

East African Journal of Business and Economics
eajbe.eanso.org
Volume 9, Issue 3, 2026
Print ISSN: 2707-4250 | Online ISSN: 2707-4269
Title DOI: https://doi.org/10.37284/2707-4269

EAST AFRICAN NATURE & SCIENCE ORGANIZATION

*Original Article*

# Work Team Stability and Quality of Health Care in Uganda; Evidence from Health Centre IVs in South Western Uganda

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**Article DOI: https://doi.org/10.37284/eajbe.9.3.5479**

**Date Published:** *04 August 2026*

**Keywords:** *Quality of Health Care, Healthy population, Work Team Stability, Western Uganda.*

## ABSTRACT

Purpose: Given the critical role of quality of health care in promoting a healthy population, this study examined the relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda. Design/methodology/approach: A cross-sectional design using a mixed-methods approach was adopted. Data were collected from health care workers in selected Health Centre IVs using questionnaires, key informant interviews, and document review. Quantitative data were analysed using descriptive statistics, Pearson correlation, and regression analysis, while qualitative data were analysed thematically. Findings: The findings revealed a positive and statistically significant relationship between work team stability and quality of health care ($r = 0.440$, $p < 0.01$). Consistent with this, regression results showed that work team stability significantly predicted quality of health care ($\beta = 0.352$, $p = 0.003$), with the model explaining 19.4% of the variation in quality of health care ($R^2 = 0.194$). Originality/value: This study provides empirical evidence on the role of work team stability in influencing quality of health care in public health facilities in Uganda, highlighting workforce stability as a critical factor in improving service delivery.

**APA CITATION**

Bangirana, S., Mulogo, E. M., Mucunguzi, C., Musiita, B. & Bakashaba, R. (2026). Work Team Stability and Quality of Health Care in Uganda; Evidence from Health Centre IVs in South Western Uganda. *East African Journal of Business and Economics*, *9*(3), 362-371. https://doi.org/10.37284/eajbe.9.3.5479.

**CHICAGO CITATION**

Bangirana, Sephas, Edgar Migema Mulogo, Charles Mucunguzi, Benjamin Musiita and Rennie Bakashaba. 2026. "Work Team Stability and Quality of Health Care in Uganda; Evidence from Health Centre IVs in South Western Uganda". *East African Journal of Business and Economics* 9 (3), 362-371. https://doi.org/10.37284/eajbe.9.3.5479.

**HARVARD CITATION**

Bangirana, S., Mulogo, E. M., Mucunguzi, C., Musiita, B. & Bakashaba, R. (2026). "Work Team Stability and Quality of Health Care in Uganda; Evidence from Health Centre IVs in South Western Uganda", *East African Journal of Business and Economics*, 9(3), pp. 362-371. doi: 10.37284/eajbe.9.3.54579.

**IEEE CITATION**

S., Bangirana, E. M., Mulogo, C., Mucunguzi, B., Musiita & R., Bakashaba, "Work Team Stability and Quality of Health Care in Uganda; Evidence from Health Centre IVs in South Western Uganda", *EAJBE*, vol. 9, no. 3, pp. 362-371, Aug. 2026.

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Article DOI: https://doi.org/10.37284/eajbe.9.3.5479

**MLA CITATION**

Bangirana, Sephas, Edgar Migema Mulogo, Charles Mucunguzi, Benjamin Musiita & Rennie Bakashaba. "Work Team Stability and Quality of Health Care in Uganda; Evidence from Health Centre IVs in South Western Uganda". *East African Journal of Business and Economics*, Vol. 9, no. 3, Aug. 2026, pp. 362-371, doi:10.37284/eajbe.9.3.5479.

## INTRODUCTION

Quality of health care is widely recognised as a fundamental component of effective health systems and population well-being (World Health Organization, 2021). High-quality care is characterised by safety, effectiveness, timeliness, and patient-centeredness, which are essential for improving health outcomes and reducing preventable mortality, particularly in low- and middle-income countries (Matovu *et al*., 2022). Across Africa, gaps in quality of care continue to be reported despite expansion in service access, with persistent challenges observed in clinical practices, patient safety, and responsiveness of services within health systems (Hategeka *et al.*, 2020). These patterns highlight the need to focus not only on access to care but also on how health services are organised and delivered within facilities.

