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Functionality and performance of COVID-19 taskforces in response to the pandemic in Uganda

David Musoke[1*], Micheal Jonga[1], Gloria Kisakye Ndagire[2], Benon Musasizi[2], Amanuel Gidebo[3], Asrat Tolossa[3], Maya Thomas[3], Peter Waiswa[1] and Richard Rumsey[2]

Abstract

Background In response to increasing COVID-19 community transmission in 2020, the Government of Uganda established the National Community Engagement Strategy. As part of this strategy, COVID-19 taskforces were recommended in response to the pandemic. However, the extent to which these taskforces supported their communities during the pandemic is not clear. This study assessed the functionality, performance and contribution of the COVID-19 taskforces to response to the pandemic in Uganda.

Methods A qualitative study was carried out that also involved functionality assessment of COVID-19 taskforces in 5 districts of Amuria, Karenga, Kamwenge, Bugiri and Pader. Twenty key informant interviews were conducted at national, district and community levels to gain insights on the COVID-19 taskforces. The data were analyzed by thematic analysis using the inductive approach with the support of NVivo version 12 pro (QSR International).

Results COVID-19 taskforces were created at national, district and village levels. Composition, surveillance and communication functions of COVID-19 village taskforce were best scored. A key feature of the COVID-19 taskforces was their multi-disciplinary and inter-sectoral composition. Coordination between the different taskforce levels particularly village, sub-county and district had gaps in communication and sharing of information. Parish level COVID-19 taskforces were either not functional or nonexistent. COVID-19 taskforces played different roles in response to the pandemic. At district level, the taskforces performed a more coordination role, mainly supporting planning and resource mobilization. However, the village taskforces were primarily engaged in interpersonal communication, awareness creation, and community mobilization for interventions including observing the standard operating procedures for controlling the pandemic.

Conclusion The COVID-19 taskforces at decentralized government levels supported the response to the pandemic. These taskforces could be strengthened and utilized during response to future outbreaks across the country.

Keywords COVID-19, Taskforces, Functionality, Performance, National Community Engagement Strategy, Uganda

*Correspondence:
David Musoke
dmusoke@musph.ac.ug
[1]Makerere University School of Public Health, Kampala, Uganda
[2]World Vision, Kampala, Uganda
[3]World Vision, Mississauga, ON, Canada

Introduction

COVID-19 remains a serious public health threat since it was declared a pandemic in March 2020 by the World Health Organization [1]. Globally, more than 770 million COVID-19 cumulative cases and nearly 7 million deaths have been reported as of 19th December 2023 [2]. The occurrence of more virulent variants compounds the current and future dilemma to eradicate the pandemic [3]. In addition, community complacency and fatigue in adherence to preventive procedures, as well as misinformation and anti-science movement are also of concern [4–7]. Owing to global disruptions in essential service delivery, systematic challenges in health systems were exposed, and governments needed to develop interventions to strengthen the resilience of their health systems [8, 9].

The Government of Uganda developed the National Community Engagement Strategy for COVID-19 in 2020 to address the challenge of rapidly increasing numbers of the virus at community level [10]. The COVID-19 pandemic affected the Ugandan health system with more than 170,000 cases and 3,600 deaths reported as of 23rd December January 2023 [11]. The strategy recommended establishment of village and subcounty taskforces to work closely with the one at district level. In the Ugandan context, villages are the lowest administrative unit, followed by parishes, then sub-counties, counties, and districts. Several villages make up a parish, several parishes constitute a sub-county, several sub-counties make up a county, and several counties constitute a district. At each level, there is a local council headed by a chairperson and comprised of other members that provide leadership on health and other matters. The strategy also defined the terms of reference for the taskforces at different levels of government. The district taskforces were charged with overall leadership, information and communication, supervision, enforcement, planning, resource mobilization, as well as monitoring and evaluation. However, the COVID-19 village taskforces were mandated to engage in community-based surveillance and case detection, community case management, contact tracing, shielding of vulnerable members, strategic information sharing and awareness creation, maintaining of village health registers, and responding to other health needs. Several implementing partners supported the Ministry of Health (MOH) and district efforts to establish and maintain functional village and subcounty COVID-19 taskforces across the country [12, 13].

