

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

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Abstract: This study investigated the relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda. The study employed a cross-sectional mixed-methods design. Data were collected from healthcare workers in selected Health Centre IVs using questionnaires, key informant interviews, and document reviews. Quantitative data were analyzed using descriptive statistics, Pearson correlation, and regression analysis, whereas qualitative data were analyzed thematically. The results indicated a positive and statistically significant relationship between work team stability and quality of health care ($r = 0.440$, $p < 0.01$). Regression analysis further showed that work team stability significantly predicted quality of health care ($\beta = 0.352$, $p = 0.003$), accounting for 19.4% of the observed variation in quality of health care ($R^2 = 0.194$). The study contributes empirical evidence on the relationship between work team stability and quality of health care in public Health Centre IV facilities in Uganda. It demonstrates that workforce stability is an important organizational factor associated with improved health care quality and provides context-specific evidence to support workforce management and health policy interventions in Uganda.

Keywords: *Work Team Stability, Quality of Health Care, Health Centre, Uganda*

1. Introduction

Quality of health care is widely recognized as a fundamental component of effective health systems and population well-being (World Health Organization, 2021). High-quality care is characterized 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 organized and delivered within facilities.

In Uganda, health sector reforms have prioritized 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 organizational 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 organizational 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). However, these studies primarily focused on workforce shortages, staffing imbalances, health system performance, and patient experiences rather than specifically examining how work team stability, reflected in staff continuity, team consistency, and role clarity, influences the quality of health care. Furthermore, none of these studies specifically investigated this relationship within Health Centre IV facilities in South Western Uganda. This study, therefore, addresses this knowledge gap by

examining the relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda.

2. Literature Review and Hypothesis Development

Work team stability is conceptualized 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 characterized 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 organized within facilities. Salas et al. (2018) argue that stable teams facilitate effective communication, coordination, and collaboration, which are essential for delivering high-quality health services. However, Waweru et al. (2020) contend that workforce instability remains a persistent challenge in many health systems, particularly where staffing shortages and frequent personnel movements disrupt teamwork and continuity of care. These contrasting perspectives suggest that although team stability is desirable, its influence may depend on the organizational context within which health care services are delivered.

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 public health facilities, variations in these dimensions are observed across settings, with differences in service delivery linked to internal organizational 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). While the World Health Organization (2021) emphasizes adherence to quality standards as the foundation of effective health service delivery, Matovu et al. (2022) demonstrate that organizational differences across health facilities continue to influence the quality of services provided. This suggests that achieving quality health care requires not only compliance with established standards but also organizational conditions that enable health workers to perform effectively.

The relationship between work team stability and quality of health care is discussed in the literature in relation to how team organization 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 organizational and workforce conditions within facilities are observed alongside differences in care processes and patient experiences (Kabunga et al., 2024). Although these studies consistently acknowledge the importance of teamwork in supporting health service delivery, they differ in their emphasis. Rosen et al. (2018) primarily associate stable teams with improved coordination and continuity of care, whereas Hategeka et al. (2020) attribute variations in service delivery to broader workforce constraints, including staffing shortages and turnover. Similarly, Kabunga et al. (2024) highlight that organizational conditions continue to influence patient experiences within Ugandan public health facilities. These differences indicate that work team stability is an important organizational factor but is unlikely to operate in isolation, thereby justifying further investigation into its relationship with the quality of health care in Health Centre IV facilities in South Western Uganda. Based on the literature, the following hypothesis is developed.

Theoretical Foundation

This study was guided by the Input–Mediator–Outcome (IMO) Framework of Team Effectiveness developed by Ilgen et al. (2005), which explains how team characteristics influence organizational performance through team processes. According to the framework, work team stability, reflected in employee retention, team consistency, and role clarity, serves as a critical input that enhances communication, coordination, trust, and collaboration among health care workers. These mediating processes improve continuity of care, reduce errors,

strengthen teamwork, and ultimately enhance the quality of health care in terms of effectiveness, patient-centeredness, patient safety, and patient satisfaction. The framework, therefore, provides the theoretical basis for the study by explaining why stable work teams are expected to improve health care quality within Health Centre IV facilities in South Western Uganda.

Hypothesis

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

3. Methodology

Research design

The study adopted a cross-sectional design within a mixed methods approach to examine the relationship between work team stability and quality of health care in Health Centre IVs in South Western Uganda. Cross-sectional designs are suitable for analyzing 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 the 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 centers for lower-level facilities (Ministry of Health Uganda, 2023). The study population comprised 43 Health Centre IV facilities, representing the organizational units under study, and within these facilities, health care providers and patients were considered as respondents because they are directly involved in service delivery and utilization of care.

