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Examining the organizational factors that affect health workers' attendance: Findings from southwestern Uganda

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Summary

Sub-Saharan Africa experiences human resources crisis in the health sector. Specifically, Uganda faces significant shortages in health care workforce at all levels. However, there is limited literature on factors contributing to health care workforce absenteeism. This study aims to explore reasons for absenteeism among health workers in rural Uganda. Data were collected using a demographic questionnaire and focus groups. Eight focus groups were conducted with participants ($n = 27$) selected from 39 selected health centers. Four main themes emerged as the reasons for absenteeism among health workers. These included personal/family related challenges, distance or transportation issues, income specifically additional sources of income, and poor support/supervision. Barriers to active engagement at work were also identified, including loss of motivation, concerns at home, patient level issues, and lack of equipment.

Recommendations were also elicited from the participants. These findings are critical in formulating and developing interventions to address absenteeism and low performance among health workers.

Keywords

absenteeism; health workers; sub-Saharan Africa

1 | BACKGROUND

Over the last decade, the Human Resources for Health (HRH) crisis has received increasing global attention particularly in sub-Saharan Africa, where the World Health Organization (WHO) has identified critical shortage of health workers in 36 countries out of 57.¹ The United Nations' (UN) 2030 Agenda for Sustainable Development underlines the importance of managing the HRH crisis as part of a major goal in enhancing health of all people,

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DECLARATION OF INTEREST STATEMENT

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especially in countries that are least developed.² Yet, despite the immense progress made in global health, the African Region suffers more than 25% of the global burden of disease, with access to only 3% of health workers and less than 1% of the world's financial resources.¹ Additionally, the needs-based shortage is focused to worsen by 2030 in the African region.¹ The African region is projected to have a health worker shortage of up to 6.1 million by 2030.³

In the context of high disease burden coupled with health workforce shortage in low and middle income countries (LMICs), the magnitude of high absenteeism among health workers and its associated costs, both direct and indirect, are especially detrimental.⁴ For instance, Chaudhury and colleagues⁵ conducted the first multi-country survey of health worker absence in Bangladesh, Ecuador, Indonesia, Peru, and Uganda. The study findings showed that on average, doctors were absent (39%) more often than other health workers (31%). Cheriyan, Arya, and Singh⁶ published a report on the rate of absenteeism in 30 health centers in Tonk District of Rajasthan, India. The health workers, which included doctors, ayurveda doctors (Indian traditional medicine), nurses, lab technicians, pharmacists, and midwives, were marked absent if they were not at the health center at their scheduled time, which was measured through the attendance records and through unannounced and secret visits during working hours for the period of 30 days. Average absence rate across all health workers was 27%, with doctors having the highest rate of 36% and male nurses having the lowest rate of 12%. The absence rates obtained through attendance records were found to be around 10% lower on average, indicating that health workers managed to sign in without being present at the health center.

The Uganda National Health Users'/Consumers' Organization (UNHCO)⁷ reported on the prevalence and factors associated with health provider absenteeism among 78 health facilities in Bushenyi District in Western Uganda. Absenteeism was defined as both authorized and unauthorized absences from the health workers' scheduled time of duty, which was measured by multiple unannounced visits to track attendance of all staff at each health facility. Many types of health workers were included in the study, with the majority being clinical staff (eg, medical doctor, enrolled and registered midwife) and the rest non-clinical staff (eg, clinical officer, laboratory assistant). The average rate of absenteeism was 48% among all types of health workers. Nursing officers had higher rates of absences (24%) compared with nursing assistants and enrolled nurses (18%), enrolled midwives (15%), and lab assistants (6%).

Numerous reasons have been documented for health worker absenteeism. A qualitative study conducted by Lindelow and Serneels⁸ on the performance of health workers in Ethiopia reported that poorly regulated work environment was a cause of health worker absences in the public sector. In some cases, health workers used tea breaks to work in private practices, while others, more so among doctors, absenteeism is as a result of a second job. This often translates to being away from work during some parts of the day, or the whole day.^{8,9} In Tanzania, Mubyazi et al¹⁰ conducted a health facility survey with clinical staff and nurses in 135 health facilities. On the day of the survey, 44% of clinical staff and 49% of nurses were absent mostly due to attending meetings, seminars or other official travels (vaccines, drugs, or wage collections). The UNHCO study in Bushenyi, Uganda reported that reasons for

authorized and unauthorized absences included primarily the following reasons: off duty (33.6%), don't know (18.1%), night duty (13%), outreach (7.6%), and sick (6.2%).⁷ However, a systematic review of absenteeism among health workers found that very few studies were conducted in LMICs and inaccurate and incomplete records made verifying reasons for absence difficult.¹¹

