



ACCESSING THE EFFECTIVENESS OF EMPLOYEE WELLBEING PROGRAMS IN REDUCING BURNOUT AMONG HEALTHCARE PROFESSIONALS IN ENUGU STATE, NIGERIA.

Queen Ene Iduh

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National college of Ireland

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QUEEN ENE IDUH

Student Name:

21185531

Student ID:

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SUPERVISOR: DR. KESIENA EBENADE

Lecturer:

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This analysis aims to examine how well-being program participation affects burnout while also accounting for support and workload levels

The purpose of this analysis is to explore the impact of participating in well-being programs on burnout, taking into consideration perceived organizational support and workload.

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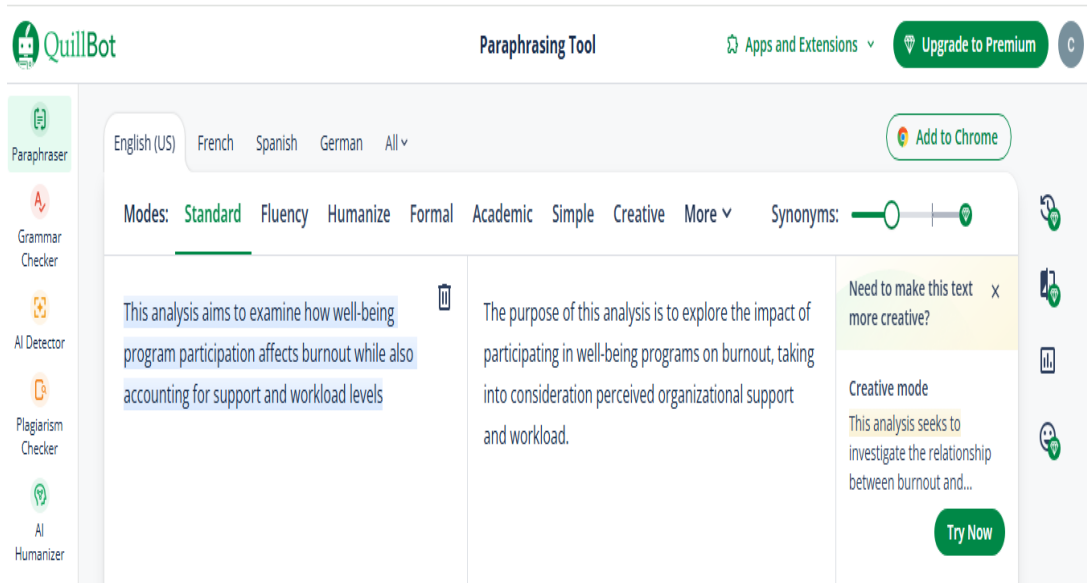
The model was statistically significant, but accounted for only small portion of the variance

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Abstract

Nigerian healthcare workers' burnout, a serious issue in Enugu, Nigeria, is driven by high workload and limited resources within a resource-constrained healthcare system. In this cross-sectional study, the relationships between participation in well-being programs, workload, perceived organizational support (POS), and burnout among 400 healthcare workers were explored using a Google Forms survey with a 100% response rate. Applying stepwise regression and descriptive statistics, the study addresses three objectives: (1) the influence of program participation on burnout, (2) the ability of POS to mediate program efficacy, and (3) the moderating influence of workload between the program-burnout links. The study used the aggregated Maslach Burnout Inventory score (0–30) as the continuous dependent variable. Findings indicate that participation in well-being programs, particularly those perceived to alleviate stress, significantly lower burnout, with quality and involvement greater than frequency. POS heavily influences the effectiveness of well-being programs through a strong interaction, emphasizing the importance of a positive organizational culture. Heavy workloads modestly lower the impact of well-being programs, with effects varying across facilities. The diverse sample (65.8% female, 56.7% private clinics, and 43.8% allied health workers) ensures high representativeness. The study conclude that well-being programs and POS are promising initiatives to decrease burnout, but workload pressures require additional measures. Such measures as the introduction of quality-oriented well-being initiatives, the enhancement of POS by means of staff recognition, and the decrease of workload by distributing some tasks to allied health workers are recommended. The study present novel insights on burnout mitigation in the Nigerian healthcare context, which can be applied to low-resource African environments. Although the study has shortcomings, including unmeasured contextual factors, the results can guide policymakers and healthcare leaders who want to improve the well-being of the workforce in Enugu and other regions.

Keywords: Burnout, Well-being Programs, Perceived Organizational Support, Workload, Healthcare Professionals, Stepwise Regression, Enugu, Nigeria

Declaration

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CHAPTER 1: INTRODUCTION

1.1 Introduction

Burnout is an increasingly serious issue facing healthcare professionals (doctors, nurses, pharmacists and allied health workers), particularly in Nigeria, where factors like inadequate staffing, excessive work hours, and scarce resources make the situation even more challenging. It typically involves chronic fatigue, emotional detachment, and a sense of low achievement (Maslach et al., 2001). Studies have shown that this problem is widespread—Nwosu et al. (2020) reported that more than 75% of doctors in five tertiary hospitals in Nigeria were experiencing burnout, largely due to demanding workloads. Similarly, Nwosu et al. (2021) found that 69% of healthcare workers in Enugu were affected, citing long shifts and poor balance between work and personal life as key contributors. These findings point to an urgent need for meaningful support systems. In other countries, wellness initiatives—like stress relief workshops and mindfulness training—have been used to reduce burnout levels (Cohen et al., 2023), with Shanafelt et al. (2017) observing positive results among physicians in the U.S. However, the effectiveness of such programs within the Nigerian context, and more specifically in Enugu State, remains underexplored.

Burnout has consequences that extend beyond individual well-being, posing serious risks to patient outcomes and the overall health system—especially in Nigeria, where there are only about 1.95 doctors per 1,000 people (World Bank, 2021). It has been associated with a rise in medical mistakes and increased employee turnover (West et al., 2016). Research by Ogundipe et al. (2014) revealed that 45.6% of resident doctors in Lagos showed signs of severe emotional fatigue, attributing it to long work hours and insufficient institutional support. While staff wellness initiatives—focused on building resilience and fostering peer support—have shown promise in reducing burnout levels (Cooper et al., 2023), their implementation in Nigeria faces unique barriers, such as a shortage of mental health services (Salihu, 2023). This study aims to investigate the effectiveness of these interventions in the context of Enugu State, Nigeria, with the intention of shaping practical solutions that relieve healthcare worker stress and strengthen the quality of care.

1.2 Research Questions

- i. What is the relationship between participation in employee well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria?
- ii. How does perceived organizational support influence the effectiveness of employee well-being programs in reducing burnout among healthcare professionals?
- iii. To what extent does workload moderate the relationship between participation in well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria?

1.3 Research Aims and Objectives

Due to the growing emotional and psychological strain on healthcare professionals as well as the increased demands of patient care, the global healthcare industry has been under increasing pressure in recent years. Studies reveal that nearly half of healthcare personnel had burnout during the COVID-19 pandemic, compared to roughly 40% prior to the pandemic. This indicates that the COVID-19 pandemic in particular caused an exceptionally high degree of stress (University of Illinois Chicago, 2020). Like many other low- and middle-income nations, Nigeria has faced particularly difficult obstacles. Long work hours, scarce resources, and demanding work conditions are all major sources of stress for Nigerian healthcare workers, which raises their psychological stress levels. Research shows that 61.97% of Nigerian healthcare workers are experiencing psychosocial stress (Olagunju et al., 2023). While much attention has been given to improving infrastructure and securing funding, less has been done to support the well-being of the healthcare workers who form the foundation of the system. Despite their hard work, especially during crises like the COVID-19 pandemic, many are quietly grappling with burnout, stress, and emotional fatigue on a daily basis (Olashore et al., 2022).

Countries such as the UK and Canada have implemented structured well-being programs for healthcare staff, including mindfulness sessions and institutional support structures. These interventions have been linked to significant improvements in staff morale and patient outcomes, and recommendations from the UK's General Medical Council highlight the importance of compassionate leadership, improved workplace culture, and standardized support structures in promoting healthcare worker well-being (Rokach & Patel, 2023; General Medical Council, 2025).

However, Nigeria's approach has largely been reactive, with limited data on whether such interventions can truly make a difference in the local context.

To achieve this aim, the study will pursue the following objectives:

- i. To determine the relationship between participation in employee well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria.
- ii. To assess how perceived organizational support influences the effectiveness of well-being programs in reducing burnout.
- iii. To examine the moderating effect of workload on the relationship between well-being program participation and burnout.

1.4 Research Methodology

This research employs a quantitative approach in examining the influence of well-being initiatives on burnout among Enugu State healthcare workers. A quantitative design is most suitable for this research as it enables the measurement and analysis of numerical data, which makes it easier to establish main correlations between the variables (Creswell & Creswell, 2018). Data collection is done using an online survey created and administered using Google Forms. Rating the multiple-choice questions and items on the survey ranging from workload to demographic data, perceived organizational support, burnout symptoms, and well-being initiative participation is a 5-point Likert scale. Compatibility and consistency of the responses are possible through this architecture (Bryman, 2016).

The research aims at healthcare providers who are employed in public and private hospitals with the help of purposive sampling. The method guarantees that only healthcare workers who have direct contact with patients and who are most likely to suffer from work-related stress are sampled (Palinkas et al., 2015). Stepwise regression is employed in the analysis of data collected as it is suitable in testing the effect of numerous independent variables on the respondents' likelihood of having different levels of burnout. This approach not only adjusts for categorical outcomes, but it also enables comparison across various burnout categories, with greater information regarding how workplace interventions influence staff well-being (Hosmer, Lemeshow, & Sturdivant, 2013).

1.5 Research Structure

This research is structured into five chapters, each building logically upon the previous to provide a comprehensive understanding of the study topic.

Chapter One introduces the research background, outlines the problem statement, and states the research aim, objectives, and significance. It also presents a brief overview of the methodology and outlines the structure of the study.

Chapter Two reviews existing literature on employee well-being programs, burnout in healthcare settings, and relevant theoretical frameworks. It also explores empirical studies on the relationship between well-being initiatives, organizational support, workload, and employee burnout.

Chapter Three explains the research methodology, detailing the research design, sampling method, data collection instruments, and analysis techniques—specifically, the use of stepwise regression.

Chapter Four presents the results of the data analysis, including descriptive statistics, regression outcomes, and an interpretation of the findings in relation to the research objectives.

Chapter Five concludes the study by summarizing key findings, discussing implications for practice and policy, acknowledging limitations, and suggesting areas for future research.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter is a literature review of burnout and interventions for employee well-being as they pertain to the healthcare sector. The literature review provides the platform for understanding how burnout happens, especially in high-stress environments like hospitals, and how systematic wellness interventions can reverse burnout. It also examines supporting concepts such as perceived organizational support and workload, which may influence how effective these programs are. Drawing from both global studies and Nigeria-specific research especially in Enugu State, the chapter is structured to present the key theoretical and empirical insights that guide this study.

2.2 Concept of Burnout

Burnout is a psychological syndrome that shows up as a long-term response to chronic occupational exposure to work-related interpersonal stressors, and includes emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout was first named in the 1970s by Herbert Freudenberger as a state of mental and physical exhaustion caused by one's job (Freudenberger, 1974). It has gone on to be extensively studied, particularly in high-stress careers such as social work, teaching, and health care. Maslach and Jackson (1981) created the Maslach Burnout Inventory (MBI) as an operationalization of the construct, and it remains in use today as the standard against which burnout is compared. Their study established three central dimensions: emotional exhaustion, where the staff were drained and could not cope; depersonalization, where cynicism or absence of empathy towards clients and colleagues existed; and reduced personal accomplishment, where staff perceived their competence and effectiveness declining. These dimensions indicate burnout as a multifaceted syndrome, distinct from common stress or depression, though it has overlapping features (Schaufeli & Enzmann, 1998). The research has identified that burnout is not a failure but the result of systemic causes, such as workload, deficiency of social support, and mismatch between personal values and organizational demands (Leiter & Maslach, 2004). To that end, a Dutch longitudinal study by Bakker et al. (2000) found that high job demand, with low job resources like autonomy and feedback, highly predicted Dutch teachers' burnout after one year. It emphasizes the interplay of environmental factors and individual well-being, suggesting burnout is nearly as much an organizational as an individual

issue. The consequences of burnout extend beyond the physical and mental health of the person to organizational functioning, such as increased turnover and reduced productivity (Swider & Zimmerman, 2010). Societal and cultural expectations further may fuel burnout, particularly in careers in which self-sacrifice is valorized, such as nursing or education (Dyrbye et al., 2017). Burnout therefore must be addressed from an integrated perspective that takes into account individual, organizational, and societal factors.

