

**WORK DEMANDS, WORK-FAMILY CONFLICT, AND COMMITMENT
AMONGST NURSES IN ESWATINI**

by

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ABSTRACT

Work-family conflict is an inter-role conflict where the demands of work spill over to the family domain and cause interference between the work and family domains. Work-family conflict can present adverse outcomes to the organisation, such as impacting the commitment to stay with an organisation. This study aimed to investigate the relationship between work-family conflict and job demands. The study also investigated the relationship between work-family conflict and the two organisational commitment dimensions: continuance commitment and affective commitment. In addition, the role of gender was examined to ascertain the differences in work-family conflict for females and males.

A quantitative approach was used to collect data and test the statistical relationship among the study variables. An online survey questionnaire was sent to 564 Nurses in all the public and mission hospitals in Eswatini, with 455 Nurses participating in the study. Pearson's correlation analysis was performed to investigate the relationship between variables of work-family conflict, job demands, continuance commitment, affective commitment, and professional commitment. The study findings showed a positive relationship between work-family conflict and job demands, a negative relationship between work-family conflict and affective commitment, and a positive relationship between work-family conflict and continuance commitment. An independent t-test analysis examined the relationship between work-family conflict and gender. The results showed no significant differences in work-family conflict for females and males.

The study emphasizes the importance of employers and human resource professionals to consider putting in place family-friendly policies that will assist in reducing this inter-role conflict, as it has been shown to bear negative consequences to both employees and organisations.

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WORK DEMANDS, WORK-FAMILY CONFLICT, AND COMMITMENT AMONGST NURSES IN ESWATINI

INTRODUCTION

Background

The shortage of healthcare workers is a global crisis affecting the quality of health services (WHO, 2014). A labour market projection of future global health workforce demand predicts a global shortage of 15 million healthcare workers globally by 2030 (Liu et al., 2017). The number of nurses retiring or leaving the profession is anticipated to remain higher than those entering it (Liu et al., 2017). It is further predicted that middle-income countries will continue battling health workforce shortages because the demand for healthcare workers will exceed the existing supply (Liu et al., 2017). The shortage of nurses adds to the pressures already experienced by nurses in their jobs.

The nursing profession is demanding and characterised by work pressure, time demands, and emotional strain. The combination of nurse staffing shortages and the increasing disease burden caused by the TB/HIV/AIDS epidemic in high-burden countries and the COVID-19 pandemic has resulted in a higher workload for nurses. Nurses must often work irregular, mainly shift hours, including evenings and weekends (McKinney, 2011). Additionally, nurses have emotionally demanding work from dealing with complex patients, coping with death, and poor work environments with limited resources to perform their duties (McKinney, 2011). These challenging work demands are likely to spill over to the personal domain, affecting the ability to cope with the demands of home responsibilities and potentially resulting in the nurses experiencing work-family conflict.

Work-family conflict is a significant area to investigate as it has adverse individual and organisational outcomes. At an individual level, the work-family conflict has been found to have both physical and mental adverse health outcomes (Minnotte & Yucel, 2018). Other studies show a positive association between work-family conflict, psychological distress, and life satisfaction (Oshio et al., 2017). Whereas poor health and psychological distress impact the individual, they inversely impact the organisation due to the direct healthcare costs associated with illness and the indirect costs of absenteeism (Ammerman et al., 2016). Furthermore, direct

relationships have been found between work-family conflict and the intention to resign (Asghar et al., 2018). These adverse outcomes on the employee and the organisation warrant work-family conflict as an essential area of study and consideration for health organisations aiming to create a conducive working environment for nurses whilst also retaining the limited number of nurses in the current workforce.

Research Aim

To investigate the relationship between work-family conflict and organisational commitment amongst nurses employed in public hospitals in Eswatini.

Research Question

1. What is the relationship between job demands, work-family conflict, and organisational commitment amongst nurses in the public sector hospitals in Eswatini?

Research Objectives

- a. To determine the relationship between job demands (work overload) and work-family conflict.
- b. To determine the relationship between work-family conflict and organisational commitment.

LITERATURE REVIEW

Work-family conflict, sometimes defined as work-family interference, is a form of inter-role conflict in which work and family demands interact to the extent that meeting demands in one domain makes it difficult to meet demands in the other (Greenhaus & Beutell, 1985). Work pressures, often in the form of time, energy, or behaviour, may spill over to the family, making it difficult to fulfil family demands. Work-family conflict is based on an understanding of inter-role conflicts, where pressures between two incompatible roles arise from participating in one role, thus causing pressure on the other role, often the family roles (Greenhaus & Beutell, 1985).

Work-family conflict assumes that work pressures are incompatible with family demands. However, some scholars argue for looking beyond family demands to life demands, such as participating in other personal interests beyond the family (Kossek & Lee, 2017). Although some scholars use this term interchangeably, there is a slight difference between work-family and work-life conflict. Work-family conflict expands personal demands from just family to factors beyond the family (Kossek & Lee, 2017).

The definition of work-family conflict suggests a bi-directional relationship where work strain can affect family demands and vice versa (Greenhaus & Beutell, 1985). Although some studies have shown the bi-directional nature of work-family interference, Greenhaus & Beutell (1985) and other scholars suggested that this inter-role conflict is more salient for work-to-family conflict than the family-to-work conflict (Grzywacz et al., 2006 & Simon, 2004). In a study across eight European countries, work-to-family conflict had a stronger association with salient outcomes than family-to-work conflict, and the results were consistent across all eight countries (Simon, 2004).

