Family Functioning Of Staff Of An Urban Hospital In Nigeria

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Abstract

Objective: Work and family are the most central domains in an individual's life. Because work and family are closely interconnected, linkages between work and family affect organizational performance and family functioning, both of which are important markers of societal well-being. This study set out to assess how functional the families of staff in an urban mission hospital setting were.

Methods: This was a cross-sectional survey of all consenting staff of Bingham University Teaching Hospital. Socio-demographic data and family function were obtained using standardized questionnaires including the Family APGAR tool. Data was collated and analysed using SPSS version 17 software.

Results: The response rate for this study was 68.8%. Most, 84.1% (185), of the health workers studied had highly functional families, 14.5% had moderately dysfunctional families and 1.4% had severely dysfunctional families. There was no significant relationship between family function category and occupation OR 0.87(0.43-1.71), gender 0.63 (0.29-1.38), marital status 0.59 (0.31-1.12), duration of employment 0.81 (0.37-1.74), age 0.92 (0.43-1.97), and educational status 0.80 (0.41-1.58).

Conclusion: This study demonstrates good family functioning among the staff of an urban hospital.

INTRODUCTION

Work and family represent the most central realms of adult life. For many employed adults, the demands made by these two areas are their most important daily task. Traditionally, these two domains have been studied independently. More recently however, the interactions between work and family roles have been the interest of a growing number of researchers.1

The impact of work on the personal lives of workers is far reaching, affecting not only the workers themselves but other family members as well.1

The potential impact that work and family issues have on employees, family members, and organizations have caused rising interest among researchers in the developed countries.2 For instance, it has been found that the more time a person spends on the job, the more conflict there is between work and family.3 It is also argued that work and family issues are at least as important to organizational functioning as family functioning.4

A clear connection between work and family stressors and employee strain has now been established.5 After more than three decades of investigation, researchers have concluded that job satisfaction influences or 'spills over' into life satisfaction, which encompasses satisfaction with family, health and work.6 Despite the rather large literature concerning work- and family-related concepts, the vast majority of studies have been conducted in the United States and other Western countries.7

According to role strain theory, the demands experienced in one role (for example, work) take time and energy away from demands experienced in another role (for example, family).8 It has been observed that changing social demographics, altering family-role expectations, shifting family structure, aging workforce, as well as recent technological developments, increasing globalization, and international business competitiveness have contributed to a blurring of boundaries between the domains of employment and family and to greater permeability between these domains. It is imperative that both roles in work and family domain have to offer varied resources to facilitate the role in another domain.

Mission hospitals in Nigeria have been associated with staff shortages, high intensity of work and relatively low remuneration. We did not come across any study that assessed the family functioning of health workers in an urban mission hospital. This study set out to measure the family function of health personnel working in an urban mission hospital.

SUBJECTS, MATERIALS AND METHODS

Setting: The hospital is a 200 bed faith-based tertiary hospital located along Zaria Bypass in Jos, Plateau state in North-Central Nigeria. It has a staff strength of about 350 employees consisting of several Nigerian and expatriate consultants, resident doctors in family medicine, nurses, pharmacists and other support staff.

The hospital is a training centre for Residents in Family Medicine and a teaching hospital for a Faith based university medical school. It serves as a referral centre for various private and government medical facilities in Northern Nigeria.

Ethical Consideration: Approval to conduct the study was granted by the Hospital Research and Ethics committee.

Study design: A cross sectional descriptive study of all consenting staff of the hospital.

This was a census of all consenting staff.

Study protocol: The target population were given a participant's information sheet and a consent form. All consenting staff were given a medium length two part questionnaire by the investigators. The first part consisted of socio-demographic data while the second part assessed their family functioning using the APGAR scoring system.

TOOLS FOR DATA COLLECTION

Smilkstein's family APGAR scale was developed in 1978.9 It consisted of questions that allowed for the quantifying of the perception that the individual had of their family functionality.10 The items were developed on the premise that a family member's perception of family functioning could be assessed by reported satisfaction with the five dimensions of family functioning. These questions allow for the assessment of the individual's satisfaction with their family functioning, based on elements considered essential in the family unit, according to the acronym APGAR:

"A - Adaptability intra-family – refers to the sharing of resources, as well as the degree of satisfaction with the attention received;

P - Participation – includes joint decision making and family communication when problem solving;

G - Growth – essentially refers to the realization of emotional growth due to the freedom within the family to change roles;

A - Affection – includes the individual's satisfaction regarding intimacy between family members and the family interactions;

R - Resolution – refers to the sharing of time and satisfaction with the commitments that family members establish".

The APGAR questionnaire can be completed in less than five minutes and consists of five questions regarding the components of family function, with three possible answers ("almost always", "sometimes", "almost never") the score varies between zero and two points. The scale is scored by summing the values for the five items for a total score that can range from 0 to 10. Families can be characterised as: a functional family (7-10) or dysfunctional family (< 7). A dysfunctional family can still be classified as mild (> 2 and < 7) and severely dysfunctional (≤ 2).11

Score Interpretation: A higher score indicates a greater degree of satisfaction with family functioning.

Psychometric Support

Reliability: Cronbach's alpha values reported across studies using Family APGAR have ranged from 0.80 to 0.85, and item-to-total correlations ranged from 0.50 to 0.65.

Validity: Smilkstein's initial assessment of validity was to establish correlations with a previously validated instrument, the Pless-Satterwhite Index, as well as with clinician reports.

The former yielded a correlation of 0.80, the latter 0.64. The Family APGAR questionnaire has been used in numerous studies (mostly clinical) investigating family functioning.12

DATA ANALYSIS: Data collected was analysed using SPSS (Statistical Package for Social Sciences) software 21.0. Multinomial regression was used to test for multivariate association.