Cost of absenteeism is high on individual, organizational, and national levels, particularly in LMICs.⁴ At the individual level, Goldstein et al¹² found that nurse absenteeism is associated with less acceptance of HIV testing, counseling services, and hospitalization use. Organizations also suffer financial cost of reduced productivity due to absenteeism. In the district of Machakos in Kenya, absenteeism led to direct costs of \$51 000 per health center each month.¹³ Health worker absenteeism is estimated to have cost the government of Uganda 26 billion Uganda shillings annually—approximately \$7 222 000.¹⁴

Similar to many LMICs mentioned previously, Uganda is faced with the persistent state of critical health worker shortage and high rates of absenteeism. In the 2015/2016 financial year, the health worker to population ratio in Uganda was 7.4 per 10 000, compared with the WHO guideline of 23 per 10 000.¹⁵ Moreover, vacancies for health workers have been particularly acute in rural areas and local level health facilities.¹⁶ According to the Ministry of Health,¹⁷ more than 70% of medical doctors and 40% of nurses and midwives work in urban areas, while most of the population (88%) in Uganda lives in rural areas. In a study discussed earlier,⁷ it was found that the average rate of absenteeism was 48% in the Bushenyi District where 80% of the population live in rural areas. More recently, the Health Monitoring Unit conducted a series of random visits to health centers in 17 districts of Uganda and found absenteeism rates as high as 61.6% in Lwengo District and 56.4% in Masaka District.¹⁸

Against this backdrop, this study intended to examine the factors contributing to health worker workplace attendance and motivation. The proposed study may contribute to efforts that address factors related to workplace attendance, and retention of health workers, specifically, those located in rural areas in Uganda. It also aims at identifying barriers to improvement of health worker's attendance as well as eliciting possible solutions that may increase work place attendance for health workers.

2. | METHODS

2.1 | Study setting

Participants in this study were recruited from 39 selected health centers in Masaka, Rakai, Kyotera, Lwengo, Bukomansimbi, and Lyantonde districts participating in the Suubi +Adherence study.¹⁹ The Suubi+Adherence study¹⁹ study examines the impact of an economic empowerment intervention on adherence to antiretroviral therapy among adolescents.

This study takes place in the Greater Masaka region, the region most affected by HIV/AIDS in Uganda with higher prevalence rates of 7.9%, compared with the national average of

6.9%.¹⁵ This is attributed to a landing site known as *Kasensero* in Rakai district which was a catalyst area contributing to the spread of HIV.

2.2 | Sample

A total of eight focus groups were conducted with 27 health workers, including expert clients ($n = 2$), lab assistant ($n = 1$), enrolled nurses ($n = 6$), counselors ($n = 9$), nursing officer ($n = 1$), laboratory staff in charge ($n = 1$), medical officer ($n = 1$), registered comprehensive nurse ($n = 3$), public health nurse ($n = 1$), in-charge staff at ART clinic ($n = 1$), and art aide ($n = 1$). Forty-four percent of these were males ($n = 12$), and 56% of these were women ($n = 15$). The age for the health workers ranged between 23 and 53 years and ranged in educational level qualifications. All health workers identified as clinic contact persons for the Suubi+Adherence study were invited to participate in the study. To ensure participation from all members, group size ranged from three to five participants per group. The relatively small number per group was also intended to maximize the capture of audio data.

2.3 | Data collection

Data were collected using a demographic questionnaire and focus groups. The demographic questions provided basic information about the participants including age, gender, and job title. The focus group interviews were designed to encourage participants to share both positive and negative experiences in a nonjudgmental atmosphere. The focus group guide allowed for participants to spontaneously communicate their experiences without over direction by interviewers. Additionally, the interview guide was designed to elicit data regarding the research questions in the event this information did not emerge spontaneously in the focus group discussion. Some of the questions asked included: “In your view, why do healthcare workers fail to attend work during working hours? We are referring to those times when healthcare workers are supposed to be at their place of duty and they do not show up”; “In your view, what prevents healthcare workers from being actively engaged at work with patients?”

