Lack of knowledge: In focus groups, some nurses stated that they were feeling bad because they put on weight, they tried some types of diets to lose weight quickly, but that they encountered health problems after the diet: "... I went on a diet to lose the weight I gained after giving birth... I followed a diet called the Swedish diet. I ate only eggs for three days, only potatoes for the next three days, and only yogurt for the following three days. I didn't eat anything else. I implemented it for nine days. I lost five kilos. But I could not tolerate it. I started to feel an excessive, uncontrolled desire to eat. That's, I couldn't stop myself from eating although I saw I had been gaining weight ... In a very short time, I gained thirty-five kilos in six months... My whole metabolism was impaired...(N13)" Some nurses stated that they did not have breakfast and preferred to stay hungry until noon: "I do not have breakfast. I don't eat anything until lunchtime... Instead of gaining weight, I'll not eat anything until twelve (until lunchtime) (N27)." A few nurses stated that it was necessary to have sufficient financial possibilities to do sports: "... My husband and daughter are enrolled in the gym. Both of them are going to the gym... I am not enrolled because it would be difficult financially if I were. I have two children attending university (N21)." In some focus groups, nurses stated that they exhibited negative eating behaviors to cope with stress, but that they felt uncomfortable with these behaviors.

Social barriers

Family responsibilities:

Childcare: In all focus groups, nurses stated that childcare took up a significant part of their time outside of work: "I was a volleyball player. I was single then. That's, it was all about myself, my job, and my life... I played for about seven years. Of course, these were very important things in my life. Right now, I can't follow my old way of living. We get tired at work until the evening ... I have a small child. I need to allocate time for my child ... You feel bad conscientiously when you can't spare time for your child ... You take care of the child. You come back to work in the morning, you are tired again. Such a vicious cycle (N9)". Most of the nurses stated that they came to the workplace tired because they took care of the children and they preferred to rest during the time remaining from work. They also mentioned the difficulties of being a mother as well as being a working woman "... I returned work when my baby was nine or ten months old ... You cannot sleep at night ... You have to come to work with a couple of hours of sleep. It affects more than working on duty; that's, it's the same every day... Our job is already difficult, and you have to fulfill your responsibilities as a mother additionally...(N13)" A nurse who had a daughter with a disability stated that she gave more importance to her daughter's healthy eating and having her do the exercises recommended by her doctor, and therefore, her health.

Chores: In most of the focus groups, nurses stated that they spent a lot of time on housework in addition to child care and that the time they spent on housework often caused them to delay or fail to perform physical activity practices. In several focus groups, nurses expressed regret for not being able to do housework because of doing the physical activity: "...I try to do Pilates 3 days a week. But I can do it once a week. Sometimes I cannot do it at all. After finishing shift work yesterday, I went home. There were a lot of chores awaiting me. It is difficult to catch up on everything. I condemn it. I have a lot of work, but I regret it very much because it is not my right to spare time for exercise. I do not have such a time; it is a luxury for me right now (N28)."

Cultural habits: In several focus groups, nurses emphasized that cultural habits negatively affected their regular physical

activities: "... As a society, we remember our health when we get sick. For example, I do not exercise ... Let's say I have high blood fats. If I walk, I know they will fall. Diet doesn't help much. But a disease will occur or a symptom will appear in our blood state. Only then, we act accordingly, even though we (nurses) know that it is wrong (N11).". In addition to the negative impact of culture on regular physical activity, nurses in several focus groups also stated that it also affected healthy eating behaviors: "Especially as summer approaches, diet issues relapse every March. Doing sports? Yes. Of course, it doesn't last very long... Maybe it's a bit of our cultural habit. There is absolutely no room for it in our lives (N18)."; "So I guess it (healthy eating) is a cultural habit. I think so. I eat just to feel full. I don't pay any attention to what I am eating; this one has this vitamin, that one has that mineral, and so on (N2)."

DISCUSSION

Working hard was one of the sub-themes for work-related barriers. It was determined that long working hours in many focus groups were important barriers for nurses to allocating time for healthy nutrition and physical activity. Consistent with this finding, in a qualitative study conducted by Phiri et al. (2014), it was reported that nurses did not have enough time due to long working hours, and therefore they could not exhibit healthy eating behaviors. Similarly, Artazcoz et al. (2007) showed that long working hours negatively affected the health behaviors of female employees and that they could spare less time for physical activity. In Turkey, there are problems in the planning and employment of nurses working in hospitals, and as a result, there are inadequacies in the number of nurses (Özkan & Uydacı, 2020). This situation causes hospitals that work with a small number of nurses to provide healthcare services by increasing the working hours of existing nurses.

Shift work was another sub-theme for work-related barriers. In most of the focus groups, depending on the nurses' shift work, it was determined that they led an irregular life, they wanted to take time to sleep and rest because they experienced fatigue and insomnia after shift work and that they could not adequately exhibit healthy eating and physical activity practices for this reason. Consistent with this finding, in the qualitative study of Bilazer et al. (2008), it was determined that the shift work system caused sleep problems, physical fatigue, neglect of self-care, and disruption in meal routines in nurses. The findings of this study were in line with the findings of several studies showing that nurses who worked on shift had unhealthy eating habits such as skipping meals (Daş Geçim & Esin, 2019) and that they could not do enough physical activity (Bostan & Beşer, 2017). Healthy living conditions require active living during the day and resting and letting the body regenerate by sleeping at night (Bilazer et al., 2008). However, shift work is a situation that nurses always encounter throughout their lives, and their well-being and quality of life are affected by the shift work system.

