The Role of Health Unit Management Committees in Promoting Community Participation in Primary Healthcare Delivery in Uganda

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Declaration:

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Signature

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ABBREVIATIONS

CAO	Chief Administrative Officer
CBOs	Community Based Organizations
CG	Central Government
CP	Community Participation
CPMC	Community Project Management Committee
CSOs	Civil Society organizations
DHO	District Health Officer
DNU	Drug Monitoring Unit
DPs	Development Partners
GBV	Gender-Based Violence
HCs	Health Centres
HMIS	Health Facility Management Information System
HRM	Human Resource Management
HSD	Health Sub-District
HSS	Health Systems Strengthening
HSSIP	Health Sector Strategic and Investment Plan
HUMCs	Health Unit Management Committees
ICHD	International Course in Health Development
LC	Local Council
LG	Local Government
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MPH	Master of Public Health
NGOs	Non-Government Organizations
NGOs	Non-Government Organization
NRH	National Referral Hospital
OPD	Outpatient Department
PFP	Private for-Profit
PHC	Primary Health Care
PNFP	Private Not-for-Profit
RRH	Regional Referral Hospital
SCHCs	Sub-county Health Committees
SMART	Specific, Measurable, Achievable, Realistic and Time-bound
SRHR	Sexual Reproductive Health and Rights
SSA	Sub-Saharan Africa
SSI-KIs	Semi-Structured Interviews with Key Informants
UAC	Uganda AIDS Commission
UACE	Uganda Advanced Certificate of Education
UEDMP	Uganda Essential Drugs Management Programme
VHTs	Village Health Teams
VMMC	Voluntary Medical Male Circumcision
VU	Vrije Universiteit
WHO	World Health Organization

DEFITION OF KEY TERMS

1. **Community: Social group of any size, whose members live in a specific locality, share government, and often have a common characteristic, interest, purpose, cultural and historical heritage with some degree of social connection (1,2).**
2. **Participation:** Participation means active involvement of people in taking a central role as social actors, members of social networks, collectives or individual stakeholders, and participate in decisions that affect their health and well-being (1).
3. **Community Participation (CP):** A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their health and well-being, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change (3).
4. **Health Unit Management Committees (HUMCs):** A group of community members who are recognised by policy and elected or appointed to oversee the management and delivery of primary healthcare services at local level (4).
5. **Health Centre (HC)/Health Facility/ Health Unit:** Any legalised place that provides healthcare services, such as hospitals, clinics, health centres, nursing homes, and rehabilitation centres (5).
6. **Primary Health Care (PHC):** A whole-of-society approach to effectively organize and strengthen national health systems to bring services for health and wellbeing closer to communities (6).
7. **Health:** A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (7). A dynamic state that involves the interaction between an individual's biological, psychological, and social factors that affect their overall well-being (7).
8. **Health Centre I (HCI):** This is found at Village Level known as Local Council I (LCI) and is the first line of contact for primary health care where Village Health Teams (VHTs) / Distributors / Community Medicine Distributors operate (8,9).
9. **Health Centre II (HCII):** Established at Parish Level known as Local Council II (LCII) serving thousand people, runs an out-patient clinic, treats common diseases such as malaria, and offers antenatal care, and is led by an enrolled nurse, working with a midwife, two nursing assistants and a health assistant(8,9).
10. **Health Centre III (HCIII):** Formed at sub-county level known as Local Council III (LCIII) with a functional laboratory, led by a senior clinical officer, who runs a general outpatient clinic and a maternity ward (8,9).
11. **Health Centre IV (HCIV):** Located at County / Parliamentary Constituency level, and is the main facility for all sub-counties within a county, it is a mini hospital. Offers all kinds of services found at health centre III, it has wards for children, women, men and admits patients. It has a senior medical officer and another doctor as well as a theatre for conducting emergency operations (8,9).
12. **Decentralisation:** Transfer of responsibility and power for public roles, duties and functions from Central Government (CG) to Local Government (LG) (10).
13. Patient Flow: Describes how patients pass through a series of stages from the moment they enter a health centre until the moment a health professional discharges them or till the moment they decide to depart on their own (11).
14. **Outpatient:** A patient who enters the health centre and leaves the same day after receiving treatment (11).

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ABSTRACT

Introduction: In Uganda, community participation in primary health care (PHC) is arranged through Health Unit Management Committees (HUMCs) at Health Centre II-IV. Despite this, there seems to be limited community participation in PHC planning and decision-making processes in Uganda. This study explored the role of HUMCs at Health Centre II-IV in promoting community participation in PHC delivery in Uganda, to suggest recommendations to strengthen community participation in PHC delivery through HUMCs.

Methodology: Between April and July 2023, a literature review with publications from 2003-2023 focused on Uganda and complemented with Sub-Saharan Africa, combined with six online semi-structured interviews with key informants was conducted. Karuga's conceptual framework was used for data analysis, with sub (themes) derived from five process indicators of community participation that define functionality of HUMCs (Leadership, Management and Planning, Resource Mobilisation, Monitoring and Evaluation, and Women Involvement).

Findings: HUMCs enable community participation in health decision-making, assist facilities with operational tasks and aid patients with health and social needs. They create platforms for community members to contribute to planning, designing, and delivering health services. However, there is a poor selection of representatives and a lack of training. In addition, there is weak coordination between HUMCs, facilities, district and village health teams; and inadequate linkages between HUMCs and people they are supposed to represent.

Conclusion: HUMCs are mechanisms for community participation in PHC at facility, but less at community level.

Recommendations: Develop more inclusive committees by reviewing their roles and composition, including HUMC guidelines and training materials to include special interest groups.

Keywords: Community Participation, Primary Health Care, Health Unit Management Committees

World Count: 13,196

INTRODUCTION

My name is Monja Minsi, a trained Social Worker from Uganda. Before completing my undergraduate course as a social worker, I was already acquiring experience as a volunteer at Uganda Reach the Aged Association/HelpAge International. After 3 years of studying, I was promoted as a Social Worker/ Gerontologist and worked for 2 years after which I became a Public Health Advocacy Officer for another 3 years dealing with policy advocacy for inclusion of older people's health issues into National Health Policies, Framework and Strategies. I worked as a Public Health Specialist at THETA Uganda for 1 year and then moved on to Mama's Club Uganda as a National MenEngage and Advocacy Coordinator attending to issues related to men and their health, gender-based violence (GBV), sexual reproductive health and rights (SRHR) and Health Systems Strengthening (HSS).

I have always observed Uganda experiencing poor human resource (HR) management and development practices in a number of health centres. Inadequate managerial skills among health Unit In-charges, poor HR development approaches by In-charges, improper planning, implementation and monitoring of health-based activities by Health Centre in-charges. Health Centres are still facing challenges of staff attrition, motivation and retention. Performance drivers such as induction/ orientation, mentorship, and refresher training are not given attention they deserve.

I got interested in this study, 'The Role of HUMCs in promoting community participation in PHC delivery in Uganda', when I was naturally drawn to the public health field because of my early exposure to public health work setting. I observed that the role of HUMCs remains untapped in promoting access to healthcare.

As a Public Health Specialist, I will use thesis findings to advocate for increased health financing for HUMCs. I will disseminate public health knowledge and promote implementation of effective public health policies and practices that support HUMCs in Uganda.

CHAPTER 1: BACKGROUND

1.1. Background

1.1.1. Global Context

Globally, community participation is recognized as a key component of primary health care delivery, and has been associated with increased access to healthcare services, and community ownership of health programmes and improved health outcomes (12). World Health Organization (WHO) emphasized and called for active participation of communities in PHC planning, implementation, and monitoring. As a result, countries have embraced and supported the introduction of committees consisting of community members in rural health facilities (13).

Community participation is when people develop their capacity to own their health and welfare, and contribute to community development (14). People come to know their own situation better and are motivated to solve their common problems enabling them to become agents of their own development instead of passive beneficiaries of development aid (14). Community participation is a human rights approach since the 1978 Alma-Ata Declaration which emphasised citizen participation in the design, delivery and monitoring of their healthcare (15). Marking 40 years of Alma-Ata Declaration, countries committed to participation by signing the 2018 Astana Declaration (16).

Community participation improves health through decentralization programmes (15). Community participation is diverse and in many low and middle income states, health structures (committees) dominate and are attached to facilities (14). Growing evidence indicates that community participation strengthens health systems in spite of the many existing barriers (16). Potentially, health committees can strengthen healthcare services when carefully planned and implemented (14). Community participation results in better health outcomes (17).

Community participation can increase demand for and utilization of immunization services, resulting in improved immunization coverage and reduced incidence of vaccine-preventable diseases (18). When communities actively participate in health promotion activities, they are more likely to adopt family planning methods, resulting in improved maternal and child health outcomes and reduced maternal mortality (19). Community participation in disease surveillance and reporting can improve early detection and better management of communicable diseases, reducing their spread within the community (20). Children's nutrition status can be improved due community participation in nutrition education and promotion programmes, and the prevalence of malnutrition can be reduced (21,22).

1.1.2. Uganda Context

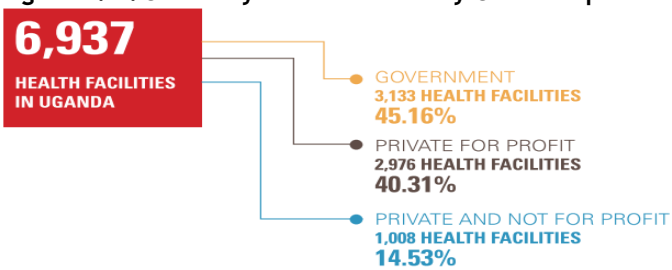
In Uganda, community participation remains an important dimension of the decentralized health system through formation of user committees (23), especially health unit management committees (HUMCs) which are the popular platforms that exist all-over Uganda for representing communities in holding healthcare providers accountable (24). From Alma Ata declaration, one immediate action to uphold community participation by Uganda was construction of health facilities and equipping them with adequate human resources including HUMCs in 2002 at Health Centre level II-IV (HCII-IV) (25,26), whom are the focus of this study.

Re-defining roles for delivery of services at local levels in Uganda is traced right from the early 1990s (27). Prominent among the health reforms (structures) were the HUMCs established in 2001 (28) in line with the decentralization policy introduced in the 1990s, which aimed to improve the management and provision of health services at local level. HUMCs were established to ensure that health services are responsive to the local health needs. Since then, HUMCs have been recognized as a key component of PHC delivery in Uganda, and their role in promoting community participation in healthcare service delivery has been emphasized in various health policies and guidelines (28).

Health centres (HCs) are formed under administrative units: Village (I), Parish (II), Sub-county (III), and Health Sub-district/County (IV) (29). They are categorized into four specific levels based on the services they provide and the service area, and are designated as Health Centre Level One (HCI) to

Health Centre Level Four (HCIV) (29). However, at only level II-IV, is where HUMCS are found (29). Beyond these levels, are Hospital Boards at District/General Hospitals, Regional Referral Hospitals (RRHs) and National Referral Hospital (NRHs) (29).

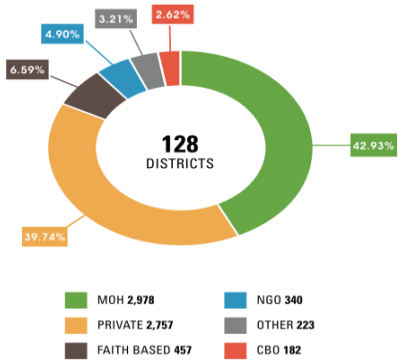
Figure 1. 1: Summary of Health Facility Ownership



Source: Ministry of Health (MOH), National Health Health Facility List(29)

Figure 1. 2: Summary of Health Facility Authorities

AUTHORITY	COUNT	PERCENTAGE
AIC	8	0.12%
CAFU	5	0.07%
CBO	182	2.62%
MOES	3	0.04%
MOH	2978	42.93%
NGO	315	4.54%
Private	2757	39.74%
SDA	13	0.19%
SOS	1	0.01%
TASO	11	0.16%
UCBHCA	51	0.74%
UCMB	245	3.53%
UMMB	59	0.85%
UNHCR	10	0.14%
UOMB	10	0.14%
UPDF	33	0.48%
UPF	64	0.92%
UPMB	130	1.87%
UPS	62	0.89%

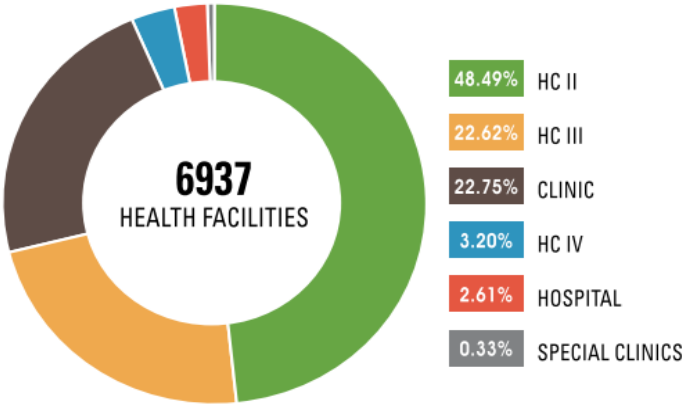


Source: Ministry of Health (MOH), National Health Health Facility List(29)

Uganda has a total of 6,937 health centres and specialized clinics in 128 districts with HUMCS attached to them (29). Uganda's health system has both private and government-funded facilities (30) where 45.16% (3,133) of health facilities are publicly owned, 14.44% (1,002) are private and non-profit (PNFP) facilities, the remaining 40.29% (2795) are private for-profit (PFP) facilities and 0.10% (7) are community-owned facilities (29). Government facilities and PNFPs are mostly higher-level health facilities, while PFP services consist mostly of lower levels (HC IIs and clinics) (29). The government of Uganda regulates the operations of all healthcare facilities in the country (30).

