Community Health Workforce Program

Financing and Sustainability Roadmap

A Pathway for Stronger Community Health Worker Programs Across Africa

April 2026

About this Roadmap

This Financing and Sustainability Roadmap presents a strategic framework for strengthening the long-term financing and sustainability of Community Health Worker (CHW) programs across Africa.

Developed under the Mastercard Foundation's Community Health Workforce Program, this document outlines approaches to support government-led, resilient, and integrated CHW systems that expand access to primary health care (PHC) while advancing dignified and fulfilling employment opportunities for young people.

The roadmap provides guidance for governments, development partners, implementing agencies, and financing institutions on sustainable financing models, workforce integration, domestic resource mobilization, partnership approaches, and transition planning to support nationally owned and scalable CHW programs across Africa.

Mastercard Foundation
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Acronyms

ACTs	Artemisinin-based Combination Therapies
Africa CDC	Africa Centres for Disease Control and Prevention
AU	African Union
BP	Blood Pressure
CHW	Community Health Worker
DALY	Disability-Adjusted Life Year
DHIS2	District Health Information Software 2
HMIS	Health Management Information System
HRH	Human Resources for Health
iCCM	Integrated Community Case Management
ID	Identification
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
IP	Implementing Partner
M&E	Monitoring and Evaluation
MNCH	Maternal, Newborn and Child Health
MoF	Ministry of Finance
MoH	Ministry of Health
MTE	Mid-Term Evaluation
MTEF	Medium-Term Expenditure Framework
MUAC	Mid-Upper Arm Circumference
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
ODA	Official Development Assistance
ORS	Oral Rehydration Salts
PBF	Performance-Based Financing
PFM	Public Financial Management
PHC	Primary Health Care
PSC	Public Service Commission
PPPs	Public-Private Partnerships
RAG	Red, Amber, Green
RDTs	Rapid Diagnostic Tests
RoI	Return on Investment
SIM	Subscriber Identity Module
UHC	Universal Health Coverage
VfM	Value for Money
VHW	Village Health Worker
WHO	World Health Organization

Executive Summary

Our Mission and Strategic Focus

The Mastercard Foundation's mission is to advance learning and promote financial inclusion for young people in Africa and indigenous youth in Canada. Guided by our Young Africa Works strategy, the Foundation seeks to enable 30 million young people across Africa - particularly young women - to access dignified and fulfilling work opportunities by 2030. Recognizing the significant potential of the health sector to expand employment opportunities for young people while improving health outcomes, the Foundation has identified health workforce strengthening as a strategic priority to enable young people in Africa and indigenous youth in Canada to access dignified and fulfilling work.

30M
Young people across Africa - particularly young women - to access dignified and fulfilling work opportunities by 2030 (Young Africa Works)

600,000
CHWs to access dignified and fulfilling work opportunities by 2030

3
Interconnected pillars: Health Employment, Health Livelihoods, Health Ecosystem

Community Health Workforce Program

The Community Health Workforce program is a flagship initiative designed to enable 600,000 community health workers to access dignified and fulfilling work opportunities by 2030. The program is anchored in three interconnected pillars:

Health Employment

Focused on training, professional development, and career pathways for CHWs.

Health Livelihoods

Focused on market-based income-generating opportunities that complement, and do not conflict with, CHW service delivery responsibilities.

Health Ecosystem

Focused on strengthening enabling policies, health systems integration, and sustainable domestic financing for CHW programs.

As Foundation-supported CHW programs scale across multiple countries, ensuring long-term financial and institutional sustainability is critical to sustaining health outcomes and employment gains. Africa CDC defines sustainability as the full integration of community health programs into formal health systems, supported by long-term governance, management and financing mechanisms. Findings from a recent continental survey show that most African countries continue to rely heavily on donor funding for community health programs, underscoring the need for more sustainable, domestically anchored approaches.

Shared Commitment to the Financing and Sustainability Roadmap

To support the long-term sustainability of CHW programs, the Mastercard Foundation, partner organizations, and African governments endorsed a shared Financing and Sustainability roadmap during the CHW program convening held from February 26 to 27, 2026 in Addis Ababa, Ethiopia.

Grounded in the principles of health sovereignty and country ownership, the roadmap supports government and partners in establishing a shared direction and coordinated transition pathway toward sustainable, nationally integrated community health programs.

Roadmap Pillars and Goals for 2030

The roadmap outlines a comprehensive sustainability approach built around four mutually reinforcing pillars:

- Government Integration and Domestic Financing
- Donor Coordination and Transition Planning
- Private Sector Engagement and Market-Based Solutions

By 2030, the roadmap aims to achieve the following outcomes:

1. Legal recognition and institutional integration of community health workers within national health workforce plans.
2. At least 70 percent of CHW program financing is sourced through domestic public financing mechanisms and managed transparently.
3. Donor financing that is aligned, coordinated, and multi-year, with reliance progressively reduced over the next five to 10 years to 20 to 30 percent of total CHW financing.
4. Innovative financing mechanisms that contribute five to 10 percent of CHW program financing.

Recognizing that countries have different economic capacities and are at different stages of transition toward sustainable community health programs, the roadmap provides operational guidance and an accountability framework for country-level priority actions tailored to each country's income level.

During the first two years, the focus is on securing a political, policy and fiscal mandate, and on agreeing a binding government-partner transition compact. In years three to five, the emphasis shifts toward the full integration of community health workers into national health systems, the progressive absorption of the majority of community health worker recurrent costs by the government, and the phased transition of donor funding.

1. Introduction and Context

1.1 Our Mission and Vision

The Mastercard Foundation is a registered Canadian charity, one of the largest foundations in the world, and the leading funder of education in Africa. It works with visionary organizations to enable young people in Africa and in Indigenous communities in Canada to access dignified and fulfilling work.

In Africa, the Foundation's work is guided by the Young Africa Works strategy, which seeks to enable 30 million young people - particularly young women - to access dignified and fulfilling work opportunities by 2030.

Recognizing the significant potential of the health sector to expand employment opportunities for young people while improving health outcomes, the Foundation has identified strengthening Africa's health workforce as a key focus area.

1.2 Strengthening Africa's Community Health Workforce

The Community Health Workforce program is a flagship initiative under Young Africa Works. The program seeks to strengthen and professionalize community health systems while enabling 600,000 community health workers to access dignified and fulfilling work opportunities by 2030.

The program is implemented through three interconnected pillars focused on:

- Strengthening CHW training, professional development, and career pathways.
- Supporting sustainable livelihood opportunities for community health workers.
- Strengthening enabling policy, financing, and health system integration for community health programs.

1.3 The Sustainability Challenge

Despite widespread recognition of the critical role of CHW programs in delivering PHC services and enabling decent work opportunities, particularly for young women[1,2], financing and sustaining these programs remain significant challenges. A Community Health Landscape Survey conducted across 51 African countries by the Africa CDC and UNICEF found that 80 percent of countries rely on donor support for more than half of their community health budgets.

At the same time, only 51 percent reported including CHW remuneration in national wage bills, highlighting persistent structural gaps in financing, ownership, and the long-term sustainability of community health programs. Encouragingly, six African countries, including Burkina Faso, reported financing 80 percent or more of their community health programs domestically, demonstrating that sustainable and nationally owned community health systems are achievable.

of countries rely on donor support to fund more than half of their community health budgets.

51%
The number of countries reporting community health worker remuneration in national wage bills

6
African countries, including Burkina Faso, finance 80 percent or more of their community health programs through domestic resources.

51
African countries are covered by the Community Health Landscape Survey.

Africa CDC defines sustainability of CHW programs as the full integration of community health programs into formal health systems, supported by long-term governance, management and financing[3]. In this context, CHW sustainability encompasses multiple dimensions:

1. **Financial sustainability:**
   Transforming from short-term grant funding to long-term, predictable, and domestically anchored financing streams.

2. **Institutional sustainability:**
   Strengthening government ownership and integration of CHW programs within national health systems.

3. **Workforce sustainability:**
   Ensuring fair compensation, career progression, professional development, and retention of trained CHWs.

4. **Service sustainability:**
   Maintaining the quality, continuity, and coverage of community health services throughout funding and implementation transitions.

5. **Innovation sustainability:**
   Supporting the continued development and scaling of market-based and locally driven solutions within the health ecosystem.

