BURNOUT AMONGST PRIMARY HEALTH CARE NURSES: A CROSS-SECTIONAL STUDY

Anna Petronella Muller

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Supervisor: Mary A. Cohen

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DECLARATION

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ABSTRACT

The imbalance between job demands and available resources could cause burnout which may impact quality patient care. A scientific investigation was conducted to evaluate burnout amongst primary health care (PHC) nurses. The objectives for the study were to identify the prevalence of burnout amongst PHC nurses and to explore the contributing factors to burnout in PHC settings.

The Job Demands-Resources (JD-R) model (Bakker and Demerouti, 2007:309) was used as a conceptual framework for the study.

A non-experimental, descriptive cross-sectional design with a quantitative approach was applied. The population and sample consisted of professional nurses (PN) and clinical nurse practitioners (CNP) (n=72) in the Eden District of the Western Cape. A self-report questionnaire was used to collect the data in an uncontrolled, natural environment.

Analysis of the results exposed high levels of burnout amongst PHC nurses. Nurses in PHC facilities all had an equal chance to develop burnout, regardless of their level of experience. The occurrence of burnout is equal in community health centres and in community clinics, although a trend was observed that subjects in community clinics may experience more emotional exhaustion.

Work pressure, workload or an increase in job demands, lack of organisational support and management problems were rated as the main factors contributing to burnout.

Recommendations were made to improve the working environments of PHC nurses in order to increase motivational levels, job satisfaction and to foster work engagement, as well as to reduce levels of burnout. Opportunities for further research are recommended.

OPSOMMING

Die wanbalans tussen beroepseise en beskikbare hulpbronne kan uitbranding veroorsaak en gevolglik kwaliteit patiëntsorg beïnvloed. ‘n Wetenskaplike studie is gedoen om uitbranding onder primêre gesondheidsorg (PGS) verpleegkundiges te evalueer. Die doelstellings van die studie was om die voorkoms van uitbranding onder PGS-verpleegkundiges te identifiseer, en om die bydraende faktore wat aanleiding gee tot uitbranding in PGS-instellings, te ondersoek.

Die Beroepseise-Hulpbronne model (Bakker and Demerouti, 2007:309) is as ‘n konsepsuele raamwerk vir die studie gebruik.

'n Nie-eksperimentele, beskrywende dwarssnit studie met 'n kwantitatiewe benadering, is toegepas. Die populasie en die steekproef het bestaan uit professionele verpleegkundiges en kliniese verpleeg praktisyns (n=72) in die Eden Distrik van die Wes-Kaap. ‘n Self-rapport vraelys was gebruik om data in ‘n ongekontroleerde, natuurlike omgewing te versamel.

Die analisering van resultate het hoë vlakke van uitbranding onder verpleegkundiges in PGS-dienste ontbloot. Verpleegkundiges in PGS-fasiliteite het almal 'n gelyke kans om uitbranding te ontwikkel, ongeag die vlak van ondervinding. Die voorkoms van uitbranding is dieselfde in gemeenskaps-gesondheidsentrums en gemeenskapsklinieke, alhoewel daar ‘n neiging sigbaar was dat personeel in gemeenskapsklinieke meer emosionele uitputting ervaar.

Werkdruk, werklas of toename in beroepseise, die gebrek aan organisatoriese ondersteuning en bestuursprobleme is aangewys as die hoof redes wat aanleiding gee tot uitbranding.

Voorstelle is gemaak om die werksomgewing van PGS-verpleegkundiges te verbeter en om motiveringsvlakke en werkstevredenheid te herstel. Dit sal werksverbintenis versterk en die voorkoms van uitbranding beperk. Geleenthede vir verdere navorsing is aanbeveel.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS USED IN THE THESIS

ANC	African National Congress
APP	Annual Performance Plan
CNP	Clinical Nurse Practitioner
DHS	District Health System
DoH	Department of Health
DP	Depersonalization
EE	Emotional Exhaustion
HREC	Human Research Ethics Committee
ICAS	Independent Counselling and Advisory Services
ICN	International Council of Nurses
JD-R	Job Demands-Resources model
MBI-HSS	Maslach Burnout Inventory – Human Service Survey
NDoH	National Department of Health
NDP	National Drug Policy
NHI	National Health Insurance
NHISSA	National Health Information System for South Africa
PA	Personal accomplishment
PN	Professional Nurse
PGWC	Provincial Government Western Cape
PHC	Primary health care
QAP	Quality Assurance Policy
RSA	Republic of South Africa
SANC	South African Nursing Council
UNICEF	United Nations Children's Fund

CHAPTER 1: SCIENTIFIC FOUNDATION OF THE STUDY

1.1 INTRODUCTION

Chapter one provides a scientific foundation of the study on burnout amongst primary health care (PHC) nurses. The rationale for this study, the problem statement, research aim and objectives are presented in this chapter. The research methodology and the conceptual framework applied to this study are briefly described.

1.2 RATIONALE

Nurses in the South African public health care sector are confronted with unmanageable demands of an increased workload, insufficient human resources and unsatisfactory working environments (Kekana, Du Rand & Van Wyk, 2007:24; Van der Westhuizen, 2008:50). This challenging situation causes an atmosphere where the increase of job demands and a decrease in job resources could contribute to the prevalence of burnout, a condition that develops over time (Ten Brummelhuis, Ter Hoeven, Bakker & Peper, 2011:268).

Bakker, Van Emmeric, and Euwema (2006:466) state that individuals do experience burnout when they are suffering from feelings of fatigue, behave indifferently toward their work and clients, and when they believe that their performance has deteriorated accordingly. This statement was introduced by Maslach, Jackson and Leiter (1996:4) who categorised burnout into three dimensions which include emotional exhaustion (EE), depersonalisation (DP) and the lack of personal accomplishment (PA).

The researcher identified the frustration amongst nurses who cannot keep up with escalating demands on PHC nursing services. This includes the fast growing number of patients attending PHC clinics and a shortage of human resources.

In PHC facilities in the Eden District, management requires professional nurses (PN) and clinical nurse practitioners (CNP) to evaluate a minimum of fifty patients per eight hour day. Each visit per patient has to include history taking, diagnosing, treatment and care. The inability to treat a patient optimally causes frustration among nurses which may contribute to burnout. The overloaded working situation appears to increase the occurrence of demotivation and lack of energy amongst nurses.

Despite understaffing, nurses are legally liable for all their acts and omissions in nursing care (Muller, 2008:52-53). Furthermore, it is required that PN's and CNP's incorporate ethical and legal principles into every aspect of their practice (Searle, 2008:202). It is a legal requisite to

document all activities performed in respect to patient care. The National Health Act, 2003 (Act 61 of 2003) requires accurate record keeping of patient care (Republic of South Africa, RSA, 2003:24). The heavy workload in practice decreases the ability of nurses to document all actions on what was said and done to the patient/client. Irrespective of the heavy workload and inadequate human resources, supervision reports emphasise that on every occasion, what was not documented was assumed to have not been done. This intensifies feelings of guilt and increases stress levels amongst the nurses, which could contribute to their feelings of emotional exhaustion.

Comprehensive services are continuously incorporated in PHC services without consideration of the available human resources. This leads to mass production which possibly results in ineffective and low quality patient care. In order to provide quality care, nursing professionals have to respect the fundamental human rights of patients/clients to health care as compiled in the National Patients' Rights Charter (National Department of Health, NDoH, 1999:2-8). This right to quality nursing care is perhaps compromised by burnout.

The National Health Act (Act 61 of 2003) declared that health care personnel have the right to be protected against injuries or damage at their working establishment (NDoH, 2003:28). Part 24(1) of the Occupational health and safety Act (Act 85 of 1993) stated that each incident occurring at work or arising out of or in connection with the activities of persons at work is considered an incident (RSA, 1993:15). The researcher identified the limitations in the workplace to recognise the consequences of occupational stress as an occupational incident. Occupational stress due to the effect of the increasing working demands and work pressure on PHC nurses will increase the occurrence of burnout.

Burnout and depression were confirmed to be common problems amongst doctors at district and community level facilities in the Western Cape (Rossouw, 2011:4). The present study explored the prevalence of burnout amongst PHC nurses in the Eden District of the Western Cape Province in South Africa.

No research on nurses in the Eden District on this topic could be found.

1.3 PROBLEM STATEMENT

The imbalance between job demands and available resources could cause burnout amongst PHC nurses. The identification of the prevalence of burnout and the possible contributing factors towards burnout is needed to assist decision makers in comprehensive planning. Interventions may improve quality service delivering and eventually increase organisational outcomes.

1.4 RESEARCH QUESTION

A research question is a clear, concise interrogative statement which guides the implementation of quantitative studies and direct the conduct of a study (Burns & Grove, 2011:163). The research question which directed this study was: What is the prevalence of burnout amongst PHC nurses in the Eden District of the Western Cape, South Africa?

1.5 RESEARCH AIM

The aim of this study was to evaluate the occurrence of burnout amongst PHC nurses in the Eden District of the Western Cape.

1.6 RESEARCH OBJECTIVES

The objectives for this study were to:

- Identify the prevalence of burnout amongst PHC nurses, and to
- Explore the factors contributing to burnout in PHC settings.

1.7 RESEARCH METHODOLOGY

The research methodology applied for this study is discussed briefly in this part, although a detailed explanation appears in Chapter three.

1.7.1 Research Design

A research design is a plan or blue print of how the research study will be conducted (Burns & Grove, 2011:253). A non-experimental, descriptive cross-sectional self-report survey using a quantitative approach was used.

1.7.2 Population and Sample

A population is a specific group of individuals, elements or objects that meet the criteria of interest for a study (Burns & Grove, 2011:290). The population of nurses identified for this study were all registered PN's and CNP's working in community health centres, community clinics, satellite clinics and on mobile clinics in the Eden District of the Western Cape.

A sample is the subset of a group of individuals or elements from a defined population that is selected to participate in a research study (Brink, Van der Walt & Van Rensburg, 2012:131-132; Burns & Grove, 2011:290). The elements considered for this study were persons. In this study, persons are referred to as subjects (Burns & Grove, 2009:344).

Census sampling was conducted of all facilities and registered professional nursing staff in the Eden District of the Western Cape. A census of six out of the seven sub-districts and the staff complement (n=146) of professional registered nurses, was conveniently sampled. The seventh sub-district was excluded to prevent bias, as the researcher was employed there.

1.7.2.1 Inclusion Sampling Criteria

The specific characteristics subjects were required to possess to be part of the target population (Burns & Grove, 2011:290) comprised of all professional nurses and clinical nurse practitioners who render PHC services in the Eden District. The District Health System of the Western Cape is divided into six district management structures of which Eden District is classified as one of the five rural districts. This research study aimed to include PHC facilities of six of the seven sub-districts of the Eden District. These PHC facilities consist of community health clinics (fixed clinics, satellite clinics and mobile clinics) and community health centres (PGWC DoH, 2010:63-66) where district health services are rendered.

1.7.2.2 Exclusion Sampling Criteria

The Mossel Bay sub-district where the researcher worked was excluded to prevent bias. In addition, operational Managers, registered enrolled nurses, registered auxiliary nurses and professional nurses who render services for non-governmental organisations were excluded.

1.7.3 Data Collection Instrument

A self-report questionnaire in the three official languages of the Western Cape, was designed, based on the literature, advise of the statistician, the researcher's supervisor and the clinical experience of the researcher, to collect data relevant to the purpose and the objectives of the research study (see Appendices G, H, I). Since the research design is a descriptive survey, the choice of a questionnaire is an acceptable data-collection method (Brink *et al.*, 2012:154; Burns & Grove, 2011:52).

The questionnaire consisted of four parts. Continuous, dichotomous, ordinal and multiple-response questions with Likert scales were designed to obtain demographic and professional data and information on factors contributing to burnout of the subjects.

A second Likert scale based on a six-point, fully anchored response format designed by Maslach, Jackson and Leiter (1996:5), was used to collect information on emotional exhaustion, depersonalization and personal accomplishment. Job-related feelings were rated on a scale from zero to six. Open-ended questions on the respondent's personal opinion of burnout enabled the subjects to provide richer and more diverse information (Brink *et al.*, 2012:155).

1.7.4 Pilot test

A pilot test was conducted to establish the feasibility of the study and to test the questionnaire for clarity and validity of the questionnaire. Six subjects (4%) of the chosen population agreed to participate. This data was excluded from the final analysis of the study.

1.7.5 Data Collection

The data were collected in one week at the subjects' place of employment. Subjects were informed about the aim and the objectives of the study. Subjects were given consent forms to complete, and on completion, they were requested to place the forms in a sealed box marked "consent forms". On completion of the consent form, each subject was provided with a questionnaire and blank opaque self-sealing envelope. Once the questionnaires were completed, the respondents were requested to place the questionnaire in the envelope provided and to seal it. The envelopes were placed in an additional sealed box marked "questionnaires". A register was kept to record the number of consent forms and questionnaires delivered and collected from each facility.

The researcher personally collected all boxes with the consent forms and the completed questionnaires.

1.7.6 Reliability and Validity

Reliability involves the consistency of the measurement method (Burns & Grove, 2011:332). This refers to the extent to which results are consistent if a data instrument is used repeatedly over time on the same person, or when it is used by two researchers (Brink *et al.*, 2012:170). Reliability of the content and construction of the questionnaire was tested during the pilot test. Internal consistency and reliability of the MBI-HSS was estimated by Cronbach's coefficient alpha (Maslach, Jackson & Leiter, 1996:12).

Validity indicates to what extent an instrument measures the concept being examined (Burns & Grove, 2011:334). Content validity is the degree to which the instrument includes all the key elements relevant to the variable being measured (Burns & Grove, 2011:335). The instrument compiled for this study was influenced by literature, consultation with the statistician who agreed support in data analysis, the researcher's supervisor and experience of the researcher in PHC settings. Convergent validity of the MBI-HSS was demonstrated on three sets of correlations which provided substantial evidence of the validity of this inventory (Maslach, Jackson & Leiter, 1996:12). Construct and face validity of the questionnaire was ensured by consultation with the researcher's supervisor.

1.7.7 Data Analysis and Interpretation

Data analysis provides the researcher with answers to the research question, which initiated the research study (Burns & Grove, 2011:450). Prof M. Kidd, an expert statistician from the Centre for Statistical Consultation at Stellenbosch University was consulted with regard to the data analysis. Analysis was done by entering data into a Microsoft Excel® spread sheet and analysed using STATISTICA 10®.

Descriptive and inferential analyses were conducted by the statistician. Descriptive statistics include frequency distributions, measures of central tendency and measures of dispersion (Burns & Grove, 2011:383). Inferential statistics have a different function than descriptive statistics as they enable the researcher to draw a conclusion (Brink *et al.,* 2012:190) or to make a judgment based on evidence (Burns & Grove, 2011:378). A *p*-value of less than 0.05 represented statistical difference between the study variables using 95% confidence levels.

The strategies used for data analysis, and coding of the open-ended questions, are described in detail in Chapter 3.

1.7.8 Ethical Considerations

Permission to conduct this study was obtained from the Health Research Ethics Committee 1 (HREC 1) of University of Stellenbosch (reference S3/03/044, see Appendix A). Permission was obtained from the Western Cape Department of Health (see Appendix B) to conduct the pilot test in the Overberg District and the main study in the Eden District. Primary health care Managers were informed in advance, on when each facility could expect the researcher.

Subjects were informed as to the purpose and nature of the study. All subjects provided written informed consent (see Appendix D, E and F) prior to completing the questionnaire (see Appendix G, H and I). Voluntary participation and the right to withdraw at any time without penalty were explained. The right to privacy of each subject was respected by assuring them that information would not be shared with others. Confidentiality was maintained by means of placement of the signed consent forms and questionnaires into sealed envelopes and separate boxes. In addition, anonymity was respected by using a coding system for each facility without identifying details of the subjects. Minimal risk of harm to the subjects was anticipated. However, each subject was encouraged to phone the toll free number of the Independent Counselling and Advisory Services (ICAS) (0800 611 093) if they needed emotional support after completing the questionnaire.

Recognition of the core functions and services provided by each facility was respected.

The researcher will keep the raw data in a sealed container in a secure place for a minimum of fifteen years. Signed consent forms will be kept in secured research files for a minimum of fifteen years as stipulated by the HREC 1 (see Appendix A).

1.7.9 Limitations

The researcher's intention to visit the six scheduled sub-districts in the Eden District was compromised due to time constraints. To avoid bias one sub-district could not be considered for participation. However, the findings can be generalised to all primary health care facilities.

1.8 CONCEPTUAL FRAMEWORK

The study was based on the Job Demands-Resources (JD-R) model designed by Bakker and Demerouti (2007:309). This model was designed to explain which combination of job demands and job resources influence job-related well-being, e.g. burnout and work engagement (Bakker & Demerouti, 2007:323). The JD-R model indicates that high job demands and limited job resources cause strain in the workplace. In contrast, high levels of motivation occur when job demands are low and resources are high (Bakker & Demerouti, 2007:323). The JD-R model indicates the negative effect strain may have on organizational outcomes in order to achieve certain goals (Bakker & Demerouti, 2007:315).

The imbalance between job demands and job resources, as stipulated in the rationale of this study, may influence the level of strain and motivation amongst PHC nurses. The factors that contribute to burnout in PHC settings were explored in order to make recommendations to the employer to minimise the occurrence of burnout and to maximise productivity.

1.9 OPERATIONAL DEFINITIONS

"Acute Care" refers to care of conditions that may change within a few hours or days and require prompt investigation, diagnosis and treatment (National Department of Health, NDoH, 2006:7).

"Chronic Care" refers to long term inpatient care and or treatment of patients relating to chronic conditions that require extended care of over 90 days (NDoH, 2006:8).

"Clinical Nurse Practitioner" refers to a professional nurse, registered at South African Nursing Council (SANC), who obtained an additional qualification in Clinical Nursing Science, Health Assessment, Treatment and Care as stipulated in Government Notice No. R. 48 (SANC, 1982).

"Comprehensive Services" refers to prevention of disease, promotion of health, curative and rehabilitative care (Provincial Government Western Cape Department of Health (PGWC DoH, 2010a:38).

"Community Day Centre" refers to a facility which is open Monday to Friday from 07h30 to 16h00, at which a broad range of PHC services are provided. It also offers accident and emergency care but not midwifery services or surgery under general anaesthesia (NDoH, 2006:9).

"Community Clinic (Fixed clinic)" refers to a permanently equipped facility at which a range of PHC services are provided. It is open at least eight hours a day at least four days a week (NDoH, 2006:9).

"Mobile Clinic" refers to a temporary service from which a range of PHC services are provided and where a mobile unit/bus/car provides the resources for the service. This service is provided on fixed routes and at a number of points which are visited on a regular basis (NDoH, 2006:8).

"Nursing" refers to a caring profession practiced by a person registered with the SANC. Such person supports, cares for and treats a health care user to achieve or maintain health. If this is not possible, care will be provided to a health care user to ensure comfort and respect of dignity until death (RSA, 2005:np).

"Operational Manager" refers to a professional registered nurse who is responsible for the effective management of the unit in terms of clinical practice, administration, education and research (Meyer, Naudé, Shangase & Van Niekerk, 2009:6).

"Primary Health Care" refers to an essential health care which is accessible and acceptable to individuals and families in the community through full participation at a cost the community and country can afford (WHO, 1978:34). Primary health care is the first-level healthcare by a member of the healthcare team. It includes the assessment, diagnosis and treatment of the patient, in addition to preventive, promotive, rehabilitative and maintenance of care (Booyens, 2008:125).

"Primary Health Care Manager" refers to the manager who is responsible to observe and direct the execution of PHC services in all the PHC facilities of a specific sub district (NDoH, 2000:5).

"Primary Health Care Nurses" in this study, refers to all professional nurses (PN) and clinical nurse practitioners (CNP) who render health services in primary health care facilities.

"Professional Nurse" is a person who is registered with the SANC in terms of Part 31 of the Nursing Act, 33 of 2005; who is qualified and competent to practice comprehensive nursing independently to the prescribed level and who is capable of assuming responsibility and accountability for such practice (RSA, 2005:25).

"Public" refers to a unit where health services are delivering with the government department as the service provider (NDoH, 2006:5)

"Satellite Clinic" is a facility that is a fixed building where one or more rooms are permanently equipped and from which a range of PHC services are provided. It is open for up to eight hours per day and less than four days per week (NDoH, 2006:8).

1.10 DURATION OF DATA COLLECTION

The instrument pilot test took place on 12 July 2013. Data collection was conducted from 15-18 July 2013 and on 23 July 2013. The sealed questionnaire and consent boxes were collected immediately.

1.11 CHAPTER OUTLINE

Chapter 1 outlines the scientific foundation of the study including a description of the rationale, problem statement, research question, aims and objectives, the outline of the research methodology and the conceptual framework for the study.

Chapter 2 presents the literature review related to the global picture on PHC, dimensions of burnout and the factors contributing to burnout. The conceptual framework, the Job Demand-Resource model, selected for this study, will be described.

Chapter 3 provides a detailed explanation of the research methodology used in this study.

Chapter 4 consists of the analysis and interpretation of the results from the research study.

Chapter 5 presents the discussion, recommendations, limitations, recommendations for future research and a conclusion of the empirical findings attained from this research study.

1.12 SUMMARY

Nurses in the South African public health care sector are confronted with unmanageable demands of an increased workload, insufficient human resources and unsatisfactory working environments (Kekana *et al.*, 2007:24; Van der Westhuizen, 2008:50). The researcher

observed the frustration amongst PHC nurses who cannot cope with the increase in demands. This challenging situation contributes to burnout, a condition that develops over time (Ten Brummelhuis *et al.*, 2011:268).

The need to scientifically explore the prevalence of burnout amongst PHC nurses in the Eden District of the Western Cape was identified. High levels of motivation amongst nurses are important to render quality patient care on PHC level.

1.13 CONCLUSION

In Chapter 1, an introduction and rationale to the research study was provided. The problem statement, research question, aims, objectives and a brief description on the research methodology and conceptual framework were presented.
A description of the literature reviewed on the global picture on PHC, dimensions of burnout and the contributory factors are presented in Chapter 2.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Since 1994, the implementation of the primary health care approach has resulted in progressive transformation of the health care system in South Africa (RSA, 2008:8). Health professionals were required to accept the transformation process and act accordingly (RSA, 2008:8). The burgeoning task lists for primary health care (PHC) workers (Lawn, Rohde, Rifkin, Were, Paul and Chopra, 2008:917) are the reason why Baumann (2008:388) pointed out that nurses, working in PHC facilities, are high risk employees for developing symptoms of burnout. Van Rensburg (2004:372) confirms the strained effect transformation in the health care sector may have on public health human resources.

It is crucial for any country to offer a balanced and productive health service (Van der Colff & Rothmann, 2009:1). The nursing profession is nationally and internationally seen as an essential component of any health care system (RSA, 2008:8). Nursing practitioners, as ethical agents should advocate the well-being of patients and their families with compassion, commitment, confidence, competence and a deep sense of moral awareness (Pera & Van Tonder, 2011:3).

Burnout is seen as a combination of exhaustion and withdrawal (Schaufeli & Taris, 2005:260). Burnout among employees has several implications on individuals and organisations (Bakker, Van Emmeric and Euwema, 2006:484), such as ineffective service delivering and poor patient care (Maslach & Leiter, 2008:510; Rossouw, 2011:13).

An analysis of the dimensions of burnout will provide a clear explanation on the phenomenon of burnout (Maslach, Jackson & Leiter, 1996:4). Predictors of burnout, as well as the factors contributing to burnout have been investigated to emphasise how these unpleasant environments may aggravate the prevalence of burnout (Maslach *et al.*, 1996:3) amongst PHC nurses.

Chapter 2 will be concluded by a discussion on the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2007:309) on which the study is based.

2.2 LITERATURE REVIEW

A literature review enables the researcher to identify what is known and not known regarding the topic. It provides the reader with the current theoretical and scientific knowledge about the matter of concern (Burns & Grove, 2011:189).

The literature for this study was reviewed to:

- explore the international views on primary health care
- explore views of primary health care in South Africa
- identify the responsibilities and accountabilities of PHC nurses in South Africa
- identify the possible predictors towards burnout amongst PHC nurses
- explain the three dimensions of burnout
- explore the factors contributing to burnout in PHC settings, and to
- identify the effect of burnout on patient care

2.2.1 Primary health care: International

The primary health care approach was accepted (World Health Organisation, WHO, 1978:1), to address inadequate health care and fragmented health systems in both developd and developing countries, by the urgent implementation of strategies towards promotive and basic health care (Dennill, King & Swanepoel, 2008:2).

2.2.1.1 The Declaration of Alma-Ata

The primary health care approach was introduced in 1978 at an International Conference on Primary Health Care at Alma-Ata. This Conference, jointly sponsored by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF), focused on "urgent action to protect and promote the health for all the people of the world" (World Health Organisation, WHO, 1978:1). The primary health care approach had a substantial impact on the global strategies of the WHO and guide health policies and programmes of many nations (Dennill *et al.*, 2008:2).

2.2.1.2 Child survival development revolution (GOBI-FFF), Ottawa Charter and Riga

The development of primary health care programmes was further influenced by three important international events in order to strengthen the commitments to provide health for all the people of the world. The first programme was called the "Child survival development revolution." It was presented in 1981 to reduce the morbidity and mortality rates of infants and children in the developing world. This led to the implementation of strategies on Growth

monitoring, Oral rehydration, promotion of Breast feeding, expanded Immunisation, Feeding supplementation, Female literacy and Family planning, known as "GOBI-FFF." The second agreement was the implementation of the Ottawa Charter in 1986 with the focus on health promotion on the primary health care level. The intention for the initiative was to empower people to foster control over their own health and to improve their well-being to achieve "health for all" by the year 2000. The third important meeting was held in 1988 at Riga where experts around the world discussed the progress made towards the commitment to "health for all by the year 2000." Resolutions were accepted at this meeting in order to reach the goal by 2000 (Dennill *et al.*, 2008:10-16).

2.2.1.3 Failure to provide "Health for all at 2000"

The goal to achieve "health for all by the year 2000" has not materialised. Inadequate funding, limited time for workers to spend on prevention and community outreach, insufficient training and equipment for the problems they encountered, poor quality of care and inadequate referral systems contributed to the failure of the optimal implementation of PHC (WHO, 2000:14-15). A follow-up policy was introduced to focus on "Health for All in the 21st Century" with global health targets as the essence of this strategy (WHO, 1998:4). The latter was reformed in 2001 by introducing the Declaration on "Health *care* for all" at a conference held in Belgium, where the unacceptable state of health in large parts of the world was discussed. A commitment to accept adequate health care as a basic human right was accepted (Health care for all, 2001:np).

2.2.1.4 Millennium Development Goals (MDG's)

Eight Millennium Development Goals (MDG's) were identified in the Millennium Declaration set by the United Nations in 2000 to focus on major social, economic and environmental concerns. An agreement was reached to achieve the eight MDG's goals by 2015 (United Nations Millennium Declaration, 2000:np).

2.2.2 Primary health care: South Africa

Various strategies have been implemented by the South African government since 1994 to rearrange the health care system of the country. One of these strategies was the transformation of health services towards a district-based primary health care system. Numerous changes were needed to implement the primary health care approach optimally (Van Rensburg, 2004:132-133).

2.2.2.1 National Health Plan

The African National Congress (ANC) introduced a socio-economic development programme as a manifest for the 1994 election with the aim to eradicate apartheid and to build a democratic future. Through this Reconstruction and Development Programme policies were developd to improve the health of all South African people (ANC, 1994a:1). The newly elected government, the ANC, identified the need for total transformation of the health sector in South Africa. Prior to 1994 emphasis was on a curative and urban-centred health system where doctors played a dominant role within the hierarchy. Members of the ANC, WHO and UNICEF compiled the first draft of a National Health Plan. This plan was based on the comprehensive primary health care (PHC) approach with emphasis on community participation (ANC, 1994b:7). Provision was made to treat and prevent disease, and to protect, maintain and improve health of all South African citizens (ANC, 1994b:59).

2.2.2.2 Constitution of the Republic of South Africa (Act 108 of 1996)

During the Apartheid era health care services were considered a privilege rather than a right where white people were seen as the main beneficiaries (Van Rensburg, 2004:116). In contrast, the Constitution of the Republic of South Africa (Act 108 of 1996) subscribed equal health care as a fundamental right to all South African citizens (Republic of South Africa, RSA, 1996).

2.2.2.3 The White Paper for the Transformation of the Health System in South Africa

The White Paper for the Transformation of the Health System was published in 1997 to guide the development of an integrated health system. The document accentuates the comprehensive PHC approach. The aim for this movement was to improve quality health care to all the citizens given the limited resources available (National DoH, 1997:1,5). The implementation of a District Health System (DHS) on District level was emphasised (National DoH, 1997:17). The PHC approach was seen as the most efficient and cost effective way to improve the health of the population (National DoH, 1997:36).

2.2.2.4 Primary Health Care Package for South Africa

The National Department of Health (NDoH) developd the PHC Package for South Africa to promote equity in health care. This Package entailed a set of norms and standards of all the necessary components for a comprehensive PHC package and describe the range of services that should be available to all South Africans (NDoH, 2000). In addition, a PHC

Facility Supervision Manual, based on the PHC Package for South Africa, was compiled to strengthen service delivery and quality care (NDoH, 2009:2).

2.2.2.5 Strategic Plan 2010-2014 – Provincial Government Western Cape

i. Fundamental concern

The main concern of the Provincial Government Western Cape (PGWC) Department of Health is to provide a comprehensive package of health services to all citizens of the Western Cape. Priorities include promotion of health, prevention of disease, curative care and rehabilitation, training and education across all levels of care. Although the need for these services outweighs the available resources, employees are expected to deliver a quality service as effectively and efficiently as possible (PGWC, Department of Health, DoH, 2010a:38).

ii. The first level of care

Primary Health Care (PHC) services are considered to be the first contact point for patients within the public health system. This first level of care for patients is available at Community Health Clinics and Community Health Centres. Community Health Clinics are nurse-driven PHC services which include fixed clinics, satellite clinics, mobile clinics and visiting points. These clinics are primarily concentrated in rural areas where access to health services is constrained by geographical and other infrastructural challenges (PGWC DoH, 2010a: 63-71).

iii. Community-based Service

Community-based Services (CBS) were introduced to focus on disease prevention, health promotion and adherence support. De-hospitalised care is included in CBS where patients have been discharged from acute hospitals but still require on-going clinical and rehabilitative care (PGWC DoH, 2010a:70) on primary health care level.