The community engagement strategy was highly accepted among health sector actors that adopted its interventions to support the community response, such as training taskforce members and increasing the reach of COVID-19 behaviour change messages [12, 13]. For example, a non-government organisation reported having trained 2,000 village taskforces and reached 400,000 people [13]. Despite, rolling-out of the community engagement strategy, little was known about how much it contributed towards the response to COVID-19. A study that documented the experiences of COVID-19 district taskforces in Uganda established the managerial and leadership perspectives at that level [14]. However, there is hardly any evidence on COVID-19 taskforces at various levels including village, parish, sub-county, and district which were involved in preventing and controlling the disease. In addition, there was limited empirical research on the functionality, performance, effectiveness, sustainability, impact on health outcomes, and changes in intended behaviour related to the community engagement strategy. This study therefore assessed the functionality and performance of COVID-19 taskforces in Uganda to generate evidence to inform ongoing and future pandemic response interventions.

Methodology

Study design and participants

A qualitative study was conducted in 5 districts that employed key informant interviews (KIIs) at national, district and community levels. In addition, a scorecard was used to assess the functionality of the COVID-19 village taskforces. The study participants were selected from a categorised pool to ensure diversity of responses. The categories included members of the district health team, district executive, district COVID-19 taskforce, local council leaders, and community health workers (CHW) representatives. District health teams are comprised of technical officers who support health activities while the district executive includes political leaders. Local council leaders included committee members at village, parish and sub-county levels such as the chairperson. CHWs in Uganda are locally referred to as Village Health Teams and are volunteers who support health activities at community level. At the national level, participants were selected from the MOH and non-governmental organisations that supported response to the pandemic. All these stakeholders at the various levels had a role in response to the pandemic including planning, policy formulation, resource mobilization, and implementation.

Study area and setting

This study was conducted in the World Vision Uganda programme areas in the country that cover 18 districts. World Vision is an international non-governmental organisation that supports various activities in Uganda including in water and sanitation, maternal and child health, as well as community health. According to the Uganda Bureau of Statistics regional classification, these districts fall within 10 regions of Bukedi, Bunyoro, Buganda, Teso, Lango, Toro, Busoga, West Nile, Karamoja and Acholi [15]. For this study, 5 randomly selected

regions were Bukedi, Karamoja, Toro, Busoga and Acholi. The corresponding randomly selected districts from the 5 regions involved in the study were Amuria, Karenga, Kamwenge, Bugiri and Pader respectively. The 5 districts have varying land sizes, populations, number of households and main economic activities. Amuria has a land size of 950 sq km, a population of 270,928, and main economic activities of agriculture and livestock. Karenga has a land size of 7,223.70 sq km, a population of 51,533 and main economic activity of agriculture. Kamwenge has a land size of 2,439.40 sq km, a population of 270,668 and its main economic activities are agro-processing and commercial farming. Bugiri has a land size of 1,046 sq km, a population of 382,913 and main economic activity of agriculture. Pader has a land size of 3,362.50 sq km, a population of 178,004 and its main economic activity is agriculture [16].