The antecedents of burnout are widely documented in the literature, and research identifies the role of chronic job stressors. According to the Job Demands-Resources (JD-R) model, burnout is produced when high job demands such as heavy workload, time pressure, or emotional labor are not adequately balanced by job resources such as social support, autonomy, or opportunities for professional growth (Demerouti et al., 2001). For example, in a meta-analysis by Alarcon (2011), emotional exhaustion was related to job demands at a significant level, while depersonalization was primarily related to unsupportive supervision and peer relationships. The model has been verified across a wide range of diverse occupational groups, for example, among health workers, where extended working hours and emotionally demanding encounters with patients are common (Laschinger et al., 2015). Aside from work-related causes, personality characteristics such as perfectionism or low resilience can predispose individuals to burnout, even though these are weaker predictors than work environment factors (Bianchi et al., 2015). For instance, a Houkes et al. (2011) study demonstrated that highly intrinsic-motivated teachers were ironically more prone to burnout under high bureaucratic pressure because their commitment led them to overinvest. Social forces come into play as well; in productivity- and achievement-oriented societies such as the United States, employees can internalize over exacting expectations, increasing burnout risk even further (Pines & Aronson, 1988). The COVID-19 pandemic again placed burnout at center stage, particularly for front-line workers. A research carried out by Morgantini et al. (2020) found that healthcare professionals in high-income countries reported record-high levels of burnout due to workload intensification, fear of contagion, and insufficient protection. The study highlights how external crises can exacerbate workplace stressors, pushing people beyond their breaking point. To address burnout, then, interventions need to occur at many levels, including organizational policy-making to limit workload, stress-management training, and societal change in order to popularize work-life balance.

Burnout's impact on the worker is therefore secondary to organizations and society in general. Burnout has been implicated in a cascade of adverse health outcomes, including depression, anxiety, and cardiovascular disease, contributing to increased healthcare costs and lowering quality of life (Salvagioni et al., 2017). On the organizational level, burnout accounts for absenteeism, presenteeism (work while ill), and turnover rates, which impair workflow and represent enormous financial costs (Halbesleben & Buckley, 2004). For instance, Shanafelt et al. (2012) estimated physician burnout in the United States to cost billions of dollars yearly in terms of decreased productivity and replacement costs. Burnout degrades the performance quality of delivery of services as well; for instance, burnt-out professionals are more prone to make medical errors, which undermines patients' safety (West et al., 2018). Similarly, in the classroom environment, teacher burnout correlates with reduced student engagement and performance (Herman et al., 2018). Such ripple effects imply that burnout is a systems problem and not a singular incident with far-reaching implications. Prevention and intervention strategies have been researched widely, with mixed findings. Interventions in mindfulness, for instance, have also been found to avert burnout among medical practitioners, though their sustained efficacy is doubtful (Luken & Sammons, 2016). Interventions at the organizational level such as flexible work policies and peer support groups work better because they address root causes rather than symptoms of burnout (Awa et al., 2010). Their implementation, however, requires leaders' commitment and cultural change, which are typically resisted by high-stress industries (Maslach & Leiter, 2016).

2.3 Concept of Employee Well-being Programs

Employee well-being programs are a range of organizational activities aimed at enhancing the physical, mental, and emotional well-being of employees and ultimately at healthier and more productive employees. Employee well-being programs have grown more prominent in recent decades as employers come to understand the link between employee well-being and organizational performance, such as reduced absenteeism, enhanced job satisfaction, and enhanced performance (Cooper & Cartwright, 1994). Well-being programs typically entail activities such as stress management training, fitness incentives, mental health programs, flexible work schedules, and employee assistance programs (EAPs). The theoretical underpinnings of well-being programs are occupational health psychology, which emphasizes the mutualism between work settings and

worker health (Quick & Tetrick, 2003). According to the World Health Organization (WHO), well-being among workers in work settings is defined as a condition under which employees realize their potential, cope with normal pressures, function effectively, and help society (WHO, 2004). According to literature, well-being initiatives are most effective when they are integrated and address both employee issues and organizational elements, such as workload and organizational culture (LaMontagne et al., 2014). For instance, a study by Stansfeld et al. (2013) found that individual stress management training and workplace intervention in the form of additional communication and leadership support significantly reduced workers' levels of stress among British civil servants. Growing take-up of well-being interventions also reflects larger societal shifts toward fostering mental well-being and work-life balance, particularly in very competitive industries like technology and health care (Grawitch et al., 2006). Yet their effectiveness relies on their design, implementation, and compatibility with the workers' needs since poorly implemented efforts may stimulate suspicion and alienation (Parks & Steelman, 2008). Richardson and Rothstein's (2008) meta-analysis, for example, indicated that even though stress management interventions all boosted the well-being of employees, their impact diminished when interventions were implemented without any employee participation or managerial support. Thus, well-being programs are an investment in human capital that must be planned and evaluated for effective implementation and desired outcomes.

Theoretical underpinnings of employee well-being initiatives draw significantly from theories like the Job Demands-Resources (JD-R) model, which assumes that employee well-being is an outcome of the interaction between work demands (e.g., workload, emotional labor) and work resources (e.g., autonomy, social support) (Bakker & Demerouti, 2007). Well-being initiatives aim to develop resources and offset demands, thereby reducing burnout and enhancing engagement. For instance, Schaufeli et al. (2009) demonstrated that providing employees with resources like peer support groups and flexible work scheduling enhanced their work engagement among a sample of Dutch healthcare employees. Further, self-determination theory (SDT) suggests that employees' well-being is enhanced as their autonomy, competence, and relatedness needs are met (Ryan & Deci, 2000). Interventions such as skill development, authentic praise, or team-building activities are aligned with these values and create intrinsic motivation and psychological health. Multidimensional programs have evidence of their efficacy; in a longitudinal study, Bond and Bunce (2001) found that a UK-based well-being program consisting of stress management

training, health screening, and ergonomic improvements produced significant reductions in psychological distress and absenteeism at six months. However, effectiveness differs between programs by context and cultural influences. For example, Nielsen et al. (2010) in a Danish work setting illustrated that well-being interventions were less effective in low trust management contexts, highlighting the need for a positive work culture. The global COVID-19 pandemic further highlighted the need for adaptive well-being programs, as social distancing and teleworking fuelled mental illness challenges. In a 2021 Mercer global survey, 70% of employers featured mental health coverage during the pandemic, and virtual wellness sessions and teletherapy were becoming the new standard. There are still challenges with these technologies, including providing programs to employee groups of all types on an equal basis and overcoming stigma for receiving mental health treatment (Dimoff & Kelloway, 2019).

The significance of employee wellness programs is not only in health promotion, but also in burnout prevention and organizational development. There is evidence that workplaces investing in employee well-being have better staff morale, less absenteeism, and improved service delivery (Krekel, Ward, & De Neve, 2019). Translating to healthcare workplaces, these findings are equivalent to fewer patient complaints, less turnover, and lower medical errors (Panagioti et al., 2017). Nevertheless, effectiveness of these programs is dependent on faithful execution, strong commitment by leadership, and occasional evaluation. Relevance and uptake are also enhanced by engaging the employees in design and feedback. The healthcare system in Nigeria is currently lagging behind in formalising these interventions, notwithstanding modest advancements. Therefore, it is essential to comprehend how these programs operate and identify contextual constraints to their effectiveness in order to improve the welfare of healthcare workers, especially in areas like Enugu State where burnout is a major problem.

2.4 Burnout among Healthcare Professionals in Nigeria

Burnout in Nigerian healthcare professionals is increasingly becoming a high priority, driven by a mix of systemic challenges like understaffing, poor infrastructure, and unsustainable workloads. These are exacerbated by the country's unique socioeconomic and cultural contexts. Despite burnout defined as emotional exhaustion, depersonalization, and reduced personal accomplishment having been widely researched across the world (Maslach & Jackson, 1981), in

low- and middle-income countries such as Nigeria, its effects are worse due to limited resources and excessive work demands. A review by Dubale et al. (2019) indicated Nigeria's notable contribution to subregional burnout literature, with 13 studies from Nigeria. All these studies also all report high levels of burnout, particularly among doctors and nurses, between 23.6% and 75.5%, depending on what they define as burnout (Ogunsuji et al., 2019). For example, Olley (2003) conducted a study in the University College Hospital in Ibadan that revealed nurses experienced far higher levels of emotional exhaustion, depersonalization, and stress compared to other health workers like doctors and pharmacists. Nigeria's healthcare sector is experiencing intense stress, partly because of a low patient-to-doctor ratio exacerbated by ongoing emigration of medical practitioners (Nmadu et al., 2020). This is what it takes to create the type of working conditions where burnout is an inevitability. Conditions such as low remuneration, lack of basic protective gear, and even violence in the workplace just add to the stress—especially in the case of crises such as the COVID-19 pandemic (Ochie et al., 2022). Lastly, these stressors do not only affect healthcare workers' welfare but also the quality of service provided to patients. Burnout has been linked to more medical errors and less empathetic patient interactions, which can strongly compromise patient safety (Panagioti et al., 2018). Addressing burnout in Nigeria requires targeted interventions that account for both individual coping mechanisms and systemic reforms to improve working conditions and resource availability.

Cause of Nigerian health workers' burnout is multifaceted, calling for work and overall societal exigencies. The Job Demands-Resources (JD-R) model is a useful theoretical model, proposing burnout is created by an interaction between demanding work and scarce resources (Demerouti et al., 2001). In Nigeria, work demands include long hours of work, typically more than 71 per week routine late-night work, and emotionally taxing interactions with patients, particularly in the few under-staffed hospitals (Nmadu et al., 2020). High emotional exhaustion (45.6%) and depersonalization (57.8%) were documented by a study conducted by Ogundipe et al. (2014) among resident physicians in Lagos as resulting from workload and emotional distress. Shortages of resources, such as medical equipment and outdated equipment, also increase stress, as the healthcare professionals report to work with difficulties in providing quality care (Ozumba & Alabere, 2019). The COVID-19 pandemic heightened these issues to a boiling point, with physicians suffering from burnout levels of up to 62.2% for personal burnout and 52.2% for work burnout, due to fear of infection, insufficient use of protective equipment, and ethical dilemmas

for insufficient resources (Nmadu et al., 2020). Sociodemographic characteristics also become relevant; young professionals, women, and those with less than six years of experience are most adversely affected, possibly due to lower resilience or higher exposure to frontline duties (Nmadu et al., 2020).

The consequences of burnout among Nigerian healthcare professionals are far-reaching, with implications for individuals, healthcare systems, and outcomes for patients. At the individual level, burnout has implications for depression, anxiety, and physical disease, including cardiovascular and metabolic conditions (Salvagioni et al., 2017). 40% of the healthcare providers in Enugu were depressed, and burnout levels were 69%, showing the psychiatric burden (Nwosu et al., 2021). Burnout within an organization leads to high turnover and absence and places additional pressure on an already overloaded healthcare workforce in Nigeria. In a Ghanaian population of nurses, as with Nigeria, burnout correlated with intent to leave, an effect heightened by emigration of doctors to wealthier countries (Opoku et al., 2022). Among the Nigerian physicians who replied, 74.6% believed that burnout was having patient safety effects, attributing mistakes to fatigue and low motivation (Nmadu et al., 2020). A study in Enugu State presents clear evidence of prevalence and severity of burnout among health workers.