2.2.2.6 Annual Performance Plan 2012/2013 - PGWC

Two main focus points are stipulated in the Annual Performance Plan (APP) developd by PGWC DoH regarding the vision of ‘quality health for all’ (PGWC DoH, 2010b:iii). Firstly, the focus is on a renewed commitment to a caring, quality, patient-centric health service. The APP accentuates the need for a more focused approach to improve health outcomes in the most efficient and productive manner possible. This approach on improvement considers the limited resource base compared to the health service demands. Secondly, the emphasis is to change the attention of managing the consequences of the burden of disease towards

improving the wellness of everybody in the Province. The prevention of illness and promotion of health is seen as the key focus areas towards a healthy society (PGWC DoH, 2010b:iii).

2.2.2.7 Wellness Management Policy for employees

The Provincial Health and Social Development Sectorial Bargaining Chamber adapted and signed the Employee Wellness Management Policy on 10 July 2013. The objectives of this policy are to meet the wellness of employees by implementing preventative and curative measures; to promote the physical, social, emotional, occupational, spititual, financial, and intellectual wellness of employees; to create an organizational climate and culture towards wellness and to identify psycho-social health risks; and to promote work-life balance through flexible policies in order to accommodate work, personal and family needs (Western Cape Government DoH, 2013b:1).

2.2.2.8 HealthCare 2030 – The Road to Wellness

The Western Cape Government Department of Health developd a draft, HealthCare 2030, on prevention of illness, promotion of health and wellness for all citizens. The vision is to establish access to patient-centred, quality care with viewpoints on patients, staff, the community, the Department, spheres of government and strategic partners. The Department see it as a challenge to make the values of caring, accountability, integrity, responsiveness and respect a living reality for each staff member. The Department will focus on caring for staff and engage them to achieve quality care. The fundamental principles toward the vision and values are towards patient-centred quality of care; to adopt an outcome-based approach; commitment of the PHC philosophy; the strengthening of the district health service model; to promote equity; to operate with efficiency; and to develop strategic partnerships (Werstern Cape Government DoH, 2013c:ix-xiv).

2.2.2.9 National Health Insurance (NHI) model

South Africa is in the process of implementing a financing system to ensure that all citizens of South Africa have access to appropriate, efficient and quality health services. This will entail major changes in the service delivery structures, administrative and management systems. Four key interventions need attention for successful implementation of the NHI. These interventions include a complete transformation on health care service provision and delivery; the total renovation of the entire healthcare system; dramatic changes to administration and management and the provision of a comprehensive package of care supported by a well organised PHC service (RSA, 2011:4-5).

2.2.3 The Responsibilities and Accountabilities of PHC nurses in South Africa

Primary health care nurses are the members of the health team who are universally involved in PHC. Due to the dynamic nature of nursing, they often are required to act on behalf of other health care professionals when those services are not available (Dennill *et al.*, 2008:189). A description of the responsibilities and accountability of PHC nurses follows.

2.2.3.1 Ethical Considerations and Professionalism

The International Council of Nurses (ICN) developd a Code of Ethics for Nurses based on fundamental responsibilities with the focus on promotion of health, prevention of illness, to restore health and to alleviate suffering (McQuoid-Mason & Dada, 2011:159). A philosophical framework has been published in South Africa, namely the Nurses' Pledge/code of service which reflects the nursing profession's specific convictions about nursing (Muller, 2008:4). This verbal agreement is made with the community by every nurse after successful completion of their studies (Muller, 2008:4-5).

Nursing practitioners should display all the characteristics of professionalism (Muller, 2008:18-20). That implies professional qualities of practitioners at all times (Muller, 2008:11). It is important for health professionals to have a strong ethical orientation (Pera & Van Tonder, 2011:62). This includes the individual's level of moral development, level of professional competence, acquaintance with moral theory, ethical principles and rules, and the individual's general moral disposition and virtue (Pera & Van Tonder, 2011:62).

2.2.3.2 National Patients' Rights Charter

The South African National Department of Health introduced the National Patients' Rights Charter to provide a caring and effective health service to every patient. In order to provide quality care, nursing professionals have to respect the fundamental human rights of patients/clients to health care as compiled in this National Patients' Rights Charter (NDoH, 1999:2-8).

2.2.3.3 The Batho Pele – 'People first' Principles

The White Paper on the Transformation of the Public Service Delivery was published in 1995 with the intention of increasing the efficacy of public service delivering. Eight principles, known as the *Batho Pele* Principles, act as guidelines on how efficient and effective public services should be to meet the basic needs of all South African citizens. The focus is centralised on high quality service delivering. These principles include the promotion and maintenance of high standards of professional ethics (RSA, 1997b:9-10). Nurses working in

primary health care facilities are public employees and need to perform accordingly to increase the delivery of a quality service.

2.2.3.4 National Health Act, 2003 (Act 61 of 2003)

The National Health Act, 2003 (Act 61 of 2003) requires record keeping to be done accurately (RSA, 2003:24).

2.2.3.5 Nursing Act 50 of 1978 and Nursing Act, 33 of 2005

The Nursing Act 50 of 1978 (Republic of South Africa, RSA, 1997a), as well as the Nursing Act 33 of 2005 (RSA, 2005) regulates and provides for matters related to the nursing profession in South Africa.

The Nursing Act 50 of 1978 defines the scope of practice for all nurses according to Regulation R.2598 (South African Nursing Council, SANC, 1984). In terms of Regulation R.387, the Rules Setting out the Acts or Omissions, disciplinary action can be taken by the South African Nursing Council (SANC) when any form of negligence in nursing care is reported (SANC, 1985:2).

The Nursing Act 50 of 1978, as amended, makes provision for registered nurses in Part 38A to physically examine any person, to diagnose any physical defect, illness or deficiency in any person, to keep prescribed medicines and may supply, administer or prescribe such medicine for prescribed conditions and to promote family planning.

The Nursing Act 50 of 1978, as amended, also stipulates in Part 45(1), the registration for qualifications and conditions thereof (RSA, 1997a:np). Regulation R.48 specifies that all general nurses will complete a diploma in Clinical Science, Health Assessment, Treatment and Care (SANC, 1982) in order to render primary health care.

2.2.3.6 Dispensing of medicine

The Medicine and Related Substance Control Amendment Act (Act 101 of 1965) makes provision for a Director-General, after consultation with the Pharmacy Board, to issue a permit for authorisation of a medical practitioner, dentist, practitioner, nurse or other person registered under the Health Professions Act, 1974, or an organisation where health services are performed, to compound and dispense medicines for the prescribed conditions (NDoH, 1965:13). According to the Nursing Act 50 of 1978 such functions may be performed only in circumstances where services of a medical practitioner or a pharmacist are not available (RSA, 1997a:np). Dennill *et al*. (2008:179) observed that registered nurses offer these services regardless of the presence of a doctor or a pharmacist, especially where the demands by the community exceeded the available resources.

The National Drug Policy (NDP) was compiled to ensure adequate and reliable supply of safe, cost-effective drugs of acceptable quality to all citizens of South Africa. According to the NDP, prescribers, dispensers and consumers should be informed on the rational use of essential drugs which are required to treat the majority of conditions in the country (NDoH, 1996:3).

2.2.3.7 Primary Health Care Services

The implementation of the PHC approach included an integrated health system structured by PHC services. These PHC services on PHC level should be provided subject to the availability of resources (NDoH, 1997:36). The White Paper on Transformation of Health Services emphasised the optimum use of the skills, experience and expertise of all health personnel for maximum coverage and for cost-effectiveness (NDoH, 1997:55).

In Table 2.1 a list of PHC services which need to be rendered by PHC nurses is presented. The PHC team should refer patients/clients to the secondary level of care when certain conditions need specialised care (NDoH, 1997:55).

Table 2.1: PHC services performed by PHC nurses (DoH, 1997:37-38)

Services	**Relevant health personnel**
Personal promotive and preventive services Health education Nutrition/Dietetic services Family planning Immunisation Screening for common diseases	PHC nurses Health educators / PHC nurses Dieticians / PHC nurses PHC nurses PHC nurses PHC nurses - Referral to generalist doctors as appropriate
Personal curative services for acute minor ailments, trauma, endemic, other communicable and some chronic diseases	PHC nurses - Referral to generalist doctors as appropriate
Maternal and child health services Antenatal care Deliveries Post-natal and neonatal care	Midwives (PHC nurses with appropriate qualification) - Referral to generalist doctors as appropriate
Provision of essential drugs	Pharmacists and assistants; PHC nurses
Services	**Relevant health personnel**

Basic oral health services	Dental therapists, oral hygienists / PHC nurses - Referral to dentists as appropriate
Basic optometry services	PHC nurses - Referral to optometrists as appropriate
Mental health services	Psychiatric nurses, social workers
School and institutional health services for children	PHC nurses
Community mental health and substance abuse services	Generalist doctors, PHC nurses, social workers
Community nursing and home care services , including care of the terminally ill	Generalist doctors, PHC nurses
Community geriatric services and care of the elderly	Generalist doctors, PHC nurses

2.2.3.8 Information Management

A comprehensive National Health Information System for South Africa (NHISSA) has been implemented to obtain reliable information. This information should be used for the effective management of available resources (NDoH, 1997:78). The NHISSA also monitors the implementation and success of health priority programmes (NDoH: 1997:81). Annual targets are established for all National Indicator Data Set (NIDS) indicators. These targets are laid down in conjunction with the relevant programme managers in the NDoH, taking into consideration international targets and existing programme performance as reflected by District Health Information system (DHIS) data (NDoH, 2011:22). Health workers are mandated to report accurate and comprehensive NHISSA data. Monitoring forms enable the evaluating and reporting thereof (NDoH, 1997:82-83). The NHISSA provides evidence for tracking data and to improve health service delivery (NDoH, 2011:15). However, the demands to record all functions performed on a daily basis, to reach the targets and to attend to all relevant health programmes at the same time, increases pressure on the daily workload of health workers which contributes to an inability to cope with the workload.

2.2.3.9 Quality Assurance

A Quality Assurance Policy (QAP) was compiled to achieve a quality health care system. The latter emphasises the national commitment to measure, improve and maintain high-quality health care for all citizens (RSA, 2007:2). Health professionals are facing challenges of frequent changes and technical innovation in the health sector. New interventions on prevention of diseases; assessment, treatment and care are available on a yearly base. It is

extremely difficult for health professionals to maintain high quality care due to this formidable task (RSA, 2007:6) as they should stay informed and in touch with the frequent changes.

2.2.3.10 Primary Health Care Supervision Manual

Primary Health Care is seen as the cornerstone of the South African national health care system. For this reason, a guide on Primary Health Care Facility Supervision was introduced to the public health sector with the focus on strengthening the delivery and improving the quality of PHC services. The aim of the PHC Facility Supervision Manual is to foster a supportive working environment in which planning; monitoring and evaluation are jointly done between management and employees (NDoH, 2009:2).

2.2.4 Predictors of burnout

The transformation of the health care system had a significant effect on public health human resources (Van Rensburg, 2004:372). A discussion follows on the factors that could act as predictors of burnout amongst PHC nurses.

2.2.4.1 Population

In-migration to the Western Cape Province is a major challenge of the PGWC DoH to meet the increasing demand for health services (PGWC DoH, 2010a:38). The increasing population due to the in-migration of citizens into the Eden District of the Western Cape Province was confirmed by censes 2011 (PGWC, DoH, 2010a:38). The figures displayed in Table 2.2 are sub-divided into different functional age groups. Statistics of 1996, 2001 and 2011 is included to show the accumulative situation over the past 15 years (Statistics South Africa, Stats SA, 2012:64).

Table 2.2: Distribution of the population by functional age group in the Eden District

	1996	2001	2011
Age			
0 - 14	114 503	129 646	148 464
15 - 64	273 111	296 351	380 944
65+	23 468	28 927	44 857
Total	375 082	454 924	574 265

In Figure 2.1, the distribution of the population in all functional age groups has increased in the Eden District over the past fifteen years (Stats SA, 2012:64) is illustrated.

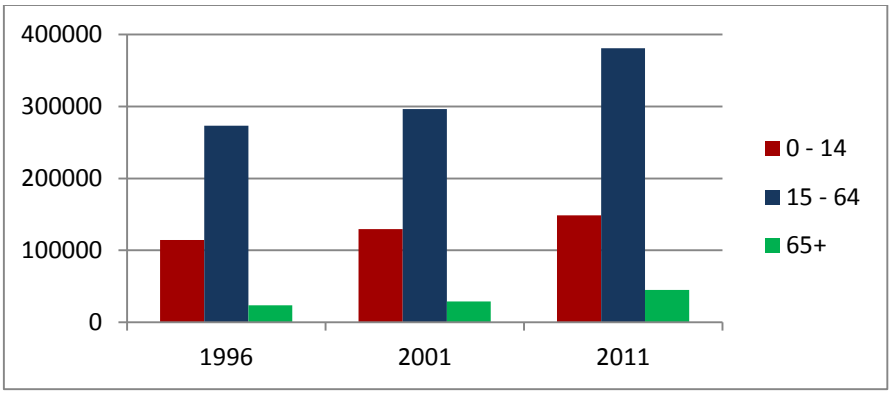

Figure 2.1: Distribution of the population by functional age group in the Eden District

2.2.4.2 Free of Charge Services

The Constitution of the Republic of South Africa (Act 108 of 1996) highlighted the concept of achieving optimal health as a constitutional right (RSA, 1996). The implementation of free of charges for services on primary health care level since 1994 (ANC, 1994b:2-5) can be seen as the reason for the fast growing number of patients (Hall, 2004:28) who attend primary health care (PHC) facilities. Moreover, it may negatively contribute towards the quality of service delivery and may cause inadequate patient care.

2.2.4.3 Burden of Disease

The increasing burden of disease with the challenge of limited financial and human resources, is another contribution to the demand on the PGWC DoH, to meet the increasing demand for health services (PGWC DoH, 2010a:38). Extensive research identified four excessive health burdens the health system is battling to cope with. The quadruple burden of disease includes communicable diseases (especially HIV/AIDS), non-communicable diseases, maternal neonatal and child deaths and deaths from injury and violence (Lawn & Kinney, 2009:2). The increasing demand on health services consequently has a negative effect on health workers' ability to render quality health services. The inability of nurses to cope with the unmanageable situation and growing demands intensify the possibility of developing burnout over time.

2.2.4.4 Unhealthy Habits and Lifestyles

The National Patients' Rights Charter (National DoH, 1999:8) stipulates the responsibilities of patients/clients. Although health care practitioners and health promoters plea for a change in unhealthy behaviour (Van Rensburg, 2004:242), some citizens tend to act irresponsibly towards their personal health. Lifestyle diseases, such as ischaemic heart conditions, hypertension, stroke, diabetes and chronic bronchitis are mostly the result of long-term unhealthy habits and lifestyles (Van Rensburg, 2004:242).

The burden of disease will escalate due to transversal issues which may contribute to the development of some diseases (PGWC DoH, 2010a:38). The major elements of health are often beyond the reach of the health sector and include a range of socio-structural factors (PGWC DoH, 2010a:15-16). Excessive alcohol consumption may increase alcohol related injuries and burden the health services (PGWC DoH, 2010a:38; Van Rensburg, 2004:242). Teenage pregnancies, risky sexual behaviour (RSA: 2010:49-50; Van Rensburg, 2004:234), unhealthy diet, tobacco use, stress and physical inactivity (Van Rensburg, 2004:242) are more factors which could overload healthcare services. Although similar risk factors increase health burdens, the main reason for the poor health status remains the result of poverty and socio-economic deprivation (WHO, 1998:20).

2.2.4.5 Educational level of Patients and Clients

An undesirable number of girls continue to drop out of school due to teenage pregnancies (RSA, 2010:49). A more educated society is more likely to increase the overall standard of living of the population and could provide a firm foundation for achieving life-long learning and skills. An educated population remains the fundamental platform for meeting most of the other MDGs. Education improves the scope for woman for equal participation in decision-making processes which affect their lives. Educated women will make strategic choices on employment, sexual and reproductive health and childcare (RSA, 2010:41-42). Thus, emphasis on education may decrease workload due to the demands in PHC facilities.

2.2.4.6 Migration

A serious human resource constraint is occurring in the South African health care system due to the migration of South African citizens (Van der Westhuizen, 2008:50; Van Rensburg, 2004:372). Hall (2004:34) identified a stressed workforce as a reason why nurses consider alternative career options. The international migration of health workers weakens the already fragile health systems in many low and middle income countries (WHO, 2006:1). Van der Westhuizen (2008:52) emphasise the importance of interventions to enhance the retention of professional nursing staff. These interventions include fair remuneration packages,

bonuses for acquiring additional qualifications and adequate training and education opportunities for nursing staff (Van der Westhuizen, 2008:52).

2.2.4.7 Human Resource

The majority of health professionals have increased since 1994, except for nurses. The nursing profession shows a sharp decrease and a negative growth in the past (Van Rensburg, 2004:319). The reason for the negative growth is partly due to the effect of efforts to accomplish targets of transformation. Public health human resources are under enormous and protracted strain which has resulted in emigration of health professionals, huge losses and underutilisation of highly skilled, competent and motivated staff. Exhausted human resources also cause a decrease in performances and the morale (Van Rensburg, 2004:372) of nurses.

The Department of Health in the Provincial Government of the Western Cape (2010a:38-51) identified the recruitment and retention of highly skilled and experienced health care personnel as another significant concern. A major challenge in the PGWC's Department of Health is the high percentage of employees aged between 51 and 65. It is confirmed that a large percentage of staff in all categories of nursing could leave the service within the next five years. A total of 500 employees will leave the service due to retirement during the next two years (PGWC DoH, 2010a: 38-51). Figure 2.2 illustrates the dispersion of age groups of professional nurses registered at SANC as of 31 December 2012 (SANC, 2013:np).

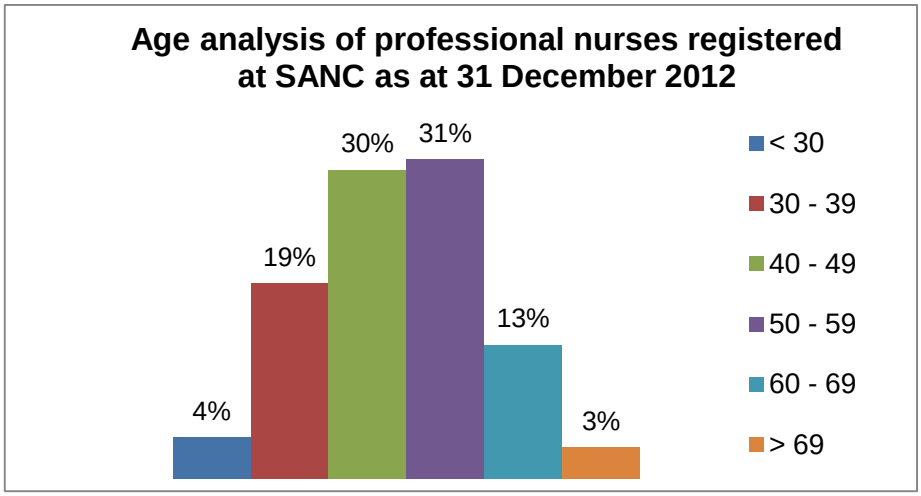

Figure 2.2: The age analysis of professional nurses registered with SANC: 31 December 2012 (SANC, 2013:np)

The imbalance between the input and output of nursing students, due to bad academic performances over the last few years (Magerman, 2011:1-2), confirms the concern of the negative growth in nursing (Van Rensburg, 2004:319). This attrition of students over the course of their programmes consequently exacerbates the nursing shortage problem. Although Government expected an increase in the number of students being trained to counteract the critical shortage of professional nurses in the country, the number of students completing their fourth year has decreased. This backlog of students completing their programmes successfully (Magerman, 2011:2) adds to the pressure of increased job demands on experienced staff in practice. The Strategic Plan of 2010-2014 specified objectives towards improvement of the current unsatisfactory working situation to develop and maintain a capacitated workforce to deliver the required health services (PGWC, DoH, 2010a:108).

The effect of HIV/AIDS epidemic may turn the current shortage of human resources into a crisis. A conservative estimate shows that 20% or 1:5 nurses are HIV positive. Such care givers will require HIV/AIDS related treatment and other medical care (Dennill, 2002:76). This scenario might increase the demands on their fellow workers and may intensify the prevalence of burnout.

2.2.5 The Dimensions of Burnout

Primary health care services require day-to-day involvement with people. Employees working in such environments may become emotionally drained and can develop burnout (Maslach *et al.*, 1996:3). The latter statement proves Baumann's (2008:388) prediction that PHC nurses are more likely developing burnout due to the transformation of the health services in South Africa and the concomitant increasing burden of disease. Maslach *et al.* (1996:3) emphasised the ambiguous and frustrating situation where staff-client interaction is centred on the client's current problems (psychological, social, or physical). Employees deal with client's problems constantly which may increase stress levels as solutions are not always easily attained. Employees are more vulnerable to burnout when the organization's priorities and task demands are not synchronised (Leiter, Gascón & Martínez-Jarreta, 2008:44).

Schaufeli & Taris (2005:260) define burnout as a combination of exhaustion and withdrawal, which is likely to impact negatively upon the delivery of quality care. Burnout can also be defined as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among human service workers (Maslach *et al.*, 1996:4). Vahey, Aiken, Sloane, Clark and Vargas (2004:63) reinforce the need for change in the

workplace that would reduce nurses' high levels of job burnout while maintaining patients' satisfaction with their care. Individuals experience burnout when they feel fatigued, behave indifferently toward their work and clients, and when they believe that their performances has deteriorated accordingly (Bakker, Van Emmeric & Euwema, 2006:466).

Effects of burnout could have critical consequences on workers, their clients and organisations (Maslach *et al.*, 1996:4). This phenomenon is associated with reduced social functioning, health problems, job demands, lack of resources and negative work outcomes (Schaufeli, Taris & Van Rhenen, 2008:192). Health problems which may result due to burnout include distress, depression, anxiety and psychosomatic health complains (Schaufeli et al., 2008:192). Scientific evidence shows that burnout is not limited to individuals but may affect a whole team and organizations (Bakker *et al.*, 2006:484).

Burnout seems to be a global problem. A study done by Xie, Wang and Chen (2011:1537) in Shanghai China, found that 74% of nurses were suffering from high levels of burnout, which was strongly associated with work-related stress. In South Africa, several factors lead to a stressed workforce who consequently considers alternative career options (Hall, 2004:28). A cross-sectional study done by Rossouw (2011:4) confirmed burnout and depression to be common problems amongst doctors at district and community level facilities in the Western Cape. High levels of emotional exhaustion (53%), depersonalisation (64%) and personal accomplishment (43%) were explored in the above mentioned study (Rossouw, 2011:10). A study done by Rothmann and Malan (2011:10) state that job-related stress (due to job demands and a lack of job resources) and coping strategies contribute to several aspects of work-related wellbeing of pharmacists in South Africa.

The analysis of the three dimensions of burnout as mentioned by Maslach *et al.* (1996:4) will be synthesized in this study to identify the prevalence of burnout amongst PHC nurses.

2.2.5.1 Emotional exhaustion

Emotional exhaustion involves the feelings of being emotionally overextended and exhausted. Employees who work with people feel they are no longer able to deal with the client's problems at a psychological level. Emotional exhaustion can also be defined as a depletion of one's emotional and physical resources (Maslach & Leiter, 2008:498; Taris, Stoffelsen, Bakker, Schaufeli & Van Dierendonchk, 2005:955).

The study done by Schaufeli *et al.* (2008:192) confirmed that exhaustion is associated with distress and job demands. Van der Colff and Rothmann (2009:8) stated that occupational

stress could have an effet on work engagement. Registered nurses seem to experience a depletion of emotional resources when they demonstrate a weak sense of coherence. In such cases they find it difficult to cope with certain circumstances and tend to perceive situations as stressfull. Depleted energy levels caused by burnout may cause nurses to seek for coping strategies like focusing on and venting of emontions (Van der Colff & Rothmann, 2009:8). It was found that the crossover of feelings of emotional exhaustion is more likely in teams with high cohesiveness and social support that could influence organisations negatively (Westman, Bakker, Roziner & Sonnentag, 2011:571).

A significant relation was found between marital status and Emotional Exhaustion in a study done by Maslach and Jackson (1981:111). Divorced and single people scored higher on EE than married people.

2.2.5.2 Depersonalization

A second aspect of burnout includes the development of negative, cynical attitudes and feelings about one's clients, known as depersonalization. This component represents the interpersonal context dimension of burnout and refers to excessively detached response to various aspects of the job (Maslach & Leiter, 2008:498; Taris *et al.*, 2005:955). Maslach *et al.*, (1996:3) emphasised the ambiguous and frustrating situation where staff-client interaction is centred on the client's current problems (psychological, social or physical) for which answers are not always obvious and easily obtained.

2.2.5.3 Lack of Personal Accomplishment (or inefficacy)

Reduced personal accomplishment (or inefficacy) refers to the tendency to evaluate oneself negatively, particularly with regard to one's work with clients. Workers may feel unhappy about themselves and dissatisfied with their accomplishments on the job (Maslach *et al.*, 1996:4). Taris *et al.* (2005:955), describe diminished personal accomplishment as a lack of self-efficacy regarding one's own performance at work. This component represents the self-evaluation dimension of burnout (Maslach & Leiter, 2008:498). Feelings of personal accomplishment gives an indication on how satisfied patients are with their care (Vahey, Aiken, Sloane, Clarke & Vargas, 2004:np).

Maslach and Leiter (2008:498) believe that if signs of burnout could be identified early, action could be taken to address the potential for burnout and to build engagement. Furthermore, early warning signs might call for a more preventive, individual approach to get

things back on track for the person who is under temporary stress, before it becomes more serious and pervasive (Maslach & Leiter 2008:510).

2.2.6 Factors Contributing to the Burnout Phenomena

Working in unsatisfactory circumstances will increase chronic stress, which can be emotionally draining and can lead to burnout (Maslach, Jackson & Leiter, 1996:3). Burnout is likely to negatively influence delivery of quality care (Rossouw, 2011:14). Numerous factors which may contribute to the prevalence of burnout amongst nurses in PHC services is noted in literature (Rossouw, 2011:14; Oosthuizen, 2009:191; Baloyi, 2009:145; Van der Colff & Rothmann, 2009:7; Bester, 2009:114; Lawn *et al.*, 2008:917; Van der Westhuizen, 2008:51; Kekana *et al.*, 2007:24; Erasmus & Brevis, 2005:51; Hall, 2004:28). Van der Colff and Rothmann (2009:8) state that occupational stress and a weak sense of coherence can predict burnout and low work-engagement.

Baumann (2008:382) divided the factors contributing to burnout into three main subparts: the ability to deal with personal issues; the working context or organizational situation and the effect of job demands. An exposition on different reasons for developing burnout follows.

2.2.6.1 Workload

Extensive workloads, also described as the increase of job demands resulting from the integration of PHC services, are associated with burnout and job dissatisfaction in PHC workers who provide comprehensive health care services (Ten Brummelhuis *et al.*, 2011:268; Rossouw, 2011:13; Lawn *et al.*, 2008:917; Van der Westhuizen, 2008:50; Kekana *et al.*, 2007:24; Xanthopoulou, Bakker, Dollard, Demerouti, Schaufeli, Taris & Schreurs, 2007:782; Erasmus & Brevis, 2005:51; Hall, 2004:28). Job demands can be divided into quantitative, emotional and cognitive demands (Bakker *et al.*, 2011:177).

Excessive administrative duties and demands from clients/patients and health risks caused by contact with patients where rated by Van der Colff and Rothmann, (2009:7) as stressors which may cause burnout. Xie, Wang and Chen (2011:1537) in Shanghai China, found that 74% of nurses suffered from high levels of burnout which was strongly associated with work-related stress.

It is extremely important for organizations to prevent employees' health impairment by avoiding overwhelming levels of job demands (Xanthopoulou *et al.*, 2007:782).

2.2.6.2 Job Control

Job control with regard to workload plays a pivotal role in improving employees' experience of their work life (Leiter, Gascón & Martínez-Jarreta, 2010:70). This statement was proven by scientific evidence where it was noted that high demands in combination with a lack of control causes high job strain (Van Yperen & Hagedoorn, 2003:339). Taris *et al.* (2005:961) confirmed in their study that job control which when objectively measured can systematically be linked to levels of burnout. To limit fatigue, high job control is important when demands increase (Van Yperen & Hagedoorn, 2003:344).

2.2.6.3 Management Problems

Effective support and performance of managerial tasks by employers, supervisors and other professional staff will reduce stress caused by increased workload and insufficient resources (Kekana *et al.*, 2007:24; Baloyi, 2009:145; Hall, 2004:28). Job control played a major role in employees' experience of their work life with regard to their relationship with their immediate supervisors and their access to organizational justice/fairness (Leiter *et al.*, 2010:70). Employees who participate in decision making and who practice self-determination in the workplace could experience a just work life or build a satisfying relationship with immediate supervisors (Leiter *et al.*, 2010:70). Poor nursing service managers and the perception that hospital management are insensitive to the nurses' problems are reasons for nurses leaving the country (Oosthuizen, 2009:238-240).

2.2.6.4 Insufficient Training

Organizations should provide sufficient job resources (e.g. autonomy, support, opportunities for development) to employees in order to offset the negative effect of job demands (Xanthopoulou *et al.*, 2007:782).

2.2.6.5 Available Time Shortage

Available time shortage was identified by 35.9% nurses as a major problem in nursing (Van der Westhuizen, 2008:50). A cross-sectional study on burnout and depression also indicated the number of working hours as a contributing factor to burnout (Rossouw, 2011:3).

The escalation of demands in PHC services may be the reason nurses work overtime. Overtime is defined as the time that an employee works during a day or a week in excess of ordinary hours of work (RSA, 1997c:np). Regulations state that an employer may not require or permit an employee to work overtime except in accordance with an agreement (RSA, 1997c:np).

This shortage in time may cause nurses to work through their lunch breaks. Part 23(1) of the Constitution refers to the right of a person to fair labour practices by establishing and making provision for the regulation of basic conditions of employment. The Basic conditions of employment Act as amended (Act 75 of 1997) stipulates the responsibility of the employer to give an employee who works continuously for more than five hours a meal interval. This Act makes provision for an employer to require or permit employees to perform only duties during a meal interval that cannot be left unattended and cannot be performed by another employee. In such circumstances an employee should receive remuneration, which is any payment in money or in kind, or both (RSA, 1997c:np).

