Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Lived experiences of long-serving (>15 years) community health workers in South Western Uganda: a phenomenological study

Edison Byamugisha
edisonbyamugisha12@gmail.com
Mbarara University of Science and Technology
Hamson Kanyesigye
Mbarara University of Science and Technology
Teddy Kyomuhangi
Mbarara University of Science and Technology
Jenn Brenner
University of Calgary
Jerome Kabakyenga
Mbarara University of Science and Technology

Research Article

Keywords: Community health workers, Village health teams, Volunteerism, Retention, Motivation, Phenomenology, Qualitative research, Uganda

Posted Date: November 6th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11638367/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

Background

Community health workers (CHWs) are central to primary health care in Uganda, yet most serve as unpaid volunteers and attrition is a recurring concern. Little is known about why some CHWs persist for more than 15 years. We explored the motivations, challenges and coping strategies of long-serving CHWs in Mbarara, Rubirizi and Rwampara districts, South Western Uganda.

Methods

We conducted a qualitative phenomenological study using in-depth interviews with 36 CHWs and 18 parish CHW coordinators who were selected and trained by Healthy Child Uganda between February 2004 and January 2008 and had served for more than 15 years. 36 village CHWs, selected by simple random sampling, and 18 parish CHW coordinators, selected purposively. Interviews were audio-recorded and transcribed, and analysed using inductive and deductive thematic analysis following Braun and Clarke. Themes were organized across the individual, interpersonal, community and organizational levels of a socio-ecological framework.

Results

Motivation arose from professional growth (social recognition, confidence in public speaking, transferable skills and the uniform as a marker of identity), community respect, trust and an advisory role, friendships among CHWs, the satisfaction of protecting community health, and modest financial and material incentives. Challenges included inadequate refresher training; health and safety risks among ageing CHWs; community resistance; conflict between CHW duties and family or farming roles; lack of transport, funds and equipment; uncooperative or corrupt local leaders; absence of an organizational structure; and declining supportive supervision. CHWs coped through faith, passion and commitment, expectations of future recognition or pay, savings and credit groups, peer and family support, subsistence farming and small businesses.

Conclusions

Persistence beyond 15 years rests largely on intrinsic and social rewards and on coping strategies that CHWs finance themselves, rather than on health system support. Regular refresher training, supportive supervision, predictable transport support, protective equipment, a clear organizational structure and formal recognition are needed to retain this ageing and experienced workforce.

Background

Community health workers (CHWs) have provided basic health services in underserved rural areas for more than 50 years(1). CHW models expanded rapidly in the 1980s and 1990s, but early reviews reported mixed results and high attrition where incentives and support were inadequate (2). The last decade has seen major investment in national CHW programmes, with integration into health systems reported in countries such as Brazil, Ethiopia and India (3).

Qualitative studies show that some CHWs remain in post for many years despite the absence of a salary. In Brazil, status recognition, pride in the profession and career perspectives were important to CHWs(4). In coastal Kenya, high-performing community health volunteers who had served for over ten years described growing standing in the community, relationships and competence as reinforcing their commitment, while faith and peer dialogue supported coping and infrastructure limits still tested persistence (5). A cross-country qualitative analysis concluded that intrinsic, social, economic and institutional dimensions all influence sustained volunteerism (6). Evaluations of salaried CHW programmes in Western Uganda and Tigray, Ethiopia, similarly underline ongoing mentoring, involvement in decisions and links to health facilities(7)

In Uganda, CHWs are organized as Village Health Teams (VHTs), which link health facilities and villages after relatively short training(8). Each village has five to eight volunteers who mobilize communities for immunization, sanitation and family planning, conduct home visits and referrals, and report data as informal extensions of the health system; most are subsistence farmers, 56% are female and 57% have primary education as their highest qualification (9). A study of VHTs in two Ugandan districts identified limited career growth, dependence on subsistence agriculture and the absence of refresher training as challenges to persistence(10). Work from Zambia describes how VHT members cope with volunteering amid health system constraints, with faith framing a moral purpose (11). A systematic review identified social responsibility as a primary driver of commitment among CHWs(12).