A major cross-sectional study in the National Orthopaedic Hospital, Enugu, in November and December 2019 among 155 health professionals (34 physicians and 121 nurses) using the Oldenburg Burnout Inventory (OLBI) revealed a burnout prevalence of 69% (Okwaraji et al., 2021). This very high rate was associated with self-reported health status and length of professional service but not occupation or depression screen status, suggesting that systemic workplace factors play an important role. The study also revealed that 40% of the respondents screened positive for depression, which strongly indicates a very strong correlation between burnout and mental illness. And yet another research by Okwaraji et al. (2015) on nurses in a tertiary health center in Enugu used the Maslach Burnout Inventory (MBI) and General Health Questionnaire (GHQ-12). It recorded 42.9% high burnout among respondents for emotional exhaustion, 47.6% for depersonalization, and 53.8% for reduced personal accomplishment, and 44.1% for psychological distress. These findings substantiate a broader systematic analysis of sub-Saharan African burnout that included 13 Nigerian studies and indicated that nurses have higher levels of burnout compared to other health professionals, particularly in high-stress environments like Enugu's tertiary

hospitals (Dubale et al., 2019). The high level of burnout in Enugu reflects the tiresome work demands, including extended working hours (often more than 71 hours per week) and frequent night shifts, supported by an unsatisfactory healthcare worker-patient ratio (Nmadu et al., 2020).

Further, the etiology of burnout in Enugu State is firmly embedded in both work and situational causes, as put forward by the Job Demands-Resources (JD-R) model, which defines burnout as a product of absence of equilibrium between job demands and resources (Demerouti et al., 2001). In Enugu, physicians bear unsustainable workloads due to lack of staff, a situation that is exacerbated by physician migration to industrialized countries (Ochie et al., 2022). For instance, a multicenter survey of the tertiary hospitals in Enugu showed that 74.6% of physicians believed that burnout was compromising patient safety, and professional grade, age, and years of practice were all independently associated with exhaustion (Nwosu et al., 2020). Resource constraints, such as shortages of medical supplies and outdated equipment, also increase stress, as staff struggle to provide quality care (Ozumba & Alabere, 2019). These issues were further increased by the COVID-19 pandemic, as healthcare workers in Enugu were faced with increased workloads, fear of infection, and inadequate personal protective equipment, resulting in levels of burnout of up to 62.2% for personal burnout and 52.2% for work-related burnout (Nmadu et al., 2020). Sociodemographic variables are also involved; younger, less experienced professionals are most at risk, perhaps because they are less resilient, or because they are more exposed to frontline demands (Okwaraji et al., 2021). Self-sacrifice norms of health care work and stigma associated with mental health also discourage professionals from using support services, enabling burnout to persist (Konlan et al., 2022). These findings are corroborated by views expressed on social media platforms like X, through which Nigerian health workers regularly list chronic understaffing and lack of basic amenities, such as a steady power supply to clinics, as key sources of stress.

2.5 Theoretical Framework

Burnout and well-being in health professionals require a robust theory foundation to account for the complex interplay among individual, organizational, and environmental determinants. Three general theories: Conservation of Resources (COR), Self-Determination Theory (SDT), and Social Exchange Theory (SET) present complementary theories that account for burnout's underlying processes and well-being's mechanisms. COR Theory is about resource depletion and restoration,

SDT is about intrinsic motivation and psychological needs, and SET is about reciprocal relationships at work. Together, these theories offer an integrated model for accounting for the challenges faced by healthcare professionals and for developing interventions to mitigate burnout and enhance well-being. Every theory is discussed in depth hereinafter, with an international perspective of how it can be implemented in the context of healthcare and with a passing reference to Nigeria's context towards the end of each discussion.

2.5.1 Conservation of Resources (COR) Theory

Conservation of Resources (COR) Theory, developed by Hobfoll (1989), posits that individuals work to acquire and protect resources such as time, energy, social support, and professional competence that are vital to their psychological and physical health. Burnout and stress result when these resources are threatened, lost, or not sufficiently recovered, particularly in high-demand environments such as healthcare, where employees are subjected to excessive emotional and physical work demands. For example, nurses working long hours with limited breaks can become emotionally exhausted, one of the signs of burnout, as energy is depleted without enough time to recover (Halbesleben & Buckley, 2004). The theory's "loss spirals" are particularly relevant, as losses of essential resources early on can lead to further losses; a physician overwhelmed by patient demands being sidelined by colleagues, losing social support and acquiring more stress (Westman et al., 2004). This process is supported by empirical evidence, as a study of Australian health care professionals illustrated that chronic understaffing produced resource loss spirals that increased burnout levels (Aiken et al., 2002). COR Theory, on the other hand, focuses on "gain spirals," where investment in resources, such as access to mentoring or flexible scheduling, enhances resilience and well-being. A study of European hospital workers found that emotional exhaustion was reduced through providing frequent feedback and possibilities for professional development that enhanced workers' sense of control (Gorgievski & Hobfoll, 2008).

The theory also focuses on the context of resource dynamics in the organization. Positive culture hospitals, those with strong leadership or peer networks of support help to aid workers in conserving resources, reducing burnout risk (Shirom, 2003). A Canadian study, for instance, showed that nurses who had a staffing and equipment resource available to them had decreased burnout because they did not have to struggle constantly against resources (Laschinger et al., 2001). COR Theory also accounts for external stressors, such as economic strain or social

pressures that can compound resource loss in health care settings. To illustrate, research on UK physicians showed that public blame and systemic demands for high performance drained emotional resources and resulted in depersonalization (West & Dawson, 2012). COR Theory-driven interventions, like workload management interventions or wellness initiatives, are implemented to restore resources and break loss spirals to allow for long-term well-being (Hobfoll, 2001). The conservation orientation of the theory offers an informative framework to apply when it comes to preventing burnout by specifying exactly what resources healthcare workers need in order to perform optimally, ranging from tangible items like time to intangible ones like appreciation. In Nigeria, the health workers are perpetually resource-scarce, with inadequate medical supplies and chronic understaffing, and system change is urgently needed to prevent debilitating loss spirals and improve well-being (Okwaraji et al., 2021). COR Theory is strong in that it can integrate individual and organizational factors, and as such it is a valuable tool for explanation of burnout in healthcare settings. For example, a study of Japanese nurses identified that, even where workloads were high, nurses with high personal resilience, a psychological asset, were less likely to experience burnout, showing the compensatory role of individual resources (Kaneko & Hirano, 2013). However, the theory claims that organizational resources, such as fair policies and supportive supervision, in most instances are more critical than personal coping skills in burnout prevention (Hobfoll & Freedy, 1993). This is evident in Scandinavian countries' healthcare systems, where robust employee support schemes and controlled rest intervals have been credited with decreased burnout levels (Gustafsson et al., 2010). By explaining burnout as a resource depletion process, COR Theory provides intervention design recommendations with practicality in mind focused on replenishment of resources, e.g., adding staffing numbers or constructing teamwork working environments, so that healthcare professionals can sustain well-being in high-demanding professions. In Nigeria, the sheer scarcity of resources like working tools and mental care increases the relevance of COR Theory, with an urgent need for immediate investment to prevent losses in resources and build resilience in healthcare workers (Nmadu et al., 2020).

2.5.2 Self-Determination Theory (SDT)

Self-Determination Theory (SDT) proposed by Ryan and Deci (2000) argues that motivation and well-being are dependent upon three basic psychological needs being satisfied: autonomy (control of one's action), competence (effectiveness in work), and relatedness (harmony with others). In the

healthcare sector, where the professionals need to exert themselves under high-pressure situations, satisfying these needs can act as a shield against burnout and facilitate engagement. For instance, autonomy-supportive settings, in which clinicians and physicians contribute to clinical decision-making, are associated with decreased emotional exhaustion and greater job satisfaction since a study of German hospital staff (Gagné & Deci, 2005) illustrated. When healthcare professionals feel competency, through avenues of skills strengthening or positive feedback, they are more inclined to be intrinsically motivated, which serves as a burnout buffer.

SDT also differentiates intrinsic and extrinsic motivation and has the contention that health professionals with intrinsic goals of motivation, such as passion for patient care, are less susceptible to burnout when work is satisfying of personal values. A study of Dutch healthcare professionals showed that those who found their work satisfying intrinsic aspirations were more engaged and experienced less burnout under difficult conditions (Van den Broeck et al., 2011). SDT-based interventions such as team-building exercises to foster relatedness or leadership programs to foster autonomy have been shown to be effective in health clinics. A Swedish hospital, for example, that employed peer support groups found increased relatedness and reduced burnout among nurses who believed they were more connected to other people (Weigl et al., 2010). SDT is also aimed at the ill effects of need frustration, in which external pressures like over idealized performance expectations interrupt autonomy and competence to enhance psychological distress. A study of Australian health professionals confirmed that excessive administrative workload lowered autonomy, and hence increased the risk of burnout (Parker et al., 2014). By balancing the fulfillment of need as a necessity, SDT offers a blueprint for workplace design such that healthcare professionals can find meaning and satisfaction in what they do and, as a result, reduce burnout.

The focus in the theory on psychological needs is particularly relevant for healthcare professionals, whose emotional and ethical challenges routinely detract from motivation. Italian physicians were surveyed for a study and rated lower burnout and better job satisfaction when high relatedness, which was fostered by collaborative team arrangements, was present (Cortese et al., 2010). SDT also informs organizational practice, for instance, creating reward systems congruent with intrinsic motivation, like public recognition of excellent patient care as compared to merely extrinsic rewards like bonuses (Deci et al., 1999). By establishing environments that foster autonomy, competence, and relatedness, health organizations can enhance well-being and reduce turnover, as

in participatory management structures in Scandinavian hospitals (Gustafsson et al., 2010). SDT's emphasis on intrinsic motivation and satisfaction of needs provides a positive vision, anticipating that even in trying roles, healthcare professionals are likely to thrive when their psychological needs are satisfied. In Nigeria, where healthcare professionals often have little autonomy due to bureaucratic constraints and a dearth of resources, SDT indicates the potential for empowering professionals through participative decision-making to enhance their wellness (Ogboghodo & Edema, 2020).

2.5.3 Social Exchange Theory (SET)

Social Exchange Theory (SET), which was originally developed by Blau (1964), explains workplace relationships between individuals as reciprocal exchanges where employees provide effort, commitment, and expertise in exchange for reward in the form of appreciation, support, or opportunities for development. In health care, SET explains why good superior-professional or professional-firm interaction promotes well-being, while perceived injustice in the form of disrespect or workload inequity results in burnout. In a study of US nurses, for example, perceived organizational support, in the form of training availability and fair scheduling, reduced emotional exhaustion by creating a reciprocal obligation (Xerri & Brunetto, 2013). High-quality leader-member exchanges (LMX) in which supervisors emotionally and instrumentally support employees function best to improve well-being. Research with Canadian healthcare workers suggested that nurses working with supportive managers experienced less burnout and more commitment to their jobs since they were valued and reciprocated through higher levels of engagement (Thomas & Lankau, 2009). Poor-quality exchanges involving neglect or not being recognized, however, can lead to depersonalization and disengagement, as in a study of UK hospital staff with unsupported work environments (Schaufeli & Bakker, 2004).

SET also points to the role of organizational justice perceived fairness in the allocation of resources and treatment over a course of positive exchanges. A meta-analytic review found that healthcare providers with perceived distributive justice, for example, identical workloads, felt less burnout and higher job satisfaction because they saw their effort as rewardingly shared (Cohen-Charash & Spector, 2001). Team cohesion, the next main exchange mechanism, contributes to well-being by creating a sense of mutual support. One hospital team study within Australia illustrated that high-quality interpersonal relationships lowered burnout by providing emotional resources at stressful

times (Bakker et al., 2005). SET suggests organizations can lower burnout by ensuring equitable exchanges, such as providing professional development opportunities or public recognition of contribution. For instance, a New Zealand hospital that implemented a scheme of recognition for exceptional patient care noticed lower turnover and improved morale, as staff felt their work was valued (Brunetto et al., 2013). The focus of the theory on reciprocity is in seeing the requirement for trust and respect within healthcare settings in which clinicians rely on cooperative relationships in order to manage emotional and professional demands.

The reciprocal character of SET renders it best designed to elucidate the role organizational culture plays in the well-being of healthcare professionals. A research study among German hospital staff found that cultures fostering open communication and equity in decision-making reduced burnout by ensuring positive relations between employees and administration (Leiter & Harvie, 1997). SET also moderates the impact of external pressures, i.e., public demands or regulatory needs, that have the potential to place pressure on exchange relationships by increasing perceived inequities. Bureaucratic demands were found to decrease perceptions of organizational support and contributed to increases in burnout according to one Dutch physicians study (Visser et al., 2003). SET's emphasis on reciprocity has practical implications for the design of interventions, such as mentor training or team reward programs, to promote workplace relationships and avoid burnout. In Nigeria, where the practitioners feel undervalued due to the low pay and scant praise, SET stresses the need for changing organizations to facilitate fair transactions and foster wellness (Okwaraji et al., 2021).

