

# **Uganda Health Workforce Study:** Satisfaction and Intent to Stay Among Current Health Workers

Executive Summary  
March 2007



**Ministry of Health**  
**The Republic of Uganda**

A study of facility-based health workers in Uganda conducted in July 2006 and intended to measure health worker satisfaction, motivation and intent to stay in the health field to serve the Republic of Uganda.



*With additional support from:* Aga Khan University  
Makerere University  
University of Washington

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## **Abstract**

This report summarises the results of a study of health worker satisfaction, working conditions and intent to continue working in the health sector in Uganda. The findings point to the importance of a number of factors that contribute to satisfaction and intent to stay, including differences by cadre, gender, age, sector (public or non-profit) and location. The results suggest several policy strategies to strengthen human resources for health in Uganda. More than 700 health professionals were surveyed in nine districts and 18 health facilities. Three focus groups were conducted in each facility, with health workers separated by cadre (physicians, nurses and allied health). The study was conducted in July 2006 using a team of 20 Ugandan health professionals, most of them recent graduates of or current students at the universities in Kampala. The study was conducted by the USAID-funded Capacity Project with the Uganda Ministry of Health, with support from the US Health Resources and Services Administration and three universities (Makerere, Aga Khan and University of Washington). It was conducted under the oversight of the Uganda Health Workforce Advisory Board, a group of Uganda health system stakeholders.

## Acknowledgements

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We appreciate the participation of each health worker who took time to fill out a questionnaire or attend a focus group discussion. Hospital administrators, nursing directors and medical superintendents were most gracious. We also appreciate the time of each of the district directors of health services in our nine regions. Kibuli Muslim Hospital in Kampala offered valuable assistance by volunteering to host our teams during training as a test site.

Unfortunately, our computers for data entry became infected with a virus and some files were corrupted. We were ably assisted in sorting out this difficulty by Nathan Natseri <natserin@ug.afro.who.int> of the World Health Organization in Kampala, and we are grateful to him.

Kibuli Muslim Hospital served as our field worker training and testing site at the outset of the project, and we are grateful for that cooperation.

The official list of Uganda health professional training schools (not including universities) was received from the European Union's Developing Human Resources for Health program, coordinated through the African Medical and Research Foundation (AMREF). Our thanks to Edward Walugembe, Carol Idusso and Deana Leadbeter for this list. Thanks also to the European Union for the list of National Classification of Health Occupations (based on the International Standard Classification of Occupations, or ISCO) codes adapted for use in health professions in Uganda.

### *Authorship*

This draft of the executive summary has been authored by Amy Hagopian, PhD, with support from the USAID-funded Capacity Project and the US Health Resources and Services Administration. Dr. Hagopian analyzed the quantitative data with statistical assistance from Bert Stover, PhD and Emily Bancroft, MPH. Editing assistance was provided by Jim McCaffery, Ph.D., Pamela McQuide, Ph.D., Anneke Zuyderduin, Ph.D. Fatu Yumkella, Msc, MPhil., Paul Kiwanuka-Mukiibi, M.D., and others at the Capacity Project.

Analysis of the qualitative data in this study was conducted by Dr. Stella Neema of the Makerere University Social Institute for Social Research.

## **I. Introduction**

The Uganda Health Workforce Study was conceived as part of a group of projects to be conducted by the Uganda Ministry of Health (MOH) with the support of, and in collaboration with, the United States Agency for International Development (USAID)-funded Capacity Project to further the goal of strengthening the nation's health workforce. The study was conducted in July 2006, with results reported to the MOH during the following October.

This study was done in response to MOH (and other stakeholder) concerns about health workforce morale, satisfaction, motivation, intent to stay and out-migration. There is a growing consensus that the significant health status challenges facing sub-Saharan Africa cannot be addressed without strengthening health systems and the health professionals who work in those systems. There are many assumptions and speculations about what factors contribute to health worker satisfaction and intent to continue in their jobs, but very little data about specific motivators and disincentives. These data are particularly scarce at the country level. Uganda's commitment to health workforce policy reforms is real, but the success of those reforms will be significantly enhanced if they are based on current, accurate information.