2.2.6.6 Low Levels of Job Satisfaction

Adaptation to some working conditions differs amongst employees in terms of their personal characteristics (Xanthopoulou *et al.*, 2007:782). Factors which contribute to a state of poor job satisfaction are limited career advancement and safety concerns (Van der Westhuizen, 2008:51; Oosthuizen, 2009:191). A prospective cohort study confirmed that low job satisfaction is a cause for higher risk of absence due to sickness. They mentioned that if nurses' job satisfaction improves, sickness absence might be prevented (Roelen e*t al.*, 2012:372).

2.2.6.7 Lack of Motivation

Employees who are exposed to a lack of adequate resources and poorly motivated co-workers experience withdrawal and might develop indifferent attitudes towards their jobs (Van der Colff & Rothmann, 2009:7-8). Low morale can be a reason for burnout amongst staff (Maslach *et al.*, 1996:3). On the other hand, job strain can be reduced and employees may develop higher levels of intrinsic motivation when job control and job social support are improved (Van Yperen & Hagedoorn, 2003:346). In addition, employees feel appreciated by the organization when they are involved in decision making (Bakker *et al.*, 2011:177).

A study done by Bakker *et al.* (2006:482) on the crossover of burnout and engagement in work teams supported the proposition that team-level burnout and work engagement have unique effects on individual members' experiences of burnout and engagement. Co-workers play a vital role in the development of burnout where symptoms of burnout was expressed by colleagues and transferred to employees. In contrast, it was also found that employees who worked in highly engaged teams expressed higher levels of vigour, dedication and absorption regardless of their working conditions (Bakker *et al.*, 2006:482).

2.2.6.8 The Lack of Organisational Support

The lack of organizational support should be a concern for organisations. Development of disengagement from, or depersonalised feelings towards patients should be prevented at all times (Van der Colff & Rothmann, 2009:8). It is stated that the most effective way to enhance intrinsic motivation is by increasing the supportive interaction available between co-workers and supervisors in the working situation (Van Yperen & Hagedoorn, 2003:346). The lack of supervision, support, opportunities for development and participation in decision making, exacerbates work-home interference (Bakker *et al.*, 2011:177). This may intensify the occurrence of burnout amongst employees. A lack of coherence could predict high levels of emotional exhaustion and depersonalisation (Van der Colff & Rothmann, 2009:8).

Social support is important in achieving work goals and protects employee from the pathological consequences of stressful experiences. When specific and accurate information is provided in a constructive way, both employees and supervisors can improve or change their performance (Bakker & Demerouti, 2007:315).

2.2.6.9 Inadequate Human Resources

Primary health care nurses experience emotional and physical strain as a result of the shortage of human resources (Mohale & Mulaudzi, 2008:60). The task lists for primary health care (PHC) workers are not matched by long-term human resource planning, better training and supportive supervision (Lawn *et al.*, 2008:917). Predictors of burnout in organizations include inadequate human resources (Van der Colff & Rothmann, 2009:7; Mohale & Mulaudzi, 2008:60). The risks that nurses and patients are exposed to, as a result of the shortage of personnel (Oosthuizen, 2009:239), may lead nurses to consider an alternative working environment. The latter may result in the intensity of workload on the remaining personnel.

Low staff levels could also be caused by absenteeism. Absence includes not only the presence of sickness, but also arriving late for work, leaving early from work, extended tea or lunch breaks, attending to private business during working hours, extended toilet breaks, feigned illness and other unexplained absences from work (Motsepe, 2011:34). These bad habits may intensify the enormous workload on dedicated personnel who are at risk of developing burnout.

2.2.6.10 Personal Factors Beyond the Workplace

Personal factors which influence burnout refer to a person's ability to deal with stress, home circumstances and the demands made on them (Baumann, 2008:382). Social or relationship

skills have an effect on efficient work performance, including competencies and the ability to cope with the stressors of life and work (Bergh & Theron, 2003:197). Unsatisfied needs on the physiological, safety, social, esteem and self-actualisation levels are identified by Oosthuizen (2009:240) as personal issues which may influence nurses' decisions in considering alternative career options.

2.2.6.11 Financial Constraints

The degree of fair remuneration (Hall, 2004:28; Erasmus and Brevis, 2005:51; Kekana *et al.*, 2007:24; Lawn *et al.*, 2008:917) poor budgeting and financial constraints (Baloyi, 2009:145) are associated with job dissatisfaction in PHC workers providing comprehensive health care services.

2.2.6.12 Unproductive Co-workers

Absenteeism could be a manifestation of under commitment, especially if this type of behaviour points to anti-organizational behaviour such as dishonesty and disloyalty. Absence from work could be a main indicator of organizational stress and give cause for loss of productivity (Bergh & Theron, 2003:430; Maslach *et al.*, 1996:4). A descriptive, quantitative study done by Nyathi and Jooste (2008:36) prove the abovementioned statement where personal and managerial characteristics, as well as organisational and working conditions were identified as reasons for high levels of absenteeism in the workplace. This statement could strengthen the phenomenon of burnout as absenteeism exacerbates the co-workers' workload which contributes to the development of burnout.

Unproductivity is intensified by co-workers who fall into the habit of arriving late for work, leaving early from work, extended tea or lunch breaks, attending to private business during working hours, extended toilet breaks, feigned illness and other unexplained absences from work (Motsepe, 2011:34).

The perception stated by older nursing professionals obtained from an open ended question provided by Van der Westhuizen (2008:52), was that younger nurses do not have sufficient commitment and lifetime dedication. This confirms the view of subjects who participated in a study done by Van der Colff and Rothman (2009:7), were fellow workers who do not perform their jobs properly act as a relatively severe stressor.

2.2.6.13 Lack of Equipment

Hall (2004:28) identified a lack of equipment as another factor which leads to a stressed workforce who consequently may consider alternative career options. Inappropriate allocation and possible embezzlement of funds by administrators in public services (Cart Blanche, 2013) may be reasons why nurses are inhibited to render quality care.

2.2.6.14 Communication Problems

Primary health care nurses experience strain as a result of unreliable referral systems and communication networks (Baloyi, 2009:153). Poor communication between management and staff has a negative impact on the level of job satisfaction amongst nurses (Bester, 2009:114). Suggestions were made by Van Yperen and Hagedoorn (2003:346) that mechanism to improve interpersonal skills could be achieved by clarifying understandings, providing constructive feedback and asking for help from others in order to improve a positive work life.

2.2.6.15 Work-home Interference

Bakker, Ten Brummelhuis, Prins and Van der Heijden (2011:176) prove that a combination of high job demands and low job resources results in most work-home interference. Work-home interference is described as employed parents who experience problems combining work and family demands. Work-home interference may occur when employees are burdened with a high workload and have emotionally and cognitively demanding tasks (Bakker *et al.*, 2011:177). Work overload (Byron, 2005:169), long work hours, working overtime and pressure at the job (Bakker and Geurts, 2004:345) are strong predictors of work-home interference.

2.2.6.16 Family-work Interference

Individuals preoccupied with problems beyond the workplace come to work already burdened and are more vulnerable to burnout (Baumann, 2008:386). Scientific evidence shows the negative effect of family-work interference on co-workers. The work outcomes of fellow-workers can be affected by a colleague who has worrying family matters. Co-workers are more likely to change jobs or to take more sickleave when family-work interference is experienced by co-workers (Ten Brummelhuis *et al.*, 2010:467).

2.2.7 The Effect of Burnout on Patient Care

Maslach *et al.* (1996:4) proved that burnout may cause deterioration in the quality of care or service provided by the staff. Vahey *et al.* (2004:63) reinforce the need for change in the workplace that could reduce nurses' high levels of job burnout while maintaining patients' satisfaction with their care.

2.3 CONCEPTUAL FRAMEWORK

A conceptual framework provides the theoretical foundation for a research study based on phenomena, assumptions and philosophies (Burns & Grove, 2007:167). The JD-R model is described in the following part as the foundation for this study. It shows the importance of a well-balanced relation between job demands and resources to improve employee well being and performance (Bakker & Demerouti, 2007:310).

2.3.1 The Job Demands-Resources (JD-R) model

The JD-R model, as illustrated in Figure 2.3 below, was designed to explain how the combination of job demands and job resources influence job-related well-being such as burnout and work engagement (Bakker & Demerouti, 2007:323). The central assumption of the JD-R model indicates the effect of high job demands and limited job resources on job strain. Work engagement on the other hand, will occur when job resources are high (Bakker & Demerouti, 2007:323). The model includes three propositions:

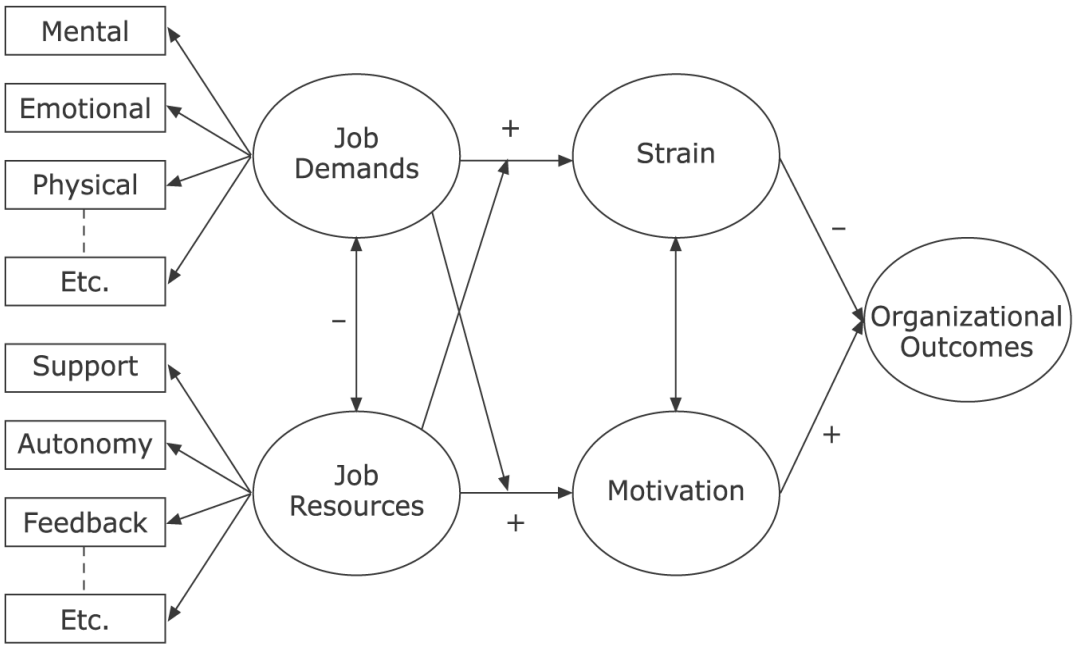

Figure 2.3: The Job Demands-Resources model (Bakker & Demerouti, 2007:313)

2.3.1.1 First proposition

The first proposition of the JD-R model classified job demands and job resources as risk factors towards burnout, associated with job stress (Bakker & Demerouti, 2007:312). Job demands are physical, psychological, social, or organisational aspects of the job which require physical and/or cognitive and emotional skills at physiological and/or psychological costs. Job resources on the other hand, refer to physical, psychological, social, or organizational aspects of the job. Job resources are important to deal with job demands, but are also essencial on its own right (Bakker & Demerouti, 2007:312).

2.3.1.2 Second proposition

In the second proposition of the JD-R model two underlying psychological processes play a role in the development of job strain and motivation (Bakker & Demerouti, 2007:313).
Health impairment process, poorly designed jobs or chronic job demands (e.g. work overload, emotional demands) drain the mental and physical resources of employees and may therefore lead to the depletion of energy and health problems. This is known as the first process.

The second process emphasised on the motivational potential job resources may have towards high work engagement, low cynicism and excellent performance. It may play either an intrinsic motivational role to foster employees' growth, learning and development, or can play an extrinsic motivational role because they are instrumental in achieving work goals (Bakker & Demerouti, 2007:314). In both cases the satisfaction of basic needs or through the achievement of work goals, the presence of job resources leads to engagement, while the absence of job resources may evoke a cynical attitude towards work (Bakker & Demerouti, 2007:314).

The JD-R model indicates how important the interaction is between job demands and job resources in the development of job strain and motivation. Different types of job demands and job resources may interact in predicting job strain. Several resources can facilitate the achievement of a specific goal while goals are likely to be influenced by different resources (Bakker & Demerouti, 2007:314).

2.3.1.3 Third proposition

The final proposition of the JD-R model is that the motivational potential of job resources might increase particularly when employees are confronted with high job demands (Bakker & Demerouti, 2007:314).

The imbalance between job demands and job resources, as stipulated in the rationale of this study, will influence the level of strain or motivation amongst PHC nurses. The JD-R model indicates the negative effect strain (burnout) may have on organizational outcomes, which, in this study, refers to quality service delivering and patient care on PHC level. For this reason the researcher aim to determine what the prevalence of burnout is amongst PHC nurses.

2.4 SUMMARY

The literature review provides a broad picture on the international and national strategies towards the implementation of primary health care in order to improve health for all around the world. The PHC approach was adapted by the newly elected government of South Africa in 1994 to transform the health care system. The description of the responsibilities and accountabilities of PHC nurses indicates to what extent PHC nurses should stay informed in order to render quality health services. Due to the high job demands and limited resources, nurses are likely to develop burnout. Burnout was described in three dimensions. A synthesis on possible predictors of burnout and the factors contributing to burnout as found in scientific studies were discussed. The JD-R model was applied to identify the effect or outcome of burnout on the organisation's efficiency. This model will be applied to the findings of this study on the prevalence of burnout in PHC nurses.

2.5 CONCLUSION

Chapter 2 summarised the literature on different aspects of primary health care. Primary health care nurses are confronted with a significant increase in job demands, insufficient human resources and unsatisfactory working environments that negatively influences nursing care. The JD-R model illustrates the effect of job demands and job resources on an organisation's outcome and was used as the conceptual model for this study.

Chapter 3 will explain the research methodology applied in conducting the study to determine the prevalence of burnout amongst PHC nurses in the Eden District of the Western Cape of South Africa.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the processes and tools used in the study to evaluate the occurrence of burnout amongst PHC nurses the Eden District of the Western Cape.

3.2 RESEARCH DESIGN

The research design is a plan or blueprint of how the researcher proposes to conduct a study (Mouton, 2009:55; Burns & Grove, 2011:253). It enables the researcher to answer the research question (De Vos, Strydom, Fouché & Delport, 2011:109) and to meet the purpose and objectives (Brink *et al.*, 2012:55).

A non-experimental, descriptive cross-sectional survey design with a quantitative approach was selected for this research study. The survey is non-experimental because no manipulation of variables occurred (Brink *et al.*, 2012:9).

Descriptive designs obtain information about characteristics within a specific field of study to provide a picture of a situation in a natural setting (Burns & Grove, 2011:256). The study was conducted to evaluate the phenomenon of burnout amongst Primary health care (PHC) nurses in an uncontrolled, natural environment. The design is cross-sectional as this study was conducted in the present to examine the current situation (Brink *et al.*, 2012:10). Data was not collected across time (Burns & Grove, 2011:258). The researcher aimed to identify the current state of burnout amongst PHC nurses within the Eden District of the Western Cape.

A quantitative approach was selected as the most appropriate for the collection of predominantly numerical data about the phenomena (Burns & Grove, 2011:20). Part one of the self-report questionnaire contains demographic data including dichonomous, continuous and nomina data. Part two and part three contains ordinal data. Part four consisted of three open-ended questions to obtain personal opinions about the phenomenon of burnout.

3.3 POPULATION AND SAMPLING

The population is all elements, which include individuals, objects or substances that meet certain criteria for participation in a study (Burns & Groove, 2011:51). The target population identified for this study consisted of 146 (N=146) subjects. Table 3.1 shows all PHC nurses working in community health centres, community clinics, satellite clinics and on mobile

clinics in the Eden District of the Western Cape. The Eden District is divided into seven sub districts. Each sub-district renders PHC services in the above-mentioned facilities. The seventh sub-district was excluded to avoid bias as the researcher is employed there.

A sample is a subset of the selected population for a particular study (Burns & Grove, 2011:51). Brink *et al.* (2012:132) describe sampling as a process of selecting a sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest. De Vos, Strydom, Fouché and Delport (2011:224) emphasised that the sample of a relatively small population should be a reasonably large percentage thereof. In this study, the population (N=146) is fairly small, thus a larger sample was needed to draw more representative and accurate conclusions. A sample size of 83 subjects (57%) who met the inclusion criteria participated.

Census sampling of the facilities and staff in the Eden District was conducted. In this study a census of six out of the seven sub districts and the staff complement of PHC nurses were conveniently sampled (see Table 3.1). The researcher approached each facility in the different sub-districts to identify available subjects on the day of data collection non-randomly because rendering of core functions were respected.

Table 3.1: Primary health care clinics with the total PHC nurses in the Eden District

Sub Districts in the Eden District	1	2	3	4	5	6	TOTAL
Community Health Clinics	1(9)	3(26)	0	0	0	1(9)	5(44)
Community Clinics	4(9)	9(24)	4(15)	4(10)	6(16)	5(12)	32(86)
Satellite Clinics	1(1)	2(2)	2(2)	1(1)	1(2)	0	7(8)
Mobile Clinics	1(-)	5(3)	3(1)	4(1)	4(1)	3(2)	20(8)
TOTAL	**7(19)**	**19(55)**	**9(18)**	**9(12)**	**11(19)**	**9(23)**	**64(146)**

3.3.1 Inclusion Sampling Criteria

Inclusion sampling criteria involves the identification of specific characteristics, subjects or elements in the target population (Burns & Grove, 2009:345).

The inclusion criteria for this study were all:

- professional nurses and clinical nurse practitioners
- who rendered primary health care in

- community day centres, community clinics, satellite clinics and on mobile clinics in the Eden District of the Western Cape.

3.3.2 Exclusion Sampling Criteria

The following staff and facilities were excluded:

- registered auxiliary nurses;
- registered staff nurses;
- professional nurses who are rendering services for non- governmental organisations;
- primary health care facilities located in outpatients departments;
- Primary health care Managers;
- Operational Managers;
- PHC nurses on sick leave, maternity leave and annual leave during the data collection period; and
- the personnel working in the seventh sub-district where the researcher works.

3.4 DATA COLLECTION INSTRUMENT

A self-report questionnaire was used to collect data (Burns & Grove, 2009:245). A questionnaire has to meet the objectives of the research study and demonstrated a connection between the content and the research problem (Brink *et al.*, 2012:154). The questionnaire was designed to gather a broad spectrum of information from subjects, such as biographical facts about the subject, persons, events and situations known to the subject (Burns & Grove, 2011:353).

The data collection instrument consisted of the following Parts:

- **Part 1:** Demographic and Professional Profile
- **Part 2:** Factors contributing to burnout
- **Part 3:** Human Services Survey: Job-related feelings
- **Part 4:** Burnout experienced in the work environment

Part one identified the demographic and professional characteristics of the participative research subjects.

In part two, a five part Likert scale, containing declarative statements (Burns & Grove, 2011:357), gathered information on the factors contributing to burnout. This scale was rated

one to five. A score of one indicated a feeling of strongly disagree and a score of five, indicated a feeling of strongly agree. The score of three indicated the choice of neutral.

A Likert scale with seven responses after each statement was used in part three of the questionnaire. It aimed to collect information utilising the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) about feelings on emotional exhaustion, depersonalization and personal accomplishment. Job-related feelings were rated on a scale from zero to six. The statements were evaluated on how frequently the subjects experienced these feeling. Feelings were rated between “never” as a zero, “a few times a year or less” as a one, “once a month or less” as a two, “a few times a month” as a three, “once a week” as a four, “a few times a week” as a five and “every day” as a six (Maslach *et al.,* 1996:9). Permission was obtained from the authors for the use of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) on emotional exhaustion (EE), depersonalization (DP) and lack of personal accomplishment (PA) to determine the prevalence of burnout amongst PHC nurses.

Burnout is conceptualised as a ordinal variable, ranging from low to moderate to high degrees of experienced feeling. Therefore, it cannot be viewed as a dichotomous variable, which indicates the present or absent of a variable (Maslach *et al.,* 1996:5).

Scores for EE and DP were considered high if they were in the upper third of the normative distribution, average if they were in the middle third and low if they were in the lower third. Revised scores for PA were applied for reflection of burnout. These scores were presented separately for each subscale and were not combined into a single, total score (Maslach *et al.,* 1996:4-5). The scores were computed individually by the statistician for each subject on each subscale.

Part four consisted of three open-ended questions on the participant’s personal opinion of burnout in order to enable the subjects to provide richer and more diverse information (Brink *et al.*, 2008:132).

To increase the response rate, the four part questionnaire was available in the three official languages of the Western Cape, namely English, isiXhosa and Afrikaans (see Appendices G, H, I). A comparative edit was done by Stellenbosch University Language Centre (Appendix C), to ensure accuracy of the content of the three documents. A trained translator was available to explain unclear statements to the subjects.

3.5 PILOT TEST OF DATA COLLECTION INSTRUMENT

The pilot test of the instrument was was done to detect possible flaws in the instrument, such as confusing instructions or wording, insufficient time limits and the validity and sensitivity of the questions (Brink *et al.*, 2012:175). Six subjects (4%) from the adjacent district Overberg District, who met the inclusion criteria of the selected population (Brink *et al.*, 2012:174) agreed to participate. By conducting the pilot test, the researcher gained experience of the subjects and the setting (Burns & Grove, 2011:49). This was necessary since the accessability of the sampled subjects could have been jeopardised by the nature of their work which required travel to distant rural areas.

The pilot test was conducted in a sub-district of the Overberg on 12 July 2013. Permission was obtained from the PHC Manager to enter the PHC facilities. The subjects were informed of the proposed visit in advance. The PHC Manager assured the researcher that ten percent of the intended population (n=15) would be available. Six subjects (4%) agreed to participate.

The exclusion criteria caused several possible subjects to be excluded from the study. The pilot test subjects found the content of the questionnaire clear and understandable. The time period for completion was adequate. No changes were made to the questionnaire. A few practical challenges, which include time restriction due to respect for core functions and traveling time, were identified and needed to be taken into consideration when conducting the main study. This data were excluded from the main study.

3.6 RELIABILITY AND VALIDITY

Reliability and validity is essential for the credibility of the research findings.

3.6.1 Reliability

Reliability is the degree to which an instrument can be depended upon for consistent results if it should be used repeatedly over time on the same person, or when used by two researchers (Brink *et al.*, 2012:169). Reliability of the content and construction of the questionnaire was tested during the pilot study. Internal consistency of the MBI-HSS was estimated by Cronbach's alpha coefficient. A high degree of consistency was proved with reliability coefficients for the subscales of the MBI-HSS as follows: .90 for Emotional Exhaustion (EE), .79 for Depersonalization (DP) and .71 for Personal Accomplishment (Maslach *et al.,* 1996:12). The Cronbach statistical procedure was also performed by the statistician on the variables of each subscale to determine the alpha coefficient value in the

data collection instrument as paper and pencil scales were used to collect data (Burns & Grove, 2011:395). A Cronbach alpha coefficient value of 0.86 for emotional exhaustion, 0.71 for personal accomplishment and 0.76 for depersonalization were identified. These data is in correlation with the stipulations for consistency as done by Maslach *et al.* (1996:12). Thus, the measurement was sufficiently reliable for the study.

3.6.2 Validity

Validity refers to the extent to which the measuring instrument accurately measures the intended concepts of the research study (Burns & Grove, 2009:43). The facets of validity in this research study were instrument, content, face and convergent validity.

3.6.2.1 Instrument Validity

Instrument validity refers to the extent to which the instrument accurately measures what it is supposed to measure (Brink *et al.*, 2012:165).

The instrument was based on the experience of the researcher, relevant literature, as well as the questionnaire designed by Maslach *et al.* (1996:5). The instrument validity was confirmed to be acceptable for the chosen population by conducting a pilot study.

3.6.2.2 Content Validity

Content validity is an assessment of how well the instrument represents all the components of the variable to be measured (Brink *et al.*, 2012:166). Content validity of the questionnaire was validated by the researcher's supervisor, literature review and the researcher's personal experience in the field of primary health care practice. In addition, the statistician who agreed assistance in the analysis of the data for this study was consulted in advance to ensure content validity. The content included in the questionnaire was used with the intention of reaching the objectives of the study.

3.6.2.3 Face Validity

Face validity refers to the superficial appearance or face value of a measurement procedure (De Vos *et al*., 2011:173). Face validity was ensured by consultation with the researcher's supervisor.

3.6.2.4 Convergent Validity

Convergent validity is the comparison of a new instrument with an existing instrument that measures the same construct and is administered to a sample concurrently. When correlational analyses indicates a highly positively correlation, the validity of each instrument

is strengthened (Burns & Grove, 2011:335). The convergent validity of the MBI-HSS was demonstrated on three sets of correlations which provide substantial evidence for the validity of MBI-HSS (Maslach *et al.*, 1996:12).

3.7 DATA COLLECTION PROCESS

Data collection in quantitative research involves obtaining numerical data to address the research objectives, questions or hypotheses (Burns and Grove, 2009:44) and it includes both the pilot test (12 July 2013) and the main study.

The researcher personally collected the data for the main study at the subjects' place of employment in the various sub-districts on 15-18 July 2013 and on 23 July 2013. A presentation on the information regarding the study was done in group sessions or individually to familiarise the subjects with the aim, the objectives, and the structure and completion of the self-report questionnaire. Questionnaires and consent forms were available in English, isiXhosa and Afrikaans (see Appendices G, H, I) to allow subjects to answer the questionnaire in the language they were comfortable with. A trained translator accompanied the researcher to explain the study to the subjects in the language they were comfortable with. The importance of written informed consent and measures to protect the subjects from harm was explained. The measures taken to ensure anonymity, privacy and confidentiality were discussed. No remuneration for their participation was provided and no risk was identified.

The process of signing consent and data collection was explained to the subjects. Subjects who agreed to participate were placed in tea rooms or in consultation rooms to complete the questionnaire in private after signing consent. The places varied in different facilities. Subjects were encouraged to contact the Independent Counselling and Advisory Services (ICAS) if they should need emotional support after completion of the questionnaire. Care was taken not to interrupt the core functions of service delivery during data collection period.

The original consent forms were deposited in a secure container marked 'signed consent forms' and a copy was given to the subjects. The facilities were coded to ensure anonymity, privacy and confidentiality. After signing consent, each subject received a questionnaire and an opaque self-sealing envelope. The researcher emphasised the importance of completion of each question. The subjects were asked to place the completed questionnaire in the self-sealing envelope and to deposit the envelope into the additional sealed box marked "questionnaires." The researcher personally collected all boxes with consent forms and completed questionnaires. A register was kept to record the number of consent forms and questionnaires delivered and collected from each facility.

It was explained that the findings of the research would be made known to all subjects by sending the research reports to all participating facilities in the Eden District.

3.8 DATA ANALYSIS

Data analysis is the method by which raw data is explored and organised in addition to the analysis and interpretation in order to give the data meaning (Brink *et al.*, 2012:177). A statistician at the Centre for Statistical Consultation at the University of Stellenbosch was consulted regarding the data analysis for this study.

3.8.1 Data preparation

On receipt of each questionnaire, the researcher assigned each one with an individual number for anonymity and privacy and to facilitate the capturing process of the raw data on an Excel spreadsheet. It enabled the researcher to trace and re-evaluate the entered data on each questionnaire. A Microsoft Excel® spread sheet was formulated by the statistician to enable accurate analysis. Each variable as compiled in the questionnaire was indicated on the spread sheet in vertical columns. The subjects were listed in numbered rows. Data was double checked for accuracy. It was submitted to the statistician for analysis by using the STATISTICA 10® programme.

Descriptive and inferential analyses were conducted by the statistician.

Coding was used to analyse data obtained from the open-ended questions. By using coding the researcher read the data and divided the written text (Burns & Grove, 2011:94) into words or phrases (Burns & Grove, 2009:522). These data was categorised into groups for similarities and differences (Brink *et al.*, 2012:193) which enabled the researcher to put these findings in a larger context for the purpose of improving clinical practice (Burns & Grove, 2011:97).

3.8.2 Descriptive Statistics

Descriptive statistics, also referred to as summary statistics, are applied to numerical data (Burns & Grove, 2011:383) to describe and summarise the data so that it is meaningful to the readers of the research report (Brink *et al.*, 2012:179).

Descriptive statistics include frequency distributions, measures of central tendency and measures of dispersion (Burns & Grove, 2011:383).

The method for frequency distribution was used to organise nominal/categorical data in tables. This method shows all the numerical values of a particular variable for examination (Burns & Grove, 2011:383).

Measures of central tendency indicate the midpoint or the average of the data (Burns & Grove, 2011:385). The measures of central tendency used in this study are the mean and median. The mean is the sum of the scores divided by the number of the data set (average value), while the median indicates the score at the exact centre of the ungrouped frequency distribution (Burns & Grove, 2011:385-387).

The measures of dispersion or variability are measures of individual differences of members of the sample to give an indication of how scores in a sample are spread around the mean (Burns & Grove, 2011:387). The measures of dispersion used in this study were variance and the standard deviations (SD's). The variance for scores indicates the spread or dispersion of the scores in a study, while standard deviation is the average specific difference (deviation) value (Burns & Grove, 2011:387).

Descriptive statistics will be expressed in frequency tables with percentages for nominal/categorical variables and by mean, median and standard deviations for continuous measurements.

3.8.3 Inferential Statistics

Inferential statistics has a different function than descriptive statistics as it enables the researcher to draw a conclusion (Brink *et al.*, 2012:190) or judgment based on evidence (Burns & Grove, 2011:378). Inductive reasoning is used for inference, also known as generalisation (Burns & Grove, 2009:452). Inference about a population of the study at hand can be made from a smaller sample (Brink *et al.*, 2012:179). Analysis of variance (ANOVA) was used for testing relationships of continuous variables between groups. Pearson product-moment correlation analysis (*r* - value) was used for comparing continuous variables.

