COMMUNITY HEALTH ROADMAP
Announcements Call
September 10, 2019
**WHY COMMUNITY HEALTH?**

**Foundation of UHC:** Community health is part and parcel of effective primary health care and the “entry” point for UHC

**Lives saved:** 2.5 million maternal and child deaths can be prevented annually\(^1\). In the 15 Roadmap countries it is estimated that 550,000 lives could be saved by 2030 through fully effective community health systems.

**High ROI:** Every $1 invested in CH results in ~$10 in economic gains, driven by increased productivity from healthy people, insurance against disease outbreaks and higher employment\(^2\).

**Cost effective:** $5 - $25 cost per DALY saved through community-based RMNCH interventions (comparable to child immunization)\(^3\).

**Employment, in particular for women:** Reaching the existing targets for Africa alone could provide employment to ~2M people, representing the largest formal jobs program in the continent’s history in an area where levels of vulnerable employment rise above 70%\(^4\).

**Proven results:** CHW programs associated with Ethiopia’s 75% decline in child and maternal mortality over 25 years, and Rwanda’s fastest annual reduction in child mortality over the past decade (70% total, 5% year-over-year)\(^5\).

---

In order to ensure healthy lives and promote wellbeing for all ages...

...and achieve Universal Health Coverage, including equity, quality, and financial risk protection in access to health care...

...we need Primary Health Care, which is the most effective, efficient, and equitable approach to enhance health...

...and community health models are a proven, cost-effective, and high-impact platform that serve as the foundation of PHC.

- Health promotion and service delivery activities that primarily occur outside of a health facility
- Both supply of and demand for health care, including activities that community members undertake as agents of their own health
- Community health workers (CHWs) as one, but not the only, delivery channel
- Service delivery through public, NGO, and private sectors
- Linkages to a broader, multi-sectoral community system
Why a Community Health Roadmap?

Objectives

MoH Leadership
- A platform to elevate Ministry of Health/national priorities, informed by stakeholders
- Priorities that help Ministries take forward in their own efforts
- A framework that facilitates cross-country fertilization of ideas

Investments
- Aligning of existing funding and raising of new resources against priorities expressed in the Roadmap
- A rallying point for global resource mobilization (and inter-agency alignment)

Support
- A framework that clearly defines global forms and functions to support CH in-country work
- A mechanism that will allow the tracking of progress of in-country work against the national priorities

The CH Roadmap was initiated in March 2018 by USAID, UNICEF, RF and UNSEO (and builds on ICHC 2017 and other country support processes). A Steering Committee also including BMGF, the World Bank and WHO has been guiding the work thus far.
ANNOUNCEMENTS OVERVIEW

1. Fully optimized community health platforms in the 15 roadmap countries could meaningfully bridge three gaps, including the **POTENTIAL TO CLOSE THE GAP TO REACHING SDG 3 BY 50%**

2. **14 COUNTRIES** have established their national community health priorities that require action

3. There are **6 CROSS-COUNTRY INVESTMENT PRIORITIES**

4. A **CATALYTIC FUND** will be ready to support national priorities

5. There will be another institutionalizing community health conference in March 2020 (**ICHC 2020**)

6. The Roadmap process will be on-going and led through a **SECRETARIAT**; it will also share progress across the 15 countries
For this exercise, we defined “fully optimized community health platforms” as being able to effectively implement a comprehensive package of interventions at the community level and achieving at least 90% population-level coverage of each intervention by 2030 in each of the fifteen countries selected for initial inclusion in the Roadmap.

Lives saved from reducing unmet need for family planning is not included in this analysis. This decision is mainly due to the challenge of defining a specific share of unmet need addressed (e.g., 90%) associated with community-level service delivery vis-à-vis other parts of the healthcare system. While the effective provision of several contraception methods at the community level is well demonstrated, the rest of the health care system (especially primary care level) is also essential to ensuring the opportunity for women to obtain a method that suits their needs.

The "gap closure effect" for a given mortality indicator is the estimated mortality rate reduction in 2030 attributed to fully optimized CH platforms (which assumes a comprehensive package of interventions to be delivered at the community level would have reached 90% coverage in 2030) relative to the total projected gap in 2030 between following the current trajectory and the SDG target.

In addition, the projected "gap closure effect" is 23% for neonatal mortality.