## **2. Methods**

A team of approximately 20 field researchers (mostly Ugandans) were recruited and trained in July 2006 to collect qualitative and quantitative data from health workers in 18 facilities across nine randomly selected districts. Data entry, focus group transcription and analysis were conducted in August and September, with results reported to the MOH in October.

We grouped districts into seven regions, as defined by the 2006 Uganda Districts Information Handbook. Districts were stratified to ensure that "hard-to-reach" areas were selected, and selection was weighted by population so that the results would be generalisable to the country.

At each facility, questionnaires were administered to three groups: those currently in health care positions in our selected hospitals; those who voluntarily left a different health care employer during the previous year; and two groups of managers—health district directors and facility administrators. Focus groups were conducted in each facility, typically one group comprised of nurses, one of doctors and one of allied health and pharmacy staff combined. Clinical officers were dealt with differently in each site, depending on logistics and their numbers. Sometimes they were combined with doctors, sometimes with allied health and sometimes they met separately.

The primary means we used to rate satisfaction overall was to evaluate responses to the statement, "Considering everything, I am satisfied with my job." Responses were made on a five-point scale: "strongly agree," "agree," "neutral," "disagree" or "strongly disagree." We used this question as a primary outcome variable to see which other measures best predicted higher satisfaction. The same scale was used with a variety of statements about job situations and working conditions.

To measure intent to stay, we asked, "Which of the following statements is true for you?" with responses offered about intent to leave their current jobs "as soon as possible," or within one year, two years, three to five years or an intent to stay indefinitely. If respondents were eager to leave "soon," they were asked if they wanted to stay with the

same organization (e.g., MOH or Uganda Catholic Medical Bureau) but change locations, change to another employer in Uganda, change to a job out of the health sector or move out of the country.

Prior to the development of our questionnaires, we conducted a thorough review of the literature on job satisfaction, morale and retention<sup>1,2</sup>. Questions were adapted from well-tested questionnaires used previously in both the US and developing countries.

There are additional data not included yet in this report. We collected 38 surveys from people who had changed jobs within the health sector during the previous year; these data have not yet been analyzed. Also, we have not analyzed the text responses to open-ended questions.

The project proposal was approved by the MOH, Makerere University, Aga Khan University faculty, and Capacity Project. The final design was approved by the Uganda Health Workforce Advisory Board. Human subjects approvals were obtained from the Uganda Council for Science and Technology (HS 156) and the University of Washington (06-1098-G 01), after extensive review and revisions of procedures and consent material.

### **3. Limitations of Study**

There are limitations to this study. The random selection of nine PNFP hospitals resulted in the selection of seven Catholic Medical Bureau facilities. The one Muslim facility selected was very small. This means that we cannot say anything about Protestant facilities, and we have nothing reliable to say about the Muslim facilities. This problem will be corrected with a follow-up study scheduled for 2007.

When we arrived at the facilities, we relied on volunteers to participate in focus groups and answer our surveys. We did not randomly select health workers and compel their participation. There could have been some bias to the selection of participants in our selection method.

The Capacity Project plans to conduct a separate study in 2007 to identify individuals who have left health-sector jobs, to discover workers' reasons for leaving and their intent regarding future health-system employment in Uganda.

## **4. Findings**

### **4.1 Study Sample**

We collected 641 surveys from people who had been in their jobs at least a year (or were new to the profession), 38 surveys from people who had changed jobs in the health sector in the last year and 61 surveys from health system managers (including district directors of health services). There were 56 focus groups conducted to complement the survey data.

