Community Health Workforce Program

Common implementation guidance for partners implementing the Mastercard Foundation's Community Health Workforce Program in Africa

Strengthening Africa's Community Health Workforce: Alignment, Implementation and Sustainability

April 2026

About this Guidance

This document provides practical implementation guidance for partners delivering the Mastercard Foundation's Community Health Workforce Program across Africa. It outlines shared principles, implementation considerations, and minimum standards to support coordinated, context-responsive, and high-quality program delivery.

The guidance is intended for governments, implementing partners, training institutions, employers, and other ecosystem stakeholders involved in the design, implementation, supervision, and sustainability of CHW programs. It should be used alongside national policies, regulatory frameworks, and country-specific program approaches.

Foreword

Across Africa, communities stand on the frontlines of resilience, care, and opportunity. Community Health Workers (CHWs) are central to this reality, bridging households and health systems, advancing equitable access to care, and responding to both everyday health needs and extraordinary public health shocks. At the same time, millions of Africa's young people continue to seek dignified, meaningful pathways into work and service. This Common Implementation Guidance is grounded in the conviction that these two realities can, and must, be addressed together.

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. Strengthening Africa's community health workforce represents one of the most compelling opportunities to advance this ambition while also supporting countries' progress toward universal health coverage (UHC), resilient health systems, and inclusive economic growth.

This guidance sets out a clear, evidence-based framework for partners implementing the Mastercard Foundation's Community Health Workforce Program. It outlines non-negotiable standards, particularly in relation to dignified and fulfilling work opportunities, fair compensation, professionalization, and government stewardship, while recognizing the diversity of national contexts and the importance of adaptive implementation. Drawing on global and African evidence and aligned with guidance from the World Health Organization (WHO), the Africa Centers for Disease Control and Prevention (Africa CDC), and the African Union (AU), this document positions CHW programs not as short-term interventions, but as integral components of national health and employment systems.

Importantly, this guidance reframes CHW programs as structured employment pathways for young people. It emphasizes standardized training and certification, predictable and fair remuneration, supportive supervision, digital enablement, career progression, and sustainable financing anchored in domestic resources. Gender equality and social inclusion are embedded throughout, reflecting our commitment to addressing the structural barriers that young women and economically disadvantaged groups continue to face in accessing quality health services and dignified, fulfilling work opportunities.

We extend our sincere appreciation to the governments, partners, practitioners, and young people whose experience, leadership and insights informed this work. Their contributions reinforce a critical lesson: when community health workers are recognized as professionals, supported by strong systems, and compensated with dignity, the returns - in health, employment, and resilience - are profound and lasting.

As you engage with this guidance, we invite you to view community health not only as a health intervention, but as a nation-building investment - one with the power to strengthen systems, empower a generation of young leaders, and improve the lives and livelihoods of millions across the continent.

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Contents

Acronyms

AfDB	African Development Bank
AU	African Union
CDC	Centers for Disease Control and Prevention
CHW	Community Health Worker
CPD	Continuing Professional Development
CSR	Corporate Social Responsibility
HECSI	Higher Education, Collaboratives and Strategic Initiatives
HEP	Health Extension Program
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
IMF	Impact Measurement Framework
IT	Information Technology
ITU	International Telecommunication Union
KPI	Key Performance Indicator
LMIC	Low- and Middle-Income Country
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, and Learning
mHealth	Mobile Health
NCD	Non-Communicable Disease
PBIs	Performance-Based Incentives
PHC	Primary Health Care
PTC	Portfolio Technical Committee
RACI	Responsible, Accountable, Consulted, and Informed
SDGs	Sustainable Development Goals
SM	Shared Measure (e.g., SM1, SM7, SM9)
TB	Tuberculosis
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VSLA	Village Savings and Loan Association
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
YiW	Youth in Work

Executive Summary

This guidance document presents a streamlined approach to strengthening and deploying community health workers across Africa, aligned with the Mastercard Foundation's mission to enable 30 million young people to access dignified and fulfilling work opportunities by 2030. It responds to two critical challenges: a projected health workforce shortage of 6.1 million workers by 2030 and persistently high youth unemployment, with more than 10 million young people entering the labour market each year while only approximately three million formal employment opportunities become available.

The Common Implementation Guidance supports implementing partners and Mastercard Foundation teams in designing, implementing, and scaling CHW programs that strengthen health systems while creating dignified and fulfilling employment opportunities for young people.

Drawing on frameworks and guidance from the Africa CDC, WHO, the AU, and other global and regional institutions, the document establishes minimum standards alongside adaptable implementation approaches across core CHW program components. It complements national policies and priorities and serves as a practical reference for program design and implementation, partner alignment, and government and stakeholder engagement. This guidance is not intended to prescribe a single or uniform model; rather, it is designed to support context-responsive implementation across diverse country settings.

Importantly, the guidance advances a model that positions CHW programs as structured employment pathways, particularly for young women, refugees and displaced persons, and persons with disabilities. It emphasizes youth-centered recruitment; standardized training and continuous professional development; fair and sustainable compensation models, including salaries and performance-based incentives; digital enablement for supervision, learning, and data management; sustainable financing mechanisms; and clear career pathways into the formal health sector. Gender equality and social inclusion are integrated throughout the implementation approach.

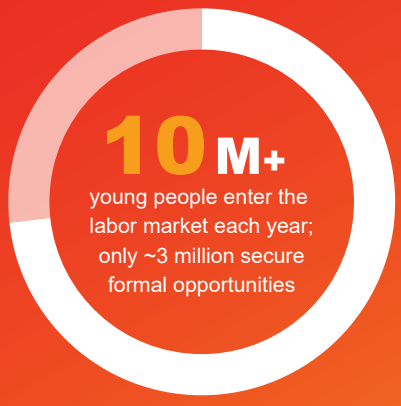
Through this approach, the guidance seeks to support dignified and fulfilling employment opportunities for up to 600,000 young people, expand access to primary health care (PHC) for 50 million underserved people, strengthen community-based health systems, and contribute to progress toward UHC and the Sustainable Development Goals (SDGs).

6.1M
projected health workforce shortage of workers by 2030

600,000
young people supported into dignified and fulfilling employment opportunities

50M
underserved people reached with expanded access to primary health care (PHC)

30M
young people the Foundation seeks to enable into work by 2030.



01 Introduction and Context

1.1 The Dual Challenge: Health Workforce Gaps and Youth Unemployment

Africa faces a dual challenge of severe health workforce shortages and persistent youth unemployment. WHO projects a shortage of 6.1 million health workers in Sub-Saharan Africa by 2030[1]. At the same time, while approximately 70 percent of Africa's population is under the age of 30, youth unemployment remains high: each year, over 10 million young people enter the labor market, yet only about three million secure formal employment[2].

Community health workers are recognized as part of national health systems in more than 60 percent of African countries; however, CHW density remains low, averaging approximately one CHW per 1,235 people, indicating substantial scope for expansion[3]. Evidence suggests that closing the global health workforce gap could generate over USD1 trillion in economic value, including approximately $300 billion from direct employment opportunities, while reducing preventable morbidity and mortality[4]. Given that Africa is home to more than 530 million young people, expansion of the health workforce represents a significant opportunity for large-scale employment opportunities and productivity growth in youth-dominated economies[2].

Professionalized and integrated CHW programs present a strategic response to these interconnected challenges. When effectively designed and implemented, CHW programs can help address health workforce shortages, expand access to PHC, create employment opportunities for young people, strengthen community-facility linkages, and build resilient health systems capable of responding to epidemics and advancing UHC[5].

1.2 Alignment with our Mission and Strategic Goal

This CHW Common Implementation Guidance aligns health system strengthening with youth employment by advancing learning, financial inclusion, support for priority populations, catalyzing economic growth, and creating dignified and fulfilling work opportunities for young people across Africa.

The guidance advances learning through competency-based training that equips young people with market-relevant health, digital, and professional skills, supporting quality service delivery as well as pathways to further education and career progression. It also promotes financial inclusion by linking community health workers to predictable income, opportunities that strengthen savings, access to financial services, and economic resilience.

In addition, the guidance intentionally prioritizes young women, refugees and displaced persons, and people with disabilities, recognizing the strengths and lived experiences they bring while addressing persistent barriers to formal employment.

By supporting the expansion of the health sector, one of Africa's fastest-growing employment areas, the guidance contributes to catalyzing economic growth through expanded employment opportunities and improved population health outcomes that underpin productivity and resilience. Central to this approach is enabling access to employment opportunities through the formalization of CHW roles as compensated positions within national health systems, characterized by fair and reliable income, respect and recognition, safe working conditions, and clear pathways for learning, advancement and career progression, in line with the Foundation's definition of dignified and fulfilling work.

