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WORK LIFE BALANCE AND EMPLOYEE PRODUCTIVITY IN PUBLIC HEALTHCARE

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2. ABSTRACT

Public healthcare organisations need staff who can sustain safe performance while meeting responsibilities outside work. This narrative review examines how work demands, recovery opportunities and organisational support relate to employee wellbeing and productivity, with implications for Ministry of Health services in Chipata District, Zambia. A focused synthesis draws on foundational organisational theory, peer-reviewed Zambian studies, international research and WHO guidance. Local qualitative evidence from Chipata and Chadiza links motivation and retention to professional development, working conditions and community relationships. Zambian burnout studies add national context, while international evidence associates longer shifts with burnout and physician burnout with productivity loss, turnover intention and patient safety incidents. Two graphs display selected published estimates and confidence intervals, with populations and comparisons identified. The evidence supports considering predictable rosters, workload review, supportive supervision, confidential occupational health services and career development. It does not establish current working hours, burnout prevalence or intervention effects in Chipata. Most quantitative evidence is observational and its transferability requires caution. Managers should assess local working conditions and pilot feasible changes while monitoring staff wellbeing, service continuity and safety. Prospective research combining staff measures with staffing, attendance and service records is needed to test district-level relationships and intervention outcomes.

3. KEYWORDS: Work-life balance; employee productivity; health workforce; burnout; shift work; Zambia.

4. INTRODUCTION

Work-life balance concerns how paid work fits with health, family, caring, community and other responsibilities. In public healthcare, night duties, emergency care and emotionally demanding work make that fit especially important. The management problem is to sustain service availability while protecting the people who deliver care. Productivity must therefore include safe, reliable work as well as the volume of tasks completed.

Work-family conflict can arise through incompatible demands on time, strain and behaviour (Greenhaus & Beutell, 1985). The job demands-resources model distinguishes demands that consume effort from resources that support functioning and engagement (Demerouti et al., 2001). Together, these perspectives suggest plausible links among schedules, recovery, organisational support and performance. Work-life balance, burnout and productivity nevertheless remain distinct concepts and should not be measured as if they were interchangeable.

Evidence relevant to Chipata already exists. Manda et al. (2023) examined rural primary healthcare workers' motivation and retention in Chipata and Chadiza. Their findings make local working conditions and career opportunities central to the discussion. However, that study does not estimate current work-life balance or quantify its effect on productivity across Ministry of Health facilities in Chipata.

This review examines the mechanisms linking work demands and resources to staff wellbeing, evaluates the relevance and limits of published evidence, and proposes practical priorities for district-level assessment. It asks how scheduling and workload may affect recovery and performance, which organisational resources warrant consideration, and what evidence is needed before local interventions can be judged effective.

5. MATERIALS AND METHODS

Review design and source selection

A focused narrative review was undertaken rather than an original employee survey or a systematic review. Source checks completed on 18 October 2026 used combinations of 'work-life balance', 'healthcare workers', 'burnout', 'productivity', 'shift work', 'Chipata',

'Chadiza' and 'Zambia'. Publisher pages, PubMed records, university repositories and WHO publications were used to verify relevant studies and bibliographic details.

Priority was given to peer-reviewed research from Chipata or Zambia, quantitative studies with identifiable populations and effect estimates, foundational organisational theories and authoritative occupational-health guidance. Sources were selected for relevance and verifiability rather than through exhaustive database screening. The review does not claim a registered protocol, complete coverage, formal risk-of-bias scoring or a reproducible systematic-study count.

Synthesis and use of numerical evidence

Sources were examined for setting, population, design, outcomes and limitations. The narrative separates direct district evidence, evidence from elsewhere in Zambia and international evidence. Thematic interpretation considers work demands, recovery and strain, organisational resources and service outcomes. Qualitative findings are treated as explanations of experiences rather than prevalence estimates.

Figure 1 redraws three published pooled associations from Hodkinson et al. (2022). Figure 2 redraws three adjusted associations from Dall'Ora et al. (2015). Point estimates and 95% confidence intervals are displayed on logarithmic odds-ratio axes. These are graphical summaries of published results; no new meta-analysis, combined effect or Chipata estimate was calculated. The displayed outcomes are selected for relevance, not a complete set of findings from either paper.

Ethical scope

The review uses published literature and contains no newly collected participant information, personnel records or patient data. Published studies are cited for their own findings. Recommendations are proposals for local evaluation and do not imply that an intervention has already been implemented or tested in Chipata.