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<sup>1</sup> Yumkella F. Retention: health workforce issues and response actions in low-resource settings. Capacity Project resource paper. Chapel Hill, NC: The Capacity Project, 2005. Available at: [http://www.capacityproject.org/images/stories/files/retention\\_paper\\_long050823.pdf](http://www.capacityproject.org/images/stories/files/retention_paper_long050823.pdf)

<sup>2</sup> Martineau T, Lehmann U, Matwa P, Kathyola J, Storey K. Factors affecting retention of different groups of rural health workers in Malawi and Eastern Cape Province, South Africa. Final report. Liverpool, UK: Liverpool School of Tropical Medicine, 2006. Available at: <http://www.interchurch.org/resources/uploads/files/310MalawiRetentionStudyReportFinal06.pdf>

## 4.2 Demographics and Location

The average health worker in the study was female and married with seven dependents. Most respondents (64%) worked in the public sector. The average respondent was 39 years old, and this average age held across three of five cadres, although medical officers were slightly younger (age 36) and pharmacy staff slightly older (age 43). Nurses comprised 55% of the sample, were mostly female (89%) and were the cadre least likely to be married (57%), perhaps because a portion of this group includes Catholic Sisters. Allied health workers were mostly male (83%), and 83% were married. Physicians were almost all (90%) men, and 62% were married.

Public-sector workers were older (average age 42 compared to 35), had been at their jobs longer (11 years compared to 7 years) and with their organisations longer (15 years compared to eight years). They are also more likely to be male (43% compared to 29%), married (70% compared to 51%) and have more dependents (7.7 compared to 5.6).

Health workers were likely to be working in the regions where they were born, except in Kampala. Hospitals that organise their own training schools usually employ large numbers of their own graduates. There were no significant differences among health care worker profiles in hard-to-reach areas compared to those working in “easier” areas.

Managers tended to be male (64%), older (67% were over 40) and stable (48% had been in their positions for at least 10 years).

## 4.3 Job Stability and Longevity Are High

We found remarkable stability in the health workforce. Our sample, by design, was drawn from the people we found on the job in hospitals (not people who have already left), giving us what is called in statistics a “survivor’s bias,” and we have no comparison numbers on longevity or turnover to help us evaluate the significance of our findings. It is remarkable, nonetheless, that 81% of our respondents were still in their first jobs. The average length of stay was 10 years, with 13 years working for the same employer and 13.5 years in their professions overall.

Slightly more than half (54%) of health workers planned to stay in their jobs indefinitely, and another 20% would stay at least three years. The rest reported that they were eager to leave their jobs soon, with 9% saying “as soon as possible.” Of those ready to leave soon, 11% would leave Uganda and 4% would leave the health sector. Older respondents (age 41 and up) were far less likely to indicate an intent to leave their jobs within two years, leave Uganda or leave the health profession. Private-sector workers were more likely to be in their first jobs (86%) compared to workers in the public sector (79%).

Doctors, compared to the other cadres in our study, were the group most likely to say they are eager to leave their jobs within two years (57%), and they are most at risk for leaving Uganda or the health sector (46% said they would leave if they could). Regression analysis helped us determine that even after gender was accounted for, the status of being a doctor was highly predictive of a desire to leave their positions.

Nurses were the cadre least likely to report an interest in leaving Uganda or the health profession (80% intended to stay in their jobs at least three years), and with 85% still in their first jobs. For one point of reference, there is about a 20% turnover among nurses in the US

and UK annually<sup>3</sup>. Clinical officers also showed low turnover numbers, with a large majority still in their first jobs (87%) and most (77%) reporting an intent to stay in their jobs.

Region was a significant predictor of intent to stay overall. Living in the central region, compared to other regions, increases the odds of leaving when other factors remained equal. The region where health workers expressed the least likelihood of leaving was the north.

In regression analysis, when considering age, gender, cadre, sector and region simultaneously, odds were more than two times higher intent to leave Uganda or the health sector when respondents rated more highly the importance of salary, other factors being equal.

Besides the importance of salary, factors that reduced the odds of leaving included the following, with all other factors in the equation held equal, in order of importance:

- Active **involvement** in the facility
- Manageable **workload**
- **Flexibility** to balance the demands of work and personal life
- Better opportunities for **promotion**.