Figure 1. 3: Summary of Health Facilities Levels

LEVEL	COUNT	PERCENTAGE
Clinic	1578	22.75%
HC II	3364	48.49%
HC III	1569	22.62%
HC IV	222	3.20%
Hospital	163	2.35%
RH	3	0.04%
NRH	2	0.03%
RRH	13	0.19%
SC	23	0.33%



Source: Ministry of Health (MOH), National Health Health Facility List(29)

HUMCs are health structures (28) set-up to bring together voluntarily elected community representatives tasked with improving communication between people *(health users)* and healthcare providers on health-related activities both inside and outside the facility (26). HUMCs are management committees commissioned at HCII-IV except for HCI at village level, and are not political committees (27). HUMCs are tools for people to own their health, and ensuring that their

health needs are properly met in PHC decision-making processes (31). HUMCs are key shareholders in decision-making processes, mobilising resources, and tracking and assessing health services (31).

HUMCs lead and oversee community health service delivery (32,33). HUMCs develop and review health centres' overall mission, vision & strategy (29), lobby for improved quality of service delivery, hold health providers accountable and promote transparency in human resources for health and materials (28,31).

HUMCs play an important role in Uganda's healthcare system as they are structures for community participation and vehicles for democratic governance in health systems that aim for health equity (34). HUMCs are mechanisms for enabling community members to participate in PHC and improve health outcomes (35). HUMCs can be used to raise the standard of healthcare by giving management and healthcare professionals feedback (36). HUMCs can help address social and physical environmental risk factors that affect health outcomes (37).

Figure 1. 4: National Structure of the Health System in Uganda

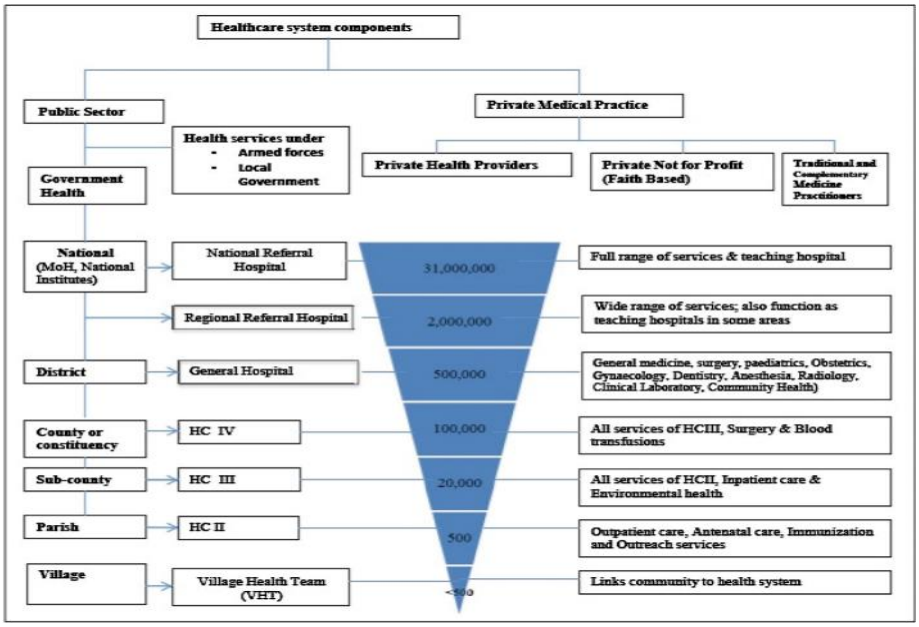
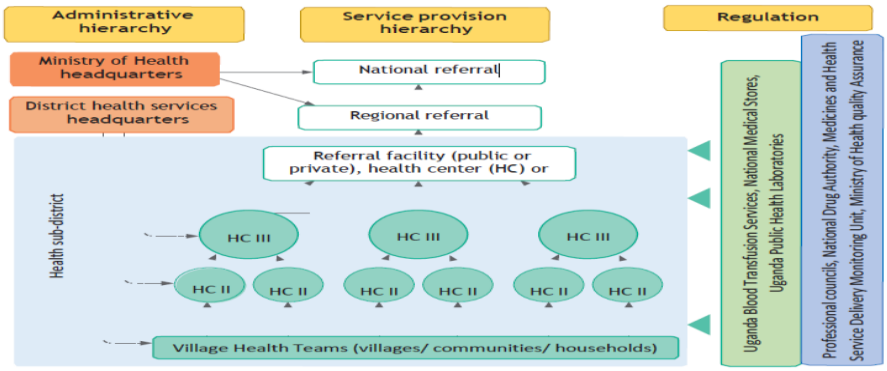


Figure 1. 5: Health Care System Linkage to the Community Health System



Source: Uganda National Commuity Strategy (2)

Despite existence of HUMCs, community participation in PHC planning and decision making is still low. HUMCs' functionality in promoting community participation in PHC remains unstudied. This qualitative study will explore the role of community participation through HUMCs in PHC delivery in Uganda in order to suggest appropriate solutions to strengthen community people's participation in PHC. The study will specifically investigate community participation and PHC delivery through HCII-IV HUMCs in government health facilities.

CHAPTER 2: PROBLEM STATEMENT, JUSTIFICATION & OBJECTIVES

2.1. Problem Statement

Despite official recognition of HUMCs in Uganda's healthcare system, low level of community participation in PHC decision-making processes at health centre level II–IV still exists (38,39). This means that people are not optimally participating in processes of determining their health needs and healthcare services (26,38). There is a gap in understanding the underlying reasons contributing to the limited participation of communities in PHC services (17,33,39–41). This is problematic, as limited community participation in PHC planning and decision-making processes can result in insufficient healthcare services targeting the health needs of the people (25,33,35).

Poor community participation in PHC has resulted in inadequate assessment of community health needs, as health professionals may have incomplete awareness of people's unique health problems, priorities and cultural influences (25,42). Insufficient community participation in healthcare can result in inefficient healthcare planning and resource allocation (25,35,39,43). Poor community participation in PHC results in a disconnection between health providers and community people (44,45). Due to limited participation in healthcare, community members often feel that healthcare providers inadequately listen to their concerns, and are unwilling to answer their fears or include them in healthcare decision-making (42,46,47). Health providers may have limited understanding of the unique socio-cultural circumstances, attitudes and preferences of the people leading to lack of patient-centred care and potentially contributing to disparities in healthcare outcomes (25,39,48).

Due to inadequate participation in decision-making processes, communities may also not be aware of or understand the range of healthcare packages provided at health centres (33,39,49). If communities are not armed with the information they need about services they are entitled to, people may not access health services available (17,25,26,50,51). Low community participation can also cause a lack of faith in the healthcare system, which further deters people from obtaining necessary healthcare (17,42,45).

Community participation beyond HUMCs is also limited, with the majority of community people having little to no participation in making decisions regarding their own health (2,17) While Uganda has well-defined structures in place, community health governance, and coordination mechanisms are weak (2,17,26). There is absence of formal means for people to connect with public administration structures (line ministries and agencies on community health) as many stakeholders use various and disjointed approaches to connect with the community in decision-making processes (2,33).

Kugonza & Mukobi (2015), in a study in Buikwe District, found that when people do not actively participate, efforts to prevent disease may be less effective as their concerns are less known during decision-making (49). Devas (2003) in Uganda and Kenya explains that limited participation may be due to a lack of mechanisms for holding health providers accountable (52) resulting in people not trusting in the healthcare system anymore (52). Kim et al. (2022) in Uganda argues that poor community participation results in missed opportunities for health innovation and local solutions (53). Kuule et al. (2017) in rural Uganda found that communities have valuable local knowledge and insights that can contribute to creative ideas and locally appropriate healthcare initiatives, however, because of low community participation in PHC planning and decision-making, valuable resources (skills, knowledge) may not be tapped into by health providers (54).

Poor community participation in PHC has also been as a result of not having a fully-fledged policy framework for HUMCs and inconsistent implementation of existing ones such as the National Health Policy 2010 and the Health Sector Strategic and Investment Plan 2010/1-2014/15 also resulting in limited community ownership of health decision-making through the HUMCs (33,41). Due to absence of a strong policy framework, HUMCs have been underutilised as health governance structures that advocate for community health needs (17,33,39,41).

2.2. Justification

In Uganda, the aim of creating HUMCs was to increase people's participation in healthcare services (55). This study is timely for several reasons. First, HUMCs are part of Uganda's healthcare system, and their effectiveness in encouraging people's participation in healthcare delivery is prime for the PHC success (12). Second, community participation in healthcare delivery is associated with better health outcomes, improved accountability and better utilization of resources (41). Third, limited research exists on the role of HUMCs in promoting community participation in PHC delivery (42). This study seeks to fill this knowledge gap in Uganda.

There is an active national debate on community health structures including HUMCs (56). Furthermore, with a strong political commitment on community health models, the Ministry of Health has been engaging with partners and is currently examining costing analyses of various community health models including HUMCs, which will be used in policy revisions (56). This study can inform this process.

Study findings will inform policy, guidelines, strategies and their implementation on how best to strengthen the role of HUMCs in promoting community participation in PHC in Uganda. Policies, plans and strategies to be informed by the study include: Health Act 2000, Health Sector Strategic and Investment Plan III 2010/11–2014/15, Health Strategic Plan 2020/21–2024/25, MOH Facility Committees Guidelines 2010, Health Facility Management Information System (HMIS) Manual 2016, National Community Health strategy 2021/22–2025/26, and Uganda National Community Health Roadmap 2021. Overall, these policies provide a legal and policy framework for the establishment and functioning of HUMCs in Uganda, and emphasize the importance of HUMCs in promoting community participation in PHC. But they are outdated and need to be updated.

The study will inform HUMCs in addressing challenges and improve HUMC assistance in monitoring operations of health centres for improved healthcare service provision. The study could contribute to increasing community awareness about HUMCs and their role, which could increase people's participation in PHC planning and decision-making. The study will also contribute to future research, as researchers can utilise the findings to inform efforts that address low community participation in PHC delivery in Uganda and beyond.

2.3. Study Questions

1. What is the role of HUMCs in promoting community participation in PHC delivery?
2. What are the challenges that inhibit community participation in primary health care delivery through Health Unit Management Committees?
3. What are the enablers of community participation in PHC delivery through HUMCs?
4. What recommendations are appropriate for strengthening community participation in PHC delivery through HUMCs?

2.4. Study Objectives

2.4.1. Overall Objective

To explore the role of HUMCs at health centre level II-IV in promoting community participation in PHC delivery in Uganda, in order to suggest appropriate recommendations for strengthening community participation in PHC delivery through HUMCs.

2.4.2. Specific Objectives

1. To examine the role of HUMCs in promoting community participation in PHC delivery.
2. To identify challenges that inhibit community participation in PHC delivery through HUMCs.
3. To identify enablers of community participation in PHC delivery through HUMCs.
4. To suggest recommendations appropriate for strengthening community participation in PHC delivery through HUMCs based on study findings.

CHAPTER 3: METHODOLOGY & ANALYTICAL FRAMEWORK

This chapter explains the approach and conceptual framework adopted to address the research objectives 1, 2 & 3 under section 2.4 above.