6. RESULTS AND DISCUSSION

Evidence from Chipata and Zambia

Manda et al. (2023) conducted 28 in-depth interviews with rural primary healthcare workers in Chipata and Chadiza. They identified professional development, the work environment and rural community dynamics as themes shaping motivation and retention. This is directly

relevant to the district context, although it covers two districts and examines motivation and retention rather than measured productivity. It supports attention to career development and local working relationships without supplying a district-wide burnout rate.

Elsewhere in Zambia, Kruse et al. (2009) surveyed 483 clinical staff in 13 Lusaka public clinics and reported occupational burnout in 51%. Mumbwe et al. (2020) received responses from 160 anaesthesia providers and reported burnout in 51.3% (95% CI 43.2-59.2). These findings show that burnout has been documented in particular Zambian workforces. Different populations, periods and measures prevent treating the figures as equivalent or applying either percentage to Chipata.

Table 1: Main empirical evidence and its relevance.

Source	Setting and design	Contribution and limit
Manda et al. (2023)	Chipata and Chadiza; 28 qualitative interviews	Local evidence on motivation and retention; no productivity effect estimate.
Kruse et al. (2009)	Lusaka clinics; 483 survey respondents	Historical burnout context; not current Chipata prevalence.
Mumbwe et al. (2020)	Zambian anaesthesia providers; 160 respondents	Occupation-specific burnout estimate; not all health workers.
Dall'Ora et al. (2015)	12 European countries; cross-sectional nurse survey	Shift-length associations; transferability and causality limited.
Hodkinson et al. (2022)	International observational-study meta-analysis	Burnout associations with work and care outcomes; heterogeneous evidence.

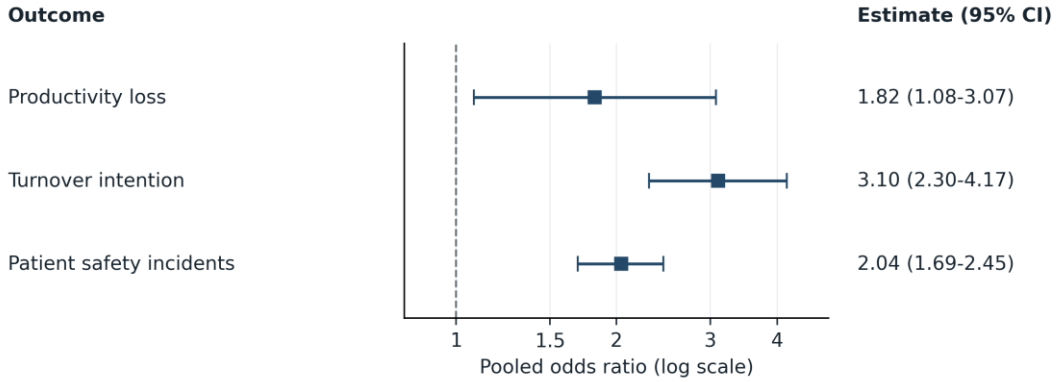
Workload recovery and employee performance

A plausible pathway begins when work demands reduce the time and energy available for recovery and personal responsibilities. Fatigue and strain can then affect attention, attendance and willingness to remain in a role. Under the job demands-resources model, adequate staffing support, useful feedback and access to necessary resources may help staff manage demanding work (Demerouti et al., 2001). This framework identifies relationships to examine; it does not prove a specific pathway in Chipata.

Burnout is relevant to performance but is an incomplete measure of work-life balance. A person can experience competing home and work demands without meeting a burnout threshold, and burnout can arise from factors beyond scheduling. Productivity also depends on available medicines, equipment, team composition, case complexity and administrative

systems. Attributing service delays entirely to individual staff motivation would miss these constraints.

Hodkinson et al. (2022) report pooled associations between physician burnout and productivity loss, turnover intention and patient safety incidents (Figure 1). Their study-specific evidence sets differ: the productivity analysis included seven studies, turnover intention 25 and patient safety incidents 35. Heterogeneity was substantial, with I-squared values of 83%, 97% and 87%, respectively. The estimates describe associations, cannot be read as percentage reductions in productivity and do not establish local baseline risks.