Population across the fifteen Roadmap countries

---

**Bridge the gap on survival**

... by accelerating reductions in mortality to achieve SDG 3.1 and 3.2

**Over half million lives saved** between 2020 and 2030

**50% closure** of the gap in under-5 mortality by 2030 between current trajectory and SDG 3.2

**Bridge the gap of equitable access**

... by extending the healthcare system to where people face the biggest barriers to access

**Half billion** people have the option to access healthcare in their communities

**Bridge the gap in thriving**

... by ensuring equal opportunities for all to thrive

**Contribution to achieving UHC** by making community health a possible entry point to the health system

**Contribution to SDG2 and all other SDGs by reducing malnutrition**

**Contribution to gender empowerment** through reproductive health services and female employment

---

1. For this exercise, we defined “fully optimized community health platforms” as being able to effectively implement a comprehensive package of interventions at the community level and achieving at least 90% population-level coverage of each intervention by 2030 in each of the fifteen countries selected for initial inclusion in the Roadmap.
2. Lives saved from reducing unmet need for family planning is not included in this analysis. This decision is mainly due to the challenge of defining a specific share of unmet need addressed (e.g., 90%) associated with community-level service delivery vis-à-vis other parts of the healthcare system. While the effective provision of several contraception methods at the community level is well demonstrated, the rest of the health care system (especially primary care level) is also essential to ensuring the opportunity for women to obtain a method that suits their needs.
3. The "gap closure effect" for a given mortality indicator is the estimated mortality rate reduction in 2030 attributed to fully optimized CH platforms (which assumes a comprehensive package of interventions to be delivered at the community level would have reached 90% coverage in 2030) relative to the total projected gap in 2030 between following the current trajectory and the SDG target.
4. In addition, the projected "gap closure effect" is 23% for neonatal mortality.
5. Population across the fifteen Roadmap countries.
14 COUNTRIES HAVE COMPLETED THEIR NATIONAL PRIORITIES THAT REQUIRE ACTION (1/2)

Priorities completed
- Niger
- Mozambique
- Haiti
- Cote D’Ivoire
- Burkina Faso
- Malawi
- Kenya
- Uganda
- Zambia
- Ethiopia
- Liberia
- Afghanistan
- Mali
- DRC

On hold
- CAR
<table>
<thead>
<tr>
<th>Country</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Ethiopia  | 1. Close the HR Gap  
            2. Re-evaluate/update roles to reflect changing needs  
            3. Strengthen and ensure the quality of community health services  
            4. Update national guidelines |
| Burkina Faso | 1. Harmonization of national strategies and financing  
                          2. CH investment framework finalized and mobilization of resources in progress  
                          3. Extend the removal of user fees at the community level by employing community based insurance  
                          4. Extending community-based services to cover urban and peri urban areas  
                          5. Motivating community actors, including through performance-based financing  
                          6. Strengthen the procurement system by integrating the community health component  
                          7. Investing in national health information system and capitalizing on use of ICT  
                          8. Accelerate the operationalization of the national agency for managing PHC to manage multisectoral action |
THERE ARE 6 CROSS-COUNTRY INVESTMENT PRIORITY AREAS

For each of the 6 we have developed details, which are included in the website

1. **Financing** – Mobilize funding for CH/PHC, including sustainable domestic financing
2. **Fragmentation** – Reduce fragmentation by integrating community health into national system - in particular in areas of human resources, supply chain, and information systems
3. **Optimization** – Improve quality of care via better design and implementation of CH programs
4. **Future fit** – Identify design options for future CH/PHC systems
5. **Performance management** – Enhance performance management systems for CH
6. **High-level commitment** – Foster high-level political commitment to community health, in line with existing movements to achieve SDG 3

