

## Prevalence and Determinants of Burnout Syndrome: A Cross-sectional Study among Healthcare Providers in Akuapem North Municipality of Ghana



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### Abstract

**Aim:** This study examines the prevalence and factors associated with burnout in healthcare providers in Akuapem North Municipality, Ghana.

**Methods:** A descriptive cross-sectional survey was conducted among 277 healthcare workers using a structured questionnaire between February and March 2024. The Maslach Burnout Inventory (MBI) assessed EE, DP, and PA. Work-related and organizational factors were analyzed using Pearson chi-square tests and multiple regression analysis to identify key predictors of burnout. Statistical significance was set at  $p < .05$ . Data were analyzed using SPSS Version 19.

**Results:** Emotional exhaustion was high, with 15.5% of participants experiencing extreme fatigue. Depersonalization levels were high for 48.0% of respondents, while 74.0% reported low personal achievement. Chi-square tests indicated that marital status significantly impacted emotional exhaustion [ $\chi^2(8) = 17.561, p = .025$ ], and profession was significantly related to depersonalization [ $\chi^2(2) = 22.201, p < .001$ ]. Regression analysis revealed that work-related factors, such as overall comfort ( $\beta = 5.978, p < .001$ ) and support ( $\beta = 4.416, p < .001$ ), were significant predictors of burnout. Organizational factors like fairness ( $\beta = 2.563, p < .001$ ) and work-life balance ( $\beta = 7.294, p < .001$ ) also had significant effects.

**Conclusion:** Burnout is prevalent among healthcare providers in Akuapem North Municipality, with notable levels of emotional exhaustion, depersonalization, and reduced personal achievement. Work-related and organizational factors are key contributors.

**Recommendations:** Targeted interventions, including improved support systems and organizational fairness, are recommended to address burnout effectively. Future research should evaluate targeted interventions addressing these factors and monitor changes in burnout over time. Additionally, it should investigate the interactions between individual and organizational factors across various healthcare settings.

**Keywords:** *Burnout, healthcare professionals, emotional exhaustion, depersonalization, personal achievement, Ghana.*

## INTRODUCTION

Burnout syndrome (BOS) is a psychological condition resulting from prolonged exposure to work-related stressors (von Känel, 2018). First described by Herbert Freudenberger in 1974, burnout is characterized by severe mental and physical exhaustion due to professional demands, leading to feelings of depletion and difficulties in coping (Hillert, 2018). While the World Health Organization (WHO) recognizes burnout as an "occupational phenomenon" in the International Classification of Diseases (ICD-11), it is not included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and is classified among adjustment and stress-related disorders (Wood, 2017).

Burnout is particularly prevalent among healthcare professionals, especially nurses, who face constant demands and intense patient interactions (De Paiva et al., 2017). The condition manifests through three primary symptoms: emotional exhaustion (EE), depersonalization (DP), and reduced professional achievement (PA) (Luan et al., 2017). Emotional exhaustion involves a profound lack of energy and motivation, often triggered by heavy workloads and personal conflicts, and is associated with physical symptoms such as insomnia and headaches (Luan et al., 2017). Depersonalization is marked by emotional detachment and impersonal treatment of others, leading to increased cynicism and diminished empathy (Chemali et al., 2019). Reduced professional achievement reflects a negative self-assessment, resulting in job dissatisfaction and decreased productivity (López-López et al., 2019). These symptoms contribute to emotional stress and job disillusionment, which can manifest as anxiety, depression, and negative attitudes towards work and colleagues (Al-Hashemi et al., 2019).

The healthcare environment is inherently stressful due to demanding responsibilities, long working hours, and limited control over work conditions. Additional stressors, such as dealing with patient suffering, traumatic events, and delivering bad news, further exacerbate burnout (Ansert & Rushing, 2021). Personal life stressors also play a role, leading to increased emotional exhaustion (Aiken et al., 2022). Although burnout is widely recognized, there is a lack of consensus on its prevalence and incidence rates, with many studies indicating a high prevalence among healthcare professionals. The condition remains relatively misunderstood by the general population, yet its significant impact on both physical and mental health underscores the need to address it as a public health issue (Konlan et al., 2022).

