Session 13: Financing CHW programs – the case, financing sources, enablers and prioritization
Mickey Chopra, World Bank; Dan Palazuelos, PIH and Financing Alliance for Health partner; Phyllis Heydt, UNSEO and Financing Alliance for Health partner
OBJECTIVES OF THIS SESSION

• **Sharing some input** on CHW financing process

• **Discussing with you** the most feasible and largest financing opportunities you see for your country context

• **Getting your input** on what you require to do the in-country work on CHW financing

This presentation is focusing on financing national gvt.-led scale-up, so where MoHs have national plans and costings already
QUESTION TO THE AUDIENCE

Survey input from you all – challenges in financing

• **Funding amounts**: insufficient overall funding; Insufficient private financing for community level programs

• **Resource mobilization**: Ineffective advocacy tools and mechanisms

• **Management**: Time-consuming coordinating of donor funds

• **Disbursement systems**: Lack of standardized systems to remunerate and retain CHWs

What else are challenges/problems?
FINANCING COMMUNITY HEALTH (HIGH LEVEL) IS A PROCESS

All these steps happen in the context of the bigger health system/national strategies (and not in isolation)

Note: Steps may happen in parallel or in a sequence different from that described above
THERE ARE TOOLS AVAILABLE TO YOU TO SUPPORT ALL WITH THESE STEPS

Key tools available

- **Strategy, policies, costing**
  - Tool: Community Health Costing model (UNICEF/M SH)
  - Tool: analytical ROI
  - Tool: Wage bill overview and checklist

- **The case (incl. ROI)**
  - Template: Gap analysis
  - Template: Prioritization of resources

- **Financial gap analysis**
  - Template: Financing/investment plan

- **Identification sources of financing**
  - Template: Financing/investment plan

- **Finance/investment plan**
  - Tool: analytical ROI
  - Tool: Wage bill overview and checklist

Others
(examples, not exhaustive)

- Multiple guidance available
- One-Health tool
- Various costing tools (e.g. MMB, etc)
- Malaria ROI
- Resource mapping approach/tool (RMNCH and CHAI)
- GFF investment cases

What additional tools are you using?
ALL COSTING AND INVESTMENT PLANS HAVE TO BE DONE IN FULL ALIGNMENT WITH THE TOTAL HEALTH SYSTEM AND NATIONAL STRATEGIES

ILLUSTRATION: Overall Health Sector Investment Plan Costs

- Total health system investments can also be broken down differently (e.g. primary care etc.)
- In either way though, CHW cost and financing plans always have to be part of the overall health system costings and financing plans (so a sub-set/section rather than a stand-alone)
THE GFF IS SUPPORTING THE OVERALL HEALTH SYSTEM FINANCING APPROACH

### What is the GFF?

- **A financing platform in support of Every Woman Every Child 2.0:** [http://globalfinancingfacility.org/](http://globalfinancingfacility.org/)
- **It is a ‘country driven financing partnership’ to support reproductive, maternal, newborn, child, and adolescent health**
- **Focused on a targeted set of countries:**
  - **Front runners:** DRC, Ethiopia, Kenya, and Tanzania
  - **Second wave:** Bangladesh, Cameroon, India, Liberia, Moz, Nigeria, Senegal, Uganda
- **Allows countries to leverage their own resources and IDA funding toward more financing**

### How can it support community health costs?

- **Front runner and second wave countries have been asked to produce an investment case that details proposed interventions and potential health gains**
- **Community health can be included as a priority within the GFF investment case**

### Who can I speak with to learn more?

- **MOH lead for the GFF process**
- **GFF consultants are available in the front runner and second wave countries**
- **The World Bank country office will also be able to support you in learning more**
• **The Case for CHW financing**
  
  • Sources of financing and finance/investment plans
  
  • Political prioritization
  
  • Operational enablers
  
  • Group breakout: prioritizing financing sources
WE HAVE IDENTIFIED “FOUR PILLARS” OF THE CASE FOR INVESTMENT IN CHWS