Minimum Standards for Dignified and Fulfilling CHW Work

- Reliable and transparent remuneration meeting or exceeding national minimum wage or poverty line benchmarks.
- Formal contracts or written agreements with defined roles, workload, and grievance mechanisms.
- Reasonable and documented working hours.
- Safety protections and mechanisms to prevent harassment or abuse.
- Opportunities for certification, skills development, and career progression.

Performance-based incentives income may supplement, but not replace, core remuneration. Standards should be adapted to national labour laws and the fiscal and health systems.

Partners are expected to design CHW roles that meet these standards, avoid reliance on unpaid volunteer labour, track dignified work outcomes, and align CHW employment models with national youth employment and PHC strategies.

This guidance is intended not only as a technical reference but also as a **shared platform for negotiation and alignment** among governments, development partners, funders, and implementing agencies. It clarifies where standards are non-negotiable (e.g., dignified pay, government leadership) and where contextual flexibility is appropriate, supporting transparent decision-making, risk management, and sustained national ownership.

1.3 Evidence Base for CHW Programs in Africa

Evidence from across Africa demonstrates the effectiveness and scalability of CHW programs. South Africa's ward-based outreach teams have strengthened HIV, TB, and chronic care delivery through integrated supervision and defined CHW roles[7]. Ethiopia's Health Extension Program (HEP), with over 38,000 workers, has contributed to major reductions in child mortality and increased immunization coverage through standardized training and career pathways[8]. Multi-country evidence from Benin, Burkina Faso, Ghana, Malawi, Mali, Niger, and Zambia shows that CHW effectiveness depends on adequate training, fair compensation, supportive supervision, and strong health system integration[9]. Across contexts, compensated and well-integrated community heatlh workers demonstrate higher motivation, retention, accountability, and impact[4].

1.4 Current Landscape and Challenges

Despite progress, CHW programs face persistent systemic constraints. Recruitment criteria and gender targets are inconsistently applied, particularly in rural and underserved areas, leaving women facing safety risks, unpaid care burdens, limited advancement, and uneven access to standardized training and continuous professional development[10] [11]. Fragmented compensation systems mean many community health workers remain volunteers or receive irregular stipends, driving attrition and constraining participation in income-generating models[12] [13].

Weak supervision and digital support, combined with incomplete integration into Human Resources for Health (HRH) plans, financing, supply chains, and health information systems, continue to limit effectiveness and sustainability[11]. These challenges are compounded by a heavy reliance on donor financing (approximately 60 percent) and fragmented, disease-specific funding models that undermine government ownership and integrated PHC delivery[11].

Donor reliance

Approximately **60 percent** of CHW financing currently relies on donors, alongside fragmented, disease-specific funding models that undermine government ownership and integrated PHC delivery.

02 Vision, Goals, Principles and Use

2.1 Vision

A thriving network of young, skilled, and professionally recognized community health workers serving as the cornerstone of equitable, accessible, and resilient health systems across Africa, while creating dignified employment pathways for 600,000 young people by 2030.

2.2 Strategic Goals

1 Goal 1: Youth Employment and Economic Empowerment.

600,000 roles

Create 600,000 CHW roles for young people aged 18 to 35, with a strong focus on inclusion. At least 70 percent of community health workers will be young women, with a minimum of five percent recruited from refugee or displaced populations and three percent persons with disabilities. Community health workers will be engaged through formal salaried employment models aligned with national public sector systems and CHW compensation will not rely on supplementary or self-generated income.

2 Goal 2: Health Systems Strengthening.

50M reached · 90% retention

Expand access to essential PHC for 50 million people in underserved communities. Achieve a 90 percent CHW retention rate through adequate pay, supervision, and support. Integrate community health workers into national health workforce strategies in all target countries and establish functional referral linkages between community health workers and health facilities in 100 percent of implementation sites[5].

3 Goal 3: Professional Development and Career Progression.

40% progress in 5 yrs

Provide standardized six-month initial training for all recruited community health workers and establish nationally recognized certification systems endorsed by health ministries[14]. Ensure that at least 40 percent of community health workers progress to education or formal health employment within five years, supported by clear career pathways into nursing, clinical, or health management roles.

4 Goal 4: Sustainable Financing.

70% domestic by yr 5

Achieve 70 percent domestic government financing for CHW programs by year five and reduce donor dependency over the next five to 10 years to approximately 20 percent to 30 percent through innovative financing approaches. Digital health technologies will be leveraged to improve efficiency and reduce operational costs[14] [5].

2.3 Guiding Principles

Implementation will be grounded in youth-centered design, ensuring that recruitment, training, supervision, and progression pathways respond to young people's aspirations and capabilities. It will also be guided by principles of dignified work, including fair compensation, safe working conditions, professional recognition, protection of rights, and opportunities for career development.

Programs must promote gender equality and inclusive participation by prioritizing recruitment of young women and addressing barriers related to safety, mobility, caregiving, disability, displacement, and discrimination, including childcare or caregiving support, safe transport, flexible deployment, inclusive recruitment with reasonable accommodation, and clear safeguards to prevent and respond to harassment or abuse.

CHW programs will emphasize community ownership, operating through and strengthening existing community health structures, and health system integration, with clear roles, referral pathways, supervision, and data systems linked to facilities. Implementation will follow evidence-based adaptation, drawing on proven African CHW models while allowing contextual flexibility. Sustainability and resilience will be embedded through long-term financing and governance models that withstand political and economic shocks, and partnership and collaboration will underpin delivery, aligning governments, communities, civil society, training institutions, the private sector, and development partners around shared accountability.

03 Implementation Components

3.1 Target Population and Recruitment Strategy

Effective CHW programs require context-specific workforce planning and inclusive, community-embedded recruitment aligned with population needs and health system capacity. Recruiting community health workers from the communities they serve, while prioritizing young women, youth from low-income households, refugees with legal work status, and people with disabilities, strengthens trust, equity, and accountability, and is associated with improved service uptake and continuity of care in African settings[5][15].

A phased, community-led recruitment approach is recommended that combines mobilization, transparent screening, community verification, structured selection, and formal onboarding to improve community health worker motivation, retention, and performance, particularly when recruitment is linked to dignified and fulfilling work conditions, predictable remuneration, and clear career pathways[16] [17]. These principles align with continental accountability frameworks that emphasize governance, workforce institutionalization, and community engagement as the foundations of sustainable CHW programs[18].

3.1.1 Community Health Worker Candidate Profile

Selection criteria should balance minimum education and core competencies with strong community embeddedness, local language proficiency, and demonstrated commitment to service. WHO guidance recognizes this balance as essential for quality, acceptability, and sustainability, while allowing national flexibility[5]. Indicative criteria include youth aged 18 to 35 years, completion of secondary education, residence or strong ties to the catchment area, fluency in local languages, and personal attributes such as reliability, empathy, and communication skills. Priority should be given to young women (minimum 70 percent), youth from low-income households, refugees and displaced persons with legal work authorization, people with disabilities, and youth with prior health training.

3.1.2 Recruitment Process

Recruitment should follow a transparent, phased process that combines community ownership with formal health-system oversight. WHO recommends participatory recruitment, community validation, and formal onboarding to support accountability and long-term integration[5]; the Africa CDC Community Health Program Continental Landscape Survey Report similarly highlights transparent recruitment, registration, and onboarding as prerequisites for workforce institutionalization and performance monitoring[14]. Indicative phases include community mobilization and outreach; application, screening, and verification; structured selection through inclusive panels and interviews; and formal onboarding, including orientation, contracting, registration with Ministry of Health systems, and issuance of identification.

Recruitment Accountability Snapshot

- **Responsible:** Implementing partners; local governments.
- **Accountable:** Ministry of Health.
- **Consulted:** Community leaders, health facilities, youth representatives.
- **Informed:** Ministry of Finance, civil service commissions (where applicable).

Core principle: *Recruitment decisions should reinforce government stewardship, even where partners support implementation.*

3.2 Training Curriculum and Capacity Building

Training and capacity building are central to CHW effectiveness and safety, and should be grounded in competency-based education aligned with defined scopes of practice and referral pathways.

The WHO Global Curriculum Guide for community health workers provides a structured framework of universal and role-specific competencies that can be adapted to national contexts, covering priority health areas, digital health, community engagement, and emergency preparedness[19].

Evidence from CHW programs shows that blended, practice-focused models, combining classroom instruction with supervised community and facility-based learning, improve skills, confidence, and service quality, particularly when reinforced through certification, refresher training, and structured continuing professional development[20] [21]. These approaches align with continental quality-assurance priorities emphasizing accreditation, certification, and ongoing skills reinforcement as prerequisites for safe scale-up and system resilience[18].

3.2.1 Initial Training Program (six to 12 months)

In alignment with the WHO guidance on competency-based training for community health workers, the standardized curriculum proposes 10 core modules with indicative durations that should be adapted to national contexts based on starting proficiency, context, and needs. Modules cover community engagement and mobilization; maternal, newborn, and child health; immunization; nutrition; communicable diseases, including HIV, TB, and malaria) non-communicable diseases; mental health; sexual and reproductive health; data, digital health, and reporting; and health emergencies and outbreak response.