**Description of the problem to solve**

**What to build on/exists already**

**Selected (illustrative) investments**
### ANNOUNCEMENTS

**CATALYTIC FUND WILL BE READY TO SUPPORT NATIONAL PRIORITIES**

<table>
<thead>
<tr>
<th>Mission</th>
<th>How it will work</th>
<th>Timing &amp; Scope</th>
</tr>
</thead>
</table>
| • Allow countries **get activities done** (only projects that are defined as being catalytic to national priorities as part of the CH Roadmap process)  
• Offer **support options to countries** for these activities (experts to shape projects, TA providers, consultant rosters, other TA mechanisms, etc.)  
• Only kicks in when there are **no other in-country and other flexible support options** for countries  
• Offers opportunity to make support offers to countries more transparent and known (e.g. could be seen as a well structured “database” for country support) | • Through the Catalytic Fund, MoH teams can either receive a **activity-based grant OR the Catalytic Fund is contracting** on their behalf for a specific activity with a third party  
• Example activities could include: Country consultations when developing national strategy; Peer-to-peer country learning; financial gap analysis; advocacy campaigns  
• MoH and catalytic fund will have to draw on **pre-approved list of providers/partners/individuals** with expertise in certain disciplines  
• Funding will be capped to $50,000 – $75,000 per project | • The CF is in establishment and the aim is to have it operational by February 2020  
• Currently, donors have pledged over $1m towards the CF (RF, OWAGS, USAID, BMGF) and the aim is to raise $2m (for 2020/2021) |
There will be another Institutionalizing community health conference (ICHC 2020)

- March 2020
- Follow up of ICHC 2017 (Johannesburg) to country teams
- Organized by USAID, UNICEF and BMGF
- Will take place in Dakar, Senegal

Also another important milestone for the CH Roadmap

- All 15 Roadmap country national priorities updated and finalized
- An operationalized Catalytic Fund with additional funding
- Additional engagement with funders and implementers against national priorities
- A plan for monitoring progress
THE ROADMAP PROCESS WILL BE ON-GOING AND LED THROUGH A SECRETARIAT; IT WILL ALSO SHARE PROGRESS ACROSS THE 15 COUNTRIES (1/2)

On-going CH Roadmap Secretariat

- **Country engagement** – Engagement with countries on national priorities, including updates to country profiles and national priorities, facilitation of donor conversations with countries
- **Running the CF** – Oversight of the Catalytic Fund, including the evaluation of applications, efficient distribution of funds and monitoring of progress
- **Progress tracking** – Tracking of progress across countries
- **Resources** – Global advocacy and resource mobilization for countries, including the promotion of community health in context of SDG 3-UHC-PHC, the presentation of national priorities in global meetings and the facilitations of donor meetings

**Likely 2 FTEs. Continued oversight through SC**
THE ROADMAP PROCESS WILL BE ON-GOING AND LED THROUGH A SECRETARIAT; IT WILL ALSO SHARE PROGRESS ACROSS THE 15 COUNTRIES (2/2)

CH Roadmap impact pathway

Coordinated inputs of the CH Roadmap (to countries)

In-country CH system levers

Program delivery in communities

Outcomes

Triple impact Bridging of triple gaps

Country 1

Country 2

Country 3

Country ...

On-going progress sharing
- Focusing on most actionable and relevant parts of the Roadmap’s impact pathway
- Monitored annually
- To be carried out by the Community Health Roadmap Secretariat and in consultation with governments

Not a focus of the Roadmap’s monitoring
- Led by government and supported by in-country partners
- Further supported by the Roadmap’s cross-country investments in CH performance metrics

In-depth impact analysis
- “Bridging the gap” impact analysis to estimate the progress
- Done every few years
- To be carried out by designated researchers and in consultation with governments

ANNOUNCEMENTS
EXAMPLE – SUMMARY OF NATIONAL PRIORITIES: MALAWI
Developed in July 2018, presented at Astana 2018

Overview of community health system and scale-up plan

• **Community Health**: Malawi is in the process of implementing its first-ever National Community Health Strategy (NCHS, 2017-2022); the NCHS is embedded in the Health Sector Strategic Plan (HSSPII) and the community health workforce includes both formal and non-formal cadres

• **Scale-up plan and vision**: Malawi has a formal community health workforce that does not yet meet estimated needs (e.g., approximately 9,000 active HSAs/SHSAs out of a targeted minimum of 16,500). Community Health cadres’ delivery the integrated community components of the Essential Health Package and focus on child and maternal health issues

• **Linkages with broader PHC system**: Community health core team is directly linked through supervision, supply chain and referral networks to the health center and the broader PHC system

Priority needs

1. **Close the HR Gap**: Hire +7,000 additional HSAs, as well as increasing number of AEHOs, CHNs, CMAs

