Burn Out Among Health Workers: Just Evaluations Or Measures Also?

KS Meena Iyer[1], *Upasana Sharma*[2]

Background

Burnout is a psychological term that refers to long-term exhaustion and reduced interest in work. Burnout is not a recognized disorder in the DSM [1] although it is recognized in the ICD-10[2] and specified as a "State of vital exhaustion" (Z73.0) under "Problems related to life-management difficulty" (Z73), but not considered a "disorder".

The term burnout was launched in 1974 by psychiatrist Herbert Freudenberger. The majority of research literature describes burnout as a concept with three dimensions: exhaustion and loss of enthusiasm, emotional detachment and reduced academic performance and self-esteem [2-5]. The emotional exhaustion is a result of prolonged stress at work burdened by their own high expectations and situational demands. This is, in most people's opinion the primary dimension [5-6]. It is believed to cause cynicism and the inability to empathize with the client or patient's situation. Some researchers have argued that burnout occurs exclusively in the service and care professions while others describe burnout also in occupations with clients [7, 8].

When it comes to burn out among health professionals, research indicates general practitioners have the highest proportion of burnout cases; according to a recent Dutch study in Psychological Reports, no less than 40% of these experienced high levels of burnout [1].

The purpose of this paper is to have a look into the issues leading to burn out among health workers who work at the community level.

Search methodology

A desk review of selective published and unpublished articles and reports on primary healthcare programs was conducted to analyze and organize findings on the elements of burn out among health workers. Literature was searched by means of the databases of PubMed, Medline and the Cochrane reviews and electronic journals.

1 . **Assistant Professor, Department of Health Education, NIMHANS,Bangalore,India**

2 . **PhD Scholar, Department of Health Education, NIMHANS,Bangalore,India**

Risk factors of Burn out among Health Workers

External stress (load and organization of work, emotional interaction with the patient, constraints, lack of recognition, conflicts between private and professional life) interacts with endogenous stress (idealism, acute feeling of responsibility, mood disorder, difficulty in collaborating, character, personality). Burn-out symptoms would appear preferentially when these two stresses coexist. Despite huge number of publications, there is still a lack of knowledge of the causes of burn-out, requiring therefore increased research efforts, in order to improve the implementation of preventive measures, beneficial to the health workers as well as to their patients [9].

Research on job-related burnout among human service workers, nurses in particular, suggests that organizational stressors in the work environment are important risk factors of burnout [10-12] .Risk factors of job burnout can be summed up as :

- Lack of control
- Unclear job expectations
- Dysfunctional workplace dynamics
- Mismatch in values
- Poor job fit
- Extremes of activity

The multidimensional theory of Burn out

The underlying theory of Burn out, i.e, the multidimensional theory has three principal dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment [13]. Among these three dimensions, emotional exhaustion is the "central quality" of burnout - that is to say, it is the most analyzed, the most frequent, and the most obvious dimension [14].

Although burnout shares some features of depression disorder and anxiety, both are nonetheless distinct. According to Maslach , five characteristics distinguish burnout from depression:

- dysphoric symptoms (mental and behavioral) are more significant than the physical symptoms;
- symptoms are linked specifically with work;
- burnout or symptoms of burnout can appear without a history of psychological or
- psychopathological disorders;

- negative behaviors and attitudes lead to diminished work performance and effectiveness ([14]

The relevance of multidimensional theory lies in the fact that it is not merely a reaction/response stress model, but – according to Maslach–, a continuum: we can experience not only burnout, but also its opposite, engagement. The concept of a burnout-to-engagement continuum enhances our understanding of how the organizational context of work can affect workers' well-being. It recognizes the variety of reactions that employees can have to the organizational environment, ranging from the intense involvement and satisfaction of engagement, through indifference to the exhausted, distant, and discouraged state of burnout. More precisely, engagement is defined by the following dimensions: energy (opposed to exhaustion), involvement (opposed to depersonalisation), and sense of efficacy (opposed to reduced personal accomplishment); in short, it is the positive side of the engagement/burnout continuum [14].

Workload plays a defining role in the level of productivity and quality that of health workers. Workload is a multifactorial concept that can be described by the interplay of the number and organization of tasks and the catchment area (the number of households covered). Evaluations have reported that health workers often become "overwhelmed by a very broad range of tasks with negative effects on the overall quality of their performance" [15].