To ensure the sustainability and long-term viability of CHW programs, the Mastercard Foundation, representatives from Ministries of Health across 20 African countries, and 21 partner organizations developed a shared Financing and Sustainability Roadmap. It aims to support countries and partners in establishing a shared understanding, a common direction, and a coordinated transition pathway toward sustainable community health programs, with a primary focus on strengthening financial sustainability.

The roadmap is grounded in a broader understanding of health sovereignty: the ability of countries to define their own priorities, and to own, govern, finance and continuously strengthen their community health programs over time in alignment with national agendas, population needs, and evolving risks and opportunities. This shift away from fragmented, externally driven health systems is essential not only for improving health outcomes and strengthening national ownership, but also for building resilient systems that support inclusive economic growth and dignified and fulfilling employment opportunities.

1.4 Alignment with Foundation Values

The Financing and Sustainability Roadmap is grounded in the Mastercard Foundation's core values and strategic priorities:

Youth-centred:

The program prioritizes employment opportunities for young people, particularly young women who face the highest social and economic barriers to employment.

Dignified work:

CHWs are supported through fair compensation, professional recognition, safe working conditions, and opportunities for career growth and advancement.

African-led solutions:

Strategies are locally driven and implemented through the leadership of African governments, institutions, and communities.

Partnership and collaboration:

Multi-stakeholder engagement strengthens shared ownership, coordination and resource mobilization.

Innovation and livelihoods:

CHWs are supported to access non-conflicting livelihood opportunities that complement their public service responsibilities.

Financial inclusion:

CHWs savings groups, and related mechanisms strengthen access to financial services and economic empowerment opportunities.

2. Financing and Sustainability Roadmap

2.1 Purpose and intended use of the roadmap

This Financing and Sustainability Roadmap is designed to support countries in strengthening the long-term sustainability of CHW programs through nationally led financing, governance and system integration approaches. In this context, sustainability refers to countries' ability to finance, manage, and support their community health workforce reliably and predictably over time through domestic public resources, complemented by aligned partner and private-sector contributions.

This roadmap is intended to serve as a practical planning alignment framework that supports governments and partners in:

- Assessing current financing and system capacities
- Defining a context specific sustainability vision
- Identifying sequenced transition priorities and actions, and
- Strengthening country ownership, coordination and long-term system performance.

Recognizing that countries are at different stages of health system and financing maturity, the roadmap is designed to be adaptable to national contexts and priorities. It is not intended to function as a compliance, ranking, or performance assessment tool.

The roadmap also complements broader regional and continental initiatives, including Africa CDC's community health scorecards and surveys, which support benchmarking, accountability, and regional learning. While those mechanisms provide comparative and monitoring insights across countries, this roadmap is primarily intended to guide country-level planning, transition management, and partner coordination in alignment with national systems and priorities.

2.2 Strategic Goals

The roadmap seeks to achieve the following goals by 2030:

1 **Goal 1:** CHWs are legally recognized and institutionally integrated within national human resources for health (HRH) plans as part of the formal health workforce.

Legal recognition

2 **Goal 2:** At least 70 percent of the CHW program budget is domestically funded, predictable, and transparently managed within national systems.

70% domestic

3 **Goal 3:** Donor support for CHW programs is aligned with national priorities, coordinated, and delivered through multi-year approaches, with reliance progressively reduced over the next five to 10 years to 20 to 30 percent of CHW financing.

20–30% donor

4 **Goal 4:** Innovative financing mechanisms, such as performance-based financing linked to health outcomes, health insurance contributions, earmarked levies and public-private partnerships, contribute five percent to 10 percent to CHW financing.

5–10% of financing

Note: These targets represent directional continental benchmarks. Countries will define context-specific pathways based on their fiscal capacity, health system maturity, and level of donor dependency. The pace and approach to achieving these targets will therefore vary by country context: **low-income and fragile settings** may require gradual transition pathways with extended donor co-financing, while **middle-income countries** may pursue accelerated domestic financing approaches, supported where appropriate by blended financing models.

2.3 Strategic Framework: Four Pillars of Sustainability

The Finance and Sustainability Roadmap is organized around four mutually reinforcing pillars that address key dimensions of long-term sustainability. Each pillar includes a strategic objective and a set of illustrative actions intended to guide country-level implementation in ways that are context-specific, adaptable, and responsive to national priorities and capacities.

Pillar 1: Government Integration and Domestic Financing

Objective: Transition CHW programs from donor-dependent projects to government-owned, domestically financed components of national health systems.

Evidence from successful CHW programs demonstrates that sustainability is achieved when CHW programs are formally integrated into national health systems and supported through sustained investment and political leadership[4,5,6]. The experiences of Ethiopia, South Sudan, Malawi, Zambia, Ghana, and Nigeria provide practical examples of community health workers being integrated into national health systems and government payroll structures[7]. The Ghana case study below further illustrates the importance of political commitment and the progressive expansion of domestic financing for community health programs.

Ghana Case Study: Legislating Annual Health Budget Increases

Securing domestic financial resources for health requires sustained political commitment and legislative backing that translate political intent into predictable, protected fiscal flows. Comparative evidence shows that health financing reforms anchored in law, through protected budget lines, earmarked revenues or statutory entitlements, are more resilient to political turnover and fiscal shocks, and more likely to support progress towards universal health coverage (UHC). Ghana's National Health Insurance Scheme (NHIS) exemplifies this dynamic. The scheme was established and consolidated through high-level political leadership and legislative instruments that embedded health financing priorities within the national budgeting process, creating a more stable framework for sustained domestic investment in health.

As part of the legislated approach, the Government of Ghana committed to annual increases in NHIS financing of approximately eight to 10 percent over successive budget cycles, thereby steadily expanding the domestic resource base. Between 2010 and 2022, NHIS enrolment increased from around four to over 70 percent of the population, accompanied by documented reductions in out-of-pocket spending and improvements in financial protection, particularly for lower-income households.

Ghana's experience demonstrates how politically backed and legislatively anchored domestic financing can help transition health systems away from reliance on out-of-pocket payments toward pooled public financing, while creating fiscal space to scale priority services. These lessons are directly relevant to the long-term financing and sustainability of CHW programs.

Strategic approaches

1. Strengthening line-item budgeting and fiscal integration for CHW programs within national health budgets.
2. Expanding integration with national health insurance and social protection programs.
3. Advancing decentralization and subnational financing approaches to support locally responsive implementation.
4. Strengthening policy and regulatory frameworks that support the recognition, financing and integration of CHWs within national health systems.

Pillar 2: Donor Coordination and Transition Planning

Objective: Strengthen the effectiveness of donor contributions through strategic coordination, harmonization, and planned transition toward government ownership.

Several African governments and their development partners have committed to aligning and synergizing health workforce investments through government-led partnerships and collaboration[8]. When donors align investments around a government-led plan, their contributions become complementary rather than duplicative. For example, The Mastercard Foundation can finance training in alignment with its charitable purpose, while other partners can cover remuneration or supply chain costs in line with their own objectives. This co-financing creates leverage that no single donor can achieve on their own.

Equally important is a planned transition to ensure a phased transfer of responsibilities to the government and the institutionalization of programs within government systems. Nigeria's experience below exemplifies the successful transition of a donor-supported CHW initiative into government systems[9].

Nigeria Case Study: Transitioning a Donor-Supported CHW Initiative

Nigeria's Village Health Worker (VHW) scheme in Gombe State provides a practical example of how a community health program initially supported by development partners can be successfully transitioned to government leadership while maintaining continuity in frontline service delivery. The program was established to strengthen PHC in underserved communities by formalizing a community-based health workforce with clearly defined roles, training requirements, supervision structures, and referral linkages to nearby health facilities.

The transition was enabled by early alignment with state priorities, and by deliberately shifting program functions (planning, financing and oversight) from the implementing partner to government systems. This included embedding responsibility within state and local health structures, strengthening routine supervision and performance management, and ensuring that operational details (training, tools and reporting) were standardized and understood by government counterparts.

Rather than relying on a one-time handover, the approach emphasized phased transition, joint problem-solving, and documentation of processes to support integration into routine public-sector systems. This enabled government counterparts to gradually assume ownership and operational responsibility while maintaining service continuity and program performance.