3.1. Study Design

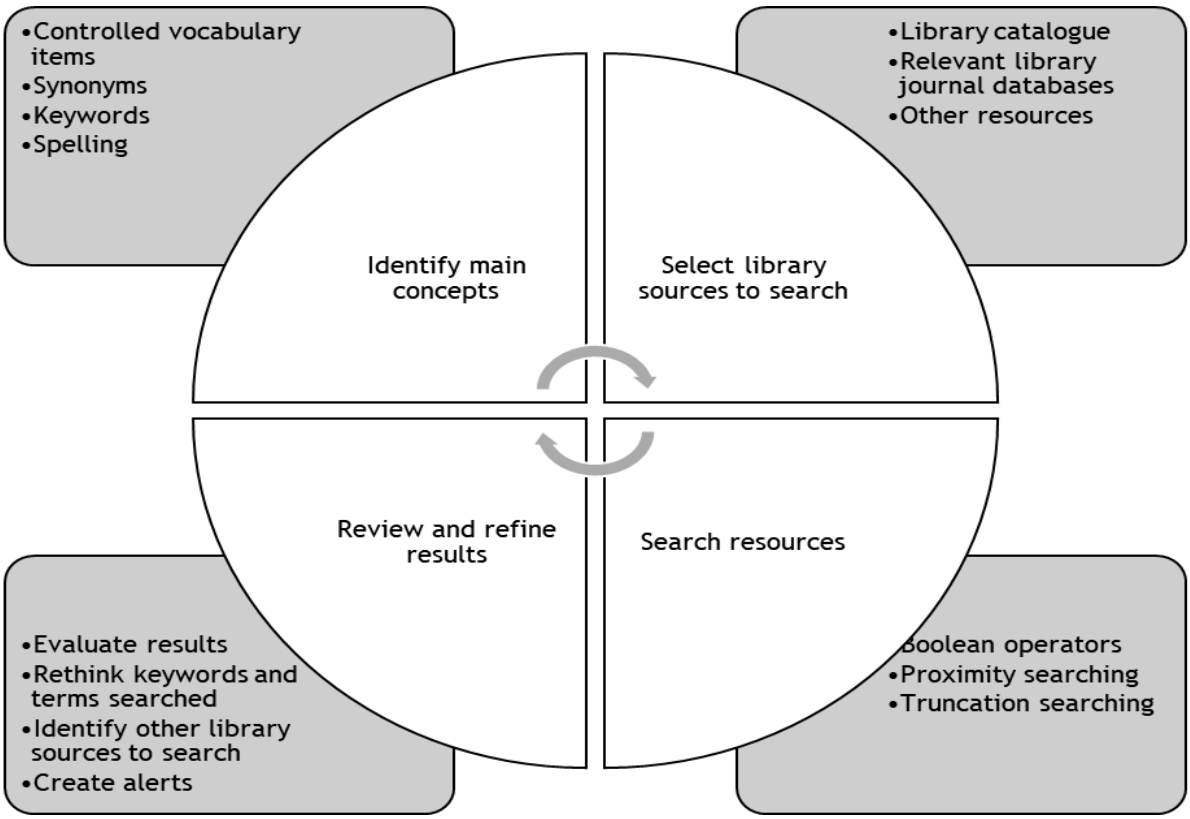
Between April and July 2023, this qualitative study was conducted based on a desk literature review combined with semi-structured interviews with key informants from NGOs that worked or are working with HUMCs to understand concepts, opinions and experiences on community participation in PHC through HUMCs.

3.1.1. Search Strategy and inclusion and exclusion criteria of the literature review

3.1.1.1. Search Strategy

Between April and July 2023, online materials were searched using four electronic databases, including VU Library, PubMed, Google Scholar, and Africa Journals Online content from 2003 onward. Considered, were peer-reviewed journal articles, books, and reports published in English containing the concepts on HUMCs, community participation and PHC as detailed in **Annex 1** (Boolean Operator Matrix). Concurrently, grey literature was searched using www.google.com / www.google.co.ug for reports, strategies, and guidelines on HUMCs, community participation and PHC using the same terms. Other databases were utilised using snowballing technique and searched websites of organizations such as Ministry of Health, World Health Organization and Non-Government Organizations and web-archives known to specialise in HUMCs, and community participation in PHC. Grey and peer-reviewed literature in Uganda and neighbouring countries in Sub-Saharan Africa **(Annex 4)** were considered**.** A literature searching and planning cycle was adopted as indicated in **Figure 3.1** below:

Figure 3. 1: Literature Searching and Planning Cycle (57)



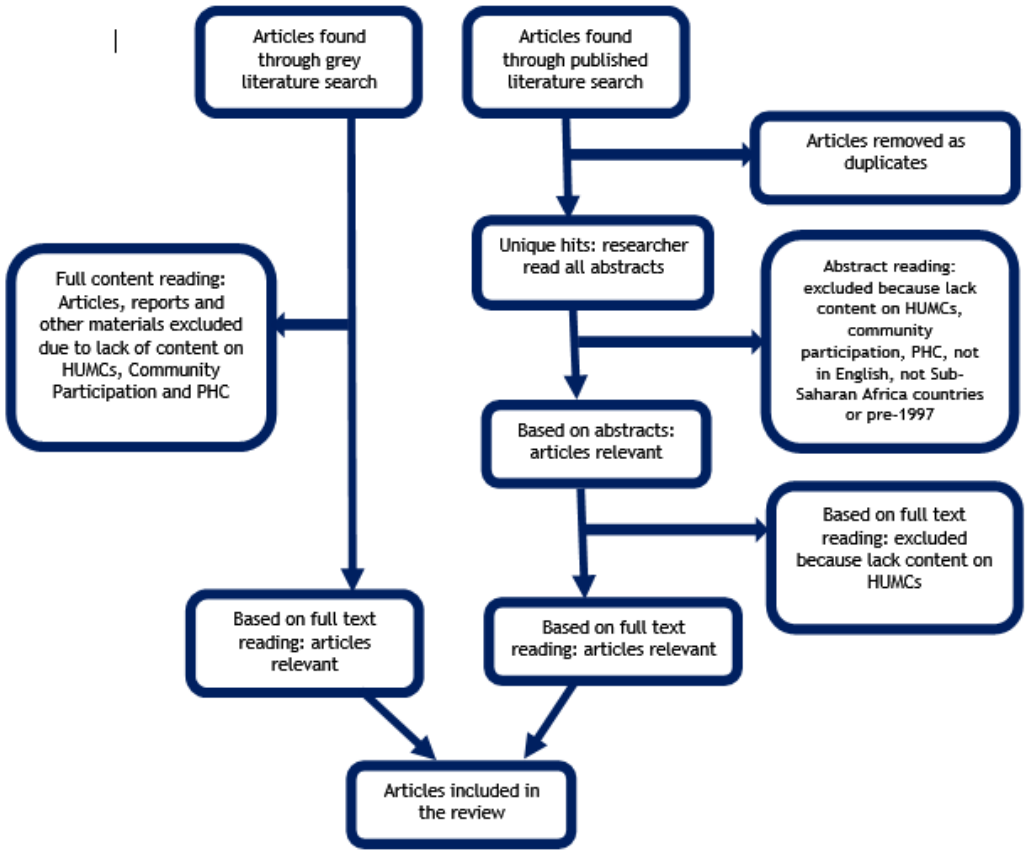
Source: Adopted from Library DU, 2017

3.1.1.2. Inclusion and Exclusion Criteria

Journal articles, reports and other materials were included in this review if they met the following criteria: contained substantial content on HUMCs, defined as groups containing some layperson representation, having a formal link to the government, and existing to improve local well-being; are about existing HUMCs rather than calls to develop HUMCs in the future; focus on Uganda and some neighbouring countries (Sub-Saharan Africa); are in English and were published between 2003 and 2023.

The titles and abstracts of all publications found during the search were read by the researcher. Articles were excluded during this stage if their titles and abstracts indicated failure to meet the inclusion criteria. All other articles were passed to the second screening, where the entire article was read to determine whether it met the inclusion criteria (**Figure 3.2**). Documents that did not relate to HUMCs, community participation and primary health care were excluded.

Figure 3. 2: Article Screening Process



Source: Adapted from George et al. / Social Science & Medicine 133 (2015) 159e167 (58)

3.2. Data Collection

3.2.1. Desk Review of Literature

A desk review of literature was conducted to comprehensively gather existing knowledge and insights on the role of HUMCs in promoting community participation in PHC delivery in Uganda. A detailed search was performed using databases, academic platforms, and relevant sources such as academic journals, government reports, policy documents and reputable websites such as World Health Organization. Keywords and search terms related to “HUMCs” AND “community participation” AND “PHC” AND “Uganda” were used, with Boolean operators employed to identify relevant studies. For details on key words and search terms refer to **Annex 1.** Only articles, reports and policy documents published in English from 2003 – 2023 were searched for review.

The screening process involved reviewing titles, abstracts, and full texts of the selected sources to assess their relevance to the research objectives one, two and three using Karuga's Conceptual Framework. Pertinent information was extracted, including key concepts, theories, empirical findings, and policy implications. The extracted data were then analysed to identify common themes, patterns, and gaps in the literature. A literature review synthesis matrix was developed and utilised including theme, article and type of content extracted. This literature review provided a foundation of existing knowledge, served as a basis for further research, and informed the study design and methodology on promoting community participation in PHC through HUMCs in Uganda.

3.2.2. Semi-Structured Interviews with Key Informants (SSI-KIs)

To support the literature review, a sample of six (6) important individuals were selected to participate in structured interviews. These interviews were conducted with the aim of exploring the factors in the community that influence participation and access, to healthcare (PHC). Additionally, the researcher sought to identify challenges faced by the community in Uganda's health system through Health Unit Management Committees. For data collection, the researcher specifically chose participants from Civil Society Organizations (CSOs) who have had experience working with HUMCs.

To ensure accuracy, the researcher enlisted the help of individuals working in PHC, government and NGOs in the areas where key informants were located. The participants' details are summarized in **Table 3.1.** The researcher conducted each interview online using platforms such as Zoom, Google Meet or Microsoft Teams. All interviews lasted between 90 and 120 minutes. The researcher took interview notes and shared transcripts with the interviewees, for confirmation purposes.

Table 3. 1: Profiles of Key Informants

Number	Location (District)	Role	Organization / Institution (NGOs)	Gender (M/F)	Experience working with/ supporting HUMCs (in years)
1.	Kampala	Capacity Building Officer	Coalition for Health Promotion and Social Development (HEPS-Uganda)	Male	5 Years+
2.	Wakiso	Health Systems Strengthening (HSS) Officer	Uganda Network of AIDS Service Organizations (UNASO)	Female	7 Years+
3.	Kampala	Community Engagement Officer	Center for Health, Human Rights and Development (CEHURD)	Male	6 Years+
4.	Kampala	Youth Advocacy Officer	Naguru Teenage Information and Health Center (NTIHC)	Male	4 Years+
5.	Mukono	Partnership and Networking Manager	Foundation for Male Engagement (FOME)	Female	8 Year+
6.	Kampala	National Community Engagement Officer	AIDS Information Centre-Uganda (AIC)	Male	9 Years+

3.3. Data Processing and Analysis

A systematic approach was applied classifying contents found in the literature and interview scripts in (sub) themes and these themes, according to an analytical framework were guided by Karuga's Conceptual Framework. For the SSI-KIs, derived from the sub (themes) of the conceptual framework, a coding matrix/framework was developed using MS Word/Excel and imported into NIVO. Based on the coding framework, transcripts were coded. The categorised data was read to make meaning of (sub) themes through interpretation and summarizing issues. Major issues and concerns of respondents were edited and presented through direct quotations. Preliminary findings were shared with respondents for validation and fine-tuning for final reporting.