2. **Financing**: Improve integration, mobilization, efficiency and effectiveness of resources

3. **Infrastructure**: Construct 900 Health Posts and support CHW accommodations in hard-to-reach areas

4. **Integrated Community Health Information System**: Harmonize data reporting for Community Health System, and integrate all data into DHIS2

Main development partners

**Funders**

- Bill & Melinda Gates Foundation
- USAID
- UNICEF
- Gavi
- DFID

**Implementing partners / NGOs**

- The Global Fund
- World Vision
- Save the Children
- Partners In Health
- MSH

Note: (1) Malawi’s NCHS plan recommends that the health system employ a minimum of 17,000 total HSAs (15,000 HSAs and 1,500 Senior HSAs)

Source: MoH, National Community Health Strategy, 2017-2022
EXAMPLE – COMMUNITY HEALTH ROADMAP IMPACT STORY: MALAWI

“The national priorities we established are helpful to us in partner communication. It’s easier to talk to others about what we need. And that includes the Ministry internally. Other departments are now advocating on our behalf, and just lately the Department of Planning sent a private company our way that offered to help with infrastructure work.”

— MoH team member

Inputs through the Roadmap

- Collaborating with MoH to highlight national priorities (workshop together with all in-country partners)
- Motivating investments from new external partners (against national priorities)

Impact pathway

CH system levers

Strengthened national-level inputs for CH

- Leadership – Ministry of Health colleagues and partners fully aware of five national priorities (and opportunity for top-level awareness raising)
- Stakeholder alignment – Alignment with in-country partners on results from Year 1 implementation
- Partner recruitment – MOHP has secured new partnership to support national priorities such as training of HSAs, development of community health information system, integration of community health services delivery, development of financing strategy, construction of health posts
- Increased/aligned financing – Integrated financing plans at district level in development and incorporating community health interventions. Partner and program coordination forums to enhance alignment to community health strategy. District level partner mapping exercise in progress.

CH system levers

Program delivery | Outcomes | Triple impact

Unfolding over the next few years (with the Roadmap just being one of many inputs)

“This has helped shape our conversations with new partners, and we have had new partners come on-board since the CH Roadmap kick-off. It has helped to focus critical needs which bring a sustainable impact MOHP Team members”

— MoH team member
EXAMPLE – SUMMARY OF NATIONAL PRIORITIES: NIGER

**Vision**

‘...To contribute to the reduction of infant and child mortality through health promotion, improved access and utilization of health services in remote communities through community participation...’

**Overview of community health system and scale-up plan**

- **Status:** Niger is finalizing its National Community Health Strategic Plan (validation planned for October 2019) to be followed with the development of an investment case and financing gap analysis. This will encompass mapping of partners engaged in the community health space.

- **Scale-up plan:** Niger has been expanding coverage of the iCCM CHWs (Relais Communautaires iCCM) from 13% (2016) to more than 50% (2019) of the districts.

- **Coordination & Linkage with PHC:** currently steered by the National Coordinating Committee for Community Health Interventions within the Ministry of Public Health. A **multisectoral coordination committee** supports the community-based development workers (Relais Communautaires de Développement) (Ministry in-charge of community development through the Niger Agency for Volunteer Development)

**National Priorities**

1. **Financing:** Improve coordination, integration, mobilization, efficiency and effectiveness of resources, including through the establishment of a multi sectoral steering committee for community health & PHC

2. **Integrated Community Health Information System:** Harmonize data reporting for Community Health System, and integrate all data into DHIS2

3. **Integrated supply chain:** Strengthen and integrate community-based supply chain into the national supply chain system

4. **Inclusion & participation:** Ensure a participatory and inclusive process, with particular regard for gender dynamics & meaningful engagement of the youth, in the development and implementation of community-based interventions

**MAIN PARTNERS**

<table>
<thead>
<tr>
<th>Funders</th>
<th>Implementing partners / NGOs</th>
<th>UN Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Symbols of donors/foundations]</td>
<td>[Symbols of implementers]</td>
<td>[Symbols of UN agencies]</td>
</tr>
</tbody>
</table>
EXAMPLE – UPDATE ON NATIONAL PRIORITIES: NIGER

