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Investigating Nurse Burnout in Anambra State: A Comparative Study

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Abstract

Nurse burnout, characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment, remains a persistent concern within healthcare systems globally, with particular significance for resource-constrained public health systems such as those found in Nigeria. This paper investigates nurse burnout in Anambra State through a comparative study design, examining how burnout levels and their contributing factors differ across public (government-owned) and private healthcare facilities, and across urban and rural practice settings within the state. Anchored in Maslach's tripartite model of burnout and the Job Demands-Resources (JD-R) theoretical framework, the paper draws on a qualitative synthesis of nursing workforce literature, occupational health studies, and documented health-sector workforce reports specific to Nigeria and comparable Sub-Saharan African contexts. The paper finds that nurses in public tertiary and secondary healthcare facilities in Anambra State report comparatively higher burnout indicators than counterparts in private facilities, a pattern attributed primarily to higher patient-to-nurse ratios, greater exposure to resource shortages, and more limited administrative support in public institutions. Rural-urban comparisons reveal a more complex pattern, with rural nurses reporting lower workload-related exhaustion but higher scores on depersonalization and professional isolation, linked to limited peer support networks, restricted access to continuing professional development, and infrastructural deficits. The paper concludes that effective burnout mitigation strategies in Anambra State's nursing workforce must be differentiated by facility type and practice setting rather than applying uniform, one-size-fits-all interventions, and recommends targeted staffing reforms, professional support structures, and infrastructural investment tailored to these distinct burnout profiles.

Keywords: Nurse burnout, comparative study, Anambra State, Job Demands-Resources, healthcare workforce

1. Introduction

Burnout among nursing professionals has long been recognized as a significant occupational health concern, with documented consequences for individual nurse wellbeing, patient care quality, and healthcare system retention capacity. In the Nigerian context, and in Anambra State specifically, this concern is compounded by well-documented structural features of the health system, including nurse-to-population ratios below World Health Organization recommended thresholds, uneven distribution of healthcare infrastructure between urban and rural areas, and persistent disparities between public and private healthcare sector working conditions.

This paper investigates nurse burnout in Anambra State through a comparative lens, examining how burnout prevalence and its contributing factors differ across two key dimensions: facility ownership type, comparing public and private healthcare institutions, and practice location, comparing urban and rural settings. The central questions guiding this inquiry are: do meaningful differences in burnout levels and burnout sub-dimensions exist across these settings, and if so, what structural and organizational factors account for these differences? Answering these questions is essential for designing burnout mitigation interventions that are appropriately targeted rather than uniformly applied across a heterogeneous nursing workforce.

The paper proceeds as follows: section two reviews relevant literature on nurse burnout generally and within the Nigerian context specifically; section three presents the theoretical framework; section four outlines the methodology; section five discusses comparative findings across facility type and practice location; and section six concludes with recommendations.

2. Literature Review

2.1 Conceptualizing Nurse Burnout

Burnout among nurses is most commonly conceptualized using Christina Maslach's tripartite model, which identifies three core dimensions: emotional exhaustion, the depletion of emotional resources through sustained occupational stress; depersonalization, characterized by cynical or detached responses to patients and colleagues; and reduced personal accomplishment, reflecting diminished feelings of competence and achievement in one's work. This model, operationalized

through the widely used Maslach Burnout Inventory, has been extensively validated across healthcare contexts internationally, including in Sub-Saharan African nursing populations.

2.2 Nurse Burnout in Sub-Saharan Africa and Nigeria

Studies of nurse burnout within Sub-Saharan African health systems consistently document elevated burnout indicators relative to international benchmarks, attributed to a combination of high patient loads relative to available nursing staff, resource and equipment shortages, limited administrative and managerial support, and, in various contexts, inadequate remuneration relative to workload demands. Nigerian studies specifically have documented significant burnout prevalence among nurses in public tertiary hospitals, with emotional exhaustion typically identified as the most pronounced burnout sub-dimension, though comparative research disaggregating burnout patterns by facility ownership type or urban-rural practice setting within specific Nigerian states remains comparatively limited.

2.3 Facility Type and Location as Structural Determinants

A smaller body of comparative literature has examined how burnout patterns differ across public and private healthcare facilities, generally finding that public sector nurses report higher workload-related exhaustion linked to higher patient volumes and staffing shortages, while private sector nurses, though generally reporting more favourable staffing ratios, may face distinct pressures linked to performance expectations and job security concerns. Similarly, limited comparative literature addressing urban-rural differences in nurse burnout suggests that while rural healthcare workers may experience lower absolute patient volumes, they often face compounding stressors linked to professional isolation, limited access to continuing education, and infrastructural deficits, including unreliable power supply and limited diagnostic equipment.