In the Akuapem North Municipality, healthcare providers face challenges such as high workloads, limited resources, and exposure to emotionally charged situations. These factors contribute to increased absenteeism and stress-related symptoms (Municipal Health Directorate, 2022; Municipal Health Directorate, 2023). Such studies can inform evidence-based decision-making, policy development, and the implementation of effective interventions to improve healthcare providers' well-being and enhance patient care quality (Vargas et al., 2014). Understanding the specific contributing factors in this region will provide valuable insights into managing burnout effectively and contribute to the local literature, laying the groundwork for further research and exploration of burnout issues within Ghana's healthcare system.

Recent research has begun to explore the cause-and-effect relationships and preventive measures for burnout (Pereira et al., 2021). Despite these advancements, there is still a notable lack of studies focusing on the prevalence and contributing factors of burnout in specific regions like the Akuapem North Municipality in Ghana. This region presents unique challenges that may differ

from other areas globally or within Ghana (Muntean et al., 2022). Therefore, this study aims to assess the prevalence and associated factors of burnout syndrome among healthcare providers in the Akuapem North Municipality. Addressing this gap in research will help develop targeted strategies that consider local dynamics and stressors impacting healthcare providers.

## **METHODOLOGY**

### **Study Area**

The study was conducted in the Akuapem North Municipality, which, as of June 2023, employs 610 healthcare workers (Municipal Health Directorate, 2023). Established in 1988 and elevated to Municipal Assembly status in 2012, the municipality is managed by a Municipal Chief Executive and a Municipal Coordinating Director. It is divided into eleven areas and four town councils. The Akuapem North Municipal Health Directorate, under the Ghana Health Service, oversees health policy implementation and resource management. The municipality has eight health sub-districts. Healthcare facilities include Tetteh Quarshie Memorial Hospital and MEDICAS Hospital in Mampong-Akuapem, and the Centre for Scientific Research into Plant Medicine. There are eight health centers and thirty-three CHPS Compounds across various communities. CHPS Compounds are crucial in remote areas but are inadequate given the extensive rural population.

### **Study Design and Type**

An institution-based descriptive cross-sectional survey research design was adopted for this research work. The study focused on burnout syndrome as the dependent variable among healthcare providers, examining how work-related, organizational, and socio-demographic factors (such as age, gender, education, and marital status) influenced its prevalence.

### **Study Population and Sampling**

The study targeted healthcare workers in the Akuapem North Municipality. Participants were included if they had at least one year of professional experience. Those who were on leave, on vacation, or attending professional training during the study period were excluded. A simple random sampling technique was employed to recruit participants for this study. Initially, a comprehensive list of all healthcare providers in the Akuapem North Municipality was obtained from the Municipal Health Directorate. This list served as the sampling frame for the study. Each healthcare provider on the list was assigned a unique identifier to ensure that each individual could be randomly selected without bias. To achieve this, a random number generator was utilized to produce random numbers corresponding to the unique identifiers. This method facilitated the selection of the required number of participants in a purely random manner. Once the sample was drawn, the selected healthcare providers were contacted through their provided contact information. They were informed about the study's objectives, procedures, and the importance of their participation. Following this, invitations to participate in the study were extended to the selected individuals. This rigorous approach ensured that the sample was representative of the population, thereby enhancing the reliability and validity of the study's findings.

### **Sample Size**

As of June 2023, the Municipal Health Directorate reported a total of 610 healthcare workers in the municipality. Given this finite population, the initial sample size was determined using Yamane's formula with a 95% confidence level and a 5% margin of error:

$$n = N/[1+N(\alpha)^2]$$

where  $n$  is the sample size,  $N$  is the total population, and  $\alpha$  is the margin of error. This calculation yielded an initial sample size of 242. To account for potential non-responses, an adjustment of 10% was added, resulting in a revised sample size of 266. To ensure robust representation and further account for non-responses, the final target sample size was set at 277 respondents. This strategy aimed to ensure the study's findings were both reliable and representative.

### **Data Collection Tools, Techniques and Procedures**

Data were gathered using a structured questionnaire, which was divided into four sections. Section A collected socio-demographic information, including age, gender, shift patterns, work unit, marital status, qualifications, and years of experience. To measure burnout syndrome, Section B utilized the Maslach Burnout Inventory - Human Services Survey (MBI-HSS) (Forné & Yuguero, 2022), a widely accepted tool that consists of 22 items distributed across three subscales: EE, DP, and PA (Pereira et al., 2021). High scores in EE ( $\geq 27$ ) and DP ( $\geq 13$ ), combined with a low PA score ( $\leq 31$ ), indicate significant burnout. Section C explored work-related factors influencing burnout, such as workload, job demands, autonomy, control over work, shift patterns, overtime hours, and perceived social support, using the Job Content Questionnaire (JCQ). Section D assessed organizational factors impacting burnout, including leadership style, organizational culture, recognition and rewards, teamwork, communication, and resource availability, using the Organizational Culture Assessment Instrument.