Strategic shifts needed

- Strengthen governance and community health leadership at all levels of Niger's health system
- Optimize the coordination of community health interventions (with alignment to a national road map)
- Strengthen collaboration with the Nigerian Agency for Volunteering for Development in the search for sustainable mechanisms for payment of the motivation of CHWs (*Relais Communautaires*)

Actions to accelerate progress

- Enhanced political prioritization of community health
- Mobilize domestic resources to ensure sustainability
- Strengthen stakeholder alignment with national priorities
- Improve municipal involvement in management and accountability
- Strengthen health facilities at the primary level with infrastructure and qualified human resources to ensure quality in the implementation of community interventions

Immediate Next Steps

- Map CHWs (*Relais Communautaires*) – mapping existing and needs
- Revise national guidelines for community-based interventions that take into account new WHO CHW recommendations with special attention to gender dynamics
- Develop an investment case, gap analysis and financing pathway for the community health strategic plan
- Mobilization of resources for the implementation of the National Strategic Plan for Community Health
**EXAMPLE – SUMMARY OF NATIONAL PRIORITIES: NIGER**

**Impact pathway**

<table>
<thead>
<tr>
<th>CH system levers</th>
<th>Ongoing-future Roadmap inputs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership &amp; coordination</strong> – Strengthened government leadership &amp; coordination with the establishment of a national committee for coordinating community-based health interventions</td>
<td><strong>Strengthening the alignment of the partners</strong> with the new national community health strategy leveraging the financing opportunities of the GF, WB, IDB and bi-laterals (USAID, China, BMZ)</td>
</tr>
<tr>
<td><strong>Political commitment</strong> – Evidenced by the adoption of the National Strategy for Community Participation in Health in Niger and guidance on Community Development Workers (<em>Relais Communautaires de Développement</em>)</td>
<td><strong>Influencing the development of the GFF Investment Case</strong> to include investment in community health</td>
</tr>
<tr>
<td><strong>Stakeholder alignment</strong> – Convening and aligning key partners refocusing their areas of intervention towards the identified priorities (UNICEF, WHO, UNFPA, USAID, GF, WB)</td>
<td><strong>Leverage the ongoing decentralization process</strong> to involve municipalities in supporting community-based service delivery</td>
</tr>
</tbody>
</table>

**Inputs through the Roadmap**

- Reinforced Niger’s ICHC 2017 action plan:
- Enhanced political commitment for community health (adoption of the key national strategy & guidance documents)
- Strengthened coordination (national committee & partner alignment)

**ICHC 2017 July 2018-up to date (August 2019) On-going**
EXAMPLE - JOURNEY TOWARD INSTITUTIONALIZATION OF CH: MALI

MAIN PARTNERS

Funders

Implementing partners / NGOs

[Images of logos for various organizations]
EXAMPLE – NATIONAL PRIORITIES: MALI

1. **Narrow the HR Gap**: Recruitment of additional 24,576 CHWs by 2022; more qualified HR for rural maternities, community health centers (Cscom).

2. **Institutionalize community health financing**: Mobilize domestics resources to subsidize CSCOM for integration of to CHWs salary in the budget of the CSCOM.

3. **Infrastructure**: Rehabilitation of CSCOM, rural maternity to provide quality services.

4. **Foster the demand through** free health services to the most vulnerable at the community level; strengthening and harmonization of community platforms.

5. **HMIS at community level** (digitalization).

6. **Improve governance and accountability of community health actors** (PBF, Accreditation ...).
HOW TO ENGAGE AS A FUNDER

**FOCUS**
Focus investments towards the national priorities of the 12 existing countries

**ALIGN**
Make investments in line with cross-cutting investment priorities

**FUND**
Contribute to the Catalytic Fund
THANK YOU

... AND

CHECK OUT THE WEBSITE WITH FULL DETAILS ON ALL OF THE ANNOUNCEMENTS AND MORE:
WWW.COMMUNITYHEALTHROADMAP.ORG

And with regular updates on country priorities, etc.

STAY IN TOUCH WITH IN-COUNTRY PARTNERS AND THE CH ROADMAP SECRETARIAT
The maximum impact on lives saved from fully optimized Community Health (CH) platforms in the 15 countries is estimated to be ~550,000 between 2020 and 2030.