Focus groups were conducted primarily in English although respondents were allowed to use Luganda (the native language in the area). The data were collected by Uganda two research staff, one of whom also analyzed the data and is an author on this paper. They were fluent and able to understand as well as communicate in that language. Group discussions lasted 45 minutes to 1 hour and were conducted at selected health facilities within the area. All focus groups were audio recorded.

Focus group methodology is one of the ways that can be used to enable participants discuss shared attitudes and gives room for one to identify commonalities in the way they see and understand things.²⁰ Focus group protocol included semi-structured interview questions. Questions intended to cover participant thoughts and experiences related to helping health workers come to work and remain engaged in their work. Based on McCracken's²¹ interviewing method, participants were afforded latitude to describe their unique realities, perceptions, and experiences, yet the interviews were sufficiently structured to elicit critical

data. In so doing, we maintained an essential balance between honoring participants' uniqueness and deriving pertinent and interconnected data for analysis.

2.4 | Data analysis

Focus group data were transcribed verbatim and translated where necessary. Following transcription, audiotapes were erased, and unique study identifiers were assigned to each participant. Transcripts were uploaded to Dedoose software.²² Thematic analysis using open and axial coding^{23–25} was utilized to analyze the data. This software program allows for each discourse to be categorized into individual and group themes. Three coders analyzed the data. These were all Ugandans that understood both Luganda (local language) and English.

A system of multistage coding was used to assist in data analysis. This approach called for the initial use of open coding (codes that reflect the actual words of respondents) of the raw data to identify key concepts. This was followed by axial coding to organize the open codes into themes and to look for subsequent patterns in the data.

Each person analyzed the data separately and independently. Topics in the focus group guidelines were used to come up with an initial coding scheme. These included topics such as reasons for absenteeism, frequency of absenteeism, reasons for lack of engagement at work, and possible solutions or prevention practices. Following the identification of themes through the first round of coding, a second round of coding was used to identify sub themes such as lack of motivation, personal/family related issues, distance, and transportation. These were then discussed in meetings with dissenting views addressed. Following this, coding was finalized.

2.5 | Ethical considerations

This study received IRB approval from Uganda Virus Research Institute and research clearance from Uganda National Council for Science and Technology. No participant was excluded from the list of participants because of age, ethnicity, race, tribe, gender, sexual orientation, religion, political affiliation, or any other socio-economic characteristics. Participation in the study was voluntary. Participants were informed about the purpose of the study. Written informed consent was obtained from each study participant prior to participation in the study. Participants were informed about the anonymity of the data collected. Verbal and written consent was obtained to record the participant's voices during the discussions. Refusal to participate in the study did not interfere with the collaboration between the study participants and the research staff.

3 | FINDINGS

Four main themes emerged from the focus group discussions as the reasons for absenteeism among health workers. These included personal/family related challenges, distance or transportation issues, financial incentives, and lack of regular supervision. Barriers to active engagement at work were also identified. These included loss of motivation, concerns at home, patient level challenges, and lack of equipment.

3.1 | Absenteeism

Absenteeism was defined as the period when health workers were supposed to be at work/ their place of duty but did not show up. Numerous reasons were brought up in the focus groups, both at the individual/family and organizational levels.

3.1.1 | Personal/family related challenges—Most of the study participants voiced personal commitments and issues as reasons for not showing up to work during working hours. Health workers were also affected by the AIDS epidemic in the area. In some cases, health workers' children or themselves were HIV positive. Relatedly, they would need to seek HIV services and would miss work. However, health workers would rarely disclose the HIV status to their employers, most likely due to HIV stigma or fear.