3.4. Analytical / Conceptual Framework

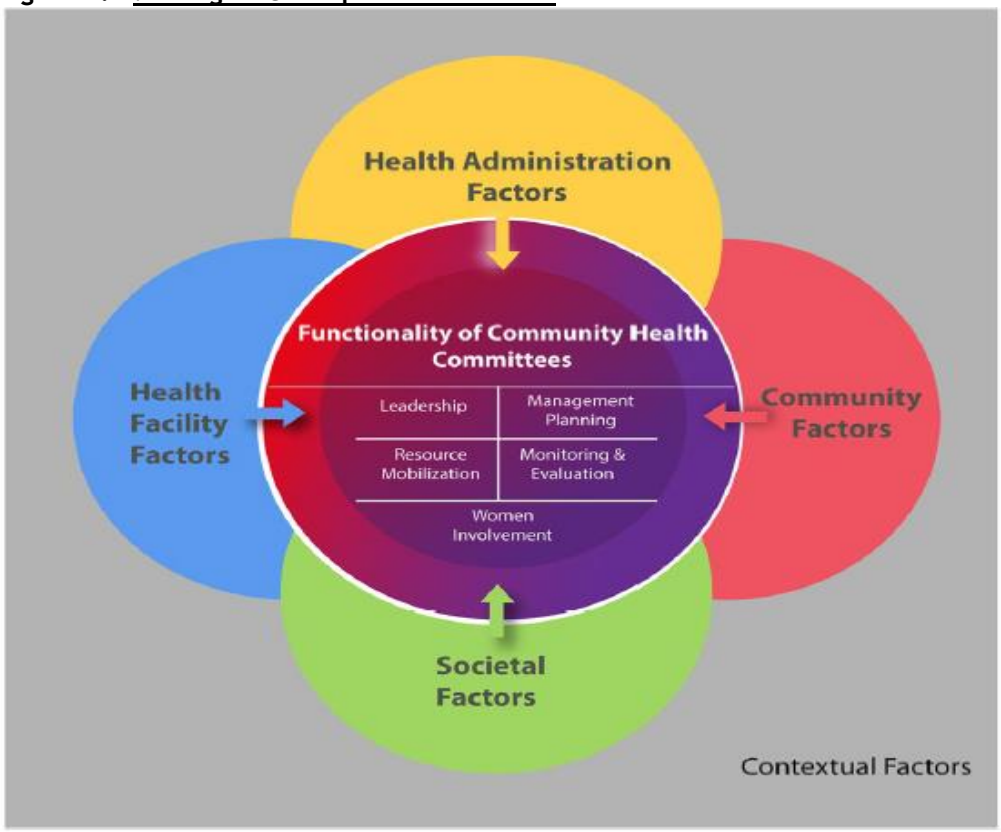
The analysis and presentation of study findings were done using Karuga's Conceptual Framework for assessing community participation in health through community health committees (CHCs) in Kenya as indicated in **Figure 3.3** (59). Karuga et al. (2023) looked at the functionality of CHC in Kenya in light of their ability to promote community participation (59). CHCs in Kenya are comparable structures of voluntary community members having specific tasks in promoting and overseeing health services.

The conceptual framework outlines four contextual factors which influence the five process indicators that determine functionality of HUMCs. These four contextual factors with their examples include: Health Facility Factors *(awareness, trust, benefit, resources, and social inequalities)*; Health Administration Factors *(resources, capacity building, and decentralising mandates);* Community Factors *(awareness, trust, benefit, resources, and social inequalities)*; and Society Factors *(legislative reforms, political parties, NGOs, markets, media, history including decentralisation and social movements, and social inequalities)* (58).

While presenting findings, the study mainly focused on the five process indicators of the framework that determine the functionality of HUMCs with contextual factors used in explaining some of the influencing factors under each process indicator. These five process indicators of community participation include Leadership, Management and Planning, Resource Mobilisation, Monitoring and Evaluation, and Women Involvement (59). These indicators are explained in **Table 3.2.** It is worth noting that Karuga's framework combines two existing frameworks from George and Draper (58–60).

This particular conceptual framework helps to evaluate the quality and level of community participation through community-based health committees, with the primary objective of enhancing health outcomes and fostering community ownership and sustainability. This framework also provides direction in identifying the elements that impact community participation.

Figure 3. 3: Karuga's Conceptual Framework



Source: Adopted from Karuga et al. (2023) (59)

Table 3. 2: Process Indicators of Community Participation

Indicator	Definition of Process Indicator
Leadership	The extent to which HUMC members provide leadership in decision-making and interests of diverse community groups are represented through HUMCs.
Management and Planning	The extent to which HUMCs set priorities, manage community health services, and forge partnerships between health workers and the community are forged.
Resource Mobilization	The degree to which HUMC members find opportunities to mobilize resources (finances) to implement health-related activities at community level.
Monitoring & Evaluation (M&E)	The extent to which HUMC members do a participatory assessment of how beneficiaries are involved in health services and programmes that deliver locally meaningful outcomes. The ability of HUMCs to systematically collect, analyse, and use data to assess the performance and impact of health system.
Women Involvement	The extent to which HUMC members ensure representation of women's active participation in decision-making.

Source: Draper et al. (2010) and Karuga et al. (60,61)

3.5. Study Limitations

Uganda's health system lacks adequate and up-to-date information especially around community participation and health governance structures in particular the HUMCs. It was challenging to find information appropriate to some process indicators in the framework. For example, indicators including resource mobilization, monitoring and evaluation, and women involvement. Only studies published in English with a focus on HUMCs, community participation and PHC were considered for this thesis. The NGO participants provided some complementary information on the role of HUMCs in promoting community participation in PHC, but the sample size was small.

3.6. Ethical Clearance

No ethical approval was required since this was a literature-based study complemented with a few interviews with key informants. The KIT Royal Tropical Institute Review Ethics Committee (REC) granted ethical waiver for the interviews. The waiver was granted based on the criteria that the study involved no risk to the participants as they provided information based on their professional capacity, and the procedures were consistent with ethical principles and standards. Steps were taken to protect participants' privacy and confidentiality. The study design and procedures were reviewed by both Thesis and Academic Advisors to ensure that they met ethical standards.

Before interviews kicked off, the study objective was clarified to the participants. Written informed consent was obtained from all participants. Participants were interviewed individually and interviews were recorded to ensure participants' confidentiality. No matter who they were in the study, participants were treated with respect, and they were given the freedom to leave the study whenever they wanted to. Data is kept in google drive and shall be deleted after six months.

3.7. Dissemination and use of results

The researcher will publish research articles in peer-reviewed journals, presenting the findings at relevant conferences, symposiums and seminars, and sharing the results with policy-making bodies and healthcare organizations such as Ministry of Health, Ministry of Gender, and Uganda AIDS Commission (UAC). HUMCs, CSOs, and other stakeholders will be engaged through community meetings, workshops, and presentations, where study findings will be shared in accessible language and formats. The researcher will actively seek opportunities to collaborate with policymakers and healthcare providers to ensure study findings inform local and national policy developments, decision-making process, and initiatives aimed at strengthening community participation in PHC in Uganda. The researcher will continue to circulate study findings using Blogs, Twitter, Facebook, and List Servs such as google groups.

CHAPTER 4: STUDY FINDINGS/RESULTS

This chapter presents study results divided into six parts. **Part one** explores the general findings on HUMCs. **Part two** describes leadership. **Part three** explains management and planning. **Part four** demonstrates resource mobilization. **Part five** presents monitoring and evaluation. **Part six** explores women involvement.

4.1. General findings on HUMCs

In Uganda, there are 5,155 HUMCs at Health Centre level II-IV as indicated in **Table 4.1** (29). However, no evidence was found on how many of these facilities are government owned. Also, there was no data to indicate how many of these HUMCs were active.

Table 4. 1: Number of HUMCs at Health Centre level II-IV

Health Centre (HC) Level	Structure	Number	Percentage
Health Centre II	Health Unit Management Committee	3,364	48.49%
Health Centre III	Health Unit Management Committee	1,569	22.62%
Health Centre IV	Health Unit Management Committee	222	3.20%
	Total	**5,155**	**74.31%**

Source: Ministry of Health National Health Facility Master List 2018 (29).

4.1.1. Main Tasks of HUMCs

The formation of HUMCs aimed to ensure that communities have the right to fulfil their tasks, take responsibility for their health and ensure their active participation in planning, and health services management (31). According to 2019 MOH Guidelines for HCII-IV HUMCs, HUMCs are supposed to perform the following duties (28,62):

1. Sensitise communities on health rights, roles and responsibilities.
2. Monitoring general administration of the health unit on behalf of the Local Council and the Ministry of Local Government within the policy and guidelines of the MOH.
3. Management of health facility finances:
    - Supervise management of health centre funds by ensuring that accounting rules and financial standards are followed by the unit.
    - Approve the annual work plans and budgets prepared by the unit management team.
    - Ensure that annual work plans are drawn up reflecting priority needs of the community.
    - Monitor the performance of the approved work plans and budgets for health centres.
    - Ensure that funds released for HCII, III & IV are accounted for to the Chief Administrative Officer (CAO) through Health Sub-District (HSD).
    - Authorise reallocation of funds within the budget lines if need arises and with full approval of HSD (in case of HCII & III).
    - Ensure that unit funds are not diverted to other activities
4. Advise upon, regulate, and monitor, collection, allocation and use of finances from other sources besides government funding including individual well-wishers, CSOs, and business corporations including banks and industries.
5. Monitor the procurement, storage and utilization of all goods and services in line with Local Government regulations. In particular, the HUMC should evaluate tenders.
6. Foster improved communication between community people and healthcare providers.

4.1.2. People elected and their selection process/criteria to the HUMCs

HUMCs comprise of nine voluntary members, at least three of whom should be women with a minimum education level of Uganda Advanced Certificate of Education (UACE) (28,62):

Table 4. 2: Composition and Role of Health Unit Management Committee

HUMC Member	Role and Profile
Chairperson	Chairs HUMC meetings, accounts signatory (Public figure of high integrity not holding a political position)
Vice Chairperson	Responsibilities of chairperson in absentia (Public figure of high integrity not holding a political position)
Secretary	Facility In-charge (accounts signatory, organizes meetings, records minutes)
Treasurer	Accounts signatory
Member	A centre teacher of the zone where the HC II-IV is located
Women's Representative	Represent interests of women: Not holding any political position
Special Interest Groups' Representative	Represent interests of special interest groups: Not holding any political position
Youth Representative	Represents interests of youths: Not holding any political position)
Member of County or Sub-county Council	Ex-officio (co-opted whenever necessary)

Source: Adopted from Ministry of Health Guidelines for Health Centre III-IV (28,62)

Members of HUMCs are volunteers appointed to serve for three years and are only permitted to serve for maximum six years (26). The process of recruiting new committee members begins six months before the period of six years of office of the current committee expires. The date of expiration of the HUMC is notified to the district chairpersons by the Local Council II Chairperson or Local Council III Chairperson or Town Clerk or Health Sub-District Director (28,62).

HUMC members are individuals voluntarily drawn from the community as representatives in the routine implementation of health facility-based planning and service programmes (33). According to MOH HUMC guidelines, a transparent selection process is supposed to be made through announcements for vacancies open using community information boards for the community to prepare and identify representatives for nomination (28).

HUMC members are supposed to be recruited through a process aimed to ensure representation and people's participation in healthcare decision-making (63). The HUMC recruitment process is supposed to be inclusive and representative of a wider community, involving selecting members from different demographic groups, including women, youth, older people and marginalized populations (25,63).

The specific recruitment process may differ across different regions of Uganda and health centres, however, the general steps involved include:

- *Community selection:* through community meetings, consultations, or nominations, community members are supposed to actively participate in the selection process to identify individuals who should represent their interests on HUMCs (28,62).
- Submission of nominees' list to local and higher authorities *(Local Councils II-III, Town Clerks, Health Sub-District and MOH through the District Health Officers – DHOs)* (27,28,62). Once selection is complete, the In-charges at HCII, III & IV forward nominees list to the councils (II, III, Town Clerks, & Health Sub-District - HSD) for approval at these local levels. The list is then forwarded to the higher-levels of District Health Officer (DHO) and Chief Administrative Officer (CAO) for final approval.
- *Appointment by higher authorities (MOH through the DHOs and CAOs)* (26)*:* Once the community identifies potential HUMC members, the authorities appoint them to serve on the committees based on recommendations and nominations received from the community and healthcare providers (33).
- *Training, orientation and building capacity:* After the appointment, HUMC members are supposed to undergo orientation, training and capacity building programmes which aim to arm HUMCs with necessary knowledge and skills to effectively carryout their roles (64). These HUMC trainings are supposed to be locally organised and delivered by the MOH through the District Health Offices in partnership with other stakeholders such as NGOs and development partners (65,66). The MOH provides training guidelines and curricula, and

support for HUMC training programmes. The training duration varies depending on particular context and training objectives. However, the current practice is that training timeframe can go from days to weeks (65,66). From the literature review, ***no evidence from the Ministry of Health was found on whether these trainings are happening and how many HUMCs have been trained, and in which districts in Uganda*** (25).