In India, according to Indian Public Health Standards (IPHS), a sub centre is the most peripheral and first contact point between the primary health care system and the community. Currently, each sub centre has one Family Health Worker commonly known as Auxilary Nursing Midwife (ANMs) and one Male Health Worker (commonly known as Multi Purpose Health Worker Male). Based on the projected bases on the expected number of beneficiaries, one more ANM is provided in addition to existing staff.

ANM is the key functionary at the village level for managing the maternal and child health programme. The major services ANM is expected to provide covers maternal and child health, family planning, MTP (Medical Termination of Pregnancy), nutrition, Universal Immunization Programme (UIP), communicable diseases, vital events, treatment of minor ailments, record keeping and team activities. She also plays a role as a facilitator of ASHA (Accredited Social Health Activist) [16].

The concerns that ANM is overburdened and spend large amount of time in filling registers and reports stem from the fact that many sub centres in the country are performing sub-optimally. The facility survey done under DLHS – 3(District Level Household and Facility Survey) indicates that the sub centres are poorly equipped and staffed. A paper on the Changing Role of ANMs analyzed that role of ANMs has changed from a midwife whose main job was to deliver babies and maternal and child health care, to a paramedical whose activities are limited to family planning, immunization and superficial antenatal care. Further, ANM not residing at the sub-

centre village are not easily accessible to the community in emergency such as delivery as they visit assigned villages and are busy with other administrative work [17].

To fill the gaps in the health care delivery system, ASHAs are provided and they complement the work of ANMs at community level. The issues like non availability of ANMs at sub-centers, early winding up of work, absenteeism, not reporting daily to duty and staff not residing at the sub centre villages also affect the effective functioning of sub centers [17].

A multi-country study noted "an evolution over time, whereby community health workers (CHW) take on additional responsibilities and skills, which are learned on-site" [18]. Given the serious financial and human resources constraints in developing countries, CHWs are expected to do more work although they may not always receive the necessary support to do their jobs well, such as supportive supervision, and supplies and equipment leading to burnout and high attrition.

A study of the working conditions of health extension workers in the Federal Democratic Republic of Ethiopia found that most of them worked for long hours, including on Sundays [19]. A qualitative study of Lady Health Workers in the Islamic Republic of Pakistan illustrated that the addition of responsibilities in their job descriptions, such as involvement in polio eradication campaigns, loading and unloading of medicines, and transportation of stocks, took valuable time away from their regular work [20].

According to a literature review on CHWs, "despite the wide range of tasks that CHWs can do, they cannot do everything—their limited educational background and training mean that they can only be expected to perform a limited number of tasks that complement the work of health professionals" [21]. When there are too many tasks to perform, HWs may not perform them all but instead select a few that they prefer to do, ones that they do best, or those that are most feasible . A study on the role of health surveillance assistants (HSA) in the Republic of Malawi showed that they do not perform all the tasks in their job description, which include a plethora of activities such as vaccination, growth monitoring, disease surveillance, health education, tuberculosis follow-up, family planning provision, treatment for common diseases, and supervision of traditional birth attendants [22]. An assessment in Pakistan showed that Lady Health Workers become stressed in their job because they have little say regarding their increasingly expanding job scope and are seldom consulted when their job description changes [23].

Intervention to minimize Burn out

1. The health worker could use a checklist, questionnaire or any other survey method to identify the client's health needs and provide all the services and referral to primary health centre. This would bring down the burden and increase the efficiency by decreasing the number of visits to houses, plan for effective time management and reduce costs on transport

2. Programs must take care to monitor the catchment area assigned to health workers to ensure that they can satisfactorily reach all the targeted members within the specified geographic area and community and provide quality of care.

3. To be successful, the health worker requires regular and reliable support and supervision. Offering them supportive supervision within the structures and functions of the health team would demonstrate better outcomes.

4. Community perception of health workers knowledge, skills, and overall ability to help them with their health needs is important for inspiring their respect and acceptance of CHW services.

