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Strengthening Primary Health Care through Community Health Workers:

Closing the \$2 Billion Gap

IN PARTNERSHIP WITH:

Financing Alliance
for Health

From CII's Investing for Impact Series

USAID's **Center for Accelerating Innovation and Impact (CII)** takes a business-minded approach to fast-tracking the development, introduction and scale-up of health interventions that address the world's most important health challenges. CII invests seed capital in the most promising ideas and novel approaches, using forward-looking business practices to cut the time it takes to transform discoveries in the lab to impact on the ground.



The **Financing Alliance for Health (FAH)** supports governments to advance health goals by understanding costs and examining alternative financing such as taxation, insurance, earned income, partner support, and other approaches. The goal is to tailor, with each country, the appropriate mix of funding, creating a sustainable cadre of well-trained, paid community health workers. The FAH works closely with AMP Health, which works with ministries of health to strengthen management and leadership capacity for community health.

Financing Alliance for Health

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Community health is a critical component of strong health systems and is essential to achieving universal health coverage and meeting the United Nations Sustainable Development Goals (SDGs). In 2015, **Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations** made a powerful economic and impact case for investing in community health, outlined principles for building strong community health platforms, and presented a pathway to sustainably financing those platforms. Following up on that report, we are delighted to present **Closing the \$2 Billion Gap**, which strengthens the knowledge base around the need for community health financing and draws lessons from two unique examples—Zambia and Ethiopia—on financing pathways to secure additional resources. A forthcoming report will demonstrate how innovative financing can be used to close the financing gap.

Community health is severely underfunded. In this report, we present a new analysis estimating a \$2 billion funding gap for community health in sub-Saharan Africa. We also examine the political commitments, structures, and processes needed at the country level to close that gap, drawing on lessons learned from Ethiopia and Zambia on how to mobilize funding, increase resource efficiency, and build strong, integrated community health platforms. Many of these lessons apply not only to community health but also more broadly to health financing.

USAID's Center for Accelerating Innovation and Impact and the Financing Alliance for Health are both committed to building the knowledge base on community health financing to support all stakeholders in strategy development and resource mobilization. **We recognize that community health platforms and financing are most effective when they are part and parcel of broader human resources for health and health systems strengthening efforts and when they encourage integration and alignment of community health financing with broader health system priorities, plans, and budgets.**

The global health community has an opportunity to accelerate growing momentum toward integrated community health platforms. We hope that our findings will help governments, donors, and other partners develop and strengthen country-level financing pathways for community health to unlock the economic and social returns that strong, integrated community health platforms promise.

Sincerely,



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DEFINITIONS

Community health – Delivery of promotive, preventive, and basic curative health services that occurs at the community level, i.e., outside a facility setting. (May include care delivered by health posts, depending on a country's health infrastructure.)

Cadre – A group of community health workers with a certain set of responsibilities. (Many countries have multiple cadres.)

Financing pathway – The process a country takes to mobilize resources for community health, and the combination of different funding sources used over time to finance a community health system. A financing pathway and steps along that pathway serve as inputs to (and are summarized in) an investment plan.

Integrated – Explicitly and intentionally linked to and working in tandem with a national health care system and strategy (in community health as well as more broadly) and working across disease priorities.

Investment plan – A document summarizing a community health strategy, associated costs, expected returns on investment, existing resources to support the strategy, and potential additional financing sources and strategies. This document can be used to engage funders to advocate for and secure resource commitments.

Horizontal interventions – Programs whose goals and activities cut across multiple health or disease priorities.

Vertical interventions – Programs focused on specific health or disease priorities, e.g., HIV/AIDS, tuberculosis, maternal health.

IMCHW – One Million Community Health Workers Campaign

CBV – community based volunteers

CHW – community health worker

CHA – Community Health Assistants (Zambia)

CHAI – Clinton Health Access Initiative

CII – USAID's Center for Accelerating Innovation and Impact

DAH – development assistance for health

DFID – Department for International Development (UK)

FAH – Financing Alliance for Health

GAVI – The Vaccine Alliance

GRZ – Government of the Republic of Zambia

HDA – Health Development Army (Ethiopia)

HEP – Health Extension Program (Ethiopia)

HEW – Health Extension Worker (Ethiopia)

HRH – human resources for health

iCCM – Integrated Community Case Management of diarrhea, pneumonia, and malaria

IHP+ – International Health Partnership

MCDMCH – Ministry of Community Development, Mother and Child Health (Zambia)

PM – Prime Minister

SDGs – United Nations Sustainable Development Goals

UHC – universal health coverage

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNFPA – United Nations Population Fund

USAID – United States Agency for International Development

WHO – World Health Organization

USAID's Center for Accelerating Innovation and Impact and the Financing Alliance for Health estimate that an additional \$2 billion is needed annually to build and strengthen community health systems in sub-Saharan Africa. Investments in community health are required to meet global health objectives, produce significant long-term returns, generate short-term cost savings, and deliver further benefits to society, including employment opportunities and women's empowerment. Despite the strong investment case and potential for impact, current funding lags. Significant additional investment is needed to build strong, integrated community health programs across the continent.

Current annual expenditures of \$1.1 billion on community health in the region, while insufficient, could be more efficiently spent. Much of the existing funding supports vertical, disease-specific community health worker programs, despite strong evidence for the efficacy and cost-effectiveness of integrated horizontal platforms. Integrated horizontal programs offer cost-saving opportunities compared to vertical programs, which are often duplicative and run in parallel to government health systems. Integrated horizontal programs can also be more effective, as they build community trust and demand for health services. Yet roughly less than 40 percent of community health funding today supports the salaried, integrated, horizontal cadres known to be the best investments.

Existing funding is heavily donor-dependent. An estimated 60 percent of current community health funding comes from donors. As donor health dollars are increasingly stretched, and as many African countries transition to middle-income status and thus away from aid, the need for new financing sources—from private sector partnerships to increased tax revenue to innovative financing mechanisms—becomes even more pressing.

Meeting the need for community health financing in the most efficient way possible will require governments (supported by donors and implementing partners) to work across a financing pathway. The Financing Alliance for Health has identified key steps in a country's process to mobilize financing for an integrated community health approach, and research in Ethiopia and Zambia highlights lessons learned across this financing pathway. These insights can help countries create the conditions required for strong, integrated, sustainably financed systems.

