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Familial Caregiving of Hospitalised Patients: A Sustainable Cultural Etiquette

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ABSTRACT
It is evident that involving family members in caring for their hospitalised relatives is a phenomena that is gaining more ground in healthcare delivery, especially in the fields of modern nursing, medicine and psychology. This can be seen in the rising advocacy for patient and family centred-care. The development has been attributed to restorative benefits of psychological and emotional supports provided to patients by their family and the need to support the inefficient caring activities due to shortage of healthcare personnel. However, little is known of the cultural predisposition of the familial caregiving practices especially in Africa where culture dictates healthcare practices. Using interview and questionnaire survey, this study investigates the underlying relationship between the familial caregiving and cultural healthcare provisions of family system in Nigerian hospital wards. The findings reveals family solidarity, spiritualism and domestic chores among the cultural attributes that characterised the familial caregiving. This indicates that some form of caregiving of hospitalised patients provided by their family members in Nigeria and entails cultural etiquette that not be undermined. Thus, effective caregiving in Nigerian hospital wards can only be achieved by taking into cognisance the cultural traditions of the society as it relates to healthcare practices.

Keywords: Family caregiving, Culture, Health, Sustainability

1. Introduction

It is obvious that recognising the famous role family play as a phenomena in caring for their hospitalised relatives is gaining more ground in healthcare delivery, especially in the fields of modern nursing, medicine and psychology. This can be seen in the rising advocacy for patient and family centred-Care (Care, 2012; Carr and Springer, 2010; DiGioia III, Greenhouse, Chermak, and Hayden, 2015). In addition to the psychological and emotional supports provided to patients, families in advanced countries are involved as partners especially during decision making and collaboration (Rolland, 2015). However, in developing countries like Nigeria, they become a useful human resource in healthcare setting because of the chronic shortage of healthcare personnel (Nord, 2003; Zarins, 2010).

Similarly, as opposed to the practices in developed countries where patients' family involvement is limited to specialise cases such as paediatric, psychiatry, dementia, and ICU, the family's involvement in many developing countries cut across all types of ailments (Alkali, Ahmad, & Said, 2014). This emergent need for family presence and participation as advocated and promoted by the Patient and Family-Centred-Care (PFCC) model have been empirically ascribed to the need for promoting restoration through salutogenic approach and the need to compliment the insufficient manpower.

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However, little is known of the cultural inclination of the familial caregiving practices especially in Africa where culture dictates healthcare practices (Brown, 2012). Considering the fact that the future trends in the advocacy for family inclusion in care may involve cultural and gender-based refinements in care management (Rolland, 2015), this study investigates the underlying familial caregiving relationship with cultural provisions of Nigerian family system in hospital wards.

The investigation of this underlying relationship is against the backdrop suggesting theoretically and practically that a thorough study of human beings cannot be complete without invoking cultural dimensions of human life (Galanti, 2014). Similarly, the current research climate according to Delva (2014) is susceptible to using quantitative modeling in meeting certain scientific paradigm anticipations, where culture is often treated as independent characters that are isolated from daily living and from broader social, economic, and political contexts (Kao, Hsu, and Clark, 2004). Thus, the consequence of this isolation was found to adversely affect the findings and interpretation of the research (Kao et al., 2004).

2. Culture and Health Relationship

Understanding the dyadic relationship between culture and healthcare is an important aspect of modern nursing especially as it has direct effect on healthcare facilities design. Thus, healthcare is considered as cultural concept by many scholars due to its ability to shape the life and experience of individuals and the environment in which they live. Studies have demonstrated that healthcare practices and regard for healthcare is not the same across cultures because patients differs in many perspectives (Delva, 2014). Even though, culture was found to be the most unending factor, these differences according to Day and Cohen (2000) are found in patient's illness, personality and socioeconomic status. For instance, race, religion, language, ethnicity and economic status are cultural attributes that has significant influence on an individual's health, illness and wellbeing (Bennet, Wolin, and McAvity, 1988).