4.2. Leadership

Leadership is the extent to which HUMC members provide leadership in decision-making and interests of diverse community groups are represented through HUMCs (59,60). The Uganda Network of AIDS Service Organisations (2014)indicated that what makes HUMCs functional, are the regular meetings that demonstrate active participation and commitment of HUMCs to manage health facility issues (26). Mulumba et al. (2022) argued that HUMCs have capacity to make decisions that are informed and give guidance on matters affecting health facility(33).

The National HUMC Guidelines clearly define the composition and role of HUMCs; and the National Health Policy 2010, and National Health Sector Strategic and Investment Plan (HSSIP) 2010/11-2014/15 recognise HUMCs as health governance structures that promote community participation in PHC (67,68). However, there are inconsistencies in implementation which affects the level of community participation in PHC delivery (33,41,63).

A study in Uganda, Kenya, Zimbabwe and Peru found that active HUMCs participate in discussions and make decisions on matters related to healthcare service provision, budget allocation, personnel infrastructure growth, and community health priorities (69). HUMCs offer input based on their experience and understanding of the local needs, available resources, and communities' viewpoint (69). In Kiboga and Kyankwanzi districts, during discussion spaces, HUMCs aired out community health challenges and worked with healthcare providers and authorities *(local council II, III & IV chairpersons)* to fix them (33), and ensured that health services met community needs (39,69). However, another study in East Central Uganda found that HUMCs being confined only at health facility (II-IV) lower levels of the health system is not enough to attain meaningful community participation (25). The study recommended a stronger connection between HUMCs and communities (25).

In Uganda, HUMCs spread information to ensure that healthcare users know of available services, illness prevention and treatment strategies and as a result, more people are empowered to make knowledgeable decisions about their health (70). In South Africa, it was also found that CHCs help communities to realise their right to health through health education and awareness campaigns within their respective communities (71). HUMCs lead effective interactions and feedback mechanisms like Barrazas between communities and healthcare providers for accounting for all decisions (72). Through their quarterly meetings, HUMCs reflect and learn about people's health needs, and hold discussions about them and identify possible solutions (33). However, some HUMC members have inadequate skills in facilitating community dialogues, which needs active listening and a strong background in expressing complex health information for easy understanding by people in the community (51).

The literature review found that HUMCs engage policy-makers and healthcare providers by setting the agenda, writing and implementing policies within health centres and the community at large (66). HUMCs provide input into local health policies, guidelines and protocols (33). For example in the development of non-discriminative service delivery bylaws at sub-county level, HUMC help to ensure that these policies are culturally appropriate and responsive to people's health needs (66). In South Africa, CHCs promote adoption of these laws and regulations at health centres and community (70). Some HUMCs have faced challenges in implementing the new laws and regulations due to bureaucracy and resistance to change from facility staff as operationalization of laws may need training, more resources, and change in existing practices (26). In Kyankwanzi District, some communities and service users have opposed certain policy changes because of fear to change, limited awareness on the benefits of the policies and negative cultural beliefs (51).

Muwanguzu et al. (2019) in Eastern Uganda revealed that HUMCs delegated roles related to implementing policies and strategies within the health centres (12). HUMCs ensured that facility staff were adequately informed about and abide by policies, protocols, and procedures. HUMCs

designated specific individuals (HUMC members) to keep an eye on policy compliance and give feedback (input) on how effective the policy is (12). However, HUMCs faced problems in providing feedback due to hierarchies and power dynamics within heath facilities, worries about reprisals, and no openness to criticism from authorities above hampering HUMCs' capacity to give constructive input (39). A study from East-Central Uganda found weak coordination between HUMCs, facilities, district and village health teams resulting in health programmes that do not meet community needs (25).

On the one hand, findings from literature indicate that HUMCs serve as mouth-piece for communities' health needs, engage with patients seeking their opinion and feedback on service quality and the responses have been used to inform decision-making (27,70). HUMCs ensure that people's voices including young people, older people, people living with HIV or disability are listened to and considered in matters related to healthcare service provision (27,70). On the other hand, Muwanguzi et al. (2020) in Eastern Uganda argued that HUMCs do not represent all the people and there is little interaction between HUMCs and the people (25). Muwanguzi further argued that in some communities, cultural norms and hierarchies may discourage open discussion and participation especially if community members believe HUMC members to be having higher social status /authority (25).

The above findings from the literature were confirmed by a key informant in Wakiso district:

"Uganda has many active HUMCs that represent the voices of local people in decision-making in health centre affairs. One big issue that not all people are represented. We have observed limited interaction between HUMCs and the community people. These committees are mainly confined at health centres which blocks open dialogue between HUMCs and the people. That connection between HUMCs and the people is not so much felt".

(Female Key Informant 2, Wakiso)

Study findings indicate that HUMCs in some regions in Uganda have successfully resolved disputes among facility staff, and between staff and the communities (66). Common disputes that seem to be between facility in-charges and their subordinates included allegations of misconduct, theft of medicines, absenteeism and disrespect, HUMCs have regularly intervened where possible and resolved them (26,33,41). Another study discovered that complaints and grievances of some marginalised groups poorly represented on HUMCs, have not received full attention and resolution (25). HUMC members may have limited mediation skills to stimulate constructive negotiation dialogues between conflicting parties, which may escalate conflict causing further tension (25).

According to the State House Health Monitoring report (2017) on capacity building of HUMCs in Karamoja region, most of the HUMC members shy away from addressing problems faced by the community to health workers due to seniority of health workers (38). A good number of the HUMC members are illiterate and can only communicate in their local languages making it difficult to address the problems of the people (38).

In Tanzania, Health Facility Governing Committees (HFGCs) established open lines of contact between community people and health workers, facilitating exchange of opinions, worries, and feedback (73). HFGCs arranged forums, surveys and focus groups to collect community ideas on areas of improvement for healthcare delivery (73). The study identified some poor communication between HFGCs and other stakeholders, however, the study fails to pinpoint and succinctly describe communication routes best suited for disseminating information to stakeholders by HFGCs (73). Also, in Uganda, as stated by one of the key informants;

"One common channel of communication that HUMCs use to share information among themselves and health providers is meetings, this method alone is insufficient to maintain stable communication. Other channels (phones) are weak due to rural connectivity problems delaying information sharing. In addition, some HUMC members lack phones making it difficult for them to interact or receive needed information on time through this form of communication route other than physical meetings".

(Male Key Informant 1, Kampala)

Gangu et al. (2020) in East-Central Uganda, found two main other key challenge the leadership role of HUMCs (25):

- Inadequate capacity building and training opportunities *(low participation in meetings, inadequate training, lack of seminars/workshops)* for HUMC members, leaves them demotivated and makes them hesitant to take on leadership roles as they feel unable and overwhelmed to contribute to decision-making developments.
- Limited access to needed information about updates, decisions and changes in policies as it may result in HUMC frustration and exclusion. For example weak communication channels between HUMCs, community, and healthcare workers affect the flow of information, weakening HUMCs' ability to make well-informed decisions and engage key stakeholder efficiently.

Gihembo (2012) in Uganda found that a few HUMCs in consultation with healthcare providers have led the redesigning of patient flow processes (sequencing of clinical care activities that patients go through from entry point until exit of health centre premises) (74,75). HUMCs determined the average of waiting time for patients in outpatient departments (OPD), identified challenges experienced by facility staff in handling patient flow, and mapped efforts to improve patient flow in OPD (74). Redesigning patient flow was necessitated by the insufficient workflows and increased patient demand for healthcare services that resulted in overcrowding, prolonged waiting times, and poor quality of healthcare ((74). In this process, HUMCs faced resistance to change from facility staff who perceived the process as disrupting their already established routines and workloads (74). Many HUMCs have insufficient expertise in patient flow process redesign blocking smooth assessment and redress of inefficiencies in the patient flow (74,75).

4.3. Management and Planning

Karuga et al. (2023) in Kenya, described management and planning as the extent to which CHCs set priorities, manage community health services, and forge partnerships between health workers and the community (59,60). In Uganda, HUMCs engage communities to map and prioritise the most pressing health related needs of community people and ensure that these needs are aligned with healthcare programmes and services (39). However, Muwanguzi et al. (2020) in East Central Uganda argued that HUMCs did not have adequate experience in conducting needs assessments and it is not clear whether these prioritization engagements were done at community or facility levels (25). Also, ***no information was found on whether HUMCs had a standardised tool that guided them to conduct needs prioritization exercises***.

Kapiriri et al. (2003) in Uganda, found that HUMCs' oversee the day-to-day operations of HCII-IV by ensuring cleanliness, repairs and maintenance of health centre premises as well as ensuring accessibility of necessary utilities like electricity and water at the facility (70). Kapiriri et al. (2003) and Muwanguzi et al. (2020) further argued that most HUMCs in Uganda do not have sufficient experience to effectively oversee complex healthcare operations as this resulted in problems in making decisions that were informed in addressing health facility operational challenges (25,70).

Mulumba et al. (2022) in Uganda indicated that in some regions, HUMCs work with health providers, community groups *(women, older people, youth, people living with HIV or disability),* and appropriate authorities (Local Councils I, II, III, and IV) to develop approaches and action plans well-aligned with the set objectives (33). These plans specify key activities, timelines, accountable parties, and specific indicators to gauge how well strategic objectives are being achieved (51). Muwanguzi et al. (2020) in East Central Uganda found that although HUMCs establish action plans, implementation has been difficult due to limited access to financial support and time constrains as they are volunteers and other commitments (25).

CEHURD (2015) in Uganda shows that HUMCs in Nyamiringa HCIII in Kiboga District and Kikoolimbo HCII in Kyankwanzi district were supported by NGOs including CEHURD to map and set priorities to inform work planning processes which begun by issues identification, objective and activity setting (40). The process was informed by revisiting HUMC functions outlined in the MOH guidelines. Discussions were led by HUMC chairpersons with guidance from NGOs on practical application of the

set objectives and proposed activities, and a set of priority interventions were agreed upon (40). These findings from the literature were confirmed by a key informant;

"We supported these two specific HUMCs by conducting two separate half-day community dialogues in the locality of Kikoolimbo HCIII in Kyankwanzi and Nyamiringa HCIII in Kiboga. The aim was to introduce HUMC members to the community; sensitize them about HUMC roles and responsibilities; inform them about HUMC priority actions; and how community members could support HUMCs' work. These dialogues were chaired by the respective HUMC chairpersons and moderated by CEHURD. During the dialogues, HUMCs introduced themselves to community people and there was a discussion on their roles and responsibilities. HUMCs further introduced their priorities and work plans, and received input from community at respective health centres. The health centre in-charges informed community members about the available services at their respective health centres, and then community members has an opportunity to ask questions and made comments".

(Male Key Informant 3, Kampala)

A study by Uganda Network of AIDS Service Organizations (2014) in 8 Districts in Uganda, found that some HUMCs were highly knowledgeable of their planning, budgeting and resource allocation role (26). It was evident in Layibi HCIV in Gulu City where HUMC members were active in planning and budgeting ensuring that the on time construction and completion of the house for health centre staff as HUMCs evaluated the tender, constituted Community Project Management Committee (CPMC) and monitored construction (26).

The study further found that Layibi HCIV HUMC was more functioning than other HUMCs due to active engagement with the DHO, and lively support from their community *(provision of information)*, HUMC members were found to be committed, passionate and energetic in helping with health improvement in their respective communities. HUMC members had exhibited good interpersonal relationship among themselves, good working relationship with health centre staff, and the liaising role demonstrated by the health centre in-charge were reasons behind the functioning of Layibi HCIV HUMC (26).

Another study by Gangu et al. (2019) in Eastern Uganda found that trainings piloted in Buyende and Iganga District capacitated HUMCs to have substantial powers over management of health centres as they were trained on program management and planning (41). These trainings improved the quality and frequency of HUMC minutes as compared to other districts where there was not training at all (41).

A study by Mulumba et al (2018) in Uganda and South Africa found that some HUMCs reviewed action plans and strategic objectives where activities were prioritized according to community needs, urgency, resource available and impact (63). The study indicated that HUMCs bring social knowledge, experience, perspectives on health problems, and solutions (63). HUMCs set due dates and milestones for planned activities to ensure on time completion (63). Kyomuhangi et al. (2020) in South Western Uganda indicated that was due to trainings provided to HUMCs to improve their performance (66). Mulumba et al. (2018 further indicated that some HUMCs failed to track progress and impact of the action plans due to poor monitoring and evaluation systems and this may result in challenges in identifying achievements and gaps for improvement (63).

