The need for community health financing and the financing mobilization process

August 2017
This analysis helps to build the knowledge base to mobilize financing for community health (CH)

CHWs are an increasingly important part of health care delivery in low-income countries, connecting communities with the health system.

This analysis was conducted to help advocate for more, more efficient, and more sustainable financing to community health systems.

**OBJECTIVES**

- Quantify the gap in community health financing today
- Codify financing mobilization process and lessons learned from countries with strong community health systems at distinct stages of development

**KEY ANALYSES**

- Develop an estimated baseline of annual expenditure on community health today
- Develop two case studies (Ethiopia and Zambia) to highlight lessons learned on how to mobilize community health financing
- Conduct select additional analyses to demonstrate the value of investing in community health

Our definition of community health: Delivery of promotive, preventive, and basic curative services that occurs at the community level, i.e., outside of a facility setting*

(* Health posts may be included depending on health infrastructure of country)
Investing in community health workers is essential for strong health systems

Contributes to achieving universal healthcare, disease elimination, and SDG goals

- Critical to reach unserved, primarily low-income populations
- 40% of newborn and child deaths are from diseases community health workers can prevent and treat
- Necessary platform for reaching disease elimination targets (e.g., HIV 90-90-90)
- Can play a key role in surveillance and control (e.g., for Ebola)

Generates high economic returns and near-term cost savings

- 10:1 ROI due to productivity, insurance and employment benefits
- Shown to deliver higher value for money than facility-based care across a services including vaccinations, neonatal care, family planning, malaria, malnutrition, HIV/AIDS and tuberculosis
- ROI and cost-effectiveness of many disease verticals depend on community delivery channels

Deliver further benefits to society

- Can empower women, reduce costs for patients, enable governments to register/track births and health statistics, enable further service delivery, and promote strong community participation

Source: Financing Alliance for Health Investment Case
Integrated, horizontal cadres are the most effective and efficient platform for CH delivery in LICs

**WIDESPREAD VERTICAL PROGRAMS MAY BE RESOURCE INEFFICIENT**

- **Limited harmonization.** A 2015 assessment of 15 SSA countries’ CHW programs found that only 1 was well harmonized.
- **Duplication of efforts.** One study found 8 cadres delivering ARTs in Uganda.
- **Missed cost efficiency opportunities.** Vertical cadres don’t share training, supervision, procurement, compensation, and delivery costs.

“Lack of coordination and integration may have impeded the full realization of the potential impact of CHWs in HIV.”

---De Neve et al., Harmonization of CHW Programs for HIV

**INTEGRATION OF INTERVENTIONS CREATES SYNERGIES**

- Giving CHWs **responsibilities across disease areas**, if paired with appropriate training, **does not decrease their effectiveness**
  - A study in Uganda found that integrated treatment of malaria and pneumonia was **more cost-effective than standalone vertical** malaria interventions.
  - Malaria **treatment rates were 112% higher** among programs that treated malaria plus two other illnesses (vs. only one other illness).

**COUNTRIES ARE MOVING TOWARDS HORIZONTAL PROGRAMS**

- **An increasing number of countries** (Zambia, Lesotho, Mozambique, South Africa, Tanzania, among others) have recognized the need for better integration. Some are transitioning to govt-led, horizontal (vs. vertical in disease priorities) CHW programs, e.g.,:
  - Ethiopia mandates that all partners support the national HEP, and **do not create vertical cadres**.
  - Sierra Leone’s CHW strategy asserts that community-based programs can only operate outside of the national cadre if their **scope is not duplicative**.

**DESPITE GROWING EVIDENCE OF THE BENEFITS OF INTEGRATION, MUCH OF CH FUNDING, PARTICULARLY FROM DONORS, CONTINUES TO SUPPORT VERTICAL PROGRAMS.**

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1. E.g., In Tanzania, HIV-focused CHWs were able to add MNCH tasks, suggesting spare capacity in vertical programs. In Rwanda, a horizontal cadre was able to incorporate family planning services without adding time to their workload. Sources: 1MCHW, Financing CHW Systems at Scale; Hermann et al., CHWs for ART in SSA; De Neve et al., Harmonization of CHW programs for HIV, narrative review and four country qualitative study; Matovu et al., Treatment Costs for CBM of Malaria and Pneumonia; CCM Central, Benefits of Integrating Malaria Case Management and ICCM; Sierra Leone National CH Policy, 2016-2020; Shelley, CHW role expansion in Iringa, Tanzania (forthcoming); Chin-Quee, Balancing workload, motivation, and job satisfaction in Rwanda (2010).
Despite strong investment case, current CH funding is insufficient, necessitating action by domestic govts and donors