- **Political prioritization:** Mobilizing political will is both a prerequisite for initiating a community health system and an ongoing requirement for sustaining it. Diverse champions can use tailored advocacy to build support for community health across stakeholder groups, making the case through a focus on return on investment, cost efficiency, and health impact.
- **Strategy, policies, and costing:** Planning for the integration of community health programs into the broader health system is critical, as is determining the appropriate means of horizontal integration based on local context.
- **Resource mapping and identification:** Domestic government resources and flexible start-up funds from donors are two high priority and high leverage funding sources that can unlock further investment in community health.
- **Investment plans:** Strong investment plans include clear strategies for scaling up domestic resources and transitioning away from donor funds over time.
- **Operational enablers:** A team with a clear responsibility and dedicated capacity for community health, e.g., a community health directorate, can play a critical role in leading the financing mobilization process. Coordination bodies can make it easier to align funding and strategies across actors.

THE CASE FOR COMMUNITY HEALTH

Integrated community health platforms are the backbone of the health care system. In the context of shortages in human resources for health (HRH) across sub-Saharan Africa, community health workers (CHWs) have emerged as a critical platform for accelerating progress on health goals. CHWs are on the front lines of surveillance against emerging infectious threats like Ebola. They are among those most well positioned to engage communities in preventive and promotive health activities, such as the use of bed nets and family planning, and to support home-based management of the growing burden of chronic diseases. CHWs are a relatively low-cost way to extend health services to the hardest-to-reach communities. Of course, investments in community health must be a part of broader efforts to strengthen health systems and fill HRH gaps at all levels. When well-integrated with the national health strategy, community health workers serve as an entry point to, and interface with, the broader health system for many. They are most effective when the system is well-resourced and functioning well.

The Financing Alliance for Health's (FAH) 2015 [Investment Case and Financing Recommendations](#) articulates four overarching reasons to support community health:¹

1. **Community health workers are a necessity if sub-Saharan Africa is to achieve critical global health objectives.** Achieving the United Nations Sustainable Development Goals (SDGs), universal health coverage (UHC), and disease elimination targets depends on frontline health workers who can deliver services to the last mile. The Joint United Nations Programme on HIV/AIDS (UNAIDS), for example, recently called for the scale-up of community health worker programs to meet 90-90-90 targets for HIV.^{2,3}
2. **Community health workers offer significant long-term return on investment (ROI).** FAH analysis shows a 10:1 ROI for investments in community health, driven by increased productivity from a healthier population, avoidance of future global health crises, and increased employment.
3. **Community health offers near-term and longer-term cost savings to the health system, which can be redirected to finance system scale-up.** Community health is shown to be more cost-effective than facility-based care across a range of interventions, including vaccinations, neonatal care, family planning, plus specific interventions for malaria, HIV/AIDS, and tuberculosis.⁴ Shifting these services to CHWs would save money and relieve pressure on overburdened nurses and doctors in health facilities, freeing up their capacity to address more complex health concerns.
4. **Community health has far-reaching benefits for society.** From empowering women to reducing patient out-of-pocket travel and health services costs to filling civil registration data gaps, CHWs impact more than a community's health.

¹ Financing Alliance for Health, Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations (2015).

² 90-90-90 targets refer to the goal that by 2020, 90 percent of all people living with HIV will know their HIV status, 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy, and 90 percent of all people receiving antiretroviral therapy will have viral suppression.

³ UNAIDS, 2 million African community health workers (2017).

⁴ See FAH (2015), p. 7, for a summary of the evidence base comparing community health workers to facility-based delivery across a number of health interventions.

THE BENEFITS OF INTEGRATION

Community health workers are a good investment—and an even better investment when they deliver a broad suite of health services across disease areas. Given their relatively low cost, ability to reach the last mile, and strong links to the community, CHWs have historically delivered a number of targeted services, including HIV screenings, tuberculosis treatment monitoring, and maternal care. In the short term, vertical CHW cadres can effectively scale up prevention, diagnosis, and treatment of an urgent health concern. However, a proliferation of vertical cadres, often working in siloes and in parallel to national health systems, has led to widespread inefficiency.

The true value of community health can only be unlocked through investment in “horizontal” community health platforms that integrate a broad suite of health interventions across verticals and integrate with the national health strategy and system. These integrated platforms can be both more efficient and more effective than today’s widespread vertical cadres. (See Figure 7 in the Annex for more detail on opportunities for cost savings through integration.)

MORE EFFICIENT

- **Duplication of efforts.** One study found eight cadres delivering ARTs in Uganda;⁵ some villages in Swaziland and South Africa are HIV tested multiple times, while others receive no services⁶
- **Missed cost-efficiency opportunities.** Vertical cadres don’t share training, overhead, supervision, procurement, or delivery costs⁷
- **Potential for greater cost-effectiveness.** A Uganda study found integrated treatment of malaria and pneumonia more cost-effective (greater impact/dollar) than a standalone, vertical malaria program⁸

MORE EFFECTIVE

- Giving CHWs **responsibilities across disease areas**, with appropriate training and workload management, does not decrease effectiveness⁹
 - **Malaria treatment rates were 112 percent higher** among programs that treated malaria plus two other illnesses (vs. one illness)¹⁰
- A single, repeated interface with a CHW can **foster trust and build demand** for health services
 - In Mozambique, multiple vertical cadres led to **community confusion and poor perception of CHWs**¹¹
 - Districts in Uganda with iCCM programs saw a **21 percent increase in fever care seeking** (vs. those without integrated programs)¹²

⁵ Hermann et al., CHWs for ART in SSA (2009).

⁶ De Neve et al., Harmonization of CHW programs for HIV, narrative review and four country qualitative study (2017).

⁷ See Figure 7 in Annex for more information on opportunities for synergy.

⁸ Matovu et al., Treatment costs for community-based management of malaria and pneumonia (2014).

⁹ Eg., in Tanzania, HIV-focused CHWs were able to add MNCH tasks, suggesting spare capacity in vertical programs. In Rwanda, a horizontal cadre was able to incorporate family planning services without adding time to their workload. Shelley, CHW role expansion in Iringa, Tanzania (forthcoming); Chin-Quee, Balancing workload, motivation, and job satisfaction in Rwanda (2016).

¹⁰ CCM Central, Benefits of Integrating Malaria Case Management and iCCM (2015).

¹¹ Simon et al., An integrated approach of community health worker support for HIV/AIDS and TB care in Angónia district, Mozambique (2009).

¹² Evaluation of iCCM in Uganda (2014), draft, as cited in iCCM Financing Task Team, Benefits of Integrating Malaria and iCCM, draft (2015).

