

# **Workplace Stress and Burnout among Rural Health Unit Employees: Evidence from a Municipal Primary Healthcare Setting in the Philippines**

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**Abstract**— Workplace stress and burnout remain critical challenges in healthcare systems, particularly in rural primary healthcare settings where limited resources and high service demands intersect. This study examined workplace stress and burnout among employees of a municipal Rural Health Unit (RHU) in the Philippines, focusing on the relationships among demographic characteristics, workplace stress, and burnout dimensions. A descriptive-correlational quantitative design was employed involving 24 RHU employees selected through total enumeration. Data were gathered using a structured questionnaire measuring demographic profile, workplace stress using a five-point Likert scale, and burnout using an adapted Maslach Burnout Inventory assessing emotional exhaustion, depersonalization, and personal accomplishment. Results revealed a moderate level of overall workplace stress, with overlapping responsibilities and resource insufficiency identified as key stressors. Burnout analysis showed moderate emotional exhaustion, high depersonalization, and moderate reduced personal accomplishment among respondents. Inferential analysis indicated no significant relationship between demographic variables and both workplace stress and burnout. However, workplace stress demonstrated a strong positive and significant relationship with emotional exhaustion. The findings suggest that workplace stress in rural healthcare settings is primarily driven by organizational factors rather than individual characteristics. Strengthening workload management, staffing adequacy, and psychosocial support systems is essential to mitigate burnout and improve employee well-being in primary healthcare environments.

**Keywords**— Workplace stress; burnout; Rural Health Unit; healthcare workers; Job Demands–Resources Model.

## **I. INTRODUCTION**

Workplace stress and burnout have become increasingly prominent concerns in modern healthcare systems, particularly in primary care settings where service delivery is continuous, multifaceted, and resource-dependent. Globally, healthcare workers are exposed to high job demands, emotional labor, and organizational constraints that compromise both their well-being and performance. The World Health Organization has recognized burnout as an occupational phenomenon characterized by chronic workplace stress that is not successfully managed, typically manifested as emotional exhaustion, depersonalization, and diminished professional efficacy (World Health Organization, 2019). These dimensions reflect a growing imbalance between job demands and available resources, particularly evident in healthcare settings where personnel are expected to deliver high-quality care under constrained conditions.

In many countries, including developing health systems, primary healthcare facilities serve as the first point of contact for community health services. These facilities often operate under limited staffing, inadequate infrastructure, and increasing patient loads, creating conditions conducive to occupational stress. According to the U.S. Surgeon General (2022), healthcare workers worldwide are experiencing escalating levels of burnout driven by excessive workload, insufficient organizational support, and persistent resource limitations. Similarly, Maslach and Leiter (2016; 2022) emphasize that burnout arises not merely from individual incapacity to cope but from chronic exposure to workplace environments that are misaligned with employee needs. This perspective highlights the importance of examining organizational and structural determinants of employee well-being rather than attributing burnout solely to personal resilience.

The Job Demands–Resources (JD–R) Model provides a strong theoretical foundation for understanding workplace stress and burnout in healthcare settings. According to Bakker and Demerouti (2007) and Demerouti et al. (2001), job demands are physical, psychological, social, or organizational aspects of work that require sustained effort and entail physiological and psychological costs. Conversely, job resources are aspects that help reduce job demands, achieve work goals, and foster personal growth. In the absence of sufficient job resources, high job demands can lead to energy depletion and emotional exhaustion, which may eventually progress to burnout. The model has been widely applied in healthcare research to explain how workload, emotional demands, and administrative pressures contribute to deteriorating mental health among healthcare professionals (Bakker et al., 2014; Schaufeli & Taris, 2014).

Empirical studies have consistently demonstrated the prevalence of burnout among healthcare workers across different contexts. Prasad et al. (2021) found high levels of stress and burnout among healthcare professionals, particularly those engaged in frontline and community-based services. Similarly, Huang et al. (2022) reported moderate-to-severe burnout among primary healthcare workers, driven primarily by workload pressure and administrative burden. In Southeast Asia, Abdul Aziz and Ong (2022) highlighted that emotional exhaustion among healthcare workers is significantly associated with job stressors, including long working hours, role overload, and inadequate institutional support. These findings reinforce the global nature of the issue and underscore the vulnerability of healthcare workers in both hospital and community-based settings.