A key lesson from the Gombe experience is that sustainability extends beyond replacing donor financing; it requires institutionalizing CHW programs within government systems. The case highlights the importance of establishing a shared understanding of government ownership from the outset, investing in management capacity at state and local levels, and implementing gradual transitions that preserve service quality while strengthening long-term system resilience.

Strategic approaches

1. Strengthening donor harmonization and coordinated financing approaches, including virtual or pooled funding mechanisms.
2. Developing phased and government-led transition plans.
3. Providing technical assistance and capacity strengthening for national and subnational systems.
4. Expanding results-based financing approaches linked to health system and community health outcomes.

Pillar 3: Private Sector Engagement and Market-Based Solutions

Objective: Mobilize private-sector resources, expertise, and market-based mechanisms to support CHW program sustainability while creating business opportunities.

An analysis of World Bank initiatives highlights the potential of blended financing approaches to attract private investment toward projects that create societal value but are perceived as having low prospective profitability or high risk of failure[10]. Rwanda's experience further demonstrates how public-private partnerships (PPPs) and innovative financing mechanisms can support the integration of private health care providers to strengthen PHC services.

Rwanda Case Study: Public-Private Partnerships and Innovative Financing

Rwanda offers a practical example of how a government can use PPPs and innovative financing to strengthen PHC while deliberately integrating private actors into a single, accountable system. After rebuilding its health system in the 2000s, Rwanda expanded coverage through community-based insurance, strategic purchasing and performance-based financing (PBF). The core of the model is an explicit financing-and-accountability chain: pooled funds (insurance premiums and public subsidies) are used to purchase services, while PBF payments reward verified delivery and quality. Facilities, including faith-based and other private facilities that meet accreditation and contracting requirements, can be paid through the same purchasing arrangements, reducing fragmentation and encouraging private providers to deliver priority services aligned with national protocols.

At the community level, Rwanda institutionalized community health workers as part of routine service delivery and connected them to facility performance systems, with performance incentives provided. Crucially, private-sector integration was not treated as a parallel delivery channel. Instead, private providers were brought into the same rules of the game through contracting, reporting requirements, supervision, and verification. Over time, this created space for partnerships with mobile network operators and financial service providers to support digital reporting and timely payments, and with private distributors to strengthen last-mile availability of commodities, while keeping stewardship with the government.

The result is a financing architecture that mobilizes both public and private resources, aligns incentives with coverage and quality, and maintains a clear line of accountability from national priorities to community-level delivery.

Strategic Approaches

1. Expanding corporate social investment and PPPs in support of CHW programs.
2. Advancing innovative financing models and impact investment mechanisms for community health.
3. Strengthening the integration of private-sector actors.

2.4 Phased Implementation Approach

Financial sustainability is not a fixed end state, but a managed, adaptive process that requires deliberate planning, sequencing and risk management. To support practical implementation, this roadmap adopts a phased approach.

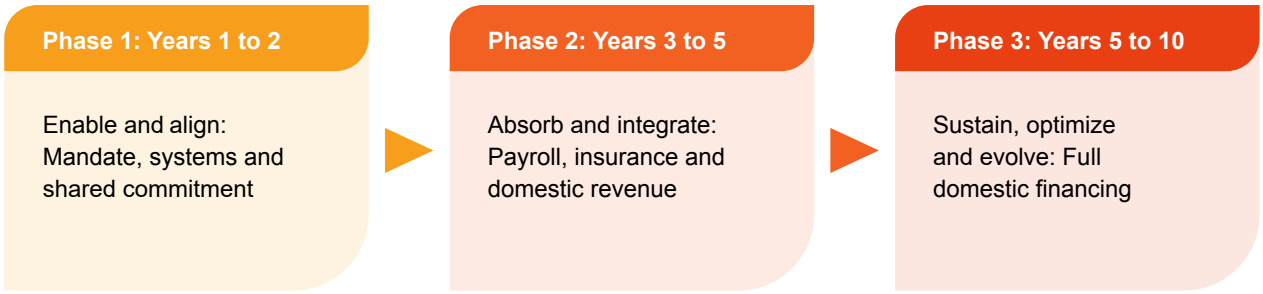


Figure 1. Phased implementation approach for the strategic actions.

3. Operationalizing the Roadmap

Implementing the strategic actions outlined in this roadmap requires countries to consider important contextual factors, including fiscal space constraints and the maturity of existing CHW programs. This section outlines a minimum sustainability package, a sequenced country action plan, and key political economy and reform considerations that influence the pace, feasibility and sustainability of implementation.

3.1 Minimum Viable Sustainability Package

A minimum viable sustainability package for the CHW program is the smallest set of inputs and initial actions that keep the program functional, effective, and financially viable in the long term. The table below illustrates the components and indicative costs that should be adapted to the country context.

1. Financing and compensation
2. CHW workforce
3. Commodities and toolkits
4. Data, reporting and governance
5. Referral system

Table 1. Minimum viable sustainability package.

Program component	Input	Indicative cost per year
Financing and compensation		
CHW stipends	Monthly stipend $20 to $60 per CHW, depending on the country	$240 to $720 per CHW per year
Performance incentives	Incentives or airtime rewards tied to service targets	$5 to $20 per CHW per month
Supervisor salaries	1 supervisor per 10 to 15 CHWs	The government pays where supervisors are civil servants; donors pay initially, otherwise
CHW workforce		
CHW training	6-month MoH-approved competency-based training (iCCM, MNCH, NCD basics)	$150 to $400 per CHW initial; $50 to $100 per CHW per year refresher; Monthly stipend $20 to $60 per CHW depending on country
Supervision system	Quarterly field visits, group reviews, call-based check-ins	$30 to $60 per visit
Commodities and toolkits		
CHW drug kits	Per MoH policy: ORS, zinc, malaria RDTs and ACTs, pregnancy test kits	$80 to $200 per kit per year
Mobile phones and data	Basic smartphone, SIM and monthly data bundle for reporting	$80 to $150 device; $3 to $8 per month data
Equipment	BP cuff, MUAC tape, torch, weighing scale	$30 to $80 per CHW one-off; replacement every two to three years
Data, reporting and governance		
Digital platform	DHIS2, CommCare or KoboToolbox setup, hosting and training	$10,000 to $50,000 setup; $5,000 to $20,000 per year hosting
Paper registers (backup)	Household registers, referral forms, tally sheets	$5 to $15 per CHW per year
National CHW policy	Policy development, legal recognition, scope-of-practice definition	Technical assistance cost: the government owns the process
Community structures	Village health committees for oversight and accountability	Volunteer time; facilitation costs $200 to $500 per community per year
Referral system		
Referral and feedback	Standardized referral slips; facility feedback mechanism to CHW	Minimal cost: requires facility staff buy-in
Emergency transport fund	Motorbike ambulance or community transport kitty	$500 to $2,000 seed per community; replenished locally

3.2 Country Action Plans and Success Triggers

Countries should adapt the actions below to their context, including their income level (low- or middle-income) and the maturity of their CHW system. The full action sequence with success triggers is provided in Annex A. The summary below presents the headline actions per phase.

Table 2. Headline actions and success triggers by phase.

Phase	Headline actions	Key success trigger
Phase 1 Years 1 to 2	Establish a government-led coordination mechanism; map financing sources and gaps; secure cross-government political mandate; define a single national CHW model; complete rapid costing; introduce a CHW budget line; negotiate a co-financing compact; standardize remuneration and the national registry; align reporting tools and build institutional capacity.	Cabinet or presidential commitment to a CHW sustainability target (e.g, 70 percent domestic financing within five years); CHW budget line approved; co-financing compact signed; national CHW registry operational.
Phase 2 Years 3 to 5	Progressively raise the domestic share of recurrent costs and embed in medium-term expenditure framework (MTEF); integrate CHWs into the government payroll or formal contracting; enroll CHW services in national health insurance and social protection; formalize subnational co-financing rules; introduce innovative domestic financing mechanisms; convert partner support to time-bound gap financing; institutionalize quarterly performance reviews.	Domestic share rises year-on-year, confirmed by audited accounts; CHWs on formal payroll or time-bound contracts; CHW services gazetted in the NHIS benefit schedule; residual donor funding below 20 percent of the total CHW program budget.
Phase 3 Years 5 to 10	Achieve full domestic financing independence; expand and update the CHW service package (including NCDs, mental health and climate-health adaptation); professionalize the CHW cadre; embed CHWs in national health workforce planning; activate cross-sectoral and shock-response financing; lead regional learning exchanges.	Three consecutive fiscal years with 100 percent domestic financing; CHW cadre recognized in legislation; CHW projections in National Health Workforce Account; shock-response protocol tested; regional knowledge-exchange agreements signed.