3.8.3.1 The Mann-Whitney U test

The Mann-Whitney U test is a non-parametric test used to determine differences between groups of ordinal or continuous data (Brink *et al.*, 2012:191) meaning, it is used to compare differences in two groups (Burns & Grove, 2009:572). In this study, the Mann-Whitney U test was used to identify the correlation of burnout amongst subjects working in the community health centres and community health clinics. Two satellite clinics and six mobile clinics were excluded from this test due to very low amounts (Burns & Grove, 2009:505) of subjects

available in comparison to the amount of subjects working in the abovementioned health centres and health clinics (see Table 4.7).

3.8.3.2 Analysis of Variance (ANOVA)

Analysis of variance (ANOVA), reported as an *F* statistic, tests for differences between means of dependent variables. ANOVA permits the researcher to compare the means of two or more groups simultaneously. The larger the *F* - value the greater the variation or difference between the groups compared with the variation within the groups (Burns & Grove, 2009:505). In this study ANOVA was applied to compare the means of each subscale of burnout to the working areas of subjects. Only community health centres and community health clinics was analised as two satellite clinics and six mobile clinics were excluded from this analisys due to very low amounts.

3.8.3.3 Probability Theory

The probability theory is used to test a specific hypothesis. It indicates if an event will occur in a given situation or if that event can be accurately predicted. This assumption is expressed as a null hypothesis. This means that there is no difference among the variables (groups) included in the hypothesis. Probability is expressed as a lowercase letter *p (p-*value*)*. The level of statistical significance (alpha) is the probability level at which the results of statistical analysis are judged to indicate the statistically significant difference between the groups (Burns & Grove, 2011:377). Values can be expressed as percentages or as a decimal value ranging from zero to one (Burns & Grove, 2011:376). The degree to which the percentage increases indicates a higher chance for an event to occur. In this study the level of statistical significance is set at $p < 0,05$ which is common in nursing studies (Burns & Grove, 2011:377).

3.8.3.4 Pearson Product-moment Correlation Analysis

Pearson Product-moment Correlation Analysis (*r* - value) indicates the degree of linear relationship between two variables. The strength of the linear relationship decreases as the negative or positive values of *r* - value approach zero (Burns & Grove, 2009:480). This method of analysis was applied to identify the relationship between more years of experience and each of the three subscales of burnout.

3.8.4 Coding

Coding was used to analyse data obtained from the open-ended questions. By using coding the researcher read the data and divided the written text (Burns & Grove, 2011:94) into words or phrases (Burns & Grove, 2009:522). These data were categorised into groups for

similarities and differences (Brink *et al.,* 2012:193) that enabled the researcher to put these findings into a larger context for the purpose of improving clinical practice (Burns & Grove, 2011:97).

Throughout the coding prosess the researcher was sensitive for the risk of reflexive thoughts. Literature advises against reflexive thoughts which are personal feelings and experiences of the researcher which may influence the study (Burns & Grove, 2011:94-95; Brink, Van der Walt & Van Rensburg, 2012:193). However, the researcher applied personal experience and information of the phenomenon under study within brackets where it was seen in relation to the phenomenon. This is known as synthesis of intentionality (SOI) which is a historical relationship between an individual and the objects or events of experience. The two components of synthesis of intentionality were taking in consideration when analysing the open-ended questions in this study. The first component was themes derived from the open-ended questions and understanding of the subject's experiences, and the second component was the researcher's own assumptions, beliefs, and pre-understanding that have been bracketed (Drew, 2004:220-221).

It was the intention on the researcher to explore the true picture on the prevalence of burnout in Eden District. Bracketing was used to avoid getting the wrong idea about the phenomenon as it is being experienced by the subjects. In other words, the researcher consciously 'bracketed out' her personal experiences and ideas in order to obtain the true feelings and experiences of participating subjects (Burns & Grove, 2011:95; Brink *et al.*, 2012:193), but combine the bracketed beliefs to create an SOI. This SOI enable the rsearcher to describe the phenomenon by including both the subject's experience and these of the researcher (Drew, 2004:222).

Statements made by subjects were qouted from questionnaires to provide the reader with evidence of the subjects' personal feelings. The results obtained from close-ended questions on work related issues correlate with the feelings expressed in the statements made by the subjects.

3.9 ETHICAL CONSIDERATIONS

Ethics is a widely accepted set of moral principles, which provides rules and behavioural expectations about the correct conduct towards all participating research parties (De Vos *et al.,* 2011:114). Therefore, it is important to receive ethical approval to ensure protection towards subjects in a research study (Burns & Grove, 2011:159).

3.9.1 Internal review boards

Ethical approval was obtained from the Human Research Ethical Committee 1 (HREC 1) of Stellenbosch University, reference number: S13/03/044, to conduct the study (Appendix A). After permission was obtained from HREC 1 the Western Cape Department of Health was approached for permission to conduct the pilot study in the Overberg District, as well as the main study in the Eden District. As soon as permission was obtained from Western Cape Department of Health, the PHC managers of each sub-district were informed of the proposed dates for data collection.

Ethical principles of respect for persons, beneficence and justice relevant to research involving human subjects (Burns & Grove, 2011:107) will be explained in the following paragraphs.

3.9.2 Principle of Respect for Persons

3.9.2.1 Autonomy

The principle of autonomy expresses respect for the unconditional worth of an individual and for individual thought and action (Pera & Van Tonder, 2011:53). This allows people to make choices according to their convictions without limiting the freedom of choice of others and to do no harm (Pera & Van Tonder, 2011:54). In conclusion, it involves providing an individual with the relevant information to make informed decisions for self-determination.

In this study, every subject had a choice whether or not to participate. Subjects were informed of their right to withdraw from the study at any time and to withhold information without penalty.

3.9.3 Principle of Non-maleficence and Beneficence

In recognition of the principles of non-maleficence and beneficence, decisions in healthcare are based on how to avoid harm to the patients/subjects (Pera & Van Tonder, 2011:55). In other words, non-maleficence is the duty not to inflict harm, while beneficence is the duty to do or to promote good (Muller, 2008:67). The researcher secured the well-being of the subjects by protecting them from physical, emotional, psychological, spiritual, moral, or any other harm (Pera & Van Tonder, 2011:56; Brink *et al.*, 2012:35). Informed written consent was obtained from the participants.

Showing respect for organisational culture and reputation was provided by not mentioning the identity of the different institution in the final report. Minimal risks were predicted for this research. A confidential support service is provided to all employees of the Western Cape

Department of Health. Subjects were encouraged to phone the toll free number of the Independent Counselling and Advisory Services (ICAS) (0800 611 093) if they needed emotional support after completion of the questionnaire.

3.9.4 Principle of Justice

The subjects have the right to fair selection and treatment (Brink *et al.*, 2012:35). The subjects who participated in the survey were not well-known to the researcher. The chosen population are directly related to the research problem. The seventh sub district was excluded because the researcher is employed there.

3.9.4.1 Right to Privacy

All subjects received an information leaflet in a language they were comfortable with. Everybody was informed of the purpose of the study. Feelings and opinions of subjects were collected with their written permission. All subjects were assured that no private information would be shared with anyone other than the researcher's supervisor and statistician.

3.9.4.2 Right to Anonymity

The right to anonymity means that identities of subjects should remain secret (Brink *et al.*, 2012:37). The anonymity of subjects was enhanced by a coding system that protected the identity of the facilities. No system was used that could trace the identity of a subjects' individual opinion. Subjects were assured that no personal identification will be made known when the study is published.

3.9.4.3 Right to Confidentiality

Confidentiality refers to the responsibility of the researcher to prevent connecting collected data to a specific individual or facility without authorisation from the subjects (Brink *et al.*, 2012:37). Confidentiality was enhanced by the researcher who personally collecting the data instruments. The questionnaires were placed in an opaque self-sealing envelope and were deposited in a sealed container. The data was entered into the spread sheet by the researcher. After entering the data the questionnaires were securely stored for at least 15 years as stipulated by the HREC 1 (see Appendix A).

3.9.5 Informed Consent

Autonomy refers to the right of an individual to choose to voluntarily participate in a research study (Brink *et al*., 2012:35). Consent is considered informed if the researcher has fully explained the details of the research project to the potential subjects and whom, on

comprehension of the information, provide consent to participate in the study (Burns & Grove, 2011:52). Essential study information was made known to the subjects by providing an information leaflet in each of the three official languages (see Appendices D, E, F). A trained translator was present to clarify unclear questions. The subjects were encouraged to ask for translation or explanation. A detailed explanation on what to expect and what was expected of the subjects was discussed. The significance of voluntary consent was emphasised and that they were free to decline to participate or to withdraw at any point without penalty. The subjects signed voluntary consent in duplicate. Information leaflets as well as copies of the signed consent forms were given to all participative subjects.

3.10 LIMITATIONS

One sub-district, except for the sub-district where the researcher is employed, was excluded from the study due to time restriction. Some primary health care nurses who worked on Mobile clinics were excluded as on the day of data collection, they had already left the premises. However, the high acceptance rate in the participative sub-districts increased the representativeness of the results.

3.11 SUMMARY

A non-experimental, descriptive cross-sectional survey design with a quantitative approach was selected for this research study. The population and sample consisted of professional registered nurses working in PHC settings in the Eden District of the Western Cape. A self-report questionnaire was used to collect the data. A statistician was consulted. Reliability and validity of the questionnaire was established. Ethical considerations were ensured. The data was analysed using descriptive and inferential statistics and coding for the open-ended questions.

3.12 CONCLUSION

In this chapter the research methodology relevant to the research design, population and sample, data collection instrument, pilot study, reliability and validity was explained. The data collection process and the data analysis procedures that were applied were described. The ethical principles taken into consideration for the study were defined.

Chapter 4 provides a broad explanation on data analysis, interpretation and the presentation of results and findings of the research study.

CHAPTER 4: DATA ANALYSIS, INTERPRETATION AND PRESENTATION OF RESULTS

4.1 INTRODUCTION

The analysis, interpretation and presentation of results will be described in this chapter. The raw data compiled through the data collection was summarised and organised by various analysis strategies (Burns & Grove, 2009:44). The strategies entail categorising, ordering, manipulating and summarising, and presenting the data in meaningful terms (Brink *et al.*, 2012:177). Descriptive and explorative procedures, as well as statistical techniques and analysis techniques were used to find answers to the objectives and the research question in this quantitative research study (Burns & Grove, 2009:44).

4.2 DATA ANALYSIS

Data analysis is the method by which raw data is explored and organised in addition to the analysis and interpretation in order to give the data meaning (Brink *et al.*, 2012:177). A complete description on the methods of data analysis was described in Chapter 3.

4.3 QUESTIONNAIRE RESPONSE RATE

Professional nurses and clinical nurse practitioners, who render primary health care in community health centres, community clinics, satellite clinics and on mobile clinics in the Eden District of the Western Cape, were surveyed.

The total population which met the inclusion criteria for participation in the study were 146 (N=146). Sub-district one, as indicated in Table 4.1, as well as three clinics in sub district five were not provided the opportunity to participate due to time restriction.

The subjects in the study who met the inclusion criteria formed part of a sample size of 83 subjects (57%). The study population and response rate is illustrated in Table 4.1.

The non-response rate was 9% (n=7). Two subjects (n=2) were lost to attrition to the study which caused a three per cent (3%) attrition rate. Seventy four subjects completed the required questionnaire. The retention rate was 89% (n=74). Two incomplete questionnaires were excluded. A total of 72 completed questionnaires were analysed (97%). The questionnaire response rate is calculated by dividing the number of returned questionnaires by the number of the study population. The response rate (n=74/89%) was enhanced by the researcher who personally provided the consent forms and questionnaires to each subject in

each facility. In addition, the researcher collected the consent forms and questionnaires after completion on the same day.

Table 4.1: The study population and response rate

Sub-district	Population (N)	Number meeting sampling criteria (n)	Number accept participation (n)	Acceptance rate (%)
Sub-district 1	19	-	-	-
Sub-district 2	55	37	34	41
Sub-district 3	18	8	8	10
Sub-district 4	12	8	8	10
Sub-district 5	19	15	9	11
Sub-district 6	23	15	15	18

4.4 PART 1: DEMOGRAPHIC AND PROFESSIONAL PROFILE

4.4.1 Variable 01: Gender of subjects (n=72/100%)

The majority of subjects (n= 69/96%) who participated in the survey were female. The ratio of male to female was 0.04 which is slightly lower than the 0.06 ratio stated by the South African Nursing Council on the provincial distribution of nursing manpower (SANC, 2013:np) (see Table 4.2).

Table 4.2: Gender of subjects

Gender	Sample (n)	Percentage (%)
Female	69	96
Male	3	4

4.4.2 Variable 02: Current age in years (n=72/100%)

The ages of the subjects who participated in the survey, are indicated in Table 4.3. A box plot in conjunction with a histogram was used to indicate the distribution of age. The mean and median age of subjects was 47 years with a standard deviation of 9.0 years. The youngest subject was 27 years of age and the oldest was 63 years of age. The age distribution correlates with the age analysis of registered nurses/midwives as provided by SANC. The majority of registered nurses/midwives (61%) registered with SANC are between 40 and 59 years of age (SANC, 2013:np).

Table 4.3: Age of subjects

Age of subjects	Median	Mean	Standard deviation (*SD*)
Age	47.0	47.0	9.0

4.4.3 Variable 03: Race of subjects

The majority of registered nurses who participated in the survey were coloured subjects (n=43/60%) (see Table 4.4). Thirty two per cent of subjects (n=23/32%) were white registered nurses while only eight per cent of subjects (n=6/8%) were black. This data partly correlates with data from census 2011 were the coloured population group were identified as the majority (55.0%) of all population groups in the Eden district. The black population group consisted of 25,1%, the Indian of 0.2% and the white population group of 19.1% of the all population groups according to the census data (Statistics SA, 2012:11).

Table 4.4: Race of subjects

Race	Sample (n)	Percentage (%)
Black	6	8
Coloured	43	60
Indian	0	0
White	23	32

4.4.4 Variable 04: Years of experience in primary health care

Data obtained from subjects indicated a mean of 12 years of experience in PHC. The median was 11 years while the standard deviation was 7.88 years of experience. The maximum years of experience in PHC settings was 30 years. The mean of 12 years correlates with the years since transformation in 1994, when the PHC approach was implemented (ANC, 1994b:1).

4.4.5 Variable 05: Course completed in PHC

The majority of subjects (n=54/75%) had completed a diploma in PHC as required according Regulation R. 48 (see Table 4.5). A Diploma in Clinical Science, Health Assessment, Treatment and Care (SANC, 1982) is recommended in order to render primary health care.

Table 4.5: Course completed in PHC

Course	Sample (n)	Percentage (%)
Certificate	11	15
Diploma	54	75
None	7	10

4.4.6 Variable 06: Employment of subjects

The majority of subjects (n=68/94%) were permanently employed (see Table 4.6). Only four (n=4/6%) were employed on contract.

Table 4.6: Employment of subjects

Employment	Sample (n)	Percentage (%)
Permanent	68	94
Contract	4	6

4.4.7 Variable 07: Work settings of subjects

The majority of subjects (n=40/56%) worked in community clinics (see Table 4.7). Twenty four (n=24/33%) work in community health centres, while a small percentage of subjects worked in satellite clinics (n=2/3%) and on mobile clinics (n=6/8%).

Table 4.7: Work settings of subjects

Work settings of subjects	Sample (n)	Percentage (%)
Community health centre	24	33
Community clinic	40	56
Satellite clinic	2	3
Mobile clinic	6	8

4.4.8 Variable 08: Clinical Responsibility of subjects

The majority of subjects (n=66/92%) were rendering comprehensive services (see Table 4.8). This indicates how well comprehensive PHC services are incorporated into the health care system as result of the transformation toward adapting the PHC approach (ANC, 1994b:1). Only a small percentage of subjects render either preventative or curative services (n=6/9%).

Table 4.8: Clinical Responsibility of subjects

Responsibility	Sample (n)	Percentage (%)
Preventative services	4	6
Curative services	2	3
Comprehensive services	66	92

4.5 PART 2: FACTORS CONTRIBUTING TO BURNOUT

4.5.1 Variable 09: I feel that my workload or increase in job demand causes burnout

Workloads are associated with burnout and job dissatisfaction (Lawn *et al.*, 2008:917; Kekana *et al.*, 2007:24; Hall, 2004:28; Erasmus and Brevis, 2005:51; Ten Brummelhuis *et al.*, 2011:268; Van der Westhuizen, 2008:50; Rossouw, 2011:13; Xanthopoulou *et al.*, 2007:782) amongst PHC workers. The majority of subjects (n=67/93%) responses mirrored the finding in the above-mentioned studies that workload or increase in job demands cause burnout (see Figure 4.1). None of the subjects chose the strongly disagree option.

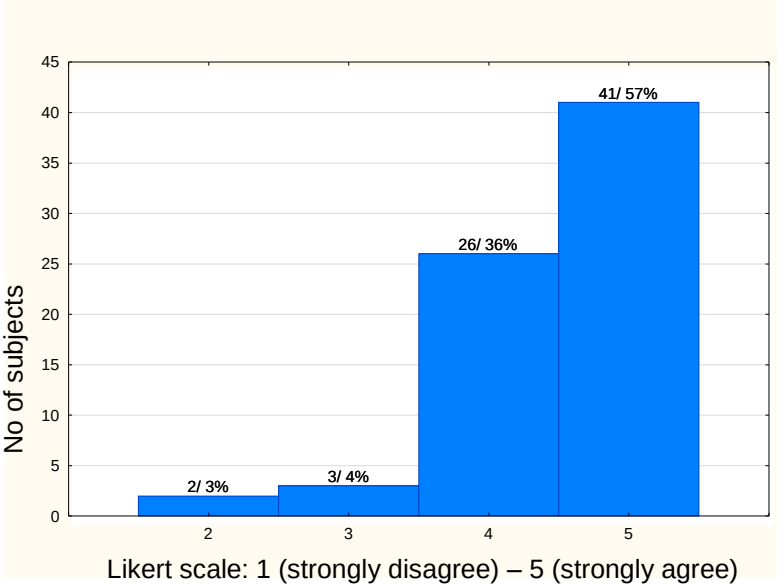

Figure 4.1: Histogram of workload or increase in job demands

4.5.2 Variable 10: I feel that management problems causes burnout

Effective performance of managerial tasks by employers, supervisors and other professional staff is extremely important in order to reduce stress caused by increased workload and insufficient resources (Kekana, Du Rand & Van Wyk, 2007:24; Baloyi, 2009:145 and Hall,

2004:28). Sixty-two subjects agreed that management problems are the main reason why nurses develop burnout (n=62/86%) (see Figure 4.2).

Effective job control of employees' experience of their work life with regard to their relationship with immediate supervision and their access to organizational justice/fairness is important (Leiter, Gascón & Martínez-Jarreta, 2010:70).

Poor nursing service managers and insensitivity of managers towards nurses' problems were identifed as reasons why respondents leave the country (Oosthuizen, 2009:238-240) to find alternative career options. A general feeling of lack of respect from managers, physicians and nursing colleagues were seen as reason for negative attitudes among staff (Van der Westhuizen, 2008:48).

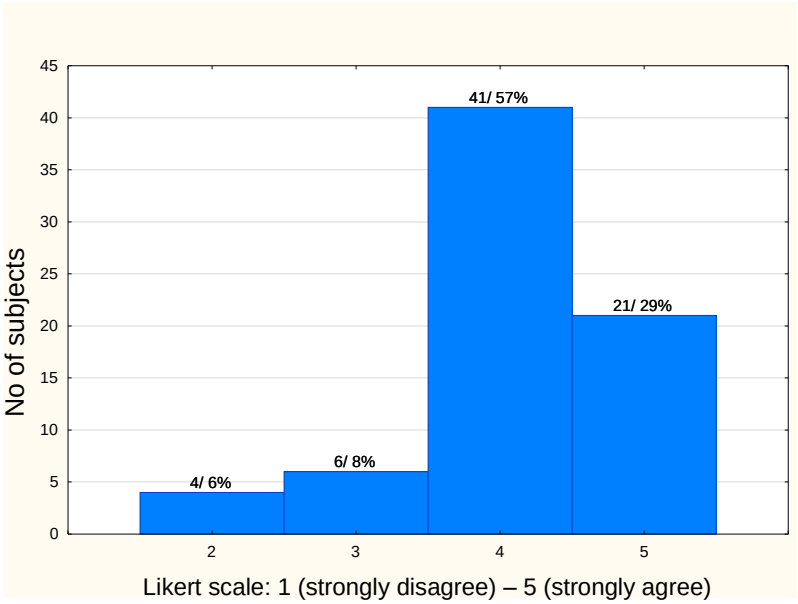

Figure 4.2: Histogram of management problems

4.5.3 Variable 11: I feel that insufficient training causes burnout

Insufficient training was not seen as a dominant reason to develop burnout, although most of the subjects agreed. The fact that 14% (n=10/14%) chose to remain neutral is a reason for concern. Forty-one percent of subjects disagreed with this statement (n=30/41%), while 32 (n=32/44%) agreed (see Table 4.9). There is a lack of findings in the literature to prove to what extent insufficient training does cause burnout.

Table 4.9: Insufficient training

I feel that insufficient training causes burnout	Sample (n)	Percentage (%)
1. Strongly Disagree	11	15
2. Disagree	19	26
3. Neutral	10	14
4. Agree	24	33
5. Strongly Agree	8	11

4.5.4 Variable 12: I feel that the tendency to work overtime causes burnout

The majority of subjects (n=46/64%) agreed that the tendency to work overtime will increase the possibility for them to develop burnout (see Table 4.10). In a study by Van der Westhuizen (2008:50), 35.9% nurses identified the available time shortage as a major problem in nursing. This statement was confirmed in a cross-sectional study on burnout and depression by Rossouw (2011:3).

Table 4.10: Tendency to work overtime

I feel that the tendency to work overtime causes burnout	Sample (n)	Percentage (%)
1. Strongly Disagree	7	10
2. Disagree	9	13
3. Neutral	10	14
4. Agree	25	35
5. Strongly Agree	21	29

4.5.5 Variable 13: I feel that low levels of job satisfaction causes burnout

Low levels of job satisfaction was identified by 58 (n=58/80%) subjects as a possible reason for developing burnout (see Figure 4.3). The low levels of job satisfaction are probably caused by management who expect professional nurses to evaluate a minimum of fifty patients per eight hour day in PHC facilities. To add to that enormous task, pressure is put on health workers to achieve annual targets on every domain of nursing which have been set in conjunction with the relevant programme managers (NDoH, 2011:22).

Additionally, new interventions are incorporated into the health care sector in short intervals, which inhibits continuous high quality of care (RSA, 2007:6), as it is health care workers' responsibility to stay informed and in touch with the frequent changes. Findings on low job satisfaction can be critically evaluated against findings stated by Xanthopoulou *et al.* (2007:782). The difference in adaptation amongst employees to some working conditions, in

terms of their personal characteristics, may influence their level of job satisfaction. It is also true that co-workers, who experience low levels of job satisfaction and irrespective of their personal characteristics, can transfer the phenomenon to fellow-employees (Bakker *et al.,* 2006:482).

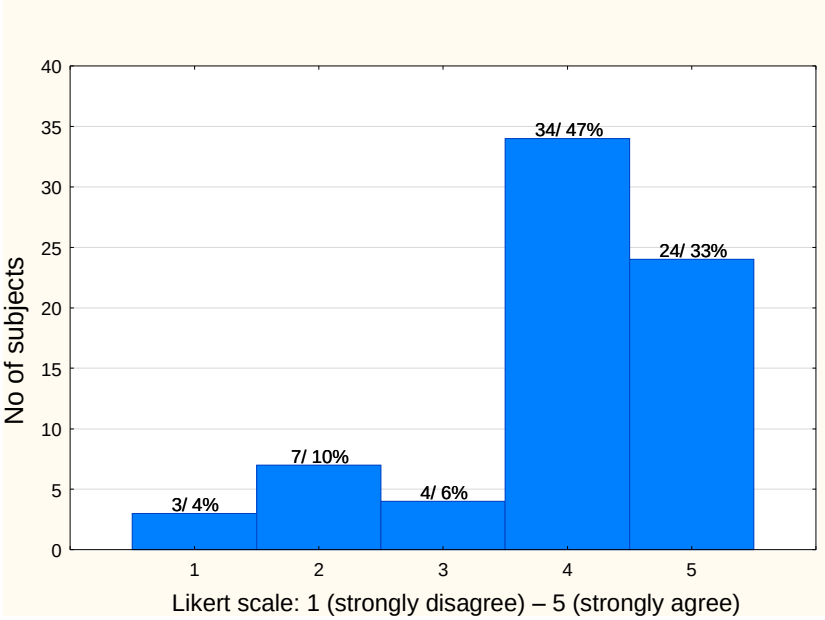

Figure 4.3: Histogram of low levels of job satisfaction

4.5.6 Variable 14: I feel that lack of motivation causes burnout

The majority of subjects (n=53/74%) indicated lack of motivation as a reason for developing burnout (see Figure 4.4). Exhausted human resources lead to low morale amongst nurses and a decrease in performances (Van Rensburg, 2004:372) which results in lack of motivation.

Lack of motivation has been seen as a huge problem as scientific evidence showed that poorly motivated co-workers will experience withdrawal and might develop indifferent attitudes towards their jobs (Van der Colff & Rothmann, 2009:7-8). This statement was emphasised by Maslach *et al.* (1996:3) that low morale can be a reason for burnout amongst staff. In contrast to the above, employees feel appreciated by the organization when they are involved in decision making (Bakker *et al.*, 2011:177).

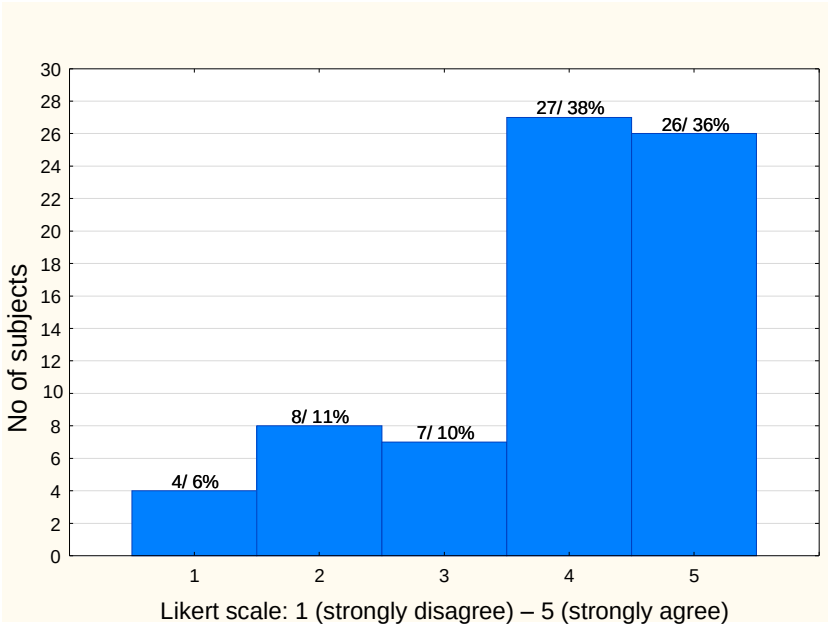

Figure 4.4 Histogram of lack of motivation

4.5.7 Variable 15: I feel that lack of organisational support causes burnout

A lack of organisational support was seen as a major factor for developing burnout. Ninety per cent of subjects (n=65/90%) indicated lack of organisational support as a great problem which may cause burnout in the PHC facilities of the Eden District (see Figure 4.5).

A lack of organizational support should be seen as a great concern for organisations as disengagement from work by employees could influence service delivery (Van der Colf & Rothmann, 2009:8). Effective support by employers, supervisors and other professional staff will reduce stress caused by increased workload and insufficient resources (Kekana *et al.*, 2007:24; Baloyi, 2009:145; Hall, 2004:28).

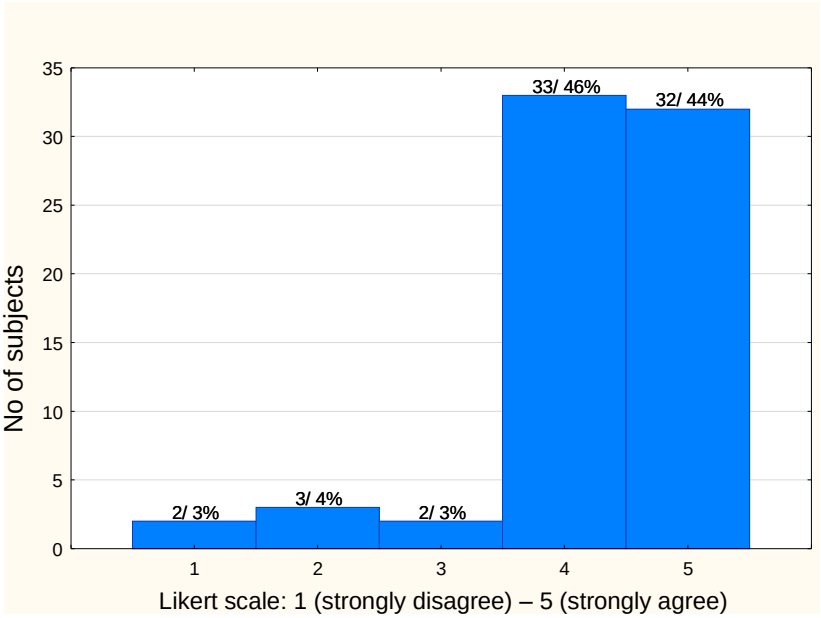

Figure 4.5 Histogram of lack of organisational support

4.5.8 Variable 16: I feel that inadequate human resources cause burnout

The majority of subjects (n=57/80%) identified inadequate human resources as a factor which may cause burnout (see figure 4.6). This finding confirms scientific evidence obtained on predictors of burnout in organizations (Mohale & Mulaudzi, 2008:60; Van der Colff & Rothmann, 2009:7). Nurses and patients are exposed to risks in the workplace as the result of the personnel shortage (Oosthuizen, 2009:239). This may intensify emotional and physical strain on PHC nurses (Mohale & Mulaudzi, 2008:60). The fact that the nursing profession showed a sharp decrease and a negative growth on newly trained nurses in the past (Van Rensburg, 2004:319; SANC, 2013:np) is a matter of concern. This backlog of students completing their programmes successfully (Magerman, 2011:2) adds to the scenario where job demands increase pressure on staff in practice.