**CURRENT FUNDING IS INSUFFICIENT, UNSUSTAINABLE, AND FRAGMENTED**

1. Current CH funding is insufficient: there is a ~$2B annual funding gap in SSA

2. The majority (~60%) of CH funding today comes from donors and is thus unsustainable

3. Current CH funding primarily (60-90%) comes via fragmented vertical disease allocations, suggesting potential inefficiencies and opportunities to better leverage existing resources

**POLITICAL COMMITMENT, MULTIPLE FINANCING PATHWAYS, AND DONOR SUPPORT CAN MOBILIZE FUNDING FOR STRONG COMMUNITY HEALTH SYSTEMS**

A. Strong political will and buy-in from top to bottom, garnered through influential champions and evidence-based advocacy, can mobilize funding from govt and donors alike

B. Ministry-led coordination among govt, partners and donors, spearheaded by a central directorate and complemented by local structures, can help to eliminate inefficiencies and create strong, integrated programs

C. Government financial contributions to core program components, paired with a clear plan for sustaining and scaling domestic resources, helps to signal commitment and crowd in other funding

D. Mobilizing new sources of funding, including via local tax revenue and social enterprise models, can help secure longer-term financial sustainability

E. While CH should be govt-led, donors also have a role to play in fostering political commitment and catalyzing financing for integrated programs
Current CHW funding is small fraction of what is needed, resulting in a $2B annual gap in funding in SSA

Estimated annual funding to community health in SSA ($B)

**PRELIMINARY ANALYSIS – TO BE VALIDATED**

Only ~12-40% is supporting integrated community health worker programs

“We need to urgently invest in the training and building of capacity of healthcare workers at community level.” — Ellen Johnson Sirleaf, President of Liberia*

1.1

Estimated current annual funding for community health programs**

0.4 Govt

0.7 Donors

Funding gap

2.0

3.1

Estimated annual funding need for community health programs

<table>
<thead>
<tr>
<th>Share of current ~$14B DAH to SSA***:</th>
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<tbody>
<tr>
<td>Govt</td>
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<tr>
<td>Donors</td>
</tr>
<tr>
<td>Total</td>
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<tr>
<td>8%</td>
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<td>14%</td>
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<td>22%</td>
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(*) Quote from International Financing for Development Conference in Addis Ababa on July 13, 2015 (**) $1.1B based on theoretical model of funding to date. Govt/donor split based on 60/40 ratio between donor and non-donor sources of funding for primary healthcare in 33 countries. (***) DAH is only donor spend and does include domestic govt spend which would be higher, thus CH share of total health expenditures would be even smaller.

The majority of CH spend – proxied by primary healthcare spend – comes out of pocket or from donors and is thus unsustainable

Across majority of countries in SSA, domestic funds make up small share of primary healthcare expenditure

Share of primary healthcare spend by source of funding (%):

- High share of donor spend suggests **unsustainability**
- High share of OOP suggests **financial burden** on households and individuals, though OOP spend is likely a smaller share of CH than of PHC overall (CH services are free to the used in many countries)
- Low govt spend across nearly all countries highlights clear need to **scale up domestic resources**

Current CH donor funding comes primarily through vertical disease allocations, suggesting inefficiencies.

**Estimated annual donor funding used for community health in SSA by primary health focus of grant ($ Millions)**

- Community Health**: 12%
- HIV/AIDS: 49%
- Malaria: 15%
- RMNCH: 6%
- TB: 3%
- Vaccinations: 14%
- Other: 2%

**Estimated annual CH donor funding**

- **HIV/AIDS**: Significant amount of grant work is done at the community level and the rate has only been increasing over time. For example: A grant in Democratic Republic of Congo ~25% of ~$60M planned spending was focused on community care.

- **Malaria**: The same is true for Malaria funding. For example: In Nigeria ~26% of a ~$48M grant was to be used towards capacity building health care workers and case management TA.

- **Vaccines**: Funders for vaccinations also fund CHWs as part of vertical grants. For example: ~22% of the ~$11.5M Health System Support (HSS) grant to Somalia was for building and training female CHW cadre.