**Comment:** Health sector jobs are relatively high status, stable and reasonably compensated compared to many alternatives for educated people in most countries, which may explain some of the job longevity we view in this sample. The international literature on health worker turnover, however, cautions us that there is a strong relationship between intent to leave and turnover, and that job satisfaction is predictive of turnover<sup>4</sup>. There are considerable regional differences in our findings (health workers in Kampala are much more likely to leave their positions than workers in the north), as well as differences among cadres (physicians are much more eager to leave their positions than nurses). The important conclusion from our study, however, is that if the stability within the workforce continues as in the past, there is no imminent danger of a broad-scale exodus of health workers from their jobs in Uganda.

#### **4.4 Workers Are Divided as to Satisfaction and Morale**

Health worker job satisfaction and motivation is related to the worker's ability, willingness and means to achieve high performance on the job.

We found the average overall health worker job satisfaction to be neutral—about 3.2 on a scale of 1 to 5. The average, however, masks a bi-modal finding—health workers were either satisfied (48.7%) or dissatisfied (35.3%), with only 16% reporting that they were “neutral.”

Older respondents were more satisfied than younger ones, and satisfaction was higher for each successively older group. Older respondents (age 41 and up) were far less likely to indicate an intent to leave their jobs within two years, leave Uganda or leave the health profession. Attachment to the facility and the community tended to be stronger with each older age group, and relationships with supervisors were better. Older respondents reported receiving more recognition for good work.

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<sup>3</sup> International Council of Nurses. Global nursing shortage: priority areas for intervention. Geneva, Switzerland: International Council of Nurses, 2006, p. 42.

<sup>4</sup> Hayes LJ, O'brien-Pallas L, Duffield C, et al. Nurse turnover: a literature review. *International Journal of Nursing Studies*. 2006;43:237-263.

This is consistent with other studies on worker (and even patient<sup>5</sup>) satisfaction, suggesting a universal aspect to this finding rather than something specific to Uganda.<sup>6,7</sup> The literature suggests that older health workers may feel more commitment to the profession (these are the ones who haven't already left their professions) and more control over their jobs.

There was no difference between public- and private-sector workers in regard to overall satisfaction, but morale was higher in the private sector. Women were no more likely than men to be satisfied, overall, in their jobs, but they were more likely to say they felt attached to their facilities in a social and emotional way.

Slightly more than a third (37%) of physicians said they were satisfied, overall, with their jobs, and they scored the lowest satisfaction ratings on a number of individual job satisfaction measures. Pharmacists were the cadre most likely to report job satisfaction (3.7 on the five-point scale) and recognition for good work. They were also the most likely to report satisfaction with their supervisors, and believe that their opinions matter at work.

A large majority of managers (83%) said employee job satisfaction was "very important," yet only 13% felt their organizations performed "very well" (on a three-point scale) on this indicator. Areas where managers felt their organizations were performing better included placing people in suitable jobs (49%), taking measures to protect workers against disease (49%), training (37%), preventing harassment by supervisors (32%), creating flexibility for employees (32%) and valuing and respecting each worker (30.5%).

Previous African studies have identified the most important human resources tools to manage job satisfaction. In order of importance, these include materials, salary, training, working environment, supportive supervision, living conditions and recognition<sup>8</sup>. This was relatively consistent with our findings.

In regression analysis, we were able to evaluate the effects of several job-related factors simultaneously to judge their relative importance in predicting satisfaction. In order of importance, the following were the most important significant contributors to overall satisfaction:

- Job was a **good match** with worker's skills and experience
- Satisfaction with **salary**
- Satisfaction with **supervisor**
- Manageable **workload**
- Job is **stimulating or fun**
- **Job security**.

Satisfaction in the eastern region was lower than in the central region (Kampala), holding other variables constant, although the results were only marginally significant. Public or private sector was not significant in predicting satisfaction.

**Comment:** Job satisfaction matters to health system managers because it is an important factor in predicting system stability (reduced turnover) and worker motivation<sup>9</sup>. If

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<sup>5</sup> Hagopian A, House P, Dyck S, et al. The use of community surveys for health planning: the experience of 56 northwest rural communities. *The Journal of Rural Health*. 2000;16(1):81-90.