Sampling and data collection

KIIs were conducted among various stakeholders (such as local leaders at village, parish and subcounty levels, members of district health teams, and MOH officials) to assess functionality and performance of COVID-19 taskforces. We conducted 3 KIIs per district, and 5 at national level hence a total of 20 KIIs which were sufficient to achieve data saturation. Data saturation was determined by the research assistants when no new information was emerging from the interviews. Study participants were selected purposively based on the role they played in response to the COVID-19 pandemic. The KII guide (see Supplementary file), developed for this study and translated to the various local languages (*Lusoga*, *Lutoro*, *Ateso*, *Acholi* and *Ngakarimojong*), collected information on COVID-19 taskforces including establishment, structures, roles and responsibilities, performance, contribution, and facilitation. All KII were conducted in the most spoken language in the local context. Indeed, the national level KIIs were conducted in English, while the district level KIIs were held in English or the local languages where applicable. The COVID-19 village taskforce functionality was assessed against the National Community Engagement Strategy prescribed roles and responsibilities against the pandemic. CHWs who were part of COVID-19 village taskforces were also interviewed. A scorecard was used to quantify the functionality of village COVID-19 taskforces. The scorecard measured functionality across 8 indicators of: composition of members of the taskforce; community-based surveillance and case detection; community case management including self-isolation, community-based drug distribution and referrals; community contact tracing; shielding of vulnerable members; strategic communication, creating awareness, information and education; and maintaining village health registers on households, data management and reporting. This scorecard was developed with reference to the national COVID-19 community engagement strategy [10]. For each of the indicators, a scale of 0 to 4 was used as follows: 0– none; 1– poor; 2– fair; 3– good; 4– very good. Data was collected by experienced research assistants who had bachelors degrees and were trained by the investigators (DM and MJ) for 2 days on the use of the research tools and qualitative research skills. The research assistants pre-tested the tools among comparable populations that spoke the same language as the respective study area.

In each district, the COVID-19 village taskforce functionality was assessed against 8 indicators. In each district, 3 stakeholders scored the functionality on a scale of 0 to 4 (given the highest score on the scale was 4, the maximum score for the eight indicators being 32). The stakeholders' score per indicator were averaged to get the functionality indicator average. The functionality indicator averages were summed to get the district averages. Lastly, the district COVID-19 village taskforce functionality average was expressed as a percentage of the highest score of 32 to estimate the district COVID-19 village taskforce functionality score.

Data management and analysis

The KIIs were audio recorded during the sessions. These recordings were then transcribed verbatim by the research assistants and translated to English (for those in the local languages). Once the transcripts were verified, analysis was done by thematic analysis using the inductive approach with the support of NVivo version 12 pro (QSR International). The analysis, which was done by MJ and DM who are experienced qualitative researchers, involved reading the transcripts several times to familiarize themselves with the data. Thereafter, words or related phrases from the transcripts were grouped together to form codes. Coding was done independently by the 2 researchers who later met and reconciled the codes. No other researcher was needed during the reconciliation of codes. Related codes were grouped to form sub-themes, and related sub-themes grouped together to form themes.

Ethical considerations

The study was approved by the Makerere University School of Public Health Research and Ethics Committee (SPH-2022-306) and the Uganda National Council for Science and Technology (HS2502ES). In addition, administrative clearance to conduct the study was obtained from the respective districts. All study participants provided written informed consent before they were involved. Anonymity was ensured during the study, and all data was handled confidentially. A modest

compensation was provided to the participants given their time commitment to the study.

Results

In addition to the functionality of COVID-19 village taskforces, other findings from the study are presented under 6 main themes: establishment of COVID-19 taskforces; roles and responsibilities of taskforces; performance of COVID-19 taskforces; support to COVID-19 village taskforce operations; contribution of COVID-19 taskforces; and community satisfaction with the performance of COVID-19 taskforces.

Functionality of COVID-19 village taskforces

Out of the 8 functionality indicators, the composition of village COVID-19 taskforces, surveillance, and communication were best scored in all the districts. The worst scored indicator was the involvement of the taskforces in COVID-19 case management (Fig. 1).

From the district COVID-19 village functionality score, Pader scored the best (87%) while Bugiri was the worst (52%) (Fig. 2).

Establishment of COVID-19 taskforces

The COVID-19 response was spearheaded by the national COVID-19 coordinating structures. An intersectoral committee for COVID-19 response was created under the Office of the Prime Minister championed by the President of the Republic of Uganda, in addition to other taskforces at lower administrative levels.