Building strong, integrated community health systems in sub-Saharan Africa will require an additional \$2 billion investment annually. Despite the visible benefits of community health, investment is lagging. There is a clear opportunity to provide additional, more efficient, and more sustainable funding to achieve the transformative impact on health systems that community health workers are poised to deliver.

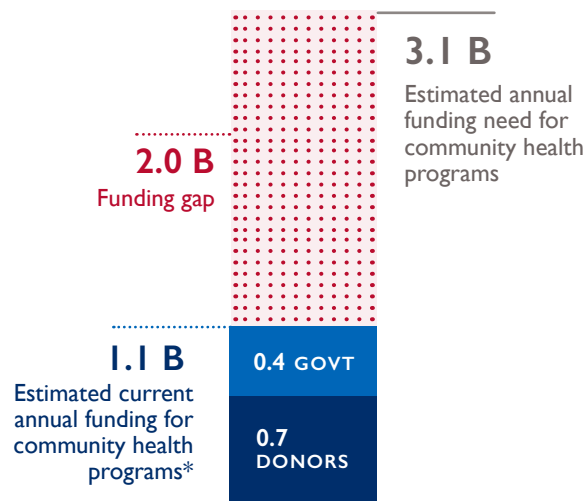
ESTIMATING THE SHORTFALL

The Earth Institute and the One Million Community Health Workers Campaign (IMCHW) campaign estimated that, as of 2015, it would cost roughly \$3.1 billion annually to sustain a fully scaled, integrated CHW system in sub-Saharan Africa.^{13,14} More recent analyses suggest even higher figures, given Africa's growing population and health workforce needs.¹⁵

New analysis presented in this report reveals that current funding for community health in sub-Saharan Africa falls short of this need. (Figure 1). (See Annex for more detail on methodology.) While that number is

an approximate directional estimate and not a precise figure—but includes an estimate of both domestic government and donor expenditures—it represents only 8 percent of total development assistance for health (DAH) from donors. By comparison, donors and domestic governments spent an estimated \$19.1 billion on HIV/AIDS interventions in low- and middle-income countries in 2016, largely in sub-Saharan Africa.¹⁶ Collectively, the global health community must nearly triple its investment in community health to build the strong systems needed around the world.

FIGURE 1: Estimated annual funding to community health in sub-Saharan Africa (\$B)



* Govt/donor split based on 60/40 ratio between donor and non-donor sources of funding for primary healthcare in 12 SSA countries. Source: Institute for Health Metrics and Evaluation (IHME), Financing Global Health Database; IMCHW report; Wang and Maele, Primary Healthcare Expenditure Analysis (2017); Dalberg analysis.

¹³ This analysis implied a cost of roughly \$3,000 per salaried horizontal community health worker, a figure in line with country-level costing data.

¹⁴ Earth Institute/IMCHW campaign, One Million Community Health Workers, Technical Task Force Report (2013).

¹⁵ UNAIDS (2017).

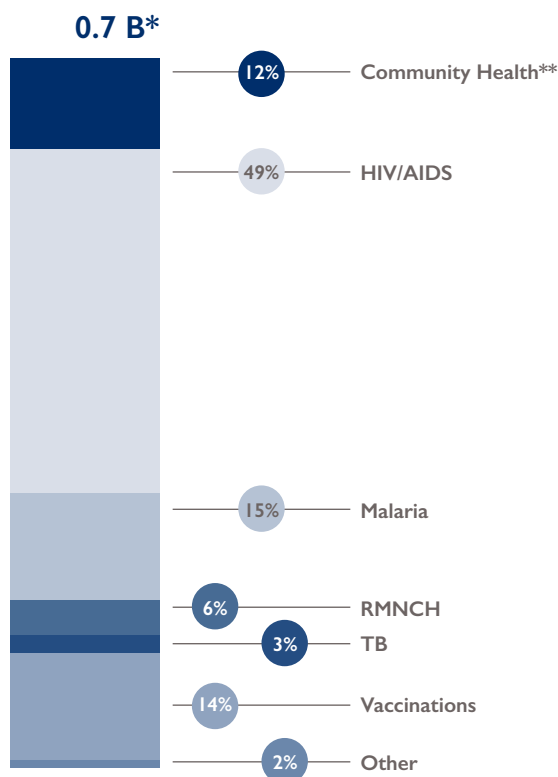
¹⁶ AVERT, Funding for HIV and AIDS (2017).

INCREASING EFFICIENCY

While significant new resources need to be mobilized, more can be done with the funds already allocated to community health. As discussed above, integrated

horizontal cadres are the most effective and cost-efficient means of delivering community health care. In addition, multiple studies have shown that monetary incentives are critical to success: salaried CHWs are better connected to the health system and more effective vehicles for health delivery.¹⁷ Yet most

FIGURE 2: Estimated annual donor funding used for community health in SSA by primary health focus of grant (\$B)



(*) Based on \$1.1B estimate for total CH spend and 60/40 ratio of donor to domestic spend on primary healthcare across 12 SSA countries. (**) Includes vertical grants that were targeted 100% for CH activities (vs. grants that have a community health component), so might actually be an overestimate. Source: Institute for Health Metrics and Evaluation (IHME); Financing Global Health Database; Wang and Maele, Primary Healthcare Expenditure Analysis (2017); expert Interviews, Dalberg analysis.

community health funding continues to flow through disease verticals (Figure 2), and less than 40 percent of estimated funding today supports fully salaried, government-owned cadres (Figure 3).

The vertical nature of a great deal of community health funding contributes to inefficiency. A majority of donor funding for community health comes through grants for specific disease priorities—primarily HIV/AIDS (Figure 2). Many grants support parallel cadres focused on singular disease priorities, thus missing opportunities to capture cost efficiencies and maximize effectiveness. Even when disease-specific grants do support government-led horizontal cadres, limited coordination across donors and partners can lead to duplicative or inefficient use of resources, e.g., multiple overlapping trainings for different priorities.

There is growing momentum for funding integration among countries and donors alike, both in community health and, more broadly, in global health. A recent study found consensus among policymakers and practitioners in South Africa, Swaziland, Lesotho, and Mozambique on the value of more harmonized systems.¹⁸ Beyond community health, UHC 2030 and the Global Financing Facility, among others, are championing more integrated approaches to strengthening health systems, including for funders.¹⁹ Donors and domestic governments have an opportunity to build on this momentum and increase the efficiency of their expenditures by making coordinated investments in integrated community health systems.

