

ENSIGN GLOBAL UNIVERSITY, KPONG

EASTERN REGION, GHANA

FACULTY OF PUBLIC HEALTH

DEPARTMENT OF COMMUNITY HEALTH

**BURNOUT RATE AMONG HEALTH WORKERS: A CASE STUDY AT LEKMA
HOSPITAL IN THE LEDZOKUKU MUNICIPAL, GREATER ACCRA REGION,
GHANA**

BY

CANDICE FRIMPONG

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JUNE, 2026

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**A THESIS SUBMITTED TO THE DEPARTMENT OF COMMUNITY HEALTH IN THE
FACULTY OF PUBLIC HEALTH IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE MASTER OF PUBLIC HEALTH**

JUNE, 2026

DECLARATION AND CERTIFICATION

I, Candice Frimpong, hereby declare that this submission is my own work towards the Master's Degree in Public Health and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the college, except where the acknowledgment has been made in the text.

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DEDICATION

This work is dedicated to all healthcare staff at LEKMA Hospital and Ghana in general, who continue to serve with dedication, fortitude and compassion under trying circumstances. You all are so inspiring with the time you invest in patients and your communities.

It is also dedicated to my family for their support, encouragement, and patience during this long academic pursuit.

To all those wishing to improve healthcare workers' well-being and health systems for the best patient care, this work is dedicated.

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I also thank the management and staff of LEKMA Hospital for giving permission to undertake this study and for cooperating in participating. I am very grateful for their time and willingness in this respect, without which the work would not have been feasible.

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DEFINITION OF TERMS

Burnout: A psychological syndrome resulting from prolonged exposure to occupational stressors, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment

Healthcare Workers: any person engaged in actions whose primary intent is to enhance health.

Mitigation Strategies: Interventions and approaches aimed at preventing or reducing the impact of burnout among healthcare workers

LIST OF ABBREVIATIONS

aOR	Adjusted Odds Ratio
CI	Confidence Interval
df	Degrees of Freedom
DP	Depersonalization
EAP	Employee Assistance Program
EE	Emotional Exhaustion
GHS	Ghana Health Service
HCWs	Healthcare Workers
JD-R	Job Demands–Resources Model
LEKMA	Ledzokuku Krowor Municipal Assembly
MBI	Maslach Burnout Inventory
MBI-HSS	Maslach Burnout Inventory–Human Services Survey
MoH	Ministry of Health
OPD	Outpatient Department
PA	Personal Accomplishment
PPE	Personal Protective Equipment
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

ABSTRACT

Background:

Healthcare systems globally depend on the dedication and resilience of their workforce to navigate challenges, particularly in high-stress environments like hospitals. A country without a proper healthcare system and personnel always suffers. Healthcare workers operate in highstress environments, often juggling long hours, heavy workloads, and emotionally demanding tasks. In such conditions, staff burnout has become a universal issue, raising significant concerns about the well-being of healthcare workers and the overall efficiency of healthcare delivery. Burnout among healthcare workers has increasingly been recognized as a major global public health problem, which may have an impact on workforce stability, quality of care, and patient safety.

Aim of the Study: The study aims to determine the prevalence, correlates, consequences, and preventive strategies of burnout among health care providers at the LEKMA Hospital in Ghana.

Methodology: A quantitative cross-sectional study design was employed to recruit 250 healthcare workers from various departments of LEKMA Hospital. Data were collected using a structured questionnaire incorporating the Maslach Burnout Inventory–Human Services Survey (MBI-HSS). Descriptive statistics were used to summarize socio-demographic characteristics and burnout levels. Inferential analysis, including Chi-square tests and Fisher’s Exact test, was conducted to assess associations between burnout and explanatory variables. Variables that were statistically significant at the bivariate level were entered into a multivariable logistic regression model to identify independent predictors of burnout.

Results: The findings revealed that 58.0%, 7.2%, and 34.8% of participants had high emotional exhaustion, high depersonalization, and low personal accomplishment, respectively. The overall prevalence of burnout was 15.2%.

Multivariable analysis showed that poor management support was a significant predictor of burnout (AOR = 2.68, 95% CI: 1.32–5.41, $p = 0.006$). Burnout was also significantly associated with lack of work–life balance ($p = 0.004$), frequent night shifts or unpredictable schedules ($p = 0.011$), long working hours ($p = 0.028$), and lack of resources ($p = 0.009$).

Additionally, burnout was significantly associated with reduced motivation ($p < 0.001$), decreased concentration ($p < 0.001$), difficulty maintaining work–life balance ($p < 0.001$), lower job satisfaction ($p < 0.001$), and negative effects on patient interactions ($p < 0.001$).

All identified mitigation strategies, including recognition and reward systems, staff support meetings, stress management training, peer support, flexible scheduling, wellness initiatives, and employee assistance programs, were found to be significantly associated with burnout outcomes ($p < 0.05$).

Conclusion: The study concludes that burnout among healthcare workers at LEKMA Hospital is characterized primarily by high levels of emotional exhaustion and is driven largely by organizational and workplace factors rather than individual characteristics. Key determinants include poor management support, work–life imbalance, demanding work schedules, long working hours, and inadequate resources. Burnout significantly affects both healthcare delivery and worker well-being, with implications for productivity, patient care, and staff retention.

Strengthening organizational support systems, improving work structures, and enhancing the implementation of mitigation strategies are essential to reducing burnout and promoting a healthier and more effective healthcare workforce.

Keywords: Healthcare workers; Occupational stress; Burnout; Workplace factors; Healthcare delivery; Well-being.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

The World Health Organisation (WHO) in its International Classification of Diseases classified burnout as an occupational phenomenon (W.H.O, 2019). Staff burnout in healthcare is defined as a state of emotional, physical and mental exhaustion caused by prolonged exposure to chronic stressors in the workplace, which is often worsened by high job demands, insufficient resources and a lack of support (Khammissa *et al.*, 2022). It typically manifests through feelings of depersonalization (negative or detached attitudes toward patients), emotional exhaustion (feeling drained or overextended) and reduced personal accomplishment (a sense of inefficacy or incompetence in the workplace) (Sayapathi *et al.*, 2020)

Burnout is particularly common among healthcare workers due to the high-stakes nature of the field, long working hours, emotional labour and exposure to suffering or trauma. Burnout is not only detrimental to individual healthcare workers but also compromises the quality of care provided by them to patients (Al Hamad *et al.*, 2018).

The challenge of burnout in healthcare is further intensified by the disparity in working conditions between rural and urban settings (Harry *et al.*, 2024). Urban healthcare workers often face issues such as overcrowded facilities, understaffing and administrative burdens. Equally, rural healthcare workers grapple with isolation, inadequate resources and limited professional development opportunities (Harry *et al.*, 2024; Ward *et al.*, 2020). These contrasting conditions necessitate an indepth analysis to understand how burnout manifests differently across these environments. This study sought to explore the causes, consequences and mitigation strategies for staff burnout in healthcare.

1.2 Problem Statement

Burnout among healthcare workers has become a pressing issue with widespread consequences.

While much research has explored burnout among healthcare workers (Ghahramani *et al.*,2021; Jalili *et al.*,2020). The unique challenges faced by health workers in various departments often go unexamined. Many healthcare professionals face chronic stress, emotional exhaustion, and reduced job satisfaction, which negatively affect their mental well-being and the quality of patient care. In some hospital settings, health workers struggle with limited access to specialized training, fewer support networks, and overwhelming patient-to-staff ratios, complex bureaucratic requirements, and difficulty maintaining a work-life balance. Despite the critical role of healthcare workers, insufficient attention has been given to understanding and addressing burnout within Ghana's health system. Providing evidence of burnout among health workers is crucial for developing targeted strategies to address burnout effectively. Without such evidence, interventions may fail to account for the specific needs of healthcare workers in diverse settings, perpetuating the cycle of burnout and its adverse effects on healthcare systems.

LEKMA hospital, one of the busiest district hospitals, faces significant challenges including high patient volumes, limited resources and intense clinical demands. Report suggests that many health workers at the hospital work under strenuous conditions with little or no institutional support or structured interventions to manage stress and burnout, long working hours, emotional labor, shift duties and administrative pressures may contribute to burnout rate, yet these experiences are often under report and poorly understood.

The lack of comprehensive data and targeted interventions hinders efforts to improve workforce resilience, retention, and healthcare outcomes, making this an urgent issue for research and policy.

This study was therefore designed to ascertain the level of burnout rate among clinical health workers at the LEKMA hospital in Ghana.

1.3 Rationale of the study

This study holds significant value for policymakers, healthcare administrators and practitioners. By throwing light on the underlying causes and consequences of burnout, the research will inform the development of interventions to support healthcare workers. The comparative analysis of the various departments will provide insights, enabling stakeholders to address location-specific challenges effectively.

Furthermore, the study contributes to the academic discourse on healthcare worker well-being, offering a comprehensive understanding of burnout dynamics in diverse settings. This knowledge can serve as a foundation for future research and policy development, fostering a more sustainable and resilient healthcare workforce.

1.4 Conceptual Framework

Burnout among healthcare professionals is a multifaceted phenomenon influenced by a combination of job demands, workplace resources, coping mechanisms, and institutional interventions. This study conceptualizes burnout as an outcome of job-related stressors, shaped by the availability of organizational support and the implementation of coping strategies. experiences of healthcare workers.

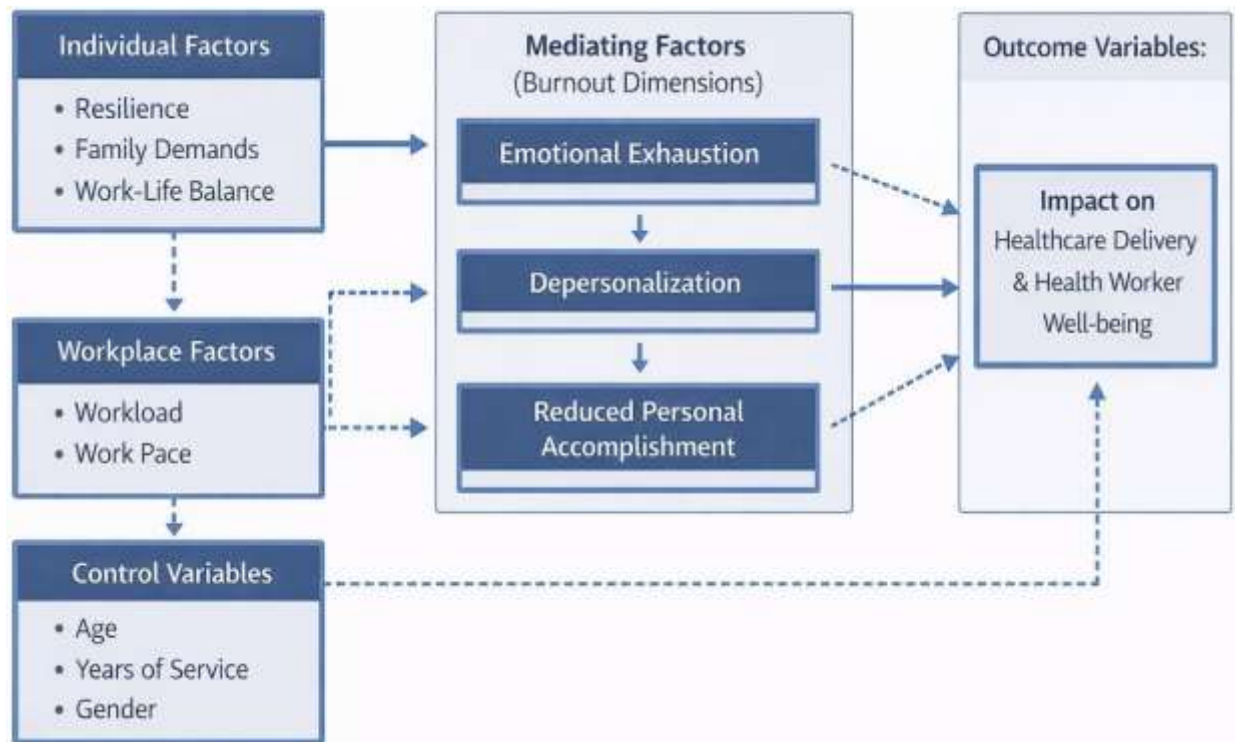


Figure 1: Conceptual framework for assessing staff burnout.

Source: Author's Own Construct.

1.4.1 Burnout as a Function of Job Demands and Resources

The Job Demands-Resources (JD-R) Model (Bakker & Demerouti, 2007) provides a theoretical foundation for understanding burnout in this study. The model suggests that burnout occurs when job demands exceed available resources, leading to physical and emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Leiter, 2017). Job demands include workload, time pressure, emotional strain, and administrative burdens, while job resources encompass management support, autonomy, professional development opportunities, and institutional policies aimed at preventing burnout.

1.4.2 The Role of Coping Mechanisms and Workplace Interventions

Coping mechanisms and workplace interventions play a moderating role in shaping burnout outcomes. Healthcare professionals employ individual coping strategies, such as seeking social support, engaging in mindfulness practices, and setting professional boundaries (Sharif *et al.*,2024). However, the effectiveness of these strategies is moderated by institutional interventions, including work-life balance policies, leadership support, and stress management programs (Dyrbye *et al.*,2020).

Institutions that prioritize employee well-being by reducing excessive workloads, providing mental health support, and fostering a collaborative work culture tend to have lower burnout rates among healthcare workers (West *et al.*,2018). Thus, the conceptual framework underscores the dynamic interaction between individual resilience and systemic support, suggesting that burnout is not solely a personal issue but a structural and organizational challenge that requires institutional interventions.

