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Transactional Leadership and the Performance of Health Service Delivery: A Qualitative Case Study of Lira Regional Referral Hospital, Uganda

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Abstract: *Background: Leadership shapes how health services are organized and experienced in resource-constrained public referral hospitals. Transactional leadership relies on clear expectations, supervision, accountability, rewards and corrective action; if experienced mainly as punitive control, these mechanisms may undermine staff motivation and service delivery. This study examined how transactional leadership shaped staff absenteeism and clinical shift compliance at Lira Regional Referral Hospital (LRRH), Uganda. Methods: The study adopted an interpretivist paradigm and qualitative case-study design. Twenty participants were purposively selected across four categories: five administrators and departmental heads, seven medical professionals, four support staff and four patients. Data were generated through semi-structured interviews, focus groups and documentary review, and analyzed using Braun and Clarke's (2006) six-phase thematic analysis in NVivo 12. Trustworthiness was strengthened through triangulation, member checking, reflexivity and an audit trail. Results: Transactional leadership at LRRH operated primarily through administrative monitoring, supervision, attendance checking and disciplinary procedures that reinforced formal accountability. Frontline staff, however, often experienced this monitoring as punitive, where personal and organizational circumstances were overlooked. A gap emerged between recorded attendance and actual professional commitment: some remained beyond scheduled shifts during emergencies, while registers did not always reflect availability. Leaders addressed staffing shortages through flexible redeployment, while prolonged acting appointments in management weakened authority and accountability. Conclusion: Transactional leadership can support service delivery by clarifying expectations and strengthening accountability, but its value is limited when supervision becomes mere control and punishment. Sustainable performance requires accountability combined with supportive supervision, recognition, flexible coordination, stable leadership and adequate staffing.*

Keywords*: transactional leadership; accountability; staff absenteeism; clinical shift compliance; supervision; health service delivery; regional referral hospital; Uganda.*

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1. Introduction

Health service delivery in public referral hospitals depends on the effective coordination of personnel, resources, professional responsibility, and institutional process. Although infrastructure, medicines, equipment, and staffing are fundamental, these inputs do not automatically translate into consistent and responsive care. Leadership shapes how available resources are deployed, how expectations are communicated, how staff performance is monitored, and how problems are addressed. Leadership is

therefore an important determinant of health service delivery, particularly in low-resource settings where managers must coordinate services under persistent constraint (Gilson & Agyepong, 2018; Sfantou et al., 2017).

Leadership is especially consequential in regional referral hospitals, which receive complex cases from lower-level facilities while simultaneously providing routine outpatient and inpatient services. The resulting workload demands reliable staff attendance, coordinated clinical practice, and clear accountability. When healthcare workers are absent, arrive late, leave duty prematurely, or are unavailable during periods of high demand, the consequences can extend beyond individual performance to affect workload distribution, waiting times, continuity of care, and patient experience. Conversely, where staff remain committed during emergencies and managers coordinate scarce personnel effectively, service continuity can be preserved even under difficult conditions.

Transactional leadership offers a particularly useful lens for understanding these dynamics. It is grounded in a structured exchange between leaders and followers in which expectations are clarified, and performance is linked to reward, recognition, or corrective action. Bass and Riggio (2006) identify contingent reward and management-by-exception as its central mechanisms. In practice, these may include performance monitoring, attendance registers, supervision, appraisal, recognition, and disciplinary procedure. In healthcare, such mechanisms can help establish minimum standards and reinforce professional responsibility.

Yet the value of transactional leadership should not be equated with strict punishment. Health workers operate within institutional and personal circumstances that can influence attendance and performance. Staffing shortages, heavy workloads, inadequate accommodation, transport difficulty, delayed promotion, limited recognition, and insufficient resources may all shape how staff experience institutional requirements. A system that records lateness without examining its causes risks enforcing procedural compliance without cultivating genuine commitment. The distinction between administrative compliance and substantive professional contribution is therefore central to understanding the role of transactional leadership in health service delivery.