In South Western Uganda, Mbarara University of Science and Technology and the University of Calgary, through the Healthy Child Uganda (HCU) partnership, have supported CHW programmes in Rubirizi, Mbarara and Rwampara districts for about 20 years. More information about this partnership is available at www.healthychilduganda.org/resources. A retrospective survey of CHWs trained by HCU between February 2004 and July 2009 found that 96% served for one year, 91% for two years and 86% for five years (13). No study has since followed this cohort to explore the experiences of those who have remained for more than 15 years. This gap matters in districts with poor health indicators, including a maternal mortality ratio above 300 per 100,000 live births(14), an infant mortality rate of 56 per 1,000 live births and only 60% of births occurring in health facilities (15), where CHWs carry much of the work of health promotion, basic care and referral.

We therefore explored the lived experiences of CHWs who have served for more than 15 years in Mbarara, Rubirizi and Rwampara districts, focusing on (i) the factors that motivate them, (ii) the challenges they face and (iii) the strategies they use to cope and persist in their voluntary roles. The findings are intended to inform retention strategies and national community health policy.

Methods

Study design

We used a qualitative phenomenological design, which seeks to understand the essence of a shared experience through participants' own accounts(16). The study explored motivations, challenges and coping strategies related to sustained voluntary service as a CHW. Reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ)(17) (Additional file 1).

Study setting

The study took place in Mbarara, Rubirizi and Rwampara districts, South Western Uganda. These were the first districts in which HCU selected and trained CHWs (phases 1 and 2, February 2004 to January 2008).

Study population and eligibility

The target population was CHWs and coordinators who were selected and trained by HCU between February 2004 and January 2008 and had served for more than 15 years. Eligible participants were active CHWs and coordinators who were resident in the three districts and willing to give written informed consent. We excluded CHWs who were unable to give informed consent or to complete an in-depth interview, and those who had not been selected and trained by HCU within the stated period.

Sampling and participants

We used the updated HCU register of CHWs. Eighteen parish CHW coordinators, who had been chosen by fellow CHWs to coordinate them, lead VHT meetings, implement activities and link VHTs to NGOs, local government and VHT associations, were selected purposively. With the help of the register and the coordinators, we then selected 36 village CHWs by simple random sampling from those meeting the inclusion criteria. Participants were contacted individually and interviews were scheduled at their convenience. In total, 54 participants were interviewed. Recruitment continued until thematic saturation was reached(18). To ensure this was achieved systematically, the team monitored code frequency and conceptual stability over the final 12–15 consecutive interviews. Once it was clear that the conceptual boundaries of all major themes were fully established and data collection yielded redundant information, recruitment was intentionally concluded.

Data collection

Data were collected between April 2024 and June 2024 after ethical approval and district clearance. An HCU official introduced the research team to parish coordinators, who in turn introduced the team to

CHWs. Two researchers conducted each interview, one moderating and the other taking notes; EB the first author with a Post graduate diploma in monitoring Evaluation and Research, experienced qualitative researcher with a training in MicroResearch and Research Ethics interviewed the participants. And he was assisted by a female Research assistant with a certificate in research ethics whose role was note taking and recording. Interviews took place at or near participants' homes in a private, secure setting, so that participants did not incur transport costs. A semi-structured guide covering motivations, challenges and coping strategies, developed from the study objectives, was used. (Additional file 2). This interview guide was pre tested on 6 community health workers of the same districts with the same experience and refined. Interviews were conducted in Runyankole and later transcribed and then translated into English for analysis, lasted about 30 to 45 minutes, were audio-recorded and supported by field notes. Each participant received UGX 20,000 as compensation for their time.

Data management and analysis

Recordings were transcribed from Runyankole to English by EB and then shared with JK to check against the audio. Transcripts were stored on a password-protected computer and participants were identified only by unique codes (sex, role, district and number).

EB (An experienced qualitative analyst with a post graduate in monitoring, evaluation and research listened to voice audio recordings captured from each participant and transcribed into a written text. The written transcripts (Additional files 3 and 4) from all the audio interviews were analyzed manually by EB using inductive and deductive thematic analysis following the six phases of Braun and Clarke(19): familiarization with the transcripts, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and writing up. Themes and sub-themes were then organized by level of a socio-ecological framework (individual, interpersonal, community and organizational)(20)

EB and JK read the transcript several times on separate days so as to get familiar with all responses and developed meanings from which codes, subthemes and themes were generated. The audio recordings, transcript and analyzed data were shared with JB, TK and HK (experienced qualitative researchers) to do the refining. Analysis was repeatedly discussed between EB, JK, JB, TK and HK until consensus was reached.