In the Philippine context, workplace stress and burnout among healthcare professionals have become increasingly concerning due to systemic challenges in the public health sector. Studies by De los Santos (2023) and Seamrem et al. (2023; 2024) indicate that primary healthcare workers in rural and community settings experience high levels of workload, multitasking demands, and emotional strain. These stressors are often compounded by manpower

shortages, limited medical supplies, and administrative workload pressures. Furthermore, Reyes and Mendoza (2024) emphasize that organizational factors such as poor resource allocation, inadequate support systems, and high job demands significantly influence employee burnout. The Philippine healthcare system, guided by policies such as the Magna Carta of Public Health Workers (Republic Act No. 7305) and the Occupational Safety and Health Standards Law (Republic Act No. 11058), recognizes the importance of protecting healthcare workers; however, implementation gaps remain in many local settings, particularly in rural health units.

Burnout has also been shown to have significant implications for healthcare quality and patient safety. Ryu and Shim (2021) found that emotionally exhausted healthcare workers are more likely to experience reduced engagement in patient safety practices, which may increase the risk of errors in care delivery. Likewise, Kumareswaran et al. (2024) emphasized that burnout adversely affects the quality of patient care, professional performance, and organizational effectiveness. When healthcare workers experience depersonalization, their ability to provide empathetic and patient-centered care is significantly reduced, thereby compromising service quality. These consequences highlight the urgency of addressing workplace stress not only as an employee welfare issue but also as a critical component of healthcare system performance.

Despite the growing body of international and local literature on burnout, there remains a notable gap in studies focusing specifically on rural primary healthcare units in smaller municipal contexts. Most existing research has concentrated on hospital-based healthcare workers or urban health facilities, leaving rural health units underexplored. Rural healthcare environments often present unique challenges, including limited staffing, broader service coverage responsibilities, and increased dependence on a small workforce. As noted by Cainglet (2022), these structural constraints intensify workplace stress and increase the likelihood of burnout among healthcare professionals. Therefore, localized empirical evidence

is necessary to better understand how these factors operate in municipal primary healthcare settings.

The present study is grounded in this gap, focusing on employees of a municipal rural health unit in the Philippines. The study assumes that workplace stress and burnout are influenced by a combination of demographic characteristics, organizational conditions, and job demands, consistent with the JD–R model framework. By examining these relationships in a localized healthcare setting, the study contributes to a more contextualized understanding of occupational well-being among primary healthcare workers. Furthermore, it aims to provide evidence-based insights that may guide the development of targeted interventions and workplace policies to improve employee well-being and service delivery outcomes.

Specifically, this study is guided by the following objectives: (1) To describe the demographic profile of Rural Health Unit employees in terms of age, sex, job position, employment status, and length of service; (2) To determine the level of workplace stress experienced by Rural Health Unit employees in a municipal primary healthcare setting; (3) To assess the level of burnout among Rural Health Unit employees in terms of emotional exhaustion, depersonalization, and personal accomplishment; (4) To examine the relationships among demographic profile, workplace stress, and burnout dimensions among Rural Health Unit employees; and (5) To generate evidence-based insights that may inform workplace stress and burnout management strategies in municipal primary healthcare settings.

## **II. METHODOLOGY**

This study employed a descriptive-correlational quantitative research design to examine workplace stress and burnout among employees of a municipal Rural Health Unit in the Philippines. The descriptive component was used to determine the demographic profile, workplace stress levels, and burnout levels of the respondents, while the correlational component was used to examine the relationships among demographic characteristics, workplace stress, and burnout dimensions. The study was conducted among

employees of the Rural Health Unit in Bicol Region, Philippines. Total enumeration sampling was used because of the limited number of personnel in the unit, resulting in the participation of 24 employees, including doctors, nurses, midwives, dentists, medical technologists, sanitary inspectors, and administrative personnel.

Data were collected using a structured survey questionnaire comprising three parts. Part I collected respondents' demographic profiles, including age, sex, job position, employment status, and length of service. Part II assessed workplace stressors using a five-point scale: 1 = Not Stressful, 2 = Slightly Stressful, 3 = Moderately Stressful, 4 = Stressful, and 5 = Very Stressful. The workplace stress indicators covered job-related stressors such as heavy workload, overlapping responsibilities, documentation and reporting requirements, emotional demands from patient care, limited manpower, insufficient supplies or resources, time pressure, work–life imbalance, lack of administrative support, and limited opportunities for rest or recovery. The self-constructed Workplace Stress Questionnaire was subjected to reliability testing and obtained a Cronbach's alpha coefficient of 0.949, indicating excellent internal consistency.