3.2.2 Training Methodology

Training should follow a blended, competency-based approach that prioritizes practical skills while ensuring foundational knowledge. WHO guidance recommends an appropriate balance between classroom instruction and supervised community- and facility-based practice to support safe and effective service delivery[19]. The indicative model includes approximately 60 percent practical, skills-based learning in communities and health facilities and 40 percent classroom-based instruction, with digital learning modules embedded across both modalities. Assessment should be continuous and competency-focused, combining practical skills assessments, written and oral examinations, and a supervised community-based practicum, leading to national certification upon successful completion.

3.2.3 Continuing Professional Development

Continuing professional development (CPD) is essential to maintaining competencies, supporting motivation and retention, and enabling community health workers to adapt to evolving health priorities. WHO recommends structured, needs-based CPD integrated with supportive supervision and linked to clear career progression pathways[19] [5]. The Africa CDC Continental Landscape Survey Report similarly identifies ongoing training, certification, and skills reinforcement as key indicators of workforce institutionalization and system maturity[14] [18]. Evidence from multi-country African studies shows that learning embedded within supervision systems is associated with higher CHW motivation and retention[16].

Ongoing training (post-initial training) should be delivered through structured learning embedded in routine supervision and mentorship, including regular on-the-job training, periodic refresher sessions, annual continuing education, specialized modules as new priorities

If training capacity is limited,	>	Prioritize minimum competency-based initial training with supervised practice rather than expanding scope prematurely.
If national certification systems exist,	>	Then CHW training should be accredited and linked to formal credentials.

If certification frameworks are under development,	>	Interim certification should be recognized by Ministries of Health and transitioned to national systems within an agreed timeframe.
If retention is a concern,	>	Invest first in supervision-linked learning and clear progression pathways rather than expanding cohort size.

Core principle: *Scale should never outpace training quality and supervision capacity.*

Career advancement training is critical to sustaining the community health workforce. Pathways should enable progression to supervisory, mentoring, and training roles and, where national policy allows, transition into higher-level health cadres such as nursing or midwifery, including bridge courses, leadership and health management training, specialized certifications (e.g., mental health, non-communicable diseases), and train-the-trainer programs, aligned with national health workforce strategies[19 5 14].

3.3 Compensation and Incentive Models

3.3.1 Compensation Structure

CHW compensation should be anchored in predictable, regular remuneration, with fixed salary models preferred where system capacity allows. Salaries should be paid through government payroll systems and aligned with national labor laws, HRH policies, and public-sector wage frameworks[11]. Where blended financing is applied, salaries should be progressively transitioned and absorbed into government budgets and payrolls[18 3 24]. Complementary incentives may be introduced but must not substitute for core remuneration. Salaries should be paid monthly, independent of performance, benchmarked to national minimum wage or entry-level health worker scales, set to meet basic living costs, and adjusted annually for inflation. Phased financing and absorption plans should be jointly agreed with Ministries of Finance and Civil Service[24].

While no uniform amount is prescribed, current CHW compensation levels of approximately $50 per month in many contexts are inadequate. Indicative long-term planning benchmarks include $150 to $250 in urban settings and $100 to $180 in rural settings, to be validated against national salary scales and cost-of-living data.

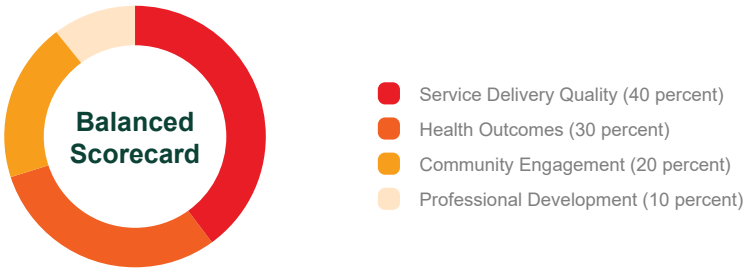
Core Rules for CHW Compensation

- Salaries are a condition of dignified and fulfilling work, not incentives.
- Paid regularly through government systems.
- Independent of performance metrics.
- Benchmarked to living costs and public-sector wage frameworks.
- Progressively absorbed into national budgets.

3.3.2 Performance-Based Incentives (PBIs)

Performance-Based Incentives (PBIs) are encouraged but not mandatory and should be applied only where minimum system readiness exists, including functional data systems, adequate supervision capacity, and alignment with broader HRH incentive frameworks[11]. In fragile or low-capacity settings, salary-only models are appropriate. Where applied, PBIs should be grounded in objective indicators, paid quarterly, include both individual and team components, and be designed to encourage quality performance while minimizing unintended incentives.

A balanced scorecard approach is recommended, with performance assessed across four areas: service delivery quality (40 percent), health outcomes (30 percent), community engagement (20 percent), and professional development (10 percent). Indicators may include quality and timeliness of services, coverage of priority interventions, community outreach and engagement, and participation in training and mentoring.



3.3.3 Non-Financial Incentives

Non-financial incentives are mandatory conditions of work and should not be treated as optional rewards, nor linked to performance[11] [25]. Essential tools, equipment, and supplies are occupational requirements and must be provided to all community health workers, regardless of performance, in line with WHO guidance on safety and service quality[11] [26]. These include standard CHW kits, uniforms and identification, mobile phones and data packages, appropriate transport, and protective gear. Social protection measures, such as health insurance, life and disability coverage, maternity and paternity provisions, retirement savings, and access to emergency support, should be integrated into CHW employment packages[11] [25].

Professional recognition and career development mechanisms may include registration, certification, public recognition, clear progression pathways, access to further education or scholarships, leadership roles, and representation in health governance structures, aligned with national workforce strategies[27] [28] [24].

Decision Implications: CHW Compensation Models

If fiscal space exists for wage absorption today,	>	Then community health workers should be placed directly on government payroll with fixed monthly salaries benchmarked to public-sector scales.
If fiscal space is constrained but systems exist,	>	Then partners may finance salaries temporarily, with formal agreements for progressive absorption into government payroll within a defined timeline (e.g., three to five years).
If government payroll systems are not yet functional,	>	Then interim payment mechanisms may be used, but only with written transition plans, clear accountability, and protection of CHW employment rights.
If performance-based incentives are being considered,	>	Then they should be introduced only where data systems and supervision capacity are sufficiently mature; otherwise, salary-only models are preferred.

Non-negotiable standard: Community health workers must receive predictable, regular pay that meets dignified work thresholds. Volunteer or stipend-only models should not be supported.

Compensation and Incentives Accountability Snapshot

- **Responsible:** Ministry of Health, Civil Service, payroll authorities.
- **Accountable:** Ministry of Finance.
- **Consulted:** Implementing partners, CHW representatives.
- **Informed:** Donors and financing partners.

Core principle: *Salary decisions and wage-bill integration are sovereign government responsibilities. Partner financing should be transitional and aligned to formal absorption plans.*

3.4 Supplementary Income-Generating Activities

Core Principle

Supplementary income should complement – not replace – fair, government-financed compensation for CHW compensation.

3.4.1 Income-Generating Activities

Additional income should be clearly separated from compensation for CHW work; CHW salaries must be independent of any income-generating activity. No program design should require or assume that community health workers will engage in supplementary economic activities to sustain their livelihoods. Income-generating activities should be non-clinical, aligned with national regulations and local market opportunities, and designed to strengthen household economic security without compromising CHW performance. Health-related commercial activities, including consultations, diagnostics, product sales, prescriptions, or commission-based referrals, present conflicts of interest and regulatory risks and are therefore not supported under Foundation-funded CHW programs. Only non-healthcare income-generating activities are permitted.

3.5 Supervision, Digital Enablement, and Accountability

Supervision should follow a multi-level, supportive model that combines peer learning, facility-based technical oversight, and district-level management, in alignment with WHO and Africa CDC guidance, while allowing for contextual flexibility.

Evidence from African and Low- and Middle-Income Country (LMIC) settings shows that mentoring-focused supervision, regular feedback, and joint problem-solving are associated with stronger CHW performance, motivation, and quality of care[12 14 25 32].

Multi-Level Supervision Model

LEVEL 1 — Peer Support Groups

Groups of CHWs should meet biweekly to share experiences, challenges, and solutions through peer learning and collaborative problem-solving, with rotating facilitators. While meeting frequency may be adapted to local contexts, sessions are recommended at least monthly.

LEVEL 2 — Facility-Based Supervision

Each CHW should be supervised by designated health facility staff (such as a nurse or clinical officer), with monthly supervisory visits to observe work, review registers, assess data quality, and support service delivery. Supervision should include on-the-job mentoring focused on quality assurance, problem-solving, and skills reinforcement, with an indicative ratio of one supervisor to 10 to 15 community health workers.