Rigour and reflexivity

Credibility was supported by member checking of transcripts, thick description, peer debriefing with impartial colleagues and consideration of negative cases. Dependability was supported by detailed field notes, transcript checking against recordings, an audit trail of codes and themes, and standardized interview and analysis procedures. The research team kept a reflexive journal and bracketed prior assumptions(21).

Ethical considerations

The study was approved by the Mbarara University of Science and Technology Research Ethics Committee (MUST-2023-1294) on19/03/2024 and registered with the Uganda National Council for Science and Technology (SS2538ES) on 16/04/2024. Administrative clearance was obtained from the Chief Administrative Officers of the three districts. All participants gave written informed consent. Interviews were held in private, recordings were stored securely with access limited to the study team, quotations are identified only by codes, and recordings will be deleted after study completion.

Results

Participant characteristics

The mean age of participants were 54.1 years for Parish coordinators and 51.3 years for community health workers. Parish coordinators were predominantly male 11, whereas most community health workers were female 22. All coordinators and 31 of community health workers were married. Secondary education was the most common qualification in both groups 13 and 22, respectively. All participants had over five years of experience (Table 1).

Table 1
Characteristics of study participants (N = 54)

Characteristic	Category or statistic	Community health workers (n = 36)	Parish coordinators (n = 18)
District	Mbarara	12	6
	Rubirizi	12	6
	Rwampara	12	6
Age in years	Mean ± SD	51.3 ± 5.5	54.1 ± 4.0
	Range	42–65	45–59
Sex	Female	22	7
	Male	14	11
Marital status	Married	31	18
	Divorced	2	0
	Widowed	2	0
	Single	1	0
Education	Primary school	12	4
	Secondary school	22	13
	Certificate	1	1
	Bachelor's degree	1	0
Religion	Christian	36	17
	Muslim	0	1
Training phase	Phase 1 (Feb–Mar 2004)	25	13
	Phase 2 (Mar 2006–Jan 2008)	11	5
Experience	3–5 years	0	0
	More than 5 years	36	18

Themes are summarized in Table 2 and described below by socio-ecological level. Quotations are identified by participant code (sex, role, district, number).

Table 2
Motivational factors, challenges and coping strategies of long-serving CHWs by socio-ecological level

Level	Motivational factors	Challenges	Coping strategies
Individual	**Professional growth and development** Social recognition Confidence in public speaking Personal development Professional recognition	**Training and development gaps** Inadequate refresher trainings **Safety and risk management** Health and safety risks	**Personal growth and future planning** Future-oriented thinking **Motivation and drive** Passion and commitment **Emotional and spiritual resilience** Faith-based coping
Interpersonal	**Community leadership and trust** Community respect Community trust Community advisory role **Social connection and networking** Social networking	**Community and stakeholder challenges** Community resistance Role conflicts	**Social support networks** Peer support mechanisms Family support
Community	**Public health and safety impact** Community health protection	–	–
Organizational	**Incentives and rewards** Financial incentives Material incentives	**Resource and infrastructure constraints** Lack of transport Lack of financial support Lack of equipment and materials **Leadership and organizational issues** Uncooperative or corrupt leaders Lack of organizational structure	**Economic and livelihood strategies** Subsistence farming Running small businesses

Level	Motivational factors	Challenges	Coping strategies
		Insufficient supportive supervision	

Motivational factors

Individual level: professional growth and development

Participants said that training and deployment made them known in their communities. One man described that “after we were selected and trained, we became known by different people” (Male CHW, Mbarara, 17), and a woman explained that she became “known by health workers and other important people in her community” (Female CHW, Rubirizi, 10). Several had gained confidence in public speaking: “I also gained confidence to speak in public, which I did not have before” (Female CHW, Rwampara, 27).

The role also opened personal and professional opportunities. One woman used her certificates to apply for other jobs (Female CHW, Mbarara, 04), and another was recruited by a different organization because of her experience (Female CHW, Mbarara, 30). The uniform was a visible marker of identity: “When I put on my VHT T-shirt, all community members give me respect and this increases my strength to serve more” (Male parish coordinator, Rubirizi, 08).