Theoretical model

The job demands and resources model (JD-R) helps us understand the association between job demands and work-family conflict. According to the job demands and resources model, high job demands can negatively impact an employee's level of well-being and motivation (Bakker & Demerouti, 2014). The model specifies job characteristics as job demands and resources (Bakker & Demerouti, 2017). Job demands are the aspects of a job that require continual physical and psychological effort, consequently associated with specific physiological and psychological effects (Bakker & Demerouti, 2017). Examples of job demands include physical work overload, the pressure to perform tasks quickly, the physical environment, and shift work. Subsequently, job resources are defined as the aspects of the job that facilitate achieving work goals and stimulating self-growth and development (Bakker & Demerouti, 2017). Examples of job resources include social support, performance feedback, skill variety, autonomy, and learning opportunities within the work environment (Demerouti et al., 2001)

The effect of job demands on an employee may spill over to their personal life, thus causing interference with their ability to perform personal obligations. Studies have shown that the strain of work responsibilities interferes with the employee's personal life, confirming a positive association between high job demands and work-family conflict (Ng et al., 2017). Job demands such as long and non-standard hours outside the standard 8:00 a.m. to 5:00 p.m. working hours make it difficult for employees to attend to personal roles, thus increasing the conflict between work and personal roles (Tammelin et al., 2017). Adkins and Premeaux (2012) studied the number of hours worked, and they found a relation between the amount of time spent at work, particularly after exceeding an average of 40 hours a week, and interference with other non-work roles. Recent studies also confirm the relationship between long work hours and work-family conflict (Fein & Skinner, 2015).

However, studies demonstrating the relationship between job demands and work-family conflict have been conducted mainly in Western (Henz & Mills, 2015) and Asian settings (Ng et al., 2017). Work-family conflict has yet to be investigated in Eswatini, where a high work overload, irregular work schedules, and long work hours are likely to keep nurses away from their families and private lives, thereby increasing the likelihood of a conflict between work and personal responsibilities.

The job demands-resources model presumes that job resources buffer the impact of job demands and that the imbalance of the two increases employee well-being and motivation (Demerouti et al., 2001). Some resources weaken or strengthen employee well-being, such as receiving feedback about work performance, rewards for good performance, control of their role, job security, and supervisor support (Demerouti et al., 2001). The work of Demerouti and his colleagues (2001) demonstrates that social support buffers the effects of job demands on work-family conflict. Goh et al. (2015) confirm this in their work, showing that supervisor support buffers work-family conflict.

Organisational Commitment

Our understanding of organisational commitment has evolved. Some early approaches to defining organisational commitment are based on the work of Becker's (1960) side-bet theory.

He argued that the employee's side bet largely influences an employee's decision to attach or disassociate from an organisation. These side-bets are the perceived gains an employee may lose out on if they dissociate themselves from the organisation. These may include but are not limited to societal expectation to remain with the organisation or even loss of monetary gains earned from continued service over time (Becker, 1960). This conceptualisation of organisational commitment has been termed the behavioural approach to organisational commitment.

Other scholars presented an attitudinal approach to understanding organisational commitment. Porter et al. (1974) defined organisational commitment as an individual's attachment to their organisation. Specifically, they define organisational commitment to include three aspects; "(1) a strong belief in and acceptance of the organisation's goals and values; (2) a willingness to exert considerable effort on behalf of the organisation; and (3) a strong desire to maintain membership in the organization" (Porter et al., 1974, p. 226).

Meyer and Allen's (1991) three-component theory of organisational commitment incorporates both the side-bet theory and the attitudinal approach while adding a third approach drawn from the sociological literature, normative commitment. Meyer and his colleague conceptualised organisational commitment as a psychological state that describes an individual's attachment to an organisation and affects the decision to stay with the organisation (Meyer & Allen, 1991). They argued that these psychological states differ in three ways: affective, normative, and continuance. Affective commitment refers to an attachment to the organisation because the value of the individual aligns with that of the organisation. In contrast, normative commitment refers to an attachment to the organisation based on an obligation. Finally, continuance commitment refers to an attachment based on the costs associated with leaving the organisation; an employee stays because the costs outweigh the benefits. While other conceptualisations of organisational commitment have followed, most researchers rely on the three-component model of organisational commitment (Cohen, 2007).

There have been mixed results in studies examining the relationship between work-family conflict and organisational commitment. Some show positive associations (Castle, 2006) and

some negative associations (Cory et al., 2018). Others have found that higher work-family conflict levels led to lower organisational commitment (Thompson et al., 1999). Additionally, Hatam et al. (2016) found that work-family conflict predicts adverse outcomes for organisations, such as decreased organisational commitment. All agree that studying the relationship is essential and adds value to decision-making in human resource management by broadening understanding of employee behaviour and retention.

Most studies on the relationship between organisational commitment and work-family conflict have been conducted in Western or Asian contexts (Azeem & Akthar, 2014; Thompson et al., 1999). This study adds to our understanding of organisational commitment and work-family conflict by investigating this relationship in an African context. Investigating family life conflict in an African context will provide a baseline for future research.