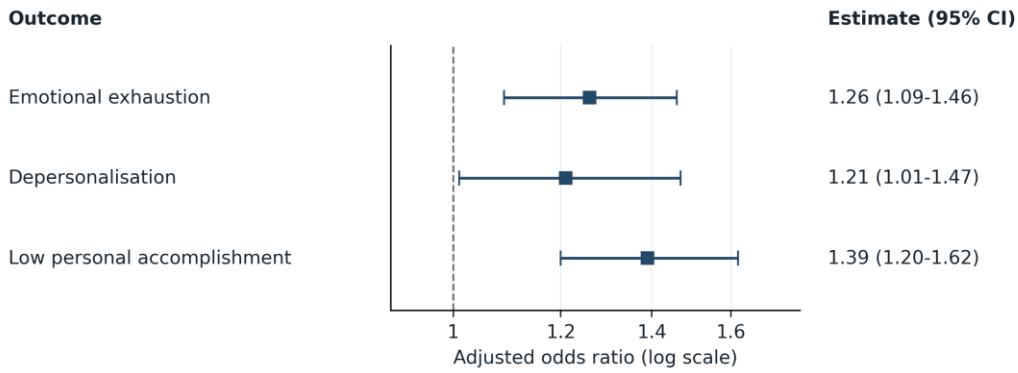


Hodkinson et al. (2022). Published pooled associations; no new pooling.
Higher values indicate greater odds of the adverse outcome among physicians with burnout.

Figure 1: Selected published associations between physician burnout and adverse outcomes. Source: Hodkinson et al. (2022), doi:10.1136/bmj-2022-070442. Squares show pooled odds ratios and horizontal lines show 95% confidence intervals. The dashed line marks an odds ratio of 1.

Shift design and work life balance

Dall'Ora et al. (2015) analysed 31,627 registered nurses in 12 European countries. Compared with shifts of eight hours or less, shifts of at least 12 hours were associated with higher odds of emotional exhaustion, depersonalisation and low personal accomplishment (Figure 2). The measures concern burnout dimensions, not direct productivity changes. This observational comparison cannot establish that shortening every shift would improve outcomes in a different health system.



Dall'Ora et al. (2015). Shifts of at least 12 hours versus 8 hours or less.
Registered nurses in 12 European countries; these are not Chipata estimates.

Figure 2: Published associations between long shifts and burnout dimensions. Source: Dall'Ora et al. (2015), doi:10.1136/bmjopen-2015-008331. Squares show adjusted odds ratios and lines show 95% confidence intervals. The comparison is at least 12 hours versus eight hours or less; the dashed line marks 1.

Scheduling decisions should consider workload intensity, consecutive nights, overtime, predictability, commuting and staff preferences alongside shift length. A rigid shift rule introduced without sufficient staffing can transfer pressure to colleagues or interrupt service coverage. Chipata managers would first need actual roster and overtime records to identify where recovery is being constrained. The literature reviewed here does not establish current district working hours or recovery intervals.

Organisational support and occupational health

WHO's Guidelines on mental health at work identify organisational measures, manager training, worker training and support for workers with mental health conditions as intervention areas (WHO, 2022). Its recommendations for addressing psychosocial risks in health and emergency work are conditional and based on very low-certainty evidence. This supports careful local adaptation and monitoring rather than promises of a guaranteed productivity gain.

The WHO and ILO guide on occupational health programmes places responsibility at national, subnational and facility levels (WHO & ILO, 2022). For district planning, its relevance is the integration of worker protection into routine management, with defined responsibility and monitoring. Confidential support and referral arrangements should sit alongside improvements in working conditions. An individual coping programme alone cannot resolve persistent overload or shortages of basic resources.

Local qualitative evidence also shows why support should extend beyond counselling. Professional development and relationships within facilities and communities can shape retention (Manda et al., 2023). Predictable access to training and fair consideration of staff needs may therefore belong within a broader workforce strategy. These proposals require consultation across professional groups and do not assume that every facility faces the same constraints.

Priorities for Ministry of Health facilities in Chipata

An initial assessment should compare planned and actual rosters, identify unfilled shifts and overtime, and invite confidential staff feedback on recovery and scheduling. Managers could then select a limited change, such as earlier publication of rosters or a fair process for exchanging duties. Any pilot should preserve minimum service coverage and define how staff can raise concerns without retaliation.

Table 2: Proposed actions and measures for local evaluation.

Priority	Practical action	Measures to examine
Rosters and recovery	Review actual hours and test more predictable scheduling.	Roster notice; overtime; reported recovery.
Workload and resources	Map demand and staffing by service and shift.	Vacancies; workload by shift; service interruptions.
Support and supervision	Provide confidential referral and train supervisors.	Support access; staff feedback; wellbeing measures.
Career development	Use transparent access to training and development.	Training access; retention intention; actual departures.
Balanced performance	Review wellbeing alongside service quality and activity.	Attendance; case-adjusted activity; safety and patient experience.