Recommendations:

1. Need to look into the multiple roles that the health worker is doing and how much of work can they undertake before productivity suffers

2. Need to discuss with the health worker in the decision as to whether newer service scan be added to their portfolio, and if so, which would be desirable and most effective

3. There is an urgent need to understand how the health worker manages/designates the work assigned to them and what difficulties are faced and how that can be minimized for optimal functioning and work output.

4. Strengthen human resources management systems to facilitate a standard level of working conditions that enhance good performance within an enabling work environment.

5. Make the health workers aware of latest technologies in communication, so that there is a constant flow of communication happening and problems are addressed thus improving work efficiency.

References

1) Ulrich Kraft, "Burned Out", Scientific American Mind, June/July 2006 p. 28-33
2) ICD-10: International Classification of Diseases. Geneva: World Health Organization, 1994
3) Maslach C. Burnout: The cost of caring. NY: Prentice-Hall, 1982.
4) Maslach C. Understanding burnout: definitional issues in Analyzing a complex phenomenon. In: Paine W, eds. Job stress and burnout. Beverly Hills, CA: Sage, 1982: 29 – 40
5) Leiter M. Coping patterns as predictors of burnout. Journal of Organizational Behavior 1991, 12: 123 – 44

6) Shiroma A. Burnout in work Organization. In: Cooper CL, Robertson I, ed. International review of industrial and organizational psychology. Chichester: Wiley, 1989: 25 – 48

7) Cox T, Ferguson E. Individual differences, stress and coping. In: Cooper CL, Payne R, eds.Personality and stress. Chichester: Wiley, 1991: 7 – 30

8) Roness A. Burned out? Work Stress and mental illness among people in vulnerable occupations. Oslo: University Press, 1995
9) Aiken LH, Sloane DM. Effects of organizational innovations in AIDS care on burnout among urban hospital nurses. Work Occup. 1997;24:453–477.
10) Lake ET. Advances in understanding and predicting nurse turnover. Res Sociol Health Care. 1998;14:3–26.
11) Maslach C, Jackson SE. Burnout in health professions: a social psychologists analysis. In: Saunders G, Suls J, editors. Social Psychology of Health and Illness. Lawrence Erlbaum Association; Hillsdale, NJ: 1982. pp. 227–251.
12) Maslach C, Jackson SE. Maslach Burnout Inventory Manual. 2nd ed. Consulting Psychologists Press; Palo Alto, CA: 1986
13) Maslach C, Goldberg J. 1998. Prevention of burnout: new perspectives. Applied and Preventive Psychology 7:63-74.
14) Hermann K, *et al*.: Community health workers for ART in sub-Saharan Africa: learning from experience – capitalizing on new opportunities. *Human Resources for Health* 2009, 7:31.
15) Retreived 29th July 2012 from http://www.mohfw.nic.in/NRHM/Documents/IPHS_for_SUBCENTRES.pdf
16) Mavalankar D; Vora K S; Sharma S; The Changing Role of Auxiliary Nurse Midwife (ANM) in India: Implications for Maternal and Child Health (MCH) IIMA Working Papers 2008-03-01, Indian Institute of Management Ahmedabad, Research and Publication Department; 2008.
17) Celletti F, et al.: Can the deployment of community health workers for the delivery of HIV services represent an effective and sustainable response to health workforce shortages? Results of a multicountry study AIDS 2010, 24(suppl 1):45-57
18) Teklehaimanot A**,**Study of the working conditions for health extension workers in Ethiopia.Ethiopian Journal of Health Development 2007, 21(3):246-259.
19) Afsar HA, Younus M: Recommendations to strengthen the role of lady health workers in the national program for family planning and primary health care in Pakistan: the health workers perspective.Journal of Ayub Medical College, Abbottabad 2005, 17:48-53.
20) 21) Abbatt F: Scaling up health and education workers: community health workers. London, DFID Health Systems Resource Centre; 2005.
21) Kadzandira JM, Chilowa WR: The role of health surveillance assistants (HSAs) in the delivery of health services and immunisation in Malawi. Zomba. Centre of Social Science, University of Malawi, Malawi; 2001
22) Haq Z, Iqbal Z, Rahman A: Job stress among community health workers: a multi-method study from Pakistan. International Journal of Mental Health Systems 2008, 2:15