Total lives saved (2020-2030) from reaching 90% coverage by 2030 of a comprehensive package of interventions in each country, thousands

- 550,000 total lives saved
- 424,000 child lives
- 71,000 neonatal lives
- 46,000 still births
- 9,000 maternal lives

1. For this exercise, we defined “fully optimized community health platforms” as being able to effectively implement a comprehensive package of interventions at the community level and achieving at least 90% population-level coverage of each intervention by 2030 in each of the fifteen countries selected for initial inclusion in the Roadmap.

2. Lives saved from reducing unmet need for family planning is not included in this analysis. This decision is mainly due to the challenge of defining a specific share of unmet need addressed (e.g., 90%) associated with community-level service delivery vis-à-vis other parts of the healthcare system. While the effective provision of several contraception methods at the community level is well demonstrated, the rest of the health care system (especially primary care level) is also essential to ensuring the opportunity for women to obtain a method that suits their needs.
The maximum impact on lives saved translates into 50% closure of the gap in child mortality and 23% in neonatal mortality in 2030 between the current trajectory and the SDG targets.

Projected “gap closure effect” of fully optimized community health platforms

Share of the gap closed in 2030 between SDG targets and mortality rates under the current trajectory, averaged across 15 roadmap focus countries.

<table>
<thead>
<tr>
<th>Mortality Rate</th>
<th>Gap Closure Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal mortality</td>
<td>23%</td>
</tr>
<tr>
<td>Under-five mortality</td>
<td>50%</td>
</tr>
</tbody>
</table>

1 The "gap closure effect" on each mortality rate is calculated by: 1) using the LiST to project the mortality rate of a country in 2030 under the current trajectory; 2) using the LiST to project a country’s mortality rate in 2030 if a comprehensive package of interventions were implemented through community health platforms; 3) calculating the total projected gap in 2030 between the current trajectory (step 1) and the SDG target for the given mortality rate; 4) calculating the mortality rate decline in 2030 due to community health (step 1 minus step 2); 5) calculating the “gap closure effect” as mortality rate decline as a share of total projected gap (step 4 divided by step 3).

2 In the analysis, we assumed fully optimized CH platforms to implement a comprehensive package of interventions (see methodology section for details) and achieve at least 90% coverage of these interventions by 2030.

Note: we have taken out maternal mortality since there is technically no country-level goal (SDG3.1 is a global target)

SOURCE: CH Roadmap team analysis
Investing in community health could contribute to the annual rate of reduction (ARR\(^1\)) countries need to reach the SDG targets, especially for under-5 mortality rate.

<table>
<thead>
<tr>
<th>ARR required between 2019 and 2030 to achieve SDG target</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent, averaged across 15 roadmap focus countries</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

ARR contribution from fully functioning CH platform\(^2\)  
ARR required to achieve SDG target

- Given where countries are now, we calculated the ARR required between 2019 and 2030 to reach the SDG target.
- We also calculated the ARR achieved from the fully optimized community health platforms\(^2\) in each country for the same time period.
- The ARR contribution of CH is 1% out of 6% neonatal mortality and 3% out of 7% for under-5 mortality.

Note: we have taken out maternal mortality since there is technically no country-level goal (SDG3.1 is a global target).

---

\(^1\) ARR refers to the annual rate of reduction, a measure used to track the rate at which mortality rate need to decrease by to achieve the SDG target.

\(^2\) In the analysis, we assumed fully optimized CH platforms to implement a comprehensive package of interventions (see methodology section for details) and achieve at least 90% coverage of these interventions by 2030.

SOURCE: CH Roadmap team analysis
ON-GOING PROGRESS SHARING COULD FOCUS ON NINE INDICATORS