Interpersonal level: community leadership and trust, and social connection

Respect, trust and being sought out for advice were strong motivators. “The respect I gain from community members motivates me a lot” (Female CHW, Rubirizi, 21). Trust was described as paramount: “The most important thing that motivates me to continue working as a community health worker is the trust community members have in me” (Female CHW, Rubirizi, 05). Participants valued being consulted: “When community members come to me for advice…I become motivated more” (Female CHW, Rubirizi, 32). Friendships formed with other CHWs also sustained commitment: “The friendship I have built from this role with other community health workers have increased my motivation to continue serving…for all these years” (Male CHW, Rubirizi, 09).

Community level: public health and safety impact

Participants were motivated by the contribution of their work to community health. One man explained, “I continued working to help my community so that it can be free from diseases that were claiming the lives of our community members” (Male CHW, Rubirizi, 35).

Organizational level: incentives and rewards

Although designated as volunteers, participants valued the periodic incentives they received. Some were financial: “Sometimes when we do an activity, the government give us incentives like a transport refund which increases our motivation” (Female CHW, Mbarara, 31). Earlier, HCU had given monthly transport money that was used for group savings rounds (Female CHW, Rwampara, 24). Material items were

valued both as practical aids and as symbols of recognition: “Incentives like t-shirts, bicycles, gumboots, and umbrellas; have increased my motivation to continue working” (Female CHW, Rwampara, 34).

Challenges

Individual level: training gaps and safety risks

Participants reported that refresher training had become rare: “We have taken long without attending refresher trainings” (Female CHW, Rubirizi, 15). They felt exposed to disease outbreaks without protective measures, and noted that many CHWs were now elderly: “Most of our community health workers have reached their old age and are at risk of getting diseases because of their low immunity” (Female CHW, Rubirizi, 15).

Interpersonal level: community resistance and role conflicts

Some community members did not act on health education or comply with programmes: “Some community members do not want to put what I educate them into practice” (Female CHW, Mbarara, 18). One participant was harassed and called nicknames. CHW duties also competed with family and livelihood activities: “Our role as community health workers conflicts with our family roles like agriculture” (Female CHW, Rubirizi, 10).

Organizational level: resource constraints and leadership issues

Transport was a major burden. One woman spent UGX 15,000 of her own money for a round trip that was “not even refunded” (Female CHW, Mbarara, 18), while others walked to collect emergency medicines, leaving them “too tired and hungry” (Female CHW, Rubirizi, 10). Participants stressed that they were unpaid yet used family income to fund their work: “We use our family income to fund this voluntary work” (Female CHW, Rwampara, 11). They lacked gumboots and umbrellas for the rainy season (Female CHW, Mbarara, 31). Some described uncooperative and corrupt leaders, and nepotism among officials (Female CHW, Rubirizi, 15; Female CHW, Mbarara, 31; Female CHW, Rubirizi, 33). They also reported having no organizational structure for coordination and reporting, and that “the government no longer carry out supportive supervision among community health workers” (Female CHW, Mbarara, 23).

Coping strategies

Individual level: future orientation, commitment and faith

Many participants endured hardship by anticipating future benefits: “I expect a lot from the government in the future, like salary and transport allowances” (Female CHW, Mbarara, 04). Passion and commitment were also described: “I am passionate about my role in our community” (Female CHW, Rwampara, 22).

Faith was a recurring source of strength: “Without faith, I would not have overcame these difficult experiences for all these 20 years” (Male CHW, Rubirizi, 25), and one woman said, “I have faith in God because he is the one who chose me to serve his people” (Female parish coordinator, Mbarara, 18).

Interpersonal level: peer and family support

CHWs formed savings and credit groups and peer groups. “We formed a peer support group where under that group we share and look for solutions to the challenges that we face” (Female CHW, Mbarara, 07); “We formulated a credit and saving group where we borrow money to use in this role” (Female CHW, Rwampara, 11). Spouses and working adult children also gave money for transport and other costs (Female parish coordinator, Rwampara, 14; Female CHW, Rubirizi, 32).