However, the management and planning function seems hampered by limited funds access to enable HUMCs implement their set activities, leaving them frustrated and powerless to make decisions (33,63). One of the key informants in Mukono confirmed the literature review findings as follows;

"We have observed that despite the commendable work done by HUMCs, financial challenges exist which have caused committee members not to attend meetings, and working without incentives discourages them. Even the budget that is planned by government does not cater for their allowances. Therefore, it becomes hard to give them allowances. We have also learnt that the Ministry of Health is making concerted effort to resolve this challenge. Discussions have started on incentivising the work of community health volunteers including HUMC members".

(Female Key Informant 5, Mukono)

While evidence above shows functionality of HUMCs regarding management and planning, there is also evidence showing the opposite. For example Gangu et al. (2020) in East-Central Uganda, further pulled out another key challenge associated with managing and planning role of HUMCs (25), the lack of remuneration for HUMC members even if the MOH Guidelines on HUMCs outline the voluntary nature of being a HUMC member.

4.4. Resource Mobilization

Karuga et al. (2023) looked at resource mobilization as the degree to which CHC members find opportunities to mobilize resources (finances) to implement health-related activities at community level (59,60).

In Uganda, HUMCs work with and present community needs and priorities to district health and community development offices and lobby for funding for health facility programmes (26). HUMCs map out and work with local NGOs which provides access to capacity building opportunities, more resources and technical expertise (26,41). HUMCs work with communities through fundraising and friend raising drives including sports tournaments and community health walks to raise money for health programmes (26). HUMCs motivate their communities to contribute cash or in-kind resources by setting up donation boxes at health facilities (65,76). However, HUMCs lack skills in resource mapping to identify potential funders, supporters and existing resources for health programmes (25). ***There was no evidence to show whether HUMCs have written and submitted proposals to any donors for funding***.

Kyomuhangi et al. (2020) found that in South-Western Uganda, HUMC members were wealthy and used their own resources to set up emergency transport funds for patients facing financial hardships to reach facilities (66). Kyomuhangi further argued that with the support of their communities, some HUMCs were able to dig and build placenta pits at their respective health centres and other put up canteens to generate more money for their health centres (66). The Uganda Network of AIDS Service Organizations - UNASO (2014) in its national study argued that while some of these HUMCs used their own resources, this is not sustainable (26).

UNASO (2014) found that HUMCs have successfully mobilised resources because of their composition which involves diversification of members who have powers to mobilise resources for facilities (26). Kyomuhangi et al. (2020) pulled out other innovations where HUMCs in South Western Uganda engaged community members for resource mobilization such as horticulture and tree planting to beautify facilities, and fencing of the facilities through communal efforts (66). Some HUMC members were farmers and able to donate trees and flowers to their facilities free of charge (66).

CEHURD (2015) in Uganda found that HUMCs at Nyamiringa HCIII (Kiboga District) and Kikoolimbo HCIII (Kyankwanzi District) engaged communities to dig pit latrines, placenta pits for proper waste disposal and installation of water sources, constructing fences to improve security and protect the facility premises from wandering domestic animals (40,65). A study by Karuga et al. (2023) in Kenya further found that although CHCs participate in mobilizing resources, they have limited skills in writing fundable proposals (59) due to:

- Inadequate training in writing fundable proposals which entails specific skills and knowledge (understanding proposal components, writing logical frameworks, and budgets).
- Limited access to guidelines, proposal templates, and sample of successful proposals.
- Lack of mentorship from experienced grant writers in developing fundable proposals.
- Language and literacy barriers hamper the ability of members of HUMCs to develop winning proposals as English is the official language for proposal development in Uganda.

Most key stakeholders interviewed highlighted the need to provide more trainings for HUMCs on proposal writing for funding the work of HUMCs from civil society organizations (CSOs) as it is stated in the interview with a health systems strengthening officer in Wakiso:

"Our leadership and governance programme ended when we had not provided any training for the HUMCs in resource mobilization especially proposal writing. We are negotiating with other new donors to see if they can provide funds to address these skills gaps among HUMC members. I can

confirm to you that if HUMC members are trained in fundraising, they will be able to get people including civil society organizations and the business community to fund health centres and operations of HUMCs".

(Female Key Informant 2, Wakiso)

Per the MOH HUMC Guidelines, HUMCs are expected to do a lot, but they are inadequately funded to fulfil their mandate (40). HUMC activities are funded from the primary healthcare grants, which are small ranging from UGSHS 350,000 (€86,42) – UGSHS 450,000 (€111,11) quarterly and it is not a guarantee that these limited funds will be available to convene HUMC quarterly meetings and finance their activity plans (40). In South Africa, studies found that lack of funding may contribute to dysfunctionality of community health committees (CHCs) making it difficult for them to launch their own developments at health centres (16). This inadequate funding may impede CHCs' ability to implement work plans and CHCs may struggle to conduct health promotion and community outreach initiatives (63,77).

Key informants in Kampala and Mukono confirmed the findings as stated below:

"I have to say that HUMC members are volunteers, and volunteering has a limit, yet funding is still required to ensure substantial community participation. Funding is needed to organize events, activate communities, reach out to actors, and give communities, local governments, and other stakeholders' feedback".

(Male Key Informant 4, Kampala)

"In most of the districts where we work, HUMCs advocate for more funding from government as they work with community people, local leaders, and relevant authorities to raise awareness about community health needs, and the importance of adequate health financing. They have influenced resource allocation for infrastructure development and essential healthcare services. HUMCs have participated in networking events, attended meetings and conferences, and built strong connections with potential funders (people with the money). By utilizing these relationships, HUMCs have aimed at acquiring financial and technical support for different health initiatives, capacity building and infrastructure projects. One challenge interfaced by HUMCs is the limited capacity in grant writing and donor negotiation skills".

(Female Key Informant 5, Mukono)

Uganda Debt Network (2020) in Eastern Uganda found that HUMCs were vibrant in engaging and presenting issues affecting health facilities to the DHOs (78). For example in Bukedea district, HUMCs reported insufficient beds at Kolir HCIII in Bukedea district to the District Health Officer (DHO) who contacted MOH Headquarters in Kampala to supply more beds (78). As an achievement, four beds *(one for labor, two for the women's ward, and another for the men's ward)* totalling to more than Euros 2,489,47 (UGX 10 million) were delivered to Kolir HCIII (78). The same study indicated that although beds were supplied, there was weak follow-up on the commitment between HUMC members and the DHO because that DHO was transferred to another district (78).

UNASO (2016) found that HUMCs in Gulu, Mayuge, Rakai, Mbale, Shema and Wakiso districts have mobilised cash or in-kind donations (26). Some secured land for building extended structures in their respective facilities from the community, and paintings from Cheap General Hardware and industries (26). HUMCs have engaged FM radio stations for free airtime since some HUMC members play other community roles such as religious and cultural leaders as they are well-connected to people of influence like District Chairpersons, and Members of Parliament (26). However, from literature review, there is ***no evidence to indicate whether HUMCs have mobilised resources from corporate community (banks, industries, and telecommunication companies). There seems to be a*** lack of awareness about funding opportunities that exist in corporate community and lack of contact with business sector (42).

Namatovu et al (2014) in Wakiso and Gulu District found that HUMCs explore volunteerism and community engagement opportunities as part of their resource mobilization strategies (42). A key informant in Mbale City confirmed that:

"In Mbale City and Bududa District, a number of HUMCs have exhorted people from their respective communities to volunteer their time, talents or knowledge to aid in health projects.

This involves recruiting health workers, setting up health education campaigns and coordinating volunteers for specific health events including immunization, malaria and TB control programmes, HIV Testing Services, and voluntary male medical circumcision (VMMC). Some of the people that have been mobilised by HUMCs to offer their volunteer time to the facilities include students on internship and both in and out-of-school youth who have provided general cleaning to facilities. However, there is limited engagement between HUMCs and the business sector denying HUMCs an opportunity to tap into funding opportunities in this corporate sector such as banks due to limited information and capacity on how to engage them".

(Male Key Informant 6, Mbale)

4.5. Monitoring and Evaluation (M&E)

According to Karuga et al. (2023), monitoring and evaluation is the extent to which CHC members do a participatory assessment of how beneficiaries are involved in health services and programmes that deliver locally meaningful outcomes (59,60).

In Uganda, HUMCs work hand-in-hand with healthcare providers to collect data on the level of community participation in healthcare services and some of the data collection methods include exit interviews with patients (26). ***Evidence on the tools used by HUMCs to collect data was not found due to absence of a national tools to be used by HUMCs*** (25). ***Also, limited evidence was linked to whether performance assessment reports were being used by HUMCs to make informed decisions*** (26,76).

Lundgren (2016) in Uganda, Kenya and Tanzania found that HUMCs promote accountability of released money, evaluate and generally oversee the effectiveness of the approved budgets (10). HUMCs keep an eye on how the funds are properly being utilised in accordance with approved work plans and budgets (10). Mutebbi et al. (2017) in Uganda found that HUMCs examined bids, invoices, receipts, delivery notes and financial statements to make sure that expenditures were made in a reasonable, open and legal manner in line with public financial policies, guidelines and regulations (17). Literature review findings show that most HUMCs lack budget tracking skills due to inadequate training and limited financial literacy on financial concepts, budgeting and accounting principles as it humpers HUMCs' ability to effectively track and manage budgets (25).

Kalyebbi (2014) in Uganda, found that HUMCs in some regions of Uganda prepared M&E plans, evaluated implemented activities and provided feedback to community and facility staff on M&E reports (76). However, limited data was obtained on which feedback mechanisms exist and are used by the HUMCs to provide feedback to the communities. A review by Karuga et al. (2022) in Sub-Saharan Africa, discovered that CHCs hold facility staff accountable through checking absenteeism by tracking daily attendance for example signing in and out sheets (61). UNASO (2014) indicated that HUMCs faced challenges in accessing accurate and up-to-date health facility performance data as reliable data varies across health centres making it more difficult for HUMCs to obtain detailed and timely data on staff performance (26).

UNASO (2014) found that HUMCs monitor acquisition, storage and use of all health centre goods and services (26). This includes monitoring cold and temperature chain systems, medicine stores and equipment storage areas and facility hygiene for compliance with recommended storage practices (26). HUMCs oversee health centre inventory management system for accurate records maintenance (26). Some HUMCs do stock-taking exercises to reconcile physical stock levels with the recorded inventory to identify discrepancies (26). These active HUMCs have been successful because some of the members used to work as store assistants in hospitals and as well health centres (26). ***However, from the literature review findings, it was not clear whether HUMCs used this supply chain data to support decision-making.***

This literature review found that HUMCs tracked movement of facility commodities and goods as they reviewed stock receipts and transfer records to ensure transparent flow of items within and outside health centres (26). HUMCs cross-referenced existing records with stock levels against usage patterns to find irregularities, discrepancies and potential stock-outs (26). HUMCs ensured that facility procurement and distribution processes were followed as they reviewed procurement plans, purchase orders, and supplier contracts (26). This was possible because some HUMC members

are literate and have worked as procurement personnel in health centres facility before (40). HUMCs worked with facility staff such as store keepers and experienced district health personnel including District Store Officers and Bio-statisticians to develop reports and provide updates on storage and usage practices as they participated in monitoring visits or audit exercises done by higher-level authorities and collaborate to identify gaps (26). However, some HUMCs lacked skills in and tools for tracking performance and usage of commodities at facilities especially in Northern Uganda (26,40). Also, ***limited evidence was linked to whether these performance assessment reports were being presented to the communities for their input*** (26,76).

The above evidence from the literature review was confirmed by a key informant in Wakiso;

"One of the major role of HUMCs is monitoring and evaluation, but there is no single national tool developed for HUMCs by Districts or Ministry of Health on how HUMCs can conduct their periodic performance reviews. HUMCs monitor facility performance through budget performance reviews, however, HUMCs have not used any instrument. The MOH has not disseminated any tool on how HUMCs assess their performance. We have already indicated these gaps to the Ministry of Health in many national discussions at both district and national level".

(Female Key Informant 2, Wakiso)

4.6. Women Involvement

Karuga et al. (2023) describe women involvement as the extent to which HUMC members ensure representation of women's active participation in decision-making (59,60).

HUMCs act as podiums for the voices of women to be listened to and their views to be considered in PHC decision-making processes (63). Through needs assessments, HUMCs have considered gender-responsive designing approaches by ensuring that PHC interventions address health needs and challenges of women, for example issues related to gender based violence, family planning, and maternal health (63).

