From Fragile Funding to Sustained Primary Healthcare (PHC) and Community Health (CH) Across Africa

Systems & Leaders that are re-inventing health financing as Aid recedes

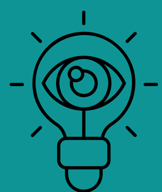
About the Financing Alliance for Health (FAH)

Financing Alliance for Health (FAH) is an Africa-based, African-led and Africa-focused organization. We work at the intersection of financing and health systems - not as implementers of service delivery, but as the technical and advocacy partner that helps governments secure, direct and spend the resources that make primary health care function.

Our starting premise is simple: domestic financing is the oxygen of primary health care. External aid can seed reform, but it cannot sustain it. The governments that will protect their populations through the next pandemic, the next aid withdrawal, the next fiscal shock, are the ones that have built robust domestic financing systems for community health and primary health care - before the crisis arrives.

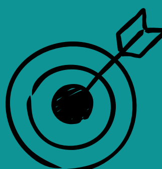
FAH works across the full financing cycle. We help governments mobilise more money for health. We ensure that money flows to frontline primary health care services and community health workers, rather than being absorbed by administrative layers or misallocated through fragmented vertical programmes. We strengthen the public financial management systems that allow funds to be spent effectively and accountably. And we build the in-ountry leadership - through our government Health Systems and Financing Accelerator Fellowship (HSFAF) and our embedded technical assistance model (TA)-, to design, champion and sustain these reforms from within ministries.

VISION

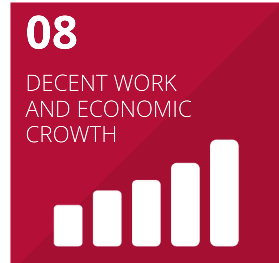


Our vision is to focus financing to improve health for all.

MISSION



Our mission is to partner with governments on all steps of financing to strengthen and sustain community health systems, integrate primary health care and advance universal health coverage.



A Message From Our LEADERSHIP

2025 was a defining year for the Financing Alliance for Health. It was a year of transition for the global health landscape at large, and for our organization as we stepped into a new leadership chapter. Across the sector, significant reductions in ODA forced governments; and all of us who serve them, to confront a simple reality: a seismic financing shift is required to secure the future of primary health care.

This new reality brought into focus an African proverb we have long believed: "When the roots are deep, there is no reason to fear the wind." In this moment of volatility, the "roots" are the horizontal systems that make frontline delivery possible; strategic purchasing, public financial management, reliable data and verification, and in-country leadership able to translate plans into execution.

At this key moment, FAH is increasingly focused on helping Ministries of Health and Ministries of Finance "move diagonally": building integrated horizontal systems that can reliably deliver vertical outcomes. Through our embedded model and government fellowship, we support governments to use data on cost and impact to optimize primary and community health; so that resources not only increase, but are targeted, executed, and translated into measurable results for women, children, and underserved communities.

Our 2025 impact story reflects this shift. Across our six focus countries, we supported governments to take increasingly decisive steps toward domestically anchored financing and stronger execution, helping strengthen the plumbing that ensures funds reach the frontline and can be tracked, verified, and improved over time. At the same time, we remain clear-eyed: the work is far from complete.

SOLEINE SCOTNEY
CO-CEO, FINANCING ALLIANCE FOR HEALTH

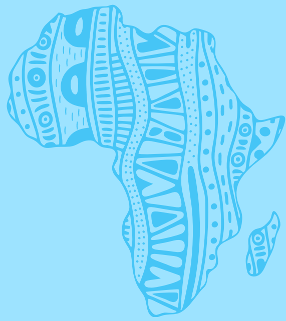
SIZWILE SIBINDI
CO CEO FINANCING ALLIANCE FOR HEALTH

Financing gaps remain significant, and the risk to essential services is real. Moving from aid dependency to sustainable, government-led systems is complex, and it requires long-term partnership, technical rigor, and unwavering commitment.

This year has also strengthened our commitment to being an alliance in practice, not just in name. We are doubling down on collaboration, working with partners including CHIC, CHU4UHC, Muso, LMH, and many other international and local actors who are delivering change at the frontline. Our intent is to help build strong systems that can absorb and scale innovations, align actors around shared outcomes, and ultimately save more lives by making improvements durable and replicable across settings.

As you read this report, you will see both the challenges and the progress that defined 2025. More importantly, you will see the emergence of a different kind of momentum, grounded in domestic leadership, integrated systems, and a shared commitment to build health systems that endure beyond cycles of external funding.

Sizwile & Soleine



A Message From Our
Board

VICTORIA GOODFELLOW
BOARD CHAIR

Head of Infectious Diseases - MedAccess

"The biggest gains in global health have always come from strong systems working together—financing, procurement, and delivery aligned around shared outcomes. FAH's focus on integration creates the conditions for healthier markets, more reliable access to life-saving commodities, and sustained reductions in infectious disease and MNCH mortality."

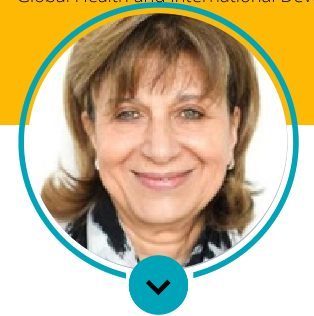
Victoria

"We are at a turning point in global health, where effectiveness depends on shifting power and ownership closer to countries themselves. FAH plays a critical role in that transition—working alongside governments to strengthen their institutional capacity and reshape the global health architecture around country leadership."

Hind

HIND AL-KHATIB
BOARD MEMBER

Senior Advisor - Global Health and International Development



AMB. JOHN SIMON
FOUNDING BOARD MEMBER

Managing Partner - Total Impact Capital

"The challenge today is not only finding more money for health, but finding smarter ways to mobilize and deploy it. FAH helps governments navigate innovative financing approaches with discipline and realism—unlocking new resources while ensuring they translate into real improvements on the ground."

John

"Moments of disruption reveal whether a system has been built to last. What FAH does exceptionally well is help countries strengthen the financing spine of community health—so that when shocks come, services don't collapse, but hold. That kind of resilience is not accidental; it is designed."

Daniel

DR. DANIEL PALAZUELOS, MPH
FOUNDING BOARD MEMBER

Medical Education and Community Health Care System Advisor - The Family Van

Dr. Amit Chandra
BOARD MEMBER

Adjunct Professor - Georgetown University

"This past year's events have made one thing clear: countries must be equipped to make critical health decisions using the resources they have. The Financing Alliance for Health brings rigor to cost and impact decisions, partnering with governments across the continent on their journeys toward universal health coverage. I'm proud to support their work."

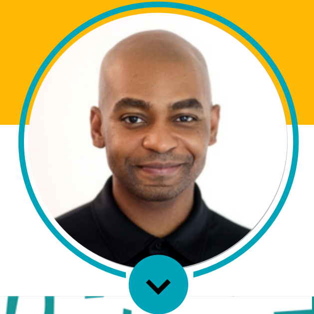
Amit

"Sustainable health systems aren't funded into existence; they're built by people who can turn strategy into execution. What makes FAH's work powerful is its investment in African leadership: equipping the next generation to shape financing decisions, steward reforms, and build systems that last beyond any single funding cycle."

Varsay

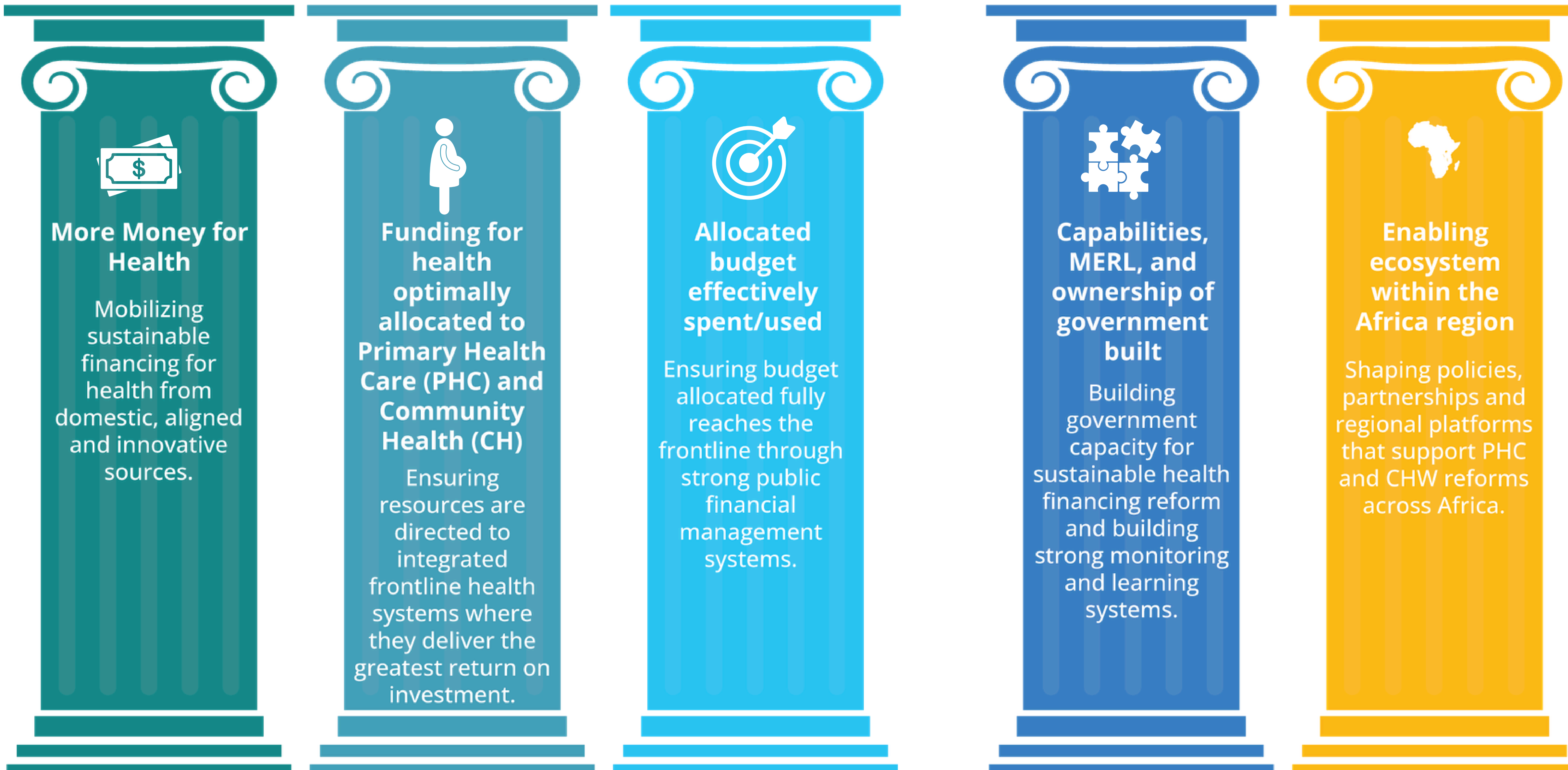
VARSAY SIRLEAF
BOARD MEMBER

Senior Director, Community, Public Sector and Global Engagement - Essence Communications Inc.



HOW WE
WORK

Our impact model is based on the four strategic pillars of our 2023–2027 Financing Alliance for Health strategy, designed for scale and sustainability. This year, we have expanded these pillars into five strategic focus areas to better reflect the breadth of FAH's work and respond to government's stronger requests for support on budget execution and efficiency in a constrained fiscal landscape.



The first two pillars concern the volume and direction of financing - mobilising more money for health and ensuring that funding is optimally allocated to integrated primary health care and community health systems, rather than primarily in higher-level facilities or donor-managed programmes.

The third concerns execution: supporting governments to spend their allocated health budgets fully and efficiently through public financial management reform.