Evidence from African health systems underscore the importance of leadership, supervision, and accountability. Gilson and Agyepong (2018) emphasise the role of leadership in strengthening health-system governance, while Oleribe et al. (2019) identify leadership and system capacity among the principal challenges confronting healthcare delivery in Africa. Systematic evidence further links leadership practice to quality-of-care outcomes and staff experience (Sfantou et al., 2017; Specchia et al., 2021). These studies, however, do not fully explain how frontline healthcare workers interpret transactional mechanisms within a specific public referral hospital.

Ugandan evidence indicates that supervision and accountability are important determinants of health-worker performance. The literature reviewed for this study identifies weak supervision and inadequate accountability as contributors to absenteeism, dual practice, and declining institutional discipline, while effective supervision and performance monitoring have been associated with improved employee performance. Much of the available research, however, relies on quantitative designs or addresses broader health-system questions, leaving limited qualitative evidence on how transactional leadership is experienced in regional referral hospitals in Northern Uganda.

Lira Regional Referral Hospital provides an instructive setting for examining this question. LRRH is one of Uganda's regional referral hospitals and serves as the principal referral facility for the Lango sub-region and neighbouring areas, with a catchment population reported at more than 2.6 million people (Uganda Bureau of Statistics, 2024; Ministry of Health, 2020). The thesis from which this article is derived identified staff absenteeism, weak supervision, accountability concerns, staffing shortages, and leadership instability as significant challenges affecting service delivery at the hospital-conditions that render transactional leadership mechanisms both necessary and potentially problematic.

The empirical gap, therefore, is not simply whether transactional leadership exists, but how its practices are experienced and how they shape service delivery. In particular, there is limited qualitative evidence on the relationship between supervisory control, accountability mechanisms, staff absenteeism, and clinical shift compliance within LRRH. Understanding these experiences can help distinguish accountability that strengthens service delivery from control that produces only surface-level compliance.

This article addresses the second objective of the completed study: to examine how transactional leadership influences the performance of health service delivery at Lira Regional Referral Hospital. It responds to the question: How does transactional leadership influence the performance of health service delivery at Lira Regional Referral Hospital?

2. Literature Review

2.1 Transactional Leadership and Health Service Delivery

Transactional leadership is characterised by clearly defined expectations, contingent reward, active supervision, and accountability mechanisms through which leaders monitor performance and address deviation from established procedure (Bass & Riggio, 2006). In health facilities, the approach may be expressed through duty rosters, attendance monitoring, performance appraisal, supervision, recognition, and disciplinary procedure. Its principal contribution is to create predictable expectations in environments where adherence to standards is essential.

Evidence reviewed for the broader thesis suggests that transactional practices are widely used in public hospitals to sustain institutional discipline. Abdirahman et al. (2020) reported that hospital managers in Ethiopia relied on transactional practices to monitor staff performance and maintain compliance under resource-constrained conditions. Naidoo and Mafora (2023) similarly reported positive effects of contingent reward, performance monitoring, and management-by-exception on accountability and service delivery, while concluding that transactional leadership alone was insufficient for the complex demands of public hospitals. These findings suggest that transactional leadership can provide structure while requiring complementary leadership behaviour.

Ugandan literature further underscores the importance of supervision and accountability. Kisakye, Tetui, and Kiwanuka (2016) identified weak supervision and inadequate accountability as important contributors to absenteeism and declining institutional discipline. Bakaleke (2018), examining Mulago National Referral Hospital, associated effective supervision and performance monitoring with improved employee performance. This study extends that evidence by examining how such practices are interpreted by healthcare workers at a regional referral hospital, and how they relate to actual clinical work.

2.2 Transactional Leadership, Absenteeism, and Shift Compliance

Staff absenteeism is a major concern in healthcare because the absence of one worker can increase the workload of colleagues and disrupt continuity of care. Absenteeism may reflect individual choice, but it can equally be shaped by institutional conditions. In low-resource settings, workload, inadequate supervision, weak incentive, commuting difficulty, and limited institutional support may interact with individual behaviour. A leadership response grounded solely in punishment may therefore identify non-compliance without addressing its causes.

Clinical shift compliance is similarly more complex than physical attendance. A register can record whether a worker arrived at the workplace, but it cannot capture whether that worker remained available throughout the shift, responded to emergencies, supported colleagues, or stayed beyond the scheduled end of duty to complete patient care. Effective health service delivery therefore requires accountability systems that recognise both observable attendance and substantive professional contribution.