LEVEL 3 — District Health Management Team

Periodic (e.g., quarterly) supervision by district health officers should include performance reviews, resource allocation, problem-solving, quality assurance spot checks, and monitoring of policy implementation.

Figure 1: Multi-level supervision structure for CHW programs.

Digital tools should be embedded within routine supervision and service delivery systems to strengthen feedback loops, data use, and accountability while reducing costs. Evidence shows that integrated mobile reporting, dashboards, and decision-support tools improve supervision timeliness and data-driven decision-making when aligned with national digital health strategies and platforms, rather than implemented as stand-alone solutions[33 20 34].

Supervision and digital systems should support quality assurance and accountability mechanisms that emphasize continuous learning, improvement, and supportive performance management. Evidence shows that regular assessment, audit and feedback, mentoring, and recognition improve performance, while punitive approaches undermine motivation[37 9]. Accountability should be embedded across supervision levels through clearly defined roles, routine performance monitoring, timely feedback and follow-up, as well as transparent digital reporting tools aligned with national CHW policies and scopes of practice[11 38 39]. Community feedback mechanisms should, where appropriate, complement formal supervision, strengthening trust and enhancing responsiveness[17 14 18].

3.6 Integration into Health Systems

Effective integration of community health workers into national health systems is central to program scale, sustainability, and impact. WHO guidance, alongside evidence from Africa and other LMIC settings, consistently demonstrates that CHW programs achieve stronger coverage, continuity of care, and health system resilience when integrated into national policies, financing arrangements, service delivery models, and health information systems, rather than implemented as parallel or project-based initiatives[5 18 40]

> **Evidence-Based Principle**
> CHW programs are most effective and sustainable when integrated into national health systems rather than implemented as stand-alone projects.

3.6.1 Integration into National Health Strategies

WHO guidance emphasizes that CHW programs should be formally embedded within national development plans, health policies, PHC strategies, health workforce plans, essential service packages, and monitoring and evaluation (M&E) frameworks, supported by legal recognition and dedicated budget lines [5]. African and continental analyses further show that countries with clearer policy alignment, defined governance arrangements, and increased domestic financing for community health workers demonstrate stronger program stability, accountability, and institutionalization[14 40].

Key integration elements, therefore, include legal recognition of community heath workers as a distinct health workforce cadre; inclusion within national health workforce and PHC strategies; integration of CHW roles into essential service packages; allocation of dedicated budget lines within national health budgets; incorporation of CHW indicators into national M&E frameworks; and oversight through national and sub-national health sector coordination mechanisms[5].

3.6.2 Linkages with Health Facilities

Strong operational linkages between community health workers and health facilities are essential to ensure continuity of care, quality assurance, and effective referral and follow-up.

Guidance from WHO, alongside global and African evidence, shows that CHW programs are more effective when community health workers are functionally connected to health facilities through defined referral pathways, routine information exchange, and inclusion in facility-level supervision and planning processes, rather than operating in isolation for the broader health system[5 9 32].

Evidence from African and LMIC studies further demonstrates that well-defined referral and counter-referral systems, supported by communication mechanisms and context-appropriate transport arrangements, improve adherence to clinical protocols, timeliness of care, and patient outcomes[9 32].

3.7 The Model CHW Program

The minimum viable CHW implementation defines the core functional package required to deliver dignified and fulfilling work opportunities and measurable health impact, while enabling phased system strengthening over time. Minimum viable requirements include:

- **Employment:** Community Health workers engaged through written contracts or agreements with defined workload, rights, and grievance mechanisms.
- **Compensation:** Regular monthly pay that meets minimum dignified work benchmarks, including where partners temporarily support financing.
- **Training:** Competency-based initial training with supervised deployment aligned to the national scope of practice.
- **Supervision:** Regular, supportive supervision linked to health facilities (minimum monthly contact).
- **Payroll or payment system:** Traceable, auditable payment system with a documented transition plan to government payroll.

Countries may expand beyond this minimum as capacity grows, but these elements are non-negotiable entry points to a credible CHW program. All Mastercard Foundation-supported CHW programs should be designed to align with this model. While implementation may be adapted to the national context, programs should reflect these core elements to ensure dignified work opportunities, health system integration, and long-term sustainability.

04 Monitoring, Evaluation and Learning

The monitoring, evaluation, and learning (MEL) approach for CHW programs aligns with the Foundation's Impact Measurement Framework (IMF) and Shared Measures (SM) 2.0, with a focus on sustained improvements in the quality of life for young women and men, benefits for households and communities, and long-term systems change. MEL will track results at individual, household, community, and system levels, combining quantitative indicators with qualitative learning to strengthen adaptive management and accountability.

4.1 Results Framework

The Results Framework reflects the Foundation's pathway from access to work-enabling interventions to youth-in-work (YiW) outcomes, dignified and fulfilling work opportunities, and system-level impact, recognizing community health workers as both a health workforce and a youth employment cohort.

Impact level (system and population outcomes)

Results capture long-term changes in health systems, labour markets, and well-being beyond individual participants, aligned with SM7 (lives and livelihoods), SM8 (ecosystem strengthening), and SM9 (institutional strengthening). Intended impacts include improved population health outcomes; reduced inequities in access for underserved populations; sustained improvements in quality of life and resilience for community health workers and their households; and strengthened national and sub-national systems that recognize, value and sustain community health workers within PHC and youth employment ecosystems.

Outcome level (youth employment, dignity, and system sustainability)

Results assess whether young people are accessing, sustaining, and progressing in dignified and fulfilling work opportunities as community health workers, and whether systems are effectively absorbing and retaining the cadre. Program-level benchmarks include employment or retention of 600,000 young people in paid CHW roles, sustained access to CHW services for 50 million people, high CHW retention with a program ambition of 90 percent, domestic financing of 70 percent of CHW program costs, and progression of approximately 40 percent of community health workers into advanced, supervisory, or higher-value roles by 2030.

Output level (program delivery and system readiness)

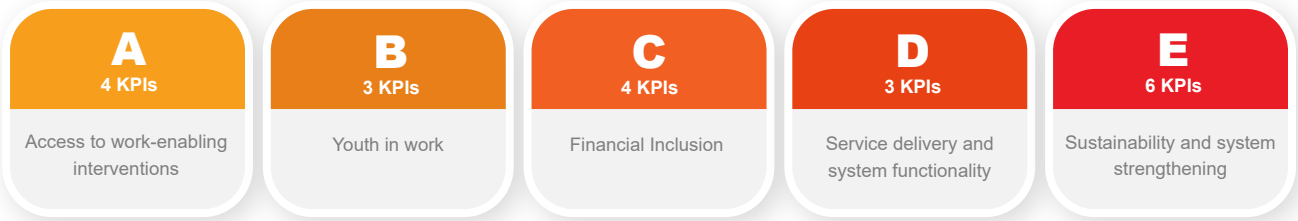
Results track delivery of work-enabling interventions, service coverage, and system readiness, aligned with SM1 and SM9. Core outputs include the numbers of community health workers recruited, trained, deployed, and supported; household and community coverage; the quality and timeliness of CHW data and reporting; the functionality of supervision and quality assurance systems.

4.2 Key Performance Indicators

The Key Performance Indicator (KPI) framework is organized around the Foundation's priority areas of youth employment and empowerment, service delivery, quality and performance, and sustainability, while aligning with SMs wherever possible. The framework comprises 20 KPIs organized across five thematic areas:

- **A. Access to work-enabling interventions (four KPIs)** – capturing CHW access to and completion of training, certification, and progression to advanced roles.
- **B. Youth in work (three KPIs)** – measuring employment of young people as community health workers, government payroll absorption, and dignified work outcomes.
- **C. Financial Inclusion (four KPIs)** – tracking access to finance, growth, market expansion, and work opportunities generated.
- **D. Service delivery and system functionality (three KPIs)** – capturing household reach, supervision coverage, and data reporting completeness.

- **E. Sustainability and system strengthening (six KPIs)** – measuring policy influence, ecosystem collaborations, institutional strengthening, domestic financing, registry coverage, and Health Management Information System (HMIS) integration.



The full KPI tables, including targets, SM codes, data collection cadence, and accountability assignments, are presented in Annex B. All KPIs are disaggregated by country, age (youth aged 18 to 35 years), gender, location (rural/urban), disability status, and displacement status, including refugees and internally displaced people.

4.3 Learning and Adaptation

Learning is embedded throughout implementation to support adaptive management, continuous improvement, and contribution to the evidence base. WHO guidance and African evidence emphasize the routine use of monitoring data, structured reflection, and feedback mechanisms within supervision and management systems to inform timely adjustments to program design and delivery[41 5 20]. Implementation science further underscores the importance of iterative testing, piloting, and course correction during scale-up[42]. Learning and adaptation will be supported through regular district and national reviews, documentation of lessons and innovations, and targeted research and South–South learning partnerships.

Structured Review and Course Correction

Year 2 Financing Review

If domestic financing targets are below agreed milestones	>	Revise transition timelines and financing mix.
If targets are met or exceeded	>	Accelerate payroll absorption and reduce parallel systems.