<table>
<thead>
<tr>
<th></th>
<th>Investing in community health workers makes sense:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Requirement to achieve critical global health objectives</td>
</tr>
<tr>
<td>2</td>
<td>Significant long-term economic return on investment</td>
</tr>
<tr>
<td>3</td>
<td>Short-term cost savings to finance system scale-up</td>
</tr>
<tr>
<td>4</td>
<td>Further benefits to society</td>
</tr>
</tbody>
</table>

CASE FOR INVESTMENT (1/3)

Requirement to achieve critical global health objectives

1. Promoting health and well-being: 40% of newborn & child deaths are from diseases CHWs can prevent and treat – key for SDGs

2. Achieving Universal Health Coverage: UHC cannot be achieved without additional CHWs

3. Preventing and containing health crises: CHWs can play a key role in surveillance and control – e.g. for Ebola, Zika, etc.

4. Eliminating diseases: High quality coverage and surveillance – e.g. through CHWs – is essential for disease elimination

Making healthcare affordable: The WHO has found that CHWs can deliver care in a cost-effective manner

**CASE FOR INVESTMENT (2/3)**

Significant long-term economic return on investment

1. Productivity
2. Insurance
3. Employment

Investing $1 in CHWs...

...can return up to $10 in the long-term

Short-term cost savings and other benefits

**Short-term cost savings**

CHWs have been shown to deliver higher value for money than facility-based care across a number of services:
1. Vaccinations
2. Neonatal care
3. Family planning
4. Malaria
5. Community Management of Acute Malnutrition (CMAM)
6. HIV
7. Tuberculosis

**Societal benefits**

CHWs deliver further benefits to society:
1. Empowering women
2. Reducing costs for patients
3. Enabling governments to conduct civil registration and gather vital statistics (CRVS)
4. Enabling further service delivery at the community level
5. Promoting stronger community participation

A HIGH ROI CAN ONLY BE ACHIEVED FOR HIGH-PERFORMING SYSTEMS

1. National and local leadership in planning, executing and monitoring
2. Part of frontline PHC teams
3. Engaged communities
4. High-impact training
5. Supportive supervision and training

6. High-quality integrated management
7. Adequate resources, tools and supplies
8. Effective incentives and remuneration
9. Sustainable financing
10. On-going monitoring and evaluation

A 10:1 return only possible with “strong program”

The Case for CHW financing

- **Sources of financing and finance/investment plans**
  - Political prioritization
  - Operational enablers
  - Group breakout: prioritizing financing sources
ONCE YOU HAVE DEVELOPED A COSTING FOR A NATIONAL CHW SYSTEM FINANCING IS THE QUESTION

Example cost for the health worker scale-up

In $ millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost (in $ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>6.0</td>
</tr>
<tr>
<td>2017</td>
<td>10.3</td>
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<tr>
<td>2018</td>
<td>14.7</td>
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<tr>
<td>2019</td>
<td>13.4</td>
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<tr>
<td>2020</td>
<td>14.1</td>
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<tr>
<td>2021</td>
<td>11.1</td>
</tr>
<tr>
<td>2022</td>
<td>11.4</td>
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<tr>
<td>Total (2016-2020)</td>
<td>80.9</td>
</tr>
</tbody>
</table>

How to meet these costs?

Do you know what the yearly costs are for your CHW program?
WE BROADLY SEE FOUR CATEGORIES OF FUNDING SOURCES

A. Domestic government financing
B. “Traditional”/existing donors
C. Private sector/individuals
D. “Newer” sources

All countries will have to develop its own mix of financing and transition over time.
IN EACH CATEGORY THERE MIGHT BE A WHOLE RANGE OF OPTIONS

Examples (in no particular order)

A  Domestic funding
1. County/Community health budgets
2. Overall health sector budget (including IDA allocations)
3. Taxes (e.g. corporate health tax for health)
4. Cross-ministry synergies (e.g. vehicles etc.)

B  “Existing” donor
5. Global Fund (all three diseases and HSS if there is a separate component)
6. Gavi (HSS component)
7. World Bank (various mechanisms)
8. USAID (often through implementers)
9. Other Bi-laterals (e.g. JICA, DFID, EU, etc.)
10. Foundations (e.g. BMGF, CIFF, Big Win etc.)