The fourth pillar builds the human infrastructure for sustained reform, equipping government officials with technical skills, political economy understanding and leadership confidence to drive change from within. The fifth shapes the continental environment in which all of this happens: the policies, partnerships, evidence and advocacy platforms that make PHC financing reform politically possible and technically credible across Africa.

These five areas are not sequential. They are simultaneous and mutually reinforcing. A government that mobilises more money for health but lacks the PFM systems to spend it effectively gains little. A country that reforms its financing architecture but has no reform leaders inside the ministry to sustain it will see gains erode. FAH works across all five areas in each country, calibrating its support to where the biggest bottlenecks to quality frontline services being available lie.

7 National governments (including 2 through partners) & 6 sub-national governments engaged across Zambia, Senegal, Sierra Leone, Central Africa Republic (CAR), Mali, Ethiopia & Kenya to increase and optimize community health funding.

1 Community Health (CH) investment case on CH financing co-developed with government of Sierra Leone and used for advocacy with the Ministry of Finance as well as other development partners, demonstrating a 12:1 return on investment (ROI) of investing in CH.

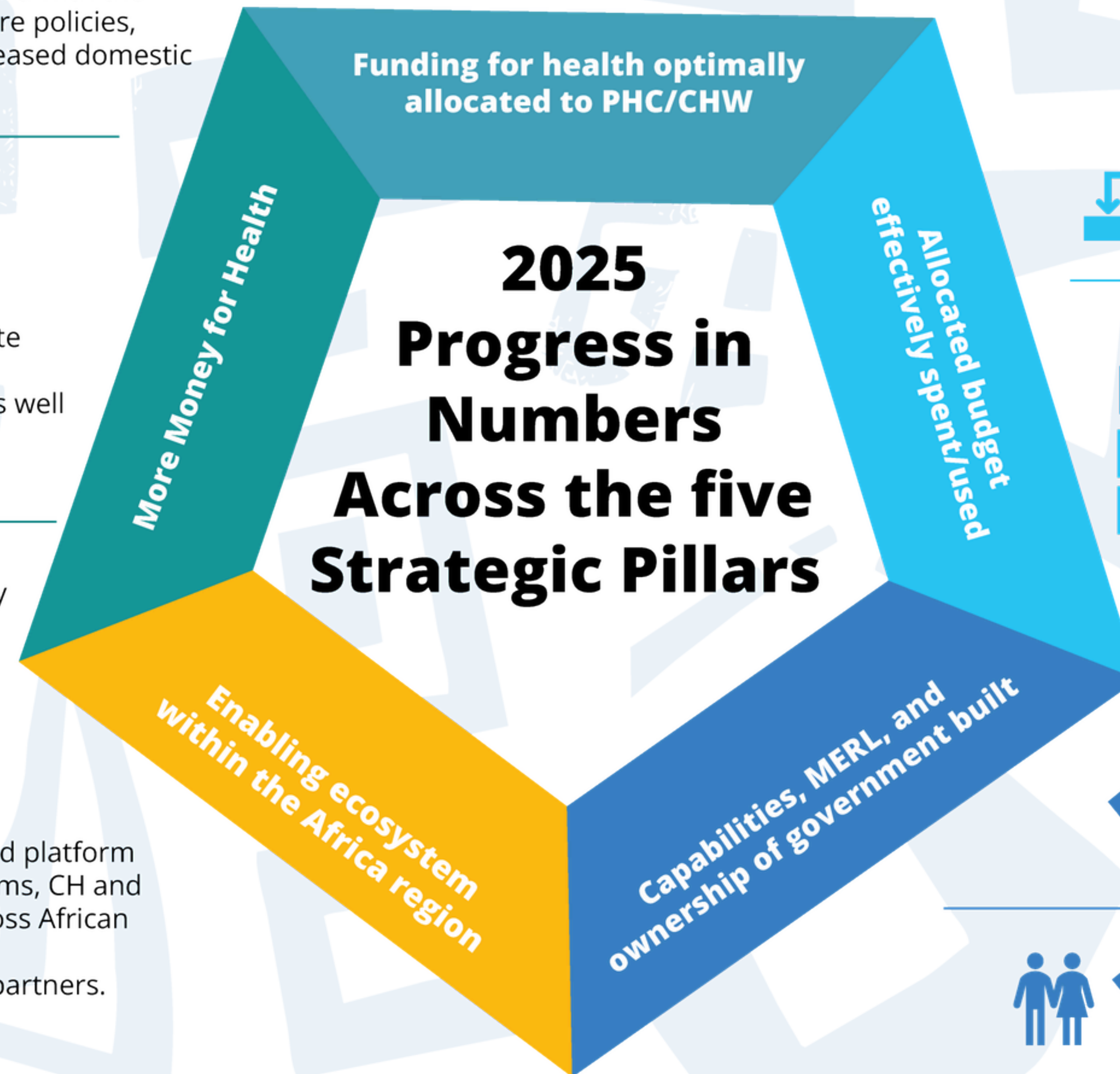
Supported the government of Sierra Leone to push forward with the design of the Sierra Leone Agency for Universal HealthCare policies, which includes innovative financing mechanisms for increased domestic resource mobilization.

$1.35B (27% increase)

Provisionally secured at the Kenya National Health Budget level for FY2026/27 through provision of targeted technical support to the State Department for Public Health and Professional Standards during Medium-Term Expenditure Framework (MTEF) budget preparation, as well as the at the National Treasury health budget retreat to advocate for higher domestic health financing.

$1M Committed by GAVI in collaboration with the Africa Frontline First (AFF) to support Community Health Workers (CHWs) in Guinea-Bissau on a joint plan with government and Global Fund.

1 **CH dashboard developed:** a centralized platform that brings together data on CH programs, CH and PHC financing, and service delivery across African countries, supporting more informed decision-making for governments and partners.



104,630 New Community Health Workers (CHWs) recognized in policy across Kenya, Zambia, Senegal, Sierra Leone, & CAR.

1 Policy brief on domestic resources mobilisation (DRM) for PHC co-developed with the government of CAR and used as an advocacy tool to secure additional resources.

$7.5M Domestic budget commitments to Community Health (CH) in Kenya, Zambia, Sierra Leone, Senegal & Central Africa Republic (CAR).

(30% increase from FY 24/25)

PHC, CH and RMNCAH resource tracking conducted in Senegal, Zambia, Sierra Leone, Tanzania, and Kenya thereby improving transparency, data ownership, and alignment of partner investments.

9 Health Financing & RMNCAH policy briefs co-developed with governments in Senegal, Zambia and Sierra Leone providing evidence-based recommendations to improve allocation efficiency, strengthen domestic resource mobilization, and inform future service delivery and financing reforms.

Approx. 1,000 Community Health leaders with skills built on Domestic Resource Mobilization (DRM) and Public Financial Management (PFM) amongst other skills.

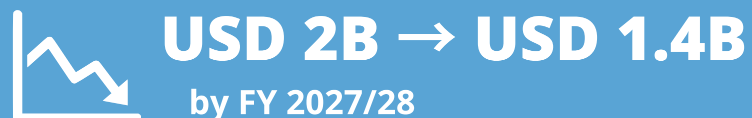
14 Government fellows upskilled and designing best in class health financing reforms through the Health Systems & Financing Accelerator (HSFA) program.

2 Health Financing/PHC reforms led by HSFA fellows operationalized in Kenya & Zambia.

THE MOMENT:
WHY 2025 CHANGED EVERYTHING

Something structural shifted in global health financing in 2025. It was not a single event but a convergence: significant reductions in US foreign assistance, tightening fiscal space among bilateral donors, and growing pressure on multilateral funding mechanisms. For primary health care systems across Africa which had been built, over decades, on the assumption of sustained external support, this earthquake suddenly put millions at risk.

For instance, in Kenya, the 2025 Health Sector Resource Mapping exercise completed by FAH projected that total health financing would fall from



Community health investment was expected to drop from

In Sierra Leone, Senegal and Zambia, USAID and FCDO transitions created immediate gaps in financing for community health workers, supervision systems and essential supplies.

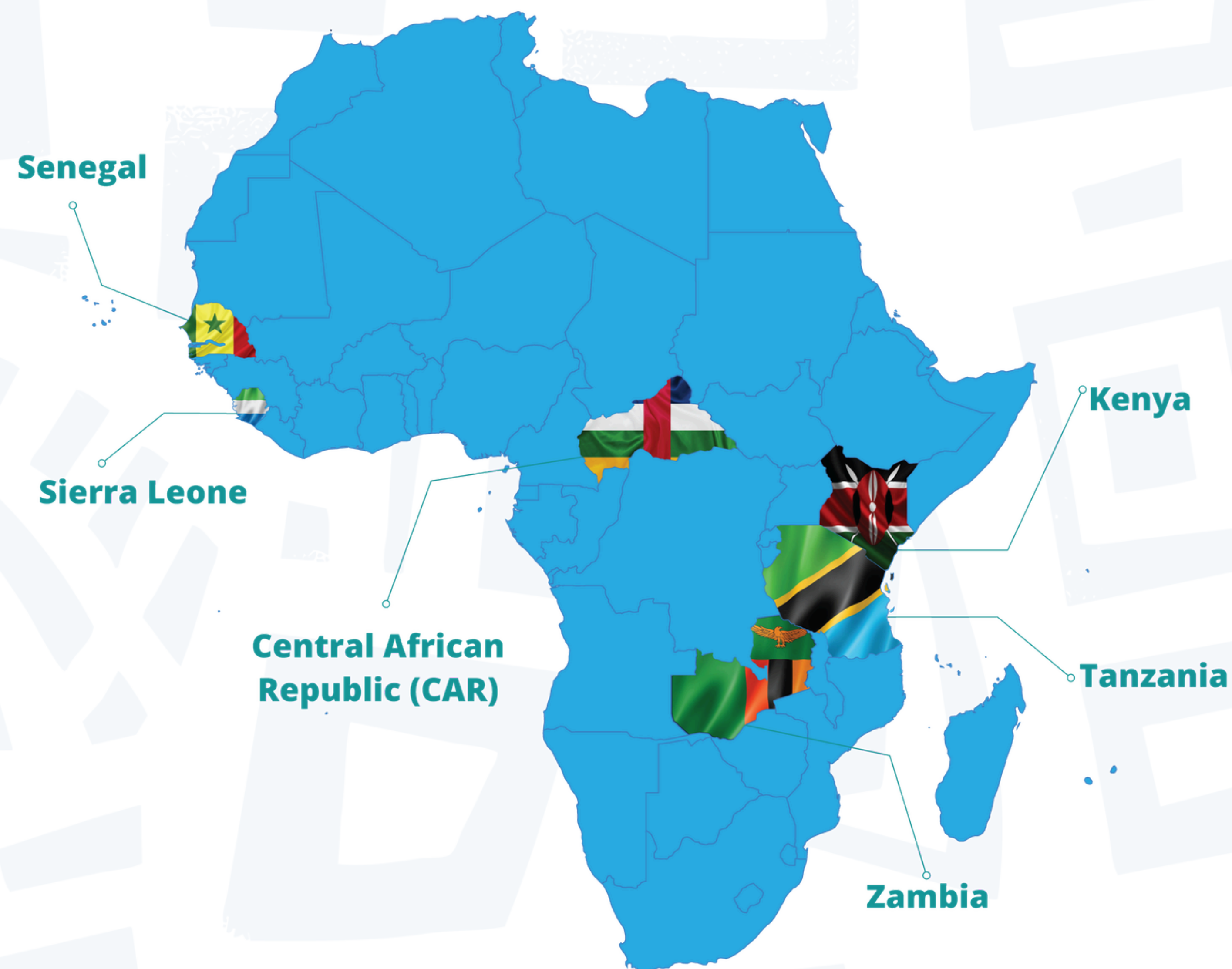
Nearly 90%

Percent of the health budget in the Central African Republic has historically relied on external aid, even modest reductions in donor flows sent shockwaves through frontline services.