Work-Family Conflict & Gender

In the past few decades, social differences have been observed where there has been a rise in women entering the job market. This shift has also contributed to families' struggle to juggle housework duties and work (Anafarta & Kuruuzum, 2012; Jacobs & Gerso, 2006, as cited in Minnotte, 2011). As a result, researchers developed an interest in work-family conflict concerning gender and investigated the relationship between demographic factors, such as gender, and work-family conflict (Minnotte, 2011). There seems to be consensus in the literature that there is a higher work-family conflict where the nature of the demographic factors increases the responsibility and strain on the working adult in the home front, such as in the event where there is a lack of adult support in the home or where the working adult is solely responsible for household duties (Winslow, 2005; Minnotte, 2011). Specifically, researchers have investigated the impact that gender and other demographic factors have on work-family relationships (Winslow, 2005).

Social gender norms based on the concept that a woman's responsibility is to care for her home largely influence women's uptake of household responsibilities in the home (Yang et al., 2015, as cited in Wang et al., 2020). Women who believe their role is to care for the family take on more household duties and are likely to experience a higher work-family interference. Higher

work-life conflict amongst females is supported by the work of Koura et al. (2017), who found that women experienced higher levels of work-family conflict when compared to men. While other studies supported these findings (Noguchi, 2012), more recent studies have shown no significant difference in work-family interference between women and men (Schieman & Young, 2017). Even in studies conducted in countries with traditional values, the results showed no significant difference in work-family interference across both males and females (Anafarta & Kuruuzum, 2012). Scientific evidence has shown contradictory findings on the relationship between work-family conflict and gender. This research will examine the relationship between WFC and gender amongst nurses in the Eswatini context. We argue that in the Eswatini context, due to the predominant traditional beliefs on gender roles, female Nurses are likely to present with higher levels of work-family conflict as compared to male Nurses.

Research Hypothesis

H1: Job Demands have a significant positive relationship with work-family conflict.

H2: Work-family conflict has a significant negative relationship with continuance organisational commitment.

H3: Work-family conflict has a significant negative relationship with affective organisational commitment.

H4: Work-family conflict has a significant negative relationship with nurse professional commitment.

H5: Female nurses experience higher work-family conflict than male nurses.

METHOD

This study investigates the relationship between work demands, work-family conflict, and organisational commitment among nurses in Eswatini. This section will describe the research context, the study participants, the research design, the measures used, and the procedure followed.

Research Context

Eswatini is a lower-income country in Southern Africa, surrounded by Mozambique and South Africa, with 17,300 square kilometers geographically divided into four regions. According to the 2016 Eswatini Population Projections 2007-2030, the country's population is 1 132 657 (Swaziland Central Statistical Office, 2021). Eswatini presents with one of the highest HIV/AIDS disease burdens, with an HIV prevalence of 27% amongst adults 15 years and older (Government of the Kingdom of Eswatini, 2019), a high incidence of Tuberculosis (TB), and Non-Communicable Diseases (NCD's) such as diabetes and cancer (Ministry of Health, 2017). In Eswatini, nurses are the first responders of the healthcare system as they are the first interface with the patient, thus a critical cadre for a well-functioning healthcare system (Ministry of Health, 2017). The higher disease burden and a growing population indicate the increasing demand for healthcare and health workers working in public and mission hospitals.

Unfortunately, Eswatini has seen high nurse attrition rates in the past decade, with nurses exiting the workforce through retirement, migration between regions, migration from public health facilities to private health facilities, and migration to higher-income countries (Masango et al., 2008). In recent years, the country has made significant strides in improving the number of nurses by increasing the number of local training institutions. The country still experiences nurse shortages, with a staff ratio of 14.6 per 10,000 population (Ministry of Health, 2017). This nurse staffing ratio falls above the WHO Africa region average of 10.7 per population but below the global average of 17.6 per 10,000 (MoH, 2017). The nurse shortage problem in Eswatini is exacerbated by the nurse-to-doctor ratio (1:12), suggesting that many doctors' clinical tasks are shifted to nurses (MoH, 2017). The shortage of nurses in Eswatini implies that the nurses in Eswatini generally experience high job demands.

Eswatini has three nursing care levels: primary, secondary, and tertiary health care, which are structured differently in bed capacity, staffing, equipment, and health care service provision (MoH Kingdom of Swaziland, 2010). Primary-level health care comprises day clinics, typically eight-hour workdays, with no admissions and minimal weekend work. A secondary level of health care comprises mainly health care centers, structured like day clinics but providing a more comprehensive array of services with limited admissions capacity due to smaller bed

capacity. Tertiary-level health care comprises main hospitals (public, private, mission) and referral hospitals providing all services, including admissions, overtime, and weekend work (MoH Kingdom of Swaziland, 2010). As a result of the services offered, and the bed capacity, tertiary healthcare facilities will typically present with higher patient numbers. Nurses working in tertiary healthcare facilities work night and weekend hours, thus increasing the likelihood of an increased work overload. Therefore, this study will focus on nurses working in tertiary-level health facilities, including public and mission hospitals. Nurses working in private hospitals were excluded from this study as they generally have a lower patient load, thus experiencing lower job demands.