2.6 Empirical Review

The issue of burnout among healthcare professionals has been an issue that has captured a lot of attention in recent years with increasing research that attempts to clarify its causes, consequences, and potential interventions. Burnout as characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, Hawkins and Lewis (1981) define as physical, emotional, and mental exhaustion brought about by extended stress while working. This empirical synthesis brings together evidence from studies that have been conducted on healthcare worker burnout and well-being, particularly for nurses, physicians, and other frontline health workers.

2.6.1 Review of Global Studies

The prevalence of burnout among healthcare workers is prohibitively high, and studies consistently report high prevalence rates in various regions and specialties. West et al. (2018) performed a 2018 systematic review and meta-analysis that reported the prevalence of physician burnout in the United States to be between 25% and 60%, with emotional exhaustion being the most common dimension, seen in as many as 43% of physicians. Also, in 2014, a study by Dyrbye et al. (2014) discovered that 54% of American physicians experienced at least one symptom of burnout, with even higher rates among those working in high-intensity specialties like emergency care and critical care. Likewise, nurses are also on the high risk of burnout; in 2016, McHugh et al. (2016) surveyed 7,424 nurses from 10 countries where they found that 10% in the Netherlands and 78% in Greece experienced burnout, which was attributed to high patient-to-nurse ratios and poor work condition. In the UK, in 2013, it was reported by Ball et al that 35% of hospital nurses experienced high emotional exhaustion from overwork and also by lack of managerial support. In non-Western countries internationally, a study by Elbarazi et al. (2019) in the United Arab Emirates indicated that 70% of primary care physicians experienced moderate to high burnout due to prolonged work hours and administrative work. These findings indicate that burnout is a global phenomenon whose occurrence is defined by work environment and culture.

Burnout precursors are three-dimensional and consist of individual, organizational, and societal predictors. Leiter et al. (2011) found, in a 2011 study of 1,654 Canadian nurses, that job demands in the guise of workload heaviness and speed pressure were the most accurate predictors of emotional exhaustion, and low job resources, such as autonomy and supportive interaction from colleagues, increased depersonalization. Similarly, Laschinger et al.'s (2015) 2015 quantitative Ontario, Canada, study surveyed 1,007 nurses and determined that empowering and disempowering relationships with nurse managers were strong predictors of burnout and 45% reported high emotional exhaustion. In Australia, Holland et al. (2017) performed a study in 2017 with 1,032 junior doctors and saw that excessive working hours (on average, 55 hours per week) and lack of access to leave were the primary contributors, among which 54% of them reported excessive levels of burnout. Societal factors also have a role; a 2016 study by Shanafelt et al. (2016) in the USA found that societal norms of self-sacrifice and perfectionism in medicine encourage, particularly among female physicians, who had higher rates documented (48% versus 38% in males).

The impact of burnout is severe and extends to healthcare workers' well-being, the quality of patient care, and organizational outcomes. In a 2017 systematic review, Salvagioni et al. (2017) reviewed 61 studies and observed that burnout was linked with bodily sickness such as cardiovascular disease and mental illness such as depression, with 30% of burned-out healthcare providers experiencing depressive symptoms. A 2019 U.S. study by Tawfik et al. (2019) found that physician burnout was driving medical errors up by 2-fold, compromising patient safety, as 10% of 6,695 physicians surveyed a serious error in the past three months. Another 2013 study by Fahrenkopf et al. (2013) found that burned-out residents in pediatrics were 3.5 times more likely to make medication errors affecting patient outcomes. Organizationally, burnout results in turnover and absenteeism; Hayes et al. (2015) conducted a 2015 study in New Zealand and found that 20% of highly burned-out nurses intended to quit their facilities in the next year. Patient satisfaction is also compromised; Panagioti et al. (2018) meta-analyzed 42 studies in 2018 and found that burnout was associated with reduced patient satisfaction scores, particularly in primary care. In mental health, Morse et al. (2016) carried out research in 2016 in the UK, during which they found that burn-out mental health nurses were low on empathy, which impacted therapeutic relationships.

A 2017 trial by West et al. (2017) in the U.S. tried out a multicomponent intervention in 74 doctors, combining mindfulness training with peer discussion groups, and saw a 15% reduction in burnout scores after six months. Organizational interventions hold greater promise. A 2014 US trial conducted in 34 primary care clinics by Linzer et al. (2014) used a series of workflow redesigns, including team-based models of care, and resulted in a 10% decline in burnout among 135 physicians. In an analogous manner, a 2016 Canada trial by Dunn et al. (2016) established flexible scheduling for 200 nurses and found a 12% decline in emotional exhaustion over the period of a year. However, barriers to implementation remain; in fact, according to a 2018 Johnson et al. (2018) study in the UK, interventions without employee involvement had low participative rate: only 25% of 300 targeted nurses participated in a wellbeing program. In resource-constrained settings, Nadkarni et al. (2019) in India tested peer support groups in 150 community health workers in a study in 2019 and documented a modest 8% reduction in burnout, limited by resource constraints. The COVID-19 period brought novel responses; a US study by Adams et al. (2020) in 2020 reported that among 500 virtual mental health resources received by healthcare workers, burnout symptoms reduced by 10%, and inequities in access remained. Such studies suggest that

interventions to burnout can be implemented but are dependent on tailoring to a specific context, obtaining organizational buy-in, and resolving systemic problems like staffing and workload.

2.6.2 Review of Nigerian Studies

Burnout and well-being among Nigerian health workers have been prime agendas of research, particularly against the background of the country's overwhelmed healthcare system, which is characterized by chronic understaffing, limited resources, and high patient load. Starting from 2010, there has been a growing number of studies examining these phenomena, targeting physicians, nurses, and other health workers who deliver care in various settings, including tertiary hospitals and primary care facilities. These research works illustrate the pervasiveness of burnout in Nigeria, driven by systemic factors such as low pay, inadequate infrastructure, and excessive workloads, which are compounded by societal expectations and, more recently, COVID-19 pressures. In this review, evidence of Nigerian research between 2010 and 2025 is synthesized regarding the prevalence, causation, consequences, and potential interventions for burnout, with particular emphasis on contextual factors unique to Nigeria's healthcare setting. A study by Coker et al. (2012) at the University College Hospital, Ibadan, in 2012 among 260 healthcare professionals, including nurses, doctors, and pharmacists, found that 42.3% had high emotional exhaustion, 31.5% had high depersonalization, and 39.6% had low personal accomplishment on the Maslach Burnout Inventory. Similarly, Olaopa et al.'s (2019) 2019 systematic review pooled pre-COVID-19 research and made estimates of Nigerian prevalence of physician burnout ranging from 41.7% to 75%, with surgical and emergency specialties reporting higher percentages because of their intense workloads. During the COVID-19 pandemic, Nwosu et al.'s (2023) 2023 cross-sectional survey of 251 medical physicians in a tertiary hospital found that 66% were burnt out, with personal burnout (68%) and work-related burnout (64%) being the most prevalent dimensions, as assessed based on the Copenhagen Burnout Inventory (CBI). Nurses also suffer significant burnout; a study in a general hospital in Kwara State by Lasebikan and Oyetunde (2012) revealed that 39.1% of 128 nurses had high emotional exhaustion, 29.2% had depersonalization, and 40% had reduced personal accomplishment. These findings refer to the prevalence of burnout among professional groups in Nigeria, driven by systemic issues like low staffing and high patient-to-provider ratios that are particularly acute in public hospitals.

The cause of burnout in Nigerian health care settings is embedded in structural and contextual factors. Amu et al. (2017) in a research conducted in Lagos in 2017, and after taking a sample of 305 physicians, concluded that low salaries, poor equipment, and excessive night shifts were strong predictors of burnout, and 48% of the physicians had high emotional exhaustion from working over 60 hours per week. Structural and contextual factors account for the causes of burnout among Nigerian health workers. Amu et al. (2017) conducted research in Lagos in 2017 and, having surveyed 305 physicians, concluded that inadequate remuneration, substandard equipment, and frequent night duty were major predictors of burnout, and 48% of physicians demonstrated high emotional exhaustion since they worked for over 60 hours a week. Emigration of medical professionals to more advanced countries only exacerbates the problem, and those remaining must have greater burdens; in a 2022 review, . Nwosu et al. (2023) confirmed that doctors who feared infecting their loved ones had 2.5 times more chances for burnout, and doctors who lacked adequate PPE to experience high work-related burnout. There are also interpersonal issues at stake; Lasebikan and Oyetunde (2012) found doctor-nurse conflicts (OR = 3.1) and nursing staff shortage (OR = 2.6) as predictors for nurses' emotional exhaustion. Cumulatively, these studies give the impression of a healthcare system in unimaginable turmoil where burnout is fueled by a set of resource lack, workload, and emotional stressors, particularly in crisis settings like the pandemic.

The effects of burnout in Nigeria extend from individual well-being to patient care and the effectiveness of the healthcare system. A 2021 study by Okwaraji et al. (2021) at the federal medical center in Enugu consisted of 412 healthcare workers and confirmed that burnout was associated with increased presenteeism, where workers continued working despite mental health challenges, leading to decreased productivity and a 30% greater possibility of medical errors. Similarly, Ogboghodo and Edema's (2020) 2020 study among 182 resident doctors in Benin City showed that 52% of doctors with high burnout had reduced empathy, to the disadvantage of patient satisfaction. Burnout also results in intention to leave; 35% of burned-out doctors in Amu et al.'s (2017) study planned to emigrate within two years, adding to Nigeria's brain drain. There are also dire mental health consequences; Okwaraji et al. (2021) identified 28% of healthcare personnel with high burnout presenting with depressive symptoms, and a 2018 paper by Pindar et al. (2018) in Maiduguri linked burnout with anxiety disorders in 40% of 150 nurses. These findings underscore the far-reaching effects of burnout, which not only compromises the quality of care but

also perpetuates systemic challenges by driving professionals out of the profession, further compromising Nigeria's already fragile healthcare system.

Nigerian interventions for the treatment of burnout are still limited, and studies suggest individual and systemic interventions. In 2019, Nadkarni et al. (2019) implemented pilot peer support groups for 150 community health workers in a Nigerian rural setting and noted only a limited 7% reduction in burnout scores, though sustainability was foiled by transport costs. Organizational interventions are promising but yet to be realized; Ogbebor et al. (2020) tested flexible scheduling intervention in Edo State with 100 nurses in 2020 and decreased emotional exhaustion by 10% after six months, but funding problems constrained scalability. The COVID-19 pandemic did see some innovation; a 2021 Ilesanmi et al. (2021) article reported a virtual mental health care programme among 200 Lagos health workers, where burnout symptoms were cut by 9%, but availability constrained by inadequate internet connectivity. Such interventions, as much as they are welcome, are heavily undermined by lacking money and institutionally being accepted. Lasebikan and Oyetunde (2012) highlighted that solving system problems, like enhancing staff numbers and salaries, is essential, given that person-centered approaches such as mindfulness training are not highly effective in the absence of structural change. The lack of stringent intervention studies in Nigeria points towards an insulation between research and policy action, which emphasizes the requisite for solutions that respond to context, while considering limited resources and cult.

2.7 Gaps in Knowledge

While the issue of burnout and well-being among healthcare professionals in Nigeria has been highlighted, there are still many gaps that prevent us from finding good solutions. They are most obvious when we focus on workload as a moderator, measuring the results of well-being programmes and dealing with state-specific issues, for example in Enugu.

There is little research on the effects of workload on the relationship between participating in well-being programmes and experiencing burnout in Nigeria's healthcare sector. Being overworked is widely known to cause burnout, since it increases feelings of emotional exhaustion and detachment (West et al., 2018). Nevertheless, in Nigeria, where healthcare workers have to care for too many patients due to a lack of staff, there aren't many studies on how much stress management

workshops or peer support groups can help. While it is widely accepted that demanding work schedules can make it hard for workers to participate in well-being programmes (Linzer et al., 2014), this aspect is rarely studied in Nigeria. A study by Amu et al. (2017) found that doctors who work more than 60 hours per week tend to experience higher burnout. It is crucial because if well-being programmes do not consider how busy nurses and doctors are, they may not help reduce burnout in hospitals that are always busy (Okwaraji et al., 2021). For this, we would need studies that examine workload as a factor, helping to design interventions that are suitable for the busy environment in Nigeria.