And yet 2025 was also the year in which something different began to happen. Governments that had worked with FAH to build domestic financing systems, develop evidence bases for primary and community health investments and embed reform leaders inside ministries were better placed than most to absorb the shock. The story of 2025 is not simply a story of crisis - it is a story of domestic financial systems beginning to hold, and of a renewed momentum to advance government-led universal health care.

This report documents what that momentum and our support to accompany it looked like in practice - in six countries, across dozens of reforms, and through the stories of the government leaders who drove them.

COUNTRY DEEP DIVE



Kenya

Moving Kenya from Schemes to Systems through Social Health Authority (SHA), Facility Improvement Financing (FIF) and Insurance Reforms

Kenya's transition toward Universal Health Coverage (UHC) is taking place at a critical moment. While the country had started introducing sweeping health financing reforms through the Social Health Authority (SHA) since 2024, declining external assistance exposed structural vulnerabilities in how primary health care (PHC) and community health services were financed.

Fortunately, Kenya understood that without continued structural reforms, these shifts threatened the sustainability of the preventive and promotive services that underpin improvements in maternal, newborn, and child health.

KENYA AT A GLANCE

27%

Increase in provisional national health sector financing

Financing increased from **USD 1.07 billion to USD 1.35 billion** supported through FAH technical engagement in the national budget process.

$0.7M

Mobilized to support health insurance coverage for indigent households through the redesigned MutulaCare scheme in Makueni County.

$ 362.1M

Mapped national investment in community health services (2021–2024), providing government with the first comprehensive view of community health financing flows.

7

Senior MoH officials completed 9-month Health Systems Accelerator Fellowship, building long-term reform leadership

944

health Facility Management Committee members trained in public financial management to strengthen facility-level governance and financial autonomy across three counties.

In Kenya, the connection between technical work and budget outcomes was unusually direct. FAH provided sustained support to the Ministry of Health through the **FY 2026/27–2028/29 Medium-Term Expenditure Framework process**, contributing to planning documents, building the analytical case for increased health sector allocations and participating in sector-wide consultations convened by the National Treasury.

These coordinated efforts contributed to an impressive Government of Kenya increase in the **provisional national health sector allocation from USD 1.07 billion** in FY 2025/26 to USD 1.35 billion in FY 2026/27, representing an **additional USD 0.28 billion and a 27 percent increase** in health sector financing in a single budget cycle.

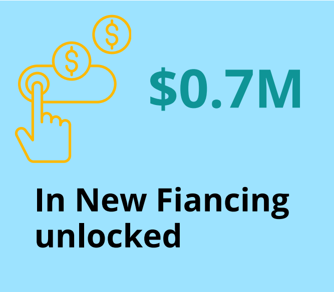
This outcome offers an important lesson for other countries navigating similar budgeting and reform processes: sustainable change is rarely the product of a single decision point but one that's built through sustained, technically grounded engagement. In this case, progress emerged from months of working alongside the Ministry to strengthen its evidence base, refine policy arguments, and sharpen its positioning within a highly competitive government-wide budgeting environment.

A key takeaway for other contexts is the role FAH chose to play. Instead of negotiating on behalf of the Ministry, FAH focused on equipping government officials with the analytical credibility and confidence to advocate for their priorities themselves. This distinction is crucial. When ministries lead their own negotiations, outcomes are more likely to endure because they are institutionally owned rather than dependent on an external actor to maintain momentum.

For countries facing similar constraints which include limited fiscal space, competing sectoral priorities, and donor transitions, the core lesson is clear: investing in government capacity and ownership creates results that last.

ADVANCING INSURANCE REFORM AT COUNTY LEVEL

In **Makueni County**, FAH supported the redesign of the county's universal health coverage program into **MutulaCare,** a scheme aligned with the Social Health Insurance Act (2023) and designed for integration into SHA. The redesign addressed major structural weaknesses in the previous scheme, including renewal rates that had fallen to just 3 percent and hospital reimbursement arrears exceeding **USD 1.57 million**.

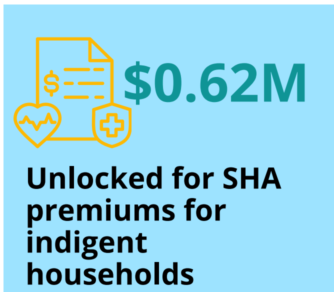


$0.7M

In New Fiancing unlocked

$0.08M

For enrolment and rapid results initiatives.



$0.62M

Unlocked for SHA premiums for indigent households

At the county level, FAH supported governments to align their health financing strategies with national insurance reforms.

Digital beneficiary registration and structured indigent identification tools are helping ensure that vulnerable households can access primary health care services without financial barriers. This scheme can serve as a useful blueprint for other counties wishing to improve social protection for vulnerable households.

Strengthening the Foundations of PHC Financing

In 2025, FAH worked with the Ministry of Health and six counties i.e. **Makueni, Nairobi, Laikipia, Nakuru, Nyeri, and Tharaka Nithi** to strengthen the operational foundations of Kenya's health financing reforms.

A central focus was improving **facility-level financial governance,** a critical bottleneck in implementing Kenya's Facility Improvement Fund (FIF) framework. Many primary health care facilities lacked the public financial management capacity required to manage and account for funds effectively.

To address this gap, FAH trained **944 Health Facility Management Committee members** on public financial management, procurement procedures, and FIF compliance. These trainings are enabling facilities to better manage revenues generated through FIF, SHA reimbursements, and PHC capitation funds ensuring that resources reach frontline services where they are most needed.

FAH also supported the **national Health Sector Resource Mapping and Tracking exercise**, consolidating financing data from government and development partners across **FY 2022/23 to FY 2027/28.** The analysis revealed both the scale of investments and structural vulnerabilities in health financing flows, laying the groundwork for institutionalizing a government-led financing dashboard to strengthen planning and accountability.

Integrating Community Health into PHC Financing

One of the most significant policy advances in 2025 was the integration of community health services into Kenya's PHC financing architecture.

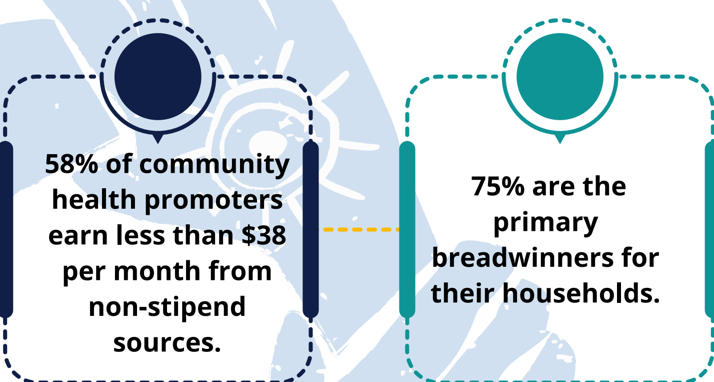
FAH provided technical support to the development of the **Primary Health Care Regulations (2026),** which will introduce a transformative policy provision: **Level 2 and Level 3 facilities must allocate at least 25 percent of their budgets to community-level preventive and promotive services.**

This reform addresses a longstanding gap in Kenya's health financing system. Community health services including outreach, supervision, community dialogues, and household visits have historically been underfunded despite their critical role in preventing illness and reducing demand for more expensive facility-based care. Once implemented, the regulation will institutionalize predictable financing for community health services while strengthening integration between primary health care facilities and community health units.

Working closely within CHU4UHC, FAH also supported the submission of a proposal to include defined community health interventions within the **PHC Fund benefits package (a component of the Social Health Assurance mechanism),** introducing digitally verifiable service units linked to the **electronic Community Health Information System (eCHIS)** and establishing reimbursement pathways under the SHA framework. Discussions between SHA and CHU4UHC on operationalization of this initiative – which could serve as a blueprint for other countries wishing to leverage social health insurance to better finance community health - are continuing into 2026.

Strengthening the Community Health Workforce through socio-economic empowerment

Recognizing that sustainable community health services depend on a stable workforce, FAH also piloted an economic empowerment model for community health promoters.



A baseline assessment in **Makueni County** revealed that **58 per cent** community health promoters earn **less than USD 38.71 per month from non-stipend income sources, while 75 percent are primary breadwinners** in their households.

To address this challenge, FAH piloted the **Community Health Unit Savings and Loan Association (CHUSLA) model across six community health units reaching approximately 210 community health promoters.**

Participants were trained using a government-approved curriculum on group governance, financial literacy, and entrepreneurship. Early results suggest the model can help stabilize incomes, strengthen cohesion within community health units, and reduce attrition risks among community health promoters.

Generating Data to Strengthen Decision-Making

Beyond financing reforms, FAH also worked to strengthen data visibility on investments and outcomes to support more informed health system management.

FAH supported the Ministry of Health and CHU4UHC to develop an **integrated community health financing and performance dashboard** that consolidates service delivery data from the electronic Community Health Information System, KDHIS2, community health worker registry data, stipend payment information, and county budget allocations. By linking financing flows with service delivery outcomes, the dashboard allows counties to better understand the relationship between investments in community health workers and improvements in service coverage, particularly for maternal and child health. The platform has already generated strong interest among national and county leadership as a tool to support evidence-based resource allocation decisions and will be updated through MOH and CHU4UHC every quarter going forward.

LOOKING AHEAD

As Kenya continues implementing ambitious health financing reforms while navigating declining external funding, strengthening domestic **financing systems for PHC and community health will remain essential.**

FAH will continue supporting the government **to operationalize SHA strategic purchasing mechanisms, finalize reimbursement pathways for community health services, continue public financial management reforms** to ensure the new SHA funds being channeled are additional instead of substitutive to county allocations and generate the targeted return on investment, and develop **financing models** which sustainably fund both community health promoters and the key enabling systems at PHC.

Together, these reforms are helping Kenya shift from a donor-dependent financing model toward a more resilient, government-led system capable of sustaining primary health care, protecting the health of mothers and children nationwide.

GOVERNMENT FELLOW SPOTLIGHT

How Dr. Daniel Wainaina Activated Existing Frameworks to Unlock Rapid Improvements in Quality & Patient Experience

Lanet Health Centre on the outskirts of Nakuru once told a familiar story: long queues, overstretched staff, ageing infrastructure and a budget so thin that the idea of people-centred care felt aspirational rather than achievable. When **Dr Daniel Wainaina, Director for Medical Services in Nakuru County, enrolled in our HSFAFP Fellowship**, he did not arrive with a proposal to build something new. He arrived with a sharper question: **why wasn't what already existed working?**

Kenya, Dr Wainaina understood, does not lack health policy.

It has robust Public Finance Management legislation, county budgeting frameworks, Facility Improvement Fund provisions and, since 2023, national insurance reform under the Social Health Authority.

The gap was not legislation. It was operationalization, the distance between what the law permitted and what facilities were actually doing with it.

Lanet Health Centre received USD 94,317 from SHA across four quarters allocations growing from **USD 2,424 in Q1 to USD 61,734** in Q4, a scale-up that reflected growing confidence in the facility's financial discipline and performance.

Facility Upgrade at Lanet

Q4 $61,73

Q3 $25,545

Q2 $4,693

Q1 $2,424

Quarterly growth in SHA reimbursements to Lanet Primary Health Centre

His approach through the Fellowship was phased and deliberate. He worked with county finance teams to **clean historical financial reporting and improve the predictability of quarterly disbursements.** He **repositioned FIF** not as a stopgap but as **catalytic capital** used to demonstrate results that justified larger and **more sustained domestic allocations. He linked quarterly performance indicators** to funding flows, so that every allocation decision was grounded in what the facility had actually delivered. The results, in FY 2024/25, were unambiguous.

The compound was upgraded. The patient waiting area was transformed from overcrowded to a space that shows every patient their care matters. New mothers received gift packs, a small gesture with a significant message about the health system Kenya aims to build.