Part III measured burnout using an adapted Burnout Self-Test based on the Maslach Burnout Inventory framework, covering three dimensions: emotional exhaustion, depersonalization, and personal accomplishment. Respondents rated burnout items using a seven-point frequency scale: 0 = Never, 1 = A few times per year, 2 = Once a month, 3 = A few times per month, 4 = Once a week, 5 = A few times per week, and 6 = Every day. Burnout scores were interpreted using the prescribed cut-off points for each dimension: emotional exhaustion was classified as low at 17 or below, moderate at 18–29, and high at 30 and above; depersonalization was classified as low at 5 or below, moderate at 6–11, and high at 12 and above; and personal accomplishment was interpreted inversely, with scores of 33 or below indicating high burnout, 34–39 indicating moderate burnout, and 40 and above indicating low burnout. Data were collected via Google Forms after the research adviser validated the questionnaire. Descriptive statistics, including

frequency, percentage, and weighted mean, were used to summarize the data, while Fisher’s Exact Test and Spearman’s rho correlation were applied to determine significant relationships among the study variables.

### III. RESULTS

#### *Demographic profile of Rural Health Unit employees in terms of age, sex, job position, employment status, and length of service*

The demographic distribution of Rural Health Unit (RHU) employees indicates a predominantly young-to-middle-aged workforce, with the largest proportion belonging to the 20–34 years age group (45.83%), followed by 35–49 years (29.17%) and 50 years and above (25.00%). This suggests a relatively balanced but slightly younger workforce composition, which

may reflect recent hiring trends or workforce turnover within rural primary healthcare settings. In terms of sex distribution, the workforce is largely female (83.33%), which is consistent with the global and national pattern in healthcare professions, particularly in nursing and midwifery-dominated environments.

Regarding occupational structure, nurses comprised half of the total workforce (50.00%), making them the dominant professional group within the RHU, followed by midwives (20.83%) and administrative staff (16.67%). Other professional roles, such as doctors, medical technologists, and sanitary inspectors, were minimally represented (each at 4.17%), indicating a potential imbalance in specialized human resources.

**Table 1. Demographic Profile of Rural Health Unit Employees (N=24)**

Profile Variable	Category	f	%
Age	20–34 years old	11	45.83
	35–49 years old	7	29.17
	50 years old and above	6	25.00
Sex	Male	4	16.67
	Female	20	83.33
Job Position	Doctor	1	4.17
	Nurse	12	50.00
	Midwife	5	20.83
	Medical Technologist	1	4.17
	Sanitary Inspector	1	4.17
	Administrative Staff	4	16.67
Employment Status	Permanent	7	29.17
	Contractual / Job Order	17	70.83
Length of Service	Less than 1 year to 5 years	14	58.33
	More than 5 years	10	41.67

Employment status further indicates a high proportion of contractual or job-order personnel (70.83%), which may imply job insecurity and limited employment stability. Additionally, most employees had relatively short lengths of service (58.33% with 1–5 years), suggesting high workforce turnover or recent staffing expansion. Collectively, these findings highlight a workforce structure characterized by nursing dominance, contractual employment, and relatively early-career professionals, which may have implications for workload distribution, institutional

support needs, and long-term workforce sustainability in rural health service delivery.

#### *Level of workplace stress experienced by Rural Health Unit employees in a municipal primary healthcare setting*

The findings in Table 2 indicate that Rural Health Unit (RHU) employees experienced an overall moderate level of workplace stress, as reflected in the composite mean of 2.98. This suggests that while stressors are present in the work environment, they are not perceived as overwhelming on a general scale.

However, the proximity of the composite mean to the upper threshold of the moderate range implies that workplace stress is approaching a level that may require managerial attention, particularly in a resource-constrained primary healthcare setting.

Among the identified stressors, the highest-rated concerns were multiple overlapping responsibilities (WM = 3.32) and insufficient supplies or resources (WM = 3.32), both interpreted as moderate stressors.

These findings highlight operational and resource-related pressures commonly experienced in rural healthcare facilities, where staff often perform multitasking roles due to limited manpower. Similarly, heavy workload (WM = 3.13) and documentation and reporting requirements (WM = 3.16) were also rated as moderate stressors, indicating that administrative and clinical demands collectively contribute to sustained workload pressure among RHU personnel.