In Uganda, health sector reforms have prioritised increased service coverage through investments in infrastructure, human resources, and primary health care systems. Reports from the Ministry of Health Uganda (2024) indicate that variations in quality of health care persist across public health facilities, including Health Centre IVs. National survey findings show concerns related to waiting times, patient safety, and consistency in care delivery, particularly in rural and semi-urban settings (Uganda Bureau of Statistics & ICF, 2022). Additional studies in Uganda report differences in facility performance linked to organisational conditions and workforce-related factors within health facilities (Kabunga *et al.,* 2024). These observations point to the importance of examining internal facility conditions associated with variations in service delivery.

Work team stability is discussed in the literature as an organisational condition within health care settings, referring to continuity of staff, clarity of roles, and consistency in team composition over time (Salas *et al.,* 2018). Studies conducted across African health systems report workforce challenges such as staff turnover, absenteeism, and staffing imbalances, which affect team composition and daily operations (Waweru *et al.*, 2020). In Uganda, similar patterns have been documented in public health facilities alongside variations in care processes and patient experiences (Apiyo *et al.,* 2022). Despite these findings, limited empirical attention has been given to how work team stability relates to quality of health care within Health Centre IVs in South Western Uganda. This study was therefore undertaken to examine the relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda.

## LITERATURE REVIEW AND HYPOTHESIS DEVELOPMENT

Work team stability is conceptualised as the extent to which health care teams maintain continuity in staffing, clarity of roles, and consistency in team composition over time (Salas *et al.*, 2018). Within health care settings, stable teams are characterised by reduced turnover, predictable team structures, and clearly defined responsibilities among staff. In contrast, instability in teams is reflected through frequent staff transfers, absenteeism, and reliance on temporary personnel, which alter team composition and disrupt routine operations (Waweru *et al.*, 2020). In primary health care environments, particularly in resource-constrained settings, these workforce conditions are commonly reported and are associated with variations in how care activities are organised within facilities.

Quality of health care is defined in terms of the extent to which health services meet established standards related to effectiveness, patient safety, and patient-centeredness (World Health Organization, 2021). These dimensions are used to assess whether care provided meets expected standards while responding to patient needs. In

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Article DOI: https://doi.org/10.37284/eajbe.9.3.5479

public health facilities, variations in these dimensions are observed across settings, with differences in service delivery linked to internal organisational conditions within facilities (Matovu *et al.*, 2022). In the Ugandan context, quality of care in Health Centre IVs is assessed through indicators such as consistency in service provision, patient experiences, and adherence to clinical standards (Ministry of Health Uganda, 2024).

The relationship between work team stability and quality of health care is discussed in the literature in relation to how team organisation is associated with care processes within health facilities. Studies in health systems report that variations in team composition are observed alongside differences in coordination of care, communication among staff, and continuity in service delivery (Rosen *et al.,* 2018). In African health systems, workforce-related conditions such as staffing imbalances and turnover are reported together with variations in service delivery practices within facilities (Hategeka *et al.,* 2020). In Uganda, similar patterns are documented where organisational and workforce conditions within facilities are observed alongside differences in care processes and patient experiences (Kabunga *et al.,* 2024). Based on the literature, the following hypothesis is developed.

### Hypothesis

H1: There is a significant relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda.

## METHODOLOGY

### Research Design

The study adopted a cross-sectional design within a mixed-methods approach to examine the relationship between work team stability and the quality of health care in Health Centre IVs in South Western Uganda. Cross-sectional designs are suitable for analysing relationships among variables at a single point in time without altering the study setting, while mixed methods approaches allow integration of quantitative and qualitative evidence to strengthen interpretation of findings (Johnson & Onwuegbuzie, 2004; Tashakkori & Teddlie, 2010). This design enabled the study to capture both measurable relationships and contextual explanations within health care facilities.