Wainaina reflects that the Fellowship instilled in him the confidence to question why existing tools weren't utilized and provided the technical expertise to address and act on it. Reform maturity is about optimizing current systems rather than creating new ones. The lesson from Lanet is a model for system-wide transformation. By activating existing financing frameworks with discipline, transparency, and a performance link, even resource-limited facilities can improve quality and patient experience. Dr. Wainaina is now scaling this approach across Nakuru County and beyond.

Zambia Finances the Frontline through PHC Strategy, USD 552K Community Health Investment, and Output-Based Budgeting

Zambia's health system faces significant structural challenges despite recent gains. While maternal mortality declined from 278 to 195 deaths per 100,000 live births between 2018 and 2024 and skilled birth attendance reached 94% (ZDHS 2024), critical gaps persist:

Only 56% women start antenatal care in the first trimester

24% of mothers and 17% of newborns miss postnatal care within the first 48 hours.

18,497 shortfall of health workers, directly affecting service availability and quality, particularly in rural areas.

$460M PHC infrastructure gap

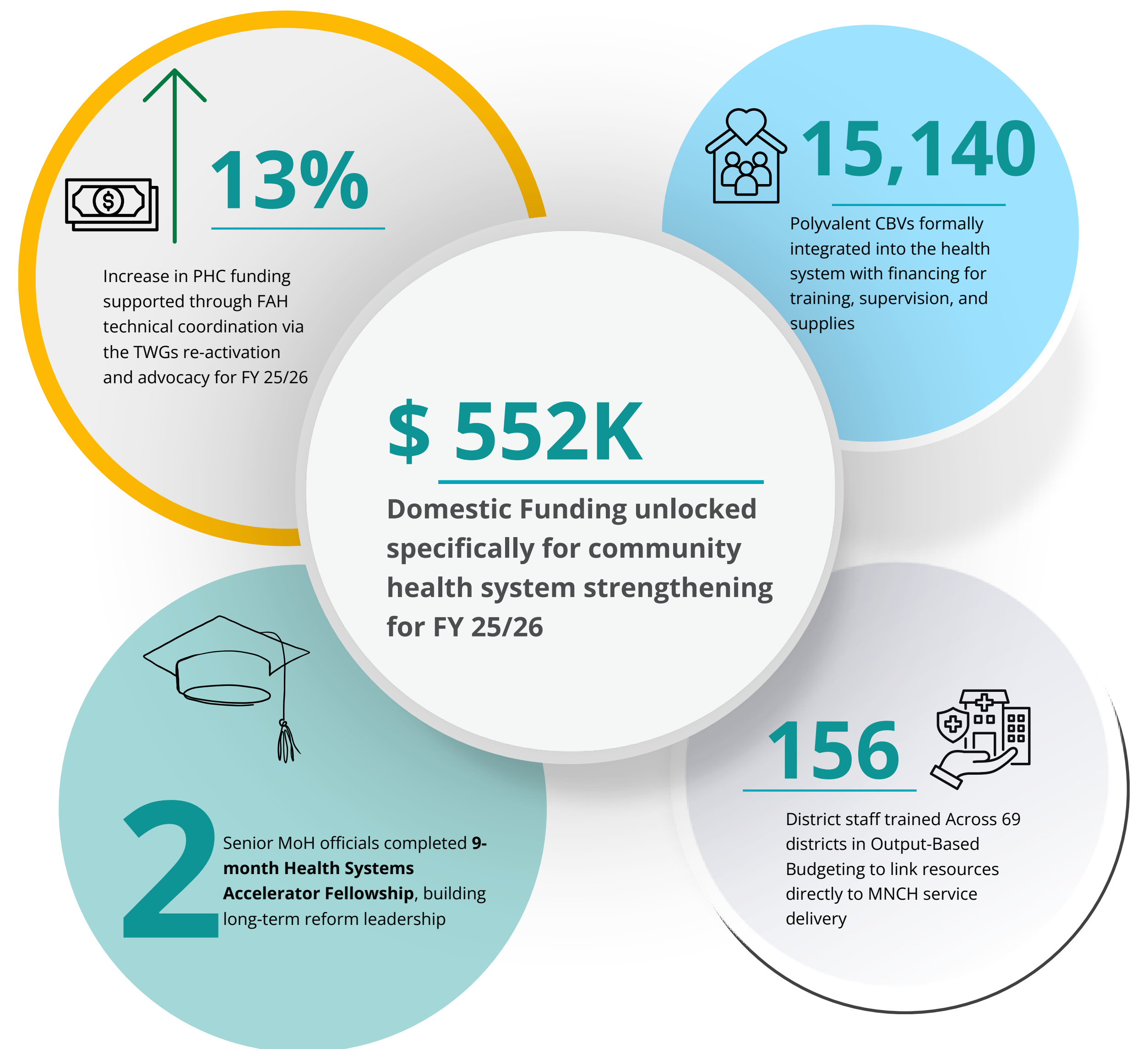
3% of GDP government health expenditure far below the WHO-recommended 5% benchmark.

A community-based volunteer participates in a gender-based violence campaign to raise awareness.

The National Health Insurance Scheme mainly covers formal sector employees, leaving households at risk of high out-of-pocket expenses and catastrophic health costs. Rural barriers to care are higher than urban, **with 66% vs. 45% financial and 53% vs. 23% distance barriers.** These inequities hinder progress toward Universal Health Coverage, necessitating urgent reforms in resource mobilization, strategic purchasing, and financial protection.

Against this backdrop, the Financing Alliance for Health collaborated with the Government of Zambia to strengthen health system governance, advance evidence-based financing reforms, and build sustainable capacity for PHC and RMNCAH delivery. Through embedded technical assistance within the Ministry of Health and targeted leadership development via the Health Systems and Financing Accelerator Fellowship, FAH supported the government to translate policy commitments into financed, implementable reforms that protect frontline services, improve equity, and accelerate progress toward maternal and child health targets.

ZAMBIA AT A GLANCE



Mobilising Domestic Resources: 13% Increase in PHC Funding and USD 552K unlocked for Community Health Systems Strengthening.

FAH revitalized the Health Care Financing Technical Working Group which provided a platform for structured policy dialogue between MoH and MoFNP. Through these dialogues, a 13% increase from **USD 286 million (2024) to USD 323 million (2025) in PHC funding for 2026 was realised.**

Within this expanded PHC envelope, FAH supported the government to unlock **USD 552,000 in domestic funding** for community health, integrating, enumerating, and equipping a **15,140 pCBVs into the formal system from 2024-2026.** This financing covered training, supervision, and supplies for Sexual Reproductive Maternal Newborn Adolescent Health (SRMNCAH)directly addressing the rural access gaps in availability and quality.

FAH also provided embedded technical assistance for **Zambia's National Health Accounts (2022–2024) and the 2025 National Health Compact,** improving visibility of financing flows and enabling better partner alignment and targeted resource allocation. These efforts strengthened domestic resource mobilization and protected frontline health services amid declining external aid.

The PHC Strategy (2025–2031): A Costed Framework Addressing MNCH Bottlenecks

FAH supported development of the **2025–2031 PHC Strategy** with **analytical, costing,** and **strategic inputs.** This included supporting Zambia to establish a **comprehensive PHC service package and financing arrangements prioritizing MNCH outcomes.**

The strategy directly addresses documented MNCH bottlenecks by costing the investment required in PHC enablers such as **workforce expansion, community health integration, facility readiness, essential commodities** etc into a medium-term financing framework, standardizing referral pathways and enabling a shift from fragmented vertical funding to integrated PHC financing.

STRENGTHENING BUDGET EXECUTION

Fellow Nalishebo Mwale's PFM Reforms

FAH addressed **weak channelling of allocated resources** to the **frontlines** of care through budget cycle reforms, where fellowship research showed that **only 62% of PHC budgets** were executed at the facility level in 2023, underscoring the urgency of reform. These included **cash-flow mapping, facility-level financing gap analysis,** and **systems tracking National Health Insurance Management Authority (NHIMA) reimbursements** alongside government grants.

Our Health Systems Accelerator government Fellow Nalishebo Mwale led targeted work within MoH's planning and financing structures, **improving PHC purchasing rules**, **accelerating fund flow visibility,** and developing reporting guidelines linking financial receipts to service delivery outputs.

Her reform project, "Sustainable Financing for Devolved Primary Health Care in Zambia," directly addressed budget execution challenges under newly devolved PHC governance.

OUTPUT -BASED

BUDGETING

Training 156 District Staff Across 69 Districts to Link Budgets to MNCH Outputs

In 2022, Zambia formally devolved responsibility for Primary Health Care (PHC) delivery to 116 Local Authorities, positioning PHC as the cornerstone of Universal Health Coverage. This shift required urgent strengthening of district-level planning and budgeting capacity to ensure that decentralisation translated into tangible service improvements. To address past challenges where budgets were insufficiently linked to service delivery outcomes, FAH introduced **Output-Based Budgeting (OBB)** as a practical tool for aligning resources with results. Beginning with **six provinces (Eastern, Southern, Western, Central, Copperbelt, and North-Western)**, FAH **trained 156 local authority staff across 69 districts** in **results-based planning, embedding accountability and performance orientation** into the newly devolved PHC system.

Training was anchored in **six strategic objectives** aligned to the 8th National Development Plan: **increasing equitable access to quality health services; improving clinical and diagnostic service delivery; advancing health promotion and disease prevention; ensuring an adequate and motivated PHC workforce; strengthening multisectoral collaboration on social determinants of health; and reinforcing health systems and governance structures.**

Districts **now link resource allocations to specific PHC and MNCH outputs:** antenatal care coverage, skilled birth attendance, child immunization rates, community outreach sessions, and essential commodity availability.

Community health workers bridge the gap to healthcare in remote areas.

OBB improves alignment between district planning, national priorities, and budget execution, reduces PHC financing fragmentation, and provides a foundation for integrating PHC performance indicators into future NHIMA purchasing arrangements.

GOVERNMENT FELLOW SPOTLIGHT

How Dr. Callen Chizuni Transformed her Frontline Insights into a Bold Fight for Zambia's Mothers & Children

Dr. Callen Chizuni didn't need statistics to understand the gaps in Zambia's maternal and newborn health system as she lived them every day as **Chief Safe Motherhood Officer at the Ministry of Health.** Despite progress, she knew too many women and babies were still dying from preventable causes.

The contradictions haunted her: **High coverage for skilled birth attendance wasn't translating into survival as the system measured volume, not timing, quality, or protection.**

Dr. Chizuni saw the barriers: **facilities unprepared for emergencies, structural inequities leaving the most vulnerable behind.** But she also saw opportunity to fundamentally shift how Zambia financed and delivered maternal care.

Through the Health Systems and Financing Accelerator Fellowship, Dr. Chizuni transformed her frontline insights into a bold reform: *"Closing the Gaps in Maternal and Newborn Health: Priorities for Action in Zambia."*

Her proposed reform calls for **smarter financing** that **rewards what saves lives** including **paying for first-trimester ANC through conditional transport vouchers, bringing services closer via mobile clinics, making emergency obstetric and neonatal** resuscitation the minimum standard, and institutionalizing women's autonomy through structured counseling. The impact is already unfolding. Dr. Chizuni's work is informing Ministry of Health discussions on budget priorities, performance-based financing reforms, and equity-focused resource allocation. Her evidence-based advocacy is **helping protect maternal health investments** even as external aid declines, ensuring that Zambia's next mortality gains come not from more facilities, but from smarter financing and bringing quality care to the women who need it most.

Dr. Chizuni's story demonstrates that **transformative health reforms come from empowering government leaders who understand both the system's failures and its possibilities.** Additionally, when **technical capacity meets personal conviction and institutional authority, change doesn't just happen on paper, it reaches the women and newborns whose lives depend on it.**

LOOKING AHEAD

- As Zambia moves into 2026, the government will **consolidate PHC reforms** by translating the 2025–2031 PHC Strategy into costed annual plans across all 116 districts, improving budget predictability, refining PHC ceilings, and integrating cost drivers into the Medium-Term Expenditure Framework to align resources with frontline needs.