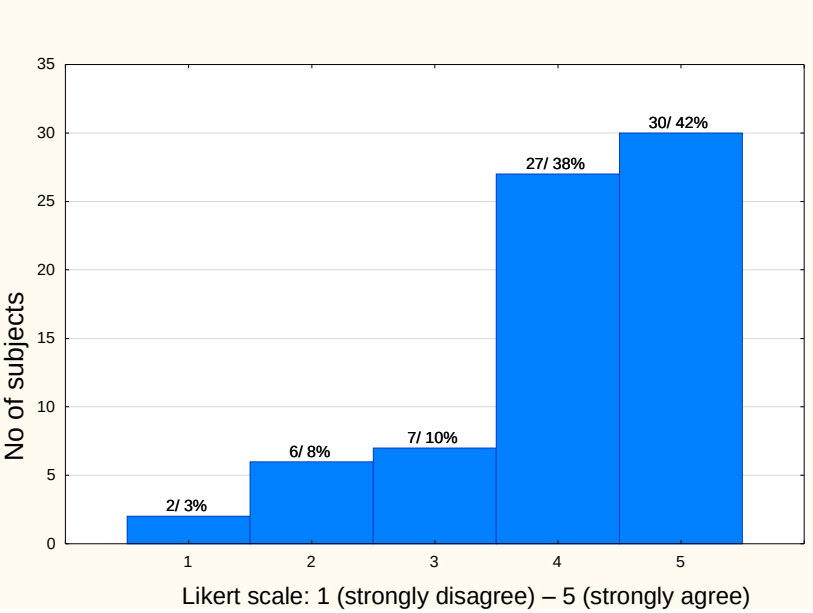

Figure 4.6 Histogram of inadequate human resources

4.5.9 Variable 17: I feel that personal problems beyond the workplace causes burnout

Only ten subjects (n=10/14%) agreed on the statement that personal problems beyond the workplace causes burnout (see Figure 4.7). The finding shows that the majority of PHC nurses have the ability to deal with personal stress, home circumstances and personal demands made on them (Baumann, 2008:382). Although, it is important that support needs to be available for those who feel they are not able to deal with personal demands made on them. The subjects who chose to stay neutral might be seen as a concern. Most of the PHC nurses seem to have competencies to deal effectively with personal problems beyond the workplace.

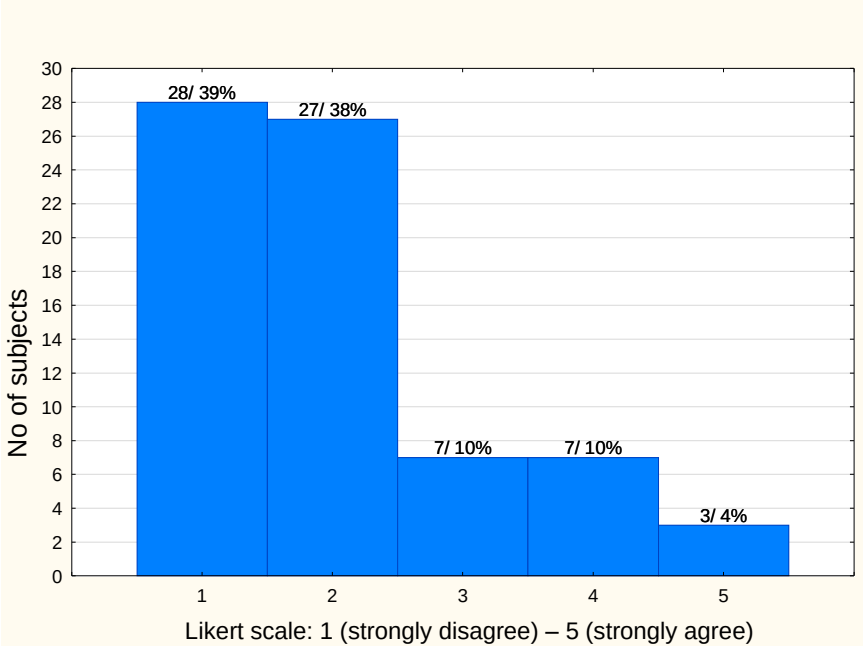

Figure 4.7 Histogram of personal problems beyond the workplace

4.5.10 Variable 18: I feel that financial constraints cause burnout

Scientific evidence indicated that the degree of fair remuneration (Lawn *et al.*, 2008:917; Kekana *et al.*, 2007:24; Hall, 2004:28; Erasmus & Brevis, 2005:51), poor budgeting and financial constraints (Baloyi, 2009:145) may be associated with job dissatisfaction in PHC workers. This is substantiated by a relatively equal feeling amongst subjects who chose agree (n=31/43%) and disagree (n=30/42%). The option to stay neutral was chosen by 11 (n=11/15%) subjects (see Table 4.18).

Table 4.11: Financial constraints

I feel that financial constraints causes burnout	Sample (n)	Percentage (%)
1. Strongly Disagree	15	21
2. Disagree	15	21
3. Neutral	11	15
4. Agree	20	28
5. Strongly Agree	11	15

4.5.11 Variable 19: I feel that unproductive co-workers cause burnout

On the statement that unproductive co-workers causes burnout, 62 subjects (n=62/86%) agreed, of which 34 (n=34/47%) felt very strongly about this statement (see Figure 4.8). Van der Colff and Rothman (2009:7) found that fellow workers who do not perform their jobs properly appear to be a relatively severe stressor.

Absenteeism could be a manifestation of under commitment, especially if dishonesty and disloyalty is expressed (Bergh & Theron, 2003:430). Studies showed that absence from work could be a main indicator of organizational stress and give cause for loss of productivity (Bergh & Theron, 2003:430; Maslach *et al.*, 1996:4). Van der Westhuizen (2008:52) identified the perception of older nursing professionals that younger nurses do not show sufficient commitment and lifetime dedication.

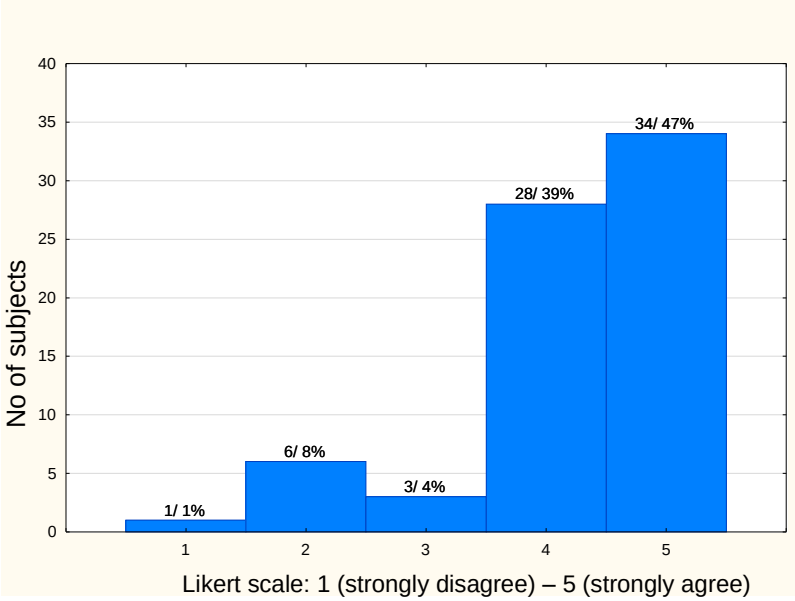

Figure 4.8 Histogram of unproductive co-workers

4.5.12 Variable 20: I feel that lack of equipment causes burnout

Hall (2004:28) identified a lack of equipment as another factor which leads to a stressed workforce who consequently considered alternative career options.

The majority of subjects (n=50/69%) feel that a lack of equipment causes burnout. Only 17 subjects disagreed (n=17/23%). Five subjects (n=5/7%) chose the neutral option (see Table 4.12).

Table 4.12: Lack of equipment

I feel that lack of equipment causes burnout	Sample (n)	Percentage (%)
1. Strongly Disagree	3	4
2. Disagree	14	19
3. Neutral	5	7
4. Agree	31	43
5. Strongly Agree	19	26

4.5.13 Variable 21: I feel that work pressure causes burnout

For this statement, 45 subjects (n=45/63%) strongly agreed and 22 (n=22/31%) agreed (see Figure 4.9). Thus, 67 (n=67/94%) subjects agreed that work pressure causes burnout. Only one subject strongly disagreed (n=1/1%), none disagreed, while four (n=4/6%) chose to remain neutral. This correlates with findings previously mentioned that high levels of workload and an increase in job demand, as well as low job satisfaction, may cause burnout.

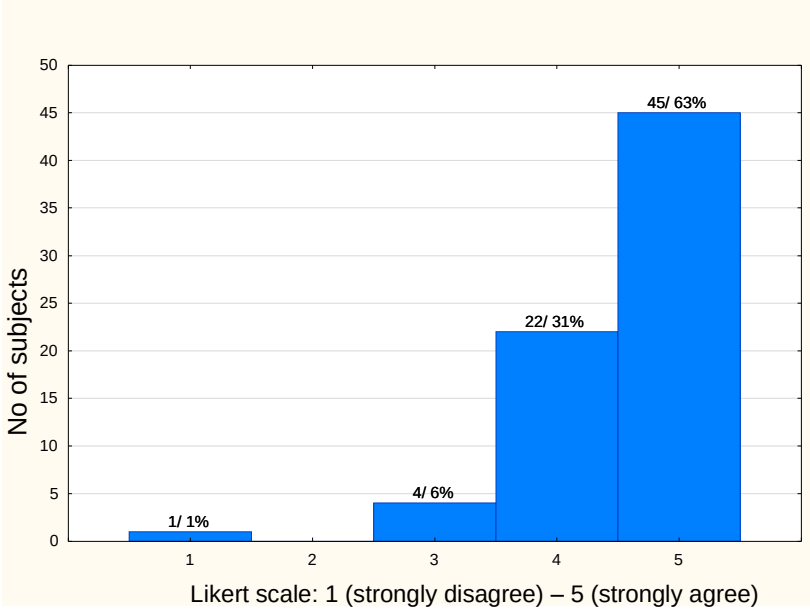

Figure 4.9 Histogram of work pressure

4.5.14 Variable 22: I feel that communication problems cause burnout

The majority of subjects (n=59/82%) indicated that communication problems are a factor that may contribute to developing burnout. Nine subjects disagreed while four chose neutral (see Figure 4.10).

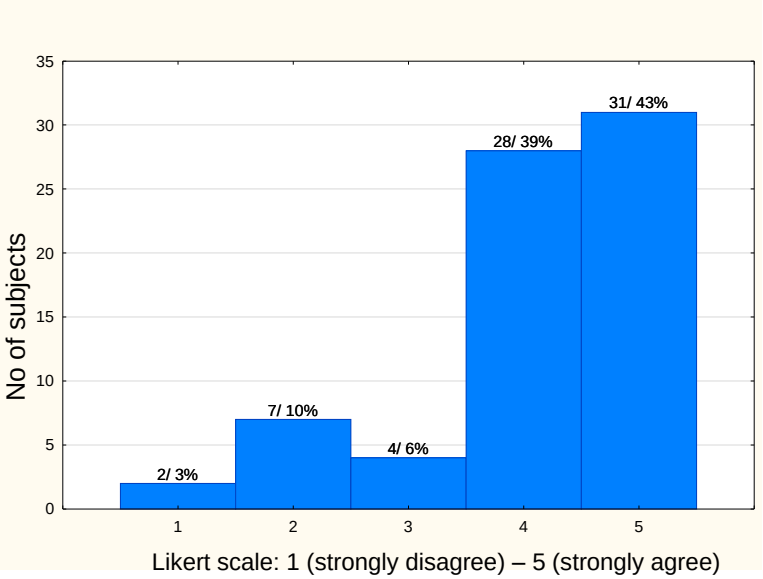

Figure 4.10 Histogram of communication problems

4.6 PART 3: JOB-RELATED FEELINGS

The attitudes of nurses were tested by the well-structured Maslach Burnout Inventory-Human Services Survey (MBI-HSS) on emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA) to determine the prevalence of burnout. Each aspect was measured separately by each subscale (Maslach *et al.*, 1996:4). The frequency with which the subject experienced feelings related to each subscale were assessed using a six-point, fully anchored response format.

Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. Therefore, it cannot be viewed as a dichotomous variable, which indicates the present or absent of a variable (Maslach, Jackson & Leiter, 1996:5).

Scores for EE and DP were considered high if they were in the upper third of the normative distribution, average if they were in the middle third and low if they were in the lower third. Revised scores for PA were applied for reflection of burnout. These scores were presented separately for each subscale and were not combined into a single, total score (Maslach *et al.*, 1996:4-5). The scores were computed individually by the statistician for each subject on each subscale.

4.6.1 Emotional Exhaustion (EE)

The subscale on EE described the feelings of being emotionally overextended and exhausted by one's work. High mean scores (≥ 27) on this subscale correspond to high degrees of experiencing burnout (Maslach *et al.*, 1996:10). The mean for this subscale was calculated and was rated as 28.3. This indicates that most of the subjects are experiencing high levels of EE.

The majority subjects (n=37/51%) expressed their true feelings as above average. The highest score of some subjects were rated as 50, while the lowest score was 6. Eighteen subjects (n=18/25%) were rated to have an average (19-26) experience of EE and only 17 subjects (n=17/24%) indicate low (≤18) feelings of EE. In other words, 76% of subjects (n=55/76%) are experiencing EE which is a strong indicator of burnout (see Table 4.13 and Figure 4.11).

Table 4.13: Emotional exhaustion

Subscale	Median	Mean	Standard deviation (*SD*)
Emotional exhaustion	28.0	28.3	10.9

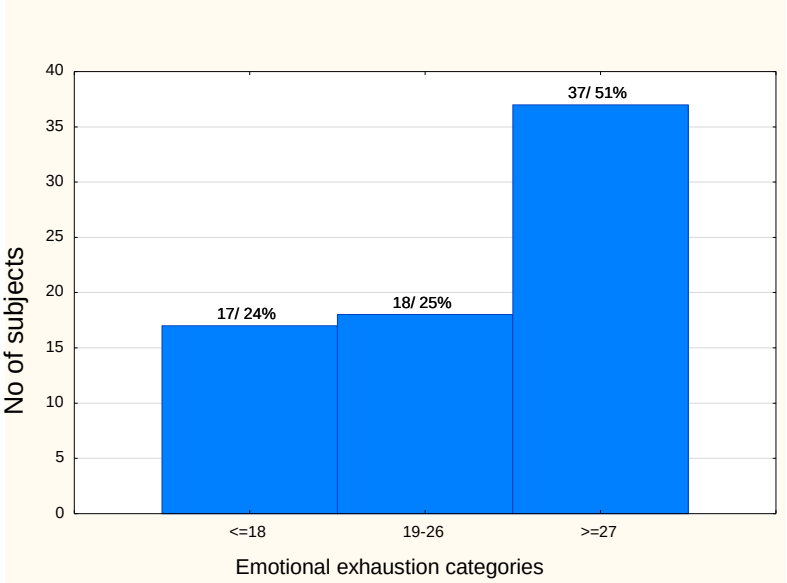

Figure 4.11 Histogram of emotional exhaustion

4.6.2 Depersonalisation (DP)

The Depersonalisation subscale describes a callous and impersonal response toward recipients to whom subjects have to render care or service. As indicated at the subscale of EE, higher mean scores (≥10) on the DP subscale corresponds with higher degrees of burnout. Emotional exhaustion and DP has a moderate correlation with aspects of burnout (Maslach *et al.*, 1996:10). The mean for DP was rated as 8.6. This score shows a moderate (6-9) level of burnout amongst participated subjects. Although the mean rate is seen as moderate, it reached borderline towards higher levels. The moderate rate of DP is directly associated with burnout.

Twenty seven subjects (n=27/38%) indicated that they did not really care about their recipient's feelings. The average score (6-9) for DP were chosen by fifteen subjects (n=15/21%). Thus, a total of 59% subjects indicated moderate and higher scores on DP (see Table 4.14 and Figure 4.12). Thirty subjects (n=30/42%) indicated low scores (≤5) of DP.

Table 4.14: Depersonalisation

Subscale	Median	Mean	Standard deviation (SD)
Depersonalisation	7.5	8.6	7.03

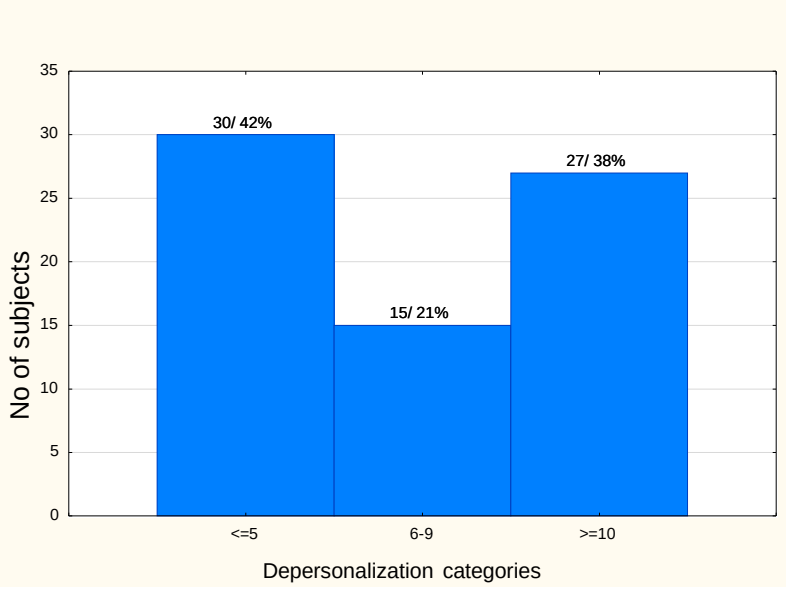

Figure 4.12: Histogram of depersonalisation

4.6.3 Personal Accomplishment (PA)

The subscale of PA describes the feelings of competence and successful achievement in one's work with people. In contrast to EE and DP, which are highly correlated with measures of psychological and physiological strain, a low mean score on this subscale relates to higher degrees of burnout. Personal accomplishment is more closely related to control-oriented coping (Maslach *et al.*, 1996:5).

Most of the subjects (n=71/99%) expressed very strong feelings on PA (see Table 4.15 and Figure 4.13). The high levels of PA give a strong indication of subjects' commitment towards the nursing profession, irrespective of the high levels of burnout. Ninety-nine per cent feel that they have made or are making a positive contribution towards patient care services. This shows that nurses still adhere to the convictions about nursing in respect of the Nurses' Pledge/code of service. This verbal agreement is made with the community by every nurse after successful completion of their studies (Muller, 2008:4-5).

Table 4.15: Personal accomplishment

Subscale	Median	Mean	Standard deviation (SD)
Personal accomplishment	13.0	13.8	8.3

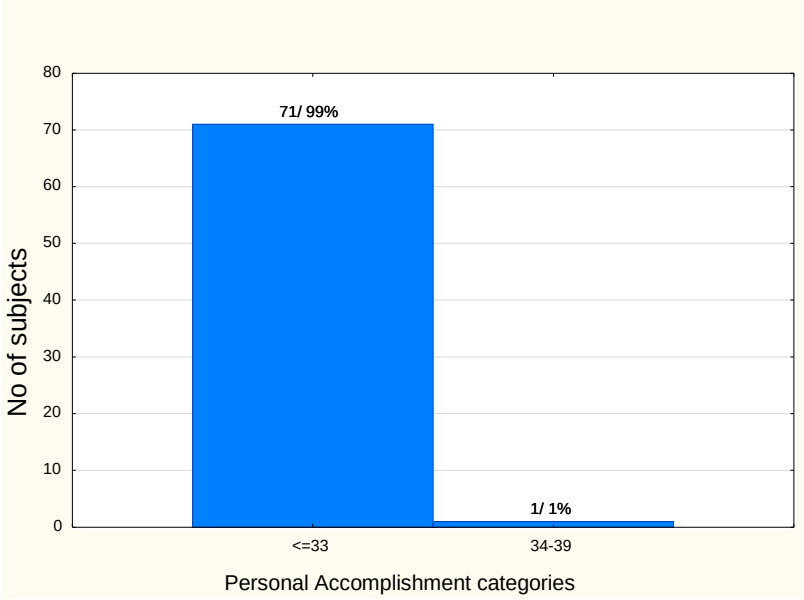

Figure 4.13: Histogram of personal accomplishment

4.7 THE RELATIONSHIP BETWEEN MORE YEARS OF EXPERIENCE ON EACH OF THE THREE SUBSCALES

The Pearson Product-moment Correlation Analysis was used to identify the prevalence of burnout amongst PHC nurses on different experience levels. It was plotted on scatterplots for the researcher to identify the relationship between the variables. The strength of a linear relationship decreases as the negative or positive values of *r* - value approach zero (Burns & Grove, 2009:480). The Pearson's correlation analysis (r=0.1) indicated a weak positive linear relationship between the two variables.

A weak positive correlation on work experience and EE was found (r=0.1) but it was not significant (p=0.36). This means that no correlation exist between years of experience and EE.

The same conclusion can be made on the relation between more years of experience and PA, as well as on DP. No statistically significent difference between the variables exist. No correlation was made between the two variables. In both cases *r*- value and *p*-value approached zero. No correlation was found between more years of experience and PA (r =0.13; p=0.25) or DP (r=0.13; p=0.26).

By inductive reasoning, one can assume that nurses working in PHC facilities all have an equal chance in developing burnout, irrespective of their level of experience.

4.8 THE RELATION BETWEEN THE WORK AREAS AND BURNOUT

Analysis of variance (ANOVA), *F* statistic, was used to test for differences between means of dependent variables. ANOVA permits the researcher to examine data of two or more groups and a dependent variable as the second variable. The larger the *F* - value the greater the variation or difference between the groups compared with the variation within the groups (Burns & Grove, 2009:505). The power of the analysis technique increases when group sizes are equal (Burns & Grove, 2009:361). Two groups, Satellite clinics and Mobile clinics, were excluded from this analysis technique because of too few clinics in each group (two and six respectively).

The experience of burnout amongst subjects in the different clinics was tested by applying ANOVA. The three subscales of burnout were tested separately, as done in the previous test.

ANOVA was used to indicate the higher occurrence of EE in certain clinics than in others. The *F*-test (*F*=0.27, *p*=0.1) indicated no statistically significant difference which was supported by the Mann-Whitney U-test (*p*=0.13). However, a trend was visible that community clinics experienced more emotional exhaustion.

For DP and PA no significant differences were found between the two groups of clinics (*F*=1.36, *p*=0.25 and *F*=0.22, *p*=0.64 respectively). This was supported by the Mann-Whitney U tests (*p*=0.39 and *p*=0.54 respectively).

4.9 PART 4 OPEN-ENDED QUESTIONS

The subjects had the opportunity to express their true feelings by answering open ended questions on burnout related issues. The first question required their opinion on the affect burnout has on quality patient care in their work environment.
By answering the second question subjects had to mention their supportive systems they rely on. Furthermore, the subjects were invited to give recommendations and suggestions on how to reduce burnout in their work environment in the third open ended question.
Quotes were expressed in Afrikaans and English only as none of the subjects chose to complete the questionnaire in IsiXhosa.

4.9.1 How do you think the effect of burnout affects quality patient care in your work environment?

4.9.1.1 Patient Care

All subjects strongly agreed that burnout affects patient care negatively. The majority feel they provide care without compassion and empathy. They cannot attend to their patient's needs in the way they are supposed to do in practice. Important information or treatments are forgotten or are not written down or not done, which may cause medical judicial risks. This is substantiated by the following quote.

> Afrikaans: "A.g.v die hoë druk en hoë werkslading word belangrike goed óf vergeet, óf nie genotuleer óf nie gedoen nie, wat medies geregtlike risiko's kan veroorsaak" (Subject 68).
>
> English: "Because of the excessive work pressure and work load important stuff is forgotten, or not written down, or not done, which may cause medical judicial risks" (Subect 68).

Burnout causes unproductivity and has a negative effect on co-workers which results in poor care. Wrong diagnoses are made and missed opportunities occur due to exhausted bodies

and souls. The following quotes state subjects' opinion about neglected patient care and inadequate treatment due to the high numbers of patients that need to be seen.

> Afrikaans: "Die gehalte daal, net die nodigste word gedoen om die getal klaar te maak" (Subject 6).
> English: "Poor quality care is rendered as only the necessary is done to get through the numbers" (Subject 6).

> Afrikaans: "Dit voel jy werk in 'n fabriek waar produksie net moet voort. Dit maak nie saak hoe jy as mens voel nie" (Subject 8).
> English: "It feels as if you are working in a factory where production should carry on. It does not matter how you as a human being feels" (Subject 8).

Some subjects also believed that irresponsible lifestyles of patients, irrespective the health education they have received make them reluctant to care. They feel burnout is the reason why they do not care for patients anymore.

> Afrikaans: "Uitbranding maak dat 'n persoon nie lus het om die ekstra myl te loop. Gee nie om wat van die pasiënte word" (Subject 27).
> English: "Burnout is the reason why one does not want to walk the extra mile. Don't care what will happen to my patients" (Subject 27).

Some subjects feel burnout intensifies unproductivity which does affect co-workers negatively, as well as not providing proper care to those who are in need. This is supported by the following quote.

> Afrikaans: "Uitgebrande individue word onproduktief en beïnvloed dikwels diegene rondom haar negatief" (Subject 46).
> English: "Burned out individuals become unproductive and often influences her fellow-workers negatively" (Subject 46).

4.9.1.2 Interpersonal Relationships with Patients

Many subjects mentioned that burnout is the reason for poor interpersonal relationships. Conflict appears to happen frequently between personnel and patients. It causes unnecessary communication problems which intensifies frustration between the nurse and the client as proven by the following quote.

> English only: "Burnout causes abrupt reply toward patient especially after hours" (Subject 47).

4.9.1.3 Frustrated Patients

Burnout affects patient care in such a way that patients merely become numbers. The patients frequently express feelings and opinions about their right to optimal health care. The patients do not receive quality health care due to lack of resources and unproductivity. This causes frustration amongst patients as they get impatient as stated by the following quotes.

> Afrikaans: “Kollegas wat uitgebrand is lewer nie kwaliteit sorg wat lei tot herhaalde besoeke van pasiënte omdat klagtes nie altyd reg hanteer word nie. Dit verhoog die werklading op res van personeel wat tot frustrasie lei, asook onderlinge ongelukkigheid tussen personeel en soms patiënte” (Subject 52).
> English: “Colleagues who experience burnout do not render quality care. This inefficacy causes patients to come back for treatment as they have not received the proper treatment at their first visit. This tendency causes an increase in workload on co-workers, which consequently results in frustration and between personnel and patients” (Subject 52).

> Afrikaans: “As gevolg van te hoë werkslading word konsekwente goeie sorg, dokumentering, gesondheidsvoorligting, ensovoorts, benadeel as gevolg van tydsdruk. Ontvangers vertrou nie meer die praktisyns nie en aangemoedig - om fout te vind” (Subject 33).
> English: “High workload is the reason why continuous quality care, documentation, health education, etcetera. are neglected due to time. Recipients do not trust practitioners anymore and find reasons to complain” (Subject 33).

4.9.1.4 Bad Quality of Service

Several subjects feel that the quality of service is neglected due to too many patients to be seen in too little time and that statistics is the only factor that counts. Subjects feel that less time for quality recordkeeping is available due to too heavy workload as expressed in the following quote.

> Afrikaans: “Rekordering moet haastig of na-ure geskied” (Subject 28).
> English: “Recordkeeping should be done hastily or after hours”
> (Subject 28).

Furthermore, some subjects feel that they cannot give their best if they are experiencing unhealthy conditions at all levels.

> Afrikaans: “Jou aandag is nie ten volle by jou pasiënt nie. Ek besef ek werk met mense se lewens, maar dat ek moet ‘fight’ om positief te bly en te konsentreer” (Subject 10).

English: “Your attention is not always focused on your patient. I mean we are working with people, but I have to fight to stay positive and to concentrate” (Subject 10).

4.9.1.5 Absenteeism

A high number of subjects feel that burnout causes absenteeism which leads to excessive workload on the remaining personnel and consequently results in poor patient care. This causes frustration. This is expressed by the following quotes.

Afrikaans: “Susters wat uitgebrand is, is baie afsiek” (Subject 63).
English: “Sisters who are burned out are often off sick” (Subject 63).

Afrikaans: “Afwesigheid neem toe- wie moet aangaan met die werk?”
(Subject 3).
English: “Absenteeism increases – who has to continue with the work? (Subject 3).

Afrikaans: “Uitbranding lei tot afwesigheid wat konflik onder werkers in die werkplek veroorsaak en dit veroorsaak baie frustrasie” (Subject 55).
English: “Burnout leads to absenteeism which causes conflict amongst employees in the workplace and causes lots of frustration” (Subject 55).

4.9.1.6 Blunted

Some subjects felt that burnout makes them feel blunted, which is the reason for bad quality patient care. These feelings are substantiated by the following quotes.

Afrikaans: “Uitbranding is die rede dat pasiënt soos masjiene behandel word” (Subject 4).
English: “Burnout is the reason for treating patients like machines” (Subject 4).

Afrikaans: “Ek as CNP raak baie gevoelloos. Ek is uiters afgestomp dus kom ek baie bot voor” (Subject 26).
English: “Me, as a clinical nurse practitioner becomes very heartless. I am unsympathetic and this is the reason why I act blunt” (Subject 26).

Afrikaans: “Dit maak mens hard en ek voel soms ek gee nie om as pasiënt nie sy samewerking gee nie” (Subject 70).
English: “It makes one heartless and I sometimes do not worry if patients do not coperate” (Subject 70).

4.9.2 Which supportive systems can you rely on when you need support?

4.9.2.1 Family and Friends

The majority of subjects rely on family and friends as support systems as indicated by the following quotes.

> English only: “My husband and family provide support. My employer, I really can’t trust even to discuss the least of my problems, for I’ve heard my colleagues’ problems in tearooms” (Subject 72).

> Afrikaans: “My huisgenote – Indien jy by die werkplek iets negatief sê word die aanname gemaak dat jy nie kan “cope” nie” (Subject 33).
> English: “My housemates – if you express your negative feelings while on duty, you get labelled as somebody who cannot cope” (Subject 33).

4.9.2.2 Colleagues

Many subjects indicate the support of their colleagues as a reliable means of support, especially colleagues who are experiencing the same problems. This is shown in the following quote.

> Afrikaans: “My onmiddelike kollegas bied ondersteuning. Die hoofde stel nie werklik belang, dit is net resultate wat tel” (Subject 65).
> English: “My close colleagues provide support. The supervisors do not really care, it is only the results that count” (Subject 65).