C  Private sector
12. Corporate support from local companies with large catchment areas
13. Corporate support large international corporates (i.e. health) with a company interest in stronger health markets
14. Revenue-generation through CHAs

D  “New” sources
15. Disease surveillance, preparedness and global health security funding/mechanisms
16. Unemployment, education and economic growth programs (e.g. ADB)
17. Philanthropic outcome funders for social impact bonds

For all of these activities to support political prioritization, the analytical case needs to be strong (case, national plan and costing)
**EXISTING/TRADITIONAL DONORS: EXAMPLE GLOBAL FUND**

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**2017-2022 strategy**

- Maximizing impact against HIV, TB, malaria
- Building resilient and sustainable systems for health
- Promoting and protecting human rights and gender equality, and
- Mobilizing increased resources, both domestically and internationally

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**2017-2019 funding window**

- Overall US$12.9 billion funding available for window
- Board approved allocations by country in November 2016
- Countries can spend allocation against HIV, TB, Malaria and resilient and sustainable systems for health (RSSH)
- Country Coordinating Mechanisms (CCMs) assess best use of funds across 3 diseases (and RSSH) and apply for funding (country-specific deadlines in 2016)
- **Biggest opportunities for Community Health:** separate RSSH proposal, and Malaria (iCCM). But CH platform cost can be included in all proposals (as long as they deliver disease-specific services)
- Some countries were offered **catalytic funding for investment priorities**; in particular data and health workforce integration relevant for community health
PRIVATE SECTOR - LOCAL COMPANIES: EXAMPLES

AngloGold Ashanti (AGA)

Overview

- Malaria was huge problem to AGA; 24% incidence rate and 7.5K cases each month. AGA implemented integrated malaria control program and expanded to other treatment areas and total healthcare as well.

Successes

- Saw 75% incidence reduction in 2 years; 90% reduction in labor and treatment costs, clear ROI. $1.5M in setup costs, worth the investment.

Ethiopian Sugar Company

Overview

- In response to widespread pneumo, malaria, and diarrhea, company first set up clinics and then preventative system that engaged nurses and other lower-skilled workers.

Successes

- Reduction in costs with preventative model.
- Measurable reductions in morbidity and mortality.
- Company had better efficiency and productivity.

Are there any companies in your country that might want to invest into community health? How could you engage with them?
<table>
<thead>
<tr>
<th>Novartis: Arogya Parivar</th>
<th>Living Goods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
<td>• Trains Community Health Promoters to work 2 hrs, 5 days/ wk to deliver health education and advocacy and sell products to 100 households each, for 10% below market price in Kenya and 30% below market in Uganda. Go through gov’t training for iCCM, tied to MoH facilities and report up to CH Assistants, increasing their value</td>
</tr>
<tr>
<td><strong>Successes</strong></td>
<td>• Sustainable – broke even in <strong>30 months</strong>; expanded sales 25x since 2009. Reaches 33,000 villages and 42M people. Expanding to Kenya, Vietnam, Indonesia. Integrated into MoH structure in Kenya by having CHFs report to community health units and help Kenyan Community Health Assistants</td>
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<tr>
<td></td>
<td>• <strong>Child mortality reduced by 25%</strong> for an annual cost of $2 (Uganda results). Product costs are 100% recouped. MoH integration is successful – 50-80% of recruits are Kenyan CH volunteers. 17% profit margin for CHPs for part time work</td>
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<tr>
<td></td>
<td>• <strong>Recovers 10-15%</strong> of total costs (including senior leaders, admin, finance); 30-40% of CHW + field costs</td>
</tr>
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</table>
EACH COUNTRY SHOULD PRIORITIZE ITS MOST IMPORTANT FUNDING OPTIONS

Feasibility
- Process complexity
- Time
- Political

Sustainability
- Low
- High

Likely Amount of Funding

“Early steps on domestic financing”

“Maximize existing donors”

“Explore new sources”