### Study Setting and Population

The study was conducted in government-owned Health Centre IVs in South Western Uganda, which provide outpatient, inpatient, maternity, and emergency services and serve as referral centres for lower-level facilities (Ministry of Health Uganda, 2023). The study population comprised 43 Health Centre IV facilities, representing the organisational units under study. Within these facilities, health care providers and patients were considered as respondents because they are directly involved in service delivery and utilisation of care.

### Unit of Analysis and Unit of Inquiry

The unit of analysis was the Health Centre IV facility since the study focused on organisational conditions at the facility level. The unit of inquiry included health care providers and patients within the selected facilities, as they provided relevant information on work team stability and quality of health care, respectively, consistent with methodological guidance that units of inquiry should be those most knowledgeable about the study variables (Kothari, 2004).

### Sample Size and Sampling Techniques

A sample of 38 Health Centre IV facilities was selected from the population of 43 facilities. At the respondent level, the study included n = 238 health care providers and n = 172 patients drawn from the selected facilities. Simple random sampling was used to select respondents for the quantitative component to enhance representativeness and reduce bias, while purposive sampling was used to select key informants based on their roles and experience within the facilities (Bryman, 2016; Patton, 2015).

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### Data Collection Methods

Data were collected using questionnaires, key informant interviews, and document review. Questionnaires were used to obtain quantitative data in a standardised form suitable for statistical analysis, while interviews were used to capture detailed explanations of team conditions and care practices within the facilities. Document review was used to complement primary data and enhance credibility through triangulation of sources, which is widely recommended in organisational and health research (Bowen, 2009; Flick, 2018).

### Measurement of Variables

The study examined work team stability as the independent variable and quality of health care as the dependent variable. Work team stability was measured using indicators such as employee retention, consistency in team composition, and role clarity, which reflect stability in team functioning within organisational settings (Salas *et al.,* 2018). Quality of health care was measured using effectiveness, patient-centeredness, patient safety, and patient satisfaction, which are recognised dimensions of care quality in health systems (World Health Organization, 2021).

### Data Analysis

Data were aggregated at the facility level since these were the units of analysis. Quantitative data were analysed using descriptive statistics, Pearson correlation, and regression analysis. Descriptive statistics summarised respondent characteristics and variable distributions, correlation analysis assessed the strength and direction of the relationship between work team stability and quality of health care, and regression analysis determined the extent to which work team stability explained variation in quality of health care (Pallant, 2020). Qualitative data were analysed using thematic analysis to identify patterns related to team stability and service delivery.

### Quality Control of Research Instruments

Quality control was undertaken to ensure that the study instruments generated valid and reliable data. This involved assessing construct validity and internal consistency reliability through a pilot study conducted among 47 respondents (approximately 10% of the study sample) drawn from selected Health Centre IVs outside the main study area.

**Table 1: Summary of Quality Control of Research Instruments**

| Quality Aspect | Method | Statistical Test | Criterion | Results |
|---|---|---|---|---|
| Construct Validity | Pilot study | KMO and Bartlett's Test | KMO ≥ 0.70; Bartlett's Test $p < 0.05$ | KMO = 0.792–0.836; Bartlett's Test $p = 0.000$ |
| Reliability | Pilot study | Cronbach's Alpha | $\alpha \geq 0.70$ | $\alpha = 0.811–0.884$ |

The KMO values exceeded the recommended threshold of 0.70, while Bartlett's Test was statistically significant for all study constructs, confirming satisfactory construct validity. Similarly, Cronbach's Alpha coefficients ranged from 0.811 to 0.884, indicating good internal consistency. The findings confirmed that the research instruments were both valid and reliable for the main study.

### Data Management

Data management involved processing, cleaning, and testing the dataset to ensure its suitability for statistical analysis. Quantitative data were coded, entered into SPSS Version 27, verified for accuracy, merged and aggregated at Health Centre IV level before analysis, while qualitative data were organised for thematic analysis.