Illness for example, have been seen by (Allen, 2000) as a depiction of personal, relational, and cultural reactions to disease. Similarly, illness is seen to be culturally shaped because the perception, experience, and coping with disease is based on the explanations of sickness that are specific to the socio-cultural disposition (Hulme, 2010).

Along with other health and disease determinants, culture defines the perception of patients and healthcare providers on health and illness (Al-Shahri, 2002). Therefore, illness is shaped by the cultural attributes that dictates the perception, labeling, explanation, and valuation of the discomforting experience. Similarly, culture according to Maya, White, & Fetters (2005) defines the type of health practices to be performed, recommended or insured and as well, the expression of sickness and pains.

Empirically, literatures have attributed cultural influence on healthcare from the way diagnosis, treatment and preventive or health promotion is accepted (Yosef, 2008). This manifest in the way cultural beliefs affects how health problems are communicated, manners by which symptoms are presented, when and to where to go for care, and how care is evaluated (Ariff and Beng, 2006). Because of this intimate association of illness

experience, the processes entrenched in a complicated cultural bond suggests its perception, thus, healthcare practices are found to have strong cultural influence.

Illness behavior being a normative experience that is governed by cultural norms, is found not to be the same across cultures (Faller, Marcon, Faller and Marcon, 2013). Variation were pertinent across ethnic, class, and family boundaries (Bennet et al., 1988). Therefore caregiving realities especially in Nigeria and many African communities are culturally constituted and differ cross-culturally and across the healthcare domains even within the same society. This however, cannot be disconnected from the socio-economic factors influencing the medical realities. For instance, studies of the social context of healthcare in a society categorized healthcare into three structural domains (Thomas, Fine, & Ibrahim, 2004): (1) the professional; popular involving family, (2) social network and community; and (3) folk (non-professional healers). It was found that majority (70% to 90%) of healthcare is carried out in the popular domain, little of it proceeds to the professional or folk domains (Thomas et al., 2004). This suggests that family represents a significant social context within which sickness occur and resolved. Thus, the interrelationship between healthcare and family is a dynamic one with each having a dramatic effect on one another.

3. Family and health Relationship

A strong correlation has been found to exist between family relationships and person's well-being and health. The nature of such family interactions having great influence on individual's general well-being (Northouse *et al.*, 2012). Sufficient levels of social support found in families cording to Adams *et al.* (1996) and North *et al.* (2008) are significant aspect of individual happiness. Since the repercussion of member's illness on the family is easily noticeable, family have been identified to be responsible for its individual member's wellbeing in all ramifications and vice-versa (Alesina and Giuliano, 2010), as the physical and psychological effect will be so glaring. Consequently family's routine activities will be distorted, especially when the family members will be expected to take up their personal responsibilities (Botha and Booysen, 2013).

Family participation in care was natural since the origin of the formal nursing was found to be from patients' homes (Wright and Leahey, 2009). World War II mark the beginning of the transition of nursing practice from homes to hospitals. Families were then not only excluded from participation in caring for their sick ones, but also from other orthodox family events such as birth and death. However, with the advent of modern nursing that is patient and family centred, patient's family's significance in care was identified. Thus, the nursing practice has now recognized with emphasis on the necessity and an obligation to invite families once again to participate in caring for its member. However, this invitation is now knowledge based, research evidenced, with total respect, and is more of collaboration (Corlett and Twycross, 2006; Kuo et al., 2012; Wright and Leahey, 2009).

The patient family being essential individuals who knows the patient best, are the most suitable in supporting the patient throughout the hospitalization period. Because of their engagement in caregiving role at home, family members are seen by Kuo *et al* (2012) to be in a better position to notice an elusive changes in the patient condition.

Similarly, they are a reliable source of vital information regarding medications, medical history, routines, and patient preferences (Siminoff, 2013). In addition, family members may contribute to and augment the formal caregiving in the hospital, alongside the provision for psychological and emotional support the patient requires (Alkali et al., 2014).