**Table 2. Level of Workplace Stress Experienced by Rural Health Unit Employees (N=24)**

No.	Workplace Stressor	$\bar{x}$	Interpretation
1	Heavy workload / high patient volume	3.13	Moderate
2	Multiple overlapping responsibilities	3.32	Moderate
3	Documentation and reporting requirements	3.16	Moderate
4	Emotional demands from patient care	2.61	Low
5	Limited manpower	2.96	Moderate
6	Insufficient supplies or resources	3.32	Moderate
7	Time pressure and deadlines	2.88	Moderate
8	Work-life imbalance	2.80	Moderate
9	Lack of administrative support	2.80	Moderate
10	Limited opportunities for rest or recovery	2.84	Moderate
	Composite Mean	2.98	Moderate

Other factors such as limited manpower (WM = 2.96), time pressure and deadlines (WM = 2.88), work-life imbalance (WM = 2.80), lack of administrative support (WM = 2.80), and limited opportunities for rest or recovery (WM = 2.84) were likewise interpreted as moderate stressors. Notably, only emotional demands from patient care (WM = 2.61) was rated as low, suggesting that interpersonal caregiving stress may be less dominant compared to structural and organizational stressors. Overall, the results indicate that workplace stress in the RHU setting is primarily driven by systemic constraints such as staffing limitations, resource insufficiency, and workload distribution rather than patient interaction alone.

**Level of burnout among Rural Health Unit employees in terms of emotional exhaustion, depersonalization, and personal accomplishment**

The results in Table 3 reveal a concerning burnout profile among Rural Health Unit (RHU) employees, particularly in the dimension of depersonalization, which emerged as the most severe burnout component.

Overall, the findings indicate a mixed burnout condition across dimensions, with emotional exhaustion and personal accomplishment reflecting moderate burnout, while depersonalization reflects high-level burnout among the majority of respondents.

**Table 3. Burnout Levels of Rural Health Unit Employees by Burnout Dimensions (N=24)**

Burnout Dimension	Burnout Level	f	%	Overall Interpretation
Emotional Exhaustion	Low-level burnout	0	0.00	Moderate Burnout
	Moderate burnout	18	75.00	
	High-level burnout	6	25.00	
Depersonalization	Low-level burnout	0	0.00	High-Level Burnout

	Moderate burnout	2	8.33	
	High-level burnout	22	91.67	
<b>Personal Accomplishment</b>	Low-level burnout	0	0.00	Moderate Burnout
	Moderate burnout	18	75.00	
	High-level burnout	6	25.00	

For emotional exhaustion, the majority of employees (75.00%) reported moderate burnout levels, while 25.00% experienced high-level burnout, and none fell under the low-burnout category. This indicates that most RHU personnel are experiencing sustained emotional strain due to workload demands, responsibilities, and service pressures, although not all have reached severe exhaustion. The absence of low burnout suggests that emotional fatigue is widespread in the workforce.

The most critical finding is in depersonalization, where an overwhelming 91.67% of respondents exhibit high-level burnout, while only 8.33% report moderate levels. This suggests a significant tendency among employees to develop emotional detachment, reduced empathy, or a psychological distancing from work and patients. Such a pattern is particularly concerning in healthcare settings, as it may directly affect the quality of patient care, communication, and service responsiveness.

In contrast, personal accomplishment shows a more balanced distribution, with 75.00% experiencing moderate burnout, 25.00% experiencing high-level burnout, and none reporting low burnout. This

indicates that while employees still retain some sense of professional effectiveness, a substantial proportion is beginning to experience reduced professional fulfillment. Overall, the combined findings suggest that RHU employees are experiencing a burnout pattern characterized primarily by emotional fatigue and severe depersonalization, signaling the need for targeted interventions focused on emotional support, workload management, and organizational well-being strategies.

### ***Relationships among demographic profile, workplace stress, and burnout dimensions among Rural Health Unit employees***

The results presented in Table 4 indicate that there is no statistically significant relationship between the demographic profile of Rural Health Unit (RHU) employees and both workplace stress and burnout levels. Across all tested demographic variables—age, sex, job position, employment status, and length of service—all p-values were greater than the 0.05 significance level, suggesting that demographic characteristics do not significantly influence how employees experience workplace stress or burnout in this setting.