3.3 Political Economy and Reform Sequencing

Across many African countries, the binding constraint on sustainable CHW financing is rarely a lack of technical solutions. It is political economy: competing priorities, fiscal and wage bill constraints, and the incentives of decision-makers[15,16]. Health competes with other sectors and visible priorities such as infrastructure, agriculture, education and security. Despite Abuja's commitment to allocate at least 15 percent of national budgets to health, only Rwanda, Botswana, and Cape Verde have consistently met the target, while most African countries still allocate well below 10 percent. This is compounded by the sharp decline in official development assistance (ODA) and rising debt stress, both of which are narrowing fiscal space for health investment. The health sector also operates within tight fiscal rules and wage-bill ceilings. It must navigate the incentives of Ministries of Finance, Public Service Commissions (PSCs), subnational governments and professional bodies.

The action outlined in the roadmap, therefore, needs to be implemented in a strategically sequenced and politically informed manner, with each step strengthening the enabling conditions for subsequent actions. The five sequenced actions below reflect this progression. Detailed implementation guidance for each action is provided in Annex C.

15%
Abuja's commitment: allocate at least 15 percent of national budgets to health

3
only Rwanda, Botswana, and Cape Verde have consistently met the target

<10%
most African countries still allocate well below 10 percent

Action 1

Secure clear political commitment across government.

Anchor CHW investment in a Cabinet paper or presidential decree, with a defined domestic financing target. Engage parliament through the health and finance committees and frame CHW investment as health security and employment policy, rather than solely a health service. The finance and labor ministries have a direct interest in a large, formally employed community health workforce that generates domestic economic activity.

Action 2

Turn political commitment into clear financing and policy commitments.

Convert the political signal into binding instruments: a costed multi-year plan, a dedicated CHW budget line embedded in the MTEF, and a written government-partner co-financing compact with annual milestones, declining donor share, and clear triggers for reductions.

Action 3

Put systems in place to track financing and strengthen accountability.

Governments cannot absorb what they cannot count, classify or manage. Establish a government-owned, biometrically verified national CHW registry; define a single national CHW model (one service package, one catchment norm, one supervision structure, one commodity kit); gazette a CHW remuneration policy; open a dedicated CHW budget line; and standardize supervision and reporting tools across all implementing partners, integrating CHW data into the national health management information system (HMIS).

Action 4

Gradually shift CHW financing to domestic resources in line with available government budgets.

A phased transition is often the most realistic approach given wage-bill ceilings and absorptive capacity constraints. The government should first absorb non-wage recurrent costs (supervision, commodities, operations), classified as goods and services rather than compensation of employees. Payroll integration should proceed in stages, beginning with contracting modalities that do not count against the civil service headcount, then transferring cohorts onto direct payroll as fiscal space allows. Governments may also engage with the International Monetary Fund (IMF) and the PSC to explore exemptions for CHW cadres from general wage-bill ceilings.

Action 5

Align national policies with how budgets are managed at the local level.

In decentralized countries, national policies without subnational financing mechanisms result in uneven implementation. Introduce conditional grants ring-fenced for CHW costs, with conditionality tied to verifiable coverage and quality metrics; establish matching-fund mechanisms where subnational governments have own-source revenue; explicitly include the CHW service package in NHIS benefit schedules; and institute quarterly subnational performance reviews using HMIS data.

Table 3. Common constraints and practical responses on the sustainability journey.

Constraint	Practical government response
Political under-prioritization of health	Cabinet mandate, costed investment case, parliamentary champions, employment framing.
Wage-bill ceilings blocking payroll integration	Contracting modality as an interim step; IMF engagement for CHW-cadre ceiling exemption; progressive cohort absorption; MTEF embedding.
Donor dependency and fragmented program design	Time-bound co-financing compact with a declining donor share; standardization of the service package, pay policy, and reporting before absorption.
No reliable domestic revenue stream for CHW services	Mobile money levy, tobacco or alcohol excise, airline ticket levy; NHIS purchasing of CHW services; dedicated budget line in MTEF.
Decentralization produces uneven implementation	Conditional grants tied to verified coverage and quality; matching-fund mechanisms for subnational own revenue; NHIS purchasing at the community level; quarterly HMIS-linked performance reviews.
Weak institutional systems	Biometric CHW registry; single national model; officially approved remuneration policy; dedicated CHW budget line; HMIS integration.

The lesson from countries that have made meaningful progress toward CHW sustainability, including Rwanda, Ethiopia, Ghana and Kenya to varying degrees, is that technical correctness is necessary but not sufficient. What distinguishes the successful cases is a government that understood the political economy of its own fiscal system and designed its CHW financing strategy around it: securing the mandate first, building the institutional systems that make absorption feasible, structuring the transition to respect fiscal rules, and using donor co-financing as a bridge with a defined end-date rather than an indefinite subsidy.

3.4 Implementation Architecture

Successful implementation of the Financing and Sustainability Roadmap requires coordinated action across multiple stakeholders, each with distinct and complementary roles and responsibilities. The summary below outlines the principal roles of key stakeholders across Phases 1 and 2, while the detailed stakeholder playbook and action-specific accountabilities are provided in Annex C.

Table 4. Stakeholder roles across the implementation architecture.

Stakeholder	Phase 1 role (Years 1 to 2)	Phase 2 role (Years 3 to 5)
Ministry of Health	Defines the national model; leads costing, registry, and policy; coordinates all actors; manages the donor compact.	Drives payroll integration; owns HMIS performance reviews; leads innovative financing and MTEF embedding.
Ministry of Finance	Validates costing; approves budget line; negotiates wage-bill implications; engages IMF on fiscal accommodation.	Approves domestic cost-share targets in MTEF; signs off on payroll ceiling exemption; enacts levy legislation.
Public Service Commission	Consulted on remuneration policy; advises on cadre classification and contracting modality.	Approves CHW cadre on payroll; negotiates headcount ceiling treatment; co-signs career pathway gazette.
Subnational Government	Co-designs supervision structures; contributes to registry roll-out; adopts harmonized reporting tools.	Executes conditional grant requirements; contributes own-source matching funds; manages district performance reviews.
Donors and bilateral partners	Finance gap analysis and costing; co-finance under the compact with a declining share; align with the national model.	Convert support to time-bound gap financing; fund equity top-ups; support only systems strengthening.
National Health Insurance	Consulted on benefit schedule design; provides data on premium collection feasibility.	Gazette CHW benefit package; establish purchasing relationship with CHW providers; manage claims verification.
Parliament	Health and finance committees briefed; champion CHW budget line in appropriation debate.	Approve levy legislation; scrutinize conditional grant formula; hold MoF and MoH accountable for targets.
Regional bodies (Africa CDC, WHO Africa)	Provide technical guidance on CHW model definition and costing standards; facilitate peer learning.	Track national progress against regional CHW targets; convene south-south learning exchanges; support IMF and donor engagement with regional evidence.
Implementing partners (NGOs and INGOs)	Execute gap analysis and costing under MoH lead; implement using the harmonized national model; manage CHW registries in assigned districts.	Convert delivery role to time-bound technical assistance and gap-filling; transition CHW contracts to government payroll, provides systems strengthening support.