- Key priorities include **scaling and embedding Output-Based Budgeting** into routine district planning, **strengthening accountability for MNCH service delivery outputs** (ANC coverage, immunization, outreach), and **stabilizing community health financing** to ensure timely district releases and sustainable CHW compensation under the integrated PHC model.

- Parallel efforts will focus on **strengthening PFM systems and facility-level financial management,** including dual reporting on grants and insurance funds, **expanding district expenditure tracking capacity, and deepening multisectoral collaboration** to address social determinants of health.

By aligning financing, governance, and system reforms with frontline realities, Zambia's 2026 agenda positions the PHC system for reliable service delivery, accelerated MNCH gains, and greater progress toward Universal Health Coverage.

Sierra Leone

Building strong foundations for Sierra Leone's Resilient RMNCAH Services

Despite notable progress following recovery from the Ebola epidemic and COVID-19 pandemic, Sierra Leone's health system remains fragile

MATERNAL MORTALITY DECLINE

Maternal Mortality Rates Still High Vs Global Average

In 2025, these pressures were compounded by a new public health shock, the **Mpox outbreak**, which stress-tested the system's ability to maintain essential services while responding to an emergency. The outbreak once again made Sierra Leone's health financing problems visible: without sustainable domestic financing for primary and community health, every crisis threatens to derail progress for women, newborns, children, and adolescents.

While the national Free Healthcare Initiative (FHCI) significantly expanded access to maternal and child health services, it was inadequately resourced and designed as a time-bound initiative rather than a sustainable system instrument, leading to structural weaknesses including unpredictable financing, delayed reimbursements, medicine stockouts, and fragmented financial management.

Fragmentation and Underfunding in Health Financing

36% of total health budget is reliant on International Aid

Risks: Donor Volatility and undermining the sustainability of frontline RMNCAH service delivery.

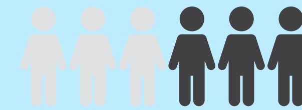
55% of total health spending is Out-of-Pocket (OOP),

56% live below the poverty line

With over 56% of the population living below the poverty line, financial barriers severely constrain care-seeking behaviour, particularly for pregnant women and mothers in rural areas. Against this backdrop, FAH, in collaboration with the Government of Sierra Leone and enabled by institutional donor support, provided targeted technical assistance to **strengthen health financing governance, operationalize critical policy reforms, and build sustainable financing mechanisms for primary health care and RMNCAH services.**

SIERRA LEONE

AT A GLANCE



$717,000

Mobilized from domestic resources for PHC for **FY 25/26.**

12:1

Return on investment demonstrated through Sierra Leone's first national CHW Investment Case, translating service delivery benefits into fiscal and economic terms that resonate with budget planners and the Ministry of Finance

2.1M+

People to be protected from financial hardship by expanding risk pooling and advancing health financing reforms that position PHC at the core of purchasing and create accountability for maternal and child health outcomes.

First PHC Technical working group

Established and operationalised as the main forum guiding PHC reform, aligning partners around national priorities, and strengthening decision-making on sustainable health financing while translating national strategies into operational tools for district managers and facility in-charges.

2

Senior MoH officials completed a 9-month Health Systems Accelerator Fellowship, building long-term reform leadership in Free Healthcare Policy for Sierra Leone and unlocking the value of CHWs and advocacy in Sierra Leone.

Mobilising Domestic Resources: From Donor Dependency to Government-Led Financing

FAH supported the Ministry of Health to calculate the true cost of essential services within the **Free Health Care (FHC) policy and PHC delivery platforms,** enabling the Ministry of Health to articulate a compelling investment case to the Ministry of Finance, grounded in fiscal reality rather than aspiration. Through this work, **the government mobilized $717,000 in domestic resources for PHC,** representing a critical shift from donor dependency toward sustainable, government-led financing.

From Strategy to Execution: Strengthening PHC Governance and Budget Credibility

FAH supported the establishment and operationalization of Sierra Leone's first **PHC Technical Working Group (TWG),** which has become the main forum for guiding PHC reform, aligning partners around **national priorities, and ensuring that RMNCAH services remain protected** within broader system strengthening efforts.

FAH also co-facilitated Health Financing TWG meetings throughout 2025, playing a pivotal role in shaping national discussions on sustainable health financing amid the dual pressures of the Mpox outbreak and declining global aid. These sessions strengthened national decision-making discipline by consolidating partner inputs into a single reform conversation, clarifying sequencing, and generating actionable follow-up commitments.

The TWG served as the primary platform to advance DRM options including sin taxes and diaspora solidarity levies and to align these with implementation needs for SLeSHI and the Free Health Care policy agenda.

To strengthen frontline accountability, FAH assisted with validation of **Facility Management Committee (FMC) guidelines and Standard Operating Procedures (SOPs).** These governance mechanisms are essential to expand community participation in oversight of frontline services, creating mechanisms to hold providers accountable for service quality, commodity availability and resource use. These tools translated **national strategies into operational guidance** that district health management teams and facility in-charges can implement.

Strategic Purchasing for PHC: Ensuring Every Leone Buys Better Maternal and Child Health through SLAUHC

FAH's strategic purchasing work focused on **translating PHC priorities into more effective financing mechanisms** that explicitly protect and prioritize RMNCAH services. The starting point was supporting the **Sierra Leone Social Health Insurance (SLeSHI) reform agenda** through development of the first fully costed benefit package that explicitly incorporated priority RMNCAH services including antenatal care, skilled delivery, postnatal care, immunization, and emergency obstetric care.

FAH also advised **development of fee-for-service (FFS) tariffs** for higher-level hospital care, ensuring alignment between cost structures, utilization patterns, and purchasing decisions, thereby creating the technical foundation for provider contracting, claims management, and equitable access as the scheme moves from legislation to implementation.

This technical groundwork established the basis for **capitation and FFS calculations** that enable scheme solvency, transparency, and accountability all of which are critical prerequisites for expanding financial protection to Sierra Leone's poorest households.

Beyond insurance design, FAH worked with MoH units to reduce fragmentation between the Free Health Care policy and SLeSHI, defining a unified, coherent benefit design that could serve as the foundation for future PHC financing reforms.

SLAUHC is the proposed unified agency for Universal Health Coverage in Sierra Leone, designed to bring the Free Health Care programme (FHC) and the Sierra Leone Social Health Insurance Scheme (SLeSHI) into one coherent institutional and financing architecture.

Its purpose is to improve access to essential services while reducing catastrophic out-of-pocket expenditure.

Under this reform, we have supported four main areas:

- **First,** we helped shape the **SLAUHC bill** and broader institutional design to align FHC and SLeSHI under one UHC framework.
- **Second,** we supported **domestic resource mobilization proposals** within the bill, including new levies intended to expand fiscal space for health.
- **Third,** under FHC, we supported detailed costing to help address underfunding and reduce hidden payments that continue to affect households.
- **Fourth,** under SLeSHI, we supported the design of the benefit package and fee-for-service tariffs, while advocating for **inclusion of vulnerable populations beyond the formal sector.** This work is helping **strengthen strategic purchasing by linking payment arrangements** to defined packages, costs, and quality standards, while placing **RMNCAH and PHC priorities** more centrally within the scheme.

At the policy level, FAH provided analytical contributions to revisions of the Sierra Leone Agency for Universal Health Coverage (SLAUHC) Bill. This bill aims to ensure that future DRM revenues could be pooled and allocated more strategically to priority services.

At the policy level, FAH provided analytical contributions to revisions of the Sierra Leone Agency for Universal Health Coverage (SLAUHC) Bill. This bill aims to ensure that future DRM revenues could be pooled and allocated more strategically to priority services.
Our Health Systems and Financing Accelerator Fellowship Program government fellow, Dr. Abdul Jibril Njai, deepened this work by supporting revenue modelling, preparing targeted policy briefs, and facilitating MoH engagement in fiscal discussions with the Ministry of Finance.

Through a combination of policy design and embedded technical support, FAH **helped position PHC financing needs more centrally in government budget processes,** strengthening the Ministry's capacity to defend health investments even amid competing fiscal pressures. The result was **a clearer, government-owned set of DRM options directly linked to PHC and RMNCAH priorities,** with policy and legislative provisions within the SLAUHC Bill that strengthen fiscal space for domestic financing of PHC and community health.

This foundation also enabled **exploration of feasible DRM mechanisms including earmarked taxes, solidarity levies, diaspora financing instruments**, and blended mechanisms capable of channelling predictable domestic resources toward PHC and RMNCAH services.

In this architecture, FHC is the tax-funded window that protects exempt groups and finances essential services at community and primary care level, while SLeSHI is the contributory insurance window that finances the broader insured package, especially more costly secondary and tertiary services. The key point is that the reform is not about running two unrelated schemes, but about creating one national purchasing system, one benefits architecture, and one referral framework, with different funding sources and payment methods used for different levels of care

Community health workers are essential to bringing health down to the last mile.

Drone shot of the newly constructed maternal center of excellence in Koidu Town, Kono District. Credit: MoH

FINANCING THE FRONTLINE

The Economic Case for Community Health Workers

FAH supported the government to develop **Sierra Leone's first national CHW Investment Case (2025-2030),** a costed, fiscally grounded policy instrument quantifying both the economic and health returns of investing in CHWs.

Developed by Our Health Systems and Financing Accelerator Fellowship Programme, Government Fellow Elizabeth Magdaline Musa, the investment case demonstrated a **12:1 return on investment,** translating service delivery benefits into fiscal and economic terms that resonate with budget planners and the Ministry of Finance. By quantifying returns from community-level prevention, early treatment, and timely referral specifically within the Sierra Leone context, **the analysis provided a compelling rationale to expand community-delivered RMNCAH services,** particularly those that improve care-seeking behaviour, and relieve pressure on higher-level facilities. Importantly, the investment case was deliberately designed as a policy instrument embedded within national planning processes.

While full budget impacts will unfold over time, the investment case has already begun influencing internal government discussions about financing priorities, strengthening the evidence base for budget negotiations and partner alignment.

During the 2025 Mpox outbreak, this foundation proved critical: **CHWs maintained essential RMNCAH services including antenatal care follow-up, immunization outreach, and early identification of danger signs,** demonstrating that sustainable community health financing is not a luxury but a prerequisite for system resilience. The investment case findings are now integrated into Health Financing Strategy and NHSSP processes, ensuring CHW financing is **embedded in national budget frameworks**. This will reduce reliance on short-term, fragmented donor projects, and provide sustainable financing to community-delivered RMNCAH services reaching Sierra Leone's most underserved populations.

GOVERNMENT FELLOW SPOTLIGHT

How Dr. Abdul Jibril Njai Turned Policy Intent into Financial Reality

Dr. Abdul Jibril Njai joined the Health Systems Financing Accelerator fellowship as a P**olicy and Planning Officer at Sierra Leone's Ministry of Health.**

His motivation ran deeper than his job alone. In his childhood, he had lost a sibling to malaria.

Every day, he witnessed a painful contradiction**: in theory, Sierra Leone had a Free Health Care policy designed to protect pregnant women and children from financial hardship. Yet women arrived at health facilities only to be told that essential supplies were unavailable, or they were informally charged fees that violated the FHC policy but reflected the facility's desperate need to stay operational.**

Dr. Njai knew the root cause: **Government allocations to the frontline were unpredictable, reimbursements to health facilities were chronically delayed, and essential medicines frequently ran out.**

Through his fellowship project, he discovered that the **government had never fully costed what it would take to deliver on the FHC promise,** leaving the Ministry of Health without an evidence-based foundation to negotiate with the Ministry of Finance for adequate funding.