**Table 4.** Relationship Between Demographic Profile, Workplace Stress, and Burnout Levels

Demographic Variable	Workplace Stress p-value	Interpretation	Burnout Level p-value	Interpretation
<b>Age</b>	0.39	Not Significant	0.931	Not Significant
<b>Sex</b>	0.60	Not Significant	0.527	Not Significant
<b>Job Position</b>	0.49	Not Significant	0.295	Not Significant
<b>Employment Status</b>	0.55	Not Significant	0.795	Not Significant
<b>Length of Service</b>	0.44	Not Significant	0.155	Not Significant

In terms of workplace stress, age ( $p = 0.39$ ), sex ( $p = 0.60$ ), job position ( $p = 0.49$ ), employment status ( $p = 0.55$ ), and length of service ( $p = 0.44$ ) all yielded non-significant results. This indicates that stress levels among RHU employees are relatively consistent

regardless of demographic differences. In practical terms, this suggests that workplace stress is more likely driven by organizational and structural conditions—such as workload distribution, resource

availability, and job demands—rather than individual employee characteristics.

Similarly, for burnout levels, all demographic variables also showed no significant relationships: age ( $p = 0.931$ ), sex ( $p = 0.527$ ), job position ( $p = 0.295$ ), employment status ( $p = 0.795$ ), and length of service ( $p = 0.155$ ).

These findings imply that burnout is experienced across all employee groups in a relatively uniform manner, regardless of professional role, tenure, or employment arrangement. This reinforces the interpretation that burnout in the RHU setting is a systemic organizational issue rather than a demographic-dependent phenomenon.

Interventions aimed at reducing workplace stress and burnout should prioritize organizational-level strategies, such as workload management, staffing adequacy, resource allocation, and institutional support systems, rather than targeting specific demographic groups.

The results in Table 5 demonstrate a differentiated relationship pattern between workplace stress and the three burnout dimensions among Rural Health Unit (RHU) employees. Using Spearman’s rho correlation analysis, workplace stress shows a strong, statistically significant positive relationship with emotional exhaustion ( $r = 0.789$ ,  $p = 0.000005$ ), while its relationships with depersonalization and personal accomplishment are not statistically significant.

**Table 5. Relationship Between Workplace Stress and Burnout Dimensions**

Variables	Spearman’s r	p-value	Interpretation
<b>Workplace Stress and Emotional Exhaustion</b>	0.789	0.000005	Strong Positive Relationship / Significant
<b>Workplace Stress and Depersonalization</b>	0.378	0.068678	Weak Positive Relationship / Not Significant
<b>Workplace Stress and Personal Accomplishment</b>	-0.085	0.691679	Very Weak Negative Relationship / Not Significant

The strongest association is observed between workplace stress and emotional exhaustion, indicating that as workplace stress increases, emotional exhaustion also increases significantly. This finding is consistent with the Job Demands–Resources framework, where increased job demands such as workload pressure, multitasking, and resource constraints directly contribute to emotional depletion among employees. The strength of this correlation suggests that emotional exhaustion is the most sensitive and immediate psychological response to workplace stress in the RHU setting.

In contrast, the relationship between workplace stress and depersonalization is positive but weak ( $r = 0.378$ ,  $p = 0.068678$ ) and does not reach statistical significance.

This implies that although increased stress may contribute to emotional distancing or reduced

empathy, the effect is not strong enough to be considered statistically reliable in this sample. Similarly, workplace stress and personal accomplishment show a very weak negative and non-significant relationship ( $r = -0.085$ ,  $p = 0.691679$ ), suggesting that stress does not meaningfully influence employees’ sense of professional effectiveness in this context.

Workplace stress primarily impacts emotional exhaustion, while its influence on depersonalization and personal accomplishment is limited.

This pattern suggests that interventions aimed at reducing workplace stress are most likely to yield immediate improvements in emotional fatigue, whereas changes in deeper attitudinal dimensions such as empathy and professional fulfillment may require longer-term organizational and cultural interventions.

## *Evidence-based insights that may inform workplace stress and burnout management strategies for Rural Health Unit employees*

Table 6 synthesizes the key empirical findings of the study and translates them into practical implications for workplace stress and burnout management among Rural Health Unit (RHU) employees. Overall, the results highlight that employee well-being in the municipal primary healthcare setting is shaped more by organizational and structural conditions than by individual demographic characteristics.

In terms of demographic profile, the workforce is predominantly composed of young, female, nursing professionals under contractual or job order arrangements with relatively short tenure. This profile suggests the need for targeted human resource strategies focusing on mentorship, structured

supervision, career development, and retention programs, particularly for early-career and non-permanent staff who may be more vulnerable to workplace instability and limited institutional attachment.

Regarding workplace stress, the findings indicate a moderate overall stress level, with the most prominent stressors linked to multiple overlapping responsibilities and insufficient supplies or resources. These results emphasize the operational challenges in rural healthcare environments, where limited manpower and resource constraints intensify workload distribution issues. Accordingly, interventions such as workload optimization, clearer role delineation, improved supply chain management, and staffing adjustments are essential to reduce stress exposure.