In Uganda, some HUMCs have inspired women to take on leadership roles in HUMCs, empowering them to contribute to PHC decision-making, and also work with community women-led groups to enhance representation of interests of women within HUMCs (25,44). However, evidence from the literature indicates that most of the HUMCs are male dominated resulting in misrepresentation of issues affecting women as most of the HUMC members are not gender experts (26).

The study found that women were underrepresent on HUMCs, with many committees having just one or no women in comparison to five or more men (26), yet the Local Government Act of 1997 stipulates that at least one third of all created committees must be made up of women. As a result, HUMCs have not been gender sensitive decreasing women's ability to make informed decisions about their health (26). Structural barriers such as gender-insensitive policies and practices impede women's representation and influence on HUMCs, and inadequate support systems, and limited recognition of women's contributions contribute to their underrepresentation (26). Poor selection of representatives on HUMCs is a big reason behind this gender gap (26).

Most HUMCs in Uganda are dominated by men compared to women limiting women's participation in PHC decision-making (61) yet the guidelines stipulate at least three positions for women on HUMCs (28,62). Studies have found various reasons for this domination. First, societal expectations and traditional gender roles which often assign women as caregivers and restrict their participation in decision-making and leadership roles including in HUMCs. This may lead to limited opportunities and social barriers for women to participate in HUMCs (79). Second, deep-rooted power dynamics and patriarchal systems may perpetuate gender inequalities, with men being seen as more suitable for leadership roles. Biases within the communities and healthcare system may discourage women from actively engaging in HUMCs (80). Third, limited awareness about the roles and importance of HUMCs may contribute to women underrepresentation. If women are not informed about HUMCs' functions, benefits and opportunities to participate, women may be less likely to engage in the process (81). These results from literature review were confirmed by a key informant;

"On paper, I mean the MOH guidelines for establishing HUMCs mention at least three positions for women. However, in practice it is a different picture. Most of the HUMCs are male dominated and

some of the members have served for a long time, no change. Women involvement is a missing link in the HUMCs. Women lack information on opportunities to participate in decision-making and they often bear a disproportionate burden of household responsibilities, which limits their availability and time to participate in HUMC processes. Guidelines should be revised to make it clear that at least 30% of HUMC members should be women".

(Male Key Informant 4, Kampala)

Although the MOH guidelines on HUMCs mention representation of interest groups, interest groups such as people with disability or HIV are missing on the HUMCs (33). HUMCs may not have established mechanisms to actively include interest groups in committee membership or decision-making processes (59). This lack of representation and failure to engage diverse stakeholders, including people with disability or HIV may contribute to their absence from HUMCs (64). The results were confirmed by one of the stakeholders interviewed in Kampala below;

"I have seen youth councillors hand-picked to represent the voices of young people but do they even have the capacity to amplify the voices of their constituencies? Young people may have limited information on HUMCs and opportunities for their participation. Young people are not reached out to limiting their participation and understanding of the roles and benefits of participating in HUMCs". Young people face limited financial resources, skills and experiences hindering their active participation in HUMCs. Stereotypes and negative perceptions about the contributions of young people may undermine their inclusion in HUMCs".

(Male Key Informant 1, Kampala).

CHAPTER 5: DISCUSSION, CONCLUSION & RECOMMENDATIONS

5.1. DISCUSSION

5.1.1. Key Findings

In Uganda, **5,155** HCII-IV HUMCs were established to ensure effective management practices, accountability, and citizen participation within health centres II, III, and IV. ***However, there was no data on how many of these facilities are government owned, and also no data on how many HUMCs at public facilities are active***. The Uganda National Health Policy 2010 clearly stipulates the importance of community participation in PHC planning and it is cognizant of HUMCs as salient governance structures that facilitate community participation in PHC (68). The National Sector Strategic and Investment Plan also recognises HUMCs as important stakeholders in promoting community participation and equity in PHC delivery (67). However, there is absence of a fully-fledged policy framework for HUMCs according to UNASO, that has resulted in underutilisation of HUMCs as health governance structures, and their role in facilitating community participation and ownership in PHC has remained untapped (26).

Under 'Leadership', 'management' and 'planning' role, HUMCs are means of community participation in PHC as they locally represent and bring community input in PHC planning and decision-making including budgeting and work planning (41). HUMCs comprise of people from the community and other stakeholders who voluntarily represent voices of local people (26). HUMCs provide oversight on assessing healthcare providers' work performance to ensure service provision quality is aligned with national standards (39,51). HUMCs exercise managerial oversight on day-to-day operations of health centres such as staff attendance records, medications inventory control systems and how medical personnel handle patients (26). In Tanzania, HFGCs are considered resourceful in PHC work-planning and budgeting processes because of their understanding of people's health needs (23,24). Results from literature review found that ***HUMCs work for free or as volunteers undermines the dedication that HUMC members ought to possess*** (26,39). The MOH should consider providing some monthly stipend for HUMCs including airtime, transport and lunch (26,33,63).

In most regions, HUMCs provide platforms where opinions of the local people can be listened to regarding issues affecting their access to or satisfaction with healthcare services provided by health centres (26). HUMCs provide advisory services that improve working relations between healthcare providers and communities through dialogue (76). HUMCs in Eastern Uganda have meaningfully participated in sub-county quarterly review and planning meetings outside the health facilities where their views have been adequately recorded (41). ***However, from the literature review, there was no data on whether HUMCs from other regions participated in sub-county quarterly review and planning meetings outside health facilities***.

Results from literature review show that HUMCs do not represent all the people as other sects of the community are missing on the HUMCs (25). There is also little interaction between HUMCs and the people they represent (25). Less evidence was found on how HUMCs are representing the communities. Despite HUMCs are promoting PHC, it is less clear whether they are representing the needs of people. ***There is limited evidence on whether HUMC trainings are taking place and on how many have been trained and in which districts***. The coordination between HUMCs, facilities, village and district health teams seems still weak (25).

In East Central region, HUMCs have served as mediators in resolving conflicts/disputes between healthcare facilities and the community due to some trainings provided to them (12). Some HUMCs have strengthened communication between patients and healthcare providers and identified peaceful solutions to the disagreements regarding inadequate service performance (26,33). However, Muwanguzi et al. (2020) in East-Central Uganda found that HUMCs that did not receive any training had limited skills in conflict resolution and mediation due to limited knowledge and expertise which makes it difficult for the HUMCs to hand complex disputes (25).

'Resource mobilisation' remains HUMCs' fundamental role for improved resource allocation in health centres II, II & IV (26). HUMCs in some regions have helped their communities to fundraise or

contribute volunteer time (labour), land and raw materials (sand, cement, paintings) for building or maintaining health centres (26). From the literature, no evidence was found on whether HUMCs receive financial support, incentives or recognition for the work done in mobilising resources. However, Muwanguzi et al. (2020) in East Central Uganda further showed that HUMCs may lose morale to continue participating in fundraising activities due to lack of incentives and recognition for their work done (25).

Other studies further highlighted that the resource mobilization function is affected by lack of technical and administrative support (40,55). HUMCs have limited skills in mapping sources of funding, potential people with money, and writing fundable proposals (59). ***From the literature review, it was not clear whether HUMCs worked alongside facility staff to identify potential grant applications*** from national, international, private, and charitable foundations. No evidence was also found on whether HUMCs assisted in writing and submitting technical proposals with the aim of securing funds for specific health centre needs. In some regions like Karamoja, HUMCs were not well connected to vibrant networks and potential partners making it difficult for them to raise resources (38). In South Africa, it was found that lack of funding led to inactivity of some health committees disenabling them to launch their own developments at health centres (16). In Tanzania, proposal writing skills were cited to be crucial for HFGCs to raise more money for healthcare in their respective communities (77).

In terms of monitoring and evaluation, HUMCs have acted as watchdogs ensuring transparency throughout health centre II-IV's financial transactions. HUMCs review financial reports regularly while cross-checking against expenditures made during implementation plans agreed upon collectively by committee members alongside facility administrators. HUMCs do prepare M&E plans, evaluate the effectiveness of approved and implemented activity plans and budgets (10), and provide feedback to community and healthcare professionals on M&E reports (76). HUMCs hold healthcare staff accountable through checking absenteeism using attendance registers, and quality of services provided to healthcare users through exist interviews (61). HUMCs appraise health centre staff, monitor the acquisition, storage and use of facility goods, commodities and services according to local government financial and accounting standards and regulations (26). ***However, from the literature, no information was obtained on whether HUMCs have budget and accountability tracking skills***. In Tanzania, accountability mechanisms such as community scorecards, citizen report cards, public hearings and social audits were weak at local and community levels due to absence of procedures and clear guidelines for HFGCs (82). ***In Uganda, there was no evidence to indicate the use of specific accountability and budget tracking mechanisms organized by HUMCs between healthcare providers and the communities***. Mulumba et al. (2022) found that HUMCs lacked capacity to effectively implement accountability mechanisms such as community parliaments and community watchdog groups if they existed (33). Little evidence was obtained on which mechanisms exist and are being used for HUMCs to give feedback to their communities.

HUMCs monitor and inspect management of facilities, and deal with indiscipline when it occurs among facility staff (26). However, many of the HUMC members shy away from addressing problems faced by the community to the health workers due to seniority (38). ***A good number of HUMC members are illiterate and can only communicate in their local languages making it difficult to address problems of their people*** (38). In Eastern Uganda, HUMCs have been vibrant in compiling reports on their findings and submitted them to relevant authorities, such as the parish offices, Sub-count Offices, and Health Sub Districts (41). These reports highlight areas of concern, progress made, and recommendations for improvement as they also provide a comprehensive overview of the health unit's performance and assist in monitoring progress over time (41). ***However, limited evidence was linked to whether these performance assessment reports were being used by HUMCs to make informed decisions*** (26,76).

Regarding 'women involvement' functionality, HUMCs act as podiums for the voices of women to be listened to and their views to be considered in PHC decision-making processes (63). Through needs assessments, HUMCs have considered gender-responsive designing approaches by ensuring that PHC interventions address health needs and challenges of women, for example issues related to gender based violence, family planning, and maternal health (63). However, literature review found that HUMCs were ***gender-insensitive*** as most of them were dominated by men compared to women, limiting the participation of women (61) yet the MOH guidelines on HUMCs stipulate at least three

positions for women (28,62). HUMCs were found to be male dominated because traditional norms expect women to focus on caregiving roles which limits women's opportunities to participate in PHC decision-making processes (61).

From the literature review, some HUMCs analyse health data to pull-out gender-specific health needs and tailor services accordingly, and advocate for consideration of gender-sensitive healthcare services in PHC planning at health facilities (63). However, most HUMCs have male chairpersons as cultural norms appeared to encourage male participation among HUMCs in the rural settings (26,59). Many HUMCs underrepresent women as they have just one or no women in comparison to five or more men (33,63). As a result, many HUMCs have not considered gender as women's ability to make informed decisions about their health has reduced (26). ***There was no information on whether HUMCs had access to proper tools and technologies, and no data was found on whether HUMCs had expertise in using technologies to do detailed gender analysis.***

Mulumba et al. (2018) found that HUMC convey wider communities' needs, priorities and feedback to the health centre management including elderly, and people living with specific health conditions (disability, HIV, diabetes), women, and youth (63). Mulumba et al. (2022) further indicated that even if HUMCs convey wider community's concerns, interest groups such as people with disabilities, HIV, older people do not have representatives or were missing on the HUMCs (33). It would be vital to map out and combat forces working to prevent community participation in health governance structures including examining how much bureaucratic, systematic, and social-cultural legal issues hinder realization of community participation in decision-making about their own health (83).

5.1.2. Reflections on the framework

Karuga's conceptual framework for evaluating the functionality of CHCs was used to develop a thorough understanding on how community people participate in PHC through HUMCs in Uganda. Themes were drawn from the five process indicators: leadership, management and planning, resource mobilization, monitoring and evaluation, and women involvement.

The framework can be used to evaluate the level and quality of community participation through community-based committees. The framework provides guidance in identifying the factors that influence community participation, with the ultimate goal of improving health outcomes and promoting community ownership and sustainability.

The framework does not explicitly specify the shortcomings. However, the following can shed some light on any potential gaps: A more thorough framework is required to evaluate the effectiveness of community health committees (CHCs) (84). Decision-makers, health administrators, and activists need to radically rethink how health committees are chosen, given authority over, and assisted in carrying out their duties (61). These results raise the possibility that there may be inadequacies in the frameworks currently used to evaluate the effectiveness of community health committees, particularly with regard to the recruitment, empowerment, and support of these CHCs.