<table>
<thead>
<tr>
<th>Performance indicator</th>
<th>Suggested measurement approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated inputs of the CH Roadmap (to countries)</td>
<td></td>
</tr>
<tr>
<td>1 Number of countries with defined national priorities</td>
<td>• Review documents containing government approved national priorities</td>
</tr>
<tr>
<td>2 Quality and level of TA provided to support national priorities</td>
<td>• Interview governments on satisfaction with TA</td>
</tr>
<tr>
<td>3 Quality and level of investment in cross-cutting priorities identified in the roadmap</td>
<td>• Analyze the flow of TA funding to national priorities</td>
</tr>
<tr>
<td>4 Existence of comprehensive and specific CH policy and clear strategy for implementation</td>
<td>• Interview government and implementing partners on satisfaction with cross-cutting investments</td>
</tr>
<tr>
<td>5 Degree of political prioritization of CH over and above level of the MoH</td>
<td>• Analyze the flow of funding to cross-cutting areas</td>
</tr>
<tr>
<td>6 Growth and permanency of government funding for CH</td>
<td></td>
</tr>
<tr>
<td>7 Growth and integration across all funding streams for CH</td>
<td>• Assess CH policy and strategy documents through peer-review by government counterparts</td>
</tr>
<tr>
<td>8 Existence of clear roles and responsibility of dedicated CH team in MOH</td>
<td>• Reference CHW Repository’s tracking of the country’s adoption of WHO Guideline</td>
</tr>
<tr>
<td>9 Existence of an active technical working group (TWG) with relevant CH stakeholders, at the invitation of MoH</td>
<td>• Interview government and local stakeholders</td>
</tr>
</tbody>
</table>

In-country CH system levers Measured separately for each roadmap country

- Analyze the allocation of government funding to CH
- Verify CH has permanent line in MoH budget
- Analyze the flow of funding across all sources to CH
- Analyze the level of fragmentation of CH funding
- Interview government and local stakeholders
- Review documents on CH team’s mandate/charter
- Interview government and local stakeholders
- Review documents on TWG’s mandate/charter
# Example — Update on National Priorities: Malawi

<table>
<thead>
<tr>
<th>National Priority</th>
<th>Updates to the National Priorities</th>
</tr>
</thead>
</table>
| **1 Close the HR Gap:** Hire +9000 additional HSAs, as well as increasing number of AEHOs, CHNs, CMA | • Work on-going on recruitment  
• New HSAs recruitments:  
  • Partner: recruited 42 HSAs  
  • District councils: 49 HSAs  
• New partners: GAVI to support development of new HSA curriculum and initial training of new HSAs  
  • Work on-going  
  • District councils: 49 HSAs  
• New partners: GAVI to support development of new HSA curriculum and initial training of new HSAs  |
| **2 Financing:** Improve integration, mobilization, efficiency and effectiveness of resources | • Work with LMH to develop integrated financing strategy for community health, resource mobilization and district partner mapping  
• Work with UNICEF in two districts on-going of demonstration of integrated community health service delivery  
• Work with mother2 mother (m2m) support district community health systems  
• Work with Amref support district community health system  
• Work on-going on GF grant preparation, community health is included  
• Potential links with GFF investment case dialogue and Human Capital Investment dialogue  
• Work on-going  
• JTI: supported 15 health posts  
• Various partners: 23 Health posts  
• AEICIDA: supported x health posts  
• New private-sector partner recruited to fund and build 15 health posts  |
| **3 Infrastructure:** Construct 900 Health Posts and support CHW accommodations in hard-to-reach areas | • New partner:  
  • GAVI support development of integrated community health register (data collection tool) and procurement of hardware for community health information system (CHIS)  
• JBI support development of integrated community health information system and initial deployment of CHIS  
• Work with JBI support community health information system (CHIS) development and initial deployment of CHIS  
• Work With LMH to support the scale up and procurement of hardware for community health information system (CHIS)  |
| **4 Integrated Community Health Information System:** Harmonize data reporting for Community Health System, and integrate all data into DHIS2 | • New partner:  
  • GAVI support development of integrated community health register (data collection tool) and procurement of hardware for community health information system (CHIS)  
• JBI support development of integrated community health information system and initial deployment of CHIS  
• Work with JBI support community health information system (CHIS) development and initial deployment of CHIS  
• Work With LMH to support the scale up and procurement of hardware for community health information system (CHIS)  |

---

**Feedback from MoH**

- Roadmap helpful to “communicate with our partners – everyone knows now what our 4 priorities are. And it helps us to push back.”
- Roadmap helped significantly to recruit new partners to the country/CH; and existing funders/partners begin to align to community health strategy by adjusting their plan
- The CH Roadmap has changed nationally Local government, local partners and MOH programs on programming by focusing on community health. At global level, the roadmap has changed major funders such as GAVI and Global Fund in global financing approaches by including community health systems. Other countries has shown interest to learn from Malawi Community Health System, evidenced by recent visit by Nigeria Primary Health Care Agency team visiting Malawi.