“Social issues like he said to attend to their children others may also be like having children who are HIV infected and they are not willing to share with their bosses. Personally, they may be themselves infected but they have never shared with their employers. So it's rare for them to disclose to their bosses/ employers to know about them so sometimes they don't appear because they have gone to attend to other services (health centers) for care and support or their children to get care and support.” (Focus Group #5, female)

Other personal issues included domestic violence in the household. According to one of the participants, health workers would “disappear” from work because they would not feel that they could perform their duties due to the trauma they experienced at home:

“Social issues that are involved within the families. Not only within the families but within the communities. Some people like in cases of domestic violence someone can't attend to the other clients because of the trauma and in case of attendance then you will not perform to give good results. So sometimes they feel they cannot perform and then they disappear. They can give reasons which are not really the actual reasons because of their confidentialities.” (Focus Group #5, female)

One participant highlighted the demands and responsibilities of a family and how it would interfere with health worker's ability to attend work: “You can't report there (at health facility) when you have other demands at home. I left the kids with no sauce (gravy) and food. I have to first look for the food and then report to work.” (Focus Group #6, male)

3.1.2 | Distance or transportation issues—Participants mentioned distance to and from work as a factor affecting their engagement at work most especially during the rainy season which made transportation difficult. Most roads in rural areas are marram (dirt roads). These are especially difficult in the rainy season because they are susceptible to flooding as well as becoming extremely muddy, making it difficult to navigate by motorcycles and motor vehicles due to the slippery roads. As a result, public transportation comes to a halt when it rains. Passengers normally have to wait until it stops raining to resume transportation which becomes scarce as a result of an influx of passengers after the rain.

“Even there are some climatic conditions for example this rainy season. Like me I am coming from some distance from where I stay and even where I work. I may

reach late and you find some clients have missed or have gone when they have not got what they are supposed to get.” (Focus Group #1, female)

Passengers using public transport are often over loaded in a vehicle following rain or storm. By the time a health worker reports to work, he/she is already exhausted and frustrated from the delayed transport to work. Their work ethic and engagement is therefore compromised. These frustrations were aired: “I get there when I am tired. I come from very far.” (Focus Group #8, female) Another respondent added: “You arrive tired from being squashed on the taxi ride.” (Focus Group #8, female)

Relatedly, participants reported that they would also leave work early during the rainy season to navigate the scarce public transportation and traffic so that they could make it home on time to attend to their family responsibilities.

Other issues regarding transportation were beyond health workers’ control, especially when they had to rely on a third part for transportation:

“Some of us who don’t have transport means (private), we are not driving, we are not drivers so the driver as a human being has family issues, so sometimes they come late, they come even when they are tired. So it makes us start a bit late at work.” (Focus Group #3, male)

3.1.3 | Financial incentives—Participants also listed financial problems, such as payment delays and low wages. Some health workers skipped work deliberately due to lack of payment. Others reported skipping work because they simply did not have funds for their transport and upkeep at work among other reasons. A health worker explained having to go incognito or in hiding to avoid debtors as a result of salary delays below:

“Sometimes you haven’t received your money on time but the owner of the money is asking you for it. So now you have to disappear for a few days until the salary comes in and you come back and pay him then return to work.” (Focus Group #2, female)

Salary delays also resulted in health workers seeking for alternative sources of income for their daily upkeep. This often meant that they had to forego their duties at their respective health centers to look for income to sustain their families. This was also contingent on how long the delays were. As expected, short delays were bearable, but the longer the salary took, the more likely other sources of income were explored:

“It depends, how many months you have missed (salary delay) because if you miss like more than two months and the children are at school yet you have other things to spend too of course I have to leave duty and go and look for greener pastures somewhere, in order to meet my needs.” (Focus Group #2, female)

Salaries were sometimes remitted in phases or bits. Health workers reported facing difficulties in collecting their salaries, especially in cases where partial payments were made. At times, officers responsible for remitting salaries required monetary incentives to process one’s salary:

“And sometimes we miss those salaries, you go to your human resource people they promise you the next month. The following month they promise you another month. If you are demanding for two months, they may pay you like one and a half month. Rather than going back to look for that other half, you rather sit at your place and wait because the transport you’re going to spend is more than what you are going to request for. Even themselves as they sit in those offices they need an extra motivation if you don’t motivate, your papers will be in the basket there.” (Focus Group #2, female)

As a result, she handled this situation by working for a private clinic to generate income during the salary delays. Private health centers are known for better pay and regular payment of employees, hence are highly sought after by health workers: “So you think, why bother a lot let me go to so and so’s private health clinic after all this one will come anytime there am going to get something faster.” (Focus Group #7, female)

Alternatively, health workers augment their salary using income generating activities such as through farming.

