Learning and Documentation of the Community Health Extension Workers (CHEWs) Programme in the Kampala Metropolitan Area: An Evidence Based Implementation Documentation for Urban Communities

Terms of Reference/ SoW

1. Background and Context

Uganda introduced the Community Health Extension Worker (CHEW) cadre to address the documented limitations of the Village Health Team (VHT) model, following evidence that a purely volunteer cadre had become underfunded, undertrained and poorly coordinated. The 2018 CHEW Strategy established a trained, supervised and remunerated community health cadre with defined roles, a six-month training programme and a career pathway, and the National Community Health Strategy 2021/22 to 2025/26 situated CHEWs within a wider community health architecture spanning the electronic Community Health Information System (eCHIS), community-based surveillance, supply chain reform and the Parish Development Model.

The original design parameters were specific: a monthly stipend of about 150,000 shillings; recruitment from within the home community; a minimum of an O-level certificate; a target of one male and one female CHEW per parish; a six-month training period; attachment to health facilities; supervision through facility and district structures; and a defined community health service package. The model was piloted and, on the strength of early lessons, has been scaled to a growing number of districts, with a national policy decision and further scale-up now approaching.

Evidence to date indicates that the model is sound and is trusted where it matters, that recruitment, training and deployment have largely been implemented as designed, and that the principal constraints lie in the operational backbone after deployment, above all the reliability of payment, supervision at household level, commodity and equipment gaps, and uneven digital reporting. Much of this evidence, however, comes from rural and mixed districts.

Rationale for a metropolitan learning and documentation activity

The Kampala metropolitan area, comprising Kampala City under the Kampala Capital City Authority (KCCA) together with the surrounding districts of Wakiso and Mukono, presents an implementation environment that differs materially from the settings documented so far. It is characterised by dense and highly mobile populations, extensive informal settlements, a large and active private and not-for-profit health sector, layered urban governance through divisions, wards and cells rather than the standard rural parish and village structure, and community health arrangements that have evolved unevenly across the three local governments. How the CHEW model is recruited, trained, deployed, supervised, financed, and integrated in this metropolitan context, and how it relates to VHTs, facilities, and the wider local government structures, has not been systematically documented.

This activity is therefore a structured learning and documentation exercise rather than an impact evaluation or a compliance audit. Its intent is to document how the CHEW programme is being implemented and experienced across the three metropolitan local governments, to surface enabling factors, promising practices, adaptations and bottlenecks specific to the urban and peri-urban setting, and to generate practical learning that informs urban scale-up, policy refinement and programme design. It is organized around the established domains of the CHEW programme, so that the metropolitan learning is comparable with, and additive to, the wider evidence base.

> **Framing note.** This is a learning and documentation activity. It prioritizes analytical depth, narrative documentation and transferable lessons over statistical representativeness or causal attribution. Where it draws on service delivery data, findings are framed as a plausible contribution rather than a measured impact.

2. Purpose and Objectives

Purpose

The purpose of this activity is to build a clear, evidence-grounded and well-documented account of how the CHEW programme is functioning across the Kampala metropolitan area, honest about what is working and direct about what needs to change, so that the distinctive lessons of the urban and peri-urban context can inform national scale-up, urban programming and policy decisions on institutionalising the cadre.

The findings will be used to strengthen CHEW implementation across the three local governments, guide the adaptations needed for urban and peri-urban community health programming, clarify how CHEWs relate to VHTs, health workers and other cadres, and support evidence-informed decisions by the Ministry of Health, the Infectious Diseases Institute (IDI) and the local governments.

Specific objectives

The specific objectives of the activity are to:

1. Document how CHEWs are recruited, trained, deployed and equipped across the three local governments, covering community-led selection and eligibility, the training and continuing development model, deployment, coverage and the community-to-facility time split, and the equipment, commodities and digital reporting that enable their work.
2. Document the CHEW scope of work and service delivery package as actually delivered, the clarity of the CHEW role within facilities and communities, and community acceptance, equity and reach, with particular attention to metropolitan vulnerable and hard-to-reach groups.
3. Document supervision, performance and motivation, together with the payment, financing, governance and sustainability arrangements that underpin them.
4. Document how CHEWs relate to and integrate with other community structures, including VHTs, health facilities, the private and not-for-profit sector, and the local government and coordination structures of KCCA, Wakiso and Mukono.
5. Identify enabling factors, promising practices, adaptations and bottlenecks specific to the metropolitan context, and generate documented learning products and prioritised, practical recommendations, including a narrative account of the emerging urban CHEW model.

This is not an impact evaluation. The scope and timeframe mean that strong causal claims are not intended; service delivery observations are framed as plausible contributions, derived by triangulating programme design, documentary evidence, routine data patterns where available, stakeholder accounts, field observation and frontline CHEW experience.

3. Scope of Work

Geographic scope

The activity covers the three local governments of the Kampala metropolitan area: Kampala City under KCCA, including its administrative divisions; Wakiso District, including its municipalities, town councils and rural sub-counties; and Mukono District, including Mukono Municipality and its rural sub-counties. Site selection within each local government will purposively cover the range of settings that define the metropolitan context, including central urban, peri-urban, informal settlement and rural fringe areas, and will be finalised in the inception phase.

For costing and comparability purposes, bidders should assume fieldwork in approximately 8 to 12 sites spread across the three local governments and the four settlement typologies described above, and should indicate the approximate number of CHEWs, VHTs, supervisors, facility staff, private providers and community members they expect to engage, recognizing that final numbers will be agreed during the inception phase.

Thematic scope

The thematic scope is organized around twelve areas of inquiry that reflect the established domains of the CHEW programme and are elaborated in Section 5. In summary, these are recruitment and selection; training and continuing development; deployment, coverage and time allocation; scope of work and service package; equipment, commodities and supply chain; reporting and digital systems; supervision, performance and motivation; payment, financing and sustainability; relationships and integration; private and informal providers; governance and coordination; and community acceptance, equity and reach.

In scope and out of scope

Area	Position
In scope	Documentation of implementation and experience across the twelve areas of inquiry; inquiry with the full implementation chain; light measurement of coverage; observation; review of programme documents and available routine data; identification of enabling factors, adaptations, bottlenecks and lessons; and generation of learning products and recommendations.
Out of scope	Impact evaluation and causal attribution; individual performance appraisal of named CHEWs or officials; a full costing or expenditure audit; primary clinical outcome measurement; and any activity that would compromise anonymity or client confidentiality.

Indicative tasks

The successful bidder will propose an approach that responds to the objectives and areas of inquiry. It is expected to include, as a minimum, the following broad tasks:

- Inception and design, including refinement of the approach, analytical framework, sampling, instruments, ethics and work plan.
- Review of relevant documents and available routine data on the CHEW model and its implementation in the three local governments.

- Stakeholder and systems mapping of the actors involved in CHEW implementation and how they relate, from the national to the community level.
- Field-based learning and documentation with CHEWs, VHTs, health workers, supervisors, local government, community structures, private providers and service users.
- A focused analysis of how CHEWs relate to other cadres and structures, including role clarity, complementarity, duplication, supervision and referral.
- Analysis of strengths, adaptations, gaps and bottlenecks, distinguishing symptoms from underlying causes and prioritising by effect on performance and sustainability.
- Development of learning products, including case stories, a learning brief and an action matrix.
- Validation of emerging findings with the Ministry of Health, IDI and the local governments, and finalisation.

4. Approach and Methodology

This is a rapid learning and documentation activity, not an impact evaluation. The Ministry of Health and IDI do not prescribe a single methodology. Bidders are invited to propose and justify a mixed-methods learning design appropriate to the metropolitan context that can document the lived experiences of CHEWs, communities, supervisors, and local government and generate practical, transferable lessons. The final methodology, sampling approach and instruments will be refined and agreed during the inception phase.

Human-centred design and encouraged approaches

The Ministry of Health and IDI encourage bidders to consider human-centred design (HCD) methodologies, which place the experience of CHEWs and the communities they serve at the centre of the inquiry. Relevant HCD approaches include discovery and empathy research; journey mapping, for example, of the CHEW working day, the client care-seeking journey, or the payment and supply journeys; participatory co-design and sense-making sessions with CHEWs, supervisors and community members; and rapid prototyping and testing of practical improvements. Used alongside conventional inquiry, HCD helps surface why things work or fail in practice and produces user-informed, actionable learning.

Bidders may also draw on the following methods, offered as indicative rather than prescriptive, and may combine or adapt them:

- Documentary review of programme policy and design documents and any metropolitan-specific programme records held by the Ministry of Health, IDI and the three local governments.
- Qualitative inquiry, including key informant interviews, focus group discussions, in-depth interviews, and documented success or most significant change stories, spanning the full implementation chain.
- A light structured CHEW survey, for example, administered through a mobile data collection platform such as KoboToolbox, to provide indicative coverage measures.
- Structured observation of CHEW equipment, tools and, where appropriate and consented, community and facility activity.
- Secondary analysis of routine eCHIS, HMIS and DHIS2 data, was used descriptively and interpreted with caution.

- Learning harvests or sense-making workshops that bring stakeholders together to interpret emerging findings.

Analytical expectations

Whatever methods are chosen, the analysis should synthesise findings across the areas of inquiry set out in Section 5, triangulate across respondent types, local governments and evidence streams, and distinguish observable symptoms, such as absenteeism, dormancy or incomplete reporting, from their underlying root causes, such as a broken payment chain, an absent supervision tool or undelivered tablets, so that recommendations act on causes rather than effects. A simple synthesis of each domain, for example, a High, Moderate and Low rating triangulated against coverage measures, is welcome where it aids clarity.

Ethics, anonymization and safeguarding

Informed consent will be obtained from all respondents. All quotations and records will be anonymized: CHEWs, VHTs and community members will be identified by role and local government only, and senior or national roles by category, with direct personal identifiers removed. The activity will maintain confidentiality in sensitive service areas, and no data collection will occur in a manner that could expose clients or respondents. The relevant research and ethics clearances will be obtained where required. This will include clearance from the Uganda National Council for Science and Technology and a registered institutional review board, with evidence of clearance provided before fieldwork begins. Raw audio recordings and transcripts will be retained only for the duration of the assignment.

Limitations

The successful bidder will state the limitations of the chosen approach openly in the reporting. These are likely to include the trade-off between depth and triangulation and statistical representativeness in a rapid design, the treatment of service delivery observations as perceptions and indicative patterns rather than measured impact, and the need to confirm specific figures, dates, and names against local government records where transcripts derive from automated recordings.

5. Key Areas of Inquiry and Documentation Themes

The table below defines what the activity will document across twelve areas of inquiry, each corresponding to an established domain of the CHEW programme and adapted to the metropolitan context. The illustrative questions are indicative and will be refined into instruments during the inception phase.

Area of inquiry	Focus of documentation	Illustrative questions
Recruitment and selection	How CHEWs were identified, selected and validated, the extent of community involvement, and the application of eligibility criteria (O-level, one male and one female per parish, residence and VHT priority).	How does community-led selection work in urban divisions and informal settlements, and were CHEWs drawn from the VHT ranks?
Training and continuing development	The training model as delivered, covering duration, classroom, practicum, revision, facilitators and tool timing, perceived	Did training follow the six-month model, and how are refresher and continuing

Area of inquiry	Focus of documentation	Illustrative questions
	competence, and refresher and continuing development needs.	development needs being met?
Deployment, coverage and time allocation	How the two-per-parish design and the community-to-facility time split translate into divisions, wards, variable density, and coverage of dense, informal, and mobile populations.	Does deployment match population and density? What is the actual time split? What pulls CHEWs to the facility?
Scope of work and service package	The service package as actually delivered, covering malaria, immunisation and zero-dose tracing, HIV, antenatal and delivery referral, family planning and follow-up, and the clarity of the CHEW role.	How does day-to-day work compare with the defined package, and are CHEWs diverted into non-mandated tasks?
Equipment, commodities and supply chain	The standard kit and its functionality, maintenance and replacement arrangements, the commodities carried, and the community-level supply line.	What is functional, is there a maintenance system, and how reliable is resupply?
Reporting and digital systems	eCHIS functionality, including tablets, training, synchronization, data costs, feedback loops, and supervisor access to CHEW data.	Is eCHIS functioning and uniform, can supervisors view CHEW data, and do CHEWs receive feedback?
Supervision, performance and motivation	The supervision structure in practice, household-level coverage, the availability of a CHEW-specific supervision tool, and the drivers of motivation and performance.	Who supervises CHEWs, how often, and how adequate is household-level supervision?
Payment, financing and sustainability	The stipend and its reliability, the partner-to-government financing flow and absorption status, ring-fenced budget lines, and the effect on retention. Detailed costing is out of scope.	How reliable and timely is payment, what is the status of absorption, and is there a ring-fenced budget line?
Relationships and integration	The CHEW and VHT relationship and the funded position of VHTs; integration with facility staff (in-charges, nurses, midwives, clinical officers, records and laboratory teams) and recognition of CHEW referrals; and links with local government and community structures, including parish chiefs, Community Development Officers, town agents, and religious, market, school, youth and women's leaders.	How do CHEWs and VHTs relate, and are the wider local government and community structures engaged across the three local governments?
Private and informal providers	How CHEWs interact with private clinics, pharmacies, drug shops and informal providers that are prominent in the metropolitan area, and how these actors shape referral, care-seeking, community trust and continuity of care.	How do private and informal providers influence referral and care-seeking, and how do CHEWs engage with them?

Area of inquiry	Focus of documentation	Illustrative questions
Governance, coordination and ownership	Ownership and coordination across the three local governments, engagement of the wider administration, the replacement mechanism for CHEWs who leave, and asset accountability.	Who owns and coordinates the programme, and is there a mechanism to replace CHEWs who leave?
Community acceptance, equity and reach	Community acceptance and trust; the perceived contribution to care-seeking, referral, and prevention; and equity of reach for vulnerable and hard-to-reach groups in the metropolitan area.	How are CHEWs received across communities, and how equitable is the reach to informal settlements and mobile populations?

Cross-cutting lenses

Across all twelve areas the activity will apply three cross-cutting lenses: gender, including how the one male and one female design and workload play out for women and men CHEWs; equity, including reach to the metropolitan poor and hard-to-reach; and the urban dimension, that is, what is genuinely distinctive about implementing the CHEW model in a dense, mobile and privately served metropolitan environment, including informal settlements, rental households, markets, schools, workplaces and transport hubs, as against rural and mixed districts.

6. Deliverables

The firm will produce the following deliverables. All written deliverables will be provided in British English, in the agreed house style, and the technical and any financial submissions will be kept separate. The final report shall not exceed 40 pages. Payment will be linked to the approval of deliverables 1, 3, 4 and 6, with the detailed schedule set out in the separate contractual and financial documentation.

#	Deliverable	Description
1	Inception report and documentation plan	Refined approach, the area-of-inquiry framework, site and respondent selection, proposed methodology and instruments, analysis plan, ethics arrangements and work plan, submitted and approved before fieldwork.
2	Data collection instruments	The instruments appropriate to the proposed methodology, including interview and discussion guides, any survey instruments, observation checklists and the consent protocol.
3	Draft learning and documentation report	A full draft structured around the twelve areas of inquiry, with domain synthesis, documented practices and lessons, and prioritised recommendations.
4	Final learning and documentation report	The report revised to address feedback from the Ministry of Health, IDI and the local governments.
5	Learning products	A concise learning brief; a validation and dissemination presentation; and a set of documented case stories, including a narrative account of the emerging urban CHEW model.

#	Deliverable	Description
6	Validation and dissemination	Facilitation of a validation session with stakeholders and delivery of the final products and underlying anonymised datasets and transcripts.

7. Duration and Level of Effort

The assignment should be delivered over a period of at least 10 weeks. Bidders should propose a realistic work plan and level of effort covering inception, document and data review, field-based learning, analysis, validation and finalisation. The detailed budget and level of effort are provided separately, in line with the requirement that financial submissions be kept apart from the technical.

As indicative phasing only, and subject to refinement in bidders' proposals, the Ministry of Health and IDI anticipate approximately: 1.5 to 2 weeks for inception, document review and instrument design; 4 to 5 weeks for field-based data collection across the three local governments; 2 to 3 weeks for analysis and drafting; and 1 to 1.5 weeks for validation and finalisation. Bidders should adjust this phasing where their proposed methodology requires it

8. Proposal Evaluation Criteria

Technical proposals will be evaluated against the following indicative criteria and weights, with financial proposals scored separately and combined according to the procuring entity's standard formula: understanding of the assignment and quality of the proposed approach and methodology, including the use of human-centred design (30%); relevant experience of the firm or team in community health worker programmes and learning and documentation assignments in Uganda or comparable urban contexts (25%); qualifications and relevant experience of the proposed team against the roles in Section 9 (30%); and the realism and clarity of the work plan, staffing schedule and quality assurance arrangements (15%). Weights are indicative and may be adjusted by the procuring entity prior to the release of the request for proposals.

9. Team Composition and Qualifications

The activity requires a small, experienced team capable of combining community health systems expertise with strong qualitative, human-centred design and documentation skills. The indicative composition is set out below and may be adjusted to the final level of effort.

- **Team leader.** A senior public health or community health systems specialist with substantial experience in community health worker programmes, mixed methods learning and documentation, and stakeholder engagement at national and local government levels.
- **Qualitative, HCD and documentation specialist.** Experienced in qualitative inquiry, human-centred design methods, and the production of learning briefs and case stories.
- **Data and survey analyst.** Skilled in mobile survey design and descriptive analysis, and in working with routine eCHIS, HMIS and DHIS2 data.
- **Field research associates.** Familiar with the metropolitan context and, where relevant, the local languages of Kampala, Wakiso and Mukono, to support data collection.
- **Policy/Governance specialist.** Familiar with Uganda's decentralised local government structures and, specifically, with divisions, wards and cells and their relationship to KCCA, Wakiso and Mukono, to support the analysis of governance, coordination and ownership. This role may

be combined with the team leader or qualitative specialist role where a single individual holds both skill sets.

The team is expected to demonstrate familiarity with the national CHEW and community health policy framework, prior experience documenting community health Workers programmes in Uganda, and the ability to work sensitively in urban and informal settlement settings.

As indicative guidance only, the team leader and the qualitative, HCD and documentation specialist are each expected to bring a minimum of eight years of relevant experience; the data and survey analyst a minimum of five years; and field research associates a minimum of two years of field data collection experience. Bidders should propose the level of effort, in person-days, for each role against the phasing set out in Section 8.

10. Management, Coordination and Reporting

The firm will be contracted by, and report to, the designated officer at the Infectious Diseases Institute (IDI), which provides contracting and administrative support to the Ministry of Health, and will work under the technical guidance of the Ministry of Health, Department of Health Promotion, Education and Communication (DHPEC), in close coordination with the health teams of KCCA, Wakiso and Mukono. KCCA, Wakiso, and Mukono will support access to their health teams, facilities, CHEWs, and community structures, and will participate in field planning and the validation of findings relevant to their jurisdictions. A brief inception meeting will confirm scope, access and site selection, and regular check-ins will track progress against the work plan. IDI, in coordination with the Ministry of Health, will facilitate introductions to the local governments and access to relevant programme documentation.

11. Ethics, Data and Safeguarding

The activity will be conducted in accordance with applicable research ethics and data protection requirements. Informed consent will be obtained from all participants, all outputs will be anonymized, and the consultant will observe confidentiality in sensitive service areas. Ownership of the data, transcripts and outputs will rest with the Ministry of Health, and anonymised datasets will be handed over on completion. The firm will adhere to the safeguarding and child protection standards of the Ministry of Health and IDI.

Please share to: gnabwire@idi.co.ug

Submission deadline: **6th August 2026**