Dr. Njai's fellowship project focused on **building the technical foundation for sustainable FHC financing** by developing a fully costed FHC service package that quantified exact would cost to deliver the promised services at the required quality and coverage levels. **He analyzed utilization data from health facilities across districts, mapped service delivery costs including personnel, commodities, infrastructure, and supervision, and modelled different financing scenarios to show the Ministry of Finance what sustainable FHC funding would require**. He also identified feasible domestic resource mobilization mechanisms including earmarked health taxes, solidarity levies, and diaspora financing instruments that could generate predictable revenue streams specifically for PHC and RMNCAH services.

Armed with this evidence, Dr. Njai supported the MoH to make a compelling case: investing in fully funded FHC wasn't just a moral imperative, it was fiscally sound. **Preventing maternal and child deaths through accessible primary care was far cheaper than treating complications at tertiary hospitals and reducing catastrophic health expenditure would protect household economic productivity.** He prepared policy briefs, facilitated high-level meetings between MoH and MoF officials, and provided technical inputs into the revision of the Sierra Leone Universal Health Coverage (SLAUHC) Bill, ensuring that legislative provisions created space for sustainable domestic financing of FHC.

His work and FAH support contributed directly to the government's mobilization **of $717,000 in domestic resources for PHC,** a tangible **shift from donor dependency toward government-led financing in a constrained fiscal environment,** with his costing work now embedded in national planning processes that inform budget negotiations and create accountability when allocations fall short.

Dr. Njai's experience offers vital lessons for countries facing similar challenges: **policy without rigorous costing is merely aspirational and can lead to unfunded mandates that erode trust and foster informal charges. Internal technical capacity is crucial.**

DR.NJAI'S WORK AND FAH SUPPORT CONTRIBUTED DIRECTLY TO THE GOVERNMENT'S MOBILIZATION OF $717,000 FOR PHC

Investing in fellows like Dr. Njai builds institutional memory and enduring leadership. Additionally, financing reform is inherently political. Dr. Njai's success stemmed from his ability to translate technical evidence into compelling fiscal arguments that resonated with key stakeholders.

Sustainable maternal and child health financing is about building the technical, institutional, and political capacity to ensure every dollar reaches those in need.

Central African Republic (CAR)

In 2025, the Central African Republic's (CAR) health system continued to **grapple with complex challenges.** Years of instability and constrained fiscal space, compounded by a decline in external funding which has historically accounted for **40% of total health expenditure**, placed increasing strain on the health system. While national frameworks such as the National Health Development Plan (Plan National de Development Sanitaire – PNDS) reflect a strong commitment to Universal Health Coverage, domestic funding for health remains low, with the sector receiving less than 10% of the national budget.

These financing gaps for health and insufficient allocations to PHC are reflected in the health outcomes across CAR. **Maternal mortality remained sky high at 829 deaths per 100,000 live** births (global average being 223 per 100,000 live births), **while infant mortality stood at 99 deaths per 1,000 live births** (global average being 28 per 1,000 live births (2021, UNICEF).

CAR AT A GLANCE

$14.7K
Domestic financing secured for PHC and community health

2.4M+
37% of the population targeted under the proposed Assurance Maladie Universelle (AMU) scheme

25%
reduction in community maternal deaths

- 7-fold decline in perinatal deaths
- Achieved in 14 underserved districts
- Resulted from deploying community matrons and better RMNCAH resource allocation.

77%
lower cost per treatment at community level (USD 1.36 vs USD 5.84 in health facilities)

2 Senior MoH officials completed 9-Month Health Systems Acclerator Fellowship, building long-term reform leadership

85%
Health funding previously off-budget, now increasingly tracked through a national digital Health Resource Tracking system, enabling real-time visibility, improved allocation, and stronger accountability

Strengthening Health Financing Governance, Accountability, and Financial Protection for PHC and CH

Credit:MoH

Given the persistent gaps in the availability of RMNCAH services, FAH supported MOH in finalizing and endorsing the national health financing strategic plan, marking a pivotal transition from strategy design to implementation. We worked across three interconnected workstreams towards greater efficiency, equity, and accountability of health services:

- **Governance and results accountability** were reinforced through the embedding of a **MOH Theory of Change** within the Health Financing Strategy. This established a coherent, government-led framework for investment prioritization, implementation oversight, and sector coordination. **An Operational Planning and Partnership Coordination Procedures Manual,** developed to align with the Lusaka Agenda and the "One Plan, One Budget, One Report" approach, aimed to reduce partner fragmentation and anchored transparent, strategic resource stewardship.

- **Resource tracking was digitized and institutionalized.** With approximately 85% of health funding flowing off-budget and fragmented across donors, evidence-based planning remained structurally constrained. FAH's TA enabled the design and institutionalization of a **national digital Health Resource Tracking (HRT) system,** integrating annual PHC and RMNCAH financial mapping into a unified platform that delivers real-time visibility into sector-wide financial flows.

The system's impact was demonstrated early: prior to formal validation, it **informed resource allocation decisions during the Global Fund budget adjustment exercise in June 2025**, establishing its value as a credible planning instrument. By enabling government to identify funding gaps, align resources with population health priorities, and strengthen performance monitoring, the HRT system represents a foundational shift toward transparent, data-driven health financing governance.

- **Financial protection took a decisive step forward** with the development and validation of a concept note for the Assurance Maladie Universelle (AMU). Targeting approximately 2.4 million people (37% of the population), the scheme offered a credible pathway to reducing catastrophic out-of-pocket expenditure, expanding access to essential services including RMNCAH and NCD services, and driving long-term reductions in maternal and child mortality through strengthened risk pooling.

IMPROVING DELIVERY OF QUALITY RMNCAH SERVICES

As the country carries one of the world's most severe maternal health burdens, preventable mortality remains a national emergency.

18%

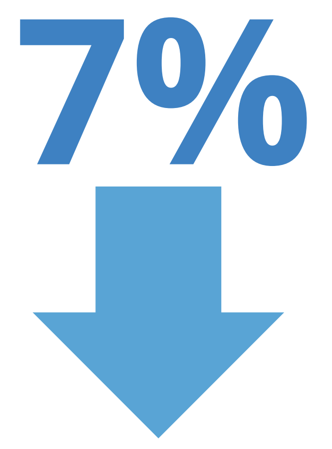
Modern Contraceptive Prevelence: Lowest in Sub-Saharan Africa

In partnership with UNFPA, FAH supported the development and costing of the Family Planning Strategic Plan (2025–2030).

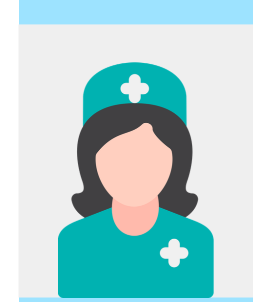
The plan provided a clear roadmap to expand access to modern contraception toward the Central Africa sub-regional target of 30% modern contraceptive prevalence rate (mCPR) by 2030, a near twofold increase from current levels, aiming to reduce unintended pregnancies and lower maternal mortality.

With FAH's technical support, CAR's Ministry of Health developed and validated the country's first National Quality Improvement Policy, a landmark achievement in one of the world's most fragile health systems. The policy establishes a unified normative framework for quality across the continuum of care, directly addressing a critical gap where fragmented, unenforceable standards **left RMNCAH services inconsistent and accountability mechanisms weak.** It shifts the national agenda from coverage alone to quality outcomes, aligned with the **National Health Policy 2019–2030 and UHC commitments.** As an example, facility-level teams now have codified standards for antenatal care, skilled birth attendance, and postnatal services, enabling system-wide, sustainable quality improvement.

In addition, **a rapid assessment of community matron deployment across 14 underserved districts** revealed compelling early impact: in 2024 alone, **community matrons facilitated 3,724 assisted deliveries and referred 1,314 pregnant women to health facilities, contributing to a 25% reduction in community maternal deaths** and **a sevenfold decline in perinatal mortality.** In a country where nearly a third of deliveries still occur at home, task-shifted and community-based care is a high-yield strategy for closing the RMNCAH equity gap in hard-to-reach populations.



Projected Annual Savings from Unlocking Efficiency Gains by Integrating Community Health Workers into the Primary Health Care System



IMPACT OF COMMUNITY MATRONS

Deployment

14 underserved districts

2024 Achievements

3,724 assisted deliveries

1,314 referrals to health facilities

Results

25% reduction in maternal deaths

Sevenfold decline in perinatal mortality

MAXIMIZING RETURNS ON INVESTMENT THROUGH CHW-LED PHC

In CAR, Community Health Workers are the primary vehicle through which care reaches communities, but historically this has often been through several fragmented, vertical, donor-funded CHW cadres. Integrating CHW programming across HIV, TB, and malaria represents a high-return systems investment. FAH's technical support to MOH unlocked structural efficiency gains: tripled CH workforce productivity, increased service utilization, and projected annual **cost savings of 2–7%.** The model demonstrates that coordinated, cross-program community health delivery generates compounding returns, making a financially compelling case for sustained donor, and government investment in integrated CHW platforms.

GOVERNMENT FELLOW SPOTLIGHT

How Dr. Mack-Allan Gbayanguele's CWH-led Approach to multi-Disease Screening in Bangui's Marketplaces:

In the heart of Bangui, the Central and Combattant markets serve as the city's economic hubs, drawing thousands of people from across the region each day. **For many traders and market goers, the pressure of earning a living means that seeking care often becomes a secondary priority. As a result, many preventable and treatable diseases go undetected and unmanaged, and people seek care when their conditions have worsened.**

Dr. Mack-Allan Gbayanguele, Director of Community Engagement at the CAR Ministry of Health, viewed **these crowded market spaces** through a **different lens.** He saw them as potential entry points for delivering healthcare closer to where people work. Through years of **close engagement with communities,** Dr. Gbayanguele had noted critical gaps in the formal health system, where care remained largely passive. Health facilities often waited to provide care to populations **constrained by distance, cost, and time and sought health care late when their conditions were already severe.**

As a Fellow in the Health Systems and Financing Accelerator Fellowship, Dr. Gbayanguele leveraged his field experience and observations to design and pilot a community-based model that sought to **bring health services closer to people.** This model combined an analysis of local needs, training and equipping Community Health Workers with multi-disease screening protocols and community mobilization. CHWs were deployed into market spaces to provide on-site multi-disease screening, diagnostics, referrals, and immediate treatment.

The model delivered compelling results. Over only 3 days of deployment, **CHWs treated 814 cases of malaria compared to 348** cases managed by formal healthcare facilities, according to weekly data from the National Health Information System. For tuberculosis, **CHWs identified 159 symptomatic individuals**, collected samples from them, and a total of 80 positive cases were linked to care. **Further, 128 people agreed to test for HIV,** and **22 positive cases were referred for treatment.**

Community Health Workers (CHWs) Impact in just 3 days

Treatment Costs Per Case

Screening Costs

Maleria Treatment

- Total Cases Treated by CHWs: 814
- Cases Managed by Formal Healthcare Facilities: 348

Tuberculosis (TB) Identification

- Symptomatic Individuals Identified by CHWs: 159

HIV Testing and Referral

Cum eumqui od millatur anissus, conet opta quam quae. Officip-sam harum am quuntiore quas

Community Model Advantage: Highly cost-effective solution for healthcare delivery

Beyond reaching populations who would otherwise have remained out of reach of formal facilities, the community-based model also proved highly cost-effective. Data showed that treating a simple case at the community level costed o**nly USD 1.36, compared to USD 5.84 in a health facility** while the cost per screening conducted in the community was a**pproximately USD 2.89, compared to USD 4.22 in health facilities.** Drawing on these compelling pilot results, Dr. Gbayanguele put forward clear recommendations for strengthening community health through full integration of CHWs into service-delivery systems, optimization in use of available resources including through regular market outreaches, standardization of CHW training and supervision and institutionalization of monitoring and evaluation systems. **These reforms will contribute to strengthening community health, detecting diseases earlier, and improving access to essential services for remote communities,** while ensuring that care is delivered in a more cost-effective way.