Research Design

This study used a cross-sectional descriptive research design using quantitative data from survey responses to test hypotheses by examining the relationship among variables. The quantitative approach adopted was consistent with examining the statistical relationships between variables (Creswell, 2014).

Creswell (2014) noted that the purpose of a survey design is to “provide a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population to which the sample results will be generalised draw inferences to the population” (p.153). This study intends to make inferences about work demands and work-family conflict from a sample of nurses that can be generalised to the nurse population in Eswatini. The main advantages of a survey design include the rapid turnaround time for data collection and its relatively inexpensive nature (Creswell, 2014). Hence, for this study, a survey design was adopted based on the following reasons: (i) because time constraints will make it impractical to collect data for all nurses in Eswatini and (ii) the minimised costs in data collection of a sample of the population rather than for all nurses in Eswatini. Survey designs quantify sample trends, attitudes, or opinions to generalise the study population's findings (Creswell, 2014). The main advantages of a survey design include the turnaround time for data collection and its relatively inexpensive nature.

A cross-sectional survey design was used to test the strength of the relationship between the independent and dependent variables at one point in time (Pandis, 2014). Nurses' work demands and work-family conflict were assessed at one point in time. The survey was administered once for all the study variables and each nurse participating.

Research Participants

Sampling strategy

The sample for this study comprised nurses employed in public and mission hospitals in Eswatini. A population represents all items in a field of inquiry (Kothari & Garg, 2014). It is seldom feasible to survey every population member (Kothari & Garg, 2014), and a sample was drawn from the total population. Attention was paid to obtaining an appropriate sample (Fowler, 2009).

For this study, a complete list of employed nurses was obtained from the hospital management of all the public and mission hospitals in Eswatini. The final list comprised 2420 nurses employed at the eight public and mission hospitals in Eswatini. To maintain the ethical principle of non-disclosure, phone numbers rather than personal names were used as unique identifiers in the nurse registers. From this sampling frame of 2420 nurses, we applied a simple random sampling technique to select study participants. Simple random sampling, a form of probability sampling, ensures that the participants chosen best represent the population (Fowler, 2009). The aim is to minimise bias in the selection process by ensuring that all members of the sample frame have an equally probable chance of being selected to participate in the study (Kothari & Garg, 2014). Randomising selection through the statistical regularity rule helps increase the probability that the sample will have the same composition and characteristics as the population (Kothari & Garg, 2014), thus increasing the veracity of inferences about the population. We used random number tables to select the study participants from the compiled list of nurses. Five hundred sixty-four nurses were sent online questionnaires, and 455 study participants responded with a response rate of 81%.

Socio-demographic Characteristics of Study Participants

A total of 417 participants were enrolled in the study. More than half (56%) of the participants were married or lived with their partners, while almost a third (30%) had one child less than 18 years old. More than two-thirds (73%) of the participants were females. Looking at the participants' work environment, 82% worked in a general hospital, 41% were midwives, and 30% were general nurses. Notably, 44% of the participants changed shifts, while another 29% worked on shifts that changed regularly. Only 25% of the participants consistently worked more than 40 hours weekly. About a third (32%) of the participants always worked overtime, and another 50% sometimes worked overtime. Data are summarised in Table 1.

Table 1: Description of participants' socio-demographics

Parameter	N	%
Marital status		
Married/living with a partner	234	56
Single/widowed	183	44
Number of children <18 years old		
1	124	30
2	88	21
3	0	0
4	111	27
5	58	14
6	22	5
7	14	3
Current position		
Nurse assistant	65	16
Midwife	170	41
Nurse	126	30
Sister (Unit Manager)	54	13
Gender		
Male	108	27
Female	293	73
Type of institution/organization		

General Hospital	340	82
National Specialized Hospital	33	8
Referral Hospital	43	10
Work schedule		
Work regular hours	113	27
Work shifts change regularly	122	29
Work changing shifts	182	44
Number of work hours per week		
≤ 40 hours	311	75
≥ 40 hours	106	25
Working overtime		
Almost always	133	32
Sometimes	209	50
Rarely	45	11
Almost never	30	7

Ethical Consideration

Ethical approval to conduct the study amongst nurses employed in Eswatini public and mission hospitals was obtained from the Eswatini National Health Research Review Board (Reference number: SHR246/2020) and the Ethics in Research Committee of the University of Cape Town (Reference number: MS_2020_MZYNT0002). In Eswatini, the public and mission hospitals are under the custodian of the Ministry of Health. Hence, additional permission was obtained from the Ministry of Health. The approval from the Ministry of Health granted access to the hospital management of the eight hospitals, where further engagements were done to explain the study objectives, request for the register of all nurses and explain the data collection process.

Alele and Malau-Aduli (2023) state that research should be ethical, guided by the ethical principle of non-maleficence, where research should ensure no harm to the study participants. Doing no harm to the research participants includes ensuring the confidentiality of the respondents, ensuring that study participants provide informed consent, and that any benefits offered to the study participants are not coercive. To ensure no harm to the study participants, confidentiality principles were applied at all stages of the research, commencing from the

sampling stage, where unique codes were assigned to each participant instead of personal identifiers.