Therefore, family caregivers are described as relatives, friends, or neighbors providing assistance related to an underlying physical or mental disability but who are unpaid for those services (Allens, 2000; Reinhard, 2008; Hoffman et al, 2012). In this study, the familial caregiving is the assistance rendered by patient's family to their hospitalised member.

4. Research Milieu

The practices in majority of Nigerian public hospitals is that hospitalised patients are accompanied by one or more family members who stay with the patient throughout the hospitalisation period. To explore the cultural inclination of such practices, this study was carried out among staff, patients and their family at Federal University Teaching Hospital Gombe, one of the tertiary public hospitals owned and operated by the Federal Government in Nigeria. It is 450 bed capacity hospital located at the center of the North-Eastern region of the country. An ethical permission was obtain from the research and ethics committee of the hospital, afterwards, an informed consent was obtained from the participating patients. The peculiarity of this hospital is its mandate to attend to referral cases from hospitals accross other five states in the geopolitical region. This makes the study more interesting for the facts that the patients and the staff are drawn from different cultural background.

5. Research Approach and Methods

In investigating the underlying cultural relationship with healthcare in Nigerian hospitals, this phenomenological sequential triangulation research employed the use of interview and survey questionnaire. At first instance, an unstructured interview was conducted with 14 patients of Federal Teaching Hospital Gombe. The patients were drawn from male and female surgical wards of the hospital whose average length of stay is 5-7 days. The transcribed interview data was analysed using classical content analysis. Subsequently, the categories and domains generated were used as sections and items of a questionnaire administered to healthcare personnel comprising of 63 nurses , 38 resident doctors, 33 health assistants of the hospital that are attached to ward and 48 patient's families. Out of the 182 questionnaires administered, 151 representing 82.9% were retrieved. After achieving the internal consistency of the instrument using Cronbach's alpha, further analysis stem from the scaling detailing of the dimension of the factors using Structural Equation Modelling (SEM-AMOS) for structural analysis and further Confirmatory Path Analysis (CFA).

6. Results and Discussion

Findings from the interview as shown in Table 1 revealed that the essence of family presence and participation in care is mostly associated with providing the patients with family solidarity, spiritual support, physical support, carrying out most of the domestic chores the patient requires and ultimately, support the hospital ward procedures that enhanced clinical activities.

Table 1: Patient's perception of familial caregiving for hospitalised patients in Nigerian hospitals

S/N	Codes	*N=14*			Category	Domain
		M	F	%		
1	Keeping me in company	8	6	100	Family solidarity	Cultural traits
2	Feeding	7	5	85.7	Domestic Chores	Culture traits
3	Preparing food	2	3	35.7	Domestic Chores	Culture traits
4	Food supply	5	6	78.5	Domestic Chores	Culture traits
5	Laundry	4	2	42.8	Domestic Chores	Culture traits
6	Assisting me in prayers on time	2	2	28.55	Spiritualism	Culture traits
7	Interpretation	4	3	50	Language	Culture traits
8	Escorting to toilet	6	6	85.7	Physical Support	Poor hospital ward operations
9	Procurement of medical essentials	8	6	100	Operational protocols	Poor hospital ward operations
10	Errand	4	5	64.2	Operational Protocols	Poor hospital ward operations
11	Assisting healthcare personnel	4	2	42.8	Clinical participation	Poor hospital ward operations
12	Emptying urine bag	5	3	57.1	Clinical participation	Poor hospital ward operations
13	Prompting the healthcare personnel	4	5	64.28	Clinical participation	Poor hospital ward operations
14	Turning Bed ridden	2	1	21.4	Clinical participation	Poor hospital ward operations
15	vigilance	4	2	42.8	Clinical participation	Poor hospital ward operations

From the domains generated, the findings indicates that family presence and participation in care can be related to cultural etiquettes and the need to support poor hospital ward operations. For instance, the caregiving functions that are more of family solidarity, spiritualism, language and some of the domestic chores identified to be provided to patients by their families are cultural traits associated with their healthcare delivery pattern. Likewise, some of the caregiving activities involving physical support, operational protocols and clinical participation are carried out to support caring activities that are supposedly responsibilities of healthcare personnel in an efficient healthcare setting.