1.4.3 Outcomes of Burnout

Burnout has far-reaching consequences for both individual healthcare professionals and healthcare systems. On a personal level, it leads to emotional exhaustion, job dissatisfaction, and increased turnover intentions (Bridgeman *et al.*,2018). At an organizational level, burnout contributes to lower patient care quality, increased medical errors, and higher absenteeism rates (Boateng & Owusu, 2022).

The framework suggests that effective burnout mitigation requires addressing both personal and institutional factors. Urban settings may benefit from interventions that reduce administrative burdens and enhance workflow efficiency, while rural areas require strategies that improve workforce retention, provide telemedicine support, and enhance professional development opportunities.

1.5 Research Questions

1. What is the prevalence and level of burnout among healthcare workers at the LEKMA Hospital?
2. What are the individual and workplace factors associated with burnout among healthcare workers at the LEKMA Hospital?
3. What is the perceived impact of burnout on healthcare delivery and health worker well-being among workers at the LEKMA Hospital?
4. What strategies are currently employed to mitigate burnout among workers at the LEKMA Hospital?

1.6 General objective

The general objective is to examine the difference in the causes, consequences and mitigation strategies of staff burnout among healthcare workers at LEKMA Hospital.

1.7 Specific Objectives

The study objectives were:

1. To determine the prevalence and levels of burnout among healthcare workers at the LEKMA Hospital.
2. To identify individual and workplace factors associated with burnout among health workers at the LEKMA Hospital.

3. To assess the perceived impact of burnout on healthcare delivery and health worker well-being at the LEKMA Hospital.
4. To evaluate existing mitigation strategies for burnout among workers at the LEKMA Hospital.

1.8 Profile of the Study Area

Ledzokuku Municipal is one of the twenty-nine districts in the Greater Accra Region of Ghana. It was originally part of the defunct Ledzokuku-Krowor Municipal, which was carved out of the Accra Metropolitan District in 1998. On 15 March 2018, part of the district was split to create the Krowor Municipal, with the remaining portion officially named Ledzokuku Municipal (Ghana Statistical Service ,2021). The Municipality is located at the central part of Greater Accra Region and has Teshie as its capital town. Ledzokuku shares boundaries with La Dadekotopon Municipal Assembly to the west. Krowor Municipality to the east, Ayawaso east and north to the north and Gulf of Guinea to the south. It covers an area of approximately 37.54 square kilometers and features both coastal savannah zones, which is characterized by low-lying vegetation, moderate rainfall, and sandy soil.(GSS,2021).

According to the 2021 Population and Housing Census, the total population of Ledzokuku is approximately 217,304, with a balanced gender distribution of 51.8% female and 48.2% male. The Municipality is highly urbanized with most residents living in communities such as Teshie, LEKMA, Tebibiano and bush road. Although the majority of the inhabitants are Ga-Dangbe and Ewe, the area is ethnically diverse due to inward migration from other parts of Ghana, driven by economic and educational opportunities (GSS,2021).



Figure 2: Map showing the location of the Ledzokuku Municipal Assembly

1.9 Scope of the Study

The study focused on healthcare workers in various departments within the LEKMA Hospital located in Accra, examining their experiences with burnout. The research included a comparative analysis of the causes, consequences, and mitigation strategies for burnout in these settings. Data was collected from healthcare workers across various roles, including doctors, nurses and allied health professionals, to capture a holistic view of the issue.

1.10 Organization of Report

The report is structured into six chapters. This is Chapter One which presents the study background, problem statement and objectives, research questions, significance of the report, scope of the study, limitation and assumption of the study as well as structure of this report. Chapter Two, literature review, examines the current body of relevant literature regarding burnout, including its conceptual and theoretical underpinnings; its prevalence among healthcare providers; individual and workplace factors associated with it; its impact on the provision of care and worker well-being; as well as investigational mitigation strategies within healthcare environments.

Chapter Three explains the study design, setting, population, sampling technique, research instrument and its procedure of data collection, data analysis method as well as ethical consideration we made during the process together with limitations and assumptions. Chapter Four describes the findings in detail, including respondents' socio-demographic characteristics, prevalence and levels of burnout, associated factors with burnout, impact on healthcare delivery and worker well-being, mitigation strategies. Chapter Five presents the findings in relation to other literature and theoretical perspectives. Lastly but not least, Chapter Six presents' implications from the study, and makes suggestions to specific stakeholders including hospital management, health care workers, industries governing agencies as well as for future research.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

Burnout is widely recognized as a serious occupational health concern for health care providers globally. Burnout is a "syndrome resulting from chronic workplace stress" that is described as having "detrimental effects on the quality of patient care, provider retention and patient safety". This narrative review aimed to explore the incidence of burnout, risk factors for burnout, impact of burnout and intervention strategies to prevent burnout in health care providers globally.

2.2 Prevalence and Levels of Burnout Among Healthcare Workers

Burnout in healthcare personnel (HCWs) is typically conceptualized as a multifaceted professional syndrome characterized by exhaustion, depersonalization, and lower personal accomplishment. Globally, burnout prevalence is high, and it varies by healthcare setting, professional category, and measurement tools used.

Globally, physicians, allied health worker, and nurse burnout have been extensively described. The studies conducted by Sexton et al., (2018) and Rotenstein et al., (2018), which were comprehensive systematic reviews, stated the prevalence of burnout was from 0% to 80.5% among physicians, demonstrating large variability across methodologies employed in these studies. Nevertheless, pooled estimates of multiple large-scale studies report that 40%–60% of healthcare providers endorse at least 1 core symptom of burnout. Likewise, Dyrbye et al., (2014) and Shanafelt et al., (2015) showed US physicians had a high prevalence of burnout and attributed this trend to both workplace related factors such as high workload and bureaucratic tasks, and to work-life conflict. Additionally, West et al., (2018) reported that burnout is most evident in high acuity specialties

associated with longer shifts, prolonged exposure to patients, and higher emotional involvement (eg emergency medicine, surgery, and critical care medicine).

Nurse burnout prevalence estimates are quite alarming, with Gómez-Urquiza *et al.*, (2017) indicating that exhaustion at work is especially prominent among nurse clinicians, with rates above 30%–40% in acute care settings. Woo *et al.*, (2020), also revealed a high level of burnout among nurses, which was characterized by emotional exhaustion being the most reported dimension. Notably, these findings highlight that burnout is not just a problem among physicians but a widespread problem facing multidisciplinary clinical teams across diverse healthcare situations.

Burnout was substantially exacerbated by the COVID-19 pandemic globally. Pappa *et al.*, (2021) found that the pooled prevalence of burnout experienced by healthcare workers was approximately 52% during the pandemic. Similarly, Lasalvia *et al.*, (2021) detected high emotional exhaustion and depersonalization in frontline HCWs, especially those working on treating COVID-19 patients. Nurses always had higher levels of emotional exhaustion compared to doctors, linked possibly to longer bedside care, more caregiving duties and lack of staff. Morgantini *et al.*, (2020) also found that limited Personal Protective Equipment (PPE), fear of infection and lack of organizational support were significantly associated with burnout during the pandemic.

In sub-Saharan Africa, there is relatively less research to draw from, but evidence suggests that these same moderate-to-high rates of burnout hold true. According to Muliira and Ssendikadiwa (2016), over fifty percent of the Ugandan nurses examined had at least moderate levels of burnout, particularly in aspects such as emotional weariness and depersonalisation.

In Ghana, Agyemang *et al.*, (2021) also reported a high emotional exhaustion prevalence among nurses in tertiary hospital and linked burnout to heavy workloads, understaffing, and lack of resources in the institution. Comparable results were reported in Nigeria and South Africa where

high client-nurse ratios, poor infrastructure and scarce resources especially fuel occupational stress and burnout. Healthcare professionals working in high acuity clinical settings also tend to demonstrate higher levels of burnout compared with their peers working in low acuity settings. For example, emergency departments and ICUs, which frequently see critically ill patients, make rapid decisions and often face end-of-life scenarios are especially at risk. A study by Embriaco et al., (2007) and Moss et al., (2016) revealed that burnout in intensive care clinicians is highly prevalent and associated with long working hours, moral distress and emotional exhaustion.

2.3 Individual and Workplace Factors Associated with Burnout

The burnout experiences of healthcare workers are dependent on the dynamics between their individual attributes and the workplace in which they are located. Research consistently underscores that personal vulnerability factors are a factor, but organisational and systemic determinants are frequently more potent predictors of exhaustion.

2.3.1 Individual Factors

Burnout vulnerability is also deeply affected by individual factors. Among others, age and professional experience are commonly reported correlations. As reported by Dyrbye *et al.*, (2020) and Rodrigues *et al.*, (2018), younger and less experienced healthcare professionals are the ones that experience high levels of emotional exhaustion and depersonalisation. Young professionals may experience added stress in adjusting to a challenging clinical environment, and they may not have had time to develop coping mechanisms.

The level of burnout is further influenced by support systems and marital status. Shanafelt *et al.*, (2019) found that health workers with strong social and familial support networks are less likely to experience burnouts. On the other hand, employees faced with low social support are more likely to suffer from emotional exhaustion.

Similarly, West *et al.*, (2018) and Embriaco *et al.*, (2007) have found that professionals working in departments with recurring exposure to trauma, critical illness, and death (e.g., emergency services or intensive care units), report more emotional exhaustion. Chronic empathic engagement but inadequate psychological recovery time may lead to compassion, fatigue and depersonalisation.

Another key individual-level factor is imbalance between work and life. Symptoms of burnout have been associated with overworking, lack of rest and insufficient personal renewal time (Dyrbye *et al.*,2014; Shanafelt *et al.*,2015). Long-term emotive depletion can result if health-care staff feel unable to switch off from work pressures.

2.3.2 Workplace Factors

While personal factors contribute to burnout, the strongest predictors are those at organizational level. Maslach and Leiter (2016) conceptualize burnout primarily as a mismatch between the worker and key workplace domains, including workload, control, reward, community, fairness, and values. Workload and long hours are regularly listed as a top cause of burnout. Studies have shown that high patient caseloads, administrative demands, and long work hours are major contributors to feelings of emotional exhaustion (Dyrbye *et al.*,2020; West *et al.*,2018; Woo *et al.*,2020). In addition, low salary and feelings of inequity are elements of low satisfaction with the job and depersonalization. Perceptions of unfairness in compensation or promotion are also linked with elevated burnout risk among health professionals (Shanafelt *et al.*,2019).

Burnout is closely related to its antecedents of lack of supervisory support, lack of recognition, communication and participation in the decision-making process (Dyrbye *et al.*,2020; Maslach & Leiter, 2016). In contrast, supportive leadership and team solidarity are buffering organizational resources. Lack of PPE limited medical equipment and lack of infrastructure were also

significantly associated with higher degrees of burnout, more so at times crisis peaks as seen in COVID-19 pandemic (Morgantini *et al.*,2020; Lasalvia *et al.*,2021). Occupational stress is exacerbated in low-resourced settings where there is chronic scarcity of basic equipment, over-crowding and poorly developed infrastructure.

In Ghana, healthcare professionals are at increased risk of burnout due to system-level factors such as over-crowding, understaffing and high client-nurse ratios. In a study at three Ghanaian tertiary hospitals, Agyemang *et al.*, (2021) identified excessive workload, staffing gaps and weak institutional support as the biggest factors associated with emotional exhaustion among Ghanaian nurses.

2.4 Perceived Impact of Burnout on Healthcare Delivery and Health Worker Well-Being

Burnout in healthcare workers has significant consequences for health professionals and the healthcare delivery system which negatively affects patient outcomes. An emerging body of empirical evidence shows that burnout is related to increased medical errors, low patient satisfaction, poor workforce retention and profound psychological and physical health symptoms among healthcare workers.

2.4.1 Perceived Impact on Healthcare Delivery

One of the most frequently described effects of burnout is its impact on patient safety and quality of care. There are a number of studies that report on the impact between clinician burnout and rates of self-reported medical errors. Shanafelt *et al.*, (2010) reported that the prevalence of self-reported major medical errors was substantially greater in both physicians and residents who experienced burn-out than in those without burn-out. Similarly, Tawfik *et al.*, (2018) speculated about the mutual causation of burnout and errors (burnout results in making errors, and at the same time errors enhance burnout, forming a vicious cycle in clinical work).

The association of burnout with unprofessional behaviors and patient-centered care has also been described. West *et al.*, (2018), who discovered correlations between higher burnout in doctors as measured by the MBI-GS and decreased empathy, attention and communication with patients. Emotional exhaustion and depersonalization can distance healthcare professionals from the ability to feel empathy for patients, which may lead to less compassionate care interactions. Such disconnection is typically ineffective and negatively affects factors beyond treatment, adherence, and clinical results, such as decreasing patients' satisfaction and their trust in caregivers. Burnout has been tied to nurses' perception of less-than-ideal care. Vahey *et al.*, (2004) found that higher burnout rates among nurses significantly correlated with lower satisfaction among patients as well as poor patient outcomes. Likewise, Aiken *et al.*, (2002) demonstrated that hospitals employing more fatigued, dissatisfied nurses suffered higher mortality rates and worse quality-of-care scores. These findings point to burnout's implications for healthcare systems, and especially those of high-stakes acute care systems in which teamwork and collective success matter.

Burnout also precipitates staff turnover. Dyrbye *et al.*, (2017) revealed that those more prone to burnout were more inclined to reduce their clinical hours or quit employment. That has significant implications for health care systems, particularly those that are short on human resources. Moreover, increased staff turnover increases strain on remaining staff and increases the incidence of burnout, resulting in a negative, self-entrenched cycle of a shrinking workforce.

Absenteeism and presenteeism are also side-effects. Exhausted care providers are also more likely to be absent or on duty with reduced efficiency because of emotional or physical exhaustion.

This level of reduced productivity probably will translate into longer waiting times for patients, inefficient service delivery and lack of continuity of care.