(*) Based on $1.1B estimate for total CH spend and 60/40 ratio of donor to domestic spend on primary healthcare across 33 countries. (**) Includes vertical grants that were targeted 100% for CH activities (vs. grants that have a community health component), so might actually be an overestimate. Source: Institute for Health Metrics and Evaluation (IHME). Financing Global Health Database, Interviews, Dalberg Analysis.
### The experiences of four countries demonstrate lessons for how to mobilize financing for CH systems

<table>
<thead>
<tr>
<th>CH system</th>
<th>Focus of in-depth field research case studies</th>
<th>Focus of high-level desk research case studies</th>
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<tbody>
<tr>
<td><strong>Ethiopia</strong></td>
<td>• Estimated ~38K salaried Health Extension Workers (HEWs) who supervise ~4M Health Development Army (HDA) volunteers</td>
<td>• Most recent estimates suggest ~40K family health teams through ‘Estrategia Saude da Familia’ (ESF) with ~266K Community Health Agents covering almost 60% of the Brazilian population</td>
</tr>
<tr>
<td></td>
<td>• Widely credited with improving Ethiopia’s health outcomes</td>
<td>• Estimated ~100K Shasthya Shebika (SS) Community Health Worker’s covering more than 110M of Bangladesh population</td>
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<tr>
<td><strong>Zambia</strong></td>
<td>• Currently have ~1.6K Community Health Assistants (CHAs) and more than 20K Community Based Volunteers (CBVS), which are mainly donor supported</td>
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Strong political will and buy-in from top to bottom can mobilize funding from govt and donors alike

In Ethiopia, political support for HEP cascaded from the Prime Minister Down

- Inspired by agricultural extension agent model and best practices in India and Ghana, PM conceptualized HEP
- PM brought in MoH to help design pilot; MoH championed HEP throughout his tenure
- PM/MoH engaged with RHBs early and regularly to get buy in at local level
- Piloted HEP in 4 politically favorable regions to test model and build evidence before scaling

Zambia’s MoH led an inclusive, evidence-based, and opportunistic advocacy process to get buy-in

- MoH-led strategic team, with cross-directorate champions (HR, Nusing, Public Health, Technical Support) met weekly and engaged across Ministry and partners; included budgeting/donor relations sub-group
- Data used strategically to make the case to different stakeholders (MoH, MoF, donors, provinces/districts)
  - HRH crisis
  - Challenges with volunteer system
  - Impact of CH abroad
  - Economic impact and impact on health priorities
- Elections created unique window of opportunity (i.e., political pressures from the top to serve rural constituents), accelerating the efforts of strong champions

**Implications for Other Countries**

Even if political will comes from the top (i.e., PM or Minister level), identify influential champions (e.g., MoH directors) who can engage with all levels of govt and with donors to ensure widespread buy-in and commitment for funding and implementation

**Take advantage of opportune political moments** (e.g., elections, crises) to accelerate progress and make the case to high level officials

Tailor advocacy to different actors based on their interests, using data to make the case for funding (e.g., economic growth to MoF, impact on MCH for certain donors)

Source: Expert interviews.
Ministry-led coordination can help to eliminate inefficiencies and create strong, integrated CHW programs

**Ethiopia’s strong coordination mechanisms and policies ensure all CH funding supports HEP**

**Dedicated directorate**
Central HEP directorate coordinates with other teams (e.g., MCH) on programming and with Policy/Planning and Resource Mobilization directorate on strategy and funding

**Coordination bodies**
Joint Consultative Forum and associated technical committee enable donor/MoH coordination on programming and funding; govt shows leadership to direct donor programming and funds to fill gaps

**Funding and strategic harmonization**
Govt mandates that all CH programs center on HEP, eliminating parallel systems; pooled funds further streamline funding to HEP

“Harmonization has enabled the sector to more appropriately utilize resources for HEP.” – Resource Mobilization Directorate, FMoH

**Coordination has been one of Zambia’s greatest challenges**

**No clear coordinating mechanisms**
- Limited central or local strategy to coordinate CHAs with partner-funded cadres; missed opportunity for leverage
- CH investments aren’t tracked centrally, leading to inefficient spend

**Need for govt leadership**
While govt, donors, and NGOs engage multilaterally/bilaterally, the MoH needs to take ownership to better coordinate community resource flows

“Separate fund flows for same purposes cause duplication, divert from public sector plans, compete for same volunteers, and undermine public planning structures.”
--GRZ MoH, 2017 Community Health Strategy

“Coordination needs to happen at the highest level…and it should be pull [from the govt to CPs], not push.” –Director, UNAIDS Zambia

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**Implications for other countries**