2.3 Theoretical Lens: Path-Goal Theory and Systems Theory

Although the broader thesis was guided by Transformational Leadership Theory, Path-Goal Theory, and Systems Theory, Path-Goal Theory provides the most direct lens for this article. House (1971) argues that leaders influence performance by providing direction, clarifying pathways to goals, removing obstacles, and selecting behaviours appropriate to followers and situation. Directive leadership is particularly relevant to supervision and accountability, while supportive behaviour becomes important where institutional or personal barriers affect performance.

The findings are further interpreted through Systems Theory (Von Bertalanffy, 1968), which conceives of institutions as interconnected systems. At LRRH, staffing, leadership authority, attendance, workload, supervision, and service continuity cannot be understood as isolated variables: a shortage of personnel can increase workload; increased workload can affect attendance and morale; attendance problems can increase pressure on remaining staff; and leadership responses can either strengthen coordination or deepen dissatisfaction. Systems Theory thus guards against attributing service-delivery problems solely to individual staff behaviour.

Together, these perspectives allow transactional leadership to be understood at two levels. Path-Goal Theory explains the practical function of direction, supervision, and accountability, while Systems Theory explains why such practices may succeed or fail depending on the wider institutional conditions in which they are implemented.

3. Methodology

3.1 Research Design and Study Setting

The study adopted an interpretivist paradigm and a qualitative case-study design, appropriate for understanding how leadership practices were experienced and interpreted within the real-life institutional context of LRRH rather than measuring statistical association. Qualitative case-study research is well suited to examining a contemporary phenomenon within its real-world context, where the boundaries between phenomenon and context are not clear (Yin, 2018).

The study was conducted at Lira Regional Referral Hospital in Lira City, Northern Uganda, approximately 340 kilometres north of Kampala. LRRH serves as a major referral facility for the Lango sub-region and neighbouring areas and provides specialised healthcare services to a large catchment population (Uganda Bureau of Statistics, 2024; Ministry of Health, 2020). The hospital was selected purposively because of persistent service-delivery challenges, including absenteeism, weak supervision, and accountability concerns.

3.2 Participants and Sampling

The study used purposive sampling to identify participants with relevant knowledge of, and direct experience with, leadership and health service delivery at LRRH. The final sample comprised twenty participants: five hospital administrators and departmental heads, seven frontline healthcare professionals, four operational support staff, and four patients. Participants were selected based on their relevance to the study objectives and the depth of their experience rather than statistical representativeness. The adequacy of the sample was guided by the depth and recurrence of relevant accounts across participants (Guest, Bunce, & Johnson, 2006).

For this article, evidence concerning transactional leadership was drawn principally from administrators, frontline healthcare professionals, and support staff, as these groups directly experienced or implemented supervision, attendance monitoring, and accountability processes. Patient data formed part of the broader thesis but were not used as primary evidence in analysing internal staff attendance and accountability systems.

3.3 Data Collection

Three complementary data collection methods were used: semi-structured interviews, focus group discussions (FGDs), and documentary review. Semi-structured interviews enabled participants to describe their experiences and perceptions of leadership practices, supervision, and accountability in depth. Two FGDs were conducted with medical professionals and support staff to explore shared experiences and perspectives on leadership and health service delivery.

Documentary review included hospital performance reports, supervision records, staff attendance registers, relevant Ministry of Health policy documents, and disciplinary and accountability records. These documents provided contextual and administrative information and were particularly relevant to Objective 2, as they enabled comparison between formal accountability records and participants' accounts.

A pilot study was conducted at Gulu Regional Referral Hospital involving five purposively selected participants from staff categories similar to those included in the main study. The pilot assessed the clarity, relevance, and sequencing of the interview and FGD guides, and the instruments were refined accordingly before the main data collection. All interviews and FGDs were conducted after obtaining informed consent, audio-recorded with participants' permission, and transcribed verbatim for analysis.