2.4.2 Perceived Impact on Health Worker Well-Being

Outside the scope of healthcare delivery, burnout has major impacts on providers' mental and physical health. Emotional exhaustion is highly correlated with symptoms of anxiety, depression and psychological morbidity. In a systematic review and meta-analysis conducted by Salvagioni *et al.*, (2017) revealed burnout as an harbinger of depressive symptoms and other mental health problems. Continuous exposure to work-related stress without sufficient recovery leads to increased susceptibility to chronic psychological disorders.

Burnout has also been associated with sleep disturbances, fatigue and somatic complaints. Healthcare workers with high levels of burnout commonly report insomnia, headaches and gastrointestinal disturbances. When such somatic inquiries are made, these side effects worsen cognitive function and decision-making ability, which increases risks to provider and patient safety.

Critically, burnout has been linked with elevated substance abuse and suicidality in health care workers. Shanafelt *et al.*, (2011) reported a significantly higher prevalence of suicidal thoughts among the physicians with burnout than in the general working population. Various reasons lead to these conclusions, among which we find emotional exhaustion and feeling of incompetence.

They also negatively affect morale and commitment to the profession. Burnout in healthcare workers often correlates with decreased motivation, job satisfaction, and involvement in activities related to professional development. This trend has the potential to result in career attrition, especially for the early career healthcare workers who potentially re-evaluate their willingness to remain active in demanding clinical functions.

2.4.3 Organizational and System-Level Implications

Burnout at an organisational level is linked to increased costs for the organisation in terms of staff turnover, recruitment and training as well as wasted time. Han *et al.*, (2019) projected that turnover and diminished number of hours worked were associated with considerable annual economic harm attributable to burnout of physicians in the US. Such cost burdens are especially concerning in low and middle-income countries where health systems have limited budgets.

Burnout is also detrimental to working in a team, including interprofessional collaboration. Lack of motivation and depersonalisation may impair colleagues' interactions, cooperation and communication that can give rise to conflicts at work.

The burden of burnout may be even more significant in resource-limited settings such as most health care facilities in sub-Saharan Africa. Healthcare delivery systems have already been brought to the breaking point by high patient volumes, staff shortages and infrastructure constraints. Such oversight becomes even less effective when the personnel whose job it is are frequently absent or leave, and these systems may become “passive” sources of coverage, further undermining levels of access and quality.

2.5 Mitigation Strategies for Burnout in Healthcare Settings

To combat burnout in healthcare, the solution must be similarly comprehensive and aimed at balancing person and system with interventions at both individual resilience as well as organizational reform levels. The literature continually stresses that while person-focused interventions can offer temporary relief, lasting burnout reduction is most successful when personal strategies are embedded in a context of structural and organizational change (West *et al.*, 2016; Maslach & Leiter, 2016). Thus, successful mitigation strategies work at three inter-related levels - individual, team and the organizational/system level.

2.5.1 Individual-Level Interventions

The intended effects of interventions which are focused on individual level, is to promote coping resources, resilience and well-being. Typical methodologies include mindfulness-based stress reduction (MBSR), cognitive-behavioral techniques, resilience training, stress management programs, and self-care promotion.

West *et al.*, (2016) who conducted a systemic review and meta-analysis reported that burnout reduced significantly in both physician-targeted, organization-targeted interventions, however, personal strategies did reduce emotional exhaustion to some extent. Similarly, Lomas *et al.*, (2018) found that mindfulness-based interventions were effective in improving burnout and stress in health-care providers through emotional regulation and present moment awareness.

Resilience training courses have shown positive results as well. Sood *et al.*, (2011) found organisation-based resilience training was effective for physician stress management and anxiety reduction. Such programs typically involve strategies like cognitive reframing, the cultivation of gratitude and skills for tolerating uncertainty and emotional turbulence.

Encouragement of work–life balance is another important strategy at the individual level. Shanafelt *et al.*, (2012) found that physicians with better work–life balance also reported lower levels of burnout. Promoting good sleep, safeguarded time off, flexible hours and a clear separation between home and work commitments can all help with chronic fatigue.

Peer support initiatives also contribute to psychological resilience. Formal peer discussion groups, reflective practice meetings and mentorship schemes offer safe places where both emotions and professional vulnerabilities can be aired. Research has indicated that social connectedness and collegial relationships can act as a buffer in emotional exhaustion (West *et al.*, 2018). According to

Maslach and Leiter (2016), the causes of burnout are essentially organizational, not personal; an individual cannot recover from burnout by using personal strategies.

2.5.2 Organizational-Level Interventions

It is generally accepted that organizational-level interventions are more effective and sustainable than individual-level strategies. These interventions target systemic stressors related to workload, staffing, leadership adequacy, and work culture.

Workload and staff shortages are some of the best predictors of burnout (Dyrbye *et al.*,2020). Efforts to right-size staffing patterns, cycle tasks and alleviate administrative burden are beginning to yield positive results. Shanafelt *et al.*, (2017) reported that workflow redesign and team-based models of care enhanced job satisfaction among physicians and decreased emotional exhaustion. It is also essential to restrict these long working hours and reduce the frequency or quantity of work and rest. There is evidence that shortening shift length, and ensuring adherence to work-hour regulations could reduce fatigue-induced strain on health and well-being (West *et al.*,2016).

Support of leadership is also found to be the key to prevent burnout. Shanafelt and Noseworthy (2017) outlined nine organizational interventions to advance clinician well-being, such as embodying leadership commitment, cultivating community in practice, and connecting organizational values with professional purpose. Emotional leadership types that show compassion, are transparent and responsive will contribute to higher levels of staff engagement and feelings of burnout. According to Dyrbye *et al.*, (2017), doctors who perceived a higher level of autonomous work and greater engagement in organizational decision-making were less likely to experience burnout. The key is to create a culture of psychological safety in which employees believe they can raise concerns without reprisals. Awards and incentives increase morale. Only

fair remuneration, opportunities for career advancement and acknowledgment of professional contribution will help counteract feelings that they are undervalued and dehumanised.

2.5.3 Team-Based and Social Interventions

Interventions that reinforce links among the team and professional relationships are also of help in burnout prevention. Collective resilience benefits from team building efforts, interprofessional collaboration education, and debrief following a critical event.

For instance, structured forums which enable healthcare staff to reflect on the emotional aspects of care provision have been linked with increased levels of empathy and less emotional suffering amongst participants (Maben *et al.*, 2018). Such reflective clinical activities encourage shared understanding and the acceptance of emotional responses to difficult clinical encounters. Early career clinicians could particularly benefit from academic mentorship, given the double jeopardy they face for burnout. Formal mentoring supports professional growth, emotional support and job satisfaction.

2.5.4 Policy and System-Level Interventions

System-level policy changes are necessary to address the structural causes of burnout. Burnout is now viewed as a system-level problem that is fundamentally linked to the organizational structure of healthcare delivery and broader health policy, rather than being predominantly a manifestation of the weakness or character flaw prevalent in individual clinicians (Maslach & Leiter, 2016; Shanafelt & Noseworthy, 2017). In this sense, investing in infrastructure and workforce expansion in health care settings coupled with a proper distribution of resources is an essential part of a sustainable strategy to address burnout, especially in low- and middle-income countries where inherent weakness within the health systems can magnify occupational stress (WHO [World Health Organization], 2020). It has been shown that imbalances between job demands and resources (e.g.,

staff shortage, lack of organisational support) are strong drivers for emotional exhaustion and depersonalisation (Dyrbye *et al.*,2020; West *et al.*,2018).

Other systemic factors, such as high patient-to-staff ratios, over-crowding and restricted resources in resource-poor environments like Ghana also increase the risk of burnout. Literature from SSA revealed that long working hours and low staffing levels are powerful predictors of burnout among nurses and physicians (Agyemang *et al.*,2021; Muliira & Ssendikadiwa, 2016). Before the outbreak and while it occurs, complementing human resource planning and reinforcing the supply chain system as well as infrastructure facilities might help to mitigate chronic occupational stress caused by decreasing staff workload pressure and promoting work environment quality (WHO, 2020). Reforms that emphasize staffing ratios and distribution of resources across the system have been shown to be associated with greater declines in burnout prevalence as compared to interventions targeting the health care professionals themselves (Panagioti *et al.*,2017; West *et al.*,2016).

There is also the potential for digital solutions to be used to mitigate burnout. While in some cases EHR implementation has had unintended consequences, such as increased administrative burden and clinician dissatisfaction, well-crafted digital solutions that eliminate redundant documentation requirements and simplify overall workflows can in turn alleviate that stress if implemented properly (Downing *et al.*, 2018; Shanafelt *et al.*, 2016). Developing tools with a user-first mentality and ensuring their appropriate use with staff is paramount to preventing tech-related burnout.

Some countries have established national frameworks aimed at capturing clinician burnout and addressing it. Shanafelt and Noseworthy (2017) stress that burnout intervention efforts that come from the institution and include wellness committees, consistent measurement of burnout, and alignment of professional purpose and organizational values are vital to sustainable change. Institutional mental health services, confidential counselling programs, and structured peer-support

models are other components of a system-level commitment to healthcare worker well-being that have been linked to higher morale and lower emotional exhaustion (West *et al.*, 2016; Maslach & Leiter, 2016).

2.5.5 Integrated and Multilevel Approaches

The predominant mechanism for mitigating burnout in healthcare workers is probably through combined interventions that combine individual and organizational level factors. A review and meta-analysis performed by West *et al.*, (2016) found that, relative to physician-directed interventions alone, organization-directed interventions including reshaping of workflows, adjustment of workload and infrastructure changes achieve greater and more durable reduction in burnout. Similarly, Panagioti *et al.*, (2017) however, found that system-focused changes were more effective compared to person-centered approaches in high-intensity clinical settings. These results support the theoretical model proposed by Maslach and Leiter (2016) in which burnout is assumed to derive from a long-term discrepancy of some characteristics of workers and fundamental aspects of work, such as workload, control, reward, community, fairness, values. Interventions should therefore target individual coping ability as well as institutional structures. Shanafelt and Noseworthy (2017) additionally reiterate leadership involvement and organizational responsibilities are critical to attain sustainable reductions in burnout.

An inclusive mitigation approach values lessening excessive work and administrative demands as one of the most direct predictors for emotional exhaustion and depersonalization (Dyrbye *et al.*, 2020; West *et al.*, 2018). Simplifying the documentation burden, optimizing staff models and freeing up front-line staff from non-clinical responsibilities are some actions that organizations can implement that contribute to reducing their clinicians' burnout.

Simultaneously, improving the level of leadership engagement within the organization is critical to any strategy of reducing burnout. Supportive, transparent and engaged leaders are less likely to report burnouts and have higher levels of job satisfaction because they help create the overall culture of the work environment by championing a fair, trust-building approach (Shanafelt & Noseworthy, 2017).

Developing a team-based approach to burnout reduction is also an important feature of any multi-component approach to addressing the problem. Healthy team dynamics and supportive work cultures protect against burnout and promote feelings of meaning at work. For example, West et al. (2016) found that providing formal opportunities for small group discussion among team members and implementing team-level change interventions are linked to greater engagement and lower levels of burnout. In addition to team-level efforts, interventions aimed at enhancing resilience and mental well-being via mindfulness training and resilience-building programs, as well as providing confidential access to counseling services result in small, albeit significant, reductions in burnout (Lomas *et al.*, 2018; West et al. 2018).

Finally, the policy and structural reforms need to be consolidated for their sustainability. Advocating sufficient staffing, efficient resource distribution and managing institutional appraisal with professional ethos will also contribute to long-term empowerment and mitigating stressors at the systemic level (Maslach & Leiter, 2016; Panagioti *et al.*, 2017). These holistic, systemic approaches recognize that burnout is both a personal and system phenomenon and must be addressed in parallel: with attention to the resilience of individual clinicians and through significant changes in how organizations operate.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Research Methods and Design

A study's research design acts as a guideline that offers information on the type of research performed, the type of data to be used and how data will be analysed (Creswell & Creswell, 2017; Sharma *et al.*, 2023). This was a cross-sectional study carried out to determine the factors associated with health worker burnout, explore its implications and possible approaches for preventing it. The cross-sectional design enables data to be gathered at one time point and gives snapshot of burnout levels and other constructs in the two different healthcare contexts (Creswell & Creswell, 2017).

3.2 Data Collection Techniques and Tools

Salmia (2023) defined a research instrument as a technique or device employed to collect data in the research context. In this study, the researcher employed closed-ended survey questionnaires as the chosen tool for data collection. The questions were adapted from a standardized burnout tool called the Maslach-Burnout-Inventory tool. To ensure the content validity of the instrument, the questionnaire was reviewed by the research supervisor and other experts in the field of healthcare management and research methodology. Their feedback helped refine the wording, relevance, and clarity of the items to ensure that the instrument adequately measured the study variables.

The reliability of the instrument was supported by the established psychometric properties of the Maslach Burnout Inventory, which has been widely validated in previous studies.

3.3 Study Population

Banerjee and Chaudhury (2010) define the target population as the population to which the researcher wants to generalise the result of the study. The target population in this research study

was the medical staff of the LEKMA Hospital. These include doctors, nurses , and all other staff. The population of staff at the LEKMA Hospital was 520.

3.4 Study Variables

To give a good empirical balance of burnout, independent, dependent, and moderating factors including all variables were considered to provide an organized analytical way to understand what is burning out and how it might be stopped.

3.4.1 Independent Variables

The independent variables were significant factors in the workplace predisposed to burnout. These include:

1. Workload – Amount of work in the form of working hours, number of patients to treat and administrative duties.
2. Resource Availability – Medical equipment, staff availability and continuing education.
3. Management Support – Quality of leadership, staff engagement, existence of support services.
4. Work-Life Balance – Balancing work responsibilities with personal life.