The study ensured that all respondents provided informed consent. A consent form was issued to all respondents on the online survey platform informing them of the purpose of the study, rights to confidentiality, ability to withdraw from the research, and non-disclosure of information freely.

Procedure

Participants were recruited through a text message with a link to the questionnaire. A unique code was allocated to each cell phone number and used only for recruiting research participants, tracking response rates, and follow-up of participants to ensure a high response rate. The estimated time for completion was 9 minutes. This study was conducted at the peak of COVID-19; hence, an online questionnaire was a cost-effective method. The questionnaire was self-administered, ensured anonymity, and eliminated any disclosure to an interviewer.

Data was collected directly on the Qualtrics online survey platform, a password-protected platform to which only the study researchers had access. Furthermore, the data collected had no unique identifiers (the cell phone numbers were allocated unique computer-generated codes). The data was kept confidential, downloaded to a password-protected flash drive, safely stored, and known only to the researchers.

Nurse managers were contacted within the hospital to provide sensitisation on the study objectives and data collection process to cascade the information to all nurses. The organisational permission letters were also posted on the hospital departmental notice boards to sensitise the nurses. Lastly, because the online nature of the questionnaire meant that study participants incurred some costs in participating, airtime reimbursements were provided to minimise resistance to participation based on the unavailability of airtime. Fowler (2009) cautions that benefits or incentives should not coerce study participants into involuntarily participating to gain the incentives. As a result, research participants who completed the study were reimbursed with E20.00 airtime, the estimated amount of airtime required to fill in a 20-minute survey.

Measures

Following Cresswell (2014), the scales used in this study had been previously validated. Unless otherwise noted, all response scales were the strength of agreement scales from 1 to 5. The following scales were used to measure work overload, work-family conflict, organisational commitment, and commitment to the profession variables.

Job Demands were measured using the work overload variable. In their work, (Baillien et al., 2011) cite that job demand and job control models have often associated job demands with work strains. Work overload, a form of work strain resulting from the quantity of work and the pace at which the work is performed, positively relates to job demands (Baillien et al., 2010). The work overload variable was measured using a 4-item scale adapted from House (1980) and Singh (2000) taken from Brown et al. (2005). The participants were asked how often (1 never, 5 always) they experienced each of the following: "The amount of work you do interferes with how well the work gets done"; "You do not have enough help and resources to get the job done well"; "You do not have enough time to get the job done well"; and "You have to try to satisfy too many different people." These items were based on the definition of role overload cited by Kahn et al. (1964).

Work-family conflict was measured using a five-item scale adapted (Netemeyer et al., 1996). The participants were asked to indicate the extent of their agreement (strongly disagree, disagree, undecided, agree, strongly agree) with each of the following statements regarding work-to-family conflict: "The demand of my work interferes with my home and family life"; "The amount of time my job takes up makes it difficult to fulfill family responsibilities"; "Things I want to do at home do not get done because of the demands my job puts on me"; "My job produces strain that makes it difficult to fulfill family duties"; and "Due to work-related duties, I have to make changes to my plans for family activities". Netemeyer et al. (1996) found this measure to have adequate levels of internal consistency.

Organisational commitment was measured using a 6-item scale adapted from Meyer and Allen (1997), measuring affective and continuance commitment to the organisation. The participants

were asked to indicate (ranging from strongly disagree to agree strongly) the extent of their agreement with the following statements "I feel a strong sense of belonging to this hospital," "I feel an emotional attached to this hospital," "I feel like a part of the family at this hospital"; "this hospital has a great deal of personal meaning for me"; "Right now leaving this organisation would involve making many sacrifices"; "It would be very costly for me to leave this hospital right now"; "Too much of my life would be disrupted if I decided that I wanted to leave this hospital now"; and "I would not leave this hospital right now because of what I would stand to lose."

Commitment to the profession was measured using a 3-item scale adapted from Wallace (1995). The participants were asked to indicate the extent of their agreement (ranging from strongly disagree to agree) with the following statements strongly; "I am dedicated to the nursing profession"; "Being a nursing professional has a great deal of personal meaning for me"; "I feel a strong sense of belonging to the nursing profession".

Demographic variables. The demographic variables of the nurses collected were the following: Marital status, actual age at next birthday, number of children under 18 years old, living at home, current position, years of service, gender, and institutional information.

Data Management and Analysis

All collected data were extracted from the Qualtrics platform as an Excel file (.xlsx) with value labels. Data were analysed using Statistical Package for Social Sciences (SPSS) version 28. All data were coded on SPSS. Descriptive statistics were computed to describe participants' characteristics using their socio-demographic variables and presented in frequency tables.

All the other variables, besides socio-demographics, were analysed in line with the study objectives and hypotheses. All negatively worded items were identified and reversed to align with the Likert scale, with 1 representing strongly disagree and 5 strongly agree. The scale's internal consistency was tested to ascertain whether the items measured the same construct, and the Cronbach reliability test was run on SPSS. Pearson's correlation analysis was performed to

investigate the relationship between variables. A p-value <0.05 was considered a statistically significant association between the independent and dependent variables. A hypothesis was rejected if the p-value ≥ 0.05 .

RESULTS

This section presents the results of the quantitative analysis of the relationship between job demands, work-family conflict, gender, and organisational commitment.