“Another thing they pay us very little according to our pocket these days. The money we get is not enough for our usual things to be done at home. So sometimes you may find yourself digging [farming] in the morning and coming to duty a bit late that’s the other fact also.” (Focus Group #7, female)

3.1.4 | Lack of regular supervision—Health centers, especially government facilities, have minimal supervision. This was associated with higher absenteeism rates. Employees were more likely to skip work if their supervisors/bosses were also absent: “If the leadership dodges duty, I will also dodge.” (Focus Group #1, female)

Due to the lack of supervision from government facilities, there was no penalty or punishment for skipping work. As a result, going to work became seemingly optional:

“Since it is a government center, as you know the salaries, even if you work, even if you don’t work the salary will be there. Now you find that even if you work hard, even if you appear on duty every day and somebody who doesn’t appear or in a month appears about 2 days you are all going to get the same salary, hmmm ... same salary, same amount of money so that one can affect the team.” (Focus Group #4, female)

3.2 | Barriers to active engagement at work

Participants indicated many factors affecting their ability to actively engage at work. Some of these are overlapping with reasons for absenteeism. Health workers may show up to work but are not productive at work. Emergent themes for reasons as to this happens include loss of motivation, concerns at home, patient level issues, and lack of equipment.

3.2.1 | Loss of motivation—Health workers reported a lack of intrinsic and/or extrinsic motivation. Some health workers simply lacked the zeal to do their work regardless of any

external factors such as incentives or proper working conditions. One health worker attributed it to a “call” for the profession:

“If you have less interest you spend less time with the patients. Devotion or interest to do the work like somebody talked of being a call. You were forced by your parents to go into that profession, you don’t have interest in what you are doing but somebody who really has interest, will sit at that place and attend to that person (patient) fully.” (Focus Group #1, male)

Extrinsic motivation was also needed for employees to be engaged at work. This was not only in the form of monetary incentives but other items such as uniforms, notebooks, all of which had been provided in the past

“Sometime back, the government used to provide uniforms, shoes those things eh but these days they keep on promising, take your measurements we are bringing you this. They would even motivate staff in different things maybe this time they would give uniforms; another time they would give you pens. Every stock that you need at the facility is there so you don’t have to spend your own money to buy something for the patient.” (Focus Group #5, female)

Poor support or supervision as earlier mentioned as a reason for absenteeism also affected the engagement at work. In addition to offering guidance and direction, supervisors were seen as playing a key role in leading to career growth and development, by motivating employees through regular feedback:

“If you don’t give feedback to a worker that also demotivates somebody you might find that someone thought he is hardworking but without feedback somebody decides to withdraw so feedback is very important.” (Focus Group #8, female)

3.2.2 | Concerns at home—Personal issues were not only a reason for missing work but were also a hindrance to active engagement at work. One respondent highlighted how family issues could affect one’s interactions with the clients. For example, a health worker might dispense drugs without talking to the patient or might talk to them harshly because of their own personal frustrations from home. A health worker emphasized:

“Even family issues matter, one may leave home when she/he is angry and one decides to keep quiet and can’t speak to the patient at all, one dispenses all the drugs without speaking to the patient at all.” (Focus Group #1, female)

Having a sick child at home also affected their active engagement at work because of concern for a sick spouse or child. One participant stated:

“Family issues, things to do with kids. Someone may call in the morning at home my child is sick, my wife is sick so you find it is hard for that person to come and concentrate here (at the clinic) when the child is sick.” (Focus Group #1, female)

3.2.3 | Patient level challenges—Given the rural context in which health workers operated, they talked about the high numbers of patients with low literacy or familiarity with illnesses and medical concepts. Hence, health workers spent longer time with patients to ensure the patients understood the information provided because they have to explain each

and every concept at a very basic level. This process hindered health care workers' ability to attend to all patients in a timely manner:

“Another thing our patients lack information, so you have to struggle to teach them what they are supposed to do because they are not informed you end up taking a longer time trying to explain what they are supposed to do. Actually the levels of illiteracy in our people are still high that's a very big factor that can hinder a health worker from actively participating with them because you have to struggle teaching them a lot of things.” (Focus Group #7, male)