<sup>6</sup> Pathman DE, Konrad TR, Williams ES, et al. Physician job satisfaction, dissatisfaction, and turnover. *The Journal of Family Practice*. 2002;51(7):593.

<sup>7</sup> Ingersoll GL, Olsan T, Drew-Cates J, Devinney BC, Davies J. Nurses' job satisfaction, organizational commitment, and career intent. *The Journal of Nursing Administration*. 2002; 32(5):250-63.

<sup>8</sup> Mathauer I, Imhoff I. Health worker motivation in Africa: the role of non-financial incentives and human resource management tools. *Human Resources for Health*. 2006;4:24.

<sup>9</sup> Mathauer.

motivation is defined as the willingness to exert and maintain effort towards attaining organizational goals, then well-functioning systems seek to boost factors (such as morale and satisfaction) that predict motivation. A survey of ministries of health in 29 countries showed that low motivation is seen as the second most important health workforce problem after staff shortages<sup>10</sup>.

The literature suggests that systems should identify facilities that are serving as “magnet hospitals” and seem especially adept at boosting motivation and performance, in order to identify the factors that can be replicated elsewhere in the system<sup>11</sup>. In our study, health workers at Angal and Rubaga hospitals registered the highest overall job satisfaction among private facilities. Among public facilities, the top performers were Apac, Kagadi and Itojo. Further study of these facilities would need to be done to determine if the difference in satisfaction is an artifact or an actual difference based on key factors of job satisfaction.

#### **4.5 Working and Living Conditions Are Poor and Workload Is High**

There are significant problems with working conditions in all health facilities. Only about a third (36%) of respondents said they thought their workload was manageable. Access to equipment, supplies, drugs, electricity and water are seriously compromised. Only half (51%) said they had the supplies they needed to do their jobs well and safely (gloves, needles, bandages, etc.), and even fewer (48%) said they had the equipment they needed to do their jobs well (x-ray, blood-pressure cuffs, etc.). About the same number (49%) said they had good access to electricity at work. As a measure of workload, only a third (31%) said they can take time to eat lunch almost every day. Men were more likely to report that they had time for lunch and that the workload was manageable.

Working conditions were consistently rated higher by private sector workers, with statistically significant differences measured for the availability of supplies, equipment and drugs, utilities, transportation and time to eat lunch. Physicians were the cadre most likely to report problems with access to supplies, equipment and medications.

Our field surveyors noted through observation that many facilities are operating without adequate access to electricity, and some facilities are operating with extreme staff shortages. We heard stories of (or witnessed) babies delivered by candlelight, dentists idle because their tools cannot operate without electricity, hospitals without any x-ray facilities, and non-functioning rest rooms and ambulances. One hospital had no physicians at all.

While working conditions were poor, living conditions may be worse. Large numbers of respondents said they don't have good access to transportation to work (61%), access to good schooling for their children (44%), access to shopping or entertainment in their communities (44%) or good electricity at home (52%).

**Comment:** When working conditions are poor and workload is high, health workers are demotivated and frustrated. They are unable to satisfy their “professional conscience<sup>12</sup>” and will distance themselves emotionally from their work, reducing their commitment and motivation. Sometimes the lack of supplies or equipment is viewed as beyond the means of anyone to control, but when poor management or corruption is perceived to be at the root of the problem, health workers told us it is especially frustrating to them.

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<sup>10</sup> Mathauer, p. 2.

<sup>11</sup> International Council of Nurses.

<sup>12</sup> Mathauer, p. 3.

## 4.5 Compensation is Very Unsatisfying

Early theory in worker satisfaction and motivation identified compensation as a “hygiene factor” rather than a motivation factor<sup>13</sup>. This means that basic salary satisfaction must be present to maintain ongoing job satisfaction, but this by itself will not provide satisfaction, and increasing amounts of salary will not contribute to increasing levels of job satisfaction. Some recent research in Africa suggests that salary increases and other improvements in compensation, in the context of highly inadequate pay and benefits, may indeed contribute to workforce retention<sup>14</sup>.