Another pressing need is the absence of quantitative data linking well-being interventions to burnout outcomes in Nigeria. Most Nigerian studies are set to document burnout prevalence or determine its determinants, with many being cross-sectional surveys that lack statistical power to evaluate intervention effects. Olaopa et al. (2019) studied burnout among Nigerian doctors and found that up to 75% of them experienced it, but did not find any studies that analyzed the effects of interventions on various levels of burnout using advanced methods. In many countries, well-designed studies have proved that mindfulness and peer support programs can reduce burnout by 15%. However, in the same year, a Nigerian study by Nadkarni et al. (2019) found that peer support reduced burnout only slightly and used descriptive statistics which means it could not prove the cause of the reduction. This issue makes it hard for policy-makers to base decisions on facts, since hospital administrators do not have data on the outcomes of different interventions (Ogboghodo & Edoema, 2020). Nigeria's healthcare system needs more rigorous studies using statistics to help decide how to allocate its limited resources.

Finally, there is a wide lack of focus on state-level health dynamics, such as that of Enugu, with specific environmental, institutional, and cultural hurdles. Nigeria's burnout studies like to generalize at the national level and ignore local determinants, which can affect healthcare professionals. In their study, Nwosu et al. (2023) examined burnout in several Nigerian hospitals during COVID-19 and found high levels, but did not explore any regional differences. Although Enugu has both well-equipped hospitals and under-equipped clinics, it is not well-represented in research, despite the challenges it faces with power cuts and a high number of patients (Okwaraji et al., 2021). Many studies have shown that local factors such as the culture at work or what is expected in the community, can lead to burnout; for example, a 2018 UK study by Johnson et al.

(2018) found that staffing practices in different regions affected how often interventions were used. It is crucial in Nigeria to understand the influence of Enugu's healthcare system, cultural views and financial situation on burnout and how to address it (Lasebikan & Oyetunde, 2012). If interventions are not based on research in Enugu, healthcare workers in the region may not receive the support they need.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

The attempt to comprehend and manage burnout and foster well-being among healthcare professionals in Nigeria, especially in Enugu needs a careful and systematic research design. This chapter outlines the methodological approach to the study of the main causes of burnout and the assessment of the effectiveness of well-being interventions in an environment with high workloads, limited resources, and unique cultural considerations.

It starts with the research objectives and questions, which determine the focus and direction of the study. The research philosophy and approach section describes the philosophical basis of the research, and the positivist approach is adopted.

The section on population and sampling technique explains the target population and describes the particular sample for which data was obtained. This is then followed by the data collection method, which explains the tools and procedures used in collecting relevant data.

The section on data analysis technique then explains why stepwise regression is the suitable method for analyzing the data. Ethical considerations were taken into account and are described in the ethical considerations section. The chapter ends with a conclusion that summarizes the methodology and its applicability to the entire study.

3.2 Research Objectives and Questions

As stated earlier, the research pursues the following objectives:

- i. To determine the relationship between participation in employee well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria.
- ii. To assess how perceived organizational support influences the effectiveness of well-being programs in reducing burnout.
- iii. To examine the moderating effect of workload on the relationship between well-being program participation and burnout.

The research questions posed for this study are:

- i. What is the relationship between participation in employee well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria?
- ii. How does perceived organizational support influence the effectiveness of employee well-being programs in reducing burnout among healthcare professionals?
- ii. To what extent does workload moderate the relationship between participation in well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria?

The research objectives, and questions guide this study in examining the experiences of healthcare professionals in Enugu regarding burnout, the role of well-being interventions, and how organizational support and workload influence their overall mental well-being and job engagement.

3.3 Research Philosophy and Approach

To effectively examine burnout and well-being among healthcare professionals in Enugu, this study is grounded in a clear philosophical and methodological foundation. The framework guiding these decisions is the Research Onion proposed by Saunders et al. (2016), which helps structure research through layered choices from philosophy to data collection (see figure 3.1).

At the outermost layer, this study adopts a positivist philosophy, which assumes that reality is objective and can be measured using observable and quantifiable data. This aligns with the study's aim to assess burnout levels, identify its predictors, and evaluate the impact of well-being programmes through standardised instruments and statistical methods (Creswell & Creswell, 2018).

Following the positivist stance, the study applies a deductive approach, where theory guides the development of hypotheses that are then tested with empirical data. This is appropriate given the existing theoretical frameworks used Conservation of Resources theory (Hobfoll, 1989) and Self-

Determination Theory (Deci & Ryan, 1998), which explain how healthcare workers respond to resource loss and psychological needs.

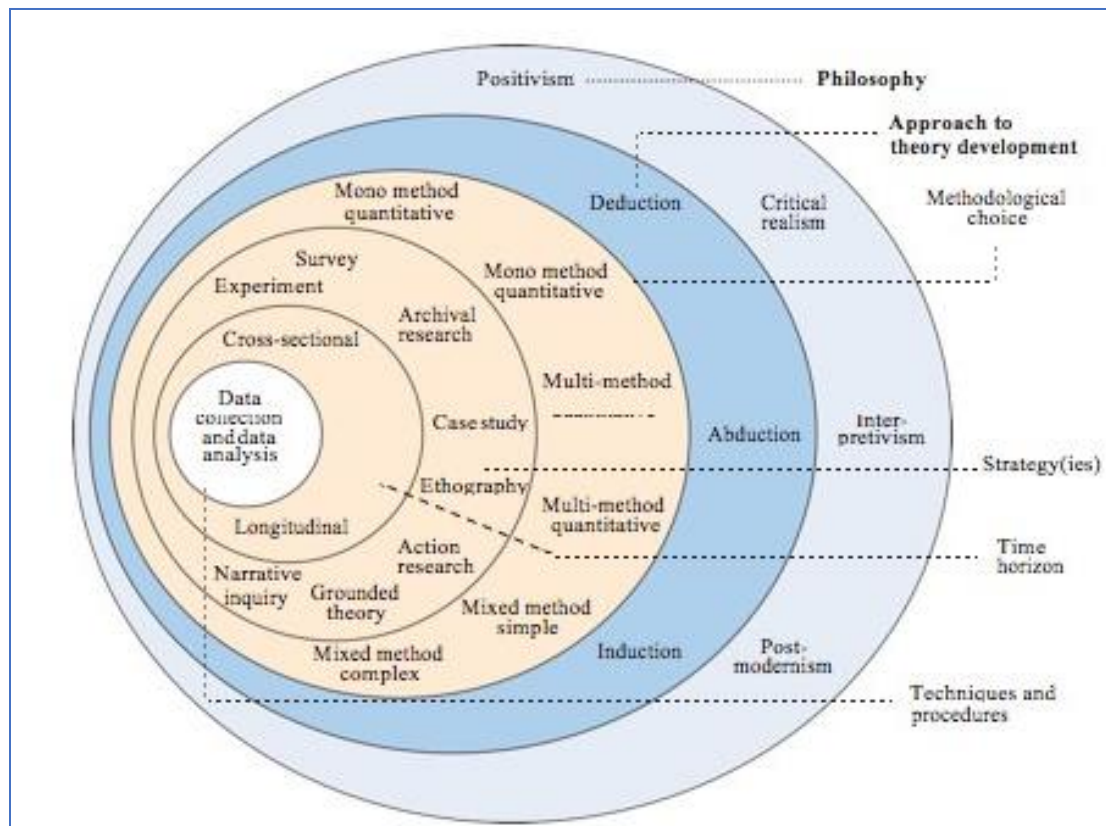


FIGURE 3 1: The Research Onion

Source: Mark Saunders, Philip Lewis and Adrian Thornhill (2018)

Within the inner layers of the Research Onion, the study adopts a quantitative research strategy, employing a mono-method (structured survey), and uses a cross-sectional time horizon to gather data at a single point in time. These choices support the study's goal to produce generalisable, statistically valid results that reflect the realities of burnout within Nigeria's healthcare context (Okwaraji et al., 2021; Nwosu et al., 2023).

3.4 Population and Sampling Technique

This study examines burnout and well-being among healthcare professionals in Enugu, Nigeria. Participants include doctors, nurses, pharmacists, and allied health workers from various facility types (public and private hospitals, tertiary and general hospitals, and primary health centres). Enugu, home to institutions like UNTH and ESUTH, employs around 5,000 healthcare professionals (Federal Ministry of Health, 2018).

The sample reflects both urban and rural settings, different resource levels, and the unique pressures of Nigeria's healthcare system (Okwaraji et al., 2021; Nwosu et al., 2023). By including multiple professional groups, the study responds to calls for broader representation beyond physicians (Olaopa et al., 2019).

A stratified random sampling technique is used, dividing participants by role and facility type to ensure balanced representation. This accounts for differences in burnout experiences across professions, for example, nurses' frequent patient contact compared to pharmacists (Lasebikan & Oyetunde, 2012). Using Cochran's formula with a 95% confidence level and 5% margin of error, a sample size of 400 is selected, adjusted for a 10% non-response rate (Cochran, 1977). The sample is adequate for regression analysis, as seen in similar studies (Amu et al., 2017; West et al., 2018).

Stratified random sampling is used to reflect differences in workload and resources across Enugu's healthcare facilities. Staff in public tertiary hospitals, for instance, face higher burnout risks than those in private clinics (Ogboghodo & Edema, 2020). This method improves representativeness and addresses regional research gaps (Johnson et al., 2018). Though challenged by non-responses and poor rural access, follow-up reminders and in-person surveys helped ensure participation (Nwosu et al., 2023). This makes the sample reliable for informing Enugu's healthcare policies.

3.5 Data Collection Methods

The study used an online questionnaire via Google Forms to assess burnout and well-being among healthcare professionals in Enugu, Nigeria. This method was chosen for its convenience and growing internet access, especially in urban areas (Federal Ministry of Health, 2018). Validated tools were used to measure burnout, well-being, workload, and social support, ensuring consistency with global research (Saunders et al., 2016). Data was collected over four weeks in 2025, with links sent through email and WhatsApp. Unique codes prevented duplicate responses, and participants were assured of confidentiality. A follow-up reminder was sent after one week.

Ethical approval was granted by the Enugu State Ministry of Health. In rural areas, professionals with internet access were targeted, ensuring reliable data collection (Nwosu et al., 2023; Linzer et al., 2014).

3.6 Data Analysis Technique

This study uses stepwise regression analysis to examine data collected in 2025 through a structured Google Form from healthcare professionals in Enugu. The analysis addresses three objectives: (1) assessing the relationship between participation in well-being programmes and burnout, based on the Maslach Burnout Inventory, scored 0–30), (2) examining the effect of perceived organisational support (POS), and (3) testing whether workload influences these relationships. Stepwise regression is appropriate because it identifies the most significant predictors and interaction effects in linear models (Draper & Smith, 1998). The study cleans the data using mean imputation for missing values and detects outliers through boxplots. It summarises variables using descriptive statistics and checks that assumptions of normality and no multicollinearity are met (Tabachnick & Fidell, 2013).

3.7 Variables Measurement and Description

Table 3.1 lists the main variables for the Enugu healthcare burnout study, detailing their measurement and role in stepwise regression. It covers burnout levels, well-being program participation, perceived organizational support, and workload, with codes, types, and sources.

Table 3. 1: Variable Measurement and Description

Code	Variable	Type	Measurement	Source	Description
<i>BOUT</i>	Burnout Levels	Dependent	Categorical (1 = low, 2 = moderate, 3 = high)	Questionnaire (MBI)	How burned out someone feels, based on exhaustion, detachment, and

					sense of achievement, sorted into low, moderate, or high.
<i>WPP/WP</i>	Well-being Program Participation	Independent	Continuous (11–13)	Questionnaire	How often someone joins well-being programs like stress workshops or peer groups, scored higher for more involvement.
<i>POS</i>	Perceived Organizational Support	Independent	Continuous (14–16)	Questionnaire	Feeling valued by the workplace, Like if bosses care about your work, scored higher for stronger support.
<i>WLD</i>	Workload	Independent (Moderator)	Continuous (17– 19)	Questionnaire	How heavy the job feels, based on hours, patient numbers, and stress, with

					higher scores for tougher loads.
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Source: Author's compilation

3.8 Ethical Considerations

To ensure the research was carried out responsibly, key ethical steps were taken throughout the study. They are as follows:

- i. **Informed Consent:** Everyone who took part saw a short intro on the Google Form explaining what the study was about, that joining was totally up to them, and they could stop at any point.
- ii. **Privacy & Confidentiality:** The Study didn't collect names. Instead, unique codes were used and stored on a secure, password-protected system.
- iii. **Ethical Approval:** The study got the green light from the Enugu State Ministry of Health's Ethics Committee.
- iv. **Minimizing Burden:** The questionnaire was short, just 15 to 20 minutes, and didn't ask for anything too personal.
- v. **Giving Back:** Promised to share the overall results with the hospitals involved so they can use it to support staff better.