4.9.2.3 Religion

Religion was mentioned by some subjects as the only support system. Several subjects rely on religion in addition to family and friends for support. The following quote states the reliability of religion as a support system.

> Afrikaans: “Net op God – op geen mens – want mens is afbrekend, veral hoër gesag. Outoriteit het geen gevoel of ondersteuning, hulle forseer werk op jou af al is die fasiliteit nie beskore vir sekere diensleweringsaksies nie” (Subject 5).
> English: “God and God alone, you cannot trust anybody as they all pull you down, especially authority. Authority do not care or support, they rather force work onto you irrespective if the facility can accommodate the specific service” (Subject 5).

4.9.2.4 The independent Counselling and Advisory Services (ICAS)

Some subjects mentioned ICAS as an effective supportive system, while other expressed negative feelings regarding the service. Inaccessibility of ICAS was mentioned by a few subjects. The next quotes substantiate positive and negative feelings about ICAS as their support system.

Afrikaans: “ICAS altyd ‘n bron van ondersteuning” (Subject 3).
English: “ICAS is always a source of support” (Subject 3).

Afrikaans: “Toesighouer weet wanneer jy ICAS gekontak het. Jy word “gelabel” as jy ICAS gebruik” (Subject 2).
English: “Supervisors know when you phone ICAS. They label if you use ICAS” (Subject 2).

4.9.2.5 Management

Support from management was hardly mentioned as a reliable support system. The following quotes indicate positive responses by subjects towards supportive management.

Afrikaans: “My suster in bevel is baie tegemoet komend, is nie onredelik nie…” (Subject 62).
English: “My sister in charge is very accommodating, is not unreasonable…” (Subject 62).

Afrikaans: “Op professionele vlak, kry ons ondersteuning van PGS bestuurder” (Subject 46).
English: “On a professional level, we do get support from the PHC manager” (Subject 46).

4.9.2.6 Psychologist/Psychiatrist

Some subjects had to turn to mental related services for support. This is stated by the following quote.

Afrikaans: “Moes selfs privaat sielkundige gaan sien as gevolg van werk stres en druk” (Subject 38).
English: “Had to visit a psychologist privately due to my inability to cope with pressure and stress in my workplace” (Subject 38).

4.9.2.7 Labour Union

Some subjects obtain support from their union.

4.9.2.8 Nonexistant support

A high tendency was found where subjects expressed their true feelings about supportive systems as nonexistent or poor support. This is substansiated by the following quotes.

Afrikaans: “In die stelsel: GEEN!!!” (Subject 26).
English: “In this system: NONE!!!” (Subject 26).

Afrikaans: “Ek weet nie regtig nie. Mens moet maar gaan slaap, rus en hoop môre gaan dit beter” (Subject 51).

English: “I don’t really know. One just has to go to sleep, rest and hope it will get better tomorrow” (Subject 51).

Afrikaans: “Ondersteuningstelsel swak. Klagtes neem baie lank om beantwoord te word. Dus is ‘n goeie ondersteuningstelsel nog ‘n droom” (Subject 52).
English: “Poor support system. Complaints take long to be answered. An effective support system is still a dream” (Subject 52).

4.9.3 Please provide a suggestion as to how burnout could be reduced where you work?

4.9.3.1 Listening Skills of management

Subjects feel management do not want to listen to what they have to say regarding several concerns in their workplace. Subjects would like management to give employees a chance to express their feelings in meetings. They want the matter management cannot respond to, referred to a higher authority and to give proper feedback quickly. The following quotes prove this.

English only: “I feel at times I haven’t done my best that I have failed my patients due to the frustrations of not being listened to” (Subject 72).

Afrikaans: “Meer aandag aan personeel se probleme met onpartydigheid te luister, op te los en te verwys – terugvoering te gee” (Subject 6).
English: “Listen objectively to problems of personnel, try to resolve, refer issue and give feedback” (Subject 6).

Afrikaans: “As bestuur ook net na verpleegkundiges sal luister en ten minste een keer per kwartaal met verpleegkunidiges vergader wat tans glad nie gebeur nie. Daar word altyd net boodskappe vir ons gestuur, maar geen terugvoer van verpleegkundiges word verwag nie” (Subject 71).
English: “If management will listen to nurses and at the very least get together with nurses once per quarter will help a lot that never happens. We always only receive messages sent to us but no input from nurses is expected” (Subject 71).

4.9.3.2 Nurses participation in decision making

Subjects feel their participation in decision making will improve service delivering and will eventually prevent burnout. This is supported by the following quotes made by some subjects.

Afrikaans: “Maak personeel deel van besluitneming” (Subject 2).
English: “Make personnel part of decision making” (Subject 2).

Afrikaans: “Deelname by besluitneming oor gesondheidsdienste vorentoe!” (Subject 55).
English: “Participation in decision making on health services in the future!” (Subject 55).

4.9.3.3 Personnel Issues

Strong feelings were expressed on effective handling and management of employee related problems. Some subjects feel managers should act objectively and need to be trained in how to handle personnel’s sensitive issues. Age, health status and level of education of personnel should be taken into account when criticizing their performances or in the case of being absent from work.

Afrikaans: “Bestuur moet opleiding kry hoe om personeel se sensitiewe sake te hanteer. Stop skinder oor personeel se afwesigheid” (Subject 2).
English: “Management needs training in how to handle sensitive issues of personnel.” “Stop gossiping about personnels’ absenteeism” (Subject 2).

Some subjects also felt that co-workers’ inability to cope with personal issues at home may influence patient care.

Afrikaans: Personeel moet persoonlike lewe so leef dat dit nie ‘n negatiewe inpak op werk het nie” (Subject 23).
English: “Personnel should live his/her personal life in such a way that work will not be negatively affected” (Subject 23).

4.9.3.4 Appreciation

Subjects felt that employees who experience low morale may be at risk of burnout. They indicated that low morale is the consequence of the inability of management to show any appreciation. Management should care for staff by showing empathy, acknowledgement and to give credit when due. Subjects felt this would mean a lot to them.

Afrikaans: “Laat personeel waardig voel” (Subject 2).
English: “Make personnel feel valuable” (Subject 2).

Afrikaans: “Baie selde word dank van ontvangers of bestuur ontvang” (Subject 33).
English: “Seldom is thanks received from managers” (Subject 33).

Afrikaans: “Dat daar geluister word na jou en of dat jy ervaar daar word omgegee” (Subject 54).
English: “That you are listered to and or that you experience that they care” (Subject 54).

4.9.3.5 Staff Performance Management System (SPMS)

A large group of subject's pleaded for the elimination of the Staff Performance Management System (SPMS). They strongly expressed negative feelings about this form of showing recognition or reward. They believe that everybody works as hard as the others. The following quotes substantiate this.

> Afrikaans: "SPMS – klug! Ek voel almal moet vergoed word vir goeie dienste gelewer, nie dieselfde persone elke jaar nie, want dis nie net enkele persone wat dienste laat glad verloop nie, maar spanwerk" (Subject 48).
> English: "SPMS is a joke! I feel everybody should receive remuneration for good services rendered, not the same persons every year because it is not individuals who help the service to run smoothly, but teamwork" (Subject 48).

> English only: "They should please stop SPMS as it is one great causative reason towards burnout. I see it as unfair and depressing to those that work hard but never get it. You never know what the real criteria are as some people get it even though you truly and honestly know that they don't deserve it" (Subject 72).

4.9.3.6 Development / Training

Some subject believed that inservice training would help to prevent burnout. Suggestions were made to allow personnel to develop without putting pressure on them. Lots of frustrations are due to colleagues who do not treat patients according to protocols, as well as the increase of workload on co-workers which may be the result of indequate training.

> Afrikaans: "Gee gereeld kwalitiet indiensopleiding aan personeel, en nie net 'n vinnige aframmeling van woorde nie" (Subject 2).
> English: "Give proper quality in service training to personnel and not just a quick gabbling of words" (Subject 2).

> Afrikaans: "Voldoende opleiding. Iemand om te verseker dat almal dieselfde opleiding het en dit toepas sal baie help" (Subject 52).
> English: "Adequate training. Appoint someone who will guarantee that everybody has the same training and to supervise will help a lot" (Subject 52).

4.9.3.7 Human Resources

The majority of subjects believed that when more trained employees with adequate experience are appointed, the workload will decrease and the chance of developing burnout will be reduced. The subjects asked management to appoint competent personnel who are human-orientated. Equal distribution of responsibilities is important to prevent burnout. Subjects felt that when enough staff is provided, all aspects of management can be done

without rushing and personnel/staff will be able to take tea and lunch breaks as stated in the next quote

> English only: “Provide enough staff so that all aspects of management can be done without rushing” (Subject 47).

The subjects suggested that the recruitment of responsible personnel should occur and not incompetent subordinates who consistently use their cellular phones and who do not take responsibility. They requested the removal of job creation personnel who work only a few days a week. Some subjects asked that management should get rid of subordinates who do not want to work and should rather employ personnel who are willing to perform the work properly.

> Afrikaans: “Genoegsame, nodige, bekwame en gemotiveerde personeel. Werk en admin raak meer sonder ekstra hande” (Subject 32).
> English: “Sufficient, necessary, qualified and motivated personnel. Work and admin escalates without extra hands” (Subject 32).

> Afrikaans: “Rotering van personeel op ‘n gereelde basis om te voorkom dat mense stagneer op een plek of area. Want baie keer raak die werk eentonig en geen uitdaging nie. ‘Knowledge is power’” (Subject 8).
> English: “Rotate personnel on a regular base to prevent stagnation in one specific area. Sometimes work gets monotonous without any challenges. ‘Knowledge is power’” (Subject 8).

> Afrikaans: “Meer personeel aanstellings om sodoende druk en werkslading te verminder sodat pasiënte effektiewe sorg kan kry en tevrede kan wees” (Subject 64).
> English: “Appoint more personnel to reduce pressure and workload to ensure effective patient care and pasient satisfaction” (Subject 64).

4.9.3.8 Relief Personnel for Annual Leave and Sick Leave

A general concern was expressed by subjects regarding relief for when colleagues are on annual leave or sick leave. Some subjects mentioned that they do not receive any relief support, while others felt the need for more qualified and competent personnel and that relief staff would be appreciated. Subjects urged management to stop sending different registered nurses to outlying clinics. They feel they cannot maintain continuity of patients care.

> Afrikaans: “Die meeste van die tyd as ‘n personeellid op vakansie gaan word daar nie hulp gestuur nie, so die wat agter bly moet daardie een of twee persone se werk ook doen” (Subject 14).

English: “Most of the time when employees go on leave no relief personnel are sent, so the remaining personnel have to do one or two persons work as well” (Subject 14).

Afrikaans: “Aflosse beter organiseer” (Subjec 48).
English: “Organise relief personnel better” (Subject 48).

4.9.3.9 *Workload*

All subjects feel that the heavy workload needs immediate attention in order to prevent the development of burnout. Suggestions included dramatic changes in practice. They have asked management to focus on things that really matter, such as frequent ordering of stock to prevent frustration.

Subjects requested that increased focus should be put on prevention rather than on curative services.

Afrikaans: “Meer fokus op voorkomende dienste as kuratief” (Subject 58).
English: “More emphasis on preventative services than curative” (Subject 58).

Subjects asked for implementation of daily task teams, daily duty rosters and mind maps. Proper referral systems could reduce the workload. Some subjects suggested better co-ordination of activities and definable demarcation between nursing categories (clinical nurse practitioners and professional nurses).

Another suggestion is to implement more Doctor Sessions at clinics to support personnel. The constant roll down of services to PHC level exacerbates the already heavy workload on over-burdened employees. Administrative tasks have increased tremendously without extra personnel. The following quotes substantiate the unpleasant feelings experienced by several subjects.

Afrikaans: “Alles word afgewentel PGS toe- werksdruk al hoe meer” (Subject 57).
English: “All services are rolled down to PHC. Work pressure increases more and more” (Subject 57).

Afrikaans: “PGS praktisyns word die ergste van alle kategorieë gesondheidswerkers misbruik. Wat niemand anders doen nie, wil, kan en sal hulle doen” (Subject 33).
English: “PHC practitioners are abused to the extreme compared to other categories of health workers. Whatever others refuse to do they are willing to, can and shall perform” (Subject 33).

> Afrikaans: “Vrag op Suster se skouers word gelaai soos ‘n “Transkei Taxi”. Een of ander tyd gaan die bande bars!” (Subject 36).
> English: “The workload is stacked on the shoulders of Sisters like baggage on a‘Transkei taxi’s’. Sooner or later the tyres will burst!” (Subject 36).

4.9.3.10 Targets

The majority of subjects stated that striving to obtain the targets set by the District Office is the main contributing factor to feeling burned out. The following opinions were quoted from the questions on management who are merely interested in statistics and administrative duties rather than quality patient care.

> Afrikaans: “Bestuurders is net gestel op statistieke, wanneer vorms voltooi moet wees en of administratiewe pligte op datum en reg gedoen is. Hulle gee niks om vir personeel en pasiënte nie” (Subject 68).
> English: “Managers are just concern about statistics, when forms are completed and if administrative task are up to date and properly done. They do not care about personnel and patients” (Subject 68).

> English only: “Work needs to be more patient-care orientated rather than target orientated” (Subject 40).

The subjects said they lose interest in patient care due to these targets. They suggested that patient care should be put first and they asked for realistic expectations. Furthermore, they urge management to stop working according population counts, but make suggestions to rather work according to what is possible for one person to do. These statements are proved by the following quotes.

> Afrikaans: “Verpleeg bestuurders moet eerder na verpleeg personeel se behoeftes kyk as na statistieke” (Subject 21).
> English: “Nursing managers should rather look at nursing personnel’s needs than to statistics” (Subject 21).

> Afrikaans: “Jy moet net werk om ‘targets’ te bereik en om al die papierwerk vir oudits reg te doen” (Subject 67).
> English: “One just has to work to achieve your targets and to get all the paperwork properly done for audits” (Subject 67).

4.9.3.11 Nurse Patient Ratio

The majority of subjects asked for a re-evaluation of the nurse patient ratio. They cannot render quality comprehensive services due to work pressure and high workload. They see themselves as sausage machines. These heavy workloads are the reason why procedures,

like PAP-smears or follow-up Tuberculosis are neglected. One professional nurse is required to see 50 patients in the seven and a half hours available per day. Therefore, comprehensive services cannot be rendered, as stated by the following quotes.

> Afrikaans: “Omvattende sorg diens kan nie gelewer word. A.g.v. die druk en hoë werkslading is dit soos ‘n worsmasjien 50 pte vir een Sr in 7 ½ uur tyd van die dag” (Subject 64).
>
> English: “Comprehensive care service cannot be rendered. Due to pressure and high workload it is like a sausage machine 50 patients for one Sr in 7 ½ hours per day” (Subject 64).
>
> Afrikaans: “Pasiënt ratio belangrik om na te kyk” (Subject 14).
> English: “Patient ratio important to look at” (Subject 14).
>
> Afrikaans: “’n Menslike en haalbare ration per PGS-praktisyn” (Subject 33).
> English: “A humanly and reachable ratio per PHC-praktitioner” (Subject 33).

4.9.3.12 Equipment, stock, more space and advanced technology

Subjects insisted on the implementation of strategies to have adequate stock and sufficient equipment in working order available at all times in order to provide quality patient care.

> Afrikaans: “Sorg dat alle toerusting elke dag beskikbaar is en in werkende toestand” (Subject 3).
> English: “See that all equipment is available every day and in working order” (Subject 3).

They felt that more space and the layout of clinics will reduce frustration and prevent burnout.

> Afrikaans: “Groter klinieke- groot lading pasiënte word met een ondersoek kamer hanteer” (Subject 32).
> English: “Larger clinics – high numbers of patients need to be seen in one examination room” (Subject 32).

The implementation of advanced technology was another suggestion made by them to save time.

> Afrikaans: “Gevorderde tegnologie te gebruik wat tydsparend sal wees” (Subject 70).
> English: “To use advanced technology which will save time” (subject 70).
>
> Afrikaans: “’n interkom” (Subject 35).

English: “an intercom” (Subject 35).

4.9.3.13 Organisational Support

Subject felt very strongly that effective support from supervisors and managers will reduce or prevent the development of burnout. They request management to attend to employee’s concerns, to provide adequate support where necessary and to show empathy. Furthermore, they expect managers to show friendliness, forbearance, understanding, and to provide constant motivation. They asked managers to eradicate unfair and partial behaviour and to improve optimal support of staff.

Effective support from supervisors and the implementation of support systems will reduce the prevalence of burnout. Some subjects challenged management to regularly visit facilities and to put themselves in the shoes of the employees for one day as stated in the following quote.

> Afrikaans: “Indien bestuur gereelde besoeke kom doen en hulself in die personeel se skoene plaas vir een dag” (Subject 12).
> English: “If management can do regular visits and put themselves in the shoes of the personnel for one day” (Subject 12).

They believe that the load on employees will decrease if managers get actively involved in patient care. Another suggestion was made that management should provide positive remarks in order to improve duties. The following quotes add to the abovementioned statements made by participative subjects.

> Afrikaans: “Verlaag werkslading deur voldoende personeel en goeie ge-organiseeerde strukture, met almal wat saam werk vir ‘n beter kliniek” (Subject 10).
> English: “Decrease workload by providing adequate personnel and an effective well-organised structure where everybody works together towards a beter clinic” (Subject 10).

> Afrikaans: “Bestuurders moet meer begrip aan werksomstandighede waaronder personeel moet werk toon” (Subject 22).
> English: “Managers should show more understanding towards the working conditions in which employees have to work” (Subject 22).

> Afrikaans: “Toesighouers moet nodige insig toon om te weet almal is nie dieselfde nie en funksioneer ook nie optimaal op dieselfde vlak nie” (Subject 44).
> English: “Supervisors should show understanding, to know everybody is not the same and do not function optimally on the same level” (Subject 44).

> Afrikaans: “Deurdat daar meer gekyk word aan watter behoeftes elkeen van ons in werksplek het en vir ons die nodige ondersteuning kan gee. Ook om elke individu te verstaan, want almal het nie dieselfde denke en vermoeëns om te “cope” met sekere problem nie” (Subject 49).
> English: “Re-evaluate each individual worker’s needs in the workplace and provide the necessary support. In addition, try to understand each individual because nobody thinks the same and they do not have similar abilities to cope effectively with certain problems” (Subject 49).

4.9.3.14 Act Pro-actively

Some employees feel that if management identified signs of burnout, action needs to be taken. Subjects felt that strategies should be implemented to prevent burnout rather than to cope with the casualties as stated in the next quote.

> Afrikaans: “As klagte van uitbranding aandui werk aan dit moenie situasie daar los nie” (Subject 3).
> English: “If attention to complaints of burnout occurs, something should be done about it … do not ignore it” (Subject 3).

Regular counselling sessions and effective support systems will assist subjects to cope in difficult circumstances.

> Afrikaans: “Positiewe motivering sal baie help” (Subject 22).
> English: “Positive motivation will help a lot” (Subject 22).

4.9.3.15 Incompetent Supervisors

Subjects feel that some managers are not experienced and competent enough to perform their managerial tasks optimally. The next quote was posed by one subject on the improvement of management skills.

> Afrikaans: “Voldoende bestuurspersoneel wat ten minste dieselfde opleiding as ons het” (Subject 26).
> English: “Competent supervisors with at least the same qualifications we have” (Subject 26).

A subject suggested that managers should resign when the time has come in order to give the opportunity to young enthusiastic employees to take over. This is stated by the following quote.

> English only: “People should retire when the time has come as this causes no growth in the work situation as people are old and have outdated management

> skills. We need young blood with vision and mission, focussed and willing to change with the times" (Subject 72).

Subjects feel that if management improved their management skills proper planning in each facility will decrease the prevalence of burnout.

> Afrikaans: "Beter beplanning op bestuursvlak" (Subject 46).
> English: "Better planning on management level" (Subject 46).

> Afrikaans: "Minder bestuurders wat van dieselfde personeel 100% resultate verwag om hul goed te laat lyk" (Subject 33).
> English: "Less managers who expect the nurses to provide 100% results in order for them to look good" (Subject 33).

4.9.3.16 Communication Skills

Subjects asked management to improve their interpersonal and communication skills toward employees as stated in the next quote.

> Afrikaans: "Effektiewe kommunikasie sal help" (Subject 27).
> English: "Effective communication will help" (Subject 27).

They want to be respected according their rights. Subjects also asked management to demonstrate self-control.

> Afrikaans: "Vriendelikheid, verdraagsaamheid van hoofde" (Subject 18).
> English: "Friendliness, tolerance by managers" (Subject 18).

4.9.3.17 Allocation of Employees

Subjects ask managers to allocate employees in departments where they have the appropriate training and passion.

> Afrikaans: "Om personeel te plaas in afdelings en hulle toe te laat om te werk in afdelings waarvoor hulle die opleiding en passie het" (Subject 38).
> English: "To allocate personnel to work in departments for what they are qualified in and feel passionate about" (Subject 38).

4.9.3.18 Overtime

Many subjects want to take overtime when they need it. Although subjects do have many hours of overtime, they feel frustrated in that they are not allowed to take it due to too busy facilities in some instances and no acknowledgement on working overtime in others.

> Afrikaans: “Werk wat gedoen word vereis die doen van admin, waar daar nie tyd voor in ‘n werksituasie is as daar massas mense vir jou wag nie en waarvoor die oortyd nie erken word as oortyd nie. Aanpassing van oortydreëlings asseblief” (Subject 63).
> English: “Mass of patients is waiting outside while you have to finalise administrative duties. This leads to working overtime which is not acknowledged. Please implement the overtime regulations” (Subject 63).

4.9.3.19 Work environment

Subjects feel that burnout will be reduced if they were able to take lunch breaks. Improvement of tearooms will enable subjects to relax and recover for the next session of the day. Some subjects feel they should be allowed to work reduced hour posts. More frequent leave periods will prevent subjects from developing burnout. A suggestion was made that management should provide special concessions for unpaid leave.

> Afrikaans: “Teekamer om te “relax” in “tea break” en “lunch” tyd (Subject 30).
> English: “Provide tea rooms to relax for tea and lunch breaks” (Subject 30).

> Afrikaans: “Meer personeel veral by susters, sodat tee of etenstye geneem kan word” (Subject 34).
> English: “More personnel especially sisters, so that tea and lunch breaks can be taken” (Subject 34).

4.9.3.20 Fair salaries

Some subjects feel that improved salaries will reduce the prevalence of burnout. They feel that salaries should be competitive with other careers within the health system, since they perform the tasks of medical practitioners, pharmacists and managers.

> Afrikaans: “Verbeter salarisse” (Subject 58).
> English: “Improved salaries” (Subject 58).

> Afrikaans: “Vergelykbare salarisse vir werk wat dokters en aptekers en bestuurders veronderstel is om te doen” (Subject 33).
> English: “Competitive salaries for work medical practitioners, pharmacists and managers are supposed to render” (Subject 33).

4.9.3.21 Unproductivity

A high number of subjects indicated that unproductive co-workers are a factor that contributes to burnout. Unproductive employees increase the workload on fellow-workers.

> Afrikaans: “Uitgebrande individue word onproduktief en beïnvloed dikwels diegene rondom haar negatief” (Subject 46).
> English: “Burned out individuals become unproductive and has a negative influence on co-workers” (Subject 46).

Suggestions were made to combine strong workers with under productive workers as some felt they were unable to continue working due to burnout.

> Afrikaans: “As alle personeel by kliniek elke dag hulle kant bring” (Subject 71).
> English: “If all personnel at the clinic contriubute every day” (Subject 71).

4.9.3.22 Team Building

Several suggestions were made by subjects regarding team building to prevent burnout. Team building on a monthly basis will allow employees the opportunity to express their concerns and to get rid of unwanted frustration. Subjects asked management to make time for employees to unload their feelings. The following quotes state the need for teambuilding and ambiance meetings.

> English only: “Regular meetings where we can openly discuss any problem with each other and not offend them” (Subject 45).

> Afrikaans: “Gereelde sessies om personeel die kans te gee om van frustasies ontslae te raak” (Subject 52).
> English: “Regular sessions to give personnel the opportunity to get rid of their frustrations” (Subject 52).

> Afrikaans: “Gereelde klimaatsvergaderings - instelling!” (Subject 53)
> English: “Implement regular ambiance meetings!” (Subject 53)

> English only: “Having opportunity to express how I feel about my problem” (Subject 59).

4.9.3.23 Transport

Some subjects experience transport as a great problem. Transport to the satellite clinics to start work on time will improve patient care and prevent burnout. Home visits could be done if transport is available. This is substantiated by the following quote.

> English only: “Better planning regarding transport to do home visits and travelling to satellite clinics” (Subject 47).

4.9.3.24 Responsibilities of Patients

Subjects find patients who show no gratitude toward the service as a reason why they may develop burnout. They suggested that patients need to be educated to be thankful and show more respect for their own health in order to prevent illnesses. This will decrease workload and prevent burnout. They suggested that the implementation of a minimum fee for services could make the patients appreciate the service.

> Afrikaans: “Pasiënte wat gratis dienste uitbuit - beperk” (Subject 57).
> English: “Patients who take advantage of free of charge services - restrict” (Subject 57).

> Afrikaans: “Pasiënte opvoeding en moontlike vergoeding vir dienste gelewer. Hulle respekteer nie gratis dienste nie” (Subject 56).
> English: “Patient education and possible compensation for services rendered. They do not respect free of charge services” (Subject 56).

4.9.3.25 Protocols and Documentation

Several subjects find it extremely difficult to keep up with the frequent changes of protocols and documentation and therefore see it as a cause of burnout.

> Afrikaans: “Protokolle verander op ‘n daaglikse basis en werk raak net meer” (Subject 60).
> English: “Protocols change on a daily basis and work just increases” (Subect 60).

> Afrikaans: “Onnodige papierwerk en vorms wat elke tweede maand verander, moet gestaak word. Ons is besig met ‘n papier oorlog en die pasiënte ly daaronder” (Subject 68).
> English: “Unnecessary paperwork and forms which change every two months should stop. We are fighting a paper war, while the patients have to bear the consequences” (Subject 68).

4.10 SUMMARY

Data obtained from the questionnaires was interpreted. The researcher explored the factors based on the literature review as leading factors for the development of burnout amongst subjects. A significant percentage of subjects showed high levels of burnout on the emotional exhaustion subscale, moderate levels were revealed on depersonalisation and a large percentage showed high levels on the reversed subscale of personal accomplishment. No correlation could be found between the impact of years of experience on burnout and no significant correlation could be found between working area and the subscales of burnout.

Valuable information was discovered by coding the open-ended questions. The subjects mentioned several aspects which influence patient care negatively. Subjects requested reliable support systems and provided suggestions on how to prevent or minimise the prevalence of burnout.

4.11 CONCLUSION

The results and findings obtained from a well-structured questionnaire were analysed, interpreted and presented in this chapter with the assistance of a statistician. The research question on the prevalence of burnout amongst PHC nurses in the Eden District of the Western Cape, South Africa, was answered.

The aim was to evaluate the occurrence of burnout amongst PHC nurses. The research objectives were to:

- Identify the prevalence of burnout amongst PHC nurses, and to
- Explore the factors contributing to burnout in PHC settings.

The aim and the objectives for this study were met.

In Chapter 5, the findings explored in Chapter 4 will be discussed according the research question, aim and objectives of the study. Conclusion and recommendations derived from the study will be described in order to change practice. Limitations in the study will be discussed. Recommendations will be made for future research based on the findings of the study.

CHAPTER 5: DISCUSSION, RECOMMENDATIONS, LIMITATIONS AND SUGGESTIONS FOR FUTURE STUDIES

5.1 INTRODUCTION

The results presented in Chapter 4 will be discussed in this chapter. This discussion provides evidence for the outcome of the research aim and answers the research question on occurrence of burnout amongst PHC nurses in the Eden District of the Western Cape, South Africa.

The objectives on the prevalence of burnout amongst PHC nurses and the factors contributing to burnout in PHC settings were met.

Recommendations for clinical practice, based on the findings of the study, are presented. Study limitations are identified and suggestions for future studies are recommended.

5.2 THE OCCURRENCE OF BURNOUT AMONGST PHC NURSES

Individuals experience burnout when they feel fatigued, behave indifferently toward their work and clients, and when they believe that their performances has deteriorated accordingly (Bakker *et al.*, 2006:466). The findings on burnout amongst PHC nurses in the Eden District are critically discussed according to the different subscales of burnout namely, emotional exhaustion, depersonalisation and lack of personal accomplishment.

5.2.1 Emotional exhaustion (EE)

At a psychological level, workers feel they cannot cope with demands made on them. Emotional exhaustion is the depletion of one's emotional and physical resources (Maslach & Leiter, 2008:498; Taris *et al.*, 2005:955).

In the analysis the mean score on EE gives a clear indication that most of the subjects who participated in this study experienced burnout. This findings correlate with the results of Rossouw (2012:10) where high levels of EE was confirmed amongst Medical Practitioners in the Western Cape.

5.2.2 Depersonalisation (DP)

Depersonalisation represents the dimension of the interpersonal context of burnout which involves the development of negative, cynical attitudes and feelings about one's clients. This

component refers to excessively detached responses to various aspects of the job (Maslach & Leiter, 2008:498; Taris *et al.*, 2005:955).

Subjects indicated that they did not really care about their patient's feelings. This is an indication of a high degree of burnout. A cross-sectional study indicated high levels of depersonalisation amongst medical doctors (Rossouw, 2012:10) which support findings of this study. The expression of high feelings of DP confirm cure without caring, which is a desolate and unfeeling experience for both the receiver and giver of health care. It poses critical ethical concerns (Pera & Van Tonder, 2011:17).

5.2.3 Personal Accomplishment

Taris *et al.* (2005:955) describe diminished personal accomplishment as a lack of self-efficacy regarding one's own performance at work. This component represents the self-evaluation dimension of burnout (Maslach and Leiter, 2008:498) and emphasises effectiveness and success as having a beneficial impact on people (Maslach *et al.*, 1996:20). Subjects expressed dedicated feelings of PA (see Table 4.15), which strongly indicates the subjects' commitment towards their patients and work, irrespective of high levels of EE. Subjects felt they had made a positive contribution towards nursing. This indicates that nurses still adhere to the verbal agreement made by them on their convictions about nursing in respect of the Nurses' Pledge/code of service (Muller, 2008:4-5). This motivation towards resilience in the workplace may add to the statement made by Rossouw (2011:14) that the level of accomplishment and job satisfaction will increase and burnout will be prevented when reliance in doctors in PHC settings is improved.