3.4 Data Analysis

Data were analysed using Braun and Clarke's (2006) six-phase thematic analysis, supported by NVivo 12. The researcher first familiarised himself with the data, generated initial codes, searched for potential themes, reviewed and refined the themes, defined and named them, and produced the final analytical account. Parent nodes were organised around the study objectives, while child nodes captured emerging patterns and sub-themes from the data. NVivo-supported matrix coding facilitated systematic comparison across participant groups and data sources, enabling recurring patterns, similarities, and differences in participants' accounts to be examined.

3.5 Trustworthiness and Ethical Considerations

3.5.1 Ethical approval and consent: Ethical approval for the study was obtained from the Catholic University of Eastern Africa Research Ethics Committee (CUEA-REC), followed by research clearance from the Uganda National Council for Science and Technology (UNCST). Permission to conduct the study was obtained from Lira Regional Referral Hospital. Written informed consent was obtained from all participants prior to their participation in the study.

3.5.2 Competing interests: The authors declare that they have no competing interests.

3.5.3 Funding: This study received no external funding.

3.5.4 Data availability: The qualitative data generated and analysed during the study are not publicly available because they contain potentially identifying information relating to participants and the study institution. Access to the data may be considered upon reasonable request, subject to applicable ethical and institutional requirements.

3.5.5 Author contributions: Daniel Comboni Odul conceptualised the study, conducted the data collection and analysis, interpreted the findings, and prepared the manuscript. Dr. Stella Karimi and Dr. Violet Simiyu provided supervisory guidance on the study design and methodology, critically reviewed the manuscript, and contributed to its revision. All authors reviewed and approved the final version of the manuscript.

4. Results and Discussion

Five interrelated themes emerged from the analysis of transactional leadership at LRRH: administrative monitoring and accountability; punitive leadership and staff absenteeism; clinical shift compliance and the distinction between attendance and professional commitment; adaptive workforce redeployment in response to staffing constraint; and leadership instability associated with prolonged acting appointments. Together, these themes show that transactional leadership contributed to institutional control, though its effects were shaped by wider structural conditions.

4.1 Administrative Monitoring and Accountability

Participants described transactional leadership primarily through administrative monitoring, supervision, and accountability mechanisms intended to sustain institutional standards and continuity of service. Because financial constraint limited the use of monetary incentive, the hospital relied substantially on attendance monitoring, performance supervision, and disciplinary procedure.

> *"Since we cannot give out cash bonuses for good work, we must rely on enforcing civil service rules. We track attendance closely, and if a staff member is repeatedly absent or late, we issue formal warning letters and escalate the matter. It is about maintaining a basic standard of compliance."* (Support 4)

This account illustrates the regulatory function of transactional leadership: leaders established minimum standards and invoked formal procedure where staff failed to meet them. Accountability was not, however, confined to sanction. Administrators described certificates of appreciation, public recognition, coaching, and additional training as measures deployed before formal disciplinary action. One administrator estimated that corrective measures succeeded only "about 50%" of the time, indicating that compliance also depended on individual attitude and willingness to change.

A notable divergence emerged between managerial and frontline perspectives. Managers tended to regard monitoring as a mechanism for ensuring fairness, discipline, and performance, whereas frontline staff more frequently experienced it as corrective or punitive. This divergence matters because leadership effectiveness depends partly on how practices are interpreted by those subjects to them; a formally consistent system can still erode motivation if staff experience it primarily as surveillance.

4.2 Punitive Leadership and Staff Absenteeism

Staff absenteeism was repeatedly identified as the domain in which transactional control was most visible. Frontline staff reported that attendance monitoring focused strongly on punctuality and physical presence while paying insufficient attention to the circumstances shaping attendance. One midwife explained:

> *"The administrators are quick to sign the red pen in the attendance register if you are late, but they never ask why. I live far from the hospital because there is no staff housing here. When I stay late to save a mother during an emergency delivery at night, no one writes that down. This punitive management makes us do just the bare minimum to avoid getting in trouble."* (Med 1)

This account reveals a tension between formal compliance and lived working conditions. The participant did not reject accountability outright; rather, she questioned a system that recorded lateness without recognising extended professional effort. Long commuting distances, inadequate staff accommodation, heavy workloads, and limited recognition were identified as factors shaping attendance and morale.