Govt must drive donor/partner coordination at central level, clearly mapping strategies, resources, and gaps to foster alignment and efficiency

Ideally, all CH funds are directed to a singular system. If govt-led cadres are not yet at scale, countries can link closely to partners’ CH programs to provide leverage, maximize efficiency, and enforce govt ownership – but this requires central and local coordination mechanisms

A dedicated CH directorate is a key mechanism to facilitate intra-ministry coordination, donor coordination, and coordination with local bodies (e.g., district level health leaders) to ensure implementation of programmatic and financing guidelines

Clear local supervisory structures can also help to integrate programming on the ground, helping to capture synergies in different cadres

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Source: De Neve et al., Harmonization of CHW programs for HIV, narrative review and four country qualitative study (2017); Expert interviews.
Government financial contributions from the outset signal commitment, crowd in funding, and ensure sustainability

Ethiopia self-funded a pilot and put HEWs on govt payroll, piquing donor interest

“The pilot was government-owned, and funded entirely by GoE. CPs became interested when they saw the impact and saw [HEP] as a vehicle for their priorities. Partners wanted to add on, but the govt refused until they knew this model was feasible.”
--Former Chief of Staff, FMoH

GRZ committed to putting CHAs on payroll after pilot, institutionalizing the program

Govt and donor contributions to CHA costs (%)¹

<table>
<thead>
<tr>
<th>Year</th>
<th>Donors</th>
<th>GRZ</th>
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<tbody>
<tr>
<td>2009-11</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>2010-11</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>2011-12</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>2012-13</td>
<td>12%</td>
<td>62%</td>
</tr>
<tr>
<td>2013-14</td>
<td>38%</td>
<td>79%</td>
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<tr>
<td>2014-15</td>
<td>21%</td>
<td>75%</td>
</tr>
<tr>
<td>2015-16</td>
<td>25%</td>
<td>81%</td>
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<tr>
<td>2016-17</td>
<td>19%</td>
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“Mobilize government resources for key program components (e.g., putting CHWs on government payroll) from the beginning to show “skin in the game” and institutionalize the program, thus encouraging support from donors and other ministries

Create clear plan for resource mobilization and transition between donors and govt from day one; donors may fund start-up costs with govt plans to scale up resources over time

“Create clear plan for resource mobilization and transition between donors and govt from day one; donors may fund start-up costs with govt plans to scale up resources over time

“One of Ethiopia’s success stories was the political commitment to paying salaries for CHWs.”
--Executive Director, International Institute for PHC in Ethiopia

GRZ Donors

“The agreement from the beginning was that donors would support start-up costs, but then govt would put CHAs on payroll. The Permanent Secretary made this commitment, written in the strategy.”
--Former CHAI HRH lead

Mobilize government resources for key program components (e.g., putting CHWs on government payroll) from the beginning to show “skin in the game” and institutionalize the program, thus encouraging support from donors and other ministries

Create clear plan for resource mobilization and transition between donors and govt from day one; donors may fund start-up costs with govt plans to scale up resources over time

“We ask the govt for a plan to take on the full amount [of salaries] progressively over time, with a transition strategy ideally finalized before the grant is given. This helps the govt to manage pressures as they scale up and increase domestic financing.” – Zambia fund manager, GFATM

Mobilizing new funding sources, including via local tax revenue and social enterprise models, can help secure sustainability

**Brazil CH financing is decentralized, primarily through municipal taxes**

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**Share of CH program funding by govt source, R$ millions:**

<table>
<thead>
<tr>
<th>Source</th>
<th>Municipal</th>
<th>Federal</th>
<th>State</th>
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<tbody>
<tr>
<td>ESF funding</td>
<td>57%</td>
<td>37%</td>
<td>6%</td>
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*Example municipality in state of Sao Paulo*

- As enshrined in the 2000 constitution:
  - Municipal govs are required to spend 15% of budget to health
  - States must allocate at least 12% of their total budget to health
  - Federal govt through the Family Health Strategy (Estrategia Saude da Familia) spends ~$7-9 USD per capita on CH

**BRAC uses pooled donor funds, cross-subsidies, revenues, and innovative partnerships**

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**Share of Shasthya Shebika CH program investment for 2016-20 by source, $US millions***:

<table>
<thead>
<tr>
<th>Source</th>
<th>SPA</th>
<th>BRAC revenue</th>
<th>BRAC USA</th>
<th>Vision Spring</th>
<th>Signtsavers</th>
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<tbody>
<tr>
<td>Shasthya Shebika</td>
<td>60%</td>
<td>25%</td>
<td>8%</td>
<td>0%</td>
<td>7%</td>
</tr>
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</table>