5.3 FACTORS CONTRIBUTING TO BURNOUT IN PHC SETTINGS

The study rated and identified significant factors in the working environment which contribute to burnout amongst PHC nurses in the Eden District of the Western Cape, South Africa as indicated by previous studies (Rossouw, 2011:14; Oosthuizen, 2009:191; Baloyi, 2009:145; Van der Colff & Rothmann, 2009:7; Bester, 2009:114; Lawn *et al.*, 2008:917; Van der Westhuizen, 2008:51; Kekana *et al.*, 2007:24; Erasmus & Brevis, 2005:51; Hall, 2004:28).

Pressure under which subjects work, the workload or increase of job demands, lack of organisational support and management problems was rated as the main reasons for subjects developd burnout. Unproductive co-workers seem to be a larger problem than inadequate human resources. This phenomenon is probably a response to low levels of job satisfaction and a lack of motivation amongst co-workers which may causes low moral.

A lack of equipment, the tendency to work overtime, insufficient training and financial constraints were indicated by subjects as additional reasons for developing burnout.
Personal factors beyond the workplace were seen by all subjects as the very last factor for developing burnout.

5.4 RECOMMENDATIONS FOR CLINICAL PRACTICE

Scientific evidence in this study provides important implications for clinical practice. The researcher proved that the current imbalance between job demands and job resources is experienced by PHC nurses in the Eden District whick may cause burnout. This imbalance was proofed by Leiter *et al.* (2008:44) who stated that burnout will occurred when organization's priorities and task demands are not synchronised. This imbalance has a major influence on the level of strain and motivation amongst PHC nurses and does affect job-related well-being. Strain and a lack of motivation will affect an organization's outcome negatively (Bakker & Demerouti, 2007:323), which in this study refers to quality service delivering and patient care on PHC level. In order to establish patient-centred care as stipulated in the Draft on HealthCare 2030 (Western Cape Government DoH, 2013c:24), indept attention need to be given to the consequences of the current situation on PHC level.

For this reason, recommendations will be presented to improve the current unpleasant clinical work situation.

5.4.1 Workload and Work Pressure

Workload and the pressure under which nurses have to work were identified as major challenges in this study as indicated by several other studies (Ten Brummelhuis *et al.*, 2011:268; Rossouw, 2011:13; Lawn *et al.*, 2008:917; Van der Westhuizen, 2008:50; Kekana *et al.*, 2007:24; Xanthopoulou *et al.*, 2007:782; Erasmus & Brevis, 2005:51; Hall, 2004:28). Inadequate human resources together with lack of organisational support and management problems are additional challenges that prove why employees cannot cope with the escalating demands made on them. These findings were stated by Kekana *et al.* (2007:24); Baloyi (2009:145) and Hall (2004:28). Paradigm shifts and different approaches need to be put in practice.

Work pressures were rated as the dominant reason why employees are developing burnout. Subjects expressed their dismay to the enormous task of evaluating a minimum of 50 patients per day and to meet the targets as implemented by National DoH (NDoH, 2011:22). Work pressure is increased due to the strict rules to reach quality assurance standards

(RSA, 2007:2). Subjects mentioned that caring for patients is neglected due to the numerous administrative duties and pressure to reach monthly and annually targets.

Provincial Government of the Western Cape (PGWC) needs to reconsider the number of patients that need to be seen by professional nurses per day and to re-evaluate the targets towards acceptable and manageable numbers. The importance of PGWC taking the limited resources in consideration towards improvement of health outcomes on service demands (PGWC DoH, 2010b:iii), was emphasised. Findings in this study indicated unacceptable assistance or support in this regards.

The current psychological state of PHC workers will impede the implementation of policies. Some of the subjects mentioned in the open-ended questions that they cannot keep up with the demands as nurses have been seen as the only ones who will do what other people cannot and will not do.

5.4.2 Preventative Approach and Patient Responsibilities

Adequate and experienced human resources are essential to render quality care in the field of PHC. Although literature identifies the enormous backlog of qualified nurses in South Africa (Van Rensburg, 2004:319; Mohale and Mulaudzi, 2008:315; Vand der Colff and Rothmann, 2009:7; Oosthuizen, 2009:239; Magerman, 2011:2), no indication exist on a positive outcome towards this critical challenge.

The mean age of subjects in PHC facilities increases the reason for concern. To add to the latter, the majority of employees are currently experiencing high levels of burnout. Limited human resources draw attention towards the implementation of additional strategies to cope with the difficult working environment.

The challenge of heavy workloads will be reduced when emphasis is placed on prevention of medical related conditions rather than treating consequence of irresponsible behaviour of clients. This statement was emphasised by Van Rensburg (2004:242). Promoting good health and preventing diseases were stated in 1994 as the central to the success of Primary Health Care (ANC, 1994:np). However, Western Cape Government did emphasised changes towards improving the wellness of everybody instead of treating the consequences of the burden of disease (DoH, 2013c:15). This strategy needs aggressive promulgation. Results on limited human resources and inability to cope with increased workloads emphasise the importance to shift focus from curative care to preventative care. Community empowerment and participation of citizens needs to be accentuated. Responsibility towards healthier lifestyles will release the stress on health care workers. Citizens are well informed on their rights towards receiving quality services but seem not being informed on their

responsibility towards their own health and health services. The community therefore, have to take ownership and responsibility for their own health care at personal level and must get involved in decision making and governance of the health services as stated by the Western Cape Government DoH (2013c:29-30). This is evident to finding of Boran, Shawaheen, Khader, Amarin and Hill Rice (2012:146) where uncooperative patients were seen as an important key source of stress.

Learners tend to leave school at an early age, as described in Paragraph 2.2.4.5, which means that they are not exposed to proper life orientation programmes. This inhibits learners from making responsible choices on their lifestyle and health. Nurses do not have enough time to spend on education to empower patients/clients to make informed decisions. Such health information is extremely important to ensure patients/clients to prevent diseases, or to understand their condition properly. Limited time to provide information has a negative impact on patients/clients ability to give their full support regarding improving their health status. Workload will be minimised when strategies are implemented to empower community members with relevant health education. It will increase the prevention of unwanted diseases/situations and may improve the ability to treat minor ailments at home before attending health facilities. The Cape Town Declaration illustrated the importance of the implementation of wellness actions in the Draft of HealthCare 2030 (Western Cape Government, 2013c:18).

Qualified and motivated health educators with adequate knowledge and experience in health sciences should be appointed to act as health promoters in health settings. This will assist citizens in making informed decisions towards their own health and will prevent risky behaviour which cause overloaded health services as indicated by Van Rensburg (2004:242,234).

Government should reconsider payment systems for primary health care providers that combine components of payment, free choice of provider and fee-for-service which will foster better possibilities for managing the system. The latter will lead to achieving high quality, cost-effective use of resources and will secure satisfaction for the user, as well as the provider (WHO, 1998:27). Abusive behaviour of citizens adds to the workload of exhausted employees as confirmed by a study done by Hall (2004:28). Everybody has the right to get quality care. Valuable time is spent on unnecessary visits while people in need for proper attention cannot receive quality treatment and care.

5.4.3 Fair Labour Practices

Subjects mentioned their inability to take lunch breaks, and no acknowledgement for working overtime as reasons for experiencing burnout. It is evident that employees have no choice to work overtime; or through their lunch intervals in order to render health care and to cope with the escalating demands. Rossouw (2012:11) indicated the number of hours worked as an important factor which contributes to burnout. Basic conditions of employees Act as amended (Act 75 of 1997) need to be put in practice regarding working through meal intervals and overtime.

It is the responsibility of the employer to give an employee who works continuously for more than five hours a meal interval. This Basic Conditions of Employment Act (Act 75 of 1997) makes provision for an employer to require or permit employees to perform only duties during a meal interval that cannot be left unattended and cannot be performed by another employee (RSA, 1997c:np). PHC nurses working on Mobiles and in Satelite clinics are more likely to work through lunch breaks due to heavy workloads as they do not have additional PN's or CNP's to relieve them. In such circumstances an employee should receive remuneration as subscribed by the law (RSA, 1997c:np).

Overtime is defined as the time that an employee works during a day or a week in excess of ordinary hours of work (RSA, 1997c:np). Regulations state that an employer may not require or permit an employee to work overtime except in accordance with an agreement (RSA, 1997c:np). Findings in this study regarding working overtime confirm a statement done by Van der Westhuizen (2008:50) where available time shortage was seen as a major problem in nursing.

Working overtime or through meal intervals is not negotiable to nurses as they have to adhere to the verbal agreement made by them on convictions about nursing in respect of the Nurses' Pledge/code of service (Muller, 2008:4-5). They have solemnly pledged themselves to the service of humanity and endeavour to practise their profession with conscience and with dignity (Muller, 2008:4). No agreements, as promulgated by the law have been made regarding this matter as managers do not acknowledge working overtime.

The consequences will be catastrophic if all PHC nurses ignore the Nurses' Pledge/code of service and if they adhere strictly to their rights as employees. Negligence of the employer to obey to the abovementioned legislation may aggravate the strong feelings expressed by subjects on the lack of organisational support as a factor contriubuting towards burnout. This lack of organisational support should be a concern for any organisation to prevent development of disengagement amongst employees (Van der Colff & Rothmann, 2009:8).

5.4.4 Reward and Appreciation System

The current practice of rewarding and offering of bonuses for performance, innovations or achievements, named as the Western Cape Provincial Government's Staff Performance Management System, is seen as unfair and inefficient. This system was indicated by subjects as another reason for experiencing burnout. Subjects expressed a very strong request to eradicate this method of showing appreciation. Leiter and Maslach (2009:337) proved that nurses who experience incongruity in rewards are more likely to show cynicism about their work.

Subjects suggested that employers should acknowledge working overtime or working through meal intervals, and asked for compensation accordingly. A nursing model of care in PHC facilities should be developd to increase fairness of professional and organisational values (Leiter & Maslach, 2009:338).

Subjects recommended unpaid leave when needed, to increase current leave periods, to allow reduced hour posts, and to appoint additional qualified personnel who will act as relievers to allow exhausted personnel to take breaks when needed.

The Public Service Co-ordinating Bargaining Council (PSCBC) should reconsider the inclusion of Clinical Nurse Practitioners in the scarce skills categories. The designated rural areas that were identified to qualify for rural allowances needs to be adjusted (PHWSBC, 2004:np). PHC services are rendered from clinics which are concentrated in rural areas where access to health services is constrained by geographical and other infrastructural challenges (PGWC DoH, 2010a: 63-71). This issue needs to be evaluated as incongruences may intensify cynical feelings amongst PHC nurses.

5.4.5 Monitoring of changes to documentation

Frequent adjustments to documentation due to constant changes to policies and protocols, needs to be monitored. The value and appropriateness of the large variety of documentation must be reconsidered as subjects feel they are fighting a "paper war". This is possibly the reason why limited time is available to spend on quality service delivering and patient care as stated by Van der Westhuizen (2008:50). Timeframes should be identified for implementation of new protocols and changes to policy documents, as well as revised documentation as nurses struggle to keep up with the escalating demands made on them. Dates need to be added to each newly implemented document to enable nurses to keep track of specific changes. Finalisation of documentation before distribution will decrease frustration amongst nurses.

5.4.6 Organisational support and management skills

This study proof the need for in-depth consideration towards development and improvement of basic management skills as stated by previous research studies (Hall, 2004:28; Kekana *et al.*, 2007:24; Baloyi, 2009:145; Oosthuizen, 2009:238-240). This includes skills in problem solving, communication skills, listening skills, conflict management, to learn to deal with issues of personnel confidentially, proper equipment distribution and transport management. Managers should be supportive, manage employee allocation properly and should show appreciation. Attention to the above-mentioned will improve low motivational and low job satisfaction levels.

The Western Cape Government identified challenges as indicated in the recent staff satisfaction survey toward achieving the objectives of a patient-centred service. Focus will be on re-engaging employees; building renewed commitment; creating a positive attitude towards the organisation; developing an environment where staff feels stimulated and listened to; and to support employees in creatively addressing their challenges (Western Cape Government DoH, 2013c:xv).

Basic knowledge on ethics is important to meet the specific moral problems that occur within the context of nursing practice (Pera & Van Tonder, 2011:8). Scientific evidence in this study shows management's inability to include employees in planning, monitoring and evaluation in the goal towards quality service delivering on PHC level as stipulated in Paragraph 2.2.3.10 (NDoH, 2009:2-7 [Part 2]). It is of utmost importance for supervisors to provide a supportive monitoring visit to each PHC facility at least once a month. The intention for this visit should be to support personnel, to monitor the quality of service and to identify the needs and priorities at each facility. This will contribute to the shared goal of improving quality PHC as stipulated in the PHC Facility Supervision Manual (NDoH, 2009:2 [Part 1]).

Management needs to reinstate an environment where nursing practitioners can demonstrate the characteristics of professionalism, which could enhance their loyalty and pride of the nursing profession as stated by Muller (2008:18-20). In addition it might reduce the prevalence of burnout. Management should possess basic and specialised knowledge. This includes knowledge of the latest developments in the specific discipline, which includes all the professional regulations and legistlation thereof. Theoretical knowledge is important to maintain a high standard of nursing practice. A professionally mature nursing manager should display positive leadership in their daily practice. Self-regulation and self-control is important, in order for managers to maintain a positive professional image. The personal and

professional appearance and conduct of managers will be conveyed positively and will encourage sub-ordinates to act accordingly (Muller, 2008:18-20).

5.4.6.1 Unproductive co-workers

Unproductive co-workers were seen as a major problem and could be the result of employees who are experiencing high levels of EE. Early identification of burnout and constant motivation could reduce unproductivity. The lack of motivation at work may cause employees to obtain support from friends via social networks due to withdrawal from and indifferent attitudes towards their job as indicated by Van der Colff and Rothmann (2009:7-8). The use of cell phones while on duty should be restricted. Better control of tea, lunch and toilet breaks in some instances need attention. An electronic identification system should be implemented in facilities to control the attendance of all employees. Increased productivity will not only reduce pressure on well dedicated and committed fellow-workers but might minimise the prevalence of burnout.

5.4.6.2 Participation in Decision-making

It is important to give employees the opportunity to participate in decision-making regarding their immediate working environment. Discretion on the day-to-day operational decisions will allow employees to influence their own working situations, work methods and pace as stated by Van Yperen and Hagedoorn (2003:346). Every organization should strive to have the right balance between job demands and job resources in order to prevent burnout (Bakker *et al.*, 2006:485).

5.4.6.3 Climate Meetings

Some subjects expressed negative feelings on receiving notes of meetings without any interaction between management and employees. The interaction on a monthly base between management and employees was suggested to allow employees to discuss written minutes and unclear issues. Frequent climate meetings should be held where employees get the opportunity to express unwanted feelings. This will eliminate negative attitudes in the workplace. Proper communication will improve job satisfaction and eventually organisational outcomes as indicated by Bester (2009:153). Problems or frustrations should be discussed at meetings where employees have the choice to participate in solving problems, as well as to foster a good sense of commitment (Bakker *et al.*, 2006:485).

5.4.6.4 Improve interpersonal skills

Refining interpersonal skills by clarifying misunderstandings, providing constructive feedback and asking for help from others (Van Yperen and Hagedoorn, 2003:346) could decrease negative feelings amongst employees and might increase a positive work climate. Managers

should share positive experiences and limit the prolonged exchange of cynical and negative information in conversations (Bakker *et al.*, 2006:485).

5.4.6.5 Recognise employee's potential

Subjects expressed their negative feelings about management who do not recognise employee's potential in decision making. Van Yperen and Hagedoorn (2003:339) state in their study the importance of organizations to maximise the use of their employees' actual and potential skills in order to become successful. Searle (2008:91) stated that professional freedom of choice is essential for accountability for all nurse's actions and omissions (Muller, 2008:52). This extends beyond the freedom to choose in which area to practice relevant to the knowledge and expertise of the practitioner. Nurses have the freedom to act responsibly, to think creatively and independently about challenges, to disagree with attitudes that affect their patients and their profession adversely and to explore new thoughts and new ways of improving the quality of nursing and professional skill and satisfaction of their profession (Searle, 2008:91).

5.4.6.6 Equipment, Stock, More Space and Advanced Technology

A lack of equipment was identified by nearly 70% of subjects as a factor which increases the prevalence of burnout. Adequate stock and sufficient equipment should be available and in working order at all times to perform quality patient care. This findings is evident to findings identified by Hall (2004:28) where lack of equipment was seen as a factor which leads to a stressed workforce. The implementation of advanced technology could save time in overloaded facilities. Inappropriate distribution of equipment may be reasons why nurses are inhibited to render quality care. Better administration is needed to secure well equipped facilities in order to render quality care. This statement was proofed during a documentary (Cart Blanche, 2013).

5.4.6.7 Competent educators

Well informed, motivated and competent educators could reduce burnout. Improper in-service training in some instances was identified as increasing frustrations amongst nurses. Opportunities for development are important to irradicate the negative effect of job demands (Xanthopoulou *et al.*, 2007:782).

5.4.6.8 Pro-active action and assessments

The early identification of signs of burnout, as well as monitoring the levels thereof is important. Managers should be trained to observe for signs of this phenomenon (Bakker *et al.*, 2006:485). Maslach and Leiter (2008:510) emphasised the importance of frequent

"check-ups" and repeated assessments by organisations. They also suggested more extended and deliberate efforts to handle existing signs of burnout.

5.4.6.9 National Health Insurance (NHI) model

Government urges the implementation of the National Health Insurance (NHI) model. Eden District was chosen as one of the 10 districts nationally to pilot the NHI project (DoH, 2013:18-19). It is impossible to implement such a model with an exhausted workforce who are overworked already and where a strong lack of organisational support exists.

5.4.7 Burnout as an Occupational Health Concern

Health care personnel have the right to be protected against injuries or damage at their working establishment (NDoH, 2003:28). Part 24(1) of the Occupational health and safety Act (Act 85 of 1993) states that each incident occurring at work or arising out of or in connection with the activities of persons at work is considered an injury. Routine medical surveillance, which is defined as a planned programme or periodic examination (which may include clinical examinations, biological monitoring or medical tests) of employees by an occupational health practitioner or, in prescribed cases, by an occupational medicine practitioner (RSA, 1993:15), should be implemented in PHC facilities.

Proper interventions need to be specified to evaluate burnout as an occupational injury and strategies to keep employees healthy by staying free from illness or injury due to occupational causes.

Changes to the working environment in PHC settings will enhance work engagement and reduce burnout amongst PHC nurses. These actions will improve quality of patient care which will improve patient satisfaction as stated in a study done by Vahey et al. (2004:np).

Appreciation was expressed to all staff for their commitment and their investment towards the Western Cape Department of Health (DoH, 2013a:2). However, taking into consideration the outcome of this study, the question could be asked if carers are truly cared for. Revitalised actions will restore the feeling of being part of a profession that plays such an important role in the life of humankind to carry the touch of life and the message of faith, hope and love (Searle, 2008:93), which will eventually improve organisational outcomes.

5.5 LIMITATIONS OF THE STUDY

The limitations of a research study refer to the components of the study that may possibly impact on the generalisability of the results (Burns & Grove, 2007:37).

One sub-district, in addition to the sub-district where the researcher works, was excluded from the study due to time restriction. The participation of subjects in that specific sub-district could add to the findings on burnout as they are daily confronted with the large population migration.

Furthermore, some PHC nurse's who perform their duties on mobile clinics, were excluded as they had left for the day by the time the researcher reached their stations. Despite them not being available for participation in the study the finding of this study can still be generalised.

The rendering of core functions was respected by the researcher at each facility which resulted in delay. Work demands and limited human resources were possible reasons for the non-response and attrition rate and time delay.

5.6 RECOMMENDATIONS FOR FURTHER RESEARCH

The following research opportunities are:

- A longitudinal study on how community participation may reduce the workload or job demands on PHC level if community members are informed on how to take responsibility for their health.
- An investigation on how burnout can be prevented or identified at an early stage to secure a stable workforce to ensure better work engagement.
- A longitudinal study on the occurrence of burnout amongst PHC nurses, once improved organisational support and management practices are implemented.
- An evaluation of the knowledge of nursing managers on relevant regulations and legislation related to PHC services.
- An action based study for the development of improved preventative services with the intention to reduce the heavy workload in PHC facilities.
- An exploratory study on the use of alcohol or tranquiliser to manage stress amongst primary health care workers.

5.7 CONCLUSIONS

By examining burnout amongst primary health care nurses in the Eden District of the Western Cape, this study confirmed the existence of high levels of burnout in the cohort. Numorous factors contributing to burnout were identified. Based on the conceptual framework, the Job Demands-Resources (JD-R) model, applied in this study, it was evident that chronic job demands drains the mental and physical resources of employees and therefore leads to the depletion of energy and eventually causes burnout. The current high levels of burnout consequently do affect the outcome in service delivery in the Eden District.

APPENDIX A

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Approved with Stipulations
New Application

10-Apr-2013
Muller, Anna AP
Stellenbosch, WC

Ethics Refernce #: S13/03/044
Title: Burnout amongst primary health care nurses : A cross-sectional study

Dear Mrs Anna Muller,

The **New Application** received on **12-Mar-2013**, was reviewed by members of **Health Research Ethics Committee 1** via Expedited review procedures on **10-Apr-2013**.

Please note the following information about your approved research protocol:

Protocol Approval Period: **10-Apr-2013 -10-Apr-2014**

The Stipulations of your ethics approval are as follows:
Burnout is often recognised as a health and safety issue therefore there should be feedback to the employer if this problem is identified from the study.

Please remember to use your **protocol number** (**S13/03/044**) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:
Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired.
The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.
Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.
For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:
Application form
SYNOPSIS
CV COHEN
CV MULLER
IC CONSENT

APPENDIX B

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857: fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: RP 76/2013
ENQUIRIES: Ms Charlene Roderick

P.O. Box 400
Mossel bay
6500

For attention: **Anna P Muller**

Re: Burnout amongst primary health care nurses: A cross-sectional study

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Eden District **Terence Marshall** **Contact No. 044 803 2752**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

pp

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE:
CC **DR H SCHUMANN** **DIRECTOR: EDEN & CENTRAL KARO**

Page 1of 1

APPENDIX C

TAALSENTRUM
LANGUAGE CENTRE
IZIKO LEELWIMI

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

28 May 2013

Ms A Muller
PO Box 400
Mossel Bay
6500

Dear Ms Muller

The Stellenbosch University Language Centre hereby confirms that we completed a comparative edit of your leaflet and consent form, and the questionnaire. The Afrikaans and Xhosa translations of these documents (as listed below), which you supplied, were compared to the English source text and returned to you on 28 May 2013 with all editing changes visible in the track changes function of MS Word:

Translated texts edited	
Afrikaans	Xhosa
Deelnemer Inligtingspamflet en Toestemming vorm – final	IsiXhosa - consent and information form - final;
Vraelys Afrikaans - final;	IsiXhosa - questionnaire - final

Please contact me if you have any questions.

Regards

Alta van Rensburg

Head: Language Service

Stellenbosch University Language Centre

Tel: 021 808 2231

Fax: 021 808 2863

E-mail: avrens@sun.ac.za

APPENDIX D

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

Burnout amongst Primary Health Care nurses: a cross sectional study.

REFERENCE NUMBER:
S13/03/044

PRINCIPAL INVESTIGATOR:

Mrs Anna P. Muller

ADDRESS:

PO Box 400 Mossel Bay 6500

CONTACT NUMBER: 0825787350

You are invited to participate in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. A trained translator is available to explain unclear questions. Feel free to ask for translation or explanation. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee 1 at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- The study is being conducted in the community health care facilities in the Eden District, Western Cape.
- The purpose of the study is to evaluate the occurrence of burnout among primary health care nurses

Why have you been invited to participate?

- Your experience of burnout in your clinical practice is requested in order to scientifically measure the prevalence of burnout among nurses in the Eden District.

What will your responsibilities be?

- Your responsibility will be to complete the attached consent form and the questionnaire. This should not take longer than 30 minutes.

Who will benefit from taking part in this research?

- All professional registered nurses rendering care in the primary health care facilities in the Western Cape and ultimately the patients/clients who utilise the services.

Are there any risks involved in your taking part in this research?

- There are no risks or discomfort involved in participating in the study. Your privacy, confidentiality and anonymity are guaranteed.
- The results will be published or presented in such a fashion that you, as the respondent and employee, will remain unidentifiable.

If you do not agree to take part, what alternatives do you have?

- You may at any time withdraw or not participate at all in this study and you will not be discriminated upon.

Will you be paid to take part in this study and are there any costs involved?

- No, you will not be paid to take part in the study. There will be no costs involved for you, if you do take part.

Is there anything else that you should know or do?

- This study involves signing a consent form and completing the questionnaire. Both documents should be placed in the envelope provided. Two secure boxes will be provided: one for the consent forms and one for the questionnaire.

Declaration by participant

By signing below, I ……..…….

agree to take part in this research project entitled:

"Burnout amongst Primary Health Care nurses: a cross sectional study"

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to participate.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2013

....

Signature of participant **Signature of witness**

Declaration by investigator

I *(name)* ……..…… declare that:

- I explained the information in this document to ……..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use an interpreter. (*If an interpreter is used then the interpreter should sign below.)*

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 2013

....

Signature of investigator **Signature of witness**

……

Signature of interpreter

APPENDIX E

Inligtingspamflet en toestemmingsvorm vir deelnemers

TITEL VAN DIE NAVORSINGSPROJEK:

Uitbranding onder verpleegkundiges in primêre gesondheidsorg: ’n deursneestudie

VERWYSINGSNOMMER:

S13/03/044

HOOFNAVORSER:

Mev Anna P Muller

ADRES:

Posbus 400, Mosselbaai 6500

KONTAKNOMMER: 082 578 7350

U word genooi om aan ’n navorsingsprojek deel te neem. Lees asseblief deur die inligting in hierdie pamflet, wat die besonderhede van hierdie projek uiteensit. Vra gerus die navorser oor enige deel van hierdie projek wat u nie ten volle verstaan nie. ’n Opgeleide tolk is beskikbaar om onduidelike vrae te verduidelik. Moenie huiwer om te vra dat inligting getolk of verduidelik word nie. Dit is baie belangrik dat u verstaan presies wat die navorsing behels en hoe u daarby betrokke kan raak. Onthou ook, u deelname is **geheel en al vrywillig**; u mag weier om deel te neem. Indien u die uitnodiging van die hand wys, sal dit u geensins negatief beïnvloed nie. U mag ook in enige stadium aan die studie onttrek, selfs al het u aanvanklik tot deelname ingestem.

Hierdie studie is deur die Gesondheidsnavorsingsetiekkomitee 1van die Universiteit Stellenbosch goedgekeur. Dit sal volgens die etiekriglyne en -beginsels van die internasionale verklaring van Helsinki, die Suid-Afrikaanse riglyne vir goeie kliniese praktyk en die Mediese Navorsingsraad (MNR) se etiekriglyne vir navorsing uitgevoer word.

Waaroor handel hierdie navorsingstudie?

- Die studie sal in die gemeenskapsgesondheidsorgfasiliteite in die Eden-distrik, Wes-Kaap, uitgevoer word.
- Die doel van die studie is om die voorkoms van uitbranding by verpleegkundiges in primêre gesondheidsorg te beoordeel.

Hoekom word u genooi om deel te neem?

- Ons wil u graag na u ervaring van uitbranding in u kliniese praktyk uitvra om die voorkoms van uitbranding onder verpleegkundiges in die Eden-distrik wetenskaplik te meet.

Wat sal u verantwoordelikhede behels?

- U sal verantwoordelik wees om die aangehegte toestemmingsvorm en vraelys te voltooi. Dit behoort nie langer as 30 minute te duur nie.

Wie sal by deelname aan hierdie navorsing baat vind?

- Alle professionele geregistreerde verpleegkundiges wat in primêre gesondheidsorgfasiliteite in die Wes-Kaap werk, en uiteindelik ook die pasiënte/kliënte wat van hierdie dienste gebruik maak.

Is daar enige risiko's verbonde aan u deelname aan hierdie navorsing?

- Daar is geen risiko's of ongerief verbonde aan u deelname aan die studie nie. Privaatheid, vertroulikheid en anonimiteit word gewaarborg.
- Die resultate sal so gepubliseer of aangebied word dat u nie as deelnemer of werknemer uitgeken sal kan word nie.

Watter ander moontlikhede is daar indien u besluit om nié deel te neem nie?

- U mag in enige stadium aan hierdie studie onttrek óf glad nie deelneem nie, sonder dat daar teen u gediskrimineer sal word.

Sal u betaling ontvang vir u deelname aan die studie, en is daar enige koste aan verbonde?

- Nee, u sal nie vir u deelname aan die studie betaal word nie. Indien u sou deelneem, sal dit u niks kos nie.

Is daar enigiets anders wat u moet weet of doen?

- Vir hierdie studie moet u 'n toestemmingsvorm onderteken en 'n vraelys voltooi. Die twee dokumente moet geplaas word in die koeverte wat aan u voorsien sal word. Daar sal twee verseëlde bokse beskikbaar wees: een vir die toestemmingsvorms en die ander vir die vraelyste.

Verklaring deur deelnemer

Deur hieronder te teken, stem ek, ……., in om deel te neem aan hierdie navorsingsprojek getiteld:

"Uitbranding onder verpleegkundiges in primêre gesondheidsorg: 'n deursneestudie".

Ek verklaar soos volg:

- Ek het hierdie inligtingspamflet en toestemmingsvorm gelees, of dit is aan my voorgelees, en dit is geskryf in ’n taal waarmee ek vertroud en gemaklik is.
- Ek is die geleentheid gegun om vrae te stel en ál my vrae is voldoende beantwoord.
- Ek verstaan dat deelname aan hierdie studie **vrywillig** is, en niemand het my gedwing om deel te neem nie.
- Ek mag in enige stadium aan die studie onttrek sonder dat ek enigsins gestraf of benadeel sal word.