Reliability Analysis

Reliability analysis using Cronbach’s alpha was conducted to assess the internal consistency of the survey items, ensuring the items measure the intended constructs. Pallant (2001) states that a Cronbach Alpha score of 0.7 suggests acceptable internal consistency. The Cronbach Alpha ranged from 0.84 – 0.94 in the measures used, except for the work overload measure, which presented a Cronbach alpha of 0.62.

Descriptive Statistics

A descriptive summary of scores for the different variables is presented in Table 2. Mean scores ranged from 0.7290 to 4.3981. The overall mean score for work overload was high (Score=3.431, SD=0.7135), above the scale's midpoint of 2.5. A high work overload shows that the study sample experienced high levels of work overload. There was a moderate affective commitment to the organisation (M=3.0821, SD=1.0079).

Table 2: Descriptive summary of scores by study variables

Variable	N	Mean	Min	Max	Std. Dev.	Skewness	Kurtosis
Work overload	417	3.4317	1.25	5	0.7135	-0.2109	-0.1812
Work-Family Conflict	417	3.5813	1	5	0.9136	-0.5651	-0.4088
Affective Commitment	417	3.0821	1	5	1.0079	-0.3736	-0.6839
Continuous Commitment	417	2.8891	1	5	1.0403	-0.0414	-0.8311

Professional Commitment	417	4.3981	1	5	0.7058	-0.7235	0.5805
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Furthermore, a high overall mean score for affective professional commitment (M=4.3981, SD=0.7058) was observed. This is above the midpoint scale of 2.5, indicating that the sample experienced high levels of affective professional commitment. According to Pallant (2001), the skewness value indicates the symmetrical nature of the distribution, with a negative skewness score indicating a grouping of scores at the right-hand side of the graph. All the variable scores presented a negative skewness score, less than -1 and closer to 0. This indicates a clustering of scores on the graph's right-hand side and on the variables' lower side. Additionally, most variables presented with a kurtosis score closer to 0, suggesting the sample follows a standard distribution curve.

Correlation Analysis

A bivariate data analysis was conducted to investigate the Pearson correlation coefficient between the study variables. The study findings in the table below show negative and positive relationships between variables, with some relationships presenting statistical significance.

Table 3: Correlation analysis

	Variable	M	SD	1	2	3	4	5	6
1	Work overload	3.431	0.713	(.620)					
2	Work-family Conflict	3.585	0.911	0.432*	(.890)				
3	Supervisor Support	3.166	0.823	-0.069	-0.151*	(.932)			
4	Affective Commitment	3.083	1.011	-0.168*	-0.161	0.319*	(.910)		
5	Continuance Commitment	2.881	1.039	-0.012	0.020	0.169*	0.513*	(.867)	
6	Professional commitment	4.396	0.709	0.086	0.112*	0.080	0.116*	0.062	(.880)

Significance level * $p < .05$; $N = 412$ with case-wise deletion of missing data. $M = \text{Mean}$; $SD = \text{Standard Deviation}$. The brackets represent the reliability coefficients.

The study findings show a medium positive association between work overload and work-family conflict ($r=0.431$, $p<0.001$), with high work overload associated with high levels of work-family conflict. This relationship was found to be significant. Wherein workload was used as a proxy for job demands, these results provide support for hypothesis 1, which suggested that job demands would be positively related to work-family conflict.

A small negative correlation was found between work-family conflict and affective commitment, and this relationship was statistically significant ($r=-0.161$, $p=0.001$), showing that high levels of work-family conflict are associated with low levels of affective commitment. These results partially support hypothesis 3, which suggested a negative relation between affective commitment and work-family conflict. The relationship between work-family conflict and continuance commitment was insignificant ($r=0.0196$, $p=0.691$). Hence, our findings did not support hypothesis 2, which suggested a negative correlation between continuance commitment and work-family conflict. The relationship between work-family conflict and professional commitment ($r=0.1116$, $p=0.23$) was also not statistically significant. Hence, our findings rejected hypothesis 4, which suggested a negative relationship between work-family conflict and commitment to the profession. The above is summarised in Table 3.

Gender Differences in Work-family Conflict

The study investigated the difference between work-family conflict levels for male and female nurses. An independent samples t-test analysis was conducted to compare work-family conflict for females and males. There were no significant differences ($t = -1.5955$, $p=0.1120$) in work-family conflict scores for females ($M= 3.6246$, $SD= 0.9400$) and males ($M= 3.4686$, $SD= 0.8410$). Therefore, the hypothesis that females experience higher work-family conflict when compared to males was not supported by our findings. The above is shown in table 4 below.

Table 4: Independent T-test Analysis

Groups	M	SD	t	df	p
Female	3.6246	0.9400	-1.5955	211.7801	0.1120
Male	3.4686	0.8410			

p= p-value significance level; significance level $p < 0.001$

In this section, the study results and the interpretation of the results were presented. The following section will discuss the study findings and provide conclusions and recommendations from the study findings.

DISCUSSION

The study investigated the relationship between work-family conflict, job demands, and organizational commitment. The relationship between work-family conflict and job demands was evaluated through Pearson's correlation analysis relationship. The findings showed a significant relationship between job demands and work-family conflict. Additionally, the findings showed a significant negative relationship between organisational affective commitment. However, contrary to our expectations, the findings showed a positive relationship between work-family conflict and continuance commitment and professional commitment. This section outlines the key findings, contributions of the study, implications of the study, limitations, and recommendations for future research.

