CHE Research Summary 71

More health for Uganda: the untapped value of community-based providers

Written by Megha Rao

Research Team: Megha Rao, Sakshi Mohan, Chrispus Mayora, Elizabeth Ekirapa, Finn McGuire, Brenda Nakimuli, Beatrice Namirembe, Perez Ochanda, Richard Ssempala, Aloysius Ssennyonjo, Paul Revill, Simon Mark Walker, and Freddie Ssengooba



Uganda, like many countries, has limited resources to meet its growing health needs. Most essential services depend on skilled health workers in hospitals and health facilities, who are often overstretched. But two groups already working within communities could help ease this pressure: Village Health Teams (volunteer community health workers) and local medicine retailers (pharmacies and drug shops), which are often the first point of care where public services are limited.

Despite their reach, both groups are used in a limited and fragmented way, often tied to specific disease programmes. Efforts to expand community-based care on a national level have struggled to secure long-term government commitment, partly due to little evidence of their value across the whole health system.

We used a decision/mathematical programming model, drawing from several national and other datasets, to estimate how much health could be gained in Uganda if these community-based providers were formally brought into the delivery of its essential health services. Our approach allowed us to estimate the potential health impact of introducing an entirely new platform for delivering services.

We compared two scenarios: one where services are delivered only by facility-based health workers, and one where Village Health Teams and medicine retailers support them by taking on tasks that fall within their remit and skills.

Our results showed that integrating these providers could allow Uganda to offer 25 more health services within its existing resources, and avert around 4.7 million more disability-adjusted life years (DALYs) compared with relying on health facilities alone. The VHTs offer very good value for money, averting DALYs at around $42 each, well below the $165 typically spent per DALY averted in Uganda.

We also found that there is considerable room to invest in these providers: spending up to $3,423 per VHT member and $19,792 per medicine retailer each year would remain cost-effective. Only about 7% of VHTs' capacity and 4% of medicine retailers' capacity were used in the model, because of limits on what they are allowed to do and how many patients they can feasibly support. When these limits were relaxed, the potential health gains rose substantially.

Bringing community-based providers into the formal health system could allow Uganda to deliver more essential services, more efficiently, to more people. For policy makers to achieve this, they would need to tackle the barriers these services face, from limited training and supervision to weak incentives and poor referral links. Expanding the roles of the services through structural and regulatory reform could also unlock further gains, provided it is backed by investment and careful attention to safety, quality, and feasibility.

More broadly, our modelling approach offers a practical tool for other countries to assess the value of new delivery platforms. For community-based services, it can help governments build the case for sustained investment on the path to universal health coverage.

Read the full paper, funding sources and disclaimers in Health Economics, Policy, and Law.

November 2026