4. Operational Financing Models and Mechanisms

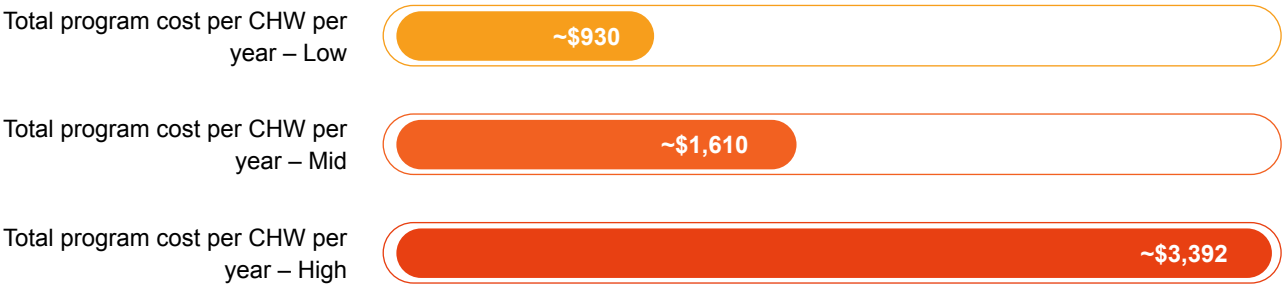
To support countries in progressively increasing the share of domestic financing for their CHW programs, the actions below should be considered in sequence.

4.1 Conduct a Foundational Costing Analysis and Financial Projection

Countries must have an accurate understanding of the costs of a CHW program, clearly distinguishing recurrent and one-off costs. Costs vary widely. A recent literature review reported that the median cost per CHW per year of an integrated community health worker program is approximately $3,793, but ranges from $197 to $9,186[17]. A summary of the principal cost components and indicative ranges is provided below; a more detailed costing breakdown is provided in Annex B.

Table 5. Summary of indicative CHW program costs per CHW per year (USD).

Cost category	Low	Mid	High
Recurrent costs (paid every year, primary fiscal burden)	$804	$1,386	$2,948
One-off/start-up costs (amortized over 5 years)	$126	$224	$444
Total program cost per CHW per year	**~$930**	**~$1,610**	**~$3,392**



4.2 Develop a Robust and Compelling Investment Case

A CHW program investment case is a structured document that makes the evidence-based argument for sustained government financing of community health workers to ministries of finance and planning, and to donor co-financing partners. Finance ministries engage seriously with a proposal when they can see exactly which cost lines will be transferred to the government in which year, what the wage-bill implications are, how the domestic share will be verified, and what happens to the program if a major donor exits. An investment case that answers those questions before they are asked is the one that survives the budget negotiation.

Table 6. Key components of an investment case and target thresholds.

Key components	Targets that signal a strong investment case
Value of averted hospitalizations. Averted emergency obstetric cases. Productivity gains (reduced morbidity). Cost-benefit ratio compared with facility-based alternatives. Link to macroeconomic growth where evidence allows.	ROI greater than 1:1 is the minimum threshold; strong cases show greater than 3:1. Cost per DALY averted within the WHO-CHOICE threshold (less than three times GDP per capita). Fiscal return framed in MoF-relevant terms (budget savings, not just health outcomes).

4.3 Financing Scenario Analysis

Following the costing analysis, countries should map their CHW resources and gaps to provide decision-makers with options, clarify trade-offs and priorities, and make realistic plans under uncertainty. Based on their starting position on the sustainability journey, countries can be classified under three scenarios:

a: Nascent:

Donor funding accounts for more than 75-80 percent of the CHW budget.

b: Developing:

Donor funding accounts for between 40-75 percent of the CHW budget.

c: Mature:

Donor funding accounts for less than 40 percent of the CHW budget.

This classification is illustrative. Countries should adapt it to their own context and use it to inform strategic actions on their transition journey.

4.4 Fiscal Space Analysis

Countries should conduct a fiscal space analysis to assess whether they can afford to increase spending on their CHW program as they transition across the maturity continuum. Typically, this analysis examines five pillars: overall macroeconomic conditions, reprioritization within the existing budget, dedicated domestic revenue instruments (such as levies on mobile money, tobacco or alcohol, external grants and loans, and efficiency gains from reducing waste or reallocating funds within a program.

1. Overall macroeconomic conditions
2. Reprioritization within the existing budget
3. Dedicated domestic revenue instruments
4. External grants and loans
5. Efficiency gains

Together, these pillars indicate the fiscal room available, the most viable financing channel, the binding constraints (whether a wage-bill ceiling, IMF conditionality, or political will), and the feasible sequence of cost absorption. The core limitation is that the analysis identifies whether the money could exist, not whether the institutional and political conditions will allow it to materialize. It must therefore be read alongside the political economy analysis set out in Section 3.3.

4.5 Pragmatic Approaches and Sources of Funding

To sustainably finance their CHW programs, countries should consider a diversified mix of sources, recognizing that no single source will be sufficient. The table below summarizes the principal sources, their main uses, and the sustainability dynamics associated with each.

Table 7. Sources of funding and their sustainability dynamics.

Funding source	Primary use	Sustainability dynamics
Government domestic revenue	Recurrent costs, salaries, and integration into the public health system.	Most sustainable; requires political commitment and sufficient fiscal capacity.
National health insurance	Service-related payments, performance incentives.	Highly sustainable when integrated into wider health financing reform.
Donor and development partner funding	Catalytic investment, transitional support, and technical assistance.	Time-bound; should be designed for transition rather than recurrent reliance.
Private sector	Co-investment in training, infrastructure and the purchase of services.	Potentially sustainable where the business case is strong.
Community contributions	In-kind support, infrastructure, and local resource mobilization.	Variable but important for ownership.
Impact investment	Growth capital for health enterprises and outcome-based financing.	Emerging mechanism; requires appropriate returns.

5. Accountability Framework

This accountability framework defines how governments and partners jointly plan, track, and enforce commitments to sustainably finance, integrate, and strengthen their CHW programs while transitioning from donor dependence to domestic financing. It sets clear transition milestones, early warning indicators, and agreed actions when commitments are delayed or not met. The primary objective is to protect decent work for community heatlh workers and the continuity and quality of community health services.

5.1 Guiding Principles

a. Country ownership: governments lead and determine national financing pathways.

b. Gradual and predictable donor transition: donor funding decreases in a coordinated, predictable manner, with clear milestones.

c. Transparency: commitments, disbursements, budget execution and results are tracked on an agreed dashboard with shared access.

d. Protection of community health workers: transition actions must protect community health worker remuneration and job security, as well as the continuity and quality of community health services.

e. Mutual accountability: both governments and partners are accountable for agreed commitments.

f. Results-based monitoring: progress is measured through clear indicators, milestones and annual reviews.

5.2 Governance and Roles

a

Country Steering Committee (semi-annual):
Chaired by the Ministry of Health, with the Ministry of Finance, PSC, subnational representatives where relevant, key donors and implementing partners. Approves annual transition plans, reviews the dashboard and authorizes corrective actions.

b

Technical Committee (quarterly):
A small joint team (MoH, MoF and partners) that maintains the costed plan, financing map and dashboard, prepares risk notes and tracks action closure.

b

Partner Coordination Group (quarterly):
Donors and implementing partners align workplans to “one plan, one budget, one report” for CHWs, agree co-financing shares, minimize parallel systems and provide predictable disbursement schedules.

5.3 Transition Milestones and Minimum Conditions

Each country-donor compact should define an agreed financing transition curve (with the government share rising and the donor share declining) and the minimum conditions that must be met before donor financing is reduced. The table below provides a common milestone structure that can be adapted to the country context.

Zero to 6 months: Compact

6 to 12 months: System readiness

1 to 2 years: Co-financing ramp

3 to 5 years: Institutionalization

Table 8. Transition milestones and conditions.

Phase	Transition milestones (examples)	Minimum conditions before donor reductions	Evidence and verification
0 to 6 months: Compact	Costed national CHW plan agreed by MoH and MoF. Signed government-donor financing compact with annual targets by cost line and disbursement calendar.	Compact signed; transition curve and triggers agreed.	Approved costing; signed compact; published financing map.
6 to 12 months: System readiness	CHW policy and strategy updated and approved; defined service package and supervision norms. CHW registry established and linked to payment controls. Dedicated CHW budget line created.	No reduction in donor share unless the registry, budget line and payment pathway are functional.	Gazetted policy; budget documents; registry audit; sample pay verification.
1 to 2 years: Co-financing ramp	The government assumes defined recurrent cost lines first (supervision, operations, commodities), then remuneration progressively. Donor funding shifts to time-bound gaps, technical assistance and systems strengthening.	Donor reductions only if budget execution and payment timeliness meet agreed thresholds.	Public Financial Management (PFM) execution reports; payroll reports; supervision coverage; stock availability.
3 to 5 years: Institutionalization	CHWs integrated into HRH plans and information systems; stable contracting or payroll mechanism in place. Domestic financing becomes the majority of recurrent costs; donor funding is limited to targeted, time-bound priorities.	Exit or transition decisions include a service-continuity assessment and safeguards.	HRH and HMIS integration proof; independent verification; annual joint sector review.