To concretise the underlying cultural relationship, this study further suggests the need for identifying the most significant factor responsible for the familial caregiving in Nigerian hospitals. Thus, data obtained from the questionnaire was analysed using Analysis of Moment of Structures (AMOS). Initially, Cronbach's alpha statistics was used in determining the internal consistency of the factors. To this end, familial caregiving and poor hospital ward operations was found to have 0.762 and 0.904 respectively (Table 2). This is found to be within the acceptable threshold (Hair Jr, Anderson, Tatham, & William, 1995). However, the value of 0.449 obtained for culture was below the 0.7 threshold, thus it was improved to 0.797 by deleting one item (Hair et al, 1995) as shown in Table 3.

Table 2: Internal consistency

Variable	**Cronbach's Alpha**	**Items**
Familial Caregiving	0.762	2
Poor hospital ward operations	0.904	4
Cultural Traits	0.797	3

Table 3: Scaling internal consistency of culture

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
RLG	11.96	1.634	.527	.095
LNG	11.90	2.231	.308	.353
FMS	11.96	1.853	.520	.162
DMC	12.63	2.214	-.060	.797

Subsequently, the model was tested to determine the fitness. A computed values for the model fit indices found suggests a perceptual model of familial caregiving practices with 1.8023 for CMIN(X^2/df), GFI (0.937), TLI (0.959), CFI (0.971), IFI (0.972) and RMSEA (0.076) at P = 0.008. This suggests that the hypothetical model of familial caregiving after satisfying the Goodness of Fit (GOF) requirements and attaining the minimum threshold of fit indices (Hair et al, 1995; Hoelter, 1983; Shuaibu, 2014) is accepted. This structural model shown in Figure 1 was achieved after the factors relied on concrete theoretical framework and confirmed with commonly acceptable model fit indices. This satisfies the statistical analysis thereby establishing the influence of the factors.