In 2025, Senegal's health system continued to navigate persistent system level constraints.

HEALTH SPENDING

9%

ABUJA DECLARATION TARGET: 15%

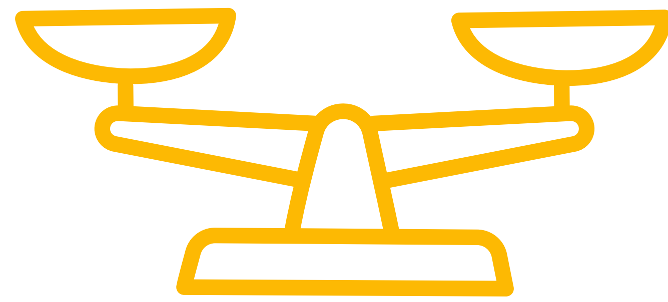
Financing for PHC and CH remained insufficient, fragmented, and unevenly executed, leaving frontline facilities under-resourced to meet the population's growing health needs. Declining external funding increased fiscal pressure underscoring the need for domestic resource mobilization, improved budget execution, and more efficient allocation to ensure delivery of essential services and improve health outcomes.

Persistent funding gaps continued to shift the financial burden to households.

OUT-OF-POCKET

CURRENT: 43%

NATIONAL TARGET: 20%



This exposed families particularly women, children, and other vulnerable groups to financial hardship and catastrophic spending.

As a result, despite steady national progress, health outcomes remained uneven, particularly across Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH).

Maternal and Child Health Statistics:

- **Maternal Mortality Rate:**
  - **134 deaths per 100,000 live births**
- **Under-Five Mortality Rate:**
  - **35.7 deaths per 1,000 live births**
- **Only 58.6% of births are attended by skilled health professionals, indicating a need for improvement.**

SENEGAL AT A GLANCE
KEY IMPACT METRICS

12% Increase in PHC budget allocation for FY 25/26

2 senior MoH officials completed 9-month Health Systems Accelerator Fellowship, building long-term reform leadership

4x Increase in the total number of children receiving Vitamin A supplementation

94% reduction in confirmed malaria cases

33% reduction in number of zero-dose children

1% Increase in LLIN use among pregnant women and children under five in just one year

62% → 93% *(MCV1)* & **24% → 36%** (MCV2)

Increase in immunization coverage

Strengthening Health Financing and Domestic Resource Mobilization

FAH worked in close partnership with Senegal's Ministry of Health to enhance government leadership, coordination, and evidence-based health financing amid fiscal pressure and declining external assistance. Through embedded technical assistance and in collaboration with WHO, FAH supported the reactivation of the Health Financing Technical Working Group, creating a critical multi-partner platform for policy dialogue and reform prioritization. Structured policy dialogue across the MoH, MoF, and partners through the revitalized Health **Financing TWG** strengthened evidence-based prioritization, supporting government to advance domestic resource mobilization and strategic purchasing for PHC. Additionally, FAH supported development of the Domestic Resource Mobilization Guide, providing government stakeholders with practical tools and guidance to effectively engage the Ministry of Finance and Parliament and advocate for increased allocation of funding for health.

The PHC Recovery Plan and Community Health Transformation represent a generational opportunity to close a UHC service coverage gap that still leaves half the population behind.

FAH also assisted the Ministry of Health in advancing operational reforms by co-developing the Performance Based Financing (PBF) Procedures Manual. This manual is crucial for a World Bank-supported **$135M Pay for Results project,** shifting budgeting to results-based and expanding access to essential health services.

Strengthening community health through evidence, financing insights, and adaptive implementation

Community health is a critical pathway towards achieving Universal Health Coverage in Senegal. FAH also worked in close partnership with Senegal's Ministry of Health to strengthen the foundations for more coordinated and evidencebased community health planning and financing.

FAH supported the development of a **maturity assessment of community health,** providing a comprehensive and structured analysis of system performance across key domains including governance, service delivery, workforce, and information systems. This assessment established **a shared baseline across government and partners,** enabling more coherent **prioritization of reforms and helping align investments** with system-wide needs. By highlighting both strengths and critical gaps (e.g. no CHWs are officially paid currently), the maturity assessment of the national community health program positioned the Ministry to move from fragmented interventions toward a more integrated and strategic approach to community health system strengthening.

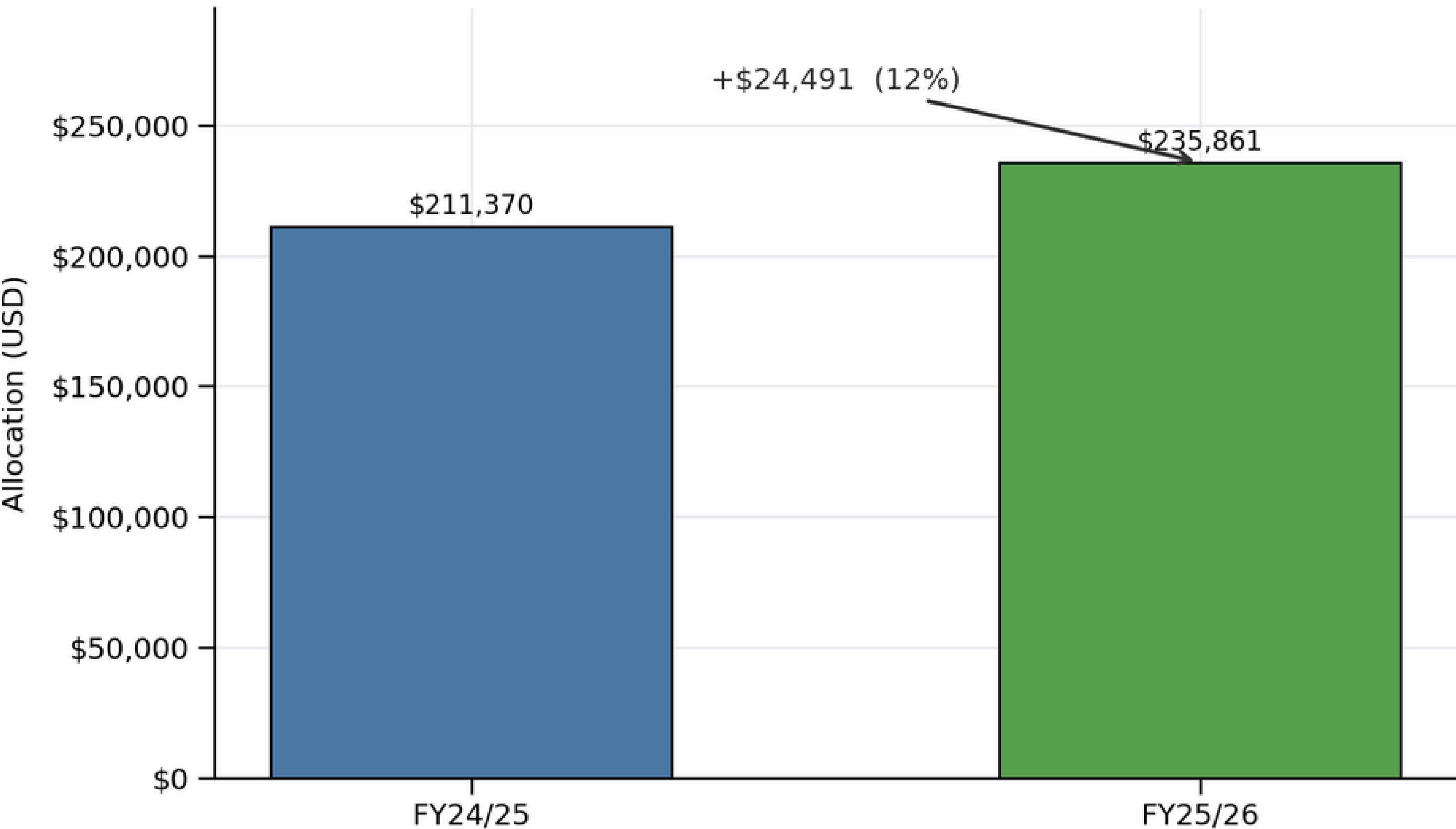
In addition to the maturity assessment of the national community health program, FAH supported the Ministry of Health to conduct a resource mapping and expenditure tracking **(RMET) exercise,** focused on community health, to strengthen transparency, coordination, and efficiency in community health financing. The exercise helped identify gaps in allocative efficiency revealing that resources were not adequately directed towards the regions with greater needs. It also highlighted that local governments' contributions towards health were unstable and appeared to be declining over the years. Further, **the RMET revealed a USD 10.1 million funding gap for community health between 2023-2024.** MoH is now using this evidence to inform GC8 advocacy and resource mobilization efforts.

To ensure these analytical outputs are translated into action, FAH also supported bi-annual reviews of community health interventions, bringing together stakeholders from all levels of the health system. These reviews went beyond routine coordination meetings by creating a structured space to identify bottlenecks and agree on time-bound corrective actions. For instance, the reviews highlighted that evidence-based decision making was constrained by an inefficient data transmission chain: CHWs collect data on paper, which supervisors then upload into the DHIS2 platform. It emerged that supervisors and heads of health posts, both overburdened by medical duties, often delay uploading data. Through these reviews, stakeholders proposed a practical solution where CHWs directly enter data into the DHIS2 using smartphones.

This shift is expected to reduce reliance on supervisors for data entry; shorten the reporting chain and improve the timeliness and completeness of health data.

Directing more funding to Community Health

Historically, seven different CHW cadres operated in Senegal, mostly through vertical donor funding. Through sustained technical assistance, FAH contributed to strengthening government capacity in community health financing. FAH supported over 100 Ministry of Health officials on community health priorities and equipped them with skills in using the Community Health Financing tool and conducting community maturity assessments. These efforts contributed to increased prioritization of primary and community health.



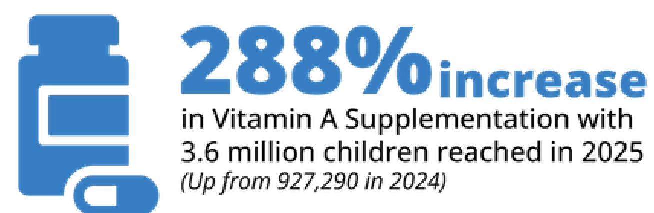
Advancing Gender Responsive community health systems

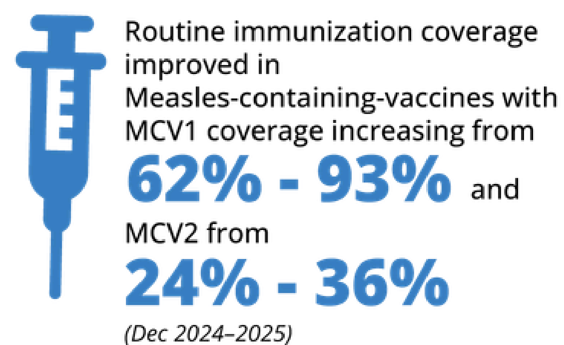
FAH provided targeted technical assistance to the Ministry of Health to review the previous **Community Health Strategy and then develop and cost the new Community Health Strategy (2025–2029).** We ensured the new Community Health Strategy is gender responsive and it's aligned with Senegal's Health Compact 2025 framework. **The USD 57 million strategy** incorporates important reforms including: dedicated national budget lines, progressive co-financing arrangements, pooled funding mechanisms, performance-based payments, CHW professionalization, and stronger data systems to ensure improved access to quality services and sustained improvements in MNCH outcomes.