These are proposed monitoring domains, not results from a Chipata intervention. Measures need explicit definitions and consistent denominators. For example, absence can be measured as absent days divided by scheduled staff-days, while activity should be interpreted alongside staffing, case mix and service availability. A rise in reported safety incidents may reflect improved reporting, so that measure should be considered with other evidence.

Limitations and research priorities

Narrative source selection can introduce selection bias and does not establish that every relevant study has been included. The review combines theories, qualitative research,

surveys, a meta-analysis and guidance that answer different questions. Much of the numerical evidence is cross-sectional or otherwise observational, leaving confounding and reverse causation unresolved. The same published evidence may contribute to more than one synthesis, so no independent pooled summary is inferred here.

Transferability is a further limit. International physicians and European hospital nurses work in settings that differ from Zambian district services. The Zambian studies concern particular occupational groups and periods. The local qualitative study covers rural facilities in two districts and cannot represent all Chipata facilities, cadres or staff experiences.

Future research should measure work-life balance, burnout and productivity separately using appropriate instruments and records. A prospective mixed-methods study could combine staff surveys and interviews with rosters, staffing, absence and service information. Repeated observations and a suitable comparison group would strengthen evaluation of an intervention. Research involving employees or personnel records would require appropriate institutional and research permissions, consent arrangements and confidentiality protections.

7. CONCLUSION

Work-life balance is a relevant workforce-management concern for public healthcare because work demands, recovery and organisational resources can shape staff wellbeing and sustained performance. Published evidence links burnout and longer shifts with adverse outcomes, while research from Chipata and Chadiza highlights the importance of professional development, working conditions and community relationships.

The available evidence supports assessing local conditions and evaluating feasible improvements in scheduling, supervision, occupational health support and career development. It does not establish current Chipata workload levels or prove a local productivity effect. District recommendations should therefore be implemented through consultation and monitored pilots, with service safety and staff wellbeing considered together.

9. REFERENCES

1. Dall'Ora, C., Griffiths, P., Ball, J., Simon, M., & Aiken, L. H. (2015). Association of 12 h shifts and nurses' job satisfaction, burnout and intention to leave: Findings from a

cross-sectional study of 12 European countries. BMJ Open, 5(9), e008331. https://doi.org/10.1136/bmjopen-2015-008331

2. Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands-resources model of burnout. Journal of Applied Psychology, 86(3), 499-512. https://doi.org/10.1037/0021-9010.86.3.499
3. Greenhaus, J. H., & Beutell, N. J. (1985). Sources of conflict between work and family roles. Academy of Management Review, 10(1), 76-88. https://doi.org/10.5465/amr.1985.4277352
4. Hodkinson, A., Zhou, A., Johnson, J., Geraghty, K., Riley, R., Zhou, A., Panagopoulou, E., Chew-Graham, C. A., Peters, D., Esmail, A., & Panagioti, M. (2022). Associations of physician burnout with career engagement and quality of patient care: Systematic review and meta-analysis. BMJ, 378, e070442. https://doi.org/10.1136/bmj-2022-070442
5. Kruse, G. R., Chapula, B. T., Ikeda, S., Nkhoma, M., Quiterio, N., Pankratz, D., Mataka, K., Chi, B. H., Bond, V., & Reid, S. E. (2009). Burnout and use of HIV services among health care workers in Lusaka District, Zambia: A cross-sectional study. Human Resources for Health, 7, Article 55. https://doi.org/10.1186/1478-4491-7-55
6. Manda, K., Silumbwe, A., Kombe, M. M., & Hangoma, P. (2023). Motivation and retention of primary healthcare workers in rural health facilities: An exploratory qualitative study of Chipata and Chadiza Districts, Zambia. Global Public Health, 18(1), Article 2222310. https://doi.org/10.1080/17441692.2023.2222310
7. Mumbwe, M. C., McIsaac, D., Jarman, A., & Bould, M. D. (2020). A cross-sectional survey to determine the prevalence of burnout syndrome among anesthesia providers in Zambian hospitals. Anesthesia & Analgesia, 130(2), 310-317. https://doi.org/10.1213/ANE.0000000000004464
8. World Health Organization. (2022). Guidelines on mental health at work. https://www.who.int/publications/i/item/9789240053052
9. World Health Organization & International Labour Organization. (2022). Caring for those who care: Guide for the development and implementation of occupational health and safety programmes for health workers. https://www.who.int/publications/i/item/9789240040779