Performance Review Checkpoints

If CHW retention falls below 80%	>	Prioritize compensation, supervision quality, and workload adjustments before scaling.
If service coverage and data quality exceed targets	>	Consider scope expansion or geographic scale-up.

These reviews should inform explicit “go/adapt/pause” decisions documented through national governance mechanisms.

05 Financing Strategy and Budget Framework

5.1 Financing Principles

The financing strategy aligns with the Financing and Sustainability Roadmap for Community Health Workers in Africa (2026). It is grounded in health sovereignty, defined as country ownership, governance, financing, and the adaptation of CHW programs to national priorities[14 18 43].

> **Financing Principle**
> Sustainable CHW programs transition from donor support to predominantly domestic public financing, with government leadership at the core.

Sustainable domestic financing. Financing is treated as a managed transition from fragmented, donor-dependent support toward integrated, government-led systems, complemented by aligned private-sector and community contributions. Sustainability is anchored in progressive government ownership, predictable public financing, and institutionalization within national systems.

WHO and Africa CDC guidance emphasize domestic budget integration, multi-year commitments, and reduced reliance on external financing as prerequisites for long-term viability and accountability[14 11 44]. Program financing prioritizes multi-year government budget commitments, protected CHW budget lines, and a progressive increase in domestic financing toward a program ambition of approximately 70 percent by 2030, subject to fiscal space.

Innovative financing mechanisms. Innovative and blended financing mechanisms may complement public funding during transition periods, including time-bound donor support, social protection and insurance integration, results-based financing, and responsible private sector co-investment. These mechanisms must supplement rather than replace public financing and remain aligned with national frameworks[14 43 45].

Efficiency and value for money are strengthened through digital systems, shared infrastructure, rational task allocation, evidence-based costing, and transparent financial management integrated within government systems[11 44 46 14].

5.2 Financing Sources

Consistent with the Financing and Sustainability Roadmap and the Africa CDC Continental recommendations, sustainable CHW programs rely on multiple financing sources with clearly sequenced roles, progressing toward predominantly domestic public financing[3 14]. Indicative financing composition includes government allocation as the foundation at approximately 70 percent, transitional development partner financing at 20 percent to 30 percent, and catalytic private sector and philanthropic funding at approximately five percent to 10 percent, aligned with public systems and governance[14].

5.3 Indicative Country Transition Timeline and Accountability

Table 1: Indicative financing sources and targets for sustainable CHW programs.

Financing Source	Target %	Key Mechanisms
Government Allocation	70%	National and subnational budgets, wage bills, social health insurance, and earmarked levies
Development Partners	20 – 30%	Aligned multi-year grants, technical assistance, and results-based financing
Private Sector and Philanthropy	5 – 10%	Corporate Social Responsibility (CSR) programs, health sector employers, private facilities, corporate partnerships, catalytic co-investment

Countries are expected to define context-specific transition pathways with time-bound milestones, reviewed through established governance mechanisms, and aligned with the Financing and Sustainability Roadmap. Early phases prioritize policy alignment and capacity building, followed by co-financing and scale, culminating in institutionalization with domestic public resources financing routine CHW service delivery.

Clear accountability underpins financing transitions. Governments retain authority for policy reform, wage bill integration, and long-term financing commitments. Implementing partners support planning, monitoring, and milestone tracking. Donors align financing with national transition plans and gradually reduce support. The Mastercard Foundation provides catalytic financing, strategic oversight, learning, and risk management to support credible transitions.

Recommended budget templates (national and district level) are provided in Annex E. These are indicative and should be adapted to country-specific contexts. Mastercard Foundation financing and budget templates will be used for internal program development, approval, and reporting.

5.4 Cost-Effectiveness Considerations

$50–$150
approximate cost per disability-adjusted life year averted, below commonly used cost-effectiveness thresholds

500–1,000
people typically served by CHWs, improving coverage at low marginal cost

High
value for money due to low unit costs, broad reach, and substitution of lower-cost community-based care

Evidence from multi-country economic evaluations shows that CHW programs offer high value for money due to low unit costs, broad reach, and the substitution of lower-cost community-based care for more expensive facility services[48]. Most evaluations report costs of approximately $50 to $150 per disability-adjusted life year averted, below commonly used cost-effectiveness thresholds[48 49].

Community health workers typically serve 500 to 1,000 people, improving coverage at low marginal cost and reducing reliance on costly hospital care[11 50]. Integration of community health workers into PHC also generates productivity gains through reduced absenteeism and lower household health expenditures[49 51]. Efficiency gains are further supported by digital tools, task sharing, community-based delivery models, and integrated multi-service delivery rather than vertical programs[48 30].

5.5 Policy Brief for Economic and Fiscal Leadership

Community health workers should be viewed as a long-term public-sector investment rather than a recurrent donor cost.

Why Community Health Workers Matter for Ministries of Finance and Government Leadership

- CHWs deliver high coverage at low unit cost, reducing pressure on hospitals.
- Investing in CHWs creates formal jobs, particularly for young women, and contributes to national employment strategies.
- Predictable wage-bill integration reduces inefficiency from fragmented, off-budget payments.

Managing Fiscal Risk

- Phased absorption protects fiscal space.
- Clear headcount controls and standardized pay scales prevent uncontrolled expansion.
- Digital payroll and HRH registries reduce ghost workers and leakage.

CHW financing reform is therefore a broader productivity, service delivery, and governance reform - not only a health intervention.

06 Risk Management and Mitigation Strategies

6.1 Risk Categories and Approach

CHW programs face risks across financial, operational, political, social, technical, and health system dimensions. A structured risk management approach is therefore essential, combining proactive identification with targeted mitigation embedded in governance, financing, and supervision systems. Implementing partners are expected to maintain risk registers, escalate emerging risks through agreed governance mechanisms, and align mitigation actions with national risk frameworks.

1	2	3	4	5	6
Financial	Operational	Political	Social	Technical	Health system

Financial risks include insufficient government funding, donor withdrawal, and inflation eroding real compensation. Mitigation centers on multi-year budget commitments, ring-fenced budget lines, phased co-financing transitions, indexed compensation, and diversified financing.

Operational risks include high CHW attrition, weak supervision, and supply chain stock-outs. Mitigation measures prioritize predictable compensation, career pathways, supervisor training, digital tools, and integrated supply chains.

Political risks include policy reversals and political interference in recruitment. Mitigation relies on legislative entrenchment, cross-party advocacy, transparent selection criteria, and community committees with grievance mechanisms.

Social risks include community resistance and safety concerns affecting women community health workers. Mitigation depends on continuous community engagement, participatory planning, safety protocols, buddy systems, and accessible reporting channels.

Technical risks include digital system failures. Mitigation requires offline functionality, backups, and IT helpdesks within the Ministry of Health IT units.

Health system risks include resistance from professional cadres, mitigated through role clarification, joint training, and collaborative supervision.

The complete risk assessment matrix, including specific risks, mitigation strategies, and primary responsibility, is presented in Annex C.

6.2 Sustainability Safeguards

Long-term sustainability of CHW programs depends on reinforcing legal, institutional, financial, and social safeguards in combination rather than as stand-alone measures. Evidence shows that CHW programs are most resilient when policy entrenchment, government institutionalization, predictable financing, and political and community support are addressed together[11 14 52].

Legal and policy safeguards are critical to continuity. Embedding CHW programs within health legislation and regulatory frameworks helps protect them from political turnover, while formally recognizing community health workers as a health workforce cadre within national HRH strategies strengthens professionalization, accountability, and retention[5 11 14 53]. Protected budget lines further reduce vulnerability to discretionary funding cuts[11 14 47 26].

Institutional safeguards anchor CHW programs within government systems. Housing program management within Ministries of Health, with clear roles at the national, district, and facility levels, reduces fragmentation and supports scalability[11 5 14]. Standard operating procedures, national implementation guidelines, and accreditation systems promote consistency, quality assurance, and sustained professional standards at scale[14 11 5 39].

Financial safeguards should prioritize progressive increases in domestic financing, guided by clear targets and timelines[11 14 47]. Diversified financing models that place public funding at the centre, while allowing limited donor, private sector, and community contributions, can help reduce exposure to fiscal shocks[14 55 4].

Social and political safeguards reinforce durability. Strong community ownership, particularly when communities participate in CHW selection and oversight, is consistently associated with higher utilization and program resilience[11 14 9]. Evidence of CHW impact on health outcomes and value for money strengthens political and fiscal commitment[54 48], and active CHW associations support advocacy and workforce stability[54 7 26 9].

07 Implementation Roadmap

The implementation roadmap follows a phased approach that supports deliberate sequencing, continuous learning, and system strengthening, while allowing flexibility to adapt to country context, institutional capacity, and financing readiness. Progression between phases should be guided by performance and system readiness rather than fixed timelines.