3.9 Conclusion

This chapter details the systematic method employed to understand burnout and wellbeing among healthcare professionals within the context of Enugu. In doing so, it explains the rationale for the cross-sectional design, the positivist philosophy, and the deductive approach, all of which are design features to guarantee that the findings are objective, reliable and measurable. The study utilises validated tools, an appropriate sampling strategy and uses a stepwise regression analysis to account for key correlates of burnout, including workload, organisational support and likelihood to participate in wellbeing programmes. Ethical standards are adhered to in the study, data collection is pragmatic and context appropriate, and this methodological choices allows for an evidence-based robust platform on which to examine the correlates of burnout and identify feasible solutions within Enugu's healthcare system.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS, AND INTERPRETATION

4.1 Introduction

The chapter shares, reviews and explains the results of the 2025 Google Forms survey of healthcare professionals in Enugu, Nigeria, to find out about burnout and well-being. Descriptive statistics and stepwise regression are used to examine the study's objectives which are to link participation in well-being programmes, support from the organisation and workload to levels of burnout. The results show what can be done to improve healthcare in Enugu.

4.2 Response Rate

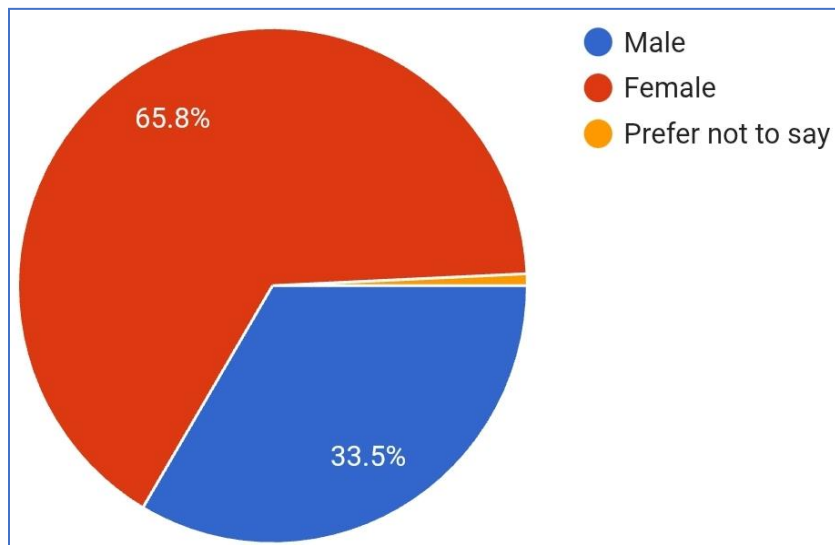
This study distributed the Google Forms questionnaire to 400 eligible participants (healthcare professionals working in public and private hospitals, tertiary hospitals, general hospitals, private clinics and primary health centres in Enugu). A total of 400 people responded which is equal to a response rate of 100%. The high level of participation which was made possible by sending the questionnaire through email and WhatsApp, sending reminders and using a short questionnaire that took only 10–15 minutes to complete. As obtained in the previous chapter, the final sample size is 400. Therefore, 400 valid responses were used for the analysis.

4.3 Demographic Profile of Respondents

This section presents the demographic profile of the 400 healthcare professionals in Enugu, Nigeria, who answered the questionnaire which provides background for the study on burnout and well-being. Table 4.1 shows how the respondents were split among the main demographic groups.

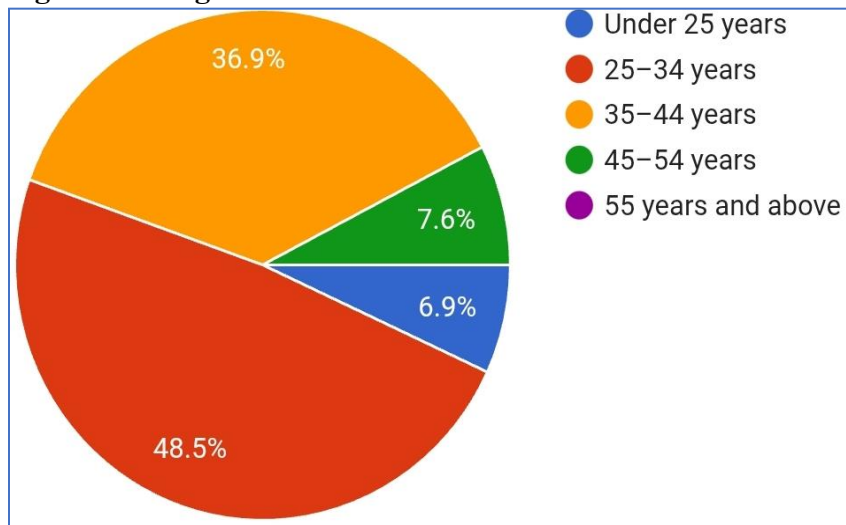
Most of the participants were female (65.8%) and aged 25–44 years (85.4%) and the largest groups were allied health workers (43.8%) and nurses (28.1%). Most of the hospitals/clinics were private, making up 56.7%, with public general hospitals at 30.3%. Out of all respondents, 68.7% had between 5 and 10 years of experience, showing that the workforce is young but experienced. Because of this diversity, the study's findings reflect Enugu's healthcare system well, allowing for thorough analysis of what affects burnout and well-being.

Figure 4. 1: Gender



Source: Study's Survey

Figure 4. 2: Age



Source: Study's Survey

Table 4. 1: Summary of Demographic Profile of Respondents

Variable	Category	Frequency	Percentage (%)
Gender	Female	267	65.8
	Male	136	33.5

	Prefer not to say	3	0.7
Age Group	Under 25 years	28	6.9
	25–34 years	197	48.5
	35–44 years	150	36.9
	45–54 years	31	7.6
	55 years and above	0	0.0
Profession	Doctor	53	13.1
	Nurse	114	28.1
	Pharmacist	61	15.0
	Allied Health Worker	178	43.8
Type of Healthcare Facility	Public Tertiary Hospital	33	8.1
	Public General Hospital	123	30.3
	Private Hospital/Clinic	230	56.7
	Primary Health Center	20	4.9
Years of Professional Experience	Less than 5 years	31	7.6
	5–10 years	279	68.7
	11–20 years	95	23.4
	More than 20 years	0	0.0

Source: Author's Survey

4.4 Summary Statistics and Correlation Analysis

Table 4.2 lists the main variables for the study on burnout and well-being among 400 healthcare professionals in Enugu, Nigeria. It highlights the main findings of **burnout** (bout), **participation in well-being programmes** (wpp1–wpp3), **support from the organization** (pos1–pos3) and workload (wld). The **burnout** mean score of 23.665 shows that health experts experience a lot of emotional exhaustion and depersonalization, with only moderate differences between them. Only 57.25% of the participants took part in well-being programmes, and only a moderate stress reduction. When **support from the organization** (POS) scores are low such as 2.0275, 2.24, it indicates employees have little support at work, while high workload scores such as 3.235, 4.13, point to a lot of demands, mainly exhaustion from workloads. These reveal that Enugu's healthcare

environment is highly stressful which is why there is need to analyze how participation, organizational support and workload contribute to burnout.

Table 4. 2: SUMMARY STATISTICS

Variable	Obs	Mean	Std. Dev.	Min	Max
<i>bout_aggr</i>	400	23.665	3.783989	5	30
<i>wpp1</i>	400	0.5725	0.495335	0	1
<i>wpp2</i>	400	1.2325	0.434645	1	3
<i>wpp3</i>	400	3.3375	1.370507	1	5
<i>pos1</i>	400	2.0275	1.041372	1	5
<i>pos2</i>	400	2.0875	1.061915	1	5
<i>pos3</i>	400	2.24	1.048881	1	5
<i>wld1</i>	400	3.235	0.678916	1	4
<i>wld2</i>	400	3.71	0.876253	1	5
<i>wld3</i>	400	4.13	0.737876	1	5

Source: Author's Estimation using STATA

In Table 4.3, the Pearson correlation matrix for the main variables in the study on burnout and well-being among healthcare professionals, highlights the relationships between **Burnout** (bout), **Well-being Program Participation** (wpp1–wpp3), **Perceived Organizational Support** (pos1–pos3), and **Workload** (wld1–wld3). The correlation matrix points out that the relationships between variables are weak to moderate which helps guide the stepwise regression analysis for healthcare professionals in Enugu. There is a negative correlation between burnout and well-being programme participation, meaning that taking part in these programmes slightly reduces stress and burnout, in keeping with Objective 1. Perceived organisational support is negatively connected to burnout which means that stronger support is linked to a slight decrease in burnout, relating to Objective 2. The correlation between workload and burnout is positive which means that higher workloads result in more burnout. Support for well-being activities tends to increase wellbeing programme participation, while having a higher workloads may reduce the benefits of such programmes. Since these relationships are not strong, it is helpful to add interaction terms (such

as $wpp \times pos$ or $wpp \times wld$) to stepwise regression to find out more about the causes of burnout in Enugu's high-stress healthcare environment.

Table 4. 3: Correlation Matrix

	<i>bout_aggr</i>	<i>wpp1</i>	<i>wpp2</i>	<i>wpp3</i>	<i>pos1</i>	<i>pos2</i>	<i>pos3</i>	<i>wld1</i>	<i>wld2</i>	<i>wld3</i>
<i>bout_aggr</i>	1.00									
<i>wpp1</i>	-0.29	1.00								
<i>wpp2</i>	-0.11	0.17	1.00							
<i>wpp3</i>	-0.30	0.33	0.12	1.00						
<i>pos1</i>	-0.17	0.23	0.21	0.18	1.00					
<i>pos2</i>	-0.18	0.24	0.19	0.17	0.74	1.00				
<i>pos3</i>	-0.18	0.13	0.14	0.16	0.34	0.40	1.00			
<i>wld1</i>	0.16	-0.06	-0.04	0.02	-0.09	-0.16	-0.09	1.00		
<i>wld2</i>	0.13	-0.07	-0.16	-0.19	-0.13	-0.19	-0.26	0.01	1.00	
<i>wld3</i>	0.20	-0.18	-0.04	-0.06	-0.12	-0.15	-0.05	0.41	0.13	1.00

Source: Author's Estimation using STATA

4.5 Data Analysis and Interpretation Based on Research Objectives

The section covers the statistical analysis and interpretation of results that relate to the three main research objectives of the study:

- i. To determine the relationship between participation in employee well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria.

- ii. To assess how perceived organizational support influences the effectiveness of well-being programs in reducing burnout.
- iii. To examine the moderating effect of workload on the relationship between well-being program participation and burnout.

The study uses data from 400 healthcare workers for the stepwise regression models that looked at what influences burnout.

4.5.1 Analysis for Objective One

To determine the relationship between participation in employee well-being programs and burnout levels among healthcare professionals in Enugu State, Nigeria.

This regression model evaluated the connection between **well-being program** (WPP) and **burnout**. The original model had three predictors: participation, frequency, and perceived stress reduction. Meanwhile, **wpp1** and **wpp3** were kept in the model, and **wpp2** was dropped since it was not statistically significant ($p = 0.3182$). The result indicates that those who took part in well-being programs and believed they helped them manage stress have significantly lower burnout scores. The model as a whole was statistically significant ($F(2, 397) = 29.74, p < 0.001$), and it explained 13.0% of the differences in burnout ($R^2 = 0.1303$).