5.4 Early Warning Indicators and Response Actions

The Financial and Sustainability Roadmap dashboard should track a small set of early warning indicators across financing, system readiness, workforce, service continuity, and partner alignment, using a RAG (Red, Amber, Green) status system. Indicators are rated Green (on track), Amber (at risk), or Red (off track). Amber and Red ratings trigger time-bound actions and escalation, as set out below.

Table 9. Early warning indicators and response actions.

Domain and indicator	Amber trigger	Red trigger	Required actions
Government budget allocation	Allocation below the annual target or delayed budget release.	No CHW line item, or no release leading to payment or commodity disruption.	MoF and MoH issue a budget execution note and cash-release plan within 14 days. The Steering Committee agrees on a corrective financing package within 30 days.
Budget execution rate	Execution lags mid-year (procurement bottlenecks, delays to districts).	Persistent under-execution leading to stockouts, supervision gaps or pay delays.	PFM bottleneck analysis and procurement acceleration plan within 30 days. Shift partner support to unblock systems immediately.
Donor disbursement predictability	Disbursement slippage or partial disbursement without agreed mitigation.	Abrupt funding stop creates risk to pay, commodities or supervision.	The donor issues a written variance note and revised disbursement date within 10 business days. Partner Coordination Group activates contingency within 30 days.
Domestic absorption of CHW salary costs	Planned absorption into payroll or contracting is delayed by one quarter.	Two consecutive quarters of missed absorption, or the government announces a hiring freeze.	MoH, PSC and MoF conduct a root cause review and issue a cure plan within 15 business days. Activate contingency to absorb CHWs within seven to 14 days.
CHW payment timeliness	Late payments in one cycle, or increasing complaints.	Two consecutive late cycles or non-payment for more than 30 days.	Pay incident response: payroll root-cause analysis and fix within 14 days. Temporary continuity measure (advance, emergency payroll run) immediately.
Service continuity	Supervision coverage drops; intermittent stockouts; reporting gaps.	Sustained stockouts or supervision failure affecting priority services.	MoH activates a service continuity plan within seven days. Partners provide time-bound surge support within 30 to 60 days.

5.5 Escalation and Remedies

When an Amber or Red trigger is reached, parties apply the escalation ladder below. The intent is corrective action and service protection, not punishment. All steps should be documented on the dashboard with a named owner and due date.

a	Notification (within five business days): The technical committee issues an exception note describing the missed commitment, the likely cause and the immediate service risks.
b	Cure plan (within 15 business days): The responsible party submits a time-bound cure plan with actions, dates, responsible officials and required approvals, endorsed by MoH, MoF or the donor lead.
c	Steering Committee decision (within 30 days): Approves one of: proceed with transition as planned; pause donor reductions; re-phase milestones; activate contingency financing; or initiate compact renegotiation.
d	Senior escalation (within 45 to 60 days): If unresolved, elevate to ministerial level (MoH and MoF) and donor leadership; agree on political or administrative actions to restore compliance.
e	Compact reset (within 90 days): If structural constraints persist (wage-bill ceiling, fiscal shock, donor policy change), formally revise targets, responsibilities and the transition curve to preserve feasibility.

Table 10. Agreed remedies by type of missed commitment.

Commitment at risk	Government-side actions	Donor or partner-side actions
Domestic co-financing not delivered	Issue a budget reallocation or a supplementary request; agree on interim financing within fiscal rules. Pause non-essential expansions; protect the minimum service package and CHW pay.	Do not reduce planned support solely due to short-term slippage that would cause service disruption; instead, activate a time-bound bridge while the compact is rephrased. Provide targeted technical assistance to MoF and MoH to resolve bottlenecks.
Donor disbursement delayed or reduced	Activate service-continuity measures (temporary budget advances, emergency procurement, reprogramming non-critical lines). Request a formal donor variance note and revised schedule via the Steering Committee.	Provide a revised disbursement schedule and interim mitigation (advance, no-cost extension or reprogramming) to avoid payment or commodity disruptions. Align conditionalities to compact triggers.
Policy or legal milestones delayed	Adopt interim administrative directives (MoH circulars) while completing formal policy or legislation. Publish a dated policy roadmap with accountable owners.	Provide legal and policy technical assistance and facilitate peer learning. If delays create transition risk, pause donor reductions tied to that milestone until minimum conditions are met.
Service quality or coverage declines during transition	Implement an immediate quality recovery plan (supervision surge, commodity redistribution, refresher training) and ensure the minimum service package is protected.	Provide time-bound surge support for supervision, data systems and supply chain while strengthening government capacity to sustain improvements.

5.6 Reporting, Review Cadence, and Documentation

a. Quarterly: Technical committee updates the dashboard (financing flows, payment timeliness, training, supervision, commodities) and circulates a one-page exception report.

b. Semi-annual: Steering Committee reviews the RAG status, verifies action completion and approves any re-phasing or contingency activation.

c. Annual: Joint review alongside national health sector review processes to confirm progress on the transition curve, update the next year's milestones and document lessons learned.

d. Record of decisions: All deviations, cures, pauses and compact revisions are captured in a written decision log (date, rationale, approvals and follow-up actions).

5.7 Accountability Scorecard

Table 11. Accountability scorecard, targets and ownership.

Indicator	Target	Responsible
Domestic share of CHW financing	Greater than 70 percent by Year 5	Ministries of Finance and Health
CHW absorption in government payroll or contracts	100 percent by Year 5	Ministries of Health and Public Service
Donor transition adherence	Annual targets met	Partners and Steering Committee
CHW payment reliability	Greater than 95 percent on time	Ministry of Health
CHW retention	Greater than 90 percent	District health offices

6. Monitoring, Evaluation and Learning

6.1 Key Performance Indicators

Tracking progress toward sustainability requires monitoring across multiple dimensions.

Financial sustainability indicators

a. Percentage of CHW program costs financed by government (target: 70 percent or higher by Year Five; 80 percent or higher by Year 10).
b. Absolute amount of government budget allocated to CHW programs (annual increase target: 15 percent to 20 percent).
c. Donor funding share of CHW program cost.
d. Number and value of private sector partnerships and co-investments.

Institutional sustainability indicators

a. Existence of national CHW policy, strategy and implementation guidelines.
b. CHW program integration into government structures (dedicated units and the health care system).
c. Number of technical institutions or colleges with institutionalized CHW training program.
d. Government capacity assessment scores for CHW program management.
e. Percentage of CHWs with formal employment contracts.

Workforce and service sustainability indicators

a. CHW deployment rates (percentage of trained CHWs employed).
b. Proportion of CHWs receiving minimum wage or higher.
c. CHW retention rates and attrition patterns.
d. Number of households accessing care from CHWs.
e. Quality of CHW care scores from supervision and client satisfaction surveys.
f. Health outcome indicators in communities served by CHWs.

6.2 Learning Agenda

A robust learning agenda ensures continuous improvement and evidence generation. Illustrative learning questions include:

a. What strategies are effective for transitioning donor-funded programs to government ownership?

b. What blended financing models achieve the best balance of sustainability, equity and quality?

c. How can private sector engagement be optimized to support CHW sustainability without undermining public sector responsibility?

d. What governance and oversight mechanisms best ensure accountability in CHW livelihood models?

e. How does community resource mobilization contribute to program sustainability and community empowerment?

6.3 Adaptive Management

a. Quarterly review meetings with implementing partners to assess progress, identify challenges and adjust strategies.

b. Annual sustainability assessments measuring progress against roadmap milestones.

c. Mid-term evaluation (MTE) with external review of the sustainability trajectory and course corrections.

d. Documentation and dissemination of lessons learned through case studies, policy briefs, and peer-reviewed publications.

e. Regular stakeholder convenings to share experiences, troubleshoot challenges, and build collective learning.