Contributions of the Study

The study's main contributions provided additional knowledge about the relationship between job demands, work-family conflict, and organisational commitment in the Eswatini context. The literature presented opposing evidence to literature with regards to the relationship between work-family conflict and continuance commitment. Our findings add to the body of knowledge and confirm a positive association between work-family conflict and affective commitment in the Eswatini context.

According to Frone et al. (1992), job strains contribute positively to work-family conflict. In their work, Baillien et al. (2011) found a positive relationship between job strain and work-family conflict, citing high work overload levels as an example of a job strain. In this study, we hypothesised that work overload, an example of a job strain, will positively affect work-family conflict. As expected, the findings showed a significant positive association between work overload and work-family conflict ($r=0.431$, $p<0.001$). These findings are consistent with the work of Ilies et al. (2015), who found that employees experienced higher work-family conflict on days when they experienced a higher work overload. These findings are further supported in earlier research where increased employees experiencing a higher work overload also experienced higher levels of work-family conflict (Butler et al., 2005).

Moreover, these findings are compatible with the context in Eswatini, where the staff complement still falls below the recommended WHO global benchmark of nurses per 10,000 population. In addition to the staffing shortages, the task-shifting approach implemented by the Ministry of Health of Eswatini to respond to the high HIV disease burden has resulted in nurses performing more responsibilities than they would ordinarily perform. In their work, Simelane-Dlamini and Moyer (2017) present that the task-shifting approach added an additional burden to nurses' work overload, as it increased the number of service points that still had to be attended by nurses. As a result, nurses felt overwhelmed with the increased work brought about by the task-shifting approach. Our findings confirm that nurses experiencing high levels of work overload, as evidenced by the nurses in Eswatini, also experience higher levels of work-family conflict.

The positive association between work overload and work-family conflict infers a positive association between job demands and work-family conflict. This study confirms the findings of Unruh et al. (2016), who found that registered nurses with higher job demands, as evidenced by a higher patient load and longer working shifts, experienced higher levels of work-family conflict. These findings have further been supported by other empirical evidence in the literature (Chen et al., 2015; Ilies et al., 2015).

As expected, our findings showed a significant negative association between affective commitment and work-family conflict. Our studies are consistent with other findings that show that an increase in work-family conflict resulted in a decrease in affective organisational

commitment (Cao et al., 2020). However, contrary to expectations, our findings showed higher levels of continuance commitment where higher levels of work-family conflict were observed. The relationship between these two variables was positive but not statistically significant. The positive and non-statistically significant relationship between work-family conflict and continuance commitment suggests that as the nurses in our sample experienced higher conflict between the work and personal domain, they felt more committed to the hospital because they would lose more by leaving the hospitals where they are employed. While these findings contradict our hypothesis, our literature review showed mixed findings with empirical evidence showing a positive association (Casper et al., 2002).

In contrast, other findings showed a negative association between continuance commitment and work-family conflict (Cory et al., 2018). Our findings showed a positive association between the two variables for the Eswatini context. A possible explanation for this positive association could be that employees are committed to the organisation because the benefits of staying with the organisation outweigh the benefits of leaving because of the limited options for employment outside their current employer. These employees may experience higher levels of work-family conflict because the commitment to stay may drive them to work extra hours or take on more work responsibilities, thus increasing the chances of job strains that may spill over to the family domain and a higher work-family conflict experience. Considering the context in Eswatini, nurses employed may feel committed to staying with the organization due to the relatively high unemployment rate in the country, with the latest data showing a 25% unemployment rate (World Bank, 2021). Limited opportunities for employment outside their current employment may result in elevated levels of obligation to stay with the organisation. Hence, a nurse investing more hours in their job due to the obligation to stay with the organization may be a strain, causing the work strain to spill over to their family life. The obligation to exert more effort into their work towards sustaining their employment may explain the positive association between continuance commitment and work-family conflict.

The study hypothesized a negative relationship between nurse professional commitment and work-family conflict. Contrary to our expectations, the study findings showed a positive association between the two variables, showing increased nurse professional commitment where high levels of work-family conflict were observed. Our findings differed from previous

studies that show that a work-family conflict had a negative effect on nurse professional commitment (Poulose & Dhal, 2020; Zheng & Wu, 2018). While this is divergent from existing literature, it could be explained by the shortage of Nurses in Eswatini. Eswatini still faces healthcare worker staffing constraints, at a staff ratio of 1.69 per 1000 patients, below the recommended staff ratio of 2.5 per 1000 patients, and the WHO global benchmark of 17.6 healthcare workers per 10 000 population (MoH, 2017). This shortage of nurses in hospitals may give nurses a sense of job security, thus increasing their commitment to the profession. Nurses may remain committed to the nursing profession because they value the job security that the profession provides. The perceived rewards of remaining, as cited by Allen and Meyer (1990), contribute to a higher commitment to stay. Hence, due to their commitment to remain in the profession, they may increase their effort into their roles, resulting in job strain spilling over to the work domain.