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**Table 2: Summary of Data Management Procedures**

| Activity | Procedure | Criterion |
|---|---|---|
| Data Processing | Coding, data entry, verification, merging and aggregation | Complete dataset |
| Missing Value Analysis | MCAR assessment and imputation | Missing values <5% |
| Outlier Detection | Z-scores, Mahalanobis distance and boxplots | Z-score ±3.29; Mahalanobis <13.82 |
| Normality | Skewness, Kurtosis, Shapiro-Wilk | Skewness/Kurtosis within ±2.5; $p > 0.05$ |
| Homogeneity of Variance | Levene's Test | $p > 0.05$ |
| Linearity | Scatterplots | Linear relationships |
| Multicollinearity | Tolerance and VIF | Tolerance >0.20; VIF <10 |

The results indicated that missing data were minimal and randomly distributed, requiring only limited imputation. No significant outliers were detected, and all assumptions for parametric analysis were satisfied. Consequently, the dataset was considered suitable for Pearson correlation and regression.

### Ethical Considerations

Ethical approval was obtained before data collection, participation was voluntary, and confidentiality of respondents was maintained throughout the study in line with accepted research standards (Israel & Hay, 2006).

## RESULTS

### Response Rate and Sample Characteristics

The study targeted Health Centre IV facilities and respondents within those facilities, including health care providers and patients. The comparison between the targeted sample and the achieved responses is presented in Table 3.

**Table 3: Target and Achieved Sample**

| Category | Target (n) | Achieved (n) | Response (%) |
|---|---|---|---|
| Health Centre IV facilities | 38 | 35 | 92.1% |
| Health care providers | 238 | 238 | 100% |
| Patients | 172 | 172 | 100% |

**Source:** *(Primary Data, 2025)*

Table 3 shows that data were collected from 35 out of the 38 Health Centre IV facilities targeted, representing a response rate of 92.1%. At the respondent level, all targeted health care providers ($n = 238$) and patients ($n = 172$) participated in the study. The number of facilities included was considered adequate for statistical analysis at the organisational level, while the full response from providers and patients strengthened the reliability of the findings.

### Descriptive Statistics

Descriptive statistics for the study variables are presented in Table 4.

**Table 4: Descriptive Statistics for Study Variables**

| Variable | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Work team stability | 35 | 1.80 | 4.60 | 3.42 | 0.58 |
| Quality of health care | 35 | 2.10 | 4.70 | 3.55 | 0.62 |

**Source:** *(Primary Data, 2025)*

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Table 4 indicates that work team stability across Health Centre IV facilities was moderate (Mean = 3.42), with noticeable variation reflected in the range of responses, suggesting differences in staff continuity, team composition, and role clarity across facilities. Quality of health care also recorded a moderate mean (Mean = 3.55), indicating that the level of care provided was not consistent across facilities, with variations observed in effectiveness, patient safety, and patient-centeredness. The spread in both variables, as shown by the standard deviations and range values, suggests that facilities differ in organisational conditions and levels of care, providing a basis for examining whether variations in work team stability are associated with corresponding differences in quality of health care.

### Correlation Analysis

Pearson correlation analysis was run to examine the relationship between work team stability and quality of health care using a two-tailed test, as presented in Table 5.

**Table 5: Pearson Correlation Coefficient Matrix**

| Variable | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Work Team Stability-1 | 1 | | | | |
| Staff retention-2 | 0.812** | 1 | | | |
| Team consistency-3 | 0.845** | 0.521** | 1 | | |
| Role clarity-4 | 0.798** | 0.488** | 0.463** | 1 | |
| Quality of Health Care-5 | 0.440** | 0.398** | 0.417** | 0.440** | 1 |

Note: $p < 0.01$ (2-tailed)

**Source:** *(Primary Data, 2025)*

Table 5 shows a positive and statistically significant relationship between work team stability and quality of health care ($r = 0.440$, $p < 0.01$), indicating that higher levels of work team stability are associated with higher levels of quality of health care across Health Centre IV facilities. The results further show that staff retention, team consistency, and role clarity are all positively related to quality of health care, suggesting that stable staffing, consistent team composition, and clear role definition are associated with higher levels of care across facilities. The overall pattern indicates a moderate association between work team stability and quality of health care. Based on these findings, the hypothesis that there is a significant relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda is accepted.