Lack of institutional support was another theme of work-related barriers. In some focus groups, nurses stated that interventions supporting a healthy lifestyle, including physical activity practices, were not offered to them in the hospital setting. In general, nurses in Turkey cannot receive a continuous health service unless they themselves present to a health service and cannot maintain their right to be healthy in working life (Özkan & Emiroğlu, 2006). WHPP, which is among the priorities of occupational health services that include efforts to maintain and improve the physical, mental, and social well-being of employees, takes into account a combination of health education and environmental actions that support healthy living conditions (ENWHP), 2018). There are studies reporting that nurses' health behaviors are positively affected at workplaces where these programs are implemented (Tucker et al., 2011). With the legislative arrangements made in the last ten years, nurses in Turkey have been seen as an employee and considered as a group that should benefit from occupational health services. It is thought that the WHPPs to be organized for nurses in the hospital environment can increase the perceived competence level, perceived benefit, and motivation of nurses to practice health behaviors.

Failure to take care of health was one of the sub-themes of individual barriers. In some of the focus groups, it was determined that the nurses smoked, they wanted to quit smoking, but that they could not quit it. On the other hand, a few nurses stated that they did not even intend to quit smoking. This finding of the study can be interpreted as nurses' failure to take care of their health by smoking or neglecting to receive

professional help to quit smoking; that is, they don't take on the responsibility for their own health. According to Pender, one's taking on their health responsibility, which is defined among HLBs, includes taking care of their health, being knowledgeable about health, being able to seek professional help when necessary, and at the same time actively feeling responsibility for their own well-being (Pender et al., 2006). In Pender's Model, perceived control in the initiation and maintenance of HLBs, including health responsibility, is one of the important motivational mechanisms. Strickland (1978) reported that individuals with high internal control about their own health are more effective in protecting their physical health and taking precautions against diseases, act more responsibly, and search for more information to protect their health. In the present study, the reason why nurses continued their smoking behavior and did not receive professional help could be attributed to their low internal control. With the education programs to be offered to nurses within the scope of WHPP, it is thought that nurses' internal controls will be improved and their health responsibilities will increase, and thus the perceived benefit will increase.

Lack of knowledge was another sub-theme of individual barriers. In some of the focus groups, it was revealed that nurses exhibited unhealthy eating behaviors, had inappropriate attitudes towards physical activity practices, and could not cope with stress appropriately. This finding may show that nurses cannot benefit from occupational health services that aim to develop a healthy lifestyle and include health education practices. Although nurses providing healthcare services to individuals are expected to have enough knowledge and practices on health protection and improvement behaviors in line with the education they receive, some studies have reported that nurses exhibit HLBs at a moderate level (Bostan & Beşer, 2017; Uncu & Üstündağ, 2018). Implementing education programs that support a healthy lifestyle for nurses within the scope of WHPP may help nurses to obtain up-to-date knowledge about HLBs and transfer this knowledge to their own lives by increasing the perceived benefit that plays an important role in HLBs.

Family responsibilities, including childcare and housework, were sub-themes of social barriers. In most of the focus groups, it was revealed that the majority of the nurses' time outside of work was occupied by childcare and housework, so they could not spare time to practice HLBs. This finding can be attributed to the fact that nurses as female employees are affected by gender roles. Although necessary legal arrangements were made about the employment of men as nurses in Turkey in 2007 (Republic of Turkey Ministry of Health, 2007), women still make up the majority of nurses, and nursing is perceived as a female profession. While sex defines the features determined by biology, gender includes the features that socially make up women and men. Studies conducted in Turkey show that these roles of women have significant effects on their working lives and that the workload in the family doubles with the participation of women in working life (Göközkut & Yüceşahin, 2021).

Another sub-theme of social barriers was cultural habits. In a few focus groups, it was determined that nurses' regular physical activity and healthy eating behaviors were prevented by cultural habits. This finding shows that nurses are affected by the culture of the society they live in. In Pender's Model, culture (Pender et al, 2006), which is one of the determinants of a healthy lifestyle, is defined as the way of life of a society (Bolsoy & Sevil, 2006). The physical activity level of Turkish society is inadequate and that the physical activity level of women is lower than that of men (Republic of Turkey Ministry of Health, 2019b). In terms of nutrition, on the one hand, inadequate and unbalanced nutrition is observed in Turkish society due to socio-economic inequalities, and health problems such as obesity are observed as a result of overeating on the other hand (Republic of Turkey Ministry of Health, 2019b). Similar to Turkish society, it was determined that the physical activity level of nurses was inadequate (Bostan & Beşer, 2017; Uncu & Üstündağ, 2018) and that they exhibited unhealthy eating behaviors (Daş Geçim & Esin, 2019).

CONCLUSION

This study revealed the work-related, individual and social barriers that nurses perceived towards HLBs. The national planning and employment of nurses working in the shift system during busy and long hours should be re-evaluated, and improvements should be made in their working conditions through studies to be carried out at both institutional and

national level such as establishing adequate rest times after the shift work. Public awareness activities should be carried out to ensure that the responsibility for childcare and housework is shared equally by the men and the woman in the family. Through WHPP programs, nurses can access up-to-date information on HLBs, perceived control, perceived competence levels, and perceived benefits can be increased, motivation for HLBs can be promoted, and environmental measures that support healthy lifestyles can be taken at an institutional level.

Due to both the insufficient number of nurses working on the night shift and the workload in the clinics they work in the hospital where the study was conducted, focus groups were not held with nurses working on the night shift. Accordingly, nurses working only on the night shift were not included in the focus groups held during the day.

AUTHOR CONTRIBUTION

Study design: S.A., A.B. Data collection: S.A. Data analysis: S.A., A.B. Study supervision: S.A., A.B. Manuscript writing: S.A., A.B. Critical revisions for important intellectual content: S.A., A.B.

CONFLICT OF INTEREST

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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