Patients expect all health centers to be able to handle all of their illnesses which is not the case. Our system has different levels of health centers that treat patients in varying levels of illness from a health center level II to a hospital. One health worker highlights how patient level ignorance affected his work:

“These patients expect that we know everything and they expect a lot from us. Once you happen to say that this one am not conversant with, he or she may think that you have refused whereas you are telling the truth. They forget that referrals within or outside your facility is part of treatment. A patient goes thinking that they have chased them from your health facility yet you are referring them to the district hospital. A patient tells you I don't have money to take me there (hospital) as if you are the one to provide it. They expect a lot from us of which we cannot afford. (Focus Group #2, female)

3.2.4 | Lack of equipment—Health workers reported many of their centers lacking the proper tools or having medical supply shortages. Hence, they were unable to provide services to clients because they lacked the instruments needed to do their work. The health workers therefore came to work but were unable to work: “For example, someone comes in with a cut wound and we don't have sutures. We don't even have forceps. I don't think you can do much.” (Focus Group #6, female) Another respondent added: “The materials to use are not sterilized because there are no sterilizers. So you just work to save life but it's not quality work.” (Focus Group #6, male)

This also led to an increased work load for the existing health workers:

“If you're the one supposed to man a full department like the ART clinic. Somehow you may not find yourself being actively relating with patients because of the work overload. You find yourself working to beat time so that you can complete the work.” (Focus Group #7, male)

3.3 | Recommendations

Health workers provided information on how absenteeism can be reduced or eliminated as well as on how to motivate health workers and reduce their stress to improve their performance. The main recommendations included improving working conditions, stronger support or supervision, salary, and workshops.

3.3.1 | Improving work conditions—Recommendation regarding working conditions included improvement of general working conditions as well as benefits and equipment.

Different salary tiers were suggested with rural areas getting a higher salary compared with their urban counter parts.

“I think there are some places which are hard to reach. There should be an extra fee given to hard to reach area staff. I think that can motivate us but you cannot work on an equal salary. You can’t compare it with someone working in the central or on the main road but currently, the same amount (salary) that is given to someone working in distant areas.” (Focus Group #7, male)

Other recommendations included ensuring that all supplies needed to perform on the job were met such as fuel:

“Motivation does not mean money alone. Even if you don’t give me an allowance, but when am riding a motorcycle, make sure that I have a helmet, rain coat, fuel, and I’m not the one to do service on the motorcycle which is not mine (government owned). That’s motivation, at the end of the day.” (Focus Group #3, male)

3.3.2 | Stronger support/supervision—Health care workers pointed out the need to receive additional trainings on various topics because of the evolving nature of medicine. They also need stronger support from supervisors such as through conflict resolutions among staff.

“Sometimes if there is any new information which has come up we do sit and we hold CME’s (continuous medical education) if someone is having any new idea, he passes it to you during that time.” (Focus Group #8, female)

They also needed stronger support from “bosses,” especially in situations where there was conflict among staff. One of the participants pointed to the importance of having an open channel of communication as well as paying attention to the dynamics at the workplace for their superiors.

“Good communication between providers (health care workers) at lower stations and the officials up, it would sometimes minimize stress. If I have something stressing or challenging within my facility (health center) between me and a fellow provider and I talk to my bosses, then they can maybe reconcile us. If it fails, they can move me elsewhere (transfer to another health center). I am ready to provide (services) but if you insist on me staying when I don’t have peace, I will not attend (work) but all that will only come about if bosses don’t come around to see what’s on ground. If they come only once a year they won’t know what’s going on at the site, then they end up saying Kooki (region) doesn’t work.” (Focus Group #2, female)

4 | DISCUSSION

This study explored factors contributing to health workers’ absenteeism and active engagement while at work in rural Uganda. In both instances, contributing factors included individual, organizational, and structural-level issues. Health workers identified personal/family-related issues, lack of financial incentives, distance from workplace and related transportation issues, and lack of regular supervision as factors contributing to absenteeism.

Lack of motivation, concerns at home, patient level challenges, and lack of necessary resources interfered with health workers' active engagement when they were at work.

Personal and family concerns at home led health workers to be minimally engaged with patients while at work, or skip work altogether. This is similar to findings from previous studies that found that employees with family or personal conflict were less likely to be committed at work and vice versa.²⁶

For health workers who lived at a distance, transportation became a factor that hindered attendance. Especially during rainy season, participants stated that many health workers chose not to come to work or leave early to be able to return home in a timely manner. Previous studies indicated transport barriers as a hindrance to health care access for patients.²⁷ However, few studies have examined this effect for service providers/health workers.