Example

1. County budgets
2. Health sector budget
3. Health tax
4. Cross-ministry in-kind
5. Global Fund
6. GAVI
7. Worldbank
8. USAID
9. Pool Fund
10. Other Bi-laterals
11. Corporate support
12. Revenue-generating program
13. Disease surveillance
14. Unemployment/education funds
15. Development Impact Bond
**Community Health Assistant Program scale-up cost & financing $m**

<table>
<thead>
<tr>
<th>Year</th>
<th>Gap</th>
<th>Existing financing</th>
<th>Donors increase by 50%</th>
<th>County governments (10% of total budgets)</th>
<th>Newer sources of financing</th>
<th>Investing incremental govt health budget (on salaries and incentives)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
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<td>2017</td>
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</tbody>
</table>

1 Assumes all CHSS salaries, and CHA incentives from 2020 onwards

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**AND THEN DEVELOP A LONG-TERM INVESTMENT PLAN THAT IT ALIGNS WITH ALL LOCAL STAKEHOLDERS**
The Case for CHW financing

- Sources of financing and finance/investment plans

- **Political prioritization**
  - Operational enablers
  - Group breakout: prioritizing financing sources
POLITICAL PRIORITIZATION OF CHW SCALE-UP IS A PREREQUISITE FOR FINANCING AND SUPPORT

Elements of political prioritization

- Political priority at the **President’s level** with explicit mentioning in national plans, presidential delivery unites transformation agenda etc
- Political priority at the **Minister of Health’s level** with explicit mentioning in health sector plans etc
- Regular engagement of President and Minister of Health on the topic
- Regular attendance of meetings on topic by Minister of Health
- Coverage in media on topic

Examples

“The government was very serious about the benefits of the health extension worker program and the way it could revolutionize our health system. In particular, our late **Prime Minister Meles Zenawi** was very committed to the effort. He really believed in the idea of HEP and in primary health care in general as the centerpiece of our health system. So despite the concerns from partners and stakeholders, we really kept pushing.”

_Dr. Tedros Adhanom Ghebreyesus, 2013 (former Minister of Foreign Affairs)_

**President Paul Kagame** pledged to provide mobile phones that will facilitate communication for health development was fulfilled Friday when over 2500 community based health workers (CBHWs) acquired phones.

Kagame made this promise to the health workers in July last year during a meeting that was held at Amahoro national stadium.

_All Africa, 2010_
### MOH CAN SUPPORT POLITICAL PRIORITIZATION FOR COMMUNITY HEALTH FINANCING

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Potential activities</th>
</tr>
</thead>
</table>
| **Action-forcing events** | - Pledging conferences  
- Identify co-financing opportunities to be matched by a certain time  
- Offer to present at big events, e.g. World Bank Spring meetings  
- Conduct side events at UNGA, WHA…etc |
| **Regular discussion/coordination** | - Regular discussion of CHW financing in donor coordination groups (e.g. repeating agenda item)  
- Launch-events for national strategies |
| **Public coverage** | - Media activities  
- Convenings of CHWs (e.g. TED conference for CHWs) |

- Donors  
- Ministry of Finance  
- Key Implementing partners  
- Local representatives of biggest donors  
- Director General of Ministry of Health/Minister of Health  
- Ministry of Finance  
- General public  
- Other types of health workers
The Case for CHW financing

- Sources of financing and finance/investment plans
- Political prioritization

- **Operational enablers**
  - Group breakout: prioritizing financing sources
**KEY ENABLERS FOR CHW FINANCING**

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ An overall national strategy/policy for community health exists</td>
</tr>
<tr>
<td>▪ There is a costing that translates the implementation of the national strategy/policy into required investments</td>
</tr>
<tr>
<td>▪ Within the MoH clear roles and responsibilities for costing and financing for the CHW system.</td>
</tr>
<tr>
<td>▪ Sufficient time capacity to drive the analytics for the costing, coordination and advocacy for financing for the CHW system proactively</td>
</tr>
<tr>
<td>▪ Existing or new coordination structures used to discuss costing and financing for CHW system regularly with all stakeholders; e.g. as part of a donor coordination meeting, or CHW technical coordination group</td>
</tr>
<tr>
<td>▪ Reliable and accurate data on CHWs and system should support decision making and financing</td>
</tr>
</tbody>
</table>