7. Risk Management and Mitigation

As countries implement this roadmap, they will need to conduct a risk assessment and employ mitigation strategies to achieve the desired goals.

Table 12. Risk assessment matrix.

Risk	Likelihood/ Impact	Mitigation strategy
Insufficient government budget allocation and wage-bill constraints	High High	Early and sustained advocacy; demonstrate cost-effectiveness; build champions. Frame CHWs as a productivity and resilience investment, not a recurrent cost: link the program to reduced morbidity and mortality, improved school attendance, workforce participation and outbreak preparedness; use a fiscal narrative showing costs are predictable and small relative to losses from preventable illness and shocks.
Donor funding ends before government readiness	Medium High	Flexible transition timelines; contingency funding; co-financing requirements.
Private sector engagement is insufficient	Medium Medium	Proactive partnership development; strong business cases; diverse private sector engagement.
Economic shocks reduce fiscal space	Medium High	Diversified financing; emergency funding mechanisms; prioritization frameworks.
Quality deterioration during transition	Medium High	Maintain supportive supervision; quality monitoring; professionalization and accreditation.
CHW attrition due to inadequate compensation	High High	Fair compensation; non-conflicting income diversification through financial inclusion support; career pathways; improved working conditions.
Lack of community ownership	Low Medium	Community engagement from the outset; local governance structures; recognition programs.

8. Conclusion: Towards a Sustainable Future

The sustainability of CHW programs in African countries is not merely a financing challenge. It is an opportunity to fundamentally transform how Africa's PHC workforce is valued, compensated and empowered. This roadmap presents a comprehensive pathway from donor dependency to sustainable, multi-stakeholder financing that creates dignified work opportunities for young Africans while strengthening health systems.

Success requires simultaneous progress across all four pillars: government integration with progressive domestic financing; strategic donor coordination with planned transitions; dynamic private sector engagement leveraging market mechanisms; and CHW livelihood models that complement, rather than compete with, public service delivery. These pillars are mutually reinforcing. Government ownership creates a stable foundation; donor harmonization reduces fragmentation; the private sector brings innovation and resources; and non-conflicting livelihoods empower community health workers and their communities.

Achieving this vision requires sustained commitment from all stakeholders, a willingness to innovate and adapt, and a sharp focus on quality, equity, and dignity. The ultimate measures of success will be:

1. CHWs receiving fair, sustainable compensation that supports dignified livelihoods.
2. Young people, particularly women and economically disadvantaged groups, are finding meaningful employment in the health sector.
3. Communities experiencing improved health outcomes and expanded access to quality primary care.
4. Governments exercising full ownership with adequate domestic resource allocation.
5. Africa’s health systems are demonstrating greater resilience and capacity to meet population needs.

The journey toward sustainability is complex and long-term. The destination is clear: a future in which community health workers are recognized, compensated and empowered as essential pillars of Africa's health systems; in which young Africans find dignified work in service to their communities; and in which the vision of opportunity for all to learn and prosper becomes a lived reality.

Annexes

Annex A: Detailed Implementation Matrix

This Annex presents the full implementation matrix of actions, lead and contributing roles, and key deliverables across Phases 1 and 2. Roles are denoted as L (Leads), R (Responsible), A (Accountable), C (Consulted) and I (Informed).

Stakeholder abbreviations: MoH = Ministry of Health; MoF = Ministry of Finance; PSC = Public Service Commission; SubNat = Subnational Government; NHIS = National Health Insurance Scheme; CHW = CHW; Parl. = Parliament; Reg. = Regional bodies (Africa CDC, WHO Africa); IP = Implementing Partners.

L Leads R Responsible A Accountable C Consulted I Informed

Action	MoH	MoF	PSC	Sub	Don	NHI	CHW	Parl	Reg	IP	Key deliverable
Phase 1 (Years 1 to 2): Enable and Align (Mandate, Systems and Compact)											
Establish government-led CHW financing coordination mechanism	L	A	C		C			I	C	I	Formal coordination body with terms of reference; MoF and PSC represented.
Map CHW financing sources, gaps and opportunities	L	C		C	C				C	R	Comprehensive financing gap analysis endorsed by MoH and shared with MoF.
Secure a cross-government political mandate for CHW investment	R	A	C		I			A	C	I	Cabinet paper or presidential decree committing to CHW sustainability target.
Develop a costed national CHW investment case	L	C		C	C			I	C	R	Investment case quantifying cost per DALY, employment return and fiscal risk of donor exit.
Define a single national CHW model	L		I	C	C		C		C	C	Gazetted national CHW model; all implementing partners aligned.
Complete rapid costing of the minimum CHW package	L	C			C				I	R	Costing report separating recurrent and one-off costs by cost driver.
Gazette CHW remuneration policy and payment mechanism	L	A	A		I		C		I	I	Gazetted pay scale; mobile money or bank transfer payment mechanism operational.
Introduce a dedicated CHW budget line in the government health budget	L	A		C				A	I	I	Approved CHW budget line in annual appropriation.
Negotiate a co-financing compact with donors	L	A			R			I	C	I	Signed a co-financing agreement with annual domestic share targets and donor exit timeline.
Build national CHW registry (biometric, government-owned, HMIS-linked)	L		C	R	C		R		I	R	All CHWs are enrolled in a verified national registry integrated with HMIS.
Standardize CHW reporting and supervision tools across partners	L			R	C		R		C	R	Harmonized reporting templates and supervision protocols adopted by all IPs.
Build the institutional capacity of training institutions and MoH	L		C	C	C				R	R	Training institutions are accredited; MoH CHW workforce management unit is operational.

L Leads R Responsible A Accountable C Consulted I Informed

Action	MoH	MoF	PSC	Sub	Don	NHI	CHW	Parl	Reg	IP	Key deliverable
Phase 2 (Years 3 to 5): Absorb and Integrate (Payroll, Insurance and Domestic Revenue)											
Progressively raise domestic share of CHW recurrent costs; embed in MTEF	L	A		R	I			A	I	I	Annual domestic funding targets in national and subnational budgets; CHW costs in MTEF.
Integrate CHWs into government payroll or contracting modality (phased by cohort)	L	A	A	R			R	I	I	I	CHWs on formal government payroll or time-bound contract; zero informal payments.
Integrate CHW services into national health insurance benefit schedule	L	C		C	I	A	R		C	C	CHW service package gazetted in NHIS benefit schedule; purchasing relationship established.
Formalize subnational co-financing rules (conditional grants, matching funds)	L	A		R				A	I	I	Intergovernmental fiscal transfer formula includes CHW coverage and quality metrics.
Introduce innovative domestic CHW financing mechanisms (levies, earmarked funds)	R	L			I	C		A	C	I	At least one new levy enacted; revenue earmarked for CHW fund.
Fully integrate CHWs into HRH information systems	L		C	R	I		R		C	R	CHW data in the national HRH information system; quarterly CHW workforce report.
Convert remaining partner support to time-bound gap financing	A	C			R			I	C	R	Residual donor and IP funding below 20% of the total CHW budget; role limited to systems strengthening.
Introduce results or performance-based financing for districts	L	C		R	C	C			C	C	PBF scheme with verification mechanism and equity safeguards.
Operationalize blended financing and private sector partnerships	L	C			C	C			C	C	Blended financing mechanism operational; private sector co-investment agreements signed.
Institutionalize quarterly district performance reviews using HMIS	L	I		R	I		R		I	I	Quarterly district CHW performance reports; the corrective action mechanism operational.
Establish contingency financing reserve	R	L			C			A	C		Contingency reserve of at least 10% of annual CHW budget, ring-fenced.
Institutionalize CHW supervision, career pathways and retention	L		A	R	I		R		C	C	Formal career ladder gazetted; supervision structure with designated supervisors.
Conduct regular value-for-money (VfM) reviews	L	C			C			I	C	I	Annual VfM review report; recommendations integrated into next planning cycle.

Annex B: Detailed CHW Costing Components

This Annex provides the detailed line-item costing components that underpin Table 5 in Section 4.1. Costs are illustrative and should be adapted to country-specific contexts.

Table B1. Detailed illustrative costing of the CHW program (USD per CHW per year).