**Table 6. Summary of Key Empirical Findings as Basis for Workplace Stress and Burnout Management Strategies**

<b>Empirical Area</b>	<b>Key Finding</b>	<b>Implication for Workplace Stress and Burnout Management</b>
<b>Demographic profile</b>	Most respondents were female, aged 20–34 years old, nurses, contractual/job order personnel, and had less than one year to five years of service.	Workforce support strategies may prioritize mentoring, supervision, retention, and professional development, especially for younger and non-permanent personnel.
<b>Workplace stress</b>	Overall workplace stress was moderate, with multiple overlapping responsibilities and insufficient supplies/resources as the highest stressors.	Task distribution, workload review, supply management, and role clarification may help reduce workplace stress.
<b>Emotional exhaustion</b>	Most respondents experienced moderate emotional exhaustion.	Stress reduction, recovery breaks, peer support, and workload monitoring may help reduce emotional fatigue.
<b>Depersonalization</b>	Most respondents experienced high-level depersonalization.	Employee wellness activities, psychosocial support, team-based engagement, and supportive supervision may help reduce emotional distancing.
<b>Personal accomplishment</b>	Most respondents showed moderate burnout in personal accomplishment.	Recognition, feedback, skills development, and performance support may help strengthen professional fulfillment.
<b>Relationship between demographic profile and stress/burnout</b>	No significant relationship was found.	Interventions should address workplace and organizational conditions rather than focusing only on demographic differences.

<b>Relationship between workplace stress and burnout dimensions</b>	Workplace stress had a strong positive and significant relationship with emotional exhaustion.	Reducing workplace stress may directly help reduce emotional exhaustion among RHU employees.
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For burnout dimensions, the study reveals a mixed pattern: moderate emotional exhaustion, high depersonalization, and moderate reduced personal accomplishment. This suggests that while employees remain moderately engaged in their roles, there is a significant risk of emotional detachment, which may negatively affect patient interaction and service quality. Therefore, recommended interventions include psychosocial support programs, employee wellness initiatives, peer support systems, recognition mechanisms, and continuous performance feedback structures to restore emotional connection and professional fulfillment.

The analysis also confirms that demographic variables do not significantly influence workplace stress and burnout, indicating that stress and burnout are experienced uniformly across employee groups. This reinforces the conclusion that interventions should focus on organizational-level reforms rather than demographic targeting.

Finally, the results show that workplace stress has a strong and significant relationship with emotional exhaustion, while its relationship with other burnout dimensions is weaker and not statistically significant. This finding underscores that reducing workplace stressors is likely to produce the most immediate improvement in emotional well-being. Consequently, management strategies should prioritize stress reduction mechanisms as a primary intervention pathway, complemented by longer-term programs addressing depersonalization and professional fulfillment.

#### **IV. CONCLUSION & RECOMMENDATION**

The study established that Rural Health Unit (RHU) employees experience a moderate overall level of workplace stress and a multidimensional pattern of burnout characterized by moderate emotional exhaustion, high depersonalization, and moderate reduced personal accomplishment. Statistical analysis further revealed that demographic factors such as age,

sex, job position, employment status, and length of service have no significant relationship with either workplace stress or burnout, indicating that these conditions are largely organizational in nature rather than individually driven. Importantly, workplace stress showed a strong and significant positive relationship with emotional exhaustion, confirming that increased job demands and resource constraints directly intensify emotional strain among healthcare workers. Overall, the findings highlight that burnout in the municipal primary healthcare setting is primarily influenced by systemic workplace conditions, particularly workload distribution and resource limitations.

To address the identified workplace stressors and burnout patterns, the Local Government Unit and RHU management should prioritize organizational-level interventions focused on workload optimization, staffing adequacy, and resource management. This includes redistributing tasks to prevent overlapping responsibilities, strengthening supply chain systems to ensure consistent availability of essential materials, and reviewing staffing policies to reduce dependence on contractual or job order arrangements. In addition, structured employee wellness programs should be implemented, including regular psychosocial support, stress management training, peer support systems, and scheduled recovery breaks to reduce emotional exhaustion and depersonalization. Leadership development and supervisory training are also recommended to enhance administrative support and improve workplace engagement. Finally, a continuous monitoring system for workplace stress and burnout should be institutionalized to track employee well-being and evaluate the effectiveness of interventions over time, ensuring sustainable improvements in workforce performance and service delivery quality.

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