The questionnaire underwent validation through semantic analysis to ensure its clarity and effectiveness. Experts in occupational health, health service management, and Human Resource Management evaluated the instrument for comprehensibility. The questionnaire was also reviewed by the research supervisor at the Department of Public Health, Faculty of Health and Allied Sciences, Catholic University College, for further refinement. A pretest was conducted with a non-participating community within the Municipality to identify and resolve any unclear questions or issues. Adjustments based on pretest feedback were incorporated into the final version of the questionnaire, ensuring its consistency with relevant literature. After selecting the sample, healthcare providers were contacted and invited to participate in the study. They received invitation emails that detailed the study's objectives, emphasized the significance of their involvement, and outlined the data collection procedures. Data collection occurred from February to March 2024. Participants who opted to complete the survey online utilized Google Forms, a secure platform designed for this purpose.

### **Data Analysis**

Data cleaning was first conducted using EPI Info software to correct errors and eliminate data that were incomplete, irrelevant, duplicated, or incorrectly formatted. Only responses from participants who answered all survey items were included in the analysis. Descriptive statistics were then computed to summarize socio-demographic data, including gender, age, staff category, education level, and years of practice. Burnout levels were measured using the Maslach Burnout Inventory (MBI). EE was categorized as high ( $\geq 27$ ), moderate (19-26), or low ( $< 18$ ). DP was classified as high ( $\geq 10$ ), moderate (6-9), or low ( $< 6$ ). PA was categorized as high ( $\geq 40$ ), moderate (34-39), or low ( $\leq 33$ ). Descriptive statistics, such as frequencies and percentages, were used to determine burnout prevalence. To explore the relationships between work-related factors and burnout,

correlation analyses were performed. Multiple regression analysis was used to identify key predictors of burnout, considering multiple factors simultaneously. Variables with a p-value below 0.05 were regarded as significantly associated with burnout. All statistical analyses were carried out using SPSS Version 19.

## FINDINGS

### Distribution of Demographic Characteristics of Respondents

Most respondents were married (46.2%) or single (40.1%). The majority identified as Christian (70.0%), with a smaller proportion as Islamic (29.6%) and a minimal number as Traditionalist (0.4%). Most were employed in permanent positions (64.3%), followed by those on rotation or national service (21.3%), and part-time or locum positions (12.3%). In terms of education, the largest group held a diploma (51.6%), followed by those with a university degree (38.3%). The number of respondents with basic education or higher qualifications (master's degree, certificate) was comparatively low (Table 1).

**Table 1: Demographic characteristics of respondents**

Variables	Frequency (N)	Percentage (%)
<b>Marital Status</b>		
Cohabiting	24	8.7
Divorced	6	2.2
Married	128	46.2
Separated	8	2.9
Single	111	40.1
<b>Religion</b>		
Christian	194	70.0
Islamic	82	29.6
Traditionalist	1	.4
<b>Employment status</b>		
Casual	6	2.2
Cleaner	1	.4
Locum / Part-time	33	11.9
Permanent	178	64.3
Rotation / National Service	59	21.3
<b>Educational Status</b>		
Basic education	3	1.1
Certificate	8	2.9
Diploma	143	51.6
Master's degree	12	4.3
Senior high	5	1.8
University degree	106	38.3

Source: Field Study (2024)



## The Prevalence of Burnout Syndrome Among Healthcare Providers

For emotional exhaustion, 15.5% of participants reported extreme fatigue. Meanwhile, 44.0% experienced less fatigue, and 40.4% had moderate fatigue. Regarding depersonalization, 48.0% of respondents reported high levels. In contrast, 19.9% had low depersonalization, and 32.1% experienced moderate depersonalization. Concerning personal achievement, a significant majority of 74.0% reported low levels. Additionally, 16.2% had moderate personal achievement, while only 9.7% reported high personal achievement (Table 2). (See more results in [supplementary\\_1](#))