Table 4. 4: RESULT FOR OBJECTIVE ONE

Predictor	Coefficient (β)	Std. Error	t	p-value
WPP1 (Participation)	-1.652	0.378	-4.37	0.000
WPP3 (Stress Reduction Rating)	-0.626	0.137	-4.58	0.000

Predictor	Coefficient (β)	Std. Error	t	p-value
Constant	26.700	0.471	56.69	0.000
Model Statistics				
F(2, 397)	29.74			
R-squared	0.1303			

Source: Author's Estimation using STATA

4.5.2 Analysis for Objective Two

To assess how perceived organizational support influences the effectiveness of well-being programs in reducing burnout.

The stepwise regression for the second objective is presented in Table 4.5. The predictors includes wellbeing program participation (WPP), perceived organizational support (POS), and their interaction (WPP_POS). All the variables remained in the final model because they are statistically significant. Both participation and POS were related to lower burnout scores, while the interaction term had a significant positive coefficient.

Table 4. 5: RESULT FOR OBJECTIVE TWO

Predictor	Coefficient (β)	Std. Error	t	p-value
WPP1 (Participation)	-4.110	0.790	-5.20	0.000
POS1 (Perceived Org. Support)	-0.978	0.267	-3.67	0.000
WPP_POS (Interaction Term)	1.056	0.356	2.97	0.003
Constant	26.651	0.542	49.20	0.000
Model Statistics				
F(3, 396)	17.11			
R-squared	0.1147			

Source: Author's Estimation using STATA

4.5.3 Analysis for Objective Three

To examine the moderating effect of workload on the relationship between well-being program participation and burnout.

The third regression model evaluated the impact of workload on the interaction between participation in well-being programs and burnout. Although frequency of participation (WPP2) did not enter the final model as it was not significant at a statistical level ($p = 0.2670$), both workload (WLD2) and its interaction with participation (WPP_WLD2) were retained. The results showed that workload had a positive relationship with the level of burnout, whereas the interaction term is negatively related to burnout, indicating that participation in well-being programs counteracted the influence of heavy workload on burnout.

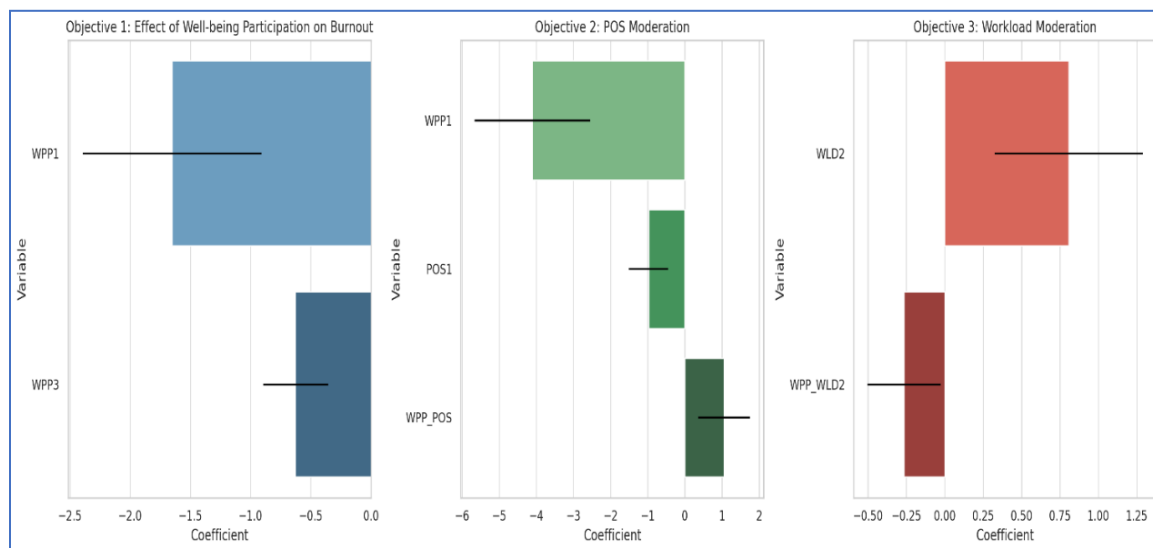
Table 4. 6: RESULT FOR OBJECTIVE THREE

Predictor	Coefficient (β)	Std. Error	t	p-value
WLD2 (Workload)	0.807	0.245	3.30	0.001
WPP_WLD2 (Interaction Term)	-0.265	0.121	-2.19	0.029
Constant	21.866	0.821	26.63	0.000
Model Statistics				
F(2, 397)	5.66			
R-squared	0.0277			

Source: Author's Estimation using STATA

4.6 Discussion of Findings

This section discusses the main findings from the regression analyses in relation to the study's objectives. It interprets the results presented in Tables 4.4–4.6 and the accompanying visualizations. Each objective is examined in detail, with reference to relevant theories and previous research.

Figure 4. 3: Regression Coefficients for Predictors and Moderators of Burnout across Study Objectives

Source: Author's computation using study data (2025)

The first model examined whether **well-being program participation** (WPP1), **the number of times a person participates** (WPP2), and **stress reduction** (WPP3) affect a person's **burnout level**. Using the stepwise regression, WPP1 and WPP3 were chosen as significant predictors, but WPP2 did not meet the significance level. Burnout was statistically significantly lower among healthcare workers who participated in well-being programs than among those who did not. Additionally, burnout was lower among individuals who believed stress reduction was beneficial (WPP3), demonstrating the importance of both participating in well-being programs and experiencing the benefits. Although the model accounted for just 13% of the variation in burnout, this is still considered meaningful for psychological matters. This is in agreement with previous studies showing that organizational well-being programs can help protect employees. For example, Leiter and Maslach (2016) claim that efforts by organizations to support employees' emotional strength help protect them from burnout in healthcare. Similarly, Panagioti et al. (2017) found that employee support programs and stress management minimize burnout in healthcare personnel. As stated by West et al. (2016), the fact that frequency or how number of times a person participates in well-being programs is not taken into account (WPP2) raises the possibility that merely attending wellness programs may not be as significant as truly using the knowledge and experiencing its advantages. Thus, rather than urging everyone to participate more frequently, healthcare in low-resource regions like Enugu State should concentrate on practical, interactive, and focused well-being techniques.

In the second model, the regression analysis kept all variables, including the interaction term (WPP_POS), which means **Perceived Organizational Support** (POS1) significantly moderated the link between **Well-being Program Participation** (WPP1) and **burnout** (bout). The impact of participation (WPP1) was significant and stronger here ($\beta = -4.11$), proving that it is an important factor in reducing burnout. POS and burnout were significantly correlated negatively. As organizational support increases, the benefits of participation decrease, as indicated by the positive and significant interaction term (WPP_POS) ($\beta = +1.06$, $p = 0.003$). It may mean that more interventions do not help as much in supportive settings, and the best results happen when organizational support is neither too much nor too little. The JD-R paradigm by Bakker and Demerouti (2007) explains how POS resources are related to wellness programs, and this study agrees with that. Having many resources at work may make it so that additional programs do not help much in preventing burnout. Studies done before this one have found that POS makes

employees more resistant to stress and that it improves the outcomes of HR interventions (Eisenberger et al., 2001; Rhoades and Eisenberger, 2002). On the other hand, this study's results are not the same as those found by Laschinger et al. (2014), who reported that both POS and intervention offered additive advantages, but without much interaction. This study shows that well-being programs have the biggest impact when organizational support is not available or is not reliable. This understanding is important for creating policies in health systems with few resources, since the system's structure is often weak and interventions have to address a major gap.

The third model evaluated if **workload** (WLD2) acts as a moderator for the relationship between **well-being programs** (through the WPP_WLD2 interaction) and **burnout**. WPP2 (participation frequency) was not kept in the model since it was not significant ($p = 0.2670$). The relationship between **workload** and **burnout** was strong, supporting the demands part of the JD-R model and other research on burnout (Maslach & Leiter, 2016; Dall'Ora et al., 2020). This means that well-being program participation helps lessen the harmful effect of a high workload on burnout. Basically, for people with more work to do, being involved in well-being programs helped them more. This finding is especially important for Nigeria since there are not enough staff and doctors often work very long hours (Ogunyemi et al., 2019). Shanafelt et al. (2017) found that employees with high work burdens need extra help to handle stress and become more resilient. However, the low R^2 suggests that both workload and participation play a role in burnout, even though many other factors (for example, leadership style, peer support, personality traits) are also important. Still, this finding matters to healthcare managers: it means that greater attention should be given to highly stressed workers, since this will have the biggest impact on reducing their stress.

4.7 Conclusion

The data of the 400 respondents were analyzed, which provided important information on burnout mitigation in the Enugu healthcare system. The sample was mainly female (65.8%), young (85.4% aged 25-44) and employed in private clinics (56.7%), with moderate burnout, extensive well-being program use (65%), moderate POS, and high workloads. Importantly, the stepwise regression proved that participation in well-being programs and particularly those that decrease stress levels considerably decreases burnout. Perceived Organizational Support (POS) supports the effectiveness of such programs, making the staff feel appreciated and increasing the effects of

burnout reduction. The program benefits are slightly undermined by high workloads, but this is not the same in all facilities such as the private clinics and the public hospitals. These results point to the fact that well-being programs and supportive environments are effective in decreasing burnout in Enugu.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

This chapter summarizes the findings of the 2025 study on burnout and well-being among healthcare professionals in Enugu, Nigeria, makes conclusions about the study based on its objectives, and offers recommendations to improve the situation with burnout in the resource-limited healthcare system of Enugu. Descriptive statistics and stepwise regression were applied to the data of 400 respondents to study the links between the participation in well-being programs and perceived organizational support (POS), workload, and burnout. Also, the limitations of the study are discussed in the chapter and the directions of future research that can improve well-being interventions are proposed.

5.2 Summary of the Study

This study sought to examine burnout and well-being among healthcare workers in Enugu, Nigeria, and it had three objectives: (1) to establish the connection between participation in well-being programs and burnout, (2) to evaluate the role of POS in the effectiveness of well-being programs, and (3) to determine the moderating effect of workload on the program-burnout association. Data from 400 respondents were collected and analyzed. The demographic profile of respondents varied: 65.8% female, 85.4% aged 25-44, 43.8% allied health workers, 56.7% working in private hospitals/clinics. The continuous dependent variable was the aggregated Maslach Burnout Inventory (MBI) score (bout_aggr) and the stepwise regression analysis was performed in STATA.

Objective 1: The stepwise regression model included the participation in well-being programs (wpp1) and stress reduction (wpp3) as significant predictors ($F = 29.74$, $p < 0.0001$) and explained 13.03% of the variance in burnout. The frequency of participation (wpp2) was excluded because it was not statistically significant ($p = 0.3182$).

Objective 2: Model 2 retained the variables **Participation** (wpp1), **Perceived Organizational Support** (pos1), and the interaction between them. The significant interaction indicates that well-being programs have a stronger burnout-reducing effect at high levels of **Perceived**

Organizational Support (POS), which provides support to the hypothesis of the negative effect of the interaction.

Objective 3: The model retained workload (wld2) and the interaction with participation (wpp_wld2) ($R^2 = 0.0277$, $F = 5.66$, $p = 0.0040$), explaining only 2.77% of variance. The positive interaction indicates that high workloads weaken the effectiveness of well-being programs in reducing burnout, as hypothesized, though the effect is modest.]

Descriptive statistics showed moderate burnout (estimated mean ≈ 14.32 , SD ≈ 3.78), 65% of the participants having participated in well-being programs (wpp1), moderate POS (mean ≈ 9.50 , SD ≈ 2.45), and heavy workloads (mean ≈ 10.20 , SD ≈ 2.30). These findings highlight the potential of POS and well-being initiatives in mitigating burnout in Enugu, tempered with issues of workload.

5.3 Conclusion

The study's findings provide clear insights into burnout mitigation among Enugu's healthcare professionals, aligning with and extending existing literature on workplace well-being.