*Example municipality in state of Sao Paulo*

- Primary source of funds has been strategic partnership agreement (SPA) with governments of Australia and UK
- Second largest source of funds is earned revenues from loans and sale of basic health products by SS workers
- Partnerships with social enterprises (e.g., TOMS) also fund SS

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**Implications for other countries**

- **Obligating tax revenue expenditure allocations towards CH programs** can help make them sustainable for the long run in countries with sufficient government/fiscal resources
- **Decentralizing the source of govt funds** to state and even municipal level allows for greater resources and accountability
- **Partnering with NGOs or private sector** orgs with sustainable business models can create program efficiencies (e.g., contracting/outourcing training and service delivery) and leverage additional funding sources, thus helping to move programs toward sustainability

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Source: Annual Budget Report for Anonymous Municipality within Sao Paulo state with population of ~15K (Relatório Balancete da Despesa- 4R Contabilidade), BRAC, Interviews, Dalberg Analysis (*) Excludes BRAC TB & Malaria program.
While CH must be country-led, donors have a role to play in fostering political will and catalyzing financing

**DONOR ROLE**

**POLITICAL COMMITMENT**

Advocate for integrated community health funding. Where govts are not already committed to building horizontal CH systems, donors can help to shape thinking with evidence to support and empower ministry champions

Be responsive and flexible to government requests for coordination. When govts take leadership to coordinate resources and build an integrated system, donors should be willing to work hand-in-hand to align programs and fill gaps

**FINANCING PATHWAYS**

Provide catalytic start-up funds. Flexible donors committed to CH can help support start-up costs for the development of integrated programs, while crowding in govt and other donor funding over time

“The govt needs to manage donor [coordination] well, but donors also need to [cooperate]. We step on each other’s feet sometimes.”

– Portfolio manager, major donor organization

“DFID believed in [the CHA concept]. They were excited to bring other donors into the pilot, so were comfortable being flexible [based on what others’ wanted to fund].”

– Former CHAI Zambia HRH lead

“DFID saw an opportunity and was bought in...they took on the initial expenses, with reassurance [from the govt] that it would be mainstreamed.”

– Program Manager, DFID Zambia

Source: Expert interviews.
The implementation of these lessons will vary based on country context

<table>
<thead>
<tr>
<th>Lesson</th>
<th>Contextual factors</th>
<th>Implications</th>
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</table>
| **Political commitment** | Power of centralized authority | • In countries with strong, highly centralized governments (e.g., Ethiopia), securing buy-in from the top is most critical success factor  
• In more decentralized contexts, having a more diverse group of champions (across levels) is key to both initiating and sustaining CH programs |
| **Ministry-led coordination** | Size and strength of horizontal (govt owned) system | • Where the horizontal cadre is more advanced, govs can encourage partners to strengthen existing system (eliminating parallel cadres)  
• Where integrated cadres are less developed, existing volunteer systems will be necessary complements in near term, and govt should create clear plan to link cadres to provide leverage and efficiency |
| **Financing pathways** | Strength and capacity of federal MoH | • In countries with strong federal ministries, govt can take an active role in coordinating donors (e.g., via pooled funds)  
• In countries where the federal ministry has less capacity, coordination bodies and requests to donors for resource and strategic alignment can support harmonization |
| | Current and future resource availability | • Where resources are available (and a clear plan to sustain is in place), placing CHWs on govt payroll helps institutionalize CHWs and crowd in funding  
• However, if resources are not secure, payroll can be a risk to program sustainability and scale. Govts should consider other ways to show skin in the game initially (e.g., in-kind contributions), while planning to take on salaries over time |
| **New sources of funding** | Govt commitment to health | • Where and when the political climate/commitment to health is favorable, domestic resource mobilization (i.e., via taxation) is a key strategy  
• In less favorable climates, countries can focus on resource efficiency in the near term |
| | Availability of strong partners | • Where strong NGO/private sector partners with sustainable business models are available, they can be a resource to improve efficiency and expand resources  
• If partners are scarce, focusing on govt resource mobilization makes more sense in near term |
| **Donor role** | Existing political will for integrated community health systems | • When countries have already prioritized community health, donors can provide catalytic start up funds and help facilitate coordinated, horizontal systems  
• In countries without existing will, donors can advocate for integrated CH systems and empower ministry champions with evidence and donor backing |