Triangulation offered further insight. Attendance registers documented physical presence, but interview and focus-group evidence pointed to instances of functional absenteeism, in which some employees signed in and subsequently left temporarily for private work or personal

responsibility. Financial pressure and limited institutional support were cited in explaining such behaviour. The evidence therefore suggests that attendance registers are valuable administrative tools but incomplete measures of staff availability and commitment.

This finding indicates that strict monitoring can encourage procedural compliance without necessarily strengthening genuine commitment. Addressing absenteeism therefore requires both enforcement of attendance obligation and attention to the conditions that shape staff behaviour — a conclusion consistent with Ugandan evidence emphasising the role of supervision, motivation, and working conditions in health-worker attendance and performance.

4.3 Leadership and Clinical Shift Compliance

Transactional leadership also shaped clinical shift compliance beyond routine attendance monitoring. Institutional records emphasised punctuality and attendance, whereas participants described professional performance as including a willingness to remain beyond scheduled shifts when patient demand was high or emergencies occurred. A nursing officer (Med 6) explained that staff frequently remained on the ward during periods of high admission because handing over unfinished care could compromise patient safety, although such additional commitment was rarely acknowledged in formal performance systems.

This finding reveals a distinction between administrative compliance and professional commitment. Attendance registers can record physical presence but cannot fully capture emergency response, teamwork, continuity of care, or extended clinical effort. Performance monitoring therefore risked rewarding what was easily measurable rather than what was most clinically meaningful.

Participants suggested that accountability would be strengthened if performance assessment recognised both attendance and professional contribution. Indicators such as emergency responsiveness, teamwork, continuity of patient care, and completion of critical responsibility could complement attendance records-a system that would retain the accountability function of transactional leadership while aligning it more closely with the realities of clinical work.

The finding also demonstrates that staff may display professional commitment exceeding the formal leader–follower exchange. When workers remain beyond their scheduled shifts to protect patient safety, they respond to professional obligation and patient need rather than administrative incentive alone. Transactional systems can reinforce such commitment when meaningful performance is recognised, rather than treating attendance as the sole indicator of performance.

4.4 Adaptive Workforce Redeployment as a Leadership Response

Participants described workforce redeployment as an important managerial response to staffing shortage. Leaders reviewed departmental workloads and temporarily reassigned available staff to high-demand units. A senior administrator explained that duty rosters were reviewed continuously and that redeployment decisions were guided by patient acuity, workload, and the level of clinical care required, with staff consulted before redeployment wherever possible.

This finding expands the conventional understanding of transactional leadership. The leadership response was not confined to monitoring and disciplinary control; it also involved the structured coordination of scarce human resources. Redeployment enabled managers to respond to fluctuations in patient demand and reduce service disruption when staffing levels were inadequate.

The evidence thus suggests two complementary dimensions of transactional leadership at LRRH: enforcing individual accountability and coordinating available resources to sustain service continuity. In a resource-constrained hospital, disciplining absent staff cannot by itself resolve service-delivery problems; managers must also determine where limited personnel are most urgently needed and adapt workforce allocation accordingly.

From a systems perspective, workforce redeployment illustrates the interaction between staffing, leadership decision, patient demand, and continuity of care. It also shows that transactional leadership can encompass adaptive managerial action, whereby leaders use established structures such as duty rosters and workload assessment to respond to shifting operational need.

4.5 Leadership Instability Through Prolonged Acting Appointments

Participants identified prolonged acting appointments as a significant challenge affecting leadership authority and accountability. Several senior administrators reported that management positions had remained in an acting capacity for extended periods, creating uncertainty about authority and responsibility. One administrator stated:

> *"I've been acting as an area manager for more than 5 years... everyone who's managing the unit is acting. I want every person who is managing to be appointed*

> *on that post. Everybody must be accountable and responsible, and vacant posts must be advertised."* (Admin 3)

This account demonstrates that accountability operates vertically as well as horizontally. Frontline workers may be monitored by managers, but managers themselves require stable authority to make decisions and enforce standards. Participants associated prolonged acting appointments with diminished decision-making authority, delayed institutional action, and weakened managerial accountability.