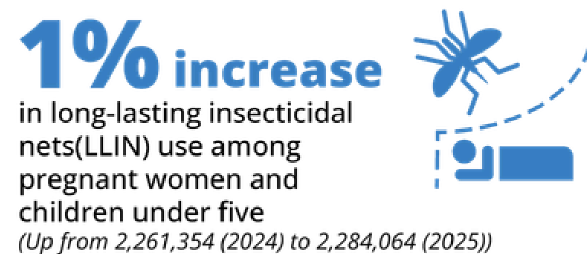
Moreover, FAH supported MoH to develop **a Gender Institutionalization Plan (2025–2029)** including a communication plan. The plan supports MoH to institutionalize gender integration within the health system and will guide the development of gender responsive health policies and strategies, including community health programs. The plan also provides a framework to better recognize and support CHWs, where women make up approximately 70% of the workforce.

Unlocked Funding Is Contributing To Enhanced Outcomes

Leveraging **AFF catalytic funding** from the Global Fund unlocked with FAH's support in 2024, MoH continued to roll out critical Community Health Worker activities, including training, supportive supervision, provision of essential supplies, and community awareness campaigns. In 2025, despite funding cuts, **FAH supported the execution and operationalization** of these activities, helping sustain implementation and maintain service delivery at community level. These efforts strengthened **CHW performance and service delivery, contributing to measurable improvements in child health and malaria prevention outcomes as below:**







GOVERNMENT FELLOW SPOTLIGHT

How Mrs Ramatoulaye Camara Turned Invisible Funds into Visible Impact for Mothers and Newborns in Senegal

When **Mrs. Ramatoulaye Camara,** from the Direction de la Santé de la Mère et de l'Enfant (DSME) at the Ministry of Health and Public Hygiene first entered the Ministry's planning room, she saw more than spreadsheets. She saw mothers and newborns whose survival hinged on every franc. Through the FAH Fellowship she turned that urgency into action. Using advanced costing, resource mapping, and policy analytics, she revealed a stark finance reality for the Plan SRMNIAN 2024–2028: **a funding gap of approximately $169 million, a 29% shortfall, and a heavy 72% dependence on external aid, while critical funds remained misaligned with regional needs.**

With FAH's support through the Fellowship program, Mrs. Camara translated those numbers into a compelling case for change. She embedded simple digital community-level RMNCAH resource mapping tools and introduced routine fiscal briefs that made off- budget flows visible and exposed regional inequities. In budget meetings, she reframed debates from political bargaining to data-driven choices: which districts should receive lifesaving supplies first, where modest domestic reallocations would yield the largest reductions in maternal risk, and how family planning investments could prevent unintended pregnancies and save lives. Those shifts helped the Ministry prioritize equity, defend domestic funding, and target scarce resources where they do the best.

For Senegal, this work strengthened institutional capacity and created practical mechanisms to track, defend, and direct funds toward mothers and children. For other countries facing similar fragility such as high donor dependence, fragmented funding, and elevated maternal and neonatal mortality, Mrs. Camara's approach offers three clear, transferable lessons:

(1) cost and map plans to reveal real gaps and regional mismatches;

(2) institutionalize simple digital tracking so every partner dollar is visible and accountable;

(3) invest in government analysts who can translate technical evidence into persuasive, politically smart briefs that mobilize domestic funding and protect the most vulnerable.

Technical skill, paired with purposeful storytelling and transparent tools, turns compassion into policy and budgets and into lives saved.

LOOKING

AHEAD

In 2026, FAH will support Senegal to strengthen primary and community health systems to ensure quality delivery of essential services particularly Maternal, Newborn, and Child Health (MNCH). Support will focus on the following strategic pillars:

Supporting the government in advancing domestic resource mobilization and increasing budget allocations for primary and community health. A key priority is the implementation of the Community Health Strategic Plan 2025–2029.

Strengthening Public Financial Management to ensure improved budget formulation, execution, and expenditure monitoring.

Supporting Delivery Unit priorities by accelerating the Program for Results (PforR) operationalizing through strengthened performance-based financing for RMNCAH outcomes.

Advancing health insurance reforms and CMU coverage to enhance equity and provide vulnerable families with better financial protection against high medical costs.

Tanzania

Tanzania's community health system is at a pivotal moment. While the country has made strong policy commitments toward strengthening primary health care, persistent structural and operational challenges continue to undermine the performance of community health services. **Fragmented linkages** between CHWs and primary health facilities, **inconsistent supervision, supply chain delays, weak integration of CHW data into national systems,** and **chronic underfunding** collectively limit Tanzania's ability to deliver high quality, equitable services at scale.

Through the new Integrated and Coordinated Community Health Workers (iCCHW) Program, the government has planned to **deploy 137,294 CHWs by 2028,** but near-term execution is constrained by financing shocks with health **ODA projected to fall ~40% in 2025 vs. 2023.** In 2025, program disruptions had already affected 14 high burden districts (nearly 60% of the population) that rely on CH delivered malaria case management. Beyond these near-term shocks, Tanzania's malaria and RMNCAH profiles show both progress and vulnerability, highlighting why stabilizing CHW financing is pivotal.

Malaria parasite prevalence among children 6–59 months is ~8.1% (with wide regional variation), while household ITN ownership is ~67% and child ITN use ~59%. These vulnerabilities are emerging amid tightening global health financing, making it harder for the country to rely on traditional donor streams to support its professionalized CHW workforce. RMNCAH outcomes have improved with skilled birth attendance ~85%, facility delivery ~81% ANC4+ ~65%, under five mortality ~43/1,000, and neonatal mortality ~24/1,000, but financing fragility threatens continued gains.

Without targeted, system-level reforms, Tanzania risks setbacks in malaria control, RMNCAH outcomes, and the broader PHC agenda.

Credit: Wizara Ya Afya Tanzania

It is against this backdrop that we deepened our partnership with the Government of Tanzania, initially through the BIRCH program enabled by the Global Fund and later also through the **Integrated and Coordinated Community Health Worker (iCCHW) Optimization Protocol** enabled by the Gates Foundation**.**

The Financing Alliance for Health helped the government **diagnose the true scale of the financing requirements for a fully functional CH system**, while the iCCHW optimization support began strengthening the operational foundations of that system. Together, these interventions are equipping Tanzania with the evidence, tools, and governance architecture needed to shift from fragmented and donor dependent systems toward a coordinated, data driven, and strategically financed community health model.

UNDERSTANDING THE TRUE COST OF TANZANIA'S COMMUNITY HEALTH SYSTEM

Under the BIRCH program, supported by the Global Fund, we partnered with the Government of Tanzania to answer a fundamental question: ***do existing resources align with the country's ambition for a professionalized CHW workforce?*** The National Community Health Strategy estimates **USD 814.2 million** is needed to train, supervise, equip, digitize, and sustain the targeted **137,249 community health workers over** the strategy period. This costed strategy underscores the importance of prioritizing the phased deployment of iCCHWs and focusing investments where they will yield the greatest impact.

MAPPING AND UNDERSTANDING COMMUNITY HEALTH FINANCING FLOWS

Through a comprehensive resource mapping exercise working with government as well as other stakeholders, we **produced Tanzania's first consolidated national picture of community health financing flows**, both domestic and external. This revealed **fragmentation of funding, duplication of investments in some areas,** and significant underfunding compared to the $814.2 million requirement. This evidence base **allowed Tanzania to move from anecdotal understanding to a precise, data-driven view of their community health system financing needs.**

Credit: Wizara Ya Afya Tanzania

MAPPING AND UNDERSTANDING COMMUNITY HEALTHDEVELOPING A GOVERNMENT-OWNED COMMUNITY HEALTH FINANCING DASHBOARD FINANCING FLOWS

Building on this analysis, we supported the Ministry of Health to develop a **community health financing dashboard**, a government-owned tool that transformed complex financial data into actionable insights. The dashboard allowed decision makers to:

- Track **commitments vs. disbursements**
- Visualize **regional and program level investments**
- Identify **underfunded CH components**
- Monitor progress toward **closing the financing gap**

For the first time, Tanzania can clearly identify where resources were insufficient and adjust strategies accordingly. The dashboard shifted national dialogue from ***"Are we funded?"*** to ***"Where exactly are the gaps and how do we close them?"***

ADVANCING SYSTEM OPTIMIZATION THROUGH THE ICCHW PROTOCOL (2025 ONWARDS)

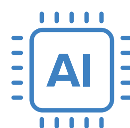
The next phase of system strengthening in Tanzania, building directly on foundational work completed under the BIRCH program including maturity assessments, costing analyses, and revitalization of the national Community Health Taskforce was initiated in 2025.

The Integrated and Coordinated Community Health Worker (iCCHW) Optimization Protocol work is a new partnership between Africa Frontline First, the Government of Tanzania, and the Gates Foundation to enhance malaria and RMNCH outcomes through integrated and optimized community health systems.

Amid declining external funding, each dollar for community health will need to be used for maximal health impact. We will support government of Tanzania to use health and financial data, alongside implementation science, to optimize iCCHW program roll out. This work centres on five core objectives that introduce a costed, scalable framework to optimize CHW performance, governance, and financing:

Strengthen National Leadership & Coordination
Build the Ministry of Health Community Health Unit's capacity to coordinate partners, mobilize resources, and operationalize the iCCHW program through costed operational plans, resource mapping, etc. thereby enhancing financing visibility and accountability.

Enhance Subnational Implementation Capacity
Empower regional and district councils to plan, strategically deploy, manage, and oversee CHW programs by pressure testing a performance management framework in high-burden districts that track key drivers like supervision, payment, and supply availability thus directly addressing fragmented CHW–facility integration and inconsistent oversight.



Accelerate Digital & AI-Enabled Solutions
Assess digital readiness and co-design tools (e.g., blended learning, AI-powered supervision) to improve CHW training, performance monitoring, and service delivery, with integration into national systems like UCS and DHIS2 thus strengthening data use and institutionalization across platforms.

Generate Transferable Learning
Codify Tanzania's CHW optimization model into a replicable framework, support development of a national MEL strategy, and scope application in 1–2 additional countries to inform regional scale-up.

Use Implementation Science for Continuous Improvement
Establish a platform for regular program reviews that link CHW systems performance to malaria and RMNCH outcomes, enabling data-driven design adjustments that enhance impact and cost-efficiency.

WHY THESE REFORMS ARE CRITICAL FOR TANZANIA

These reforms come at a critical time when global health funding is tightening and fiscal pressures on donors are increasing. As external financing becomes less predictable, it is critical that Tanzania makes every dollar count to achieve its ambitious health targets including:

KEY HEALTH TARGETS
Reduce Under-Five Mortality Current: 43 per 1,000 live births Goal: Below 25 per 1,000 live births
Lower Neonatal Mortality: Current: 24 per 1,000 live births Goal: Under 12 per 1,000 live births
Decrease Malaria Parasite Prevalence in Children Under Five Current: 8.1% Goal: Below 5%

The combined impact of resource mapping, the government-owned financing dashboard, and the iCCHW Optimization Protocol is **helping Tanzania shift from fragmented to coordinated financing and from donor dependency toward strategic domestic investment.** These tools enable tracking of the $814.2 million required to train, supervise, equip, and sustain 137,294 community health workers thus ensuring resources align with deployment priorities in high-burden malaria districts and underserved RMNCAH populations.

LOOKING AHEAD

As Tanzania moves toward developing the iCCHW Optimization Protocol and strengthening community health integration within its PHC system, the next phase of work focuses on **laying the foundations for durable, system-level impact.** A key priority is **institutionalizing the community health financing dashboard** within government systems to improve transparency and long-term planning especially important as external funding becomes less predictable.

In parallel, Tanzania will prepare to **scale evidence-informed CHW deployment models** that better reflect geographic and epidemiological needs, helping address persistent gaps in coverage, supervision, and service quality. **Strengthening domestic financing mechanisms** remains central to reducing reliance on external support and safeguarding frontline services.

Operationally, the country will **accelerate investments in digitized performance management, expand CHW data integration into DHIS2**, and begin **adopting digital and AI-enabled tools to enhance supervision, supply chain performance, and real-time system responsiveness.** These building blocks will position Tanzania to improve malaria, RMNCAH, and broader PHC outcomes once the full protocol is finalized.

Reform Leaders Are Driving Change from Within