**What other enablers do you think are critical?**
The Case for CHW financing

• Sources of financing and finance/investment plans
• Operational enablers
• Political prioritization

• Group breakout: prioritizing financing sources
### TEMPLATE 1: GETTING STARTED WITH YOUR CASE FOR INVESTMENT

<table>
<thead>
<tr>
<th>Beneficiaries of a strong CH system</th>
<th>How do they benefit?</th>
<th>Are these beneficiaries already contributing? If no, how could they?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company x in region y</td>
<td>Employee absenteeism days due to sickness of children reduced</td>
<td>No; they could allocate $x%$ of their community funds to the CHW system</td>
</tr>
</tbody>
</table>
TEMPLATE 2: MAP YOUR FINANCING SOURCES

Sustainability
- Low
- High

Likely Amount of Funding

Feasibility
- Process complexity
- Time
- Political

High

Low
TEMPLATE 3: WHAT COULD YOUR FINANCING PLAN LOOK LIKE?
HANOUT: POTENTIAL FINANCING SOURCES

Examples (in no particular order)

A. Domestic funding

1. County/Community health budgets
2. Overall health sector budget (including IDA allocations)
3. Taxes (e.g. corporate health tax for health)
4. Cross-ministry synergies (e.g. vehicles etc.)

B. “Existing” donor

5. Global Fund (all three diseases and HSS if there is a separate component)
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D. “New” sources

15. Disease surveillance, preparedness and global health security funding/mechanisms
16. Unemployment, education and economic growth programs (e.g. ADB)
17. Philanthropic outcome funders for social impact bonds
SUGGESTED APPROACH FOR CALCULATING THE RETURN ON INVESTMENT FROM COMMUNITY HEALTH (HEALTH AND ECON GAINS)

<table>
<thead>
<tr>
<th>Steps</th>
<th>Cost</th>
<th>Health and econ. benefits</th>
<th>ROI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Calculate total cost of community health program (CHW incentives, supplies costs, training, supervision, transport, etc.) – per year</td>
<td>2 Calculate increases in coverage from CHW expansion and potential additional lives saved</td>
<td>6 Compare total yearly cost to ‘run rate’ annual benefit and find ratio: e.g. 10:1, 5:1, etc. – this is the CHW program ROI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 <strong>Productivity:</strong> multiply expected lives saved by expected future economic output of each life saved (using GDP per capita, growth rate, etc.)</td>
<td>7 Compare this ROI to analysis of other potential programs to guide investment and allocation decisions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 <strong>Insurance:</strong> calculate economic potential of health care crisis and degree to which CHW may help offset</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 <strong>Employment:</strong> use economic multiplier to show how spending on CHWs will have additional positive impact on GDP</td>
<td></td>
</tr>
</tbody>
</table>

The ROI in this context is defined as the **run-rate economic benefits compared with the run-rate cost**. Note that this is only one way to calculate an ROI – the metrics and methodology will depend on your target audience and stakeholders.


All references available in report endnotes. Detailed calculation steps, assumptions, etc. available

(1) Using a lives saved calculation does not factor in improvements in morbidity, so underestimates the actual health benefits.
LIVING GOODS DEEP DIVE

Community Health Promoter (CHP)

Selects and trains CHPs

Purchases health related commodities from local manufacturers or global suppliers

CHPs use smartphone app, monthly inventory loan, and business in a bag to register and manage ~100 households

CHPs conduct education and health promotion, and sell goods related to family planning, newborn & maternal health, childhood diseases, and nutrition

In Kenya, products are sold at 10% below market price. In Uganda, medicines are sold at 30% below market price and other commodities are sold at market price

CHPs earn 17% profit margin on goods sold

CHPs return monthly loan to LG branch and keep profit

CHPs earn 17% profit margin on goods sold

TBD: results, and cost-recovery %