**Table 2: The prevalence of burnout syndrome among healthcare providers**

Burnout Syndrome	Frequency (N)	Percentage (%)
<b>Emotional Exhaustion</b>		
Extreme Fatigue	43	15.5
Less Fatigue	122	44.0
Moderate fatigue	112	40.4
<b>Depersonalization</b>		
High Depersonalization	133	48.0
Low Depersonalization	55	19.9
Moderate Depersonalization	89	32.1
<b>Personal Achievement</b>		
High Personal Achievement	27	9.7
Low Personal Achievement	205	74.0
Moderate Personal Achievement	45	16.2

Source: Field Study (2024)

### *Socio-Demographic Characteristics Associated with Burnout Syndrome Among HCWs*

The analysis of socio-demographic characteristics of burnout syndrome, as measured by Pearson chi-square tests, shows nuanced associations across different burnout dimensions. Age did not significantly influence emotional exhaustion [ $\chi^2(4) = 9.020, p = .061$ ], depersonalization [ $\chi^2(4) = 1.220, p = .875$ ], or personal achievement [ $\chi^2(4) = 1.122, p = .891$ ]. Marital status was significantly associated with emotional exhaustion [ $\chi^2(8) = 17.561, p = .025$ ], but not with depersonalization ( $\chi^2(8) = 7.404, p = .494$ ) or personal achievement [ $\chi^2(8) = 10.549, p = .229$ ]. Religion and educational status did not significantly affect any dimension of burnout, with p-values ranging from .144 to .698. Profession was significantly related to depersonalization [ $\chi^2(2) = 22.201, p < .001$ ], but showed no significant effects on emotional exhaustion [ $\chi^2(2) = 2.037, p = .361$ ] or personal achievement [ $\chi^2(2) = 3.129, p = .209$ ]. Working hours had a significant impact on personal achievement [ $\chi^2(2) = 23.532, p < .001$ ], though it did not significantly affect emotional exhaustion [ $\chi^2(2) = 1.560, p = .458$ ] or depersonalization [ $\chi^2(2) = 3.624, p = .163$ ]. Experience showed no significant association with any burnout dimension, with p-values of .086 for emotional exhaustion, .772 for depersonalization, and .794 for personal achievement (Table 3).

*Socio-Demographic Characteristics Associated with Burnout Syndrome*

**Table 3: Socio-demographic characteristics associated with burnout syndrome**

	Emotional Exhaustion			Depersonalization			Personal Achievement		
	Value	df	Sig. (2-sided)	Value	df	Sig. (2-sided)	Value	df	Sig. (2-sided)
Age	9.020 <sup>a</sup>	4	.061	1.220 <sup>a</sup>	4	.875	1.122 <sup>a</sup>	4	.891
Marita status	17.561 <sup>a</sup>	8	.025	7.404 <sup>a</sup>	8	.494	10.549 <sup>a</sup>	8	.229
Religion	2.928 <sup>a</sup>	4	.570	6.844 <sup>a</sup>	4	.144	2.203 <sup>a</sup>	4	.698
Educational status	9.198 <sup>a</sup>	6	.163	9.764 <sup>a</sup>	6	.135	7.167 <sup>a</sup>	6	.306
Profession	2.037 <sup>a</sup>	2	.361	22.201 <sup>a</sup>	2	.000	3.129 <sup>a</sup>	2	.209
Working hours	1.560 <sup>a</sup>	2	.458	3.624 <sup>a</sup>	2	.163	23.532 <sup>a</sup>	2	.000
Experience	4.903 <sup>a</sup>	2	.086	.518 <sup>a</sup>	2	.772	.462 <sup>a</sup>	2	.794

Source: Field Study (2024)

*Work-Related Factors Associated with Burnout Syndrome among HCWs*

The regression analysis assessing the relationship between work-related factors and burnout syndromes demonstrates a strong model fit, with ( $R = .863$ ) and ( $R^2 = .874$ ), indicating that approximately 87.4% of the variance in burnout syndromes is explained by the model. The ANOVA results confirm the model's overall significance, ( $F(4, 272) = 220.690, p < .001$ ). Among the predictors, "Overall comfort and functionality" ( $\beta = 5.978, p < .001$ ) and "Level of cooperation" ( $\beta = 6.161, p < .001$ ) show significant positive effects on burnout. "Support and guidance" also significantly contribute ( $\beta = 4.416, p < .001$ ). The "Decision-making process" has a smaller but still significant impact ( $\beta = 1.994, p = .003$ ). These findings highlight the substantial influence of work-related factors on burnout, with particularly strong effects from comfort, cooperation, and support (Table 4). (See more work-related analysis in [supplementary 2](#))