Geteken te (plek) ……. op (datum) …….. 2013

…….. ……..
Handtekening van deelnemer **Handtekening van getuie**

Verklaring deur navorser

Ek (naam), ……, verklaar hiermee soos volg:

- Ek het die inligting in hierdie dokument aan ……. verduidelik.
- Ek het hom/haar aangemoedig om vrae te stel en het genoeg tyd daaraan bestee om dit te beantwoord.
- Ek is tevrede dat hy/sy alle aspekte van die navorsing, soos dit hierbo uiteengesit word, voldoende verstaan.
- Ek het (nie) ’n tolk gebruik (nie). (*Indien ’n tolk gebruik is, moet die tolk hieronder teken.)*

Geteken te (plek) ……. op (datum) …….. 2013

…….. ……..
Handtekening van navorser **Handtekening van getuie**

.....
Handtekening van tolk

APPENDIX F

IsiXhosa - Iinkcukacha nemvume yomthathi-nxaxheba

Isihloko senkqubo yophando

Ukudinwa okanye ukusebenza ngokuzibulala konompilo: Uphononongo lweli candelo kule ngingqi.

INOMBOLO YESINGQINISO:
S13/03/044

UMPHENGULULI OYINTLOKO:

Ngu: Nkosikazi u-Anna P. Muller

IDILESI:

P.O. Box 400 Mossel bay 6500

Inombolo yocingo: 082 578 7350

Uyamenywa ukuba uthathe inxaxheba kweli candelo lophando. Nceda uthathe ixesha lakho ukufunda le nkcazo yondlalwe apha, eyiyeyona iya kuchaza iinkcukacha zolu phando. Nceda umbuze imibuzo ongayiqondiyo apha kolu phando lowo uphandayo. Umntu oqeqeshelwe ukuguqula iilwimi uza kukucacisela ngemi buzo ongayiqondiyo. Kubalulekile ukuba ucacelwe kakuhle yinto equlathwe lolu phando, kwanokuba wena ubandakanyeka njani kulo. Ukuthatha kwakho inxaxheba akusiso isinyanzelo kwaye uvumelekile ukwala ukuthatha inxaxheba akukho nto iza kukuchaphazela. Uvumelekile ukurhoxa nakwesiphina isigaba solu phando nokuba ubusele uvumile.

Icandelo elizimeleyo lokuncedisana nokucebisa abaqeshwa becandelo lezempilo leNtshona Koloni likhona. Uyakhuthazwa ukuba ubatsalele umnxeba kule nombolo (ICAS) 0800 611 093 xa unengxaki onayo okanye into ethe yakukhathaza emveni kokuphendula le mibuzo.

Olu vavanyo okanye uphononongo lufumene imvume kwikomiti yeenkcukacha Zoluntu kwiDyunivesithi yaseStellenbosch kwaye luza kubanjwa ngaphantsi kwemigaqo-siseko neengcebiso zesivumelwano zeHlabathi se-Helsinki, umgaqo-siseko wecandelo lokulolonga nophando loMzantsi Afrika.

Lungantoni olu phando?

- Olu phando lwenziwa kwizibonelelo zonakekelo lwezempilo yoluntu kwiNgqingqi yase-Eden eNtshona Koloni.

- Lwenzelwe ukukhangela imbangi yokudinwa ngokumandla kwabasebenzi bezempilo (onompilo) eklinikhi.

Kutheni lento uceliweyo ukuba uthathe inxaxheba kolu phando?

- Njengomntu ochatshazelweyo koku kudinwa kumandla kwindawo yakho yengqesho uyacelwa ukuba uthathe inxaxheba ekufumaniseni ubungakanani bokuchatshazelwa kwabongikazi kwiNingqi yase-Eden.

Yintoni inxaxheba yakho?

- Inxaxheba yakho kukuzalisa isivumelwano kunye nemibuzo ebuziweyo. Akusayi kuthatha ngaphezu kwemizuzu engamashumi amathathu.

Ngubani oza kuzuza ngokuthatha inxaxheba kolu phando?

- Ngabo bonke abongikazi abanika inkonzo yezempilo kumaziko ezempilo oluntu (kwiiklinikhi) kwiPhondo leNtshona Koloni kwakunye nezigulane nabantu abasebenzisa la maziko ezempilo

Ingaba kukhona imingcipheko ngokuthatha kwakho inxaxheba kolu phando?

- Akukho bungozi okanye kungakhuseleki ekuthabatheni inxaxheba. Ukuba yimfihlo nokungavezwa kwegama lakho kuyaqinisekiswa.
- Iziphumo ziya kukhutshwa ngendlela eyimfihlo.

Ukuba akufuni kuthatha inxaxheba yeyiphi enye indlela onayo?

- Uvumelekile ukurhoxa ngalo naliphina ixesha akuz'ukucalucalulwa.

Ingaba uza kuvuzwa ngokuthatha inxaxheba?

- Hayi, akukho ntlawulo okanye nzuzo ikhoyo.

Ingaba ikhona enye into ofuna ukuyazi okanye ukuyenza?

- Olu phando luqulathe isivumelwano nemibuzo ephendulweyo, kwaye wakugqiba ukuzalisa okanye ukuphendula imibuzo unika isivumelano ngokusayina kufakwe emvulophini. Kuya kusetyenziswa iibhokisi. Kuza kufakwa imibuzo kwenye ize enye ibe yeyezivumelwano. Zombini ezi bhokisi ziza kuvalwa zitywinwe.

Isibhengezo somthathi-nxaxheba:

Ngokusayinwe ngezantsi mna …….. ndiya vuma ukuthatha inxaxheba kolu phando lunesihloko esithi:

"Ukudinwa okumandla kubongikazi abasebenza eziklinikhi: uphononongo lweli candelo kule ngingqi."

Ndiyazisa ukuba:

- Ndizifundile okanye ndizifundelwe zonke iinkcukacha kunye nesivumelwano kwaye sibhalwe ngolwimi endilwaziyo nendikhululekileyo kulo.
- Ndinikiwe ithuba lokubuza imibuzo kwaye yonke imibuzo iphendulwe ngokwanelisayo.
- Ndiyayazi ukuba ukuthatha kwam inxaxheba kukuzithandela andinyanzelwanga.
- Ndinako ukurhoxa kolu phando kwaye andiz'ukohlwaywa okanye ndicalulwe ngokwenza njalo.

sibhalwe e (indawo) …….ngomhla……...2013.

…… ……..

Igama lomthathi-nxaxheba **Igama lengqina**

Isibhengezo somphengululi

Mna (igama) ……. Ndiyazisa ukuba

- Ndizichazile iinkcukacha ezikolu phando ku (igama)……..
- Ndimkhuthazile ukuba abuze imibuzo kwaye athathe ixesha lakhe ukuyiphendula.
- Ndikholiwe yindlela athathe ngayo inxaxheba kolu phando.
- Ndisebenzise okanye andisebenzisanga toliki, ukuba kusetyenziswe itoliki nayo mayisayine ngezantsi
- sibhalwe e (indawo) ……..ngomhla ……..2013.

…… ……..

Igama lomphengululi **Igama lengqina**

……

Igama letoliki

APPENDIX G

QUESTIONNAIRE

INSTRUCTIONS:

- This questionnaire consists of four sections and will take approximately 30 minutes to complete.
- Please use a black ballpoint pen to complete the questionnaire.
- Please answer the closed-ended questions by marking your choice / view / experience with a tick (√), e.g.:
  Do you work in a clinic?

  a. Yes ☑
  b. No ☐
- Please answer the open-ended questions by expressing your true feelings in writing.
- Place the completed questionnaire in the self-sealing envelope provided. Post it in the sealed "Questionnaires" box.

TAKE NOTE: *This questionnaire will be completed anonymously. A trained translator is available to explain unclear questions. Feel free to ask for translation or explanation.*

Part 1: Demographic and Professional Profile

No.	Demographic Information
01	Indicate your gender a. Male ☐ b. Female ☐
02	Indicate your age ☐
03	Indicate your race a. Black ☐ b. Coloured ☐ c. Indian ☐ d. White ☐
04	Indicate your years of experience in PHC ☐
05	I have completed the following course in PHC a. Certificate ☐ b. Diploma ☐

	c. None ☐
06	I am… a. Permanently employed ☐ b. Employed on contract ☐
07	I spend most of my time working on/in a a. Community Day Centre ☐ b. Community Clinic ☐ c. Satellite Clinic ☐ d. Mobile Clinic ☐
08	I am predominantly responsible for rendering a. Preventative services ☐ b. Curative services ☐ c. Comprehensive services ☐

Part 2: Factors contributing to burnout

	Please rate the factors contributing to burnout in your facility by scoring each item on the range from 1 to 5. A score of 1 means "strongly disagree" and a score of 5 means "strongly agree." Choose "Neutral" only if you are really unsure.					
No.	**Factors causing burnout**	**Strongly Disagree 1**	**Disagree 2**	**Neutral 3**	**Agree 4**	**Strongly Agree 5**
09	I feel that my workload or increase in job demand is the reason for burnout					
10	I feel that management problems causes burnout					
11	I feel that insufficient training cause burnout					
12	I feel that the tendency to work overtime causes burnout					
13	I feel that low levels of job satisfaction causes burnout					
14	I feel that lack of motivation causes burnout					
15	I feel that the lack of organisational support leads to burnout					
16	I feel that inadequate human resources causes burnout					
17	I feel that my personal problems beyond the workplace causes burnout					
18	I feel that financial constraints causes burnout					

	Factors causing burnout	Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5
19	I feel that unproductive co-workers causes burnout					
20	I feel that the lack of equipment causes burnout					
21	I feel that pressure under which I am working cause burnout					
22	I feel that communication problems cause burnout					

Part 3: Human Services Survey: Job-related feelings

In this survey *Recipients* to refer to the people for whom you provide your service, care, treatment or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your place of work.

Instructions: In this section you will find 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number "0" (zero) in the space after the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. If you rarely have the feeling at work (a few times a year or less), you could write the number "1." If you are experiencing the feeling frequently (every day), you would write the number "6."

No.	Job-related feelings	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
		0	1	2	3	4	5	6
23	I feel emotionally drained from my work.							
24	I feel used up at the end of the workday.							
25	I feel fatigued when I get up in the morning and have to face another day on the job.							
26	I can easily understand how my recipients feel about things.							

	Job-related feelings	**Never**	**A few times a year or less**	**Once a month or less**	**A few times a month**	**Once a week**	**A few times a week**	**Every day**
		0	**1**	**2**	**3**	**4**	**5**	**6**
27	I feel I treat some recipients as if they were impersonal objects							
28	Working with people all day is really a strain for me.							
29	I deal very effectively with the problems of my recipients.							
30	I feel burned out from my work.							
31	I feel I'm positively influencing other people's lives through my work.							
32	I've become more callous toward people since I took this job.							
33	I worry that this job is hardening me emotionally.							
34	I feel very energetic.							
35	I feel frustrated by my job.							
36	I feel I'm working too hard on my job.							
37	I don't really care what happens to some recipients.							
38	Working with people directly puts too much stress on me.							
39	I can easily create a relaxed atmosphere with my recipients.							
40	I feel exhilarated after working closely with my recipients.							
41	I have accomplished many worthwhile things in this job.							

	Job-related feelings	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
		0	1	2	3	4	5	6
42	I feel like I'm at the end of my rope.							
43	In my work, I deal with emotional problems very calmly.							
44	I feel recipients blame me for some of their problems.							

For administrative use only

EE:____ cat:_____ DP:_____ cat:_____ PA:_____ cat:_____

Part 4: Burnout in your working environment

Please answer the following questions by expressing your true feelings.

45. How do you think the effect of burnout affects quality patient care in your work environment?

……
……
……
……
……

46. Which supportive systems can you rely on when you need support?

……
……
……
……

47. Please provide a suggestion as to how burnout could be reduced where you work?

……

……

……

……

……

TAKE NOTE: *The Independent Counselling and Advisory Services (ICAS) is a confidential support service for all employees of the Western Cape Department of Health. You are hereby encouraged to phone the toll free number of ICAS (0800 611 093) if you need emotional support after completing this questionnaire.*

Thank you for your willingness to participate in this research study!

APPENDIX H

Iphepha lemibuzo

IMIYALELO:

- Eli phepha lemibuzo linezahluko ezihlanu kwaye ziya kuthatha imizuzu emashumi amathathu ukuyigqiba.
- Nceda sebenzisa usiba olumnyama ukuphendua imibuzo.
- Nceda phendula imibuzo ekwizangqa ngophawu (√) kulo mpendulo uyikhethileyo. Umzekelo ngophawu,

  Uphangela ekliniki?

  a. Ewe ☑
  b. Hayi ☐

- Nceda uphendule iimpendulo ozinikiweyo ngokubonakalisa ukunyaniseka kuleyo uyikhethileyo.
- Faka iphepha lemibuzo eligcwalisiweyo imvulophu enesincamatheli uze wakugqiba uyifake okanye uyipose kwibhokisi etywiniweyo.

QAPHELA: *Le mibuzo iya kuphendulwa ngaphandle kokuzichaza ukuba ungubani. Itoliki ikhona ukuze iphendule imibuzo engacacanga. Khululeka ukubuza xa ufuna ukucaciselwa okanye ukutolikelwa.*

Isahluko sokuqala: Iinkcukacha zokuhlala, ukuzalwa nokuphangela

Namba	Iinkcukacha zokuzalwa, ukuhlala nokuphangela
01	Bonisa ubuni bakho a. Indoda ☐ b. Umfazi ☐
02	Iminyaka yakho ☐
03	Ubuni bakho a. umXhosa ☐ b. Umntu webala ☐ c. Indiya ☐ d. Umlungu ☐
04	Iminyaka yakho yokusebenza njengonompilo ☐

05	Ndaphumelela esi siqinisekiso sobongikazi a. Isiqinisekiso sesatifiketi ☐ b. Isiqinisekiso sediploma ☐ c. Nanye kwezi zingentla ☐
06	Ndi… a. Qeshwe ngokusisigxina ☐ b. Qeshwe okwethutyana ☐
07	Ndichitha ixesha elininzi ndisebenza a. kwicandelo lezigulana zasemini ☐ b. kwicandelo loluntu (kliniki) ☐ c. kwicandelo elingesiso isigxina ☐ d. kwicandelo Iezempilo elingumahamba-ngendle ☐
08	Ikakhulu ndinoxanduva lokuhambisa ezi nkonzo a. Iinkonzo zokhuselo ☐ b. Iinkonzo zokunyanga ☐ c. Iinkonzo eziqukayo ☐

Isahluko sesibini: Izinto ezikhokelela kuxinzelelo olumandla

	Nceda thelekisa izinga loxinzelelo olumandla kwindawo yakho yengqesho ngokuthelekisa ukusuka kwisi-1 ukuya kwisi-5 isi-1 – akuvumi kwaphela isi-5 – uvuma ngokupheleleyo. Khetha uphakathi xa ungaqinisekanga ngempendula.					
Inombolo	**Izinto ezibanga uxinzelelo okanye ukudinwa**	**Akuvumi kwaphela** **1**	**Akuvumi** **2**	**Phakathi** **3**	**Uyavuma** **4**	**Uyavuma ngokupheleleyo** **5**
09	Ingathi umthamo womsebenzi wam okanye ukwanda komsebenzi kuko okwenza ukudinwa					
10	Ingathi abaphathi bam ngabo abenza uxinzelelo					
11	Ingathi ukungaqeqeshwa ngokwaneleyo kuko okwenza olu xinzelelo					
12	Ingathi kukuphangela ngaphaya kwexesha ofanele ukuphangela ngalo					
13	Ingathi ukungoneliswa ngumsebenzi owenzayo ngowona nobangela					
14	Ingathi ukuswela kokukhuthazwa nako kunegalelo					

		1	2	3	4	5
15	Ukungafumani nkxaso emibuthweni kwenza uxinzelelo					
16	Ukungabikho kwabalawuli babantu nezinto zokusebenza					
17	Iingxaki zam ngaphandle komsebenzi zizo ezenza ukukhathala					
18	Iingxaki zemali zizo ezenza olu xinzelelo					
19	Abasebenzi abangenazakhono zomsebenzi					
20	Ukunqaba kwezixhobo zokusebenza					
21	Uxinzelelo endiphangela phantsi kwalo					
22	Ukungabikho konxulumano olululo kuko okwenza oku kudinwa					

Isahluko sesithathu: Iinkonzo zoluntu: Iimvakalelo ezinxulumene nomsebenzi

Kolu vavanyo *abaXhamli* babhekiselele kubantu obancedayo nobakhathalelayo ngokubanyanga nokubafundisa. Xa uphendula olu vavanyo nceda ucinge ngabo bantu baphantsi kokhuselo nenkathalo yakho.

Imiyalelo: Kweli candelo uza kufumana iingxelo ezingama-22 ezinxulumene nendlela oziva ngayo ngomsebenzi wakho. Funda ingxelo nganye ukhangele ukuba ingaba ukhe ucinge ngale ndlela ngomsebenzi wakho. Ukuba awukhe ube nayo le mvakalelo, bhala u-“0” kwisithuba esilandela ingxelo. Ukuba ukhe wanayo le mvakalelo, bonisa ukuba uyiva kangakanani ngokubhala phantsi amaxesha okhe ube nayo ngawo ukusuka ku-“1” ukuya kwisi-“6” .Ukuba awufane uyifumane okanye uzive njalo ngomsebenzi wakho (amaxesha ambalwa ngonyaka okanye nganeno) bhala u-“1“, ukuba uyifumana rhoqo (yonke imihla) bhala u-“6”.

Inombolo	**Iimvakalelo ezinxulumene nomsebenzi**	Azange	Amaxesha ambalwa ngonyaka okanye ngaphantsi konyaka	Kanye okanye ngaphantsi ngenyanga	Amaxesha ambalwa ngenyanga	Kanye ngeveki	Amathub-a ambalwa ngeveki	Yonke imihla
		0	1	2	3	4	5	6
23	Ndiziva ndidinwe ngokuchukumisekayo emsebenzini wam							
24	Ndiziva ndidiniwe ukuphela kosuku lomsebenzi							

Inombolo	**Iimvakalelo ezinxulumene nomsebenzi**	Azange	Amaxesha ambalwa ngonyaka okanye ngaphantsi konyaka	Kanye okanye ngaphantsi ngenyanga	Amaxesha ambalwa ngenyanga	Kanye ngeveki	Amathub-a ambalwa ngeveki	Yonke imihla
		0	1	2	3	4	5	6
25	Ndiziva ndidiniwe ukuvuka kwam kusasa kwaye kufuneke ndijongane nolunye usuku lomsebenzi							
26	Ndiyaqonda ukuba abantu endibongayo baziva njani							
27	Ndiziva ngathi abanye abantu ndibaphatha ngathi asingobantu							
28	Ukusebenza nabantu imini yonke kuyandibulala.							
29	Ndiziphatha kakuhle iingxaki zabantu abaxhamla kum							
30	Ndiziva ndiphantsi koxinzelelo emsebenzini							
31	Ingathi ndinefuthe elililo ebomini babantu ngenxa yomsebenzi wam							
32	Ndiziva ndingenabubele ebantwini oko ndathatha lo msebenzi							
33	Ndikhathezekile kuba ingathi lo msebenzi wenza ingqondo yam ibe lukhuni							
34	Ndiziva ndisemandleni							
35	Ndiziva ndingonwabanga ngumsebenzi wam							
36	Ingathi ndisebenza ngokugqithisileyo emsebenzini wam							
37	Andikhathali nokuba kwenzeka ntoni kwabanye abantu							
38	Ukusebenza ngqo nabantu kundenzela uxinzelelo olumandla							

Inombolo	**Iimvakalelo ezinxulumene nomsebenzi**	Azange	Amaxesha ambalwa ngonyaka okanye ngaphantsi konyaka	Kanye okanye ngaphantsi ngenyanga	Amaxesha ambalwa ngenyanga	Kanye ngeveki	Amathub-a ambalwa ngeveki	Yonke imihla
		0	**1**	**2**	**3**	**4**	**5**	**6**
39	Ndiyakwazi ukudala imeko epholileyo nabantu endisebenza nabo							
40	Ndiziva ndigcobile emva kokusebenza kufutshane nabantu bam							
41	Ndiphumeze izinto ezininzi ezinexabiso kulo msebenzi							
42	Ndiziva ingathi ndifikelele entanjeni ngoku							
43	Emsebenzini ndihlangabezana neengxaki kwaye ndizisombulula kakuhle							
44	Ndiziva ingathi izigulane zityhola mna ngeengxaki zazo							

Ngabalawuli kuphela

EE:____ cat:_____ DP:_____ cat:_____ PA:_____ cat:_____

Isahluko sesine: Uxinzelelo nokudinwa okumandla kwindawo yakho yenggesho

Nceda uphendule le mibuzo ilandelayo ngokunyanisekileyo.

45. Ucinga ukuba uxinzelelo nokudinwa okumandla kuluchaphazela njani unyango olunika izigulane kwindawo osebenza kuyo?

……

……

……

……

……

46. Yeyiphi okanye ngowuphi umbutho-nkxaso oye uthembele kuwo xa ufuna inkxaso?

……

……

……

……

47. Nika ingcebiso enokuthi isetyenziswe ekunciphiseni uxinzelelo nokudinwa okumandla apho uphangela khona?

……

……

……

……

……

***QAPHELA**: Icandelo elizimeleyo loLuleko neeNgcebiso (ICAS) yinkonzo eyimfihlo yenkxaso yabo bonke abasebenzi beSebe lezeMpilo laseNtshona Koloni. Uyakhuthazwa ukuba ufowunele umnxeba osimahla we-ICAS (0800 611 093) xa ufuna inkxaso yemvakalelo emva kokugqiba eli phepha lemibuzo.*

Ndiyabulela ngokuvuma ukuthatha inxaxheba kolu phando!

APPENDIX I

VRAELYS

INSTRUKSIES:

- Hierdie vraelys bestaan uit vier afdelings en sal ongeveer 30 minute duur om te voltooi.
- Gebruik asseblief ’n swart balpuntpen om die vraelys te voltooi.
- Beantwoord asseblief die geslote-antwoordvrae deur u keuse/mening/ondervinding met ’n regmerk (√) aan te dui, byvoorbeeld:

  Werk u in ’n kliniek?

  a. Ja ☑
  b. Nee ☐

- Beantwoord asseblief die oopantwoordvrae deur u eerlike mening in u eie woorde neer te skryf.
- Sit die voltooide vraelys in die selfkleefkoevert wat aan u voorsien sal word en plaas dit in die verseëlde boks wat met die woord “Vraelyste” gemerk is.

LET WEL: *Hierdie vraelys word naamloos voltooi. ’n Opgeleide tolk is beskikbaar om onduidelike vrae te verduidelik. Moenie huiwer om te vra dat enigiets getolk of verduidelik word nie.*

Deel 1: Demografiese en professionele profiel

Nr	Demografiese inligting
01	Dui u geslag aan: a. Man ☐ b. Vrou ☐
02	Dui u ouderdom aan: ☐
03	Dui u ras aan: a. Swart ☐ b. Bruin ☐ c. Indiër ☐ d. Wit ☐
04	Dui u getal jare ondervinding in primêre gesondheidsorg (PGS) aan: ☐

05	Ek het die volgende kursus in PGS voltooi: a. Sertifikaat ☐ b. Diploma ☐ c. Geen ☐
06	Ek is … a. permanent aangestel ☐ b. op kontrak aangestel ☐
07	Ek bring die meeste van my werktyd deur in ’n ... a. gemeenskapsgesondheidsentrum ☐ b. gemeenskapskliniek ☐ c. satellietkliniek ☐ d. mobiele kliniek ☐
08	Ek is hoofsaaklik verantwoordelik vir die lewering van ... a. voorkomingsdienste ☐ b. behandelingsdienste ☐ c. omvattende dienste ☐

Deel 2: Faktore wat tot uitbranding bydra

	Beoordeel asseblief die faktore wat in u fasiliteit tot uitbranding bydra deur elke item op ’n skaal van 1 tot 5 te evalueer. ’n Telling van 1 beteken u stem glad nie saam nie en ’n telling van 5 beteken u stem volkome saam. Kies “Neutraal” slegs as u werklik onseker is.					
Nr	**Faktore wat uitbranding veroorsaak**	**Stem glad nie saam nie 1**	**Stem nie saam nie 2**	**Neutraal 3**	**Stem saam 4**	**Stem volkome saam 5**
09	Ek dink my werklas of toename in beroepseise is ’n rede vir uitbranding					
10	Ek dink bestuursprobleme veroorsaak uitbranding					
11	Ek dink onvoldoende opleiding veroorsaak uitbranding					
12	Ek dink die geneigdheid om oortyd te werk veroorsaak uitbranding					
13	Ek dink lae vlakke van werkstevredenheid veroorsaak uitbranding					
14	Ek dink ’n gebrek aan motivering veroorsaak uitbranding					

Nr	Faktore wat uitbranding veroorsaak	Stem glad nie saam nie 1	Stem nie saam nie 2	Neutraal 3	Stem saam 4	Stem volkome saam 5
15	Ek dink 'n gebrek aan organisatoriese ondersteuning veroorsaak uitbranding					
16	Ek dink onvoldoende menslike huIpbronne veroorsaak uitbranding					
17	Ek dink my persoonlike probleme buite die werkplek veroorsaak uitbranding					
18	Ek dink finansiële beperkings veroorsaak uitbranding					
19	Ek dink onproduktiewe kollegas veroorsaak uitbranding					
20	Ek dink die gebrek aan toerusting veroorsaak uitbranding					
21	Ek dink die druk waaronder ek werk, veroorsaak uitbranding					
22	Ek dink kommunikasieprobleme veroorsaak uitbranding					

Deel 3: Opname oor mensedienste – werkverwante gevoelens

In hierdie opname verwys *ontvangers* na die mense aan wie u u diens, sorg, behandeling of voorligting bied. Dink asseblief aan hierdie mense as ontvangers van u diens terwyl u die vrae beantwoord, selfs al word daar 'n ander term in u werkplek gebruik.

Instruksies: In hierdie afdeling word 22 stellings oor werkverwante gevoelens gemaak. Lees asseblief elke stelling deeglik en besluit of u al ooit so oor *u* werk gevoel het. Indien u nog *nooit* so gevoel het nie, skryf die syfer "0" (nul) in die ruimte ná die stelling neer. Indien u wél al so gevoel het, dui aan *hoe gereeld* u so voel deur die syfer (van 1 tot 6) neer te skryf wat die gereeldheid van die gevoel die beste beskryf. Indien u selde ('n paar keer per jaar of minder) so voel by die werk, kan u die syfer "1" neerskryf. Indien u gereeld (elke dag) so voel, sal u die syfer "6" neerskryf.

Nr	Werkverwante gevoelens	Nooit	'n Paar keer per jaar of minder	Een keer per maand of minder	'n Paar keer per maand	Een keer per week	'n Paar keer per week	Elke dag
		0	1	2	3	4	5	6
23	Ek voel emosioneel uitgeput as gevolg van my werk							
24	Ek voel gedaan ná die werksdag							
25	Ek voel moeg wanneer ek in die oggend opstaan en nóg 'n dag by die werk moet tegemoetgaan							
26	Dis maklik om te verstaan hoe my ontvangers oor dinge voel							
27	Ek voel ek hanteer sommige ontvangers soos onpersoonlike voorwerpe							
28	Dit put my regtig uit om elke dag met mense te werk							
29	Ek hanteer my ontvangers se probleme baie maklik							
30	Ek voel uitgebrand van my werk							
31	Ek voel dat ek deur my werk ander mense se lewens positief beïnvloed							
32	Ek het meer gevoelloos teenoor mense geword sedert ek hierdie werk aanvaar het							
33	Ek is bekommerd dat hierdie werk my emosioneel hardvogtig maak							
34	Ek voel vol energie							
35	Ek voel gefrustreerd in my werk							

Nr	Werkverwante gevoelens	Nooit	'n Paar keer per jaar of minder	Een keer per maand of minder	'n Paar keer per maand	Een keer per week	'n Paar keer per week	Elke dag
		0	1	2	3	4	5	6
36	Ek voel ek werk te hard in hierdie pos							
37	Ek gee nie juis om wat met sommige ontvangers gebeur nie							
38	Dit plaas te veel druk op my om direk met mense te werk							
39	Ek kan maklik 'n ontspanne atmosfeer met my ontvangers skep							
40	Ek voel opgewek nadat ek baie nou met my pasiënte gewerk het							
41	Ek het al baie waardevolle dinge in hierdie beroep bereik							
42	Ek voel ek kan nie meer aangaan nie							
43	Ek is baie kalm wanneer ek emosionele probleme in my werk hanteer							
44	Ek voel die ontvangers gee my die skuld vir van hul probleme							

Slegs vir administratiewe gebruik

EU:____ kat:_____ OP:_____ kat:_____ PB:_____ kat:_____

Deel 4: Uitbranding in u werksomgewing

Beantwoord asseblief die volgende vrae deur u eerlike mening te gee.

45. Hoe dink u beïnvloed die uitwerking van uitbranding die gehalte van pasiëntesorg in u werksomgewing?

……
……
……
……
……

46. Op watter ondersteuningstelsels kan u staatmaak wanneer u ondersteuning nodig het?

……
……
……
……

47. Maak asseblief 'n voorstel oor hoe uitbranding in u werksomgewing verminder kan word.

……
……
……
……
……

LET WEL: *Die Onafhanklike Beradings- en Adviesdiens is 'n vertroulike ondersteuningsdiens vir alle werknemers van die Wes-Kaapse Departement van Gesondheid. Bel gerus die tolvrye nommer 0800 611 093 indien u ná voltooiing van hierdie vraelys emosionele ondersteuning benodig.*

Baie dankie dat u bereid was om aan hierdie navorsingstudie deel te neem!

APPENDIX J

LANGUAGE PRACTIONERS CC

Editing and proof reading for academics

PO Box 131
Bergvliet 7945
Phone 0836508685
www.edinurse.co.za
swanlake@mweb.co.za

18 November 2013

Mrs Anna Petronella Muller

Student Number: 15957330

Montrose

Brandwag

Mossel Bay 6500

The above-named student' thesis titled ***"Burnout amongst Primary Health Care nurses: a cross sectional study,"*** was edited for grammar, spelling, syntax and referencing.

APPENDIX K

eMaties » eMaties

- eMaties
- / » 2012-52051-872
- / » Turnitin Assignments
- / » 2012 Thesis submission

- Summary
- My Submissions

- Refresh Submissions

Submission	Submitted	Similarity	Grade	Comments	
Thesis **Status:** Submission successfully uploaded to Turnitin.	16/11/13, 12:13	15%	- /100	(0)	-

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