Only 11% of respondents believed their salary packages are fair, and a large majority think their compensation packages should include health care for dependents (90%), terminal benefits such as retirement (87%), housing (83%), a food allowance (79%) and transportation (77%). It is notable that respondents said that health care for dependents was even more important than salary itself, but that managers, when asked in their own survey, significantly underestimated the importance of health care benefits to employees. About three in four (74%) managers predicted that this would be important to workers, compared to 90% of workers.

The importance of compensation was highest among nurses (2.9 on a three-point scale) compared to other cadres, perhaps because 43% are the heads of their households without spouses.

Health workers repeatedly told us of many years of service without salary or position upgrades. Sometimes new graduates are paid more than 20-year veterans. We were told that selection for further training seems arbitrary and unfair sometimes, and that trainings are a significant reward and motivator. Both focus groups and surveys confirmed that the public sector is perceived as offering significantly better job security and compensation than the private sector, but significantly poorer working conditions.

**Comment:** Given the significant gap between salaries in Uganda and those in neighbouring countries and abroad, it seems critically important to begin addressing compensation factors to avoid turnover and reduce incentives to leave the health sector or the country. The Catholic hospital database on turnover revealed that the leading reason for health workers leaving jobs in 2005 was low salary. The finding that health care coverage for dependents may be even more important than salary itself may suggest an affordable, immediately achievable compensation strategy (assuming the additional health care delivery could be affordably absorbed by the institutions where these workers are already employed).

## 4.6 Opportunities Exist for Better Supportive Supervision

Health workers reported that their relationships with supervisors were only slightly better than neutral. While a majority (60%) said that the hospital manager where they work is “competent and committed,” and that their immediate supervisor cares about them as a person (61%), there is room for improvement in those scores.

In focus groups, workers said they appreciated the opportunity to participate in regular meetings and discuss issues pertaining to the running of the facility. A majority of focus groups expressed considerable dissatisfaction about the lack of appreciation or recognition for their sacrifices and commitment on the part of management.

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<sup>13</sup> Herzberg F. *The motivation to work*. New York, NY: Wiley, 1959.

<sup>14</sup> Kober K, Van Damme W. Public sector nurses in Swaziland: can the downturn be reversed? *Human Resources for Health*. 2006;4:13.

A majority of respondents said that the morale in their departments was not good, it was not a fun place to work and no one had discussed their development at work in the last six months. Fewer than half (45%) said that someone had encouraged their development at work in the last six months. One third did not feel they were fairly evaluated on their work.

We asked a number of questions about safety and security. A sizeable proportion (42%) of health workers disagreed with or felt neutral about the statement that their employer “takes specific measures to protect me against HIV/AIDS.” Fear of HIV infection has been reported elsewhere as an underlying reason for attrition<sup>15</sup>.

One in four health workers (24%)—most of them women, and most nurses—reported that they had been abused physically, verbally or emotionally by a supervisor at their current jobs. Women were significantly more likely than men to say that they had been abused by a supervisor or by patients or friends and family members of patients. Nurses and pharmacy staff were most likely to report being abused by a supervisor or peers.

The literature on health worker abuse tends to focus on nurses, and much of it discusses physicians’ abuse of nurses. A review of the literature shows that verbal abuse by physicians accounts for the highest incidence of aggression towards nurses in health care, and that it is strongly related to turnover rates, patient care, work productivity, morale and job satisfaction<sup>16</sup>. In one South African study, 79% of the nurses reported verbal abuse. In a Turkish study, 87% of nurses reported abuse<sup>17</sup>. While our study used different methods and measures, our numbers were significantly lower than those. About one in four (27%) nurses in our study reported being abused by a supervisor, 26% by patients or their family and 18% by peers.

**Comment:** While the report of abuse among health care workers is disturbing, at more than one in four, it does not seem to be more prevalent in Uganda than in other countries. This suggests a more generic problem in the health profession rather than a specific problem in Uganda.