Active engagement of health workers was affected by working conditions, similar to other studies.¹⁰ Drug stock outs, lack of resources, and heavy workload have been identified as some of the factors that have greatly and negatively impacted the active engagement of the health workforce in Uganda. An analysis of the health system in Uganda found a shortage of equipment and supplies following decentralization—the current system in Uganda.²⁸ The impact of lack of resources was further exacerbated by the amount of time health workers had to devote to some patients due to literacy challenges and limited knowledge, which increased their workload and interfered with their efficiency in the face of scarce personnel.

While other studies have found recognition as a major factor in health worker motivation,^{29,30} financial incentives, and better working conditions including housing were more pronounced in this study. Health workers talked about the importance of having regular supervision and receiving feedback from their supervisors.

The lack of regular supervision interfered with health workers' motivation to show up at work and perform well while at work. Another important hindrance to both attendance and active engagement was financial incentives, or lack thereof. In addition to low wages, health workers also expressed concern about the irregularities in salary payment. This led to health workers looking for second jobs at higher paying clinics. Factors surrounding health worker remuneration and supervision found in our study have been raised previously in other countries. Willis-Shattuck and colleagues³⁰ conducted a systematic review of the effect of financial and non financial incentives on motivation and retention among health workers in developing countries. They found that the most effective ways to motivate health workers combined both financial and non financial incentives.

There is an urgent need to improve HRH and consistency of services in Uganda in order to address the adverse health needs of the population. Low health worker density has been found to negatively affect various health outcomes of the population including maternal and child mortality, vaccination coverage, and Disability Adjusted Life Years.^{31,32} Thus, absence of health workers is likely to aggravate the lack of access to quality care.⁴ The low density of health workers and high absenteeism rates are major barriers in achieving the Sustainable Development Goals on health in Uganda. In tandem with the UN's Sustainable Development Goals, Uganda Vision 2040 was introduced by the Ugandan government in 2013.³³ The

Uganda Vision 2040, the country's long-term development goals for socio-economic transformation, clearly states the importance of improving the quality of the country's population health as one of key tools in sustainable development for the country. Further, it emphasizes the need for improved training and remuneration for health professionals to establish Uganda as a regional hub for specialized health care services.

The main recommendations from health workers included financial incentives, improvement of working conditions, and stronger support, many of which have been recently acted upon by the government. Although the government put in place remuneration plans for health care workers,³³ issues surrounding delay in receipt of payment remained prevalent within the different health cadres.

Distance from work place/issues surrounding transportation to and from the work place are currently being addressed by the government by provision of free/affordable housing near or within the hospital premises.¹⁶ Not-for profit hospitals have provided housing for staff and transportation for the staff that reside further from the hospital.

The government is currently working to streamline remuneration of health workers by increasing the budgetary allocation to the ministry of health. While supervision of health care workers has mixed results,^{34,35} Uganda has strengthened supervision of health workers by creation of monitoring unit directly under the president's office.¹⁸ Despite these measures, there remain gaps in the supervision of health care workers which has ultimately resulted in reporting late to the workplace. Similar to findings in Kenya where health workers are paid irrespective of whether they work or not,¹³ government workers in Uganda are also paid even when there is no work performed, as also noted by the participants. Hence, the payment system needs to be linked to the hours or days worked. Adopting the monitoring systems private health centers have in place may ensure a better tracking of work hours and related compensation. Moreover, opportunities to earn more should be provided for employees that meet certain criteria such as perfect attendance, number of patients attended, and patient satisfaction ratings.

5 | LIMITATIONS

While the study recruited from 39 clinics, participants from 34 clinics participated in the study. Hence, seven types of clinics were not represented in the sample. Moreover, certain categories of the health care workforce are underrepresented in our sample, especially those holding higher (eg, supervisory) positions within clinics. Future research should include senior leadership within the health care workforce on the ground. The inclusion of the perspectives of more senior health care workers and/or administrators will allow for a deeper understanding of the dynamics leading to structural and organizational level challenges expressed by participants in this study.

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