> *"We had structures at national level which included the national coordinating inter-sectoral committee for COVID-19 response under the Office of the Prime Minister directed by the President. We also had taskforces at the ministerial and district levels."* Key informant 1, national level policy maker

In most districts, COVID-19 taskforces were created at all lower levels, and the district taskforce comprised of the Resident District Commissioner as the chairperson of the taskforce, the Chief Administrative Officer acting as the secretary, and all heads of departments such as the District Health Officer, District Police Commander, and District Community Development Officer as members. The district taskforces also comprised of other stakeholders since it was a prerequisite to include individuals such as religious and cultural leaders in the COVID-19 response. At subcounty level, the taskforces comprised of the subcounty chief, all parish chiefs and local councils (I, II, III) chairpersons. At parish level, most districts had no taskforce created. However, village level taskforces were constituted comprising of the local council I committee members, CHWs, school representatives, religious leaders, health assistants, and other local stakeholders.

> *"We created taskforces at the district, subcounty, parish, and village levels, but those that were critical in the fight against COVID-19 were the 3 levels - here at the district, at subcounty, and at village levels."* Key informant 6, district level political leader

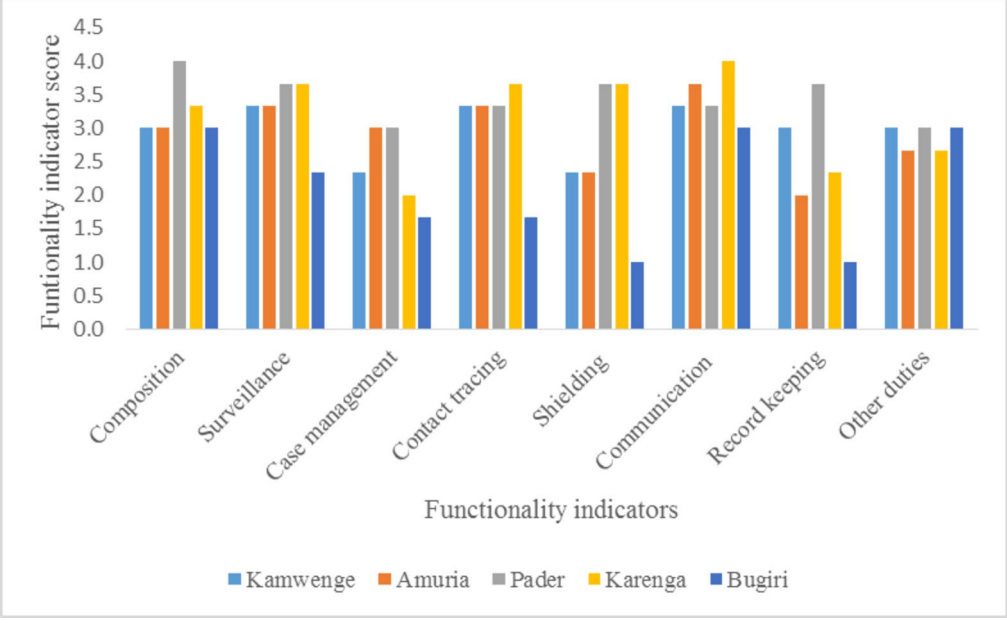

Fig. 1 Functionality of COVID-19 village taskforces per district

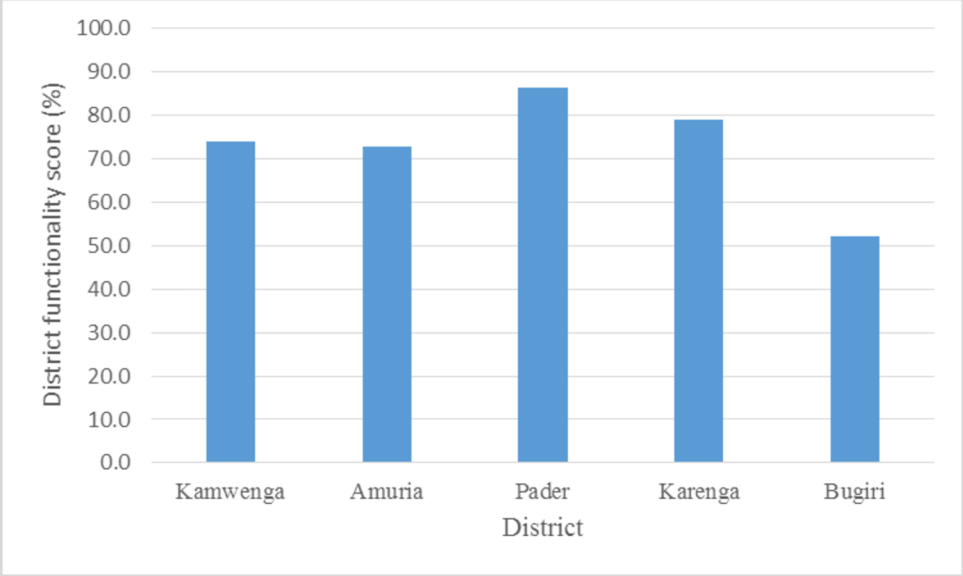

Fig. 2 District COVID-19 village taskforce functionality score, 2023

Coordination linkages among various taskforce levels were stronger between the subcounty and district. However, the link between village and parish level coordination was weak.

> *"So many times at village level, there were taskforces in place but with no similar committee at parish level, creating a weak link that may need to be strengthened in the future. However, the connection between subcounty and district level taskforces was stronger."* Key informant 2, national level policy maker

Roles and responsibilities of taskforces

The district taskforces carried out coordination of activities, and mobilized resources that supported the pandemic response such as procurement of logistics including fuel and personal protective equipment. The subcounty taskforces disseminated and distributed COVID-19 related policies, directives, aid and other resources to the lower local government administrative structures (parishes and villages). The subcounty chiefs were members of the COVID-19 district taskforces which strengthened the link between the district and lower administrative levels. The district COVID-19 plans were implemented at subcounty, parish and community levels. The various taskforces were involved in creating awareness and supporting adherence to standard operating procedures (SOPs) in institutions and the general community. The village taskforces were mainly involved in community implementation of COVID-19 SOPs through health promotion, advocacy, surveillance, mobilization for vaccination, and referral of suspected cases.