As funders shift toward integration, there is also an opportunity to allocate funds to more effective programs. CHW programs today vary widely in quality; many do not have the proper incentives and structures in place to reach their potential effectiveness. The majority of existing CHWs are either volunteers receiving no pay or semi-compensated cadres who receive some stipend, per diem, or performance-based remuneration but no salary.

¹⁷ Kok et al., Which intervention design factors influence performance of CHWs in low- and middle-income countries? A systematic review (2015); Pallas et al., CHWs in low- and middle-income countries: What do we know about scaling up and sustainability? (2013); Zulu et al., Integrating national community-based health worker programmes into health systems: a systematic review identifying lessons learned from low- and middle-income countries (2014); Smith et al., Task shifting and prioritization: a situational analysis examining the role and experiences of CHWs in Malawi (2014), and Kok and Muula, Motivation and job satisfaction of HSAs in Mwanza, Malawi (2013), as cited in UNAIDS (2017).

¹⁸ De Neve et al., Harmonization of CHW programs for HIV: a four-country qualitative study in Southern Africa.

¹⁹ UHC 2030 Alliance website, About Us.

Training, supervision, and incentives for these semi-compensated and volunteer cadres are not standardized or regulated, and many work on single disease verticals—sometimes duplicating or even competing with other programs. Fewer than 158,000 CHWs across sub-Saharan Africa (compared with the estimated 1 million needed) are fully salaried employees. The majority of salaried CHWs are part of standardized horizontal government-led programs, with clearly defined roles and relationships to the broader health system.^{20,21} These integrated, salaried cadres are the lynchpin of strong community health systems and the centerpiece of most existing government community health strategies, yet current funding does not reflect their outsized importance. Channeling existing community health funds toward strong, well-compensated, integrated cadres can begin to close the financing gap.

FIGURE 3: Estimated annual funding to community health in sub-Saharan Africa by type of cadre



Note: Nearly all salaried cadres in estimate are horizontal and government led. Semi-compensated and volunteer cadres are a mix of NGO/government and single/multiple disease focus. Salaries, training and supervision costs are segmented based on tailored assumptions about each cadre. Commodities, equipment and overhead are distributed proportionally based on the number of CHWs in each cadre. Source: Dalberg analysis.

INCREASING SUSTAINABILITY

Today, an estimated 60 percent or more of funding for community health comes from donors, which suggests an unsustainable funding structure. Data from 12 sub-Saharan African countries suggests a 60/40 ratio of donor-to-government funds invested in primary health care.^{22,23} While data on community health expenditure by source are unavailable, anecdotal evidence suggests that community health financing may be even more donor driven, given the large community-level focus of donor programs on HIV, malaria, and maternal and child health, among other priorities.

As donor dollars for health are increasingly stretched and as many African countries transition to middle-income status and away from aid, the need for new financing sources—from private sector partnerships to increased tax revenue to innovative financing mechanisms—grows even more pressing. Domestic government resources are the most likely and the most important source of increased funds for community health over the coming decade. Government ownership—both programmatic and, over time, financial—is crucial to the sustainability of community health systems.

²⁰The estimate of the number of CHWs in sub-Saharan Africa today is based on best available data from 47 countries in SSA. The cadre breakdown is based on in-depth research on 19 countries and types/compensation structure of existing CHWs.

²¹Dalberg analysis; IMCHW (2013).

²²Out-of-pocket funds are excluded from the analysis given that many community health programs are free to the consumer; but high out-of-pocket costs for primary health care across these countries (17–65 percent of total primary health expenditures), which burden poor households, further suggest that current funding sources are unsustainable.

²³Wang and Maele, Primary Healthcare Expenditure Analysis, data from SHA 2011 (2017). Ethiopia data from Harvard School of Public Health, HEPCAPS2 Project: Financing Ethiopia's Primary Care to 2035 (2015).

HOW TO FILL THE GAP: LESSONS LEARNED FROM ETHIOPIA AND ZAMBIA ON MOBILIZING FINANCING FOR INTEGRATED COMMUNITY HEALTH PLATFORMS

Unlocking the full potential impact of community health will require more and smarter funding, plus a shift in the relative share of funding sources from donor to domestic. This need raises a number of questions, among them: What does it take to mobilize financing for community health and to ensure that financing is well coordinated and optimally allocated? What roles can ministries of health, donors, implementing partners, and others play? What principles and structures need to be in place at the country level to effectively mobilize and deploy financing?

Meeting the need for community health financing and doing so in the most efficient way possible requires governments, donors, and implementing partners to work together across a financing pathway. FAH has developed a “Financing Pathway Framework” to outline key activities and support stakeholders throughout the process (Figure 4). Government ownership is essential across the pathway, with donors and implementing partners playing a supportive role in building government capacity and responding to government needs. In addition, efforts must be squarely situated within broader health financing and health system strategies. Community health must be an integrated component of national health strategies and budgets, not an isolated system.

FIGURE 4: FAH approach to community health financing: Financing Pathway Framework





ALL THESE STEPS HAPPEN IN THE CONTEXT OF THE NATIONAL HEALTH SYSTEM AND STRATEGY.

Building on this framework, lessons based on country case studies have been identified at each stage of the financing pathway.

Ethiopia and Zambia—two countries with different political and health care contexts whose community health systems are at different stages of development—demonstrate contrasting approaches to mobilizing community health financing. Taken together, they provide insights that may be relevant for a range of countries setting out on this same journey.

Research visits were conducted in Ethiopia and Zambia to glean insights into challenges and success factors across the financing pathway, and to highlight the structures, processes, and principles that need to be in place to effectively mobilize and deploy community health financing and thus close the financing gap. Drawing on these case studies, key questions for country teams to consider are presented at each stage of the pathway.

 Ethiopia's Health Extension Program (HEP) is widely cited as a success story and is credited with dramatically improving the country's health outcomes since its inception in 2003. Inspired by the agricultural extension model, Ethiopian Prime Minister Meles conceived of HEP to transform health outcomes that had been lagging since the end of Ethiopia's civil war. Since then, Ethiopia has mobilized 38,000 female Health Extension Workers (HEWs), who deliver disease prevention and control, hygiene and environmental sanitation, family health, and health education services at the community level. HEWs work in tandem with community volunteers (known as the Health Development Army) who mobilize community members and serve as role models for healthy behaviors. HEP is entirely government-owned; its success showcases the power of government leadership and political will in developing and mobilizing financing for an integrated community health platform.