1

7.1 Phase 1: Foundation Building

Months 1 to 12

Phase 1 establishes the policy, institutional, and system foundations required for sustainable scale-up. Priorities include anchoring CHW programs within national frameworks, developing core systems, and piloting early implementation to enable learning.

Key activities include the development and endorsement of national CHW policies and legal frameworks; the establishment of national and district coordination mechanisms; the finalization of training curricula; the adaptation of digital platforms; integration planning for supply chains; and the development of MEL systems.

Strategic partnerships with government, communities, training institutions, and selected private sector actors are formalized. The initial implementation is intentionally limited to a small number of districts, allowing recruitment, training, supervision, and feedback mechanisms to be tested, refined, and strengthened before scale-up.

2

7.2 Phase 2: Expansion

Months 13 to 36

Phase 2 focuses on controlled scale-up alongside strengthened systems and financing. Geographic expansion proceeds while maintaining quality and coherence, typically reaching approximately half of the target districts and scaling recruitment and training in line with national capacity.

This phase emphasizes strengthening supervision and quality assurance systems, rolling out digital platforms, deepening integration between community health workers and health facilities, institutionalizing routine data use, and expanding capacity-building for supervisors and training institutions. Financing efforts prioritize increased domestic budget allocations, engagement with the private sector, and, where appropriate, the introduction of results-based or performance-linked financing.

3

7.3 Phase 3: Consolidation

Months 37 to 60

Phase 3 focuses on consolidating gains and embedding CHW programs within permanent national systems. Programs reach the intended scale and geographic coverage, and digital systems fully operational.

Sustainability is reinforced through majority domestic public financing, fully operational legal and policy frameworks, functional career pathways, and routine supervision, accreditation, and quality assurance systems.

Program maturity is reflected in sustained improvements in priority health outcomes, high CHW retention and motivation, strong community demand for services, and learning exchanges that support replication and adaptation across contexts.

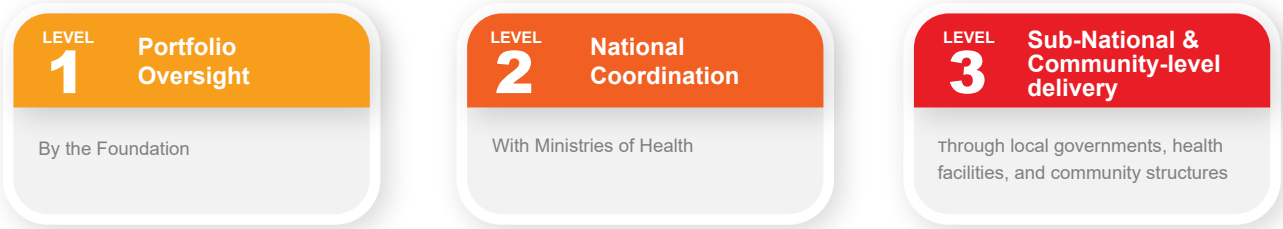
08 Implementation Architecture and Program Governance

This section defines the governance and implementation architecture for the CHW program, clarifying roles, accountability, and coordination across the Mastercard Foundation, implementing partners, and government counterparts. The objective is to ensure coherence, country ownership, and consistent execution across countries, while allowing adaptation to national context.

8.1 Overall Implementation Architecture

The CHW program follows a partner-led, government-aligned model with portfolio-level stewardship by the Mastercard Foundation. Implementing partners and national authorities are accountable for country-level delivery, while the Foundation provides strategic oversight, learning, and risk management.

Implementation operates across three connected levels: portfolio oversight by the Foundation, national coordination with Ministries of Health, and sub-national and community-level delivery through local governments, health facilities, and community structures. Clear role delineation supports government ownership, reduces duplication, and ensures consistency across the portfolio.



8.2 Roles and Responsibilities

8.2.1 Mastercard Foundation (Portfolio Stewardship)

Provides strategic leadership, catalytic support and portfolio oversight; sets shared outcomes and strategic direction; convenes and chairs the Portfolio Technical Committee (PTC), oversees partner performance; manages cross-country risks; and supports learning and knowledge dissemination. The Foundation does not directly implement activities.

8.2.2 Implementing Partners (Program Delivery)

Hold primary responsibility for country-level program design and delivery, coordination with government, oversight of sub-partners, performance and financial management, reporting, and youth engagement. Lead partners are accountable to the Foundation for overall program coordination, sub-partner management, and delivery of agreed outcomes.

8.2.3 Ministries of Health (National Stewardship)

Provide policy and regulatory oversight; ensure alignment with national CHW strategies and health workforce plans; integrate community health workers into national systems; and participate in national coordination and review mechanisms.

8.2.4 Africa CDC Continental Coordination Mechanism (CCM) (Continental Stewardship)

Africa CDC provides continental-level stewardship and coordination for CHW programs across AU Member States. The CCM will be represented on the CHW program PTC and will support alignment of Foundation-supported programs with AU and Africa CDC priorities and standards.

8.2.5 Local Governments and Health Facilities (Operational Integration)

Support the day-to-day supervision of community health workers, integration into local service delivery systems, and community engagement, feedback, and accountability mechanisms.

8.3 Program Portfolio Oversight

Portfolio oversight is provided through the PTC, which serves as the primary mechanism for strategic guidance, alignment, learning, and risk management across countries and partners. The committee complements, rather than replaces, partner-led governance structures. It supports alignment with Foundation priorities and national agendas; strengthens visibility of results and performance trends; enables coordinated management of cross-partner risks; promotes portfolio-level learning; and facilitates timely course correction.

The PTC includes representatives from the Foundation, implementing partners, and youth leadership. It is supported by two advisory groups: a Technical Advisory Group, which provides implementation-focused guidance and escalates risks as needed, and a Youth Advisory Group, which ensures structured youth engagement and input into portfolio-level decision-making.

8.4 Accountability and Coordination Mechanisms

Accountability and coordination are strengthened through standardized reporting and review cycles that link partners to the PTC; national coordination mechanisms aligned with Ministry of Health priorities; portfolio-wide risk tracking; and structured learning forums and peer exchanges to promote alignment, shared learning, and efficiency.

A detailed Responsible, Accountable, Consulted, Informed (RACI) matrix outlining roles and responsibilities across the Mastercard Foundation, lead implementing partners, sub-partners, and Ministries of Health is provided in Annex C.

09 Conclusion and Call to Action

9.1 Transformative Potential

This Common Implementation Guidance presents an opportunity to address both Africa's health workforce shortages and youth unemployment through professionalized CHW programs. Evidence from Africa, alongside global guidance, demonstrates that well-integrated CHW programs can expand access to PHC while creating dignified and fulfilling work opportunities for young people[14]. By embedding CHW programs within national systems – supported by predictable financing, professional standards, and clear career pathways – these programs can shift from project-based interventions into sustainable components of health and employment systems.

9.2 Call to Action

Realizing this potential will require coordinated commitment and collaboration among governments, implementing partners, donors, and communities. Governments are called to lead policy, financing, and integration efforts by formally recognizing community health workers within national workforce strategies and progressively integrating them into public payrolls. Implementing partners are called to align with national systems, uphold dignified and fulfilling work standards, and strengthen monitoring, learning, and youth engagement. Donors and the Mastercard Foundation are called to play a catalytic role by providing time-bound support aligned with national transition plans, helping countries build sustainable CHW programs anchored in domestic resources.

Communities, community health workers, and youth representatives are called to remain active partners in shaping program design, accountability, and adaptation. Together, these stakeholders can help advance a generation of community health workers who are recognized as professionals, supported by strong systems, and compensated with dignity, contributing to healthier populations and more inclusive economies across Africa.

A Shared Commitment

When community health workers are valued as professionals, supported by strong systems, and compensated with dignity, the returns, in health, employment, and resilience, are profound and lasting.

Annex A: Key Performance Indicator Framework

The following tables present the complete Key Performance Indicator (KPI) framework, comprising 20 indicators across five thematic areas. All KPIs are aligned with Foundation Shared Measures and disaggregated by country, age (youth 18 to 35 years), gender (female), place (rural/urban), disability status, and displacement status (refugees and internally displaced persons).