### Regression Analysis

Regression analysis was run to examine the effect of work team stability on quality of health care, as presented in Table 6.

**Table 6: Regression Results**

| Variable | Unstandardised B | Std. Error | Standardised Beta (β) | t-value | Sig. (p-value) |
|---|---|---|---|---|---|
| Constant | 1.284 | 0.412 | | 3.116 | 0.004 |
| Work team stability | 0.317 | 0.103 | 0.352 | 3.087 | 0.003 |
| Model Summary | Value | | | | |
| R | 0.440 | | | | |
| R Square ($R^2$) | 0.194 | | | | |
| Adjusted $R^2$ | 0.170 | | | | |
| F-statistic | 9.529 | | | | |
| Sig. (F) | 0.003 | | | | |

**Source:** *(Primary Data, 2025)*

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Article DOI: https://doi.org/10.37284/eajbe.9.3.5479

Table 6 shows that the overall regression model is statistically significant (F = 9.529, p = 0.003), indicating that work team stability significantly explains variation in quality of health care. The coefficient results further show that work team stability has a positive and statistically significant effect on quality of health care (β = 0.352, p = 0.003). The unstandardised coefficient (B = 0.317) indicates that a unit increase in work team stability is associated with an increase in quality of health care. The $R^2$ value of 0.194 shows that work team stability explains 19.4% of the variation in quality of health care, while the remaining 80.6% is explained by other factors not included in the study. These results confirm a positive relationship between work team stability and quality of health care, and therefore the hypothesis is accepted.

**Qualitative Findings**

Qualitative findings on work team stability and quality of health care, based on key informant interviews and documentary review, are presented below.

Additionally, the researcher conducted key informant interviews to obtain detailed explanations on staffing patterns and team functioning within Health Centre IV facilities. The findings indicated noticeable differences in staff continuity, team composition, and role allocation across facilities. Facilities with relatively stable staffing were described as having teams that were more predictable in their functioning, with members familiar with routines and responsibilities, which supported coordination of activities within the facility. In contrast, facilities experiencing frequent staff transfers and absenteeism reported interruptions in team functioning, requiring continuous adjustment of duties and affecting how work was organised within the facility.

Additionally, the researcher explored issues related to role clarity within teams. Facilities where responsibilities were clearly defined were described as having more structured work processes, with staff able to carry out duties without overlap. In facilities where roles were not clearly defined, respondents reported duplication of tasks and instances where some responsibilities were left unattended, which affected how activities were organised within the facility, particularly during periods of high workload.

Also, documentary review was conducted to complement the findings from interviews. Facility records, including duty rosters and staffing schedules, showed variation in staff continuity across facilities, with some facilities maintaining consistent staffing patterns while others recorded frequent changes in personnel. Documents further indicated differences in how duties were allocated across departments, with some facilities showing clear assignment of responsibilities and others reflecting inconsistencies in task distribution. These patterns in documented staffing and task allocation corresponded with the variations observed in team functioning across Health Centre IV facilities.

## DISCUSSION

The findings showed a positive and statistically significant relationship between work team stability and quality of health care in Health Centre IV facilities, indicating that variations in staff continuity, team consistency, and role clarity are associated with differences in how health care is organised and delivered across facilities. These findings are consistent with recent literature which emphasises that effective team functioning depends on stable structures, shared understanding, and coordination mechanisms within teams (Mathieu *et al.,* 2020; Weller, 2024). In health care settings, where service delivery is highly interdependent, stability in team composition supports coordination of tasks and consistency in care practices. However, studies such as (Bae & Mark, 2021; Leape *et al.,* 2020) indicate that improvements in quality of care are also influenced by leadership practices and organisational systems, suggesting that team stability alone may not fully explain variations in how work is organised within facilities.