3. Theoretical Framework

This paper draws on Maslach's tripartite model of burnout as its primary conceptual anchor, providing the three-dimensional structure, emotional exhaustion, depersonalization, and reduced personal accomplishment, used to organize the comparative analysis presented in this paper. This model allows for a more nuanced comparative analysis than would be possible using a

unidimensional conception of burnout, given the paper's interest in whether different practice settings produce distinct burnout sub-dimension profiles rather than uniformly elevated or depressed overall burnout scores.

This is complemented by the Job Demands-Resources (JD-R) model, developed by Demerouti and colleagues, which conceptualizes burnout as arising from an imbalance between job demands, such as workload, time pressure, and emotional labour, and job resources, such as administrative support, professional autonomy, and access to continuing development opportunities. The JD-R framework is particularly well suited to this paper's comparative aim, as it allows the analysis to explain differing burnout profiles across facility type and location in terms of the specific demands and resources characteristic of each setting, rather than treating burnout as a uniform occupational hazard independent of structural context.

4. Methodology

This paper adopts a qualitative, comparative research design based on a desk review and thematic synthesis of nursing workforce and occupational health literature specific to Nigeria and comparable Sub-Saharan African health systems, supplemented by documented health-sector workforce reports and studies addressing healthcare infrastructure and staffing patterns in Anambra State. Thematic analysis is applied to identify and compare burnout-related patterns across two structural dimensions, facility ownership type (public versus private) and practice location (urban versus rural), organized according to the three Maslach burnout sub-dimensions and analyzed through the demands-resources lens of the JD-R framework. This qualitative comparative approach is appropriate given the exploratory nature of the inquiry and the current scarcity of large-scale primary survey data disaggregating nurse burnout specifically within Anambra State by these structural dimensions.

5. Findings and Discussion

5.1 Public versus Private Facility Comparison: Emotional Exhaustion

The evidence reviewed indicates that nurses in Anambra State's public secondary and tertiary healthcare facilities report comparatively higher emotional exhaustion than those in private

facilities, consistent with the JD-R framework's prediction that higher job demands, in this case, elevated patient-to-nurse ratios and higher overall patient volumes characteristic of public facilities relative to smaller private hospitals and clinics, produce correspondingly higher exhaustion when not matched by proportionate resources.

5.2 Public versus Private Facility Comparison: Depersonalization and Accomplishment

Findings regarding depersonalization and personal accomplishment reveal a more complex public-private comparison. While public sector nurses report higher exhaustion, evidence suggests private sector nurses may report comparable or, in some documented cases, higher depersonalization linked to distinct job demands, including performance-linked job security pressures and, in some private facilities, less structured professional support systems than exist within public sector institutional hierarchies, despite the latter's greater workload burden. This finding illustrates the value of disaggregating burnout into its component dimensions rather than treating public sector employment as uniformly more burnout-inducing across all measures.

5.3 Urban versus Rural Comparison

The urban-rural comparison reveals a distinct pattern from the public-private comparison. Rural-practicing nurses in Anambra State appear to report comparatively lower workload-related emotional exhaustion, consistent with generally lower absolute patient volumes in rural facilities, but higher depersonalization and reduced personal accomplishment scores, attributed in the literature to professional isolation, limited access to peer consultation and continuing professional development opportunities, and infrastructural constraints including unreliable electricity and limited diagnostic equipment, all of which constitute job resource deficits within the JD-R framework despite the comparatively lower job demands rural nurses face in terms of patient volume.

5.4 Implications for Differentiated Intervention

Taken together, these comparative findings suggest that a uniform burnout mitigation strategy applied indiscriminately across Anambra State's nursing workforce would likely be suboptimal, given the distinct demands-resources imbalances characterizing each setting. Public tertiary facility interventions should prioritize staffing ratio improvements and workload management,

while rural facility interventions should prioritize professional support networks, telemedicine-enabled peer consultation, and infrastructural investment, and private facility interventions should specifically address job security and performance-pressure-related depersonalization risk.

6. Conclusion and Recommendations

This paper has investigated nurse burnout in Anambra State through a comparative study design, finding meaningful differences in burnout sub-dimension profiles across public-private facility type and urban-rural practice location, consistent with the demands-resources imbalances predicted by the JD-R framework and disaggregated according to Maslach's tripartite burnout model. These findings underscore that nurse burnout in Anambra State is not a homogeneous phenomenon but one shaped distinctly by the structural characteristics of each practice setting.

The paper recommends: first, public healthcare facility management should prioritize nurse staffing ratio improvements and workload redistribution measures to address the elevated emotional exhaustion documented in these settings; second, rural healthcare facilities should be supported with structured professional support networks, including telemedicine-enabled peer consultation and access to continuing professional development, to address depersonalization and reduced accomplishment linked to professional isolation; third, private healthcare facility management should examine job security and performance-pressure dynamics that may be contributing to depersonalization independent of workload considerations; and fourth, further empirical research, including direct survey-based administration of validated burnout instruments such as the Maslach Burnout Inventory across a representative sample of Anambra State nurses stratified by facility type and location, is recommended to quantitatively validate and refine the comparative patterns identified in this qualitative synthesis.

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