Organizational level: economic and livelihood strategies

Participants financed their work from the sale of crops, milk and eggs: “I sell my bananas and sugar cane to get money to support me in this role” (Male CHW, Rwampara, 16). One man ran a small business buying and selling goats, the profits of which supported his CHW work (Male CHW, Rwampara, 12).

Discussion

This study describes why CHWs trained by HCU in South Western Uganda have remained in unpaid roles for more than 15 years, what they find hard, and how they cope. Our main finding is that persistence is sustained mainly by recognition, respect and purpose, and is paid for largely by CHWs themselves through farming, small businesses, savings groups and family support, while the health system provides intermittent and shrinking support.

The importance of recognition, trust and standing agrees with studies from Brazil and Kenya, where status recognition, pride and growing standing in the community reinforced long service (4,5), and with the cross-country finding that intrinsic and social dimensions underlie sustained volunteerism (6). A systematic review also found social responsibility to be a primary driver of commitment (12), which resonates with our participants’ wish to protect their communities from disease. A feature of our findings is how much recognition was tied to visible symbols, especially uniforms and certificates, and to being known by health workers and other community leaders. Low-cost, durable recognition of this kind may therefore be an under-used retention tool. Participants also valued small financial and material incentives, in line with earlier work in the same programme area showing that retention need not be poor when incentives and supportive supervision are in place (13).

The challenges we found, namely infrequent refresher training, dependence on farming for income and unreliable support, are similar to those reported for VHTs in two other Ugandan districts(10) and for VHT members in Zambia (11). Studies of salaried CHW programmes emphasize mentoring, involvement in decisions and links with health facilities (7,8); our participants described the opposite, with no organizational structure and supportive supervision that had stopped. Challenges that received less

attention in the literature we reviewed were the exposure of ageing CHWs to disease without protective equipment, and perceptions of corruption and nepotism among local leaders. These suggest that long-serving CHWs face risks that grow with age and that retention strategies must plan for succession and safety, not only motivation.

Coping strategies reflected both inner resources and self-funding. Faith and a sense of calling are described in other settings(5,11), and our participants added future-oriented expectations of salary or allowances. Peer and credit groups provided financial and emotional support, consistent with the value of peer dialogue reported in Kenya(5). At the same time, the reliance on personal and family income to cover transport and work-related costs shows that the cost of CHW service is being shifted to the poorest households. The expectation of future pay also raises a risk: if these expectations are not met, motivation among this experienced group could decline.

Implications for policy and practice

The findings suggest that districts and the Ministry of Health should consider: regular refresher training for long-serving CHWs; restoring routine supportive supervision; predictable transport support and protective equipment; a clear organizational structure from village to district level; formal recognition and career pathways, including opportunities to mentor new CHWs; and attention to the health and safety of older CHWs.

Strengths and limitations

Strengths include the inclusion of both village CHWs and parish coordinators, interviews at participants' homes, and the use of member checking, peer debriefing and an audit trail. Limitations should be noted. We interviewed only active CHWs, so the views of those who left are missing, and the findings may overstate positive experiences. All participants were trained by one programme in three districts, which limits transferability.

Conclusions

CHWs who have served for more than 15 years in Mbarara, Rubirizi and Rwampara districts persist because of recognition, community trust, a sense of purpose and modest incentives, and cope largely through faith, peer groups, family support and their own livelihoods. Their service is constrained by a lack of refresher training, transport, equipment, supervision and organizational structure. Policies that retain this experienced workforce should reduce the personal cost of volunteering, restore supportive supervision and training, protect ageing CHWs and provide formal recognition.

Abbreviations

CHW
Community health worker

COREQ
Consolidated criteria for reporting qualitative research
HCU
Healthy Child Uganda
MUST
Mbarara University of Science and Technology
UGX
Uganda shillings
VHT
Village Health Team.

Declarations

Ethics approval and consent to participate:

The study was approved by the Mbarara University of Science and Technology Research Ethics Committee (MUST-2023-1294) on 19/03/2024 and the Uganda National Council for Science and Technology (SS2538ES) on16/04/2024. Administrative clearance was obtained from the Chief Administrative Officers of Mbarara, Rubirizi and Rwampara districts. All participants provided written informed consent. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Funding

[1]Department of Maternal Newborn and Child Health Research, Mbarara University of Science and Technology, Mbarara, Uganda. P.O Box 1410, Mbarara, Uganda

Author Contribution

EB conceptualized and designed the study, collected the data and drafted the manuscript. EB transcribed the interview audio recordings into a written text (transcript).EB and JK analyzed the transcript and developed themes and subthemes which were refined by TK and HK drafted the manuscript while JB

critically reviewed and revised it. All authors approved the final version of the manuscript .EB, JK, HK and TK are personally accountable for the integrity of this work.