 More nascent than HEP, Zambia's Community Health Assistant (CHA) program illustrates a different approach to mobilizing financing. Piloted in 2011 to provide promotive, preventive, and basic curative services across disease areas, the program was driven by a growing HRH crisis and recognition that existing community health programs were ad hoc and inefficient. Without a clear senior government champion, a Ministry of Health team led a multi-year iterative process to build buy-in for the program. The team's tenacity and strategic advocacy shed light on how to build political will, and its approach to overcoming unforeseen challenges, e.g., a civil servant wage hike and a change in ministry responsibilities, is instructive to other countries who will inevitably encounter exogenous factors that shift the course of their financing plans.

BUILDING POLITICAL WILL: IDENTIFYING CHAMPIONS AND ADVOCATING FOR INVESTMENT

Mobilizing political will is a prerequisite for developing a community health system and an ongoing requirement for sustaining it. Political will, and the continued advocacy needed to build it, is key to harnessing the resources required to close the funding gap. Diverse champions can build support for community health across ministries of health and finance, donors, and local stakeholders.



The strong authority of Ethiopia's Federal Government, and the championing of community health by Prime Minister Meles and Minister of Health Tedros ensured buy-in for HEP at all levels of government. As a result, the program has been at the heart of the country's health sector strategies since the early 2000s. Including HEP as a central pillar of the country's Health Sector Development Plan made it a spending priority in the domestic health budget and for international donors alike.



In Zambia, the impetus came not from the top but from the middle: a cross-directorate team of Ministry of Health leaders, supported by a team from the Clinton Health Access Initiative (CHAI), led an inclusive, iterative process to get community health on the Government's agenda and to build agreement and momentum around the strategy, policies, and financing of a proposed CHA program. Early champions engaged with representatives across the Ministry of Health, and with Ministry of Finance representatives, donors, and local health system leaders to advocate for the development and funding of the CHA system. The team used data on Zambia's health, HRH, and community health challenges—combined with the proven impact of integrated community health programs in other countries (including Ethiopia)—

to strategically make its case based on actors' interests. Champions also took advantage of a political window of opportunity, using pressure for upcoming elections to secure support from higher levels of government and thereby accelerating progress.

With continuous behind-the-scenes support from CHAI, the Ministry of Health team worked to sustain political will even when political changes jeopardized program continuity. When Zambia's Ministry of Health split (temporarily, as it turns out) into the Ministry of Health and the Ministry of Community Development, Mother and Child Health (MCDMCH), political support and funding for the program came under threat. The Ministry of Health team, with CHAI's support, worked to build new champions within the MCDMCH and create more fluid communication channels between the two ministries to secure continued implementation.

Building political will: Key questions to consider

- When is the window of opportunity right for making the case for funding, based, for example, on budgeting processes or a favorable political climate?
- Who will be on the team responsible for championing community health? How can a team be built ensuring diverse representation and influence, as well as sufficient capacity to drive the financing mobilization process?
- Who are the influencers within the ministries of health and finance, donor and implementing partner organizations, and local government who need to be brought in to develop the community health strategy in order to secure funding?
- What types of data and arguments will appeal to each influencer?
- How can threats to funding be mitigated that may arise if political winds shift?

STRATEGY, POLICIES, AND COSTING: PLANNING FOR INTEGRATION TO MAXIMIZE RESOURCE EFFICIENCY

A clear strategy and policies for integrating community health programs with the broader health system are critical to ensuring efficient use of resources. So, too, is determining appropriate methods for integration based on local epidemiology, available training, and cadre size.



Ethiopia has a singular, unified community health system. HEP has clear links to Ethiopia's facility-based primary care system via referrals to and supervision from primary health care centers. It also links to a network of volunteers (the Health Development Army) who play a role in community mobilization and setting an example that provides HEWs with leverage. As a horizontal system, HEP works across disease areas to deliver primary care.

Ethiopia was one of the first countries to commit to the International Health Partnership (IHP+, now UHC 2030) on effective development cooperation principles. HEP exemplifies the resulting "One Plan, One Budget, One Report" mantra. Ethiopia's strong government ownership and clear strategy for HEP (and the health sector overall) allow donors and other partners to align their funding and programs to support the integrated HEP system, rather than develop parallel systems. In fact, the Government of Ethiopia mandates programmatic integration and strictly regulates partner programs to eliminate redundancy.

In practice, all external community health programming in Ethiopia builds on HEP. Implementing partners build programs that leverage, link to, and reinforce the program, e.g., providing additional trainings or commodities for a particular health intervention or disease priority. Ethiopia's integrated strategy and funding policies ensure resource efficiency and contribute to the growth and continued development of a large, well-equipped cadre that can meet health needs across the priorities of different disease verticals.



Conversely, in Zambia, 20,000+ NGO-led community-based volunteers (CBVs) work on different disease verticals and are not currently integrated with the CHA program, which presents ongoing challenges and missed opportunities for resource efficiency. The near-term goal for Zambia—which, unlike Ethiopia, does not have a fully-scaled horizontal program—is to create links to and leverage these other cadres, not eliminate them entirely. CHAs are supposed to coordinate and supervise CBVs. However, in practice, NGOs and cooperating partners go straight to the district level to train their own CBVs, and community health investments are not centrally tracked. No clear guidelines exist for how different cadres relate, and there are no enforced policies on tracking and coordinating donor and implementing partner programs to ensure that they complement government efforts. Government-led coordination to streamline resources and programs at the central level, along with clear local supervisory structures to ensure that the cadres are mutually reinforcing, would allow CHAs to leverage CBVs to amplify their impact—making the collective resources of donors, NGOs, and the Government go much further.

Strategy, policies, and costing: Key questions to consider

- How will the community health system/strategy link to the national health system/strategy?
- What does the community health programming landscape look like today?
- How can clear links be created between existing cadres and the national cadre? How can a plan for transition to an integrated platform be created over time?
- What mechanisms are in place for engagement among the Government, donors, and partners to ensure that all programming complements and strengthens the national community health system?

RESOURCE MAPPING AND IDENTIFICATION: SECURING GOVERNMENT RESOURCES AND LEVERAGING FLEXIBLE DONOR SUPPORT

As countries map their existing resources and begin to identify, prioritize, and engage with current and new funding sources to fill the funding gap, domestic government resources and flexible start-up funds from donors are two high priority and high leverage funding sources that can unlock further investment in community health. Investment of government resources can show “skin in the game,” and thus catalyze funding from donors and other sources to close the financing gap. These resources, paired with flexible donor support for upfront costs, can lay the foundation for financially sustainable community health programs.