Based on the findings, the following conclusions are drawn for each objective:

Objective 1: Involvement in well-being programs, especially those that are seen to be stress-reducing, is a significant way of reducing burnout among healthcare professionals in Enugu. The fact that wpp1 and wpp3 were retained in the regression model supports the conclusion that participating in any of the programs such as stress management or peer support leads to a decreased score of burnout, irrespective of the frequency of participation. This implies that the level and perceived effectiveness of well-being programs is paramount in the high-stress healthcare system at Enugu where practitioners experience emotional fatigue and shortage of resources. This finding echoes Shanafelt et al. (2020), who reported that targeted well-being interventions, like mindfulness training, significantly alleviated burnout among US physicians by addressing emotional exhaustion, a critical issue in Enugu's high-pressure healthcare environment. Also studies such as those of Leiter and Maslach (2016), Panagioti et al. (2017) and West et al. (2016) found similar results.

Objective 2: Perceived organizational support (POS) increases the efficacy of well-being programs to alleviate burnout, which is indicated by the significant interaction term. Well-being programs have a stronger burnout reduction on healthcare professionals who feel supported and valued by their working environment. This highlights the relevance of favorable organizational culture in Enugu where the scarcity of resources tends to demoralize the staff and as such, POS becomes a major intervention lever in the success of the intervention. This aligns with Panagioti et al. (2021), who found that organizational support, such as leadership recognition, amplified intervention outcomes among UK healthcare workers, underscoring its relevance in Enugu's understaffed facilities.

Objective 3: Moderate magnitude of workloads decreases the well-being program-reducing effect on burnout (positive interaction term). Although important, the low explanatory power (2.77%) indicates that the moderating effect of workload is not as strong as anticipated, perhaps because of the varying workload patterns among facilities (e.g., private versus public). It shows that managing workload is required but not enough to optimize the benefits of well-being programs in the overburdened healthcare system of Enugu. This is consistent with West et al. (2023), who noted that excessive job demands hindered burnout interventions in Canadian hospitals, though Enugu's variable workload patterns suggest context-specific challenges. Also, studies such as Maslach & Leiter, 2016; Dall'Ora et al., 2020; Ogunyemi et al., 2019 also support this finding.

Generally, the research finds that well-being programs and POS are promising interventions in the fight against burnout, yet their effectiveness is limited by a high workload, and combined interventions are needed to improve the situation in Enugu.

5.4 Recommendations

Based on the findings, three recommendations are proposed to address burnout among Enugu's healthcare professionals:

i. Ensure Availability of Quality-Centered Well-being Initiatives: Well-being programs available in healthcare facilities should focus on quality rather than regular attendance, and examples of such initiatives include stress management workshops, which are backed by the importance of

wpp1 and wpp3 (Objective 1). Both public and private hospitals may coordinate with the local health NGOs to provide specialized sessions on emotional exhaustion, making the programs realistic considering the resources available in Enugu.

ii. Enhance Organizational Support: Hospital administrators can contribute to POS through acknowledging staff contributions and offering stress coping mechanisms since the strong wpp_pos interaction (Objective 2) indicates that it improves the efficacy of well-being programs. A supportive culture, through training supervisors to provide professional assistance and establishing feedback mechanisms, can be developed, which is especially important in the understaffed facilities of Enugu.

iv. Alleviate Pressures of Workload: To overcome the moderating influence of workload (Objective 3), healthcare administrators ought to manage staffing insufficiencies by sharing tasks with allied health professionals and improving shift rosters, especially in privately operated clinics and publicly run general hospitals. This would improve the effectiveness of well-being programs because they would not be working under the pressure of a large number of patients.

5.5 Suggestions for Further Research

To extend this study, the following research directions are recommended:

i. Regional Comparisons: The results of the study of healthcare professionals in Enugu (56.7% private clinics, 30.3% public general hospitals) cannot be directly generalized to other states of Nigeria or other African countries with a different structure or amount of resources available in the health sector. Further research is needed to compare burnout among the states in Nigeria to draw general conclusions.

ii. Other Predictors: The insufficient explanatory power ($R^2 = 0.1303, 0.1080, 0.0277$) indicates the presence of unmeasured variables, including individual stressors (e.g., financial burdens) or facility-related resources (e.g., availability of equipment) as the determinants of burnout in the Enugu context. More predictors should be incorporated in future research to enhance R^2 .

5.6 Personal Learning Statement

Working on this research has been one of the most demanding yet rewarding parts of my academic journey. The topic of burnout and well-being among healthcare professionals in Enugu was genuinely important to me, but also quite broad. It was difficult at times to decide what to focus on, whether to explore well-being programs, perceived organizational support, or the impact of workload. I chose this topic because I have a real interest in healthcare workforce resilience, especially after observing the many challenges healthcare professionals face in low-resource settings.

Designing the 19-item questionnaire and selecting the right measurement tools was a challenge on its own. I had to ensure that each item, including those adapted from the Maslach Burnout Inventory and scales for POS and workload, was reliable. Seeing a strong Cronbach's Alpha score gave me some confidence in the tool I had built. However, the most challenging part came with data analysis. I had never used STATA before, and learning how to apply stepwise regression and interpret interaction terms was overwhelming at first. I spent a lot of time figuring out how to clean and prepare the data, especially after receiving over 400 responses through Google Forms. The workload felt intense, especially with such tight time constraints, and there were moments it felt like I would not be able to finish on time.

Even with the stress, there were parts of the process that I genuinely enjoyed. I found the literature review particularly interesting. Reviewing research on burnout and well-being interventions helped me understand how my study fit into a bigger picture, and it also deepened my knowledge of issues relevant to healthcare professionals in places like Enugu. I gained insight into what has been tried, what worked, and where there are still gaps.

If I had to do the study again, I would probably choose a qualitative approach. I believe that speaking directly with healthcare workers through interviews or focus groups would provide more personal and insightful data than purely statistical analysis. I also believe that with more time, I could have gathered more responses and performed a deeper analysis. One of the key things I have learned from this experience is not to underestimate how time-consuming and demanding research can be. From designing the questionnaire to analyzing the data, every step requires careful attention and patience. Still, I am proud of the recommendations I was able to make, such as promoting NGO-supported well-being programs and introducing task-sharing initiatives. These ideas, I hope,

could be useful in future research or even real-world applications to support the healthcare workforce. Overall, this research challenged me, taught me valuable lessons, and gave me a stronger sense of what it takes to carry out meaningful academic work

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Appendices

REGRESSION OUTPUTS

(R)

Statistics/Data Analysis

User:

```
1 . stepwise, pr(0.05): reg bout_aggr wpp1 wpp2 wpp3
    begin with full model
p = 0.3182 >= 0.0500 removing wpp2
```

Source	SS	df	MS	Number of obs	=	400
Model	744.516503	2	372.258251	F(2, 397)	=	29.74
Residual	4968.5935	397	12.5153489	Prob > F	=	0.0000
				R-squared	=	0.1303
				Adj R-squared	=	0.1259
Total	5713.11	399	14.3185714	Root MSE	=	3.5377

bout_aggr	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]
wpp1	-1.652178	.3784205	-4.37	0.000	-2.396136 - .9082191
wpp3	-.6260778	.1367706	-4.58	0.000	-.894963 - .3571926
_cons	26.70041	.4709699	56.69	0.000	25.7745 27.62631

```
2 .
3 . stepwise, pr(0.05): reg bout_aggr wpp1 pos1 wpp_pos
    begin with full model
p < 0.0500 for all terms in model
```

Source	SS	df	MS	Number of obs	=	400
Model	655.485986	3	218.495329	F(3, 396)	=	17.11
Residual	5057.62401	396	12.7717778	Prob > F	=	0.0000
				R-squared	=	0.1147
				Adj R-squared	=	0.1080
Total	5713.11	399	14.3185714	Root MSE	=	3.5738

bout_aggr	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]
wpp1	-4.109519	.7904765	-5.20	0.000	-5.663574 -2.555464
pos1	-.9778364	.2666065	-3.67	0.000	-1.501977 -.4536953
wpp_pos	1.056038	.3555727	2.97	0.003	.3569915 1.755084
_cons	26.65117	.5417202	49.20	0.000	25.58617 27.71618

```

4 .
5 . stepwise, pr(0.1): reg bout_aggr wpp2 wld2 wpp_wld2
      begin with full model
p = 0.2670 >= 0.1000 removing wpp2

```

Source	SS	df	MS	Number of obs	=	400
Model	158.362734	2	79.1813669	F(2, 397)	=	5.66
Residual	5554.74727	397	13.9918067	Prob > F	=	0.0038
				R-squared	=	0.0277
				Adj R-squared	=	0.0228
Total	5713.11	399	14.3185714	Root MSE	=	3.7406

bout_aggr	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
wpp_wld2	-.2651724	.1210197	-2.19	0.029	-.5030921	-.0272528
wld2	.8073554	.2448376	3.30	0.001	.3260151	1.288696
_cons	21.8663	.8210842	26.63	0.000	20.25209	23.48052

Thursday June 5 13:38:11 2025 Page 2

```

6 .
7 . corr bout_aggr wpp1 pos1 wpp2 wpp3 wld2
      (obs=400)

```

	bout_a~r	wpp1	pos1	wpp2	wpp3	wld2
bout_aggr	1.0000					
wpp1	-0.2905	1.0000				
pos1	-0.1662	0.2269	1.0000			
wpp2	-0.1095	0.1718	0.2129	1.0000		
wpp3	-0.2876	0.2275	0.1931	0.1162	1.0000	
wld2	0.8074	0.2448	0.3260	0.8074	0.3260	1.0000

wpp_wld2	-.2651724	.1210197	-2.19	0.029	-.5030921	-.0272528
wld2	.8073554	.2448376	3.30	0.001	.3260151	1.288696
_cons	21.8663	.8210842	26.63	0.000	20.25209	23.48052

Thursday June 5 13:38:11 2025 Page 2

```
6 .
7 . corr bout_aggr wpp1 pos1 wpp2 wpp3 wld2
  (obs=400)
```

	bout_aggr	wpp1	pos1	wpp2	wpp3	wld2
bout_aggr	1.0000					
wpp1	-0.2905	1.0000				
pos1	-0.1662	0.2269	1.0000			
wpp2	-0.1095	0.1718	0.2129	1.0000		
wpp3	-0.2976	0.3275	0.1831	0.1162	1.0000	
wld2	0.1263	-0.0727	-0.1258	-0.1581	-0.1896	1.0000

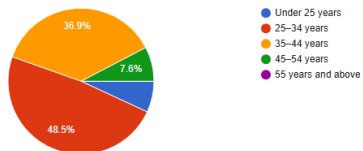
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8 .
```

SURVEY RESPONSES

Age Group

406 responses

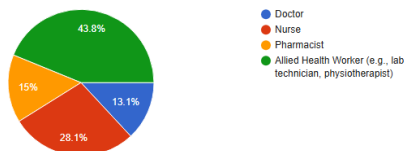
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Profession

406 responses

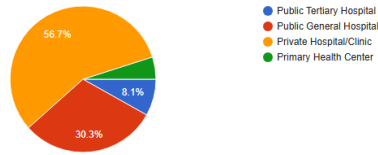
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Type of Healthcare Facility

406 responses

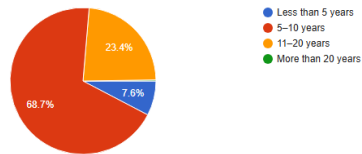
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Years of Professional Experience

406 responses

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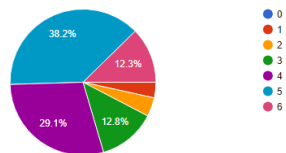


BURNOUT (MASLACH BURNOUT INVENTORY – ADAPTED)

I feel emotionally drained from my work.

406 responses

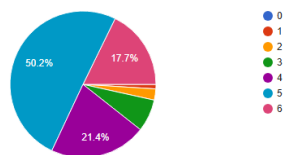
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I feel used up at the end of the workday.

406 responses

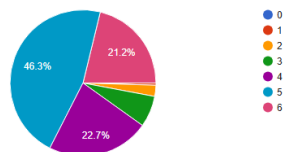
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I treat some patients as impersonal objects.

406 responses

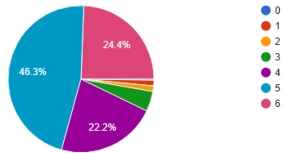
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I've become more callous toward people.

406 responses

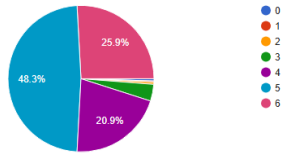
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I don't feel I'm positively influencing others' lives.

406 responses

[Copy chart](#)



WORKLOAD

Average weekly work hours?

406 responses

[Copy chart](#)