Unit of analysis and unit of inquiry

The unit of analysis was the Health Centre IV facility since the study focused on organizational 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 a population of 43 government-owned Health Centre IVs in South Western Uganda. The sample size was determined using the Krejcie and Morgan (1970) sample size determination table, which recommends a sample of 38 for a finite population of 43 units. The selected Health Centre IVs were then chosen using simple random sampling, whereby each facility was assigned a unique identification number and selected through a lottery method to ensure that every Health Centre IV had an equal chance of inclusion. At the respondent level, the study included 238 health care providers and 172 patients drawn from the selected facilities. Health care providers were selected using simple random sampling from staff lists obtained from each participating Health Centre IV. The number of providers selected from each facility was determined proportionately according to the staffing level to ensure adequate representation across facilities. Patients were selected using simple random sampling from those attending outpatient services during the data collection period after meeting the study inclusion criteria. Eligible patients were assigned sequential numbers and selected randomly until the required sample size for each facility was attained. Purposive sampling was used to select key informants, including facility in-charges and other senior health personnel, because of their knowledge and experience regarding staffing patterns, team functioning, and quality of health care (Bryman, 2016; Patton, 2015).

Data Collection Methods

Data were collected using questionnaires, key informant interviews, and document review. The questionnaire was developed by the researcher based on an extensive review of the literature on work team stability and quality of health care, with questionnaire items designed to reflect the study constructs and their respective

dimensions. The instrument was developed in line with previously published theoretical and empirical studies and was subjected to validity and reliability testing before the main data collection. Questionnaires were used to obtain quantitative data in a standardized form suitable for statistical analysis, while interviews were used to capture detailed explanations on 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 organizational 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 organizational settings (Salas et al., 2018). Quality of health care was measured using effectiveness, patient-centeredness, patient safety, and patient satisfaction, which are recognized 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 analyzed using descriptive statistics, Pearson correlation, and regression analysis. Descriptive statistics summarized 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 analyzed 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 the Health Centre IV level before analysis, while qualitative data were organized for thematic analysis.

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
Common Method Bias	Harman's Single-Factor Test	A single factor explains $< 50\%$ of the total variance

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. Common method bias was also assessed using Harman's Single-Factor Test. The unrotated exploratory factor analysis showed that the first factor accounted for less than 50% of the total variance, indicating that common method bias was not a significant concern in the study (Podsakoff et al., 2003). Consequently, the dataset was considered suitable for Pearson correlation and regression analyses.

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).

4. 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 organizational 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)

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 was also recorded at 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 organizational 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 3.

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 the quality of health care, as presented in Table 6.

Table 6: Regression Results

Variable	Unstandardized B	Std. Error	Standardized 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)

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 ($\beta = 0.352$, $p = 0.003$). The unstandardized coefficient ($B = 0.317$) indicates that a unit increase in work team stability is associated with an increase in the 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

Key informant interviews revealed that work team stability was perceived as an important organizational factor influencing the quality of health care in Health Centre IV facilities. Respondents consistently indicated that stable staffing promotes continuity of care, effective coordination, and clear allocation of responsibilities, thereby improving service delivery. As one respondent explained, *"Facilities that maintain stable teams are able to coordinate services more efficiently because staff understand each other's working patterns, strengths, and responsibilities, which reduces delays during patient management"* (Respondent 1, December 2025). This finding supports the quantitative results, which demonstrated a positive and statistically significant relationship between work team stability and quality of health care ($r = 0.440$, $p < 0.01$).

Participants further noted that frequent staff transfers and shortages disrupted teamwork and reduced service efficiency because newly deployed staff required time to become familiar with facility procedures. One respondent observed that *"Frequent staff movements disrupt service delivery because new staff require time to understand how the facility operates, including patient flow patterns and internal coordination processes"* (Respondent 4, December 2025). Similarly, another respondent stated that *"When facilities operate with fewer staff than required, the available workers become overstretched, and this affects their concentration and ability to maintain quality service standards"* (Respondent 3, December 2025). These perspectives help explain the quantitative finding that facilities with greater work team stability reported higher levels of quality of health care.

Role clarity also emerged as an important dimension of team stability. Respondents indicated that teams that work together consistently develop a clear understanding of individual responsibilities, reducing duplication of duties and improving coordination during patient care. As one respondent remarked, *"Teams that work together consistently know who is responsible for each task, and this reduces confusion when managing patients, especially during busy periods"* (Respondent 2, December 2025). These qualitative findings are consistent with the statistical evidence indicating that role clarity contributes to overall work team stability.

Documentary review further corroborated these findings. Duty rosters, staffing schedules, and health facility assessment reports revealed variations in staff retention, absenteeism, and team composition across facilities. One assessment report noted that *"The facility continues to experience staffing gaps particularly in nursing and laboratory units, resulting in increased workload for available staff, extended working hours, and occasional delays in service provision due to insufficient personnel to manage patient demand during peak periods and emergencies"* (Health Facility Assessment Report, 2024). Facilities with relatively stable staffing patterns demonstrated stronger coordination of activities and more consistent service delivery than those experiencing frequent staffing changes. The convergence of interview evidence, documentary review, and quantitative findings strengthens the credibility of the conclusion that work team stability is an important organizational factor associated with quality of health care in 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 organized and delivered across facilities. These findings are consistent with recent literature which emphasizes 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 organizational systems, suggesting that team stability alone may not fully explain variations in how work is organized within facilities.