A. Access to Work-Enabling Interventions (4 KPIs)

#	KPI	Target	Shared Measure	Cadence	Responsibility
1	# of CHWs accessing Foundation-supported work -enabling interventions (new CHWs trained and existing CHWs upskilled)	—	SM 1.1	Quarterly	Implementing Partner
2	# of CHWs completing Foundation-supported training, upskilling or education interventions	—	SM 1.2	Quarterly	Implementing Partner
3	# of Foundation-supported CHWs certified	—	SM 1.2	Quarterly	Implementing Partner
4	# of Foundation-supported CHWs transitioning from foundational training to advanced or supervisory levels	—	SM 2.1	Annually	Implementing Partner

B. Youth in Work (3 KPIs)

#	KPI	Target	Shared Measure	Cadence	Responsibility
5	# of Foundation-supported youth employed as CHWs (new CHW job, additional income stream, or better wage/conditions)	—	SM 5.1	Quarterly	Implementing Partner
6	% of Foundation-supported CHWs on government payroll	—	SM 5.1	Quarterly	Implementing Partner
7	% of CHWs accessing dignified and fulfilling work opportunities	—	SM 6.1	Annually	Foundation

C. Financial Inclusion (4 KPIs)

#	KPI	Target	Shared Measure	Cadence	Responsibility
8	% of financially-disadvantaged CHW who receive basic financial literacy training undertaking income-generating ventures	—	SM 4.1	Quarterly	Implementing Partner

D. Service Delivery and System Functionality (3 KPIs)

#	KPI	Target	Shared Measure	Cadence	Responsibility
9	# of households who accessed healthcare services from Foundation-supported CHWs	—	SM 7.1	Quarterly	Implementing Partner
10	% of Foundation-supported CHWs receiving quarterly supervision visits	≥90%	SM 9.1	Quarterly	Implementing Partner
11	Data reporting completeness rate	≥90%	SM 9.1	Quarterly	Implementing Partner

E. Sustainability and System Strengthening (6 KPIs)

#	KPI	Target	Shared Measure	Cadence	Responsibility
12	Ways in which Foundation-supported contributions have influenced or advanced policy environments to improve inclusive youth access to dignified and fulfilling work opportunities as CHWs	—	SM 8.1	Annually	Implementing Partner
13	Instances of new collaborations and investments catalyzed by Foundation-supported interventions among ecosystem actors that strengthen practices and programs for inclusive access to dignified and fulfilling work opportunities opportunities for for youth as CHWs	—	SM 8.3	Annually	Implementing Partner
14	Instances of institutional strengthening demonstrating stronger, more inclusive and sustainable CHW systems	—	SM 9.1	Annually	Implementing Partner
15	% of CHW program costs domestically financed	—	SM 8.3 & SM 9.1	Annually	Implementing Partner
16	% of CHWs included in national registries	—	SM 8.1 & SM 9.1	Annually	Implementing Partner
17	% of CHW data integrated into the national HMIS	—	SM 8.1 & SM 9.1	Annually	Implementing Partner

Annex B: Risk Assessment Matrix

The following matrix presents the complete risk assessment for CHW programs, organized by category, with specific risks, mitigation strategies, and primary responsibility. Implementing partners should adapt this matrix to country context and update it through routine governance reviews.

Table B.1: Comprehensive risk assessment matrix for CHW program implementation.

Category	Specific Risk	Mitigation Strategy	Primary Responsibility
Financial	Insufficient government funding	Secure multi-year budget commitments; ring-fenced CHW budget lines; phased co-financing transition	Implementing Partner
Financial	Donor funding withdrawal	Time-bound transition plans; domestic resource mobilization; diversified financing streams	Ministry of Health, Ministry of Finance, Partners
Financial	Inflation reduces real compensation	Annual cost-of-living adjustments; indexed stipends/salaries; compensation reviews	Ministry of Health, Treasury
Operational	High CHW attrition	Predictable compensation; career pathways; supportive supervision; social protection; strong recruitment pipeline	Ministry of Health, District Health Teams
Operational	Weak supervision systems	Standardized protocols; supervisor training; digital tools; dashboards	District Health Teams, Partners
Operational	Stock-outs of medicines and supplies	National supply chain integration; buffer stocks; digital inventory tracking	Ministry of Health, District Authorities
Political	Policy reversals or leadership changes	Legislative entrenchment; cross-party advocacy; stakeholder coalitions	Ministry of Health, Parliament
Political	Political interference in recruitment	Transparent selection criteria; community committees; grievance mechanisms	District Authorities
Social	Community resistance or mistrust	Continuous engagement; participatory planning; culturally appropriate communication	CHWs, Community Leaders
Social	Safety risks for female CHWs	Safety protocols; buddy systems; reporting channels	Ministry of Health, Local Authorities
Technical	Digital system failures	Offline functionality; backups; IT helpdesks; maintenance	Ministry of Health IT Units, Tech Partners
Health System	Resistance from professional cadres	Role clarification; joint training; collaborative supervision	Ministry of Health, Professional Councils

Annex C: RACI Matrix for Program Governance

The RACI matrix below maps responsibilities across the Mastercard Foundation, lead implementing partners, sub-partners and local implementers, and Ministries of Health for each function and decision area within the CHW Program. The matrix is intended to strengthen accountability, reduce duplication and overlap, and support consistent governance across the portfolio.

Table C.1: RACI matrix for CHW Program governance and coordination.

Function / Decision Area	Mastercard Foundation	Implementing Partners (Lead)	Sub-Partners / Local Implementers	Ministry of Health
Strategic Direction and Portfolio Outcomes	A	R	I	C
Portfolio-wide Governance and Oversight	A	C	I	I
Country Program Design and Adaptation	C	R/A	C	C/A
Day-to-Day Program Implementation	I	A	R	C
Sub-partner Coordination and Performance	I	R	R/A	I
Policy Alignment and Regulatory C ompliance	I	R	I	A
Integration with National Health Systems	I	R	C	A
CHW Supervision and Operational Oversight	I	A	R	C
Financial Management and Grant Compliance	A	R	C	I
Risk Identification and Mitigation	A	R	C	C
Monitoring, Evaluation and Reporting	A	R	C	I
Learning, Evidence Generation and Knowledge Sharing	A	R	C	C
Youth Engagement and Inclusion	A	R	C	I
Community Engagement and Feedback Mechanisms	I	A	R	C
Escalation and Course Correction	A	R	I	C

Legend: A = Accountable | R = Responsible | C = Consulted | I = Informed

Annex D: Budget Templates

The following indicative budget templates support country planning and reporting. Templates should be adapted to country-specific contexts and reviewed against national salary scales, cost-of-living data, and fiscal frameworks. The Mastercard Foundation financing and budget templates will be used for internal program development, approval, and reporting.

E.1 National-Level Budget Template (Five-Year Implementation)

Table E.1: National-level budget template (five-year implementation).

Budget Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Personnel Costs						
Initial Training Costs						
Continuing Education						
Supervision						
Supplies and Equipment						
Digital Health Systems						
Monitoring and Evaluation						
Administration						
Total Annual Cost						

E.2 District-Level Annual Budget Template

Table E.2: District-level annual budget template.

Line Item	Unit Cost	Quantity	Annual Cost
Base Stipend per CHW			
Performance-Based Incentives			
Social Protection Contributions			
Supervisor Salaries			
Supervisor Transport and Field Visits			
Initial Training (new CHWs)			
Refresher Training			
CHW Kits and Equipment			

Line Item	Unit Cost	Quantity	Annual Cost
Mobile Phones and Data Package			
M&E and Data Management			
Administrative Costs			
Total District Budget			

Annex E: Definition of Shared Measures used in the KPIs

Shared Measures (SMs) are the Mastercard Foundation's portfolio-wide measurement framework, providing common definitions across programs. The following SMs are referenced in the CHW Program KPI framework.

Access and Participation

SM1 – Access to Work-Enabling Interventions

Measures the number of young people who access Foundation-supported interventions designed to improve their readiness for work.
Includes: Technical, vocational, and digital training; education and skills development initiatives; and work-readiness programs such as CHW training.

Employment Outcomes (Core Youth-in-Work Metrics)

SM5 – Access to New, Additional, or Improved Work

Measures the number of young people who secure employment or improved livelihood opportunities.
Includes: Wage employment; self-employment; improved work (better income, stability, or conditions).

SM6 – Access to Dignified and Fulfilling Work

Measures the quality of employment, beyond simply having a job.
Includes: Fair and stable income; job security; safe working conditions; career progression opportunities; social protection and recognition.

Livelihood and Well-being Outcomes

SM7 – Improvement in Lives and Livelihoods

Measures broader improvements in the economic and social wellbeing of young people and their households.
Includes: Income stability and growth; household resilience; financial inclusion; improved living conditions.

System and Ecosystem Strengthening

SM8 – Ecosystem Strengthening

Measures improvements in the broader systems that enable employment and opportunity.
Includes: Market systems and sector growth; policy and regulatory improvements; financing systems; value chains and partnerships.

SM9 – Institutional Strengthening

Measures improvements in the capacity and performance of institutions delivering programs or services.
Includes: Government systems (e.g., HRH, HMIS); training institutions; implementing partners; data systems, supervision, and governance.