> *"Our role as a COVID-19 taskforce was to share information on preventing the disease. We took messages to the people and also shared on radio talk shows. We lobbied for protective wear to be made available in the health facilities, and arranged for referral of patients to higher level facilities for management."* Key Informant 14, district level implementer

The village taskforces and CHWs filled the gap of interpersonal communication between the community, MOH and other partners. This role supported culturally appropriate risk communication that enhanced understanding of the disease and better adherence to the SOPs. Face-to-face engagement of community members was particularly highlighted as a key approach used to share information about COVID-19.

> *"We were also charged with the responsibility of creating awareness because we used a number of approaches such as mass media, radios, and TV but we needed person-to-person engagement where one could ask questions about what they don't understand and another person must respond. That is where community health workers played a role in the pandemic under the village COVID-19 taskforces."* Key informant 4, national level policy maker

Performance of COVID-19 taskforces

The role of COVID-19 taskforces in response to the pandemic was evident. The taskforces supported and contributed to utilization of health services including COVID-19 vaccination. It was noted that the response to COVID-19 would have been challenging without

community structures such as the village taskforces that supported implementation of the SOPs.

> *"I think it is evident that we cannot fight epidemics without working with these [local government] structures. Government and other development partners need to heavily invest in all efforts geared towards promoting health at community level. We can't promote health if we do not engage or have some of these key community structures fully on board with us."* Key informant 5, national level policy maker

Stakeholder assessment of the performance of the COVID-19 taskforces was generally good. Most stakeholders noted that the taskforces were active right from when they were established. The COVID-19 taskforces took collective responsibility to perform their roles to ensure that the pandemic was controlled. Some of the key stakeholders testified that the level of collaboration exhibited among various players in response to COVID-19 was high. Some examples of high performance were in form of attendance of COVID-19 taskforce meetings, and the high turn up for vaccination and testing which contributed to the low COVID-19 morbidity and mortality in certain areas.