Cost component	Type	Low	Mid	High
Recurrent costs: paid every year (primary fiscal burden)				
CHW stipend or salary (including social contributions where applicable)	Recurrent	480	840	1,560
Performance or activity-based top-up (optional PBF supplement)	Recurrent	–	60	180
Supervisor cost: apportioned per CHW (1 supervisor per 25 CHWs)	Recurrent	96	144	216
Annual refresher training (~20 hours per year)	Recurrent	24	40	80
Commodities and medical supplies (RH, malaria, diarrhoea, nutrition package)	Recurrent	60	120	300
Data connectivity and mobile data plan	Recurrent	48	96	240
Transport and field allowance (bicycle maintenance or fuel)	Recurrent	36	72	144
Program management, M&E	Recurrent	48	90	180
Community engagement and peer supervision	Recurrent	12	24	48
Subtotal: recurrent costs per CHW per year		**$804**	**$1,386**	**$2,948**
One-off and start-up costs: amortized over 5 years				
Initial pre-service training (6 to 12 months classroom and in-service)	One-off	80	150	300
Smartphone or feature phone (amortized over 5 years)	One-off	20	30	60
Solar charger (amortized over 5 years)	One-off	6	8	12
Equipment bag or backpack	One-off	2	3	5
Basic clinical kit (MUAC tape, weighing scale, BP cuff, thermometer)	One-off	8	15	30
CHW uniform or identification (bib, t-shirt, ID card)	One-off	3	5	10
Biometric registry enrolment (one-time national system cost per CHW)	One-off	4	8	15
Policy, strategy and investment case (per CHW share)	One-off	3	5	12
Subtotal: one-off costs per CHW per year (amortized)		**$126**	**$224**	**$444**
Total program cost per CHW per year		**~$930**	**~$1,610**	**~$3,392**

Annex C: Stakeholder Playbook and Political Economy Detail

C.1 Detailed Stakeholder Roles

This Annex expands on Section 3.4 by detailing the key decisions each stakeholder owns and the principal fiscal or political constraints they face.

Table C1. Detailed stakeholder roles, decisions owned and constraints.

Stakeholder and mandate	Key decisions owned	Fiscal or political constraint
Ministry of Health (program lead and technical authority)	National CHW model; remuneration policy; registry design; HMIS standards; performance review outcomes.	Must coordinate multiple stakeholders simultaneously; budget competition with curative services; limited fiscal staff capacity.
Ministry of Finance (fiscal gatekeeper, MTEF authority and wage-bill enforcer)	MTEF allocations; wage-bill ceiling; levy design and enactment; contingency reserve; MTEF inclusion of CHW costs.	IMF conditionality on wage-bill and deficit; competing sector demands; risk of open-ended payroll commitment.
Public Service Commission (civil service headcount and cadre classification authority)	CHW cadre classification; payroll absorption schedule; headcount ceiling exemption for CHW cadre.	Headcount ceilings enforced under IMF programs; classification disputes between health and general service cadres.
Subnational Government (service delivery authority and local budget holder)	District CHW deployment; local budget allocation to CHW; compliance with national model.	Narrow own-source revenue; competing local priorities; weak monitoring capacity; variable political will across districts.
Donors and bilateral partners (transitional co-financiers)	Annual financing tranche under the compact; adoption of harmonized tools; adherence to the exit timeline.	Declining ODA budgets; short funding cycles misaligned with government MTEF; risk of fragmenting program if not aligned.
National Health Insurance (purchaser of CHW services)	CHW benefit schedule; reimbursement rates; claims verification mechanism; provider contracting modality.	Premium collection gaps in low-income settings; political pressure on benefit inclusion; claims processing capacity.
Parliament (legislative authority and budget approval body)	Annual appropriation of CHW budget line; levy legislation; conditional grant formula approval.	Annual budget calendar pressure; competing constituency priorities; limited technical health financing literacy.
Regional bodies (Africa CDC, WHO Africa)	Regional CHW normative standards and benchmarks; peer review of national investment cases; convening of multi-country learning platforms; advocacy with international financing institutions.	Limited direct financing role; influence is normative and convening; must balance technical guidance with country sovereignty; regional mandates may not align with bilateral donor timelines.
Implementing partners (NGOs and INGOs)	Adoption and enforcement of national model standards; compliance with transition timeline; data sharing with the national HMIS; contractual transfer of CHW rosters to the government registry.	Organizational incentive to maintain direct delivery role beyond transition; donor funding cycles may not align with government absorption timeline; capacity in remote areas the government cannot yet reach.

C.2 Political Economy Reform Detail

This section provides additional "how to do it" details for the five sequenced reform actions set out in Section 3.3.

Action 1: Securing the political mandate

a. Commission and publicly release a costed investment case framed in terms that ministers of finance respond to: cost per DALY averted, return on investment through reduced hospitalization, and contributions to employment and social protection. Quantify the fiscal risk of not investing.

b. Table a Cabinet paper or presidential decree committing the government to a defined CHW sustainability target (for example, 70 percent domestic financing of CHW recurrent costs within five years), creating a public accountability anchor that persists beyond individual ministers.

c. Engage parliamentarians through the health and finance committees, not just through the Ministry of Health, so that budget allocations for community health workers have champions in the legislature.

d. Frame CHW investment as a health security and employment policy, not solely a health service. This broadens the political coalition: ministries of labor and finance have a direct interest in a large, formally employed community health workforce.

Action 3: Building institutional mechanisms

a. Establish a national CHW registry that is government-owned, biometrically verified, and linked to the health information system. This is the instrument that converts a loosely defined workforce into a roster that can be put on a payroll.

b. Define a single national CHW model: one service package, one catchment norm, one supervision structure, one commodity kit. Standardization is a prerequisite for costing, and costing is a prerequisite for budgeting.

c. Gazette a CHW remuneration policy that specifies the government pay rate, the payment mechanism (bank transfer or mobile money, not cash), the payment schedule, and the basis for any performance incentive. The rate should be grounded in an independently costed living-wage analysis for the relevant rural context.

d. Open a dedicated CHW budget line in the government health budget, separately from the general PHC line. A dedicated line makes spending visible, creates an accountability anchor for the Ministry of Finance, and is the prerequisite for MTEF inclusion.

e. Standardize supervision and reporting tools across all implementing partners, integrating CHW data into the national HMIS, as a condition for the quarterly district performance reviews that maintain quality and demonstrate results.

Action 4: Phased transition step detail

Step 4a: The government first covers non-wage recurrent costs. Before absorbing payroll, governments should absorb supervision costs, commodity procurement and program operations onto the government budget. These costs do not trigger wage-bill ceiling concerns because they are classified as goods and services expenditure rather than compensation of employees. This step is fiscally safer and politically easier and demonstrates to the Ministry of Finance that the Ministry of Health can manage the CHW program expenditure responsibly before the much larger wage commitment is made.

Step 4b: Progressive payroll integration designed around civil service constraints. Full immediate payroll absorption is unachievable in most Sub-Saharan African contexts. The practical path is: (i) begin with a contracting modality, where government contracts community health workers through a third-party mechanism (a health facility or a local government entity) that does not count against the civil service headcount; (ii) as fiscal space opens, progressively transfer cohorts onto direct payroll, starting with the best-performing districts to build the internal systems needed for payroll management; (iii) negotiate with the IMF and the PSC a specific CHW-cadre exemption from the general wage-bill ceiling, justified by the documented fiscal return on CHW investment.

Action 5: Aligning national policy with subnational budget authority

a. Introduce conditional grants from the national health budget to subnational governments, ring-fenced for CHW costs (supervision, commodities and, progressively, stipends). Conditionality should be tied to verifiable CHW coverage and quality metrics, not to processes.

b. Where subnational governments have own-source revenue, establish matching-fund mechanisms: the national government matches every shilling the county or district contributes to CHW financing, up to a defined ceiling. Kenya is an example of this model.

c. In countries with national health insurance schemes (Ghana, Kenya, Nigeria, Tanzania), explicitly include the CHW service package in the NHIS benefit schedule and establish a purchasing relationship between the NHIS and community-level CHW providers. This creates a revenue stream that does not depend on annual budget appropriation.

d. Establish quarterly subnational performance reviews using HMIS data, and link conditionality of national transfers to performance. Subnational governments that consistently underperform lose the discretionary element of their transfer; those that exceed targets receive a performance top-up.

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