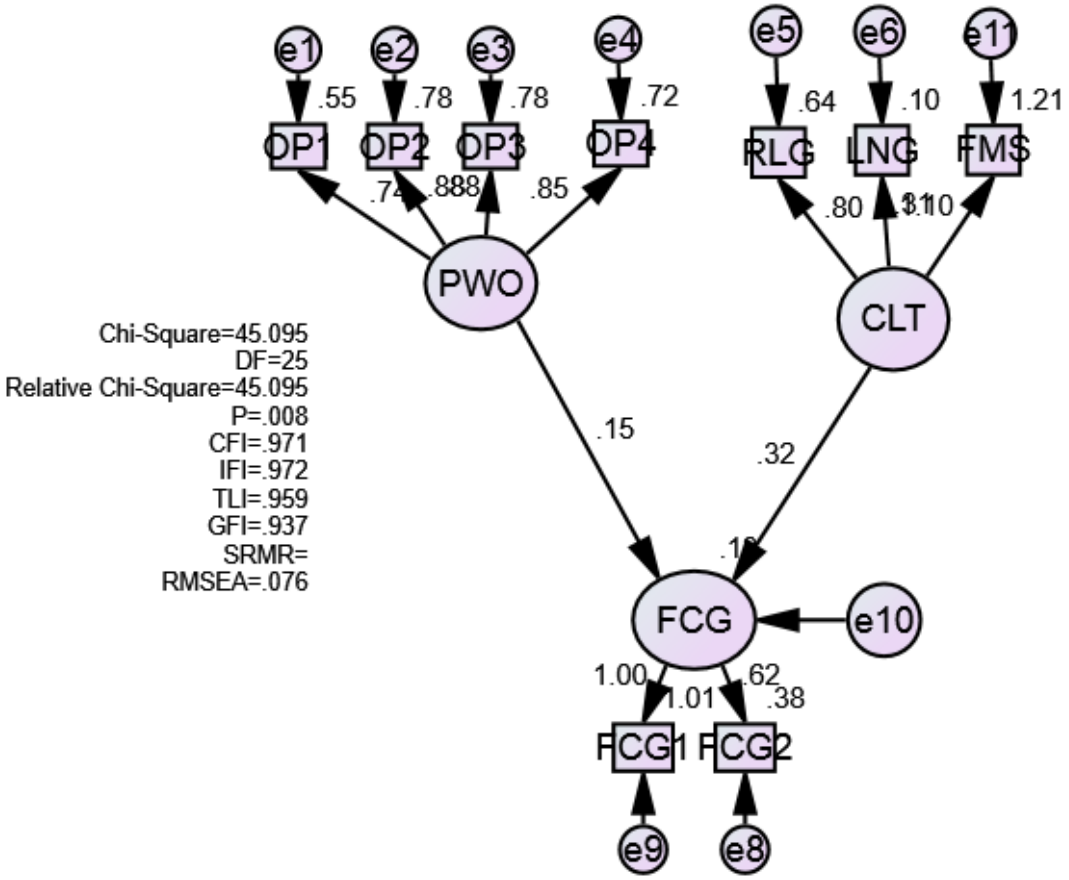

Figure 1: Perceptual model of familial caregiving for hospitalised patients in Nigerian Hospitals

The validity of the composite is further established by ensuring that the association of the latent and observed variable is significantly different from zero (Hair Jr et al., 1995). In compliance therefore, the regression weight's coefficients of the variables are significantly different from zero at 0.01 (two tailed). Also t-values between >1.96, or >-1.96 indicates significant relationship between variables, whereas the ratio between -1.96 and 1.96 signify insignificant relationship of variables that should be re-examined (Shuaibu, 2014). Remarkably, the T-values recorded are above 1.96 indicating that the construct validity has been guaranteed (Rašula *et al.*, 2012), except for poor hospital ward operations with 0.15. in addition the relationship between indicators assessed via standardised regression weight is regarded good with loadings of 0.5 or more, while values between 0.4 and 0.5 are acceptable , those less than three are regarded not good predictors therefore undesirable (Pedhazur and Schmelkin, 1991).

Table 4: Standardized Regression Weights

			Estimate
FCG	<---	PWO	.150
FCG	<---	CLT	.324
comprotocols	<---	PWO	.739
Efficiency	<---	PWO	.884
Procurement	<---	PWO	.882
Staffing	<---	PWO	.848
Religion	<---	CLT	.802
Language	<---	CLT	.309
Errand	<---	FCG	.617
Emotional	<---	FCG	1.003
FSolidarity	<---	CLT	1.100

Therefore, results from this analysis as represented in Figure 1 and Table 4 shows that cultural traits has more significant effect on familial caregiving than the poor ward operations. The findings of the analysis shows culture with regression weight of 0.32 while the poor ward operations has 0.15. This implies that poor ward operations was perceived by the respondent as not a vital factor that necessitated the need for familial caregiving. However, familial caregiving was found to be largely attributed to cultural norms and etiquettes comprising of family solidarity, religion and language among others which is the dictates of the Nigerian family lifestyle (Ipaye, 1982). Therefore, because of the cultural bond attached to familial caregiving, it thus constitutes a crucial aspect of hospitalisation as such will continue to be part of the hospital regiments.

Conclusion

The notable and substantial association found in this study between the familial caregiving in hospital wards and the traditional healthcare practices in Nigerian hospital wards reaffirms the significance of family centred care based on its restorative benefit and the need to compliment the insufficient manpower. It further indicates that culture

dictates who should be involved in the caring process and the extent of such involvement in Nigerian hospital ward regimen. The study has empirically demonstrated that some form of caregiving of hospitalised patients provided by their family members in Nigeria entails cultural etiquettes that not be undermined. Understanding of this concept will stress the fame of the family involvement and participation of care that will ultimately promote the much agitated family and patient-centred-care concept across cultures.

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