References

1. World Health Organization. Health Workforce in Africa: Challenges and Priorities. WHO Regional Office for Africa; 2022.
2. African Development Bank. Jobs for Youth in Africa: Strategy for Creating 25 Million Jobs and Equipping 50 Million Youth 2016–2025. AfDB; 2016.
3. Africa CDC. African Health Workforce Compact [Internet]. 2025 Mar. Available from: https://africacdc.org/download/african-health-workforce-compact-march-2025/
4. World Health Organization. The Economic Case for Investing in the Health Workforce. WHO; 2018.
5. WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs. World Health Organization; 2018.
6. Republic of Rwanda Ministry of Health, UNICEF. Community Health Program Investment Case in Rwanda. 2021.
7. South African National Department of Health. Ward-Based Primary Health Care Outreach Teams Implementation Manual. NDoH; 2018.
8. Federal Ministry of Health Ethiopia. Health Extension Program Implementation Review. FMOH; 2021.
9. Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health. 2014;35:399–421.
10. Kok MC, Vallières F, Tulloch O, Kumar MB, Kea AZ, Karuga R, et al. Does supportive supervision enhance community health worker motivation? A mixed-methods study in four African countries. Health Policy Plan. 2018;33(9):988–98.
11. Hill Z, Dumbaugh M, Benton L, Källander K, Strachan D, Ten Asbroek A, et al. Supervising community health workers in low-income countries – a review of impact and implementation issues. Glob Health Action. 2014;7(1):24085.
12. Africa CDC, UNICEF, Chikondi T. Africa Community Health Program – Continental Landscape Survey Report 2024/5 [Internet]. 2026 Feb. Available from: www.unicef.org
13. WHO. Global Curriculum Guide for Community Health Workers. World Health Organization; 2025.
14. Africa CDC. African Health Workforce Compact [Internet]. 2025 Mar. Available from: https://africacdc.org/download/african-health-workforce-compact-march-2025/
15. Perry HB, Hodgins S. Health for the people: past, present, and future contributions of national CHW programs. BMJ Glob Health. 2021;6(Suppl 6).
16. Ekpin VI, Nwankwo HE, Akwaowo CD, Blencowe H. Supervision and Support Interventions Targeted at Community Health Workers in Sub-Saharan Africa: A Systematic Review to Identify Characteristics Associated with Successful Outcomes. 2024.
17. Kok MC, Dieleman M, Taegtmeyer M, Broerse JEW, Kane SS, Ormel H, et al. Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. Health Policy Plan. 2015;30(9):1207–27.
18. Africa CDC. African Health Workforce Compact [Internet]. 2025 Mar. Available from: https://africacdc.org/download/african-health-workforce-compact-march-2025/
19. WHO. Global Curriculum Guide for Community Health Workers. World Health Organization; 2025.
20. Ekpin VI, et al. Supervision and Support Interventions for CHWs in Sub-Saharan Africa. 2024.
21. Kok MC, et al. Intervention design factors influencing CHW performance in LMICs. Health Policy Plan. 2015;30(9):1207–27.
22. Feyissa GT, Balabanova D, Woldie M. How effective are mentoring programs for improving health worker competence and institutional performance in Africa? A systematic review of quantitative evidence. J Multidiscip Healthc. 2019;989–1005.

23. Tesema AG, Peiris D, Abimbola S, Ajisegiri WS, Narasimhan P, Mulugeta A, et al. Community health extension workers' training and supervision in Ethiopia: exploring impact and implementation challenges for non-communicable disease service delivery. PLOS Glob Public Health. 2022;2(11):e0001160.
24. Africa CDC. Ministerial Meeting on Strengthening Community Health Workforce, Systems and Programs in Africa Internet]. 2023. Available from: https://africacdc.org/news-item/ministerial-meeting-on-strengthening-community-health-workforce-systems-and-programmes-in-africa/
25. Colvin CJ, Hodgins S, Perry HB. Community health workers at the dawn of a new era: 8. Incentives and remuneration. Health Res Policy Syst. 2021;19(Suppl 3):106.
26. WHO, ILO. Caring for Those Who Care: Guide for the Development and Implementation of Occupational Health and Safety Programs for Health Workers. 2022.
27. Africa CDC. Africa CDC Strategic Plan 2023–2027. 2023.
28. Africa CDC. African Leaders Call to Scale Up Health Workforce, Commit to Deploy Two Million Community Health Workers by 2030 [Internet]. 2026. Available from: https://africacdc.org/news-item/african-leaders-call-to-scale-up-health-workforce
29. Republic of Rwanda Ministry of Health, UNICEF. Community Health Program Investment Case in Rwanda. 2021.
30. Collins D, Griffiths U, Birse S, Dukhan Y, Bocoum FY, Driwale A, et al. Calculating the costs of implementing integrated packages of community health services: methods, experiences, and results from 6 sub-Saharan African countries. Glob Health Sci Pract. 2023;11(5).
31. Rotheram-Borus MJ, le Roux KW, Norwood P, Stansert Katzen L, Snyman A, le Roux I, et al. The effect of supervision on community health workers' effectiveness with households in rural South Africa: a cluster randomized controlled trial. PLoS Med. 2023;20(3):e1004170.
32. Agarwal S, Perry HB, Long L, Labrique AB. Evidence on feasibility and effective use of mHealth strategies by frontline health workers in developing countries: systematic review. Trop Med Int Health. 2015;20(8):1003–14.
33. WHO. Recommendations on Digital Interventions for Health System Strengthening [Internet]. 2019. Available from: https://www.who.int/publications/i/item/9789241550505
34. WHO, ITU. Digital Health Platform Handbook: Building a Digital Information Infrastructure (Infostructure) for Health. 2020.
35. UNICEF, WHO African Region, Clinton Health Access Initiative. Digital Tool Selection Guidebook for Health Campaigns [Internet]. 2025 Jun. Available from: https://www.unicef.org/digitalimpact/topics/digital-impact
36. Rowe AK, Rowe SY, Peters DH, Holloway KA, Chalker J, Ross-Degnan D. Effectiveness of strategies to improve healthcare provider practices in low- and middle-income countries: a systematic review. Lancet Glob Health. 2018;6(11):e1163–75.
37. Agarwal S, Sripad P, Johnson C, Kirk K, Bellows B, Ana J, et al. A conceptual framework for measuring community health workforce performance within primary health care systems. Hum Resour Health. 2019;17(1):86.
38. Mulat TC, Anggraeni TA, Hardi W, Kamaruddin MI, Takke JAM. Strengthening the role of community health workers through supportive supervision: a scoping review. J Interdiscip Health. 2025;1(4):91–100.
39. Mupara LM, Mogaka JJO, Brieger WR, Tsoka-Gwegweni JM. Community Health Worker programmes' integration into national health systems: scoping review. Afr J Prim Health Care Fam Med. 2023;15(1):3204.
40. WHO, UNICEF. Primary Health Care Measurement Framework and Indicators: Monitoring Health Systems through a Primary Health Care Lens. 2022.
41. Peters DH, Adam T, Alonge O, Agyepong IA, Tran N. Implementation research: what it is and how to do it. BMJ. 2013;347.
42. Mastercard Foundation. Financing and Sustainability Roadmap for Community Health Workers. 2026 Apr.

43. Annual Health Financing Forum. Financing Comprehensive Primary Health Care. 2022.
44. WHO African Region. Africa Health Workforce Investment Charter: Enabling Sustainable Health Workforce Investments for Universal Health Coverage and Health Security for the Africa We Want. World Health Organization Regional Office for Africa; 2024.
45. Saint-Firmin PP, Diakite B, Ward K, Benard M, Stratton S, Ortiz C, et al. Community health worker program sustainability in Africa: evidence from costing, financing, and geospatial analyses in Mali. Glob Health Sci Pract. 2021;9(Suppl 1):S79–97.
46. WHO. Responding to the Health Financing Emergency. 2025.
47. O'Donovan J, Kumar MB, Ballard M, Mchenga M, Martin L, Dennis M, et al. Costs and cost-effectiveness of integrated horizontal community health worker programs in low- and middle-income countries (2015–2024): a scoping literature review. BMJ Glob Health. 2025;10(7).
48. Jamison DT. Disease Control Priorities: Improving Health and Reducing Poverty. Lancet. 2018;391(10125):e11–4.
49. McCord GC, Liu A, Singh P. Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions. Bull World Health Organ. 2013;91:244–253b.
50. WHO, World Bank. Tracking Universal Health Coverage – 2023 Global Monitoring Report [Internet]. 2023. Available from: http://www.who.int/copyright
51. Ngongo N, Dereje N, Fallah MP, Tajudeen R, Folayan MO, Ndembi N, et al. Accelerating community health worker programs: a key priority of the Global Health Initiatives for the operationalization of the Lusaka Agenda in Africa. BMJ Glob Health. 2025. doi:10.1136/bmjgh-2024-017325
52. WHO. Global Strategy on Human Resources for Health: Workforce 2030. 2016.
53. Hanson K, Brikci N, Erlangga D, Alebachew A, De Allegri M, Balabanova D, et al. The Lancet Global Health Commission on financing primary health care: putting people at the centre. Lancet Glob Health. 2022;10(5):e715–72.
54. Lancet Global Health Commission on Financing PHC – supplementary analyses. 2022.

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