As the Governments of Ethiopia and Zambia identified potential resource pools available to fund their community health strategies, they made financial commitments in the initial phases of program development that signaled long-term interest in building and sustaining the platforms, which, in turn, catalyzed funding from donors and other sources.



In Ethiopia, insistent on proving the HEP model before soliciting donor support, Prime Minister Meles marshaled domestic resources to independently fund the pilot. This commitment piqued donor interest, and they ultimately helped to fill in funding gaps and support HEP scale-up. Ethiopia also placed its HEWs on the government payroll. While this funding pool includes general budget support from donors, and while HEP continues to be primarily donor funded today, the Government's commitment to institutionalizing HEWs via payroll means that its contribution must and will grow as donor support begins to wane. The Federal Ministry of Health is thinking proactively about how to mobilize more domestic resources in preparation for that transition.



In Zambia, the combination of flexible donor support and government resource commitments enabled development of the CHA program. Even when political will has been secured, many countries cannot make the initial upfront investment needed to fund strategy development, curriculum development, training, and recruitment. As a seed funder defraying upfront costs while fostering government ownership of the CHA program, the Department for International Development (DFID) played a catalytic role in its development. DFID was flexible with its funding approach and willing to adjust its own budget to accommodate areas other donors preferred to support.

Given wage bill constraints, putting community health workers on payroll at the outset can be challenging—and a liability if a country is not fully prepared to scale up resources over time. In Zambia, an unforeseen increase in the civil minimum wage meant that the resources required to pay salaries were much greater than anticipated, which jeopardized the program's sustainability. DFID's flexibility allowed it to provide bridge funding, which ultimately helped Zambia overcome this hurdle. However, governments cannot always rely on donor willingness to step in. Payroll is just one of many ways to show commitment, and Ministry of Health teams should carefully consider wage bills, fiscal space, and potential disruptions as they map and plan for resource mobilization from domestic sources.

Resource mapping and identification: Key questions to consider

- What are the existing funding pools, sources, and actors in the health system today, and which ones could be leveraged to support the community health strategy? For example, how can existing grant agreements be leveraged to fund the community health system?
- Which donors and partners may be willing to champion the program and support upfront costs? How can they be engaged?
- Which government resources (financial and in-kind) are available to support community health programming today? How can increased domestic resources be planned and advocated for over time, e.g., getting CHWs on payroll?
- How can threats to the sustainability of domestic resource commitments be mitigated?

INVESTMENT PLAN: PLANNING FOR DONOR SUNSET

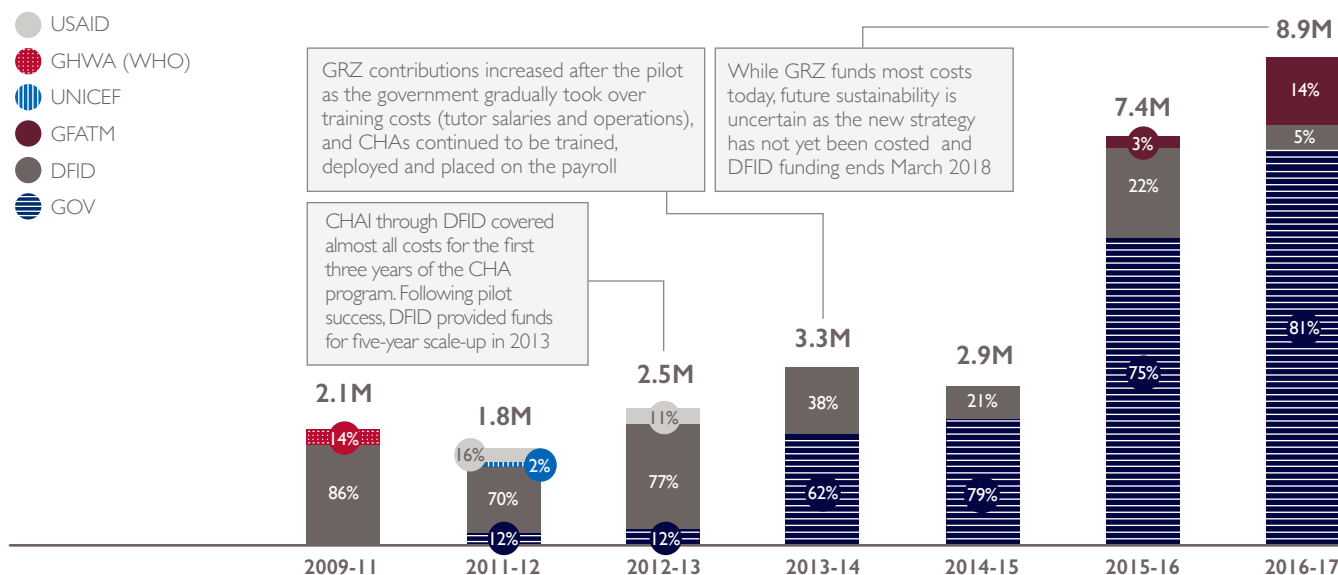
Strong investment plans must consider the scale-up of domestic resources and transition away from donor funds over time.

Financing commitments can only be successful in the context of a multi-year investment plan, linked to the national community health strategy, that considers how to increase the financial sustainability of the program over time—particularly as donor funds sunset. Donors and governments can work together to create this transition plan.



In Zambia, for example, DFID's upfront funding was contingent on the Government's commitment to assume costs over time. The strategy for the donor-funded CHA pilot included a clear stipulation that the Zambian Government would place CHAs on payroll if the pilot proved effective. The strategic team within the Ministry of Health that led the program began negotiating with the Ministry of Finance throughout the pilot phase to ensure that CHA positions were accounted for in future budgets, and thus that the Government would scale up resources over time. Today, the Government funds over 80 percent of CHA program costs (Figure 5).

FIGURE 5: Funding to Zambia Community Health Assistant Program, by source (\$M)



Excludes commodities. Sources: DFID Human Resources for Health Phase II Annual Reviews 2014 through 2017, DFID Business Case for Human Resources for Health in Zambia Programme 2013, CHAI Zambia data, National Community Health Worker Strategy 2010. These are the largest donors to the program, other smaller contributions were made from NGOs, partners, and community in-kind.