This finding carries direct implications for transactional leadership. A system of rule and sanction requires legitimate authority and clearly assigned responsibility. Where leadership positions remain uncertain, managers may lack the confidence to make long-term decisions or enforce standards consistently. Leadership instability can therefore weaken the very accountability mechanisms that transactional leadership is intended to strengthen.

Systems Theory offers a useful interpretation of this finding: instability in one subsystem can affect communication, coordination, and performance elsewhere in the hospital. Strengthening transactional leadership therefore requires not only better frontline supervision but also stable management structures with clearly defined authority and responsibility.

4.6 Discussion

The study found that transactional leadership shaped health service delivery at LRRH through supervision, administrative monitoring, attendance control, disciplinary procedure, and workforce coordination. These findings align with the theoretical foundations of transactional leadership, which emphasise clear expectation and response to performance deviation (Bass & Riggio, 2006). In a public referral hospital, such mechanisms are necessary because continuity of care depends on staff meeting professional and institutional responsibility.

The findings also show, however, that transactional leadership is not simply a system of reward and punishment. Managers combined recognition, coaching, and additional training with formal sanction, suggesting an attempt to integrate control with development. Nevertheless, frontline staff often interpreted monitoring as punitive. The gap between managerial intention and staff experience is therefore a central finding: accountability is unlikely to generate sustainable commitment when staff perceive it primarily as surveillance or punishment.

The finding on absenteeism is consistent with Ugandan evidence that weak supervision and accountability can contribute to health-worker absenteeism and declining institutional discipline (Kisakye, Tetui, & Kiwanuka, 2016). At the same time, the LRRH evidence adds an important contextual qualification: absenteeism cannot be understood solely as unwillingness to work. Participants linked attendance problems to long commuting distances, inadequate accommodation, heavy workloads, financial pressure, and limited recognition-implying that effective accountability requires a combination of enforcement and problem-solving.

The distinction between physical attendance and professional commitment constitutes a further contribution. Formal records are valuable for establishing accountability, but they may not capture the full range of behaviour that sustains healthcare delivery. A staff member who remains after a scheduled shift during an emergency demonstrates a form of professional contribution invisible to a simple attendance register; conversely, an employee who signs in but leaves temporarily may satisfy the administrative requirement while remaining unavailable to patients. Performance systems should therefore assess meaningful contribution alongside attendance.

The finding on workforce redeployment supports the proposition that transactional leadership can be adaptive. Leaders at LRRH used structured workload review and duty rosters to reallocate staff as patient demand increased consistent with Path-Goal Theory, in that leaders were not merely directing staff but responding to obstacles that could otherwise prevent institutional goals from being achieved. By reallocating available personnel, managers attempted to remove an operational barrier to continuity of care.

The findings further demonstrate the importance of combining transactional mechanisms with supportive leadership. The broader literature indicates that leadership style shapes healthcare quality and staff outcomes through multiple pathways (Sfantou et al., 2017; Specchia et al., 2021). At LRRH, the most problematic practices were those in which supervision was experienced as criticism without sufficient regard for workload or staff welfare. This does not invalidate disciplinary accountability; rather, it suggests that corrective mechanisms are more likely to improve performance when embedded within a supportive institutional environment.

Leadership instability arising from prolonged acting appointments further demonstrates why individual managerial behaviour cannot be separated from institutional structure. Transactional leadership depends on authority, consistency, and clarity of responsibility. Where senior positions remain vacant or temporary for extended

periods, leaders may lack the institutional confidence needed to make long-term decisions or enforce standards consistently a problem rooted partly in the structural architecture within which leadership operates.

These findings support the Systems Theory perspective adopted in the broader study. Staffing shortage, workload, leadership stability, accountability, and service continuity interacted rather than operating independently. A strict attendance policy may have limited effect where staff accommodation is inadequate; conversely, redeployment may protect service continuity temporarily but cannot substitute indefinitely for adequate staffing. Leadership can improve the coordination of scarce resources, but it cannot permanently compensate for structural deficit.

The findings also contribute to the broader debate concerning the place of transactional leadership in healthcare. Transactional leadership should not be regarded as inherently negative, since healthcare institutions require standards, accountability, and mechanisms for addressing misconduct. The issue lies in how these mechanisms are designed and experienced. A balanced model would retain clear expectation and consequence while incorporating recognition, coaching, fair procedure, supportive supervision, and attention to legitimate structural barriers.