> *"I can say their [COVID-19 taskforces] performance was very good. They were active and people took up their roles and responsibilities seriously which helped us to curb the spread of the disease. Our performance as a district became good because members of the taskforces were active, and we achieved a lot during response to the pandemic."* Key informant 14, district level political leader

Support to COVID-19 village taskforce operations

Monetary and non-monetary incentives were provided to motivate the COVID-19 village taskforces including CHWs. It was established that government made a one-off payment of approximately 30 US dollars to COVID-19 village taskforce members. In addition, approximately 90 US dollars were provided to CHWs as facilitation for social mobilization during the 3 rounds of COVID-19 mass vaccination. Non-monetary incentives including health educational and promotion materials, and CHW kits were provided to some CHWs, while others received megaphones. The CHW kit was comprehensive and contained several items such as a thermometer, pulsimeter, masks, aprons, gumboots, torch, t-shirt, and reading mat.

> *"As Ministry of Health, we were able to give community health worker toolkits as a form of non-monetary incentive. The toolkit had a number of things such as masks, gumboots, torches, educational materials and reporting tools, t-shirt, bag and medicine box."* Key informant 5, national level policy maker

In addition to MOH, implementing partners also supported COVID-19 interventions. The support was offered in the form of bags, thermometers, village health registers, reporting forms, gumboots, umbrellas, first aid kits, and allowances. Partners also supported the formation and activation of subcounty and village taskforces including training, as well as direct financial support to the district and subcounty taskforces. Uniforms for CHW identification were provided by some partners, as well as support to integration of COVID-19 services in routine programmes at health facilities was offered.

During implementation of COVID-19 activities, most members of the taskforces faced challenges majorly related to transportation and facilitation from the government which they mentioned was insufficient. It was noted that transport was a major problem during lockdown because public transport was not operating which made work of the village taskforces challenging.

> *"Much as the Community Health Workers and village taskforce members would have loved to go to the very last corner of their communities, it was challenging to them in terms of logistics especially transportation particularly during the lockdown hence not everyone was reached."* Key informant 6, district level implementer

Contribution of COVID-19 taskforces

National level stakeholders appreciated the contribution of lower-level structures in the COVID-19 response. The village COVID-19 taskforces were instrumental in awareness raising, building trust, and supporting home-based management of mild cases. The taskforces were also credited for taking responsibility to protect their communities from COVID-19 through active surveillance and contact tracing.

> *"Empowered communities have a strong potential to transform health and we saw areas own responsibility for ensuring that their health is protected during the pandemic through existing local structures."* Key informant 2, national level policy maker

District level key informants also highlighted that the taskforces greatly contributed to the prevention and control of the pandemic including the support offered to community members at all levels. The biggest achievements of COVID-19 taskforces were registered in social mobilization for interventions such as vaccination

and awareness creation, case detection, and referral of patients to health facilities.

> *"Some of the biggest contributions of the committees were mobilizing the masses for interventions, creating awareness that the disease is real and the mode of spread including preventive strategies especially handwashing and using face masks. Mobilizing for vaccination, directing people where they could get treatment, and demystifying myths regarding vaccination were also supported by the taskforces."* Key informant 6, district level implementer

Community satisfaction with the performance of COVID-19 taskforces

It was noted that most community members were satisfied with the COVID-19 taskforces. This was exhibited in terms of involvement in service delivery and participation in response activities such as surveillance. It was established that there was generally equitable distribution of COVID-19 response packages and necessities such as food, masks, travel permits and funds in the various districts. Thus, there was appreciation for the role of the COVID-19 taskforces in this process.

> *"I do not think there was any discrimination while giving out these travel permits because I can be a witness that whoever needed one was given but it had to be for genuine reasons. Not just because one wanted to move, but you had to give a good reason why you needed the permit."* Key informant 15, district level political leader

However, it was also stated that the community detested the enforcement of strict curfew rules that were supported by the taskforces and enforced by security personnel particularly the military and police. In addition, dissatisfaction was seen when services were delayed, unavailable, or involved lengthy procedures such as getting travel permits. Community members were also dissatisfied when initial vaccination was limited to only certain categories of people such as health workers, teachers and security personnel.