**Table 4: Regression analysis of work-related factors and burnout syndromes**

**Model Summary**

<b>R</b>	<b>R Square</b>	<b>Adjusted R Square</b>	<b>Std. Error of the Estimate</b>
.863 <sup>a</sup>	.874 <sup>a</sup>	.764	.761

**ANOVA**

<b>Model</b>	<b>Sum of Squares</b>	<b>Df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Regression	22916.348	4	5729.087	220.690	.000 <sup>b</sup>
Residual	7061.074	272	25.960		
Total	29977.422	276			

**Coefficients**

	<b>Unstandardized Coefficients</b>	<b>Standardized Coefficients</b>			
	<b>B</b>	<b>Std. Error</b>	<b>Beta</b>	<b>T</b>	<b>Sig.</b>
(Constant)	-39.384	2.356		-16.720	.000
Overall comfort and Functionality	5.978	.720	.337	8.303	.000
Level of Cooperation	6.161	.528	.445	11.679	.000
Support and Guidance	4.416	.596	.299	7.414	.000
Decision-making Process	1.994	.671	.120	2.971	.003

*R* (Correlation Coefficient),  $\beta$  (Unstandardized Coefficients), *F* (F-Statistic)

Source: Field Study (2024)

***Influence of Organizational Factors on Burnout Syndrome Among HCWs***

The regression analysis of organizational factors and burnout syndromes reveals that the model has strong explanatory power, with  $R=.861$  and  $R^2 = .741$ , indicating that approximately 74.1% of the variance in burnout syndromes is accounted for by the organizational factors included in the model. The ANOVA results show that the model is highly significant,  $F(4,271)=193.911$ ,  $p<.001$ . Among the predictors, "Fairness, policies, and practices" ( $\beta =2.563$ ,  $p<.001$ ), "Work-life balance" ( $\beta =7.294$ ,  $p<.001$ ), "Professional growth/skill development" ( $\beta =3.207$ ,  $p<.001$ ), and "Equal opportunity" ( $\beta =4.172$ ,  $p<.001$ ) all have significant positive effects on burnout syndromes. This suggests that poor perceptions of these organizational factors are associated with higher levels of burnout, emphasizing the need for improvements in these areas to mitigate burnout among employees (Table 5). (See more organizational factor analysis in [supplementary 3](#))

*Regression Analysis of Organizational Factors and Burnout Syndromes*

**Table 5: Regression analysis of organizational factors and burnout syndromes**

<b>Model Summary</b>					
<b>R</b>	<b>R Square</b>	<b>Adjusted R Square</b>	<b>Std. Error of the Estimate</b>		
.861 <sup>a</sup>	.741	.737	5.31429		

  

<b>ANOVA</b>					
<b>Model</b>	<b>Sum of Squares</b>	<b>Df</b>	<b>Mean Square</b>	<b>F</b>	<b>Sig.</b>
Regression	21905.487	4	5476.372	193.911	.000 <sup>b</sup>
Residual	7653.498	271	28.242		
Total	29558.986	275			

  

<b>Coefficients</b>					
	<b>Unstandardized Coefficients</b>	<b>Standardized Coefficients</b>	<b>Beta</b>	<b>t</b>	<b>Sig.</b>
	<b>B</b>	<b>Std. Error</b>			
(Constant)	-25.514	2.318		-11.009	.000
Fairness, Policies and Practices	2.563	.563	.155	4.550	.000
Work-life balance	7.294	.762	.480	9.572	.000
Professional Growth/ Skill Development	3.207	.788	.204	4.070	.000
Equal Opportunity	4.172	.481	.312	8.675	.000

*R* (Correlation Coefficient),  $\beta$  (Unstandardized Coefficients), *F* (F-Statistic)

Source: Field Study (2024)