Overall, the evidence indicates that transactional leadership contributed positively to accountability but produced mixed consequences for staff motivation and service continuity were implemented predominantly through punitive monitoring. Its greatest contribution to health service delivery occurred where leaders combined accountability with practical workforce coordination and where performance systems recognised meaningful clinical contribution. This suggests that transactional leadership is most effective as part of an integrated leadership and institutional system rather than as a stand-alone managerial philosophy.

5. Conclusion and Recommendations

5.1 Conclusion

This study concludes that transactional leadership was an important mechanism for accountability and coordination at LRRH, but its contribution to health service delivery depended on how accountability was exercised and on the wider institutional conditions in which leadership operated.

Transactional mechanisms were necessary: they gave hospital leaders a baseline framework for discipline and enabled adaptive responses to staffing shortages through redeployment. But they were not sufficient punitive monitoring alone, unsupported by fairness, recognition, adequate staffing, or stable leadership, produced compliance rather than commitment and left deeper service-delivery challenges unresolved.

Transactional leadership therefore functioned most effectively at LRRH not as a stand-alone solution, but as one part of a wider system in which accountability, supportive supervision, recognition, workforce coordination, adequate resources, and leadership stability operate together. This directly answers the study's objective: transactional leadership matters to performance, but its contribution is conditional, not automatic.

5.2 Recommendation

Based on the empirical findings regarding transactional leadership, accountability practices, supervision, workforce coordination, and performance of health service delivery at Lira Regional Referral Hospital (LRRH), the following recommendations are proposed.

1. Ministry of Health and Health Service Commission

1. **Strengthen institutional leadership stability:** The Ministry of Health and Health Service Commission should prioritise the timely recruitment and substantive confirmation of hospital managers to reduce prolonged acting appointments. Stable leadership can support continuity in decision-making, accountability, and coordination of health service delivery.
2. **Align staffing and resource allocation with service demand:** Staffing levels and operational resources should be reviewed and aligned with patient volume and service demands at LRRH. Addressing persistent staffing and resource constraints would enable supervisors to apply accountability measures while taking the operational realities of frontline service delivery into consideration.

2. LRRH Top Management and Human Resource Department

1. **Strengthen fair and supportive disciplinary procedures:** Hospital management should establish a standard pre-disciplinary review process through which supervisors consider documented personal circumstances, legitimate operational constraints, and service-related factors before disciplinary action is taken. This

would promote fairness and consistency in the application of accountability procedures.

2. **Complement attendance monitoring with broader performance indicators:** Human resource monitoring should not rely solely on attendance registers or biometric records. These systems should be complemented with indicators such as supervisory observation, work responsibilities completed, teamwork, and relevant service-delivery outputs to provide a broader understanding of staff performance.
3. **Strengthen non-financial staff recognition:** Management should establish structured mechanisms for recognising staff who demonstrate commitment and effective service beyond basic attendance requirements. These may include letters of commendation, staff recognition awards, peer nominations, and opportunities for professional development.
4. **Formalise workforce redeployment procedures:** LRRH should develop clear procedures for temporary staff redeployment during periods of increased workload or staffing shortages. The procedures should specify the reasons for redeployment, staff responsibilities, duration, reporting arrangements, and support provided to redeployed staff.

3. Departmental and Ward Leaders

1. **Adopt constructive supervisory practices:** Departmental and ward leaders should combine corrective administrative action with constructive feedback and professional guidance. Supervisory practices should identify the causes of performance challenges and support staff to address them while maintaining appropriate accountability.
2. **Introduce routine non-punitive staff check-ins:** Ward and departmental leaders should conduct regular structured discussions with staff to identify workplace challenges, clarify expectations, and address operational barriers before they develop into performance or disciplinary concerns. Such discussions can also provide opportunities for staff to raise legitimate attendance and workload challenges.
3. **Strengthen oversight during staff redeployment:** Departmental and ward leaders should provide clear orientation, role clarification, and appropriate support when staff are temporarily redeployed. This would help minimise role ambiguity and support continuity and safety in service delivery.

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