> *"There was dissatisfaction when the vaccination started and a certain category of people was selected and yet the community was ready to be vaccinated. If you were not a health worker, teacher or police officer, you could not get vaccinated yet community members wanted to benefit from the intervention at the time as well."* Key informant 14, district level implementer

Discussion

The study examined the functionality and performance of COVID-19 taskforces at different administrative levels in Uganda. Findings indicated that the taskforces were well-established and present across the study districts, with strategic leadership and support from the government. However, coordination and communication gaps were identified, particularly between different levels especially parishes. The roles of the taskforces varied, with national, district, and village taskforces playing distinct roles in the pandemic response. The study emphasized the critical role of community health systems, as well as the challenges faced by taskforce members, including limited facilitation and inadequate incentives. Furthermore, community members appreciated the taskforces' contribution to controlling the pandemic but expressed dissatisfaction with certain measures and access to services during lockdowns. The study highlighted the importance of coordination, performance monitoring, and community engagement to enhance the effectiveness of taskforces and improve service delivery outcomes. The findings from this study could inform strengthening of the existing structures for future outbreak response in Uganda.

The COVID-19 village taskforce functionality indicators were highly scored, and there was consistency of the scores across the study districts. The study established that COVID-19 taskforces were created nationally and at lower administrative levels of government particularly district, subcounty and village. A key feature of the COVID-19 taskforces was their multi-disciplinary composition. The strategic leadership of the government including the President's office and his representatives at the district (Resident District Commissioners) supported the establishment of the COVID-19 taskforces and shaped response at the various levels. The swift action to set up taskforces embodied in the power of leveraging executive authority has been shown to greatly support health programmes as it requires minimal funding and facilitates rapid action. Taskforces provide a quick and powerful framework to organize cross-sectoral human capital around a policy problem [17]. A study conducted in Uganda that focused on the contribution of district taskforces to the COVID-19 response found similar results regarding the establishment and existence of structures at district and lower administrative levels including the villages [15]. In addition, the study found that local governments were quick in establishing COVID-19 taskforces [15]. A study on the Nigerian presidential taskforce on COVID-19 shows that despite the many health system requirements, the taskforce was critical in mobilizing, coordination, and implementation of early mitigation measures [18].

The coordination between the different taskforce levels had gaps in communication and information sharing beyond referral support. The study established that parish level COVID-19 taskforces were either not functional or non-existent. Another study in Uganda elaborated that coordination and communication affected the district taskforces and central government, with examples of line ministries directly implementing interventions in the districts without any communication with the respective taskforces [14]. Inadequate coordination in low- and middle-income countries has been attributed to weak institutions, limited resources, overreliance on external actors, and limited capacity [19]. The extent to which these factors contributed to the communication gaps and non-functional structures was beyond the scope of this study. However, good coordination is generally considered an important factor in the success of complex problem solving including in pandemic response [20]. It is therefore important that coordination and communication of COVID-19 taskforces across various administrative levels is strengthened in any future response to the pandemic or other outbreaks in Uganda.

The different levels of COVID-19 taskforces played various roles during response to the pandemic. The national level taskforces provided strategic leadership and guidance to the COVID-19 response including the development of the national community engagement strategy. The district level taskforces played a more coordination role including planning and resource mobilization, whereas the village taskforces were engaged in interpersonal communication, awareness creation, and community mobilization. The roles played by the different taskforces are in line with the national community engagement strategy for COVID-19 response as established by the Government of Uganda [10]. The definition and clarity of the roles and responsibilities across the different levels of the taskforces is crucial for performance [21, 22]. CHWs, who were part of the village COVID-19 taskforces, are known to strengthen inter-sectoral collaboration in community-based service delivery through linking various health services to the communities they serve [23]. The aim of the national CHW strategy envisions empowering communities to take part in decisions that affect their health which was seen during response to the pandemic [24]. Indeed, CHWs were instrumental in supporting the delivery of COVID-19 village taskforce roles and responsibilities.