#### 4.7 Ethical and Organizational Issues

In addition to analyzing the results of questionnaire responses, our teams made notes on their conversations with staff during informal conversations and formal focus-group discussions. These are detailed in the technical report, but some highlights include the following observations:

- Some health workers in public facilities are illegally charging patients fees; administrators feel powerless to intervene.
- Many public-sector doctors are running private practices during time when they are supposed to be working at their “day jobs.”
- Some of these doctors are appropriating drugs and supplies from public facilities for their private practices.
- Many health workers are not properly upgraded after returning from training.

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<sup>15</sup> Ehlers VJ. Challenges nurses face in coping with the HIV/AIDS pandemic in Africa. *International Journal of Nursing Studies*. 2006;43(6):657-62.

<sup>16</sup> Joubert E, du Rand A, van Wyk N. Verbal abuse of nurses by physicians in a private sector setting. *Curatationis*. 2005;28(3):39-46.

<sup>17</sup> Uzun O. Perceptions and experiences of nurses in Turkey about verbal abuse in clinical settings. *Journal of Nursing Scholarship*. 2003;35(1):81-5.

- When workers take leave for studies (or other purposes), they are still listed as current workers at their facilities, creating shortages but not vacancies that can be filled.
- Many health workers blamed decentralisation for reduced interest in positions available in remote locations. The idea of being bonded to a rural district for life is enough to keep a doctor from even applying, some respondents indicated, and rural health facilities are left to recruit and retain workers on their own.
- The relationship between district-elected leadership and the district directors of health services and hospital administration can be problematic. When local leaders don't prioritise health, facilities suffer.
- There is corruption among some who hold positions of power. For example, occasionally health workers are required to pay or offer personal services to have their papers or paycheques processed.

**Comment:** These ethical and organizational issues represent significant challenges in the management and control of the health system, and likely contribute significantly to health worker satisfaction, motivation and morale. Many of these issues cannot be addressed at the facility level and will need the attention of the MOH.

## 5. Conclusions

The overall satisfaction among Ugandan health workers is not high—fewer than half the respondents said that they were satisfied with their jobs. Satisfaction with salary is particularly low, and doctors are the least satisfied group. Furthermore, working and living conditions are very poor, and the workload is judged to be unmanageable. Working conditions are better in the private (non-profit) sector than in the public sector, but compensation and job security were viewed as superior in the public sector.

Despite these conditions, however, health workers have been in their jobs a long time (81% say they are still in their first jobs) and are loyal (average time with their employers is 13 years). However, about one in four would leave their jobs soon if they could, and more than half of doctors (57%) say they would like to leave their jobs.

Some demographics of the health workforce will be important to monitor during a policy planning process. The average health worker is not young (mean age 39) and has many dependents (average of seven) to support. Most workers are employed where they were born or trained, suggesting some implications for recruitment and retention. In Kampala, satisfaction is lower and the intent to leave jobs is higher than in other regions.

The important correlates of intent to stay or job satisfaction include the importance of salary (but not the *satisfaction* with salary, which is uniformly low), a good match between the job and the worker, active involvement in the facility, a manageable workload, supportive supervision, flexibility to manage the demands of work and home, job security and a job perceived as stimulating or fun. Some of these issues could be addressed without a large capital investment.

Some of the field observations about ethical and organizational issues bear further examination. Systems that tolerate incompetence, inattention, inequity, faulty decision-making or corruption are signalling to health workers that their work is not valued. Nothing can be more detrimental to motivation than that.

## 6. Next Steps

The purpose of this study was to develop strategies and policies to improve health worker morale, satisfaction and intent to stay in the country and in the health sector. The results are intended to inform MOH strategic planning and offer guidance to the private-sector employers and the facilities themselves. Individual facility-level reports are being prepared to distribute to the hospitals we visited (except for those places where the number of respondents was very small, and therefore individuals could be identifiable).

There are many policy and strategy implications raised by this study. Further analysis of data is needed, as there is a considerable wealth of information that can be explored further. The Capacity Project intends to support the MOH in its policy-development efforts in response to this study.

The completion of this study is a remarkable achievement for Uganda, and a number of academic papers are scheduled to be written by project participants at the MOH, with the Capacity Project and at the universities in Uganda.

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