The findings are also consistent with health systems literature which shows that organizational conditions, including workforce environment and staffing arrangements, are associated with variations in health care quality. Studies by (Jha et al., 2021; Kruk et al., 2018) indicate that differences in care across facilities are linked to internal organizational 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 organizational 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 organizing tasks and maintaining consistency in service delivery. These observations are consistent with studies by Edmondson & Lei (2020), which shows that stability in team membership and clarity of roles support coordination and reduce inefficiencies within organizations. However, research by Blumenthal et al., (2020) also indicates that even in settings with relatively stable teams, challenges in organizing 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 organized within facilities, while also being influenced by wider organizational conditions within Health Centre IVs.

Although the findings demonstrate that work team stability contributes to the quality of health care, they also suggest that it represents only one aspect of a broader organizational system influencing service delivery. Health care quality is inherently multidimensional and is shaped by the interaction of workforce, organizational, structural, and policy-related factors. Previous studies have shown that organizational factors such as leadership effectiveness, staff motivation, supervision, organizational culture, and communication practices, together with contextual factors including availability of medicines and medical supplies, health facility infrastructure, financial resources, staffing adequacy, workload, and implementation of health policies, collectively influence the quality of care delivered within health facilities (Jha et al., 2021; Leatherman, 2020; McHugh & Aiken, 2022). Improvements in work team stability are likely to yield greater benefits when accompanied by interventions that strengthen these complementary organizational and contextual conditions, thereby promoting more comprehensive improvements in the quality of health care.

5. Conclusion, Recommendations 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 organized and delivered across facilities. Facilities characterized by more stable team arrangements exhibited more coordinated work processes, while those with unstable staffing patterns experienced disruptions in the organization 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 organizational conditions within facilities are associated with differences in how care is organized, 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.

Recommendations

Based on the findings, the study recommends that Health Centre IV managers should minimize unnecessary staff transfers within facilities to promote continuity of care and preserve institutional knowledge. Facility managers should establish regular team coordination meetings, clarify staff roles and responsibilities, and strengthen supportive supervision to improve communication and teamwork. Structured orientation and mentoring programs should be provided for newly deployed health workers to facilitate their integration into existing teams and minimize disruptions to service delivery. Health facility managers should also conduct

periodic workforce assessments to identify staffing gaps, monitor workload distribution, and ensure that critical service units maintain adequate staffing levels.

Managerial Implications

The Ministry of Health, District Local Governments, District Health Officers, and the Health Service Commission should strengthen workforce planning policies that promote staff stability within Health Centre IV facilities. Recruitment and deployment strategies should prioritize filling critical staffing shortages, particularly in nursing, laboratory, pharmacy, and clinical departments, while reducing avoidable transfers of experienced health workers. The government should provide adequate financial resources to improve staff welfare, including accommodation, retention incentives, and continuing professional development, particularly in rural and hard-to-reach facilities. The Ministry of Health should also develop and implement national guidelines on team-based service delivery, staff orientation, and role clarification to promote consistency in workforce management across public health facilities. In addition, district health authorities should incorporate indicators such as staff retention, absenteeism, vacancy rates, and team continuity into routine health sector performance monitoring to support evidence-based workforce planning.

Policy Implications

At the policy level, there is a need to strengthen workforce management policies that support the 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 personnel across facilities. In addition, policies should support institutional systems that enhance role clarity and coordination within facilities. Addressing these aspects at the policy level may contribute to improving how health services are organized within primary health care settings. Future research should examine additional factors that influence the quality of health care, given that a large proportion of variation is explained by factors beyond work team stability.

Study Limitations

The findings of this study should be interpreted in light of several methodological considerations. Although the cross-sectional design enabled the examination of relationships among the study variables at a single point in time, it does not permit causal inferences. This consideration was addressed by applying appropriate correlational and regression analyses that were consistent with the study design, while future studies may employ longitudinal designs to establish causal relationships. The study relied on self-reported data from health care providers and patients, which may be influenced by social desirability and recall effects. To minimize this possibility, respondents were assured of confidentiality and anonymity, standardized research instruments were used, and the findings were triangulated with key informant interviews and document review. Despite these measures, some degree of response bias cannot be entirely ruled out. The study was conducted in Health Centre IVs in South Western Uganda, and the findings therefore reflect the organizational context of these facilities. To enhance external validity, Health Centre IVs were selected from across the region using appropriate sampling procedures; however, caution should be exercised when applying the findings to other levels of health facilities or different geographical settings. Future research should extend this work by including a wider range of health facilities, incorporating objective performance indicators alongside self-reported measures, and examining additional organizational factors that may influence the quality of health care.

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Ethical Approval: Ethical approval for this study was obtained from the relevant institutional review body before 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 analyzed the data, interpreted the findings, and prepared the original manuscript. RB, MB, EM, and CM provided academic supervision throughout the study, contributed to the conceptualization 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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