3.4.2 Dependent Variables

The outcomes of burnout, specifically its personal and organizational consequences, are measured using these dependent variables:

1. Emotional Exhaustion Levels – Evaluated through self-assessments of stress and emotional distress.
2. Job Satisfaction – Determined by the degree to which healthcare professionals feel engaged, motivated, and satisfied with their career.

3. Turnover Rates – Calculated based on retention levels and resignation trends within healthcare facilities.
4. Patient Care Quality – Measured through medical error frequency, patient satisfaction surveys, and overall treatment efficacy.

3.4.3 Moderating Variables

The link between job demands and burnout results is affected by moderating variables, which affect the intensity and diversity of burnout manifestations:

1. Coping Mechanisms – The availability of self-care practices, mental health services, and support from peers.
2. Institutional Interventions – The presence of employee wellness initiatives, leadership encouragement, and protocols for preventing burnout.

3.5 Sampling

Sampling refers to the process of choosing a subset of individuals, objects, events, or phenomena from a larger population for research purposes (Turner, 2020). In the present study, multi-stage sampling techniques were used by the researcher to check how similar those working individuals are within the population. Sampling strata were defined as the different departments in the Hospital and a simple random sampling method was applied to select participants within each department. Sample size estimation was estimated based on Yamane's (1967) formula.

$$n = \frac{N}{\{(1 + N(e_2))\}}$$

Where:

n = sample size

N = staff population the Hospital (520)

e = margin of error (let's use 5% or 0.05)

Therefore,

$$n = \frac{520}{1 + 520 (0.05)^2} \approx 228$$

To accommodate a potential non-response or incomplete data, a slightly larger sample size was used. An additional non-response rate of 10% was estimated on the projected sample size which resulted in the final adjusted sample size of $228 + (0.10 \times 228) = 250$.

The proportional allocation techniques were then used to determine the stratum size needed for each of the selected Departments using the formula;

$$n_h = \frac{N_h}{N} \times n$$

where

n_h = projected sample size of a particular Department

N_h = Population size of a particular Department N

= Total staff population of the Hospital

n = working sample size

The Department-focused sample size is displayed in **Table 1** below;

Table 1: Required sample sizes by Department

Department	Population (Nh)	Sample Size (nh)
Medical	173	83
Obstetrics & Gynaecology	84	40
Allied Health	94	45
Pharmacy	44	21
Diagnostic	45	22
Non-Clinical Staff	80	38
Total	520	250

Source: *Field Data, 2026*

3.6 Pre-testing

The questionnaire was pretested at the Mamprobi Hospital (a facility with similar characteristics as the LEKMA Hospital), with twenty (20) respondents to validate the tool. The pretesting sought to define the time frame per questionnaire per respondent as well as reliability and validity issues. This was aimed at establishing an easy-to-understand question, the suitability of the questions posed, adequacy of response options provided, and the need for additional or removal of existing questions to ensure that relevant data is collected. Appropriate revisions were made to questionnaires where necessary before actual data collection. Pretesting has the capacity to reduce sampling errors and increase questionnaire response rates.

3.7 Data Handling

Prior to the commencement of the study, an official permission letter was submitted to the Administration of the LEKMA Hospital requesting approval to conduct the research within the facility. The study's aim, its goals, methods for gathering data, and how the research would protect the rights and safety of all participants were clearly specified in the letter. The process of collecting data began only once official permission was given by the hospital administrators.

The study was carried out at LEKMA Hospital. In order to enable fast and secure data collection, a questionnaire was constructed using Google Forms. Electronic data collection was chosen to limit data entry errors, maximize ease of use, and capture data in real-time. The survey link was shared with respondents via the hospital's WhatsApp group, as well as directly through the respondents to increase participation and improve inclusivity.

3.8 Data Analysis

For the analysis of data, the Statistical Package for Social Science was used. Descriptive and Inferential statistics were performed on the data that were collected via a questionnaire.

Burnout was measured using the Maslach Burnout Inventory–Human Services Survey (MBI-HSS), developed by Christina Maslach and Susan E. Jackson (Maslach & Jackson, 1981). This tool is made up of 22 items, with each question belonging to one of the three scales – Emotional Exhaustion (EE) (9 questions), Depersonalization (DP) (5 questions), and Personal Accomplishment (PA) (8 questions). A 7-point Likert scale ranging from 0 (Never) to 6 (Every day) was used to answer each question.

The scores for each sub-scale were summed up and classified based on the standard cut-off values of the MBI-HSS, as follows:

Table 2: Standard MBI-HSS cut-off scores

Burnout Dimension	Low	Moderate	High
Emotional Exhaustion (EE)	0–16	17–26	≥ 27
Depersonalization (DP)	0–6	7–12	≥ 13
Personal Accomplishment (PA)*	≥ 39	32–38	≤ 31

*For the Personal Accomplishment subscale, lower scores indicate higher burnout, whereas higher scores indicate lower burnout.

Overall burnout was determined using the conventional MBI-HSS criteria, whereby respondents were classified as experiencing burnout if they reported high Emotional Exhaustion ($EE \geq 27$) together with either high Depersonalization ($DP \geq 13$) or low Personal Accomplishment ($PA \leq 31$) (Maslach et al., 1996; Maslach & Leiter, 2016).

3.9 Ethical Consideration

The following ethical issues were considered whilst performing the research which involved;

1. The researcher treated the details given by the respondents with confidentiality and protected their privacy. This was done by ensuring that any questionnaire obtained from the respondents was kept safe and, for whatever cause, not made available to any third party.
2. To protect the privacy of the respondents, the researcher ensured that the questionnaire did not include a section allowing them to provide information that would reveal their identity.

3. The respondents were also adequately briefed on the study's intent. This helped the participants to decide whether to take part in the research. In no way were the respondents coerced against their will to participate. Participation was entirely voluntary.
4. This study also sought ethical clearance from the Institutional Review Board (IRB) of Ensign Global University and the Ghana Health Service Ethics Review Committee to ensure compliance with ethical standards for research involving human participants. Additionally, written approval was obtained from the administration of LEKMA Hospital prior to data collection. The clearance process involved submitting a detailed research protocol outlining the study's purpose, methodology, participant recruitment, informed consent procedures, and measures to protect confidentiality and anonymity. All ethical guidelines, including voluntary participation, informed consent, and secure data handling, were strictly adhered to throughout the study.

3.10 Limitations of Study

Despite the valuable insights generated, this study has some limitations that should be considered when interpreting the findings.

First, the study employed a cross-sectional design, which limits the ability to establish causal relationships between burnout and associated factors.

Second, the study was conducted in a single healthcare facility (LEKMA Hospital), which may limit the generalizability of the findings to other hospitals or regions in Ghana.

Third, data were collected using self-reported questionnaires, which may be subject to response bias, including social desirability bias and recall bias.

Fourth, the relatively small number of participants classified as burned out ($n = 20$) may have reduced statistical power, particularly in inferential analyses examining associations between mitigation strategies and burnout status. Small cell counts necessitated the use of Fisher's Exact test to improve robustness, but larger sample sizes would provide stronger analytical precision.

Despite these limitations, the study provides important baseline data on burnout prevalence, associated factors, and institutional response within LEKMA Hospital, offering valuable guidance for future research and organizational interventions.

Another limitation of this study is that it assessed respondents' perceptions of the availability of burnout mitigation strategies rather than their actual utilization or effectiveness. Consequently, participants may have reported that these strategies were available at the hospital without having personally accessed or benefited from them. Therefore, the findings should be interpreted as associations between the perceived availability of mitigation strategies and burnout status rather than evidence that these strategies reduce burnout. Future studies should assess the utilization and effectiveness of these interventions using longitudinal or intervention-based research designs.

3.11 Assumptions

The following assumptions underpinned this study:

There were three limitations to the present research. The research, however, admits the limitation associated with a self-administered questionnaire in considering the honesty of participants when answering about their burnout levels and work-related and management support.

Second, this study assumed that the MBI-HSS is a valid and reliable measure for detecting burnout among healthcare workers at LEKMA Hospital.

Third, it was assumed that the 250 healthcare workers were representative of the various occupational categories in LEKMA Hospital. This is a justification for generalizing the findings within the hospital.

CHAPTER FOUR

4.0 RESULTS

4.1 Background Information

A total of 250 participants were involved in this study. The age category of the respondents is presented in Table 2 below which majority of 94 (37.6%) were under 25–29 years, followed by 71 (28.4%) that was aged 30–34 years old. Also, 49 (19.6%) were aged 35–39, 29 (11.6%) were aged 40–44, and only 7 (2.8%) were aged between 45 and 49 years. In terms of gender, female health workers were more than males, with 176 (70.4%) compared to 74 (29.6%), evidently showing the relatively higher proportion of females compared to males among healthcare staff at LEKMA Hospital.

With respect to marital status, 125 (50.0%) of the patients were married, 121 (48.4%) were single, and 4 (1.6%) were divorced. Regarding educational qualifications, 66 (26.4%) held Certificate or Diploma degrees, and 157 (62.8%) had a Bachelor's degree. In addition, 15 (6.0%) had a Master's degree, and 12 (4.8%) were specialists. The largest proportion of respondents, 82 (32.8%), were from the Medical Department, followed by Allied Health professionals, comprising 45 (18.0%), and those from the Obstetrics and Gynaecology Department, who represented 40 (16.0%) of the respondents.

In terms of years of experience working in the healthcare sector, 16 (6.4%) had less than one year of experience, 46 (18.4%) had 1–2 years of experience, most respondents 101 (40.4%) had 3–5 years of experience, followed by 64 (25.6%) with 6–10 years. A smaller proportion, 23 (9.2%), had more than 10 years of experience.

Regarding the day-to-day work schedules of the respondents, 52 (20.8%) preferred the day shifts, 20 (8.0%) preferred night shifts, 92 (36.8%) preferred mixed shifts, and 86 (34.4%) preferred

rotational shifts. With regard to average weekly working hours, 12 (4.8%) worked less than 30 hours, 44 (17.6%) worked 30–39 hours, most respondents 167 (66.8%) worked 40–48 hours per week, while 15 (6.0%) worked 49–60 hours, and 12 (4.8%) worked more than 60 hours per week (Table 3).

Table 3: Socio-Demographic Characteristics of Participants

Variable	Category	Frequency (N)	Percentage (%)
Age (years)	25–29	94	37.6
	30–34	71	28.4
	35–39	49	19.6
	40–44	29	11.6
	45–49	7	2.8
Gender	Male	74	29.6
	Female	176	70.4
Marital Status	Single	121	48.4
	Married	125	50.0
	Divorced	4	1.6
Highest Educational Qualification	Certificate/Diploma	66	26.4
	Bachelor’s Degree	157	62.8
	Master’s Degree	15	6.0
	Specialist	12	4.8
Department/Unit	Medical	83	32.8
	Obstetrics & Gynaecology	40	16.0
	Allied health	45	18.0
	Pharmacy	21	8.4
	Diagnostic	22	8.8

	Non-Clinical	38	15.2
Years of Experience	<1 year	16	6.4
	1–2 years	46	18.4
	3–5 years	101	40.4
	6–10 years	64	25.6
	>10 years	23	9.2
Shift Pattern	Day	52	20.8
	Night	20	8.0
	Mixed	92	36.8
	Rotational	86	34.4
Average Weekly Working Hours	<30 hours	12	4.8
	30–39 hours	44	17.6
	40–48 hours	167	66.8
	49–60 hours	15	6.0
	>60 hours	12	4.8

Source: *Field data 2026*

4.2 The prevalence and levels of burnout among healthcare workers at the LEKMA Hospital

The Maslach Burnout Inventory–Human Services Survey (MBI-HSS) classification of burnout was used to categorize burnout into Emotional Exhaustion (EE) (9 items), Depersonalization (DP) (5 items), and Personal Accomplishment (PA), (8 items) (Maslach & Jackson, 1981; Maslach & Leiter, 2016). Responses were first scored on a Likert scale ranging from 0 (Never) to 6 (Every day), after which item scores were summed to obtain aggregate scores for each dimension. These scores were then categorized into low, moderate, and high levels using standard MBI cut-off values (Maslach & Leiter, 2016; Edu-Valsania *et al.*, 2022). Overall, burnout was defined as high

emotional exhaustion combined with either high depersonalization or low personal accomplishment (Dall'Ora *et al.*, 2020).

In terms of emotional exhaustion (EE), most respondents, 145 (58.0%), reported high levels, 57 (22.8%) moderate levels, and 48 (19.2%) low levels. In terms of depersonalisation (DP), most respondents, 164 (65.6%) showed low levels, 68 (27.2%) had moderate levels, and only 18 (7.2%) reported high levels. In terms of Personal Accomplishment (PA), most respondents, 137 (54.8%) showed strong levels of PA, indicating less burnout in this area. However, 26 (10.4%) experienced moderate levels of burnout, and 87 (34.8%) expressed low personal accomplishment, which suggests higher levels (Table 4).

Table 4: The distribution of burnout levels across the three dimensions of the Maslach Burnout Inventory–Human Services Survey (MBI-HSS).

Subscale	Burnout Level	Frequency (N)	Percentage (%)
Emotional Exhaustion (EE)	High	145	58.0
	Moderate	57	22.8
	Low	48	19.2
Depersonalization (DP)	High	18	7.2
	Moderate	68	27.2
	Low	164	65.6
Personal Accomplishment (PA)	High (Low Burnout)	137	54.8
	Moderate	26	10.4
	Low (High Burnout)	87	34.8

Source: Field data 2026

4.2.1 Overall Burnout Prevalence

Overall burnout prevalence was determined using a composite criterion based on the Maslach Burnout Inventory–Human Services Survey (MBI-HSS). Respondents were classified as experiencing burnout if they reported high emotional exhaustion together with either high depersonalization or low personal accomplishment (Maslach & Leiter, 2016; Dall’Ora *et al.*, 2020).