Acknowledgement

We thank the community health workers who participated, Healthy Child Uganda, the district health teams and local leaders of Mbarara, Rubirizi and Rwampara, and the research assistant.

Availability of data and materials

The written transcripts originating from the audio interviews has been provided as additional files 3 and 4.

References

1. Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health. 2014;35(1):399–421.
2. Bhattacharyya K, Winch P, LeBan K, Tien M. Community health worker incentives and disincentives. Va USAID-BASICS II. 2001.
3. Scott K, Beckham SW, Gross M, Pariyo G, Rao KD, Cometto G, et al. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. Hum Resour Health. 2018 Dec;16(1):39. doi:10.1186/s12960-018-0304-x
4. Fernandes A, Santinha G, Forte T. Public service motivation and determining factors to attract and retain health professionals in the public sector: A systematic review. Behav Sci. 2022;12(4):95.
5. Kirimi DM. Assessing Community Health Workers' Performance Motivation. Kent State University; 2024.
6. Panday S, Teijlingen E van, Barnes A. Exploring the motivations of female community health volunteers in primary healthcare provision in rural Nepal: a qualitative study. PLOS Glob Public Health. 2024;4(8):e0003428.
7. Godana KT, Birhanu Z, Nemera G, Eba K, Balcha F, Assefa Y, et al. Multidimensional performance enablers of Ethiopian community-based health extension program: A scoping review. Plos One. 2025;20(6):e0324377.
8. Lionis C, Symvoulakis EK, Markaki A, Petelos E, Papadakis S, Sifaki-Pistolla D, et al. Integrated people-centred primary health care in Greece: unravelling Ariadne's thread. Prim Health Care Res Dev. 2019;20:e113.
9. Mays DC, O'Neil Jr EJ, Mworozi EA, Lough BJ, Tabb ZJ, Whitlock AE, et al. Supporting and retaining Village Health Teams: an assessment of a community health worker program in two Ugandan

districts. Int J Equity Health. 2017;16(1):129.
10. Dyer C. Experiences of Secondary Trauma and Posttraumatic Growth in Community Health Workers in Zambia: A Phenomenological Study. 2025.
11. Van Iseghem T, Jacobs I, Vanden Bossche D, Delobelle P, Willems S, Masquillier C, et al. The role of community health workers in primary healthcare in the WHO-EU region: a scoping review. Int J Equity Health. 2023;22(1):134.
12. Ballard M, Montgomery P. Systematic review of interventions for improving the performance of community health workers in low-income and middle-income countries. BMJ Open. 2017;7(10):e014216.
13. Ludwick T, Brenner JL, Kyomuhangi T, Wotton KA, Kabakyenga JK. Poor retention does not have to be the rule: retention of volunteer community health workers in Uganda. Health Policy Plan. 2014 May 1;29(3):388–95. doi:10.1093/heapol/czt025
14. Nambuusi BB, Ssempiira J, Makumbi FE, Kasasa S, Vounatsou P. The effects and contribution of childhood diseases on the geographical distribution of all-cause under-five mortality in Uganda. Parasite Epidemiol Control. 2019;5:e00089.
15. Turyamureba M, Yawe BL, Oryema JB. Factors influencing public and private healthcare utilisation in Uganda. Afr Health Sci. 2023;23(3):724.
16. Neubauer BE, Witkop CT, Varpio L. How phenomenology can help us learn from the experiences of others. Perspect Med Educ. 2019;8(2):90–7.
17. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57.
18. Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. Field Methods. 2006;18(1):59–82.
19. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101.
20. Henderson DX, Baffour T. Applying a socio-ecological framework to thematic analysis using a statewide assessment of disproportionate minority contact in the United States. Qual Rep. 2015;20(12):1960–73.
21. Creswell JW, Poth CN. Qualitative Inquiry and Research Design: Choosing Among Five Approaches, 5/E. 2017.