New and innovative funding sources

While Ethiopia and Zambia are still largely funded through traditional donor and central domestic government funding streams, there are numerous other sources to consider when investment planning for community health financing. Each country will have its own unique mix of financing, including donor funds, central and local taxes and other domestic revenues, private sector financing, and more “innovative” funding mechanisms such as social impact bonds.

Non-traditional financing sources and mechanisms are not the focus of this report but are central to FAH's work going forward.

Investment planning: Key questions to consider

- How do current and potential future funding sources fit together to build the financing pathway? How will funding sources shift over time?
- How can more domestic resources be mobilized over time, e.g., through tax revenue? How can greater allocation to community health be advocated for?
- How can donors and government plan jointly for the gradual transition toward a self-funded system?

OPERATIONAL ENABLERS: FACILITATING GOVERNMENT-LED COORDINATION TO HARNESS AND ALIGN RESOURCES

Each step along the financing pathway (political prioritization, investment planning, resource mapping and identification, and strategy, policies, and costing) requires close collaboration and coordination by Ministry of Health staff across directorates, Ministry of Finance staff, local government health and finance officials, donors, and implementing partners, among other actors. **Having the right operational enablers—structures, mechanisms, and capacity—in place to manage the process has determined the relative success of various countries in mobilizing community health financing. Strong coordination bodies, a dedicated team with responsibility and capacity for community health, and coordinated funding mechanisms can facilitate alignment of strategies and funding across actors, marshalling additional and more efficiently allocated resources for community health.**

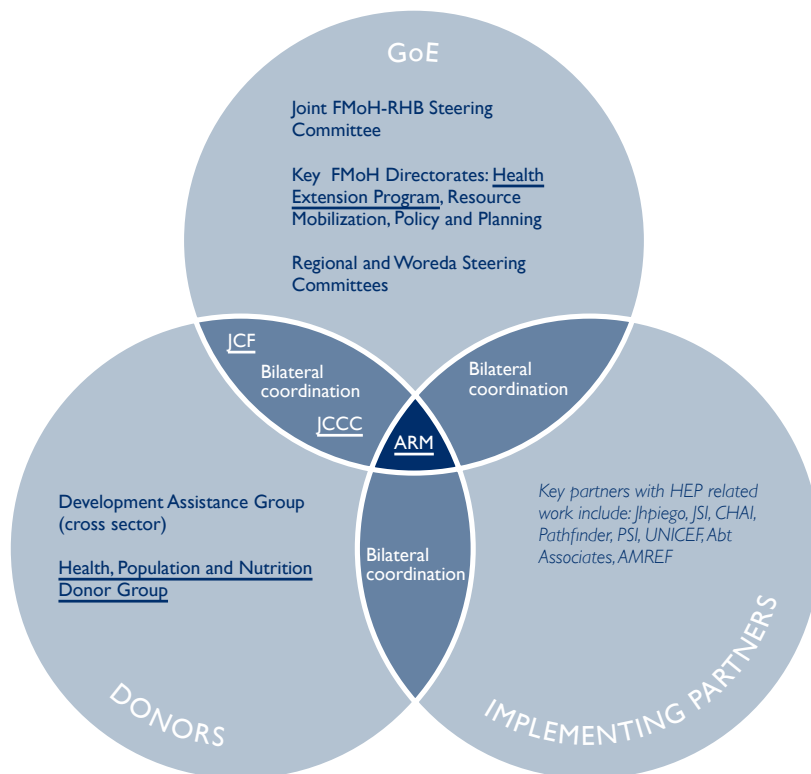


Ethiopia is the prime example of country-led coordination. It has well-functioning coordination bodies to manage collaboration among donors, implementing partners, federal ministries, and local ministries, with clearly defined fora and engagement mechanisms between and among each group (Figure 6). Several high-level bodies, such as the Joint Consultative Forum chaired by the Minister of Health and the head of the donor group, also have technical arms or subcommittees that regularly meet on tactical and operational issues and provide updates to higher bodies for decision-making—creating a system that is both nimble and well governed.

FIGURE 6: Key health coordination bodies in Ethiopia

UNDERLINE: HIGHEST LEVERAGE BODIES FOR HEP

- Health Extension Program:
The Health Extension Program Directorate (HEPD) is the dedicated, central directorate for the HEP.
- At the Annual Review Meeting (ARM), all stakeholders come together to review annual health plans, including budget, resource mapping, implementation plans and M&E.
- Joint Consultative Forum (JCF) serves as forum for GoE and donor coordination on health policy and resource mobilization.
- The Joint Core Coordinating Committee (JCCC) is the technical arm of the JCF and provides operational oversight.
- Health, Population and Nutrition:
HPN allows donors to coordinate on filling resource gaps.



Indicative, not exhaustive. Source: Expert interviews; Harmonization Manual (2008); HSDP IV (2010).

Perhaps the most important of these coordinating bodies is the HEP directorate. By creating a dedicated directorate focused solely on community health, Ethiopia's Federal Ministry of Health ensured sufficient capacity to implement the program and created a focal point for coordination. Given the cross-cutting nature of horizontal community health programs, strategy and implementation require close collaboration across many directorates, e.g., Maternal and Child Health and Disease Prevention and Control. The HEP directorate concurrently works with the Resource Mobilization and Policy and Planning teams on resource allocation and mobilization. Its leadership, execution, and coordinating powers have allowed for continued attention and funding to HEP—far beyond its initial inception.

Ethiopia has also successfully coordinated with funders to align funding toward HEP. As part of their “One Plan, One Budget, One Report” approach, the Ethiopian Government works with donors to fill resource gaps in the Health Sector Development Plan, including for HEP. Ethiopia is somewhat unique in having pooled funding mechanisms. The Protecting Basic Services fund, with contributions from the World Bank and several bilateral donors, provides general budget support to the Ministry of Finance for a range of development priorities, including health, and ultimately supports HEW salaries and some procurement. Launched in 2008, the pooled Millennium Development Goal (now Sustainable Development Goal) Performance Fund provides general support to the health sector. Its scope of activities is determined through a consultative process and an annual Joint Financing Agreement, but typically includes HEP supplies, training, and some construction. Contributors include DFID, Irish Aid, Italy, Spain, the Netherlands, GAVI, UNFPA, WHO, and the World Bank. These pooled funds offer the Ethiopian Government the ability to channel donor funds toward its health extension strategy, and ultimately build and strengthen an integrated system.²⁴

Even donors who provide funding independently of these pooled channels—USAID, for example—direct their community health resources to strengthening and supporting HEP and do not bypass the government-led system through standalone programs. Ethiopia's strong, integrated strategy and investment plan allows it to approach donors with clear requests to fund HEP components, and the country's coordination bodies provide fora for discussions on funding alignment. Country-led coordination—paired with donor responsiveness and willingness to follow the Government's lead when it comes to resource allocation—has helped secure and align the resources necessary for HEP success.