**DISCUSSION**

**Prevalence of Burnout Syndrome Among Healthcare Providers**

This study examined the prevalence of burnout syndrome among healthcare providers in Akuapem North Municipality, Ghana, and uncovered a significant presence of burnout across all three key dimensions: emotional exhaustion, depersonalization, and low personal achievement. The high prevalence of emotional exhaustion, with 31.4% of participants experiencing extreme fatigue several times a month and 20.2% weekly, is consistent with Maslach’s (1996) conceptualization of burnout. This dimension of burnout is characterized by a depletion of emotional resources, which can lead to a sense of being overwhelmed and unable to cope with daily work demands. Elbarazi et al. (2017) further corroborate this, noting that fatigue among nurses is often due to excessive workloads and staffing shortages. Additionally, Schaufeli et al. (1996) have documented physical manifestations of burnout, such as increased susceptibility to illness and sleep disturbances. The results from this study highlight the urgent need for interventions aimed at addressing workload, improving staffing levels, and providing robust emotional support to mitigate emotional exhaustion among healthcare workers.

The current study also revealed a troubling level of depersonalization, with nearly half (48.0%) of respondents reporting high levels. Depersonalization, as defined by the WHO (2017), involves a detached and often cynical attitude towards patients, which can lead to feelings of alienation and negatively impact the quality of care provided. This aligns with findings from Pisanti et al. (2013), who found that depersonalization can significantly affect patient care by reducing healthcare workers' ability to connect empathetically with patients. Addressing depersonalization requires fostering a supportive work environment and implementing programs focused on empathy and emotional intelligence. A significant 74.0% of respondents reported low personal achievement, reflecting a widespread challenge in maintaining a sense of accomplishment. This finding is consistent with research by Wang et al. (2024), who found high levels of diminished personal accomplishment among nurses, and Ogundipe et al. (2014), who noted similar issues among physicians in Nigeria. Opoku and Apenteng (2014) further reported elevated burnout levels among Ghanaian physicians. These findings underscore the need for strategies that enhance recognition and reward systems, offer professional development opportunities, and ensure a sense of autonomy in decision-making to improve personal achievement and job satisfaction.

### **Socio-Demographic Characteristics and Burnout Syndrome**

This study explored the relationship between socio-demographic factors and burnout. Age did not emerge as a significant predictor of burnout dimensions, contrasting with some previous research suggesting that age can impact burnout risk (Abdulla et al., 2021). For instance, Abdulla et al. (2021) found that younger and older age groups, particularly those under 55 or between 40-49 years, were more prone to burnout. However, Fentie et al. (2021) observed a positive association between age and personal accomplishment, but not with emotional exhaustion or depersonalization. The lack of a significant age effect in this study may reflect evolving workplace dynamics and protective mechanisms associated with older age, such as developed coping strategies and increased job autonomy (Al-Haddad et al., 2020).

Marital status emerged as a significant factor influencing emotional exhaustion, with married healthcare providers reporting lower levels of burnout. This finding supports previous research indicating that a supportive family environment can buffer against job-related stress (Alhajjar & Alhajjar, 2016). Married individuals, particularly those with children, may find additional emotional stability and resources through their familial roles, which positively impact their resilience to burnout. However, the influence of marital status may be moderated by individual circumstances, including the quality of marital relationships and the balance between work and family responsibilities (Lerman & Isen, 2017).

Religion did not show a significant association with any burnout dimension in this study, aligning with some previous findings (Belay et al., 2021). Nonetheless, exploring the potential role of religious beliefs and practices in managing work-related stress could be valuable. Educational status did not significantly affect burnout dimensions in this study, which contrasts with findings by Belay et al. (2021) and Navarro-González et al. (2015) that link higher educational qualifications with increased burnout. This discrepancy highlights the need to further explore the relationship between educational background and burnout risk. Educational qualifications can influence perceptions of job demands, control, and career advancement opportunities, which may impact burnout susceptibility. Future research should investigate how education affects burnout through factors such as training quality and professional identity formation.

Profession was significantly associated with depersonalization, indicating that different healthcare roles experience varying levels of burnout. This finding aligns with previous research suggesting that burnout varies across professions (Taranu et al., 2022). For example, physicians may face unique stressors related to clinical decision-making and long hours, while nurses might experience burnout due to high patient loads and inadequate staffing (Shanafelt et al., 2022). Exploring job demands and organizational factors specific to different healthcare professions can help identify targeted interventions to mitigate burnout.