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The findings are also consistent with health systems literature which shows that organisational conditions, including workforce environment and staffing arrangements, are associated with variations in health care quality. Studies by Jha *et al. (*2021) and Kruk *et al.* (2018) indicate that differences in care across facilities are linked to internal organisational factors such as staffing, supervision, and work environment. At the same time, research by Leatherman (2020) McHugh & Aiken (2022) highlights that resource availability, infrastructure, and policy conditions can shape service delivery regardless of staffing stability. This suggests that while the present findings align with existing evidence, work team stability operates alongside other structural and organisational factors that influence how care is delivered within facilities.

The qualitative findings provide further insight by illustrating how these patterns are experienced within facilities. Facilities with stable staffing were described as having clearer coordination of activities and more structured work processes, while those with frequent changes in team composition experienced challenges in organising tasks and maintaining consistency in service delivery. These observations are consistent with studies by Edmondson and Lei (2020), which show that stability in team membership and clarity of roles support coordination and reduce inefficiencies within organisations. However, research by Blumenthal *et al*. (2020) also indicates that even in settings with relatively stable teams, challenges in organising care may persist due to broader system-level constraints. These findings reinforce that variations in staff continuity, team consistency, and role clarity are associated with how work is organised within facilities, while also being influenced by wider organisational conditions within Health Centre IVs.

## CONCLUSION AND IMPLICATIONS

The findings demonstrate that work team stability is associated with quality of health care in Health Centre IV facilities, with variations in staff continuity, team consistency, and role clarity reflected in how care is organised and delivered across facilities. Facilities characterised by more stable team arrangements exhibited more coordinated work processes, while those with unstable staffing patterns experienced disruptions in the organisation of activities. These results highlight the importance of internal team conditions in shaping how health care services are structured within primary health care facilities.

The study contributes to the literature by providing facility-level evidence on the relationship between work team stability and quality of health care within Health Centre IVs in South Western Uganda. It extends existing work by showing that organisational conditions within facilities are associated with differences in how care is organised, rather than focusing only on system-level factors. The integration of quantitative and qualitative findings further demonstrates how variations in team stability are reflected in day-to-day operations within health facilities.

### Managerial Implications

Health facility managers should prioritise practices that promote staff continuity and stability within teams. This includes minimising unnecessary staff transfers, ensuring balanced team composition, and strengthening role clarity through clear job allocation and supervision. Attention to team structure can support better coordination of activities within facilities and reduce disruptions in service organisation. Managers should also strengthen internal monitoring mechanisms to ensure that roles are clearly defined and consistently executed across departments.

### Policy Implications

At policy level, there is a need to strengthen workforce management policies that support stability of health care teams within public health facilities. This includes developing guidelines that regulate staff deployment and transfers, improving staffing structures within Health Centre IVs, and ensuring consistent allocation of

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Article DOI: https://doi.org/10.37284/eajbe.9.3.5479

personnel across facilities. In addition, policies should support institutional systems that enhance role clarity and coordination within facilities. Addressing these aspects at policy level may contribute to improving how health services are organised within primary health care settings.

Future research should examine additional factors that influence quality of health care, given that a large proportion of variation is explained by factors beyond work team stability.

**Conflict of Interest Statement**

The authors declare that there is no conflict of interest regarding the publication of this paper. The research was conducted independently without any personal, financial, or institutional influence that could have affected the results or interpretation of the findings.

**Funding Statement**

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. All costs related to the study were met by the principal researcher.

**Ethical Approval**

Ethical approval for this study was obtained from the relevant institutional review body prior to data collection. Permission to conduct the study was also obtained from the selected Health Centre IV facilities. Participation in the study was voluntary, and informed consent was obtained from all respondents. Confidentiality and anonymity of participants were maintained throughout the research process.

**Author Contributions**

SB conceived and designed the study, developed the research instruments, collected and analysed the data, interpreted the findings, and prepared the original manuscript. RB, MB, EM, and CM provided academic supervision throughout the study, contributed to the conceptualisation and methodological refinement of the research, critically reviewed and revised the manuscript for important intellectual content, and approved the final version for publication. All authors read and approved the final manuscript.

**Data Availability Statement**

The data that support the findings of this study are available from the author upon justifiable request.

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