The study hypothesized that women experience higher levels of work-family conflict than males. Our results indicate no significant difference in work-to-family conflict for females and males. Though unexpected and contrary to our hypothesis, our results are consistent with the findings of Anafarta and Kuruuzum (2012), who also did not find a significant difference between work-family conflict experience for males and females. Our findings show that in the Eswatini context, men and women experience the same levels of work-family conflict. These results could be attributed to the workstation placement policies of the nurses employer. Nurses in Eswatini are placed in hospitals based on the human resource needs of the hospitals alone and the employee's family location and needs are rarely considered. Some hospitals are in rural health settings with limited options for education facilities for children. As a result, some nurses may reside alone, away from their families, and opt to live separately to access good education facilities for their children. In such instances, one spouse, regardless of their gender, may have sole responsibility for family and household duties, leaving the other spouse with minimal family responsibilities. Our findings demonstrating no differences in the work-family conflict experience for males and females are consistent with the work of Minnotte (2011), who found that gender is not the main contributor to experiencing work-family conflict. Minnotte (2011) found that family responsibility, the other variables like the tasks the individual is assigned and the amount of support provided by other adults interact with gender to influence work-family conflict. She also found that single parents, regardless of gender, who have limited adult support and work many work hours are likely to experience higher levels of work-family conflict.

Implications of the study

The present study showed the association between work-family conflict and job demands, thus highlighting employees' importance in limiting job strains in ensuring minimal work-family conflict. Human resource practitioners need to make efforts towards minimizing work-family conflict as high levels of this conflict bear negative consequences to both the employee and the organisation. At employee level, work-life conflict has been found to have both physical and mental adverse health outcomes, Minnotte and Yucel (2018), with empirical evidence showing a positive association between work-life conflict, psychological distress, and life satisfaction (Oshio et al., 2017). Whereas psychological distress and burnout impact the employee, this inversely impacts the organisation due to the direct healthcare costs associated with illness and the indirect costs of absenteeism, including the additional work overload imposed on the employees at work (Ammerman et al., 2016).

Our findings amplify the need for human resource practitioners to ensure a good balance between work and family demands to limit the transfer of the job strain from the work domain to the family domain. Our findings, showing an association of work overload to work-family conflict, accentuate the emphasis on putting in place systems and tracking their effectiveness to ensure a reasonable work overload for Nurses. Putting in place systems to ensure a reasonable workload for Nurses is particularly important in the Eswatini Health system, where there is an increased HIV disease burden, and Nurses are already experiencing high levels of work overload.

Our findings showing a negative association between work-family conflict and affective commitment imply that employers should put in place family-supportive programs that assist employees in balancing the work and family domain towards increasing affective commitment. Contrary to the latter findings, a positive relationship between work-family conflict and continuance commitment was observed; these findings suggest that in the Eswatini context, fewer human resource management strategies and interventions focused on increasing continuance commitment are needed. Instead, the employer needs to focus their resources and interventions on increasing affective commitment, as higher levels of affective commitment were related to lower work-family conflict.

Limitations and Recommendations for Future Research

Our findings on the positive association between work-family conflict, continuance commitment, and nurse professional commitment, though unexpected, highlight a unique finding to the body of knowledge in the Eswatini context. Our findings show that employees may remain committed to their organisations and professions amidst high work-family conflict levels. While this finding seems contrary to the job demands and resources model that associates adverse outcomes with high job demands (Bakker & Demerouti, 2017; Demerouti et al., 2001), in this instance, positive commitment outcomes of work-family were observed. The present study was limited in not considering other confounding variables that can influence the positive association between work-family conflict, continuance commitment, and commitment to the nursing profession. Future research attempting to understand the confounding factors that influence this relationship will provide a deeper comprehension of this relationship. Furthermore, future studies can consider a combination of quantitative and qualitative approaches to deepen the understanding of this positive association by understanding the real-life experiences of employees.

The present study was limited to public and mission hospitals in Eswatini. It is assumed that the public and private sectors' work settings differ, with public sector hospitals presenting with more significant job strains due to the higher patient volumes. A comprehensive investigation in both private sectors would provide a more balanced understanding of work-family and job demands issues in Eswatini. Future research may consider expanding the scope of the study to investigate job demands and work-family variables in both private and public sectors, comparing and learning from these two sectors with different contexts and issues.

Lastly, our findings showed a positive association between continuance commitment and work-family conflict. Further studies may consider understanding the direction of the relationship to ascertain which variable influences the other. Further analysis of the relationship between work-family conflict and continuance commitment will provide a deeper understanding of whether work-family conflict influences continuance commitment or continuance commitment influences work-family conflict.

CONCLUSION

The present study investigated the relationship between job demands, work-family conflict, organisational commitment, and commitment to the Nurse profession. The study aimed to provide a contextual understanding of work demands, organizational commitment, and commitment to the profession in the Eswatini context by examining the various study variables. The study findings concluded a positive relationship between job demands and work-family conflict, a negative relationship between work-family conflict and affective commitment, and a non-significant relationship between work-family conflict and continuance commitment, as well as with a commitment to the nursing profession.

The findings of this study will help organisations and human resources practitioners better understand the factors of focus for reducing employee-work-family conflict. The findings will further assist human resource practitioners in knowing which strategies and interventions to focus on to reduce the spillover of job strains from the work to the family domain.

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