DATA MANAGEMENT: Data was entered into a password-protected, designated computer. Access was allowed for Investigators only.

RESULTS

Out of the 350 hospital staff at the time of the study, 20 did not give consent and were excluded. A total of 220 consenting staff fully completed the study representing 68.8% response rate. Most of the respondents were female (66.4%), from age group 25-44 years (61.8%), married (70.5%) and had tertiary education (61.8%). Most (60%) were employed for <10 years and were mostly Health Service Providers (55.9%). Other details are in Table 1.

Table 1

Socio-demographic characteristics of study participants

Variable	Number	Percentage
Sex		
Male	74	33.6
Female	146	66.4
Age group (years)		
<24	3	1.4
25-44	136	61.8
45-64	79	35.9
>64	2	0.9
Age, Mean±SD (years)	41.6±9.88	
Marital status		
Married	155	70.5
Single	65	29.5
Educational status		
None	3	1.4
Primary	36	16.4
Secondary	45	20.5
Tertiary	136	61.8
Duration of employment (years)		
<10	132	60
10-19	37	16.8
20-29	38	17.3
30-39	13	5.9
Duration of Employment, Mean±SD years	11.3±9.79	
Duration of Employment, Median (Range) years	7.23 (0-37)	
Occupation		
Health Service Providers (HSP)		
Physicians	9	4.1
Nurse/Midwives	62	28.2
Others	52	23.6
Health Management & Support Staff (HMS)		
Professionals	35	15.9
Others	62	28.2

Based on the Family APGAR score, a majority (84.1%) of the study participants perceived that their families were highly functional. Overall, 15.9% of the staff were from dysfunctional families. Other details are provided in Table 2.

Table 2

Family function of study participants based on Family APGAR score

Family Function	Number	Percentage
Highly functional (>7)	185	84.1
Moderately dysfunctional (4-7)	32	14.5
Severely dysfunctional (0-3)	3	1.4
Total	220	100

Logistic regression to determine factors predicting family function in the study did not reveal any significant relationship for occupation, gender, marital status, duration of employment, age and educational level. Other details are provided in Table 3.

There was no significant relationship between family function category and occupation, gender, marital status, duration of employment, age, and educational status. Further analysis using multinomial logistic regression did not indicate any of the variables as significant predictors of family function in the study population. Details are provided in Table 3.

Table 3

Multinomial Logistic Regression Table Of Factors Associated With Family Function In Study Population

Variables	Wald statistic	P Value	Adjusted Odds ratio (95%CI)
Occupation (HSP)	0.18	0.69*	0.87 (0.43-1.71)
Gender (female)	1.15	0.28*	0.63 (0.29-1.38)
Marital status (married)	2.59	0.11*	0.59 (0.31-1.12)
Duration of employment (<10years)	0.30	0.59*	0.81 (0.37-1.74)
Age (<44 years)	0.04	0.83*	0.92 (0.43-1.97)
Education (tertiary)	0.42	0.52*	0.80 (0.41-1.58)

*= Multinomial Logistic Regression

DISCUSSION

Research indicates that 85% of employees report having some day-to-day family responsibilities.13 These changing demographic trends, and heightened interest of employers in employee's quality of life has prompted a proliferation of research on the relationship between work and family roles.14 This study assessed the family functioning of staff of an urban mission hospital. This is expected to serve as a basis for further research into other aspects of work-family conflicts.

The mean age of the study participants was 41.6±9.88. Majority of the study participants were female (66.4%), while most (61.8%) of the study participants had tertiary level education. The median duration of employment of the staff was 7.23 years and range of 0-37years. (Table 1). The staff were categorized as either Health Service Providers or Health Management and Support Staff based on standard criteria. The health service providers made up 55.9% of the two major occupational groups of the hospital with nursing staff contributing 50.4% to this group. The health management and support staff made up 44.1% of the occupational groups studied. (Table 1). These findings are not unexpected for a young active population working in healthcare. Similar findings were documented from a larger health facility in the same city.15

The prevalence of family dysfunction in the study population

was 15.9%, comprising 14.5% as moderately dysfunctional and 1.4% as severely dysfunctional. This is similar to the prevalence of 17.9% reported by Afolabi et al in a study of People living with HIV in Osogbo south west Nigeria.16 In view of the documented negative effects of shift work among hospital workers on mental health,17 the prevalence of family dysfunction might have been expected to be much higher. The precise reasons would need more robust study designs to elucidate such factors that might have been responsible for the low rate of family dysfunction. On the other hand, some authors have questioned whether the family APGAR score effectively measures family dysfunction adequately.18

This study did not show any statistically significant relationship between family functioning and the socio-demographic characteristics studied either on bivariate or multivariate analysis. It has been shown that juggling work and family life has become a challenge for many employees and families,19 and that unbalanced work-family relationships can result in reduced health and performance outcomes for individuals, families and organizations.20,21 However, an individual in a positive mood when leaving work likely responds more positively, patiently, and happily to his or her family members who can ultimately enhance his or her affect and performance as a parent or spouse. Involvement with family can provide a sense of focus or urgency which helps the individual become a better worker. At the same time, good work-family balance is positively related to individual's mental health, family functioning and job outcomes such as job satisfaction and organizational commitment.22-25 In essence, the failure to demonstrate valid predictors of family dysfunction among health workers could have been due to the difficulty in separating the positive and negative effects of work on family, and family on work

Further research on the effect of family functioning of health care workers as it affects job satisfaction will aid in the modification of the work environment towards greater work-family balance as well as improved productivity at home and in the work place.

CONCLUSION

The study indicated a relatively low prevalence (15.9%) of family dysfunction in hospital workers. Family physicians working with healthcare workers should remain conscious of this fact and its potential effect on the work environment.

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