5.1.3. Study Limitations

Despite the fact that this qualitative study explores how HUMCs in Uganda encourage community participation in PHC delivery, it is important to note that the findings are mostly based on a review of the literature and a small number of semi-structured interviews with key informants from NGOs. Although this analytical approach offers insightful information, it might not fully encompass all perspectives and experiences relevant to HUMCs. The results may not be generalizable to a larger group of stakeholders participating in PHC since they may represent the opinions of the interviewed informants and be influenced by the body of literature. In addition, as with any qualitative study, the interpretation of the data may be subject to inherent subjectivity, which could affect how complete the study is overall

5.1.4. Research Priorities

Future research is needed to identify and document best practices for community participation in PHC through HUMCs. This research can highlight successful strategies employed by HUMCs in

fostering community participation including community mobilization, communication, and community empowerment in decision-making processes. Another study is required on how HUMCs work with Village Health Teams (VHTs) documenting roles and responsibilities of both HUMCs and VHTs in promoting community participation in PHC delivery. Another study is required to document mechanisms that exist and are being used by HUMCs to give feedback to the communities as form of accountability.

5.2. CONCLUSSION

In Uganda, community participation remains a key component of primary health care (PHC) via Health Unit Management Committees (HUMCs). It has enormous potential to improve healthcare delivery and enhance health outcomes at community level. This literature review study has illuminated the complex dynamics of HUMCs' interactions at health facility and community level, highlighting both potential and difficulties.

HUMCs can be powerful conduits that link community members and healthcare professionals, fostering meaningful participation, teamwork, and shared decision-making. These HUMCs can promote open communication, strengthen local communities, and match healthcare treatments to the priorities and needs of the people they are intended to help. Through their initiatives, HUMCs can enable communities to take charge of their health, fight for fair access to resources, and promote community-driven responses to health issues.

The journey towards effective community participation via HUMCs is not without challenges. HUMCs seem more geared towards health facilities. Poor selection of representatives and lack of training exist. There also seems weak coordination between HUMCs, facilities, district and village health teams; and particularly inadequate linkage between HUMCs and people at community level. Weak accountability and lack of feedback mechanisms to the community limit HUMCs' functionality. It is not clear whether HUMC trainings are taking place from the side of government, how many have been trained and in which districts. Evidence on how many HUMCs are active in Uganda is also lacking. HUMC members are still volunteers with no financial support. There is still a question on their sustainability as they are resource constrained with their funding dependant on NGO support. Most HUMCs are gender-insensitive as they are male dominated leading to underrepresentation of women. HUMC are not representing people from other interest groups, because people with disability or HIV, older people and young people are missing in HUMCs.

This qualitative study underscores the need to: p*rovide comprehensive training and capacity-building program for HUMC members.* Introduce and orient community members on HUMC existence, their role and activities. Establish mechanisms for regular monitoring and evaluation of HUMC performance. Form feedback mechanisms for HUMCs back to their respective communities as a means of showing proper accountability. Provide financial and material support to HUMCs to implement their activities. Recognise and appreciate the contribution of HUMC members.

5.3. RECOMMENDATIONS

5.3.1. <u>To Ministry of Health (MOH) Uganda</u>

Provide comprehensive training and capacity-building program for HUMC members. MOH should provide standardised trainings for HUMC members in community engagement, leadership, task orientation, effective communication, facilitating dialogues, budget tracking, proposal writing, policy advocacy, and health systems strengthening components/pillars. MOH should work with training institutions to deliver HUMC capacity building programmes.

Introduce and orient community members on HUMC existence, their role and activities. MOH should use different community channels such as community meetings, dialogues, radio broadcasts, local newspapers, and posters to sensitize and inform communities about HUMCs, priority actions and seek community support towards HUMCs.

Establish mechanisms for regular monitoring and evaluation of HUMC performance. MOH should regularly evaluate HUMC performance for accountability, identify areas for improvement, and enhance their effectiveness. MOH should develop measurable performance indicators for HUMCs,

set benchmarks, and reporting tools detailing activities, outcomes, and challenges in a given timeframe (monthly / quarterly). MOH should develop monitoring and evaluation tools for HUMCs to assess their performance. MOH should support bi-annual or annual summits where HUMCs provide detailed reports summarising successes, and engage community members in strategic planning.

Form feedback mechanisms for HUMCs back to their respective communities as a means of showing proper accountability. MOH should hold community meetings where HUMC members provide updates on their activities, challenges faced, and progress made. MOH should assist HUMCs to develop reporting highlighting HUMC activities implemented and their outcomes over a specific timeframe (monthly / quarterly). Community members should be given an opportunity to ask questions, present concerns, seek clarification, and provide feedback to the HUMC representatives.

Provide financial and material support to HUMCs to implement their activities. MOH should consider institutionalise a sustainable budget line for adequately financing HUMCs.

Recognise and appreciate the contribution of HUMC members. MOH should celebrate achievements and acknowledge the positive impact contributed by HUMCs in improving PHC delivery. MOH should implement this through public recognition, certificates / appreciation events.

5.3.2. To Policy and Decision-Makers

Establish a comprehensive policy framework for Health Unit Management Committees (HUMCs) and update existing policies related to HUMCs. Policy makers should assess needs, identify gaps, challenges, and opportunities in HUMCs, and analyse policies' relevance and effectiveness. This policy framework should help in developing more inclusive committees by reviewing HUMCs' composition, roles and representation to include special interest groups. Policy makers should consider reviewing and updating existing policies such as the National Health Policy 2010, National Health Sector Strategic and Investment Plan 2010/11-2014/15 to align them with the newly developed HUMC policy framework.

5.3.3. To NGOs / Development Partners (DPs) /People with Money

Provide technical assistance to HUMCs. NGOs and DPs should give HUMCs technical advice and assistance in areas including data administration, monitoring, and planning for healthcare.

Offer resource mobilisation support to HUMCs. Help HUMCs locate funding sources, create grant applications, and obtain financing to carry out community health projects.

Support HUMCs to do resource mapping exercise. NGOs and DPs should provide support to HUMCs in identifying existing resources within their respective communities that could support HUMC initiatives.

Provide monitoring and evaluation support to HUMCs. Give advice on creating efficient monitoring and evaluation systems to determine how HUMC efforts are having an impact.

Provide HUMCs with advocacy and networking support. By putting them in touch with the appropriate stakeholders and decision-makers, you may assist HUMCs in their advocacy for more government funding and resources.

Document and disseminate information about the work of HUMCs. Encourage cross-learning among various HUMCs by facilitating the sharing of best practises, success stories, and lessons learned.

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ANNEXES

ANNEX 1: Matrix of Literature Search Strategy with Key Search Words: *Boolean Operators/Key Terms using **"OR"** or **"AND"***

OR	Problem/Issue term	AND	Factor-related terms and others	AND	Geographical Scope
	Health Unit Management Committees		Leadership		Uganda • Eastern Uganda • Central Uganda • South-western Uganda
	Community Participation		Management and Planning		Sub-Saharan Africa
	Primary Health Care		Resource Mobilization		Global
	Community		Monitoring and Evaluation		
			Women Involvement		
			Accountability		
			Community Mobilization		
			Gender-Sensitivity		
			Social Norms		
			Male Domination		
			Women Empowerment		
			Partnerships		
			Health needs assessment		
			Functionality		
			Effectiveness		
			Health Outcomes		
			Advocacy		
			Voice		
			Decision-Making		
			Other Interest Groups		
			Health Facility Factors		
			Social Inequalities		
			Health Administration		
			Resources		
			Capacity building		
			Decentralisation		
			Community Factors		
			Awareness		
			Trust		
			Society Factors		
			Legislative Reforms		
			Non-Government Organisations		
			Social Movements		
			Healthcare Providers		
			Representation		
			Volunteerism		

ANNEX 2: Service Delivery by Level of Health Facility (29)

#	LEVEL	POPULATION	SERVICES PROVIDED
1	Clinic	Not-Defined	Community based preventive and Promotive Health Services. Village Health community or similar status.
2	Health Centre II	5,000	Preventive, Promotive and Outpatient Curative Health Services, outreach care, and emergency.
3	Health Centre III	20,000	Preventive, Promotive, Outpatient Curative, Maternity, inpatient Health Services and Laboratory services.
4	Health Centre IV	100,000	Preventive, Promotive Outpatient Curative, Maternity, inpatient Health Services, Emergency surgery and Blood transfusion and Laboratory services.
5	General Hospital	500,000	In addition to services offered at HC IV, other general services will be provided. It will also provide in service training, consultation and research to community based.
6	Referral Hospital	1,000,000	In addition to services offered at the general hospital each hospital will offer a package of specialised services and training.
7	Regional Referral Hospital (RRH)	2,000,000	In addition to services offered at the general hospital, specialist services will be offered, such as psychiatry, Ear, Nose and Throat (ENT), Ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical.
8	National Referral Hospital (NRH)	10,000,000	These provide comprehensive specialist services. In addition, they are involved in teaching and research.

ANNEX 3: Summary of Health Facility Authorities, Ownership & Level by Region (29)

CENTRAL REGION	
COUNT	AUTHORITY
1	AIC
4	CAFU
82	CBO
1	MOES
613	MOH
74	NGO
2107	Private
5	SDA
1	SOS
4	TASO
2	UBTS
27	UCBHCA
80	UCMB
33	UMMB
6	UOMB
8	UPDF
25	UPF
39	UPMB
23	UPS

3,133
667 GOVERNMENT
2,129 PFP
337 PNFP

1,166 CLINIC
1,323 HC II
498 HC III
68 HC IV
62 HOSPITAL
2 National Referral Hospital
3 Referral Hospital
2 Regional Referral Hospital
9 Special Clinic

EASTERN REGION	
COUNT	AUTHORITY
3	AIC
1	CAFU
62	CBO
16	Govt
794	MOH
82	NGO
234	Private
3	SDA
4	TASO
3	UBTS
13	UCBHCA
43	UCMB
12	UMMB
2	UOMB
4	UPDF
15	UPF
34	UPMB
12	UPS

1,334
838 GOVERNMENT
243 PFP
253 PNFP

161 CLINIC
694 HC II
380 HC III
52 HC IV
37 Hospital
3 Regional Referral Hospital
7 Special Clinic

NORTHERN REGION	
COUNT	AUTHORITY
2	AIC
14	CBO
2	MOES
691	MOH
27	NGO
172	Private
1	SDA
1	TASO
3	UBTS
1	UCBHCA
70	UCMB
4	UMMB
7	UNHCR
1	UOMB
15	UPDF
13	UPF
27	UPMB
13	UPS

1,061
733 GOVERNMENT
176 PFP
152 PNFP

118 CLINIC
554 HC II
320 HC III
33 HC IV
29 Hospital
4 Regional Referral Hospital
3 Special Clinic

WESTERN REGION	
COUNT	AUTHORITY
2	AIC
24	CBO
863	MOH
134	NGO
244	PRIVATE
4	SDA
2	TASO
3	UBTS
10	UCBHCA
52	UCMB
10	UMMB
3	UNHCR
1	UOMB
6	UPDF
11	UPF
30	UPMB
14	UPS

1,410
896 GOVERNMENT
247 PFP
267 PNFP

133 CLINIC
793 HC II
372 HC III
69 HC IV
35 Hospital
4 Regional Referral Hospital
4 Special Clinic

ANNEX 4: Table Showing List of Countries in Sub-Saharan African (85)

Liberia	Nigeria	Sudan	Burundi
Cameroon	Uganda	Lesotho	Kenya
Angola	Gabon	Namibia	South Africa
Guinea-Bissau			

	Mauritania	Mauritius	Rwanda
 **Niger**	 Sierra Leone	 Equatorial Guinea	 Ghana
 **Guinea**	 Malawi	 Mali	 Mozambique
 **Chad**	 Senegal	 Tanzania	 Togo
 **Zimbabwe**	 Zambia	 The Gambia	 São Tomé and Príncipe
 **Seychelles**	 Madagascar	 Somalia	 South Sudan
 **Ethiopia**	 Democratic Republic of the Congo	 Burkina Faso	 Comoros
 **Central African Republic**	 Eswatini	 Côte d'Ivoire	 Benin
 **Botswana**	 Cabo Verde	 Eritrea	 Republic of the Congo
 **Djibouti**			