Operational enablers: Key questions to consider

- What bodies are in place for intra-ministry, cross-ministry, local government, donor, and partner coordination? How can it be ensured that these bodies are leveraged for community health? What new bodies or fora should be created?
- Can a dedicated directorate with responsibility for the community health strategy and funding be established? How will this directorate engage with other relevant directorates?
- Does the country have, or have the potential to create pooled donor funds? If not, how can donor coordination bodies and strategic advocacy be used to align donor funds toward the national community health system?
- How can specific funding gaps and requests, e.g., for commodities, be aligned with donor interests and funding mechanisms as a component of grants for disease priorities?

²⁴ Harvard/BIC, Ethiopia's Progress in Health Financing and the Contribution of the 1998 Health Care and Financing Strategy in Ethiopia, (2015).

This report has highlighted a \$2 billion gap in community health financing in sub-Saharan Africa, and a need for collective action to fill the gap and unlock significant impact for health systems across the continent. Learning from the experiences of Ethiopia and Zambia, this report suggests some practical considerations on approaches and success factors along the financing pathway to address this gap.

The analysis underpinning this report also reveals further knowledge gaps that the global health community can collectively address.

- **First, the global health community needs to better map and track community health programs across the world today, creating and maintaining a repository of information on the size, responsibilities, incentives, training, and costs of each cadre.** Such a database would help monitor the growth and quality of community health programs worldwide, as well as provide a set of costing benchmarks for countries looking to develop new programs. The research behind this report can serve as a starting point for this inventory.
- **Second, donor and domestic expenditure on community health needs to be better tracked.** While this report provides a high-level estimate for community health funding today, very few donors or countries specifically track spending on community health, which makes it difficult to evaluate the volume, efficiency, or ROI in community health today.
- **Finally, additional quantitative data is required on the benefits of integration.** Despite a clear logical case and growing country-level momentum for integrated community health cadres, little data exist on the cost savings accrued by replacing misaligned, parallel, vertical programs with a single horizontal cadre. Also, while evidence shows that verticalized community health workers with appropriate training and incentives have the capacity to add interventions without threatening their effectiveness, there is no clear evidence-based standard for how to optimize program design around workload, efficacy, and resource efficiency considerations.

Continuing to build an evidence base will help countries, donors, partners, and other stakeholders maximize the efficiency of their community health investments, and collectively build the strong, integrated community health systems sub-Saharan Africa needs to accelerate progress on its health goals.

FURTHER RESOURCES

For additional resources on community health financing, please visit <http://www.financingalliance.org>.

OVERVIEW OF FUNDING BASELINE METHODOLOGY

In an effort to estimate the funding gap, CII and FAH developed a high-level benchmark (not a precise figure) for what CHW programming in sub-Saharan Africa likely costs today. To determine the shortfall, this number was compared to the Earth Institute/IMCHW's \$3.1 billion estimate of annual funding needed for strong community health programs.

Approach: To estimate costs of existing community health programming, a model was developed using available data for both government and NGO programs across 19 countries as inputs. For example:

- Total number of CHWs active today and breakdown by cadre type (salaried, semi-compensated, volunteer)
- Monthly salary by cadre type
- Average number of days of training and cost per day of training by cadre type
- Supervisory structure and supervision costs
- One-time and recurrent equipment costs
- Coverage of commodities in rural areas, costs per commodity, and percent delivered by CHWs
- Overhead

Strengths: This approach results in a comprehensive estimate for all of sub-Saharan Africa using best available data on most existing community health programs as inputs.

Limitations:

Methodology: This approach projects costs for a theoretical CHW system, not actual expenditure. It is heavily dependent on key assumptions.

Data quality: Data availability and quality vary widely by country and cost category. The available data from different countries derive from different sources and represent different points in time.

Validation analysis: Validation relied on an alternate approach that estimated donor expenditures on community health based on development assistance to health (DAH) data, and extrapolated from those figures to estimate total funding from all sources. The analysis yielded a roughly similar figure (~\$900 million). Expert vetting of the approach suggests it may be an underestimate, which further validates the \$1.1 billion figure.

ADDITIONAL DETAIL ON OPPORTUNITIES FOR COST SAVINGS THROUGH INTEGRATION

FIGURE 7: Opportunities for cost savings through integration

Salaries

Integrated systems may require fewer total CHWs:

- Many vertical cadres are part-time and only cover one to two interventions, resulting in more total CHWs needed
- Some CHWs are paid by multiple NGOs for different interventions, suggesting redundancy
- Evidence suggests some cadres have spare capacity (though workloads should be managed carefully)
- Overall travel time and expense is lower for one integrated cadre vs. multiple cadres serving same community

Training

Integrated programs may have lower fixed training costs and lower attrition:

- Even though integrated cadres require longer, more extensive training, fixed costs for a single, unified training (e.g., curriculum development, space, trainers, travel) are likely lower than for multiple short trainings
- Attrition may be lower among integrated cadres receiving standardized salary, so fewer pre-service trainings are needed
- Fewer CHWs overall also means lower training costs

Overhead

Fewer programs means less overhead:

- Overhead is shared for a single, integrated cadre, rather than separate for each vertical program

Supervision

Fewer total CHWs means fewer supervisors required:

- Even with a higher supervisor/CHW ratio, the number of supervisors paid will likely decrease slightly if fewer CHWs are required (i.e., because redundant cadres are eliminated)
- Integrated cadres can better leverage existing health workers (e.g., nurses) for supervision, though CHW supervision should be a clear part of their job description/compensation

Equipment

Fewer CHWs and lower attrition mean less total equipment purchased:

- Fewer total supplies needed (e.g., bicycles, uniforms, backpacks)
- Lower replacement costs given lower attrition

Commodities

Integrated systems can shared procurement and distribution costs:

- A singular procurement/distribution system could offer cost savings on administration and last-mile delivery

WHILE FURTHER RESEARCH IS NEEDED TO QUANTIFY THESE OPPORTUNITIES, THERE IS CLEAR POTENTIAL FOR COST SAVINGS IN INTEGRATED PLATFORMS.

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