The findings show that 38 (15.2%) of the respondents were categorised as burnt out using the combined burnout criteria of severe emotional exhaustion and either high depersonalisation or low personal accomplishment, and most of the respondents 212 (84.8%), were not (Figure 3).

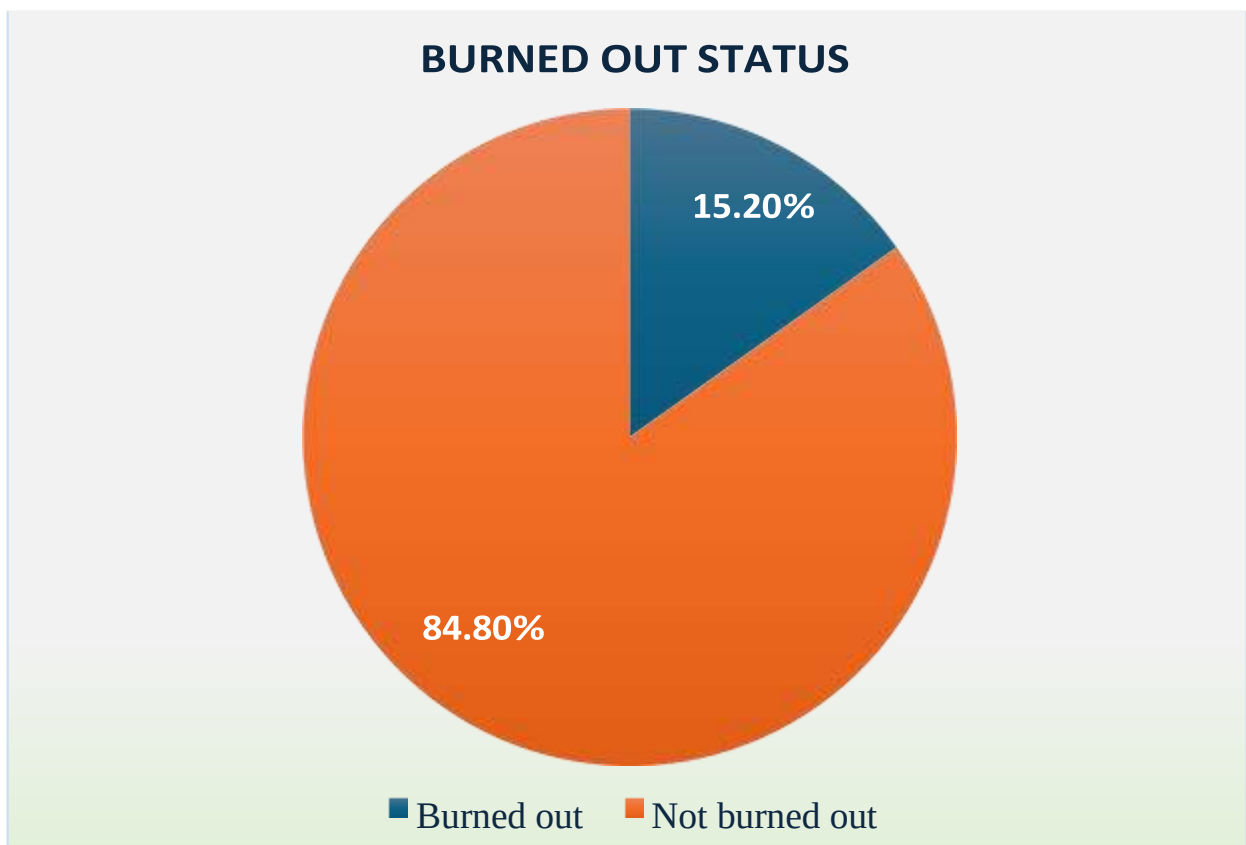


Figure 3: Overall Burnout Prevalence

4.3 Bivariate Analysis of Socio-Demographic Factors with Burnout Among Respondents

From the analysis of individual and workplace factors, there was no statistically significant association between burnout and the socio-demographic characteristics of healthcare workers at LEKMA Hospital (Table 5). With respect to age, burnout prevalence was relatively similar across most age groups, ranging from 13.8% to 15.5%, except for respondents aged 45–49 years, who recorded a higher prevalence of 28.6%.

Similarly, gender was not significantly associated with burnout ($p = 0.231$), as 14.9% of the males and 15.3% of the females had experienced burnout. Burnout prevalence was comparable in single (14.9%) and married (15.2%) respondents but slightly higher among the divorced (25.0%) participants. These differences were however not statistically significant ($p = 0.678$). Also, there was no significant difference in burnout prevalence with the educational qualifications ($p = 0.845$) since burnout was relatively similar in respondents with different levels of education. Burnout prevalence ranged from 13.6% in the diagnostic units to 18.4% in the non-clinical departments and these differences were not significant ($p = 0.611$). Burnout appears to affect staff across different departments in LEKMA. Furthermore, there was no significant difference in burnout among the respondents with different years of healthcare work ($p = 0.602$). Burnout was however slightly higher in those with over 10 years of healthcare work experience (17.4%). There was also no significant difference in burnout prevalence by the shift pattern ($p = 0.719$). Burnout was prevalent throughout the day (15.4%), night (15.0%), mixed (15.2%), and in a rotational (15.1%) shifts. No significant difference in burnout levels was found between the hours worked ($p = 0.681$) where respondents who worked less than 30 hours (16.7%), 30 to 39 hours (15.9%), 40 to 48 hours (15.0%), 49 to 60 hours (13.3%), and more than 60 hours (16.7%).

Table 5: Association Between Socio-demographic Characteristics and Burnout Status

Variable	Category	Burnout Status		P-value
		Yes (%)	No (%)	
Age (years)	25–29	14 (14.9)	80 (85.1)	0.412
	30–34	11 (15.5)	60 (84.5)	
	35–39	7 (14.3)	42 (85.7)	
	40–44	4 (13.8)	25 (86.2)	
	45–49	2 (28.6)	5 (71.4)	
Gender	Male	11 (14.9)	63 (85.1)	0.231
	Female	27 (15.3)	149 (84.7)	
Marital Status	Single	18 (14.9)	103 (85.1)	0.678
	Married	19 (15.2)	106 (84.8)	
	Divorced	1 (25.0)	3 (75.0)	
Highest Educational Qualification	Certificate/Diploma	10 (15.2)	56 (84.8)	0.845
	Bachelor's Degree	24 (15.3)	133 (84.7)	
	Master's Degree	2 (13.3)	13 (86.7)	
	Specialist	2 (16.7)	10 (83.3)	
Department/Unit	Medical	12 (14.6)	70 (85.4)	0.611
	Obstetrics & Gynaecology	6 (15.0)	34 (85.0)	
	Allied health	7 (15.6)	38 (84.4)	

	Pharmacy	3 (14.3)	18 (85.7)	
	Diagnostic	3 (13.6)	19 (86.4)	
	Non-Clinical Departments	7 (18.4)	31 (81.6)	
Years of Experience	<1 year	2 (12.5)	14 (87.5)	0.602
	1–2 years	7 (15.2)	39 (84.8)	
	3–5 years	15 (14.9)	86 (85.1)	
	6–10 years	10 (15.6)	54 (84.4)	
	>10 years	4 (17.4)	19 (82.6)	
Shift Pattern	Day	8 (15.4)	44 (84.6)	0.719
	Night	3 (15.0)	17 (85.0)	
	Mixed	14 (15.2)	78 (84.8)	
	Rotational	13 (15.1)	73 (84.9)	
Average Weekly Working Hours	<30 hours	2 (16.7)	10 (83.3)	0.681
	30–39 hours	7 (15.9)	37 (84.1)	
	40–48 hours	25 (15.0)	142 (85.0)	
	49–60 hours	2 (13.3)	13 (86.7)	
	>60 hours	2 (16.7)	10 (83.3)	

Source: Field data, 2026

4.4 Bivariate Analysis of Workplace Factors with Burnout among Respondents

Analysis of the data (Table 6) revealed that several workplace factors had a statistically significant association with burnout among HCWs at LEKMA Hospital.

Management support had a significant association with burnout ($p = 0.002$); those that agreed that support was poor had a relatively higher burnout prevalence of (21.0%) compared to the (12.5%) among the neutral, and (10.0%) among those that disagreed, thereby suggesting that poor managerial support is an important contributor to burnout. Poor work–life balance had a significant association with burnout ($p < 0.001$); among those that agreed that the work–life balance was poor, a higher burnout prevalence of (23.0%) was recorded compared with (11.3%) among the neutral, and (8.6%) among the disagree. Frequent night shifts/unusual work schedules had a significant association with burnout ($p < 0.001$); among the group that agreed that night shifts were frequent, the highest burnout prevalence was recorded (22.0%) compared to the (12.5%) among the neutral, and (8.6%) among those that disagreed. Working long hours had a significant association with burnout ($p = 0.015$); those that agreed on the long hours worked, burnout prevalence was higher (19.0%) than the counterpart. Lack of resources had a significant association with burnout ($p = 0.001$); those that agreed that resources were lacking, burnout was higher (20.0%) than those that were neutral (12.5%) and disagree (11.4%).

Excessive workload had no significant association with burnout ($p = 0.085$). There was no significant association of unfair treatment/favouritism ($p = 0.114$), and high emotional demands at work ($p = 0.148$). Lack of resources ($p = 0.001$) had a significant association with burnout, while low salaries or delays in payments ($p = 0.226$) did not. Difficult patients/clients ($p = 0.226$) did not have any significant association with burnout at LEKMA Hospital. Furthermore, the study revealed that poor infrastructure ($p = 0.371$), lack of recognition ($p = 0.403$), staff shortage ($p = 0.536$), lack

of career growth/training ($p = 0.589$), and poor communication in the team ($p = 0.602$) did not have a significant association with burnout in the study setting as the level of burnout was almost the same in their respective categories.

Table 6: Association Between Workplace Factors and Burnout Status

Variable	Categories	Burnout Status		P-Value
		Yes (n, %)	No (n, %)	
Poor management support	Agree	21 (21.0)	79 (79.0)	0.002*
	Neutral	10 (12.5)	70 (87.5)	
	Disagree	7 (10.0)	63 (90.0)	
Lack of work–life balance	Agree	23 (23.0)	77 (77.0)	<0.001*
	Neutral	9 (11.3)	71 (88.7)	
	Disagree	6 (8.6)	64 (91.4)	
Frequent night shifts/unpredictable schedules	Agree	22 (22.0)	78 (78.0)	<0.001*
	Neutral	10 (12.5)	70 (87.5)	
	Disagree	6 (8.6)	64 (91.4)	
Long working hours	Agree	19 (19.0)	81 (81.0)	0.015*
	Neutral	11 (13.8)	69 (86.2)	
	Disagree	8 (11.4)	62 (88.6)	
Excessive workload	Agree	17 (17.0)	83 (83.0)	0.085
	Neutral	11 (13.8)	69 (86.2)	

	Disagree	10 (14.3)	60 (85.7)	
Lack of resources	Agree	20 (20.0)	80 (80.0)	0.001*
	Neutral	10 (12.5)	70 (87.5)	
	Disagree	8 (11.4)	62 (88.6)	
	Agree	16 (16.0)	84 (84.0)	0.114

Unfair treatment/favoritism	Neutral	12 (15.0)	68 (85.0)	
	Disagree	10 (14.3)	60 (85.7)	
High emotional demands	Agree	15 (15.0)	85 (85.0)	0.148
	Neutral	12 (15.0)	68 (85.0)	
	Disagree	11 (15.7)	59 (84.3)	
Low salary/delayed payment	Agree	14 (14.0)	86 (86.0)	0.226
	Neutral	13 (16.3)	67 (83.7)	
	Disagree	11 (15.7)	59 (84.3)	
Difficult patients/clients	Agree	14 (14.0)	86 (86.0)	0.226
	Neutral	13 (16.3)	67 (83.7)	
	Disagree	11 (15.7)	59 (84.3)	
Poor infrastructure	Agree	13 (13.0)	87 (87.0)	0.371
	Neutral	13 (16.3)	67 (83.7)	
	Disagree	12 (17.1)	58 (82.9)	
Lack of recognition	Agree	13 (13.0)	87 (87.0)	0.403

	Neutral	12 (15.0)	68 (85.0)	
	Disagree	13 (18.6)	57 (81.4)	
Staff shortages	Agree	12 (12.0)	88 (88.0)	0.536
	Neutral	14 (17.5)	66 (82.5)	
	Disagree	12 (17.1)	58 (82.9)	
Lack of career growth/training	Agree	12 (12.0)	88 (88.0)	0.589
	Neutral	13 (16.3)	67 (83.7)	
	Disagree	13 (18.6)	57 (81.4)	
Poor communication within the team	Agree	11 (11.0)	89 (89.0)	0.602
	Neutral	14 (17.5)	66 (82.5)	
	Disagree	13 (18.6)	57 (81.4)	

Source: Field data, 2026 * Statistically significant factors

4.5 The perceived impact of burnout on healthcare delivery and health worker well-being at the LEKMA Hospital

Multiple factors, both in relation to the delivery of health care and in terms of health worker wellbeing, were found to be significantly associated with burnout. Respondents who reported burnout were significantly more likely to report ($\chi^2 = 36.724$, $p < 0.001$). Also, significant associations were found between burnout and difficulty maintaining a healthy work-life balance ($\chi^2 = 35.338$, $p < 0.001$) and decreased job satisfaction ($\chi^2 = 29.248$, $p < 0.001$). In addition, those who reported burnout also were less focused on their activities ($\chi^2 = 24.538$, $p < 0.001$), suggesting that burnout may negatively affect work performance and efficiency. In addition, burnout was also

significantly associated with emotional exhaustion after work ($\chi^2 = 14.732$, $p = 0.002$) and a lack of empathy or decreased empathy towards patients and colleagues ($\chi^2 = 12.404$, $p = 0.006$). In addition, healthcare workers who reported burnout also more frequently reported an increase in mistakes or errors in their work ($\chi^2 = 11.242$, $p = 0.010$) and more negative interactions with their family and friends ($\chi^2 = 9.738$, $p = 0.021$). Burnout was also significantly associated with symptoms such as headaches and fatigue ($\chi^2 = 7.836$, $p = 0.045$). Burnout was also significantly associated with negative interactions with patients or clients ($\chi^2 = 54.455$, $p < 0.001$) and, therefore, potentially affecting the quality of health care provided. However, in this study, a desire to leave the healthcare profession was not found to be significantly associated with burnout ($\chi^2 = 6.231$, $p = 0.078$).

Fisher's Exact test was run to verify the results of the Chi-square analysis and especially to address any potential issues associated with small cell size. The results of Fisher's Exact test mirrored the results from the Chi-square test. Specifically, Fisher's Exact test showed a significant association between burnout and a lack of motivation ($p < 0.001$), decreased concentration ($p < 0.001$), difficulty maintaining a healthy work-life balance ($p < 0.001$), and decreased job satisfaction ($p < 0.001$). In addition, significant associations were demonstrated between burnout and emotional exhaustion after work ($p = 0.004$), decreased empathy towards patients or colleagues ($p = 0.009$), negative interactions with family and friends ($p = 0.031$), and symptoms such as headaches and fatigue ($p = 0.048$). Significant associations were also seen between burnout and negative interactions with patients or clients ($p < 0.001$). However, increased work errors ($p = 0.052$) and a desire to leave the healthcare profession ($p = 0.101$) were not significant at the 0.05 level (Tables 7 and 8).

Table 7: Association Between Burnout Status and Perceived Impacts on Healthcare Delivery and Health

Worker Well-being (Chi-square)

Impact Item	χ^2	df	p-value
I feel less motivated to perform my duties	36.724	2	<0.001
I find it difficult to maintain a healthy work-life balance	35.338	2	<0.001
My job satisfaction has decreased significantly	29.248	2	<0.001
Burnout has reduced my ability to concentrate on tasks	24.538	2	<0.001
I feel emotionally exhausted after work	14.732	1	0.002
I feel detached or less empathetic toward patients or colleagues	12.404	2	0.006
I have noticed an increase in mistakes or errors in my work	11.242	2	0.010
Burnout has strained my relationships with family and friends	9.738	2	0.021
	7.836	2	0.045
I experience frequent headaches, fatigue, or other physical symptoms			
Burnout has affected my interactions with patients/clients	54.455	2	<0.001
Burnout has led me to consider leaving the healthcare profession	6.231	2	0.078

Source: *Field data, 2026*

Table 8: Fisher's Exact Test Confirmation (Agree vs Not Agree)

Perceived Impact Item	Fisher p-value
I feel less motivated to perform my duties	<0.001
Burnout has reduced my ability to concentrate on tasks	<0.001

I find it difficult to maintain a healthy work-life balance	<0.001
My job satisfaction has decreased significantly	<0.001
I feel emotionally exhausted after work	0.004
I feel detached or less empathetic toward patients or colleagues	0.009
Burnout has strained my relationships with family and friends	0.031
I experience frequent headaches, fatigue, or other physical symptoms	0.048
I have noticed an increase in mistakes or errors in my work	0.052
Burnout has affected my interactions with patients/clients	<0.001
Burnout has led me to consider leaving the healthcare profession	0.101

Source: *Field data, 2026*

4.6 Mitigation strategies for burnout among workers at the LEKMA Hospital

Multiple strategies for reducing fatigue were reported to be implemented at LEKMA Hospital when descriptive analysis was conducted. The primary method identified was the establishment of recognition and incentive systems for staff. 72.4% of respondents confirmed their presence, while 27.6% denied it. Similarly, 69.2% of respondents confirmed that regular staff meetings were held to provide feedback and support, while 30.8% disputed the frequency of these meetings. Moreover, 63.6% of participants acknowledged stress management training as a strategy provided by the school, whilst 36.4% opposed this view.

Furthermore, peer support groups or counseling services were reported by 62.8% of respondents, while 37.2% disagreed. Wellness initiatives such as fitness programs were also identified as a mitigation strategy by 61.2% of respondents, whereas 38.8% disagreed. In addition, flexible work

schedules were acknowledged by 59.6% of respondents, while 40.4% reported that such flexibility was not available. Lastly, employee assistance programs (EAP) were reported by 57.6% of respondents, with 42.4% indicating that such programs were not available (Tables 9 and 10).

Table 9: Frequency Distribution of Mitigation Strategies for Burnout

Strategy	Agree (%)	Disagree (%)
Recognition and reward systems for staff	72.4	27.6
Regular staff meetings for feedback/support	69.2	30.8
Stress management training	63.6	36.4
Peer support groups or counseling	62.8	37.2
Wellness initiatives (fitness programs)	61.2	38.8
Flexible work schedules	59.6	40.4
Employee assistance programs (EAP)	57.6	42.4

Source: *Field data, 2026*

Table 10: Association Between Mitigation Strategies and Burnout Status

Strategy	χ^2	p-value
Peer support groups/counseling	10.441	0.001
Regular staff meetings	6.876	0.009

Flexible work schedules	4.126	0.042
Stress management training	6.382	0.012
Employee assistance programs	12.844	<0.001
Wellness initiatives	11.337	0.001
Recognition and reward systems	8.718	0.003

Source: *Field data, 2026*

4.7: Multivariate Logistic Regression Analysis

A multivariable logistic regression analysis was performed to evaluate independent risk factors for burnout among healthcare workers at LEKMA Hospital (Table 11). According to the final logistic regression analysis, most socio-demographic variables and workplace factors were not significantly associated with burnout among healthcare workers. With respect to age, the difference between the categories was not statistically significant. Respondents in the age group of 45 to 49 years had higher burnout odds than in the age group of 25 to 29 years (AOR = 2.01); however, the association was not statistically significant ($p = 0.438$). With respect to gender, the difference between females and males was not significant for burnout (AOR = 1.01, $p = 0.981$). The difference was also not significant among respondents married, divorced and single for burnout. Educational qualification did not significantly influence burnout, as all categories demonstrated odds ratios close to one with non-significant p-values. The difference between the variables, department /unit,

years of experience, shift pattern and average weekly working hours, was not statistically significant for burnout among healthcare workers.

Respondents who agreed that poor management support was one of the workplace factors which contributed for burnout had significantly higher burnout odds than who disagreed (AOR = 2.68, 95% CI = 1.32 to 5.41, $p = 0.006$). Although respondents who were neutral had higher burnout odds than disagree, the association was not significant for burnout. Respondents who agreed that lack of work–life balance was one of the workplace factors which contributed for burnout had significantly higher burnout odds than who disagreed (AOR = 2.05, $p = 0.004$).

Although respondents who were neutral had higher burnout odds than disagree, the association was not significant for burnout. Respondents who agreed that night shifts and unpredictable schedules were one of the workplace factors which contributed to burnout had significantly higher burnout odds than who disagreed (AOR = 1.89, $p = 0.011$). Respondents who agreed that long working hours were one of the workplace factors which contributed to burnout had significantly higher burnout odds than who disagreed (AOR = 1.52, $p = 0.028$). Although respondents who were neutral had higher burnout odds than disagree, the association was not significant for burnout. Respondents who agreed that lack of resources was one of the workplace factors which contributed to burnout had significantly higher burnout odds than who disagreed (AOR = 1.76, $p = 0.009$).

Table 11: Multivariable Logistic Regression Analysis of Factors Associated with Burnout

Variable	Category	COR (95% CI)	COR p-value	AOR (95% CI)	AOR p-value
Age (years)	25–29 (Ref)	1.00	–	1.00	–
	30–34	1.05 (0.48–2.31)	0.902	1.02 (0.45–2.28)	0.964
	35–39	0.93 (0.39–2.22)	0.872	0.89 (0.36–2.19)	0.801
	40–44	0.88 (0.27–2.85)	0.829	0.84 (0.25–2.79)	0.773
	45–49	2.27 (0.41–12.4)	0.341	2.01 (0.35–11.6)	0.438
Gender	Male (Ref)	1.00	–	1.00	–
	Female	1.03 (0.52–2.03)	0.931	1.01 (0.49–2.06)	0.981
Marital Status	Single (Ref)	1.00	–	1.00	–
	Married	1.02 (0.53–1.96)	0.954	1.00 (0.51–1.95)	0.998
	Divorced	1.86 (0.19–17.8)	0.591	1.62 (0.16–16.4)	0.683
Highest Educational Qualification	Certificate/Diploma (Ref)	1.00	–	1.00	–
	Bachelor's Degree	1.01 (0.48–2.13)	0.981	0.98 (0.45–2.12)	0.952
	Master's Degree	0.87 (0.17–4.47)	0.864	0.82 (0.15–4.43)	0.812
	Specialist	1.12 (0.22–5.67)	0.889	1.05 (0.20–5.54)	0.954
Department/Unit	Medical (Ref)	1.00	–	1.00	–
	Obstetrics & Gynaecology	1.03 (0.37–2.85)	0.955	1.01 (0.35–2.89)	0.982

	Allied health	1.08 (0.42–2.79)	0.869	1.04 (0.39–2.76)	0.942
	Pharmacy	0.96 (0.26–3.48)	0.945	0.93 (0.25–3.44)	0.912
	Diagnostic	0.92 (0.24–3.45)	0.901	0.89 (0.23–3.39)	0.861
	Non-Clinical Departments	1.32 (0.51–3.40)	0.567	1.21 (0.45–3.23)	0.702
Years of	<1 year (Ref)	1.00	–	1.00	–

Experience	1–2 years	1.21 (0.22–6.63)	0.825	1.15 (0.20–6.55)	0.874
	3–5 years	1.10 (0.22–5.46)	0.905	1.05 (0.20–5.41)	0.952
	6–10 years	1.26 (0.24–6.68)	0.784	1.18 (0.21–6.56)	0.843
	>10 years	1.45 (0.25–8.44)	0.676	1.32 (0.22–7.98)	0.761
Shift Pattern	Day (Ref)	1.00	–	1.00	–
	Night	0.98 (0.23–4.16)	0.977	0.95 (0.22–4.11)	0.943
	Mixed	1.01 (0.44–2.33)	0.982	0.98 (0.41–2.31)	0.964
	Rotational	0.99 (0.43–2.30)	0.988	0.96 (0.40–2.28)	0.931
Average Weekly Working Hours	<30 (Ref)	1.00	–	1.00	–
	30–39	0.95 (0.17–5.33)	0.955	0.91 (0.15–5.27)	0.923
	40–48	0.89 (0.18–4.40)	0.885	0.85 (0.17–4.33)	0.834
	49–60	0.78 (0.10–6.06)	0.816	0.75 (0.09–6.01)	0.791

	>60	1.02 (0.16–6.49)	0.983	0.98 (0.15–6.43)	0.967
Poor management support	Disagree (Ref)	1.00	–	1.00	–
	Neutral	1.31 (0.52–3.29)	0.564	1.24 (0.48–3.18)	0.653
	Agree	2.63 (1.18–5.86)	0.018*	2.68 (1.32–5.41)	0.006*
Lack of work–life balance	Disagree (Ref)	1.00	–	1.00	–
	Neutral	1.42 (0.55–3.66)	0.468	1.36 (0.52–3.55)	0.529
	Agree	3.18 (1.42–7.13)	0.005*	2.05 (1.24–3.39)	0.004*
Frequent night shifts/unpredictable schedules	Disagree (Ref)	1.00	–	1.00	–
	Neutral	1.43 (0.57–3.57)	0.442	1.38 (0.54–3.52)	0.502
	Agree	3.09 (1.36–7.01)	0.007*	1.89 (1.15–3.12)	0.011*
Long working hours	Disagree (Ref)	1.00	–	1.00	–
	Neutral	1.35 (0.55–3.32)	0.513	1.28 (0.51–3.18)	0.601
	Agree	2.08 (1.02–4.24)	0.043*	1.52 (1.08–2.41)	0.028*
Lack of resources	Disagree (Ref)	1.00	–	1.00	–
	Neutral	1.21 (0.47–3.08)	0.692	1.18 (0.45–3.05)	0.731
	Agree	2.31 (1.10–4.85)	0.027*	1.76 (1.18–2.95)	0.009*

Source: *Field data, 2026.* **Reference category (Ref) used for comparison.** **Statistically significant at $p < 0.05$**

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

This chapter discusses the findings of the study in relation to the study objectives and existing literature, guided by the Maslach Burnout Theory. The discussion focuses on the prevalence of burnout, its associated factors, its impact on healthcare delivery, and potential mitigation strategies among healthcare workers at LEKMA Hospital.

A total of 250 healthcare workers participated in the study, with the majority aged 25–29 years (37.6%), followed by those aged 30–34 years (28.4%), indicating that most respondents were early-career professionals. This demographic pattern is consistent with global healthcare workforce trends, where younger professionals constitute a large proportion of frontline staff (World Health Organization [WHO], 2020). Although previous studies suggest that younger healthcare workers are more vulnerable to burnout due to limited experience and coping mechanisms (Dyrbye *et al.*, 2020; Rodrigues *et al.*, 2018), this study found no statistically significant association between age and burnout, suggesting that burnout in this setting may not be age dependent.

The study population was predominantly female (70.4%), reflecting global trends in healthcare staffing, particularly in nursing and midwifery (WHO, 2020). While some studies indicate that female healthcare workers may experience higher emotional exhaustion due to work–family conflict and caregiving responsibilities (Ghahramani *et al.*, 2021; Woo *et al.*, 2020), the present study found no significant association between gender and burnout. This aligns with research

suggesting that gender differences in burnout diminish after controlling workplace factors (Jung *et al.*,2023).

In terms of marital status, respondents were almost evenly distributed between married (50.0%) and single (48.4%). Although marital support has been reported as a protective factor against burnout (Shanafelt *et al.*,2012), the current study found no significant relationship between marital status and burnout, indicating that family structure alone may not determine burnout risk in this context.

Most respondents held a bachelor's degree (62.8%), while fewer had postgraduate qualifications. Although higher educational attainment has been linked to increased responsibility and stress (Edu-Valsania *et al.*,2022), this study found no significant association between educational level and burnout. Similarly, department/unit, years of experience, shift pattern, and working hours were not significantly associated with burnout, despite evidence from other studies linking these factors to occupational stress (Dall'Ora *et al.*,2020; West *et al.*,2016). These findings suggest that burnout at LEKMA Hospital is less influenced by individual characteristics and more by workplace conditions.

5.2 The prevalence and levels of burnout among healthcare workers at the LEKMA Hospital

Results of this study show a considerable magnitude of burnout and its dimensions in healthcare workers at LEKMA Hospital based on the three components of the Maslach Burnout Inventory, Human Services Survey. The three components of burnout that were assessed in this study are EE, DP, and PA.

In terms of the prevalence of the three dimensions of burnout, results of this study reveal that the EE component is predominant. About 58.0% and 22.8% of respondents showed high and moderate levels of EE respectively in this study. This indicates that above 80% of the respondents at LEKMA Hospital reported moderate or high levels of EE. This finding corresponds with previous studies that suggest that EE is the most prevalent and most important dimension of burnout among healthcare workers globally (Maslach & Leiter, 2016; Dall'Ora *et al.*, 2020). EE refers to a decline in emotional and physical energy due to long-term exposure to work stress (Maslach & Leiter, 2017). It is particularly experienced among those who regularly work with and attend to other people, especially health care workers in their jobs. Studies have revealed high levels of EE among healthcare workers globally including during this COVID-19 period (Ghahramani *et al.*, 2021; De Hert, 2020).

Regarding the DP dimension of burnout, results in this study suggest that most respondents (65.6%) showed low level of DP in their job and only 7.2% of them indicated high level. DP implies distancing oneself from patients as a form of coping with emotional depletion (Maslach & Leiter, 2017). The low level of DP shown in this study suggests that despite emotional depletion, most respondents in this study showed good relationship with patients. It is similar to findings of a study that found that most health care workers experienced EE before DP (Khammissa *et al.*, 2022).

As for the PA dimension of burnout in this study, results indicate that more than half (54.8%) of the respondents showed a high level of PA. This is an indication that many healthcare workers have a low PA in their job. Low PA, on the other hand, is an indication of high burnout in this component of the MBI-HSS. More than a third (34.8%) of respondents showed a low

level of PA in this study. PA implies a sense of achievement in one's job (Maslach & Leiter, 2000). High level of PA that was observed in this study may reflect a high level of intrinsic motivation among respondents in the hospital. Studies have revealed that high levels of PA among health care professionals can protect against burnout (Edu-Valsania *et al.*,2022). Even though a relatively high proportion of the respondents showed a low level of PA, this remains a problem for the organization and the health sector. Studies reveal that a low level of PA can contribute to job dissatisfaction and an increased tendency to leave the job (Bridgeman *et al.*,2018).

Based on standard criteria, burnout is assessed as high levels of EE with either a high level of DP or low PA. The overall prevalence of burnout among healthcare workers in this study was 15.2%. This value is less than the global prevalence of burnout among healthcare workers (Ghahramani *et al.*,2021; De Hert, 2020). However, based on this criterion, the burnout prevalence of 15.2% is still significant for healthcare workers in this study. The relatively low burnout prevalence despite high levels of EE suggests that many respondents are either in the beginning stage of burnout or their burnout is not fully manifested, as indicated in the Maslach Burnout Theory. This theory suggests that the first stage of burnout is usually emotional exhaustion, followed by depersonalization, and lastly a low level of PA. In the light of this finding that high EE accompanied with low DP and high PA, these findings may reflect the context of the study and a country as Ghana. Health workers may show high PA in their jobs in spite of a high EE in their jobs. A study found that even during the period of the COVID-19, Ghana health care workers showed high PA in the hospital (Odonkor, 2020). Furthermore, factors like teamwork and working among colleagues can be useful to reduce burnout (Amoah *et al.*,2021).

5.3 Individual and workplace factors associated with burnout among health workers at the LEKMA Hospital

According to the results presented here, burnout among healthcare personnel at LEKMA Hospital was caused mainly by workplace and organizational factors, and not personal characteristics. This finding is consistent with the Maslach Burnout Theory which holds that burnout is mainly the function of a number of work-related factors such as workload, control, reward and community (Maslach & Leiter, 2016). In this study age, gender, marital status, level of education and length of service were not significantly associated with burnout which implies that the key drivers of burnout are work-related factors that can be changed.

This study found that lack of management support was a strong significant predictor of burnout. Healthcare workers who reported lack of management support were more likely to be burnt out than those who had adequate management support. This finding is consistent with previous studies which emphasize the role of managerial support in promoting mental health and preventing burnout (Shanafelt & Noseworthy, 2017; Dyrbye *et al.*, 2020). Inadequacy of fair treatment, poor communication and poor leadership are known as the most powerful predictors of burnout by Maslach and Leiter (2016). Lack of management support may have even greater importance in the healthcare sector in Ghana as leadership is hierarchical and healthcare resources are lacking (Odonkor, 2020). Therefore, our findings highlight the need for management-focused interventions such as inclusive decision-making, better communication and more supportive supervision.

Similarly, lack of work-life balance emerged as a significant independent predictor of burnout, and healthcare workers who reported lack of work-life balance were more likely to be burnt

out. This finding is consistent with previous studies that found an association between worklife balance and burnout (Dyrbye *et al.*,2020; Shanafelt *et al.*,2012). Lack of work-life balance has been reported to be responsible for emotional exhaustion, low job satisfaction and poor mental health (Dyrbye *et al.*,2020; Shanafelt *et al.*,2012). According to the Job DemandsResources theory, burnout occurs when the job demands are high in comparison with the resources available to workers. It was noted from our results that our participants were more likely to be female and young, suggesting that work-life balance is another important issue as many healthcare workers would be juggling work and family responsibilities (Ghahramani *et al.*,2021; Woo *et al.*,2020). This suggests that more flexible working schedules and more supportive workplace policies are likely to enhance the integration of work and life responsibilities and reduce burnout.

This study also found that frequent night shifts and unpredictable scheduling are associated with burnout. Health care workers who reported frequent night shifts and unpredictable work schedules had higher odds of burnout. This finding is consistent with previous evidence that shift work is associated with sleep disturbance, circadian rhythm disruption and fatigue (Dall'Ora *et al.*,2020; Jalili *et al.*,2020). These unpredictable schedules may reduce the opportunity for good rest and recovery time, resulting in increased stress and emotional exhaustion. Given that several of our respondents reported a rotating shift pattern and an irregular shift schedule, this finding shows that changes in working hours and longer rest times would be an important part of burnout management.

Furthermore, this also found that long working hours are associated with burnout, which corroborates other studies which have shown a positive relationship between hours of work

and stress, fatigue and well-being (De Hert, 2020; West *et al.*,2016). Long working hours would reduce the opportunity for recovery and is likely to lead to build-up of fatigue and in turn result in increased vulnerability to emotional exhaustion and burnout.

Again, this study reported that lack of resources was another significant predictor of burnout. This suggests that a shortage of resources such as staff and equipment may be responsible for putting more demand on healthcare workers. This finding is consistent with research which indicates that insufficient resources could lead to burnout, especially in less developed countries that have weak and poorly equipped healthcare services (Dyrbye *et al.*,2020). It is possible for health care workers in these contexts to be dissatisfied or frustrated with their work performance if they cannot cater for patients adequately.

Excessive workload, perceived poor treatment by the employer, too much emotional demands, inadequate pay, dealing with difficult patients, poor infrastructure, inadequate staffing, and poor communication were not found to be significant predictors of burnout in this study though earlier research found that each of them was significantly associated with burnout (Maslach & Leiter, 2016; Dyrbye *et al.*,2020). They may not have been significant in this study because they might be indirectly related to burnout via another organizational factor. Or it may be that they may not be significant in this study because they overlap with the impact of other stronger predictors such as management support and work-life balance.

5.4 The perceived impact of burnout on healthcare delivery and health worker well-being at the LEKMA Hospital

Based on the results, this study reveals that the effect of burnout on workers at LEKMA Hospital could have wide ranging effects on patient care and the workers themselves. It is

therefore evident that the effects of burnout include lack of motivation to carry out duties, difficulty to focus on work, work-life balance issues, lack of job satisfaction and emotional exhaustion as well as effects on patient interactions which were all statistically significant. Burnout showed statistically significant association with lack of motivation to carry out work duties and lack of job satisfaction, meaning it reduces motivation for work. This confirms that work exhaustion or depletion of motivation for work is a common theme in burnout (Maslach and Leiter, 2016). The study by Edu-Valsania et al. (2022) confirms that exhaustion can lead to loss of motivation, enthusiasm and productivity as well as less job satisfaction. Several research findings also confirmed that individuals with occupational burnout tend to express greater dissatisfaction with work and work-life integration (Shanafelt *et al.*,2015), as well as less professional fulfillment and increased intent to decrease work effort (Dyrbye *et al.*,2017). The results of this study on LEKMA Hospital workers suggest that the effect of burnout may extend to productivity and job satisfaction at the workplace.

The statistically significant association between burnout and lack of ability to focus on work means that burnout also reduces the ability to focus on tasks. This is consistent with the literature on stress where it has been demonstrated that stress and exhaustion lead to a lack of focus and can also affect one's memory and decision-making abilities (Salvagioni *et al.*,2017). Other studies have found a relationship between burnout and an increased number of medical errors and reduced cognitive function. For instance, Shanafelt et al. (2010) found a significant association between burnout and major medical errors in physicians and Tawfik et al. (2018) found that the relationship is bidirectional with burnout leading to greater medical errors and medical errors leading to burnout. This study found a statistically significant association between burnout and effects on patient interactions, although the effect of burnout on errors

was borderline statistically significant, suggesting possible risk of errors and lower quality of care.

There was also a statistically significant association between burnout and work-life balance which reiterates the fact that burnout leads to lack of work-life balance. Burnout also causes exhaustion, which could lead to reduced performance in social life and family (Maslach and Leiter, 2016). Although there was a statistically significant association only at a lower level between burnout and effects on family relationships, it also shows that burnout may have negative effects on other relationships. In a country like Ghana, where family life, obligations, and work life have a significant place in the life of a worker as reported by Odonkor (2020), the effect of burnout is likely to have a greater spillover effect.

There was a statistically significant association between burnout and emotional exhaustion after work, confirming that exhaustion is a major dimension of burnout (Maslach and Leiter, 2016). The effects of fatigue or emotional exhaustion can cause a lack of compassion or empathy for work and patients. Although there was a statistically significant association with detachment or reduced empathy for patients it also means that prolonged burnout could reduce the bond between patient and worker and this confirms with previous study findings showing that burnout could lead to a loss of empathy, reduced quality of communication and patient centred care (West *et al.*,2018). There was also a statistically significant association between burnout and physical symptoms such as headaches and fatigue as burnout can lead to headaches and exhaustion in a worker. This supports literature where there is relationship between burnout and physical health (Salvagioni *et al.*,2017). However, there was no statistically significant association between intention of quitting from the health sector and

burnout although the trend suggests a potential relationship. The results in the literature show that burnout leads to the intention to quit the health sector (Dyrbye *et al.*,2017), although in this study it was not significant. This difference could be attributed to differences in the work context, especially issues related to job security and opportunities for employment that may lead to the desire to keep the health profession despite burnout.

5.5 Mitigation strategies for burnout among workers at the LEKMA Hospital

The current investigation has revealed that LEKMA Hospital implements multiple strategies to mitigate burnout among healthcare professionals, and most of the strategies assessed were perceived to be effective. The descriptive statistics revealed that recognition and reward systems (72.4%), regular staff meetings for feedback and support (69.2%), stress management training (63.6%), and peer support groups or counseling (62.8%) were identified as key strategies. Moreover, over half of the respondents also acknowledged the significance of other strategies such as wellness initiatives, flexible work schedules, and employee assistance programs. Collectively, these strategies are categorized as either individual or organizational strategies as recommended in the available literature for addressing burnout among healthcare workers (Maslach & Leiter, 2016; West *et al.*,2016).

However, contrary to previous notions, the findings of this study suggest that the availability or perceived implementation of these strategies is related to burnout outcomes among staff.

The findings of this study revealed that presence of recognition and reward systems (72.4%), which received the highest rate of agreement, were associated with burnout. This finding corroborates a key aspect of the Maslach and Leiter's (2016) burnout model on rewards, which emphasized that recognition and appreciation of employee contributions in a fair work

environment is likely to reduce burnout (Shanafelt & Noseworthy, 2017). Thus, the results suggest that organizational practices that recognize employees for work contributions will likely reduce burnout among healthcare professionals.

The second most prominent mitigation strategy that emerged from this study was the presence of regular staff meetings for feedback and support (69.2%), was also associated with burnout. Regular staff meetings provide platforms for open and transparent communication with an opportunity to provide and receive feedback and share concerns. Such opportunities promote shared decision-making, open communication, and a sense of psychological safety which have all been linked to lower levels of burnout and higher levels of well-being (Shanafelt & Noseworthy, 2017). Consequently, strengthening such opportunities through communication within healthcare environments can play an effective role in mitigating burnout among healthcare workers.

Another strategy associated with burnout in this study was the presence of peer support groups or counseling (62.8%), further supporting evidence of the association of social support on burnout among healthcare professionals (Amoah *et al.*,2021). It has been established that peer support and collegial interactions can enhance burnout resistance and provide a platform for staff to receive support from one another. Evidence suggests that such mechanisms can help reduce burnout by offering emotional support and coping mechanisms to those who have been exposed to stressful workplace situations (Amoah *et al.*,2021).

Further, the presence of stress management training was associated with burnout, a finding that aligns with existing evidence that demonstrates an inverse relationship between such interventions, such as mindfulness, resilience and coping skills training, and burnout. Although

such interventions may only produce modest improvements in reducing emotional exhaustion, they remain a key ingredient in any effective burnout prevention strategy (West *et al.*,2016). Moreover, the presence of employee assistance programs and wellness initiatives was associated with burnout, indicating that psychological support services and wellness activities are likely to play a significant role in reducing burnout among healthcare workers. Also, flexible work schedules were found to be associated with burnout, demonstrating the vital need for addressing work-life balance issues through organizational policies to improve well-being and prevent burnout.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The study examined the prevalence, predictors, and consequences of burnout among healthcare workers at LEKMA Hospital, along with the efficacy of strategies designed to mitigate it. The results revealed key insights into burnout among healthcare workers at the hospital. The overall prevalence of burnout was moderate (15.2%) but most health workers experienced severe levels of emotional exhaustion, the core element of burnout. Most respondents reported very little or no depersonalization and moderate or very high personal accomplishment, implying dedication and resilience among the study participants.

Burnout was not predicted by age, gender, marital status, level of education and number of years of experience. Burnout however was a function of organizational and work-related factors such as inadequate management support, inadequate work life balance, frequent night shifts and work in irregular patterns, working overtime and inadequate resources, as each variable had a significant prediction of burnout occurrence.

Additionally, to the impact burnout has on the health of the worker, burnout is associated with a lower work motivation, lower job satisfaction, difficulty concentrating, low morale, breakdown of work relationship, which affect the quality of care, safety of patients and health delivery. It was also found that recognition and reward systems, staff support sessions, training on stress management, co-worker support, variable work schedules and staff assistance schemes are factors associated with health worker burnout, which implies that strategies aimed at reducing burnout can be targeted at individual health workers or the hospital organization.

6.2 Recommendations (segment and target recommendations to stakeholders and interested parties)

The study further advises LEKMA Hospital to focus on organizational reforms to address burnout, particularly by strengthening support for management and improving the practices of management leaders, as well as enhancing communication between supervisors and staff. Because burnout is strongly associated with poor management support, emphasis should be on leadership training and participatory decision-making structures. And work–life balance can be enhanced by better scheduling of shifts, reducing uncertainty regarding duty rosters and providing adequate rest periods for rotational and night-shift workers. So right now, one of the challenges is to monitor how many cases are assigned and make sure they’re evenly spread across departments.

Mitigation strategies currently in place (e.g., recognition systems, peer support groups, stress management training, wellness programs) should be assessed and bolstered to target known drivers of burnout rather than act as independent interventions. At a higher level, policy makers and health authorities need to advocate workforce expansion, politicize staffing ratios, upscale infrastructure and conduct routine monitoring of burnout as commonplace organizational practice to lay the groundwork for sustainable change in approaching healthcare workers’ wellbeing and delivery. To effectively reduce burnout at LEKMA Hospital, a coordinated and system level approach integrating leadership reform with structured scheduling and strengthened support systems is required.

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APPENDIX

Participant Information Sheet

Title of Study: Burnout Among Health Workers at LEKMA Hospital, Ledzokuku Municipality

I am Candice Frimpong, a student of Ensign Global University. I am conducting a research study as part of my academic work to understand burnout among healthcare workers at LEKMA Hospital. Burnout is a state of physical, emotional, and mental exhaustion that can occur when people experience long-term stress in their work. This study seeks to find out how common burnout is among staff, what causes it, its effects, and the ways it can be reduced or prevented.

The aim of this research is to examine the differences in the causes, consequences, and mitigation strategies of burnout among health workers at LEKMA Hospital. The information gathered will help identify the challenges staff face and suggest ways to promote better wellbeing and job satisfaction.

If you agree to take part, you will be asked to complete a short questionnaire. The questions will focus on your work experiences, stress levels, and coping mechanisms. It will take about 10–15 minutes to complete. There are no right or wrong answers, please respond honestly

Your participation in this study is entirely voluntary. You may choose not to take part or to withdraw at any time without giving any reason. There will be no penalty or negative consequence for not participating.

All information collected will be kept strictly confidential. Your name will not appear anywhere in the report, and responses will only be used for academic purposes. The data will be reported in summary form, and no individual will be identified.

Although there may be no direct benefit to you, your participation will contribute to a better understanding of burnout and help improve working conditions and staff welfare at LEKMA Hospital.

If you have any questions or concerns about this study, please feel free to contact:

Researcher: Candice Frimpong

Institution: Ensign Global College

Email: candice.frimpong@st.ensign.edu.gh

Telephone Number:0550215116

INFORMED CONSENT

Title of Study: Burnout Rate Among Health Workers at LEKMA Hospital in the Ledzokuku Municipal, Greater Accra Region, Ghana

Introduction

You are being invited to participate in a research study being conducted to understand burnout among healthcare workers at the LEKMA Hospital. Before you decide whether to take part, please read the following information carefully. You may ask questions if anything is unclear.

Purpose of the Study

The purpose of this study is to determine the prevalence, causes, consequences, and mitigation strategies of burnout among healthcare workers at the LEKMA Hospital. The findings will help improve staff support systems, workplace well-being, and policy decisions. **Procedures**

If you agree to participate:

- You will complete a questionnaire that will take approximately 10–15 minutes.
- The questionnaire will ask about your work environment, stress levels, coping strategies, and experiences related to burnout.
- No identifying information such as your name, staff ID, phone number, or email will be collected.

Voluntary Participation

Participation in this study is completely voluntary. You may choose not to take part, and you may withdraw at any time without any penalty, explanation, or consequences.

Potential Risks and Discomforts

There are no anticipated risks associated with participating in this research. Some questions may cause mild emotional discomfort due to reflection on work-related stress, but you are free to skip any question you do not wish to answer.

Potential Benefits

Although you may not receive a direct personal benefit, your participation will help generate information that will support interventions aimed at reducing burnout and improving staff wellbeing at LEKMA Hospital and in similar healthcare settings.

Confidentiality and Anonymity

Your responses will remain strictly anonymous. No names or identifiable information will be collected. All data will be reported in aggregate form. Data will be stored in a passwordprotected computer accessible only to the researcher.

Voluntary Withdrawal

You may withdraw from the study at any time without providing a reason. If you choose to withdraw, no further data will be collected from you.

Contacts for Further Information

If you have any questions about this research, please contact:

Candice Frimpong

Master of Public Health Candidate

Ensign Global University

Phone: 055 021 5116

Email: Candice.frimpong@st.ensign.edu.gh

Consent Statement

Please read the statement below and indicate your agreement:

I have read the information provided above. I understand the purpose of the study, the procedures involved, and my rights as a participant. I voluntarily agree to participate in this study.

Signature/Thumbprint of Participant: _____ Date: _____

Signature/Thumbprint of Researcher: _____

Date: _____

QUESTIONNAIRE

Dear respondent,

My name is Candice Frimpong. I am a postgraduate student at Ensign Global University conducting an academic research study on the topic “BURNOUT RATE AMONG HEALTH WORKERS: A CASE STUDY AT LEKMA HOSPITAL, GHANA.”

This study forms part of the requirements for the completion of my postgraduate programme and seeks to examine the prevalence, factors, impact, and mitigation strategies of burnout among healthcare workers at LEKMA Hospital. The questionnaire is designed to gather information on your experiences, perceptions, and views regarding occupational burnout. You are kindly requested to respond as truthfully and objectively as possible. All information provided will be treated with the strictest confidentiality and used solely for academic and research purposes. Your participation is voluntary, and you may withdraw from the study at any point without any penalty.

Thank you sincerely for your time and valuable contribution to this research.

Section A: Socio-Demographic Characteristics of study participants

(Tick one option per question unless otherwise indicated)

1. Age (years)

- a) ☐ <25 b. ☐ 25–29 c. ☐ 30–34 d. ☐ 35–39
e. ☐ 40–44 f. ☐ 45–49 g. ☐ ≥50

2. Gender

Male
Female

3. Marital status

Single
Married
Cohabiting
Divorced
Widowed

4. Highest Educational qualification:

Certificate/Diploma

Bachelors

Master's

Specialist

Doctorate

Other: (please specify) _____

5. What is your professional role?

Nurse/Midwife

Medical Officer

Specialist

Pharmacist

Laboratory Scientist

Radiographer

Other (please specify): _____

6. Department/Unit:

Medical

Obstetrics and Gynaecology

Allied Health

Pharmacy

Diagnostic

Other (please specify): _____

7. How many years of experience do you have in healthcare?

<1

1–2

3–5

6–10

>10

8. Shift pattern:

Day

Night

Rotational

24-hour

Mixed

9. Average weekly working hours:

- <30
- 30–39
- 40–48
- 49–60
- 60

Section B: The Prevalence and Levels of Burnout among Healthcare Workers at LEKMA

Hospital

(Tick one option per question unless otherwise indicated)

Emotional Exhaustion (EE) using the Maslach Burnout Inventory (MBI)

Variable	Never	A Few Times per Year	Once a Month	A Few Times per Month	Once a Week	A Few Times per Week	Every Day
Scores	0	1	2	3	4	5	6
1. I feel emotionally drained by my work							
2. I feel used up at the end of the workday							
3. I feel fatigued when I get up in the morning and have to face another day on the job							
4. Working with people all day is really a strain for me							
5. I feel burned out from my work							
6. I feel frustrated by my job							
7. I feel I am working too hard on my job							
8. Working directly with people puts too much stress on me							

9. I feel like I am at the end of my rope							
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Depersonalization (DP) using the Maslach Burnout Inventory (MBI)

Variable	Never	A Few Times per Year	Once a Month	A Few Times per Month	Once a Week	A Few Times per Week	Every Day
Scores	0	1	2	3	4	5	6
10. I feel I treat some recipients as if they were impersonal objects							
11. I've become more callous toward people since I took this job							
12. I worry that this job is hardening me emotionally							
13. I don't really care what happens to some recipients							
14. I feel recipients blame me for some of their problems							

Personal Accomplishment (PA) using the Maslach Burnout Inventory (MBI)

Variable	Never	A Few Times per Year	Once a Month	A Few Times per Month	Once a Week	A Few Times per Week	Every Day
Scores	0	1	2	3	4	5	6
15. I can easily understand how my recipients feel about things							
16. I deal very effectively with the problems of my recipients							

17. I feel I'm positively influencing other people's lives through my work							
18. I feel very energetic							
19. I can easily create a relaxed atmosphere with my recipients							
20. I feel exhilarated after working closely with my recipients							
21. I have accomplished many worthwhile things in this job							
22. In my work, I deal with emotional problems very calmly							

SECTION C:

Individual and workplace factors associated with burnout among healthcare workers at the LEKMA Hospital

Please select the degree to which you agree that the following contributes to burnout.

Variable	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
Excessive workload					
Staff shortages					
Long working hours					
Lack of resources					
Poor management support					
Difficult patients or clients					
Lack of opportunities for career growth or training					
Low salary or delayed payment					
Unfair treatment or favoritism at work					

Lack of work-life balance					
Poor communication within the team or organization					
High emotional demands of the job					
Lack of recognition for efforts					
Poor infrastructure in the facility					
Frequent night shifts or unpredictable schedules					

SECTION D: The impact of burnout on healthcare delivery and health worker well-being among workers at the LEKMA Hospital

Variable	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
I feel emotionally exhausted after work					
I experience frequent headaches, fatigue, or other physical symptoms					
Burnout has reduced my ability to concentrate on tasks					
I feel less motivated to perform my duties					
I have noticed an increase in mistakes or errors in my work					
Burnout has affected my interactions with patients/clients					
I find it difficult to maintain a healthy work-life balance					
Burnout has strained my relationships with family and friends					
I feel detached or less empathetic towards patients or colleagues					
My job satisfaction has decreased significantly					
Burnout has led me to consider leaving the healthcare profession					

SECTION E: Strategies are currently employed to mitigate burnout among workers at the LEKMA Hospital

Variable	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
Stress management training					
Employee assistance programs (EAP)					
Peer support groups or counseling					
Flexible work schedules					
Wellness initiatives (e.g., fitness programs)					
Regular staff meetings for feedback/support					
Recognition and reward systems for staff					

OUR REF: ENSIGN/IRB/EL/SN-320/02

December 4, 2025.

YOUR REF:

INSTITUTIONAL REVIEW BOARD SECRETARIAT

Candice Frimpong
Ensign Global University
Kpong.

Dear Candice,

ETHICAL CLEARANCE TO UNDERTAKE POSTGRADUATE RESEARCH

At the General Research Proposals Review Meeting of the *INSTITUTIONAL REVIEW BOARD (IRB)* of Ensign Global University held on Wednesday, December 3, 2025, your research proposal entitled **"Burnout Rate Among Health Workers: A Case Study at LEKMA Hospital in the Ledzokuku Municipality, Greater Accra Region, Ghana"** was considered.

You have been granted Ethical Clearance to collect data for the said research under academic supervision within the IRB's specified frameworks and guidelines.

We wish you all the best.

Sincerely,



Dr. (Mrs.) Rebecca Acquah-Artin
IRB Chairperson