### **Work-Related Factors and Burnout Syndrome**

The analysis of work-related factors highlights significant associations between organizational characteristics and burnout dimensions. Factors such as overall comfort and functionality, support, guidance, and cooperation were found to impact burnout levels. These findings align with previous research, demonstrating that supportive work environments and adequate organizational resources are crucial in reducing burnout (Falgueras et al., 2021). High workloads and insufficient support contribute to burnout, emphasizing the need for systemic improvements in healthcare settings. Role clarity and decision-making processes were also significant.

Role ambiguity and conflicts within the workplace are known stressors that contribute to emotional exhaustion and dissatisfaction (Qedair et al., 2022). Improving organizational practices to provide clear roles and effective decision-making processes can mitigate these stressors and reduce burnout (Chunming et al., 2017). Interpersonal relationships and emotional labour are key determinants of burnout. Positive relationships among colleagues and supportive leadership can mitigate burnout, while poor support systems and high emotional labour can exacerbate it (Belay et al., 2021; Konlan et al., 2022). The study's use of the Coordination of Resources (COR) theory provides insights into how organizational characteristics influence burnout (Schieman et al., 2021). Addressing systemic issues within healthcare organizations can improve professional well-being and patient care.

### **Limitation of the Study**

The study was confined to the Akuapem North Municipality, which may have impacted the extent to which the results could be generalized to other regions or healthcare environments. This geographical limitation affected the broader applicability of the findings. Additionally, the presence of social desirability bias may have led participants to either downplay or exaggerate their burnout levels. The cross-sectional nature of the study offered only a one-time snapshot of burnout prevalence, thus precluding any longitudinal examination or determination of causal relationships.

### **CONCLUSION**

This study evaluated burnout syndrome among healthcare providers in Akuapem North Municipality, using data from 277 participants. The findings reveal high levels of emotional exhaustion, depersonalization, and reduced personal achievement. These issues reflect the impact of workplace stress on healthcare workers' well-being. Key socio-demographic factors like marital status, profession, and years of experience were significantly linked to burnout dimensions. Age, education, and religion showed minimal effects. Work-related factors, including organizational support, role clarity, and decision-making processes, significantly influenced burnout levels.

Improved organizational fairness, work-life balance, and professional growth opportunities were associated with reduced burnout.

### **RECOMMENDATIONS**

The District Health Directorate should introduce emotional and psychological support programs, including regular counselling and stress management workshops for healthcare workers.

The District Health Management Team should develop clear, fair policies regarding workload distribution and career advancement to ensure transparency.

The District Health Directorate should implement flexible work schedules and support initiatives to help healthcare providers maintain a healthy work-life balance.

The District Health Training Center should offer continuous professional development and skill enhancement programs to boost healthcare workers' competencies and job satisfaction.

Non-Governmental Organizations (NGOs) like Partners In Health can develop and promote comprehensive well-being programs tailored to the unique challenges faced by healthcare providers in different regions

Professional associations such as the Ghana Medical Association or the Ghana Nurses and Midwives Association can advocate for policy changes, offer training programs, and provide resources focused on mental health support and workload management for their members.

Educational institutions, including universities and training colleges that provide healthcare education, can incorporate stress management, resilience training, and emotional intelligence into their curricula.

The District Health Management Team should clearly define and communicate roles and responsibilities to reduce ambiguity and improve job satisfaction.

The District Health Directorate should establish programs to foster teamwork and improve interpersonal relationships among healthcare staff, including team-building activities and peer support groups.

The District Health Directorate should create a system to regularly evaluate burnout levels and the effectiveness of interventions, allowing for data-driven improvements.

Future research should test specific interventions targeting these factors. It should also track changes in burnout over time and explore how individual and organizational factors interact across different healthcare settings. This approach will help identify effective strategies for reducing burnout and improving job satisfaction among healthcare professionals.

Implementing these measures at the district level will help effectively manage burnout and enhance the well-being of healthcare providers in Akuapem North Municipality.

### **Supplementary Material**

The supplementary material can be accessed at <https://doi.org/10.6084/m9.figshare.27015760>

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### **Ethics Approval**

The study received approval from the Ghana Health Service Ethics Review Committee and the facility head. Written consent was obtained from all participants, and their data was kept confidential using numerical codes. Participation was voluntary, and individuals could withdraw at any time.

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### **Data Availability Statement**

The data is available from the corresponding author upon reasonable request.

### **Conflicts of Interest**

The authors declare no conflicts of interest.

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