The COVID-19 taskforces received financial and in-kind support from the government and implementing partners. The quality and quantity of support varied depending on the budget of the provider. The government provided some support, while implementing partners, especially in terms of in-kind assistance, provided more. This situation is not surprising since implementing partners focus on specific regions, while the government with limited resources allocates budgets at national and centralized level, resulting in delays and modest funding. Historically, CHWs are poorly incentivized as their role is based on volunteerism in many contexts including Uganda [25, 26]. Our results are consistent with experiences of facilitation for CHWs globally. Support to CHWs around the world during the pandemic included training, provision of personal protective gear, and some financial support. Furthermore, the support was reported to vary between countries, cadres, and individual CHWs [27]. It was observed in our study that taskforce members faced numerous challenges due to limited facilitation, such as transportation. Facilitating frontline workers is a critical aspect of their functions and essential for the effectiveness of their contribution to public health programmes, particularly in outbreak responses. Studies have indicated that the performance of CHWs can be achieved through non-financial incentives [28, 29]. However, motivation of CHWs during the pandemic response has not been fully explored. It is imperative to establish how to optimize motivation and incentives for CHWs and other members of taskforces considering the risks involved in outbreak response. Preparedness plans need to incorporate incentive packages for frontline workers as a key pillar in strengthening the resilience of community-based preparedness and response systems.

Community members appreciated the role of COVID-19 taskforces and their contribution to the pandemic. However, some individuals expressed dissatisfaction with the strict enforcement measures of curfews and lockdowns that the taskforces supported. As each individual had unique needs and expectations, experiences with service delivery outcomes during the pandemic are expected to vary. Public satisfaction is a crucial indicator that measures the level of service quality delivered by an institution [30]. Scholarly evidence indicates that satisfaction is a critical balance between service users' expectations and perceived performance [31]. Different lockdown measures imposed limitations on mobility, and created barriers to accessing services due to lengthy approval and permit processes, thus contributing to dissatisfaction with the government's perceived performance. A study from Indonesia revealed that most participants were not satisfied with the performance in managing COVID-19 cases including the existing local structures. They perceived that the government could have done better work and come up with improved policies and guidelines related not only to health but also other affected sectors [32]. Our study did not evaluate community satisfaction from the service user perspective but self-assessment of the COVID-19 taskforce members. Future studies could engage service users through group discussions among

the community to provide insights from the perspective of the general population.

It is important to note that our study was limited to the regions where World Vision Uganda operates. Therefore, the findings do not represent the experiences of all COVID-19 taskforces across the country. In addition, service users including community members were not involved in the study hence could be considered for future studies. Nevertheless, the findings provide insights that may be used to design interventions for responding to outbreaks in Uganda. In addition, 5 districts across 5 regions of the country were involved which is a strength of the study.

Conclusions

COVID-19 taskforces were established at various levels and played a significant role in response to the pandemic including surveillance and risk communication. However, the taskforces faced several challenges such as limited incentives to support their roles and responsibilities during response to the pandemic. These taskforces could be strengthened and utilized to support response to future outbreaks across the country.

Abbreviations

CHWs Community health workers
KIIs Key informant interviews

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12585-0.

Supplementary Material 1.

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Authors' contributions

DM, GKN, and PW conceived of the study. MJ wrote the first draft of the manuscript. DM, MJ, GKN, BM, AG, AT, MT, PW and RR were involved in data analysis, interpreting results, and manuscript writing. All authors read and approved the final manuscript.

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Data availability

The datasets used during the study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Ethical approval to conduct the study was obtained from the Makerere University School of Public Health Research and Ethics Committee (SPH-2022-306). The study was also registered at the Uganda National Council for Science and Technology (HS2502ES). Written informed consent was obtained from all participants in the most appropriate language understood before they took part in the study. Anonymity was ensured during the study, and all data was handled confidentially. A modest compensation was provided to the participants given their time commitment to the study.

Consent for publication

Not applicable.

Competing interests

DM is an Editorial Board Member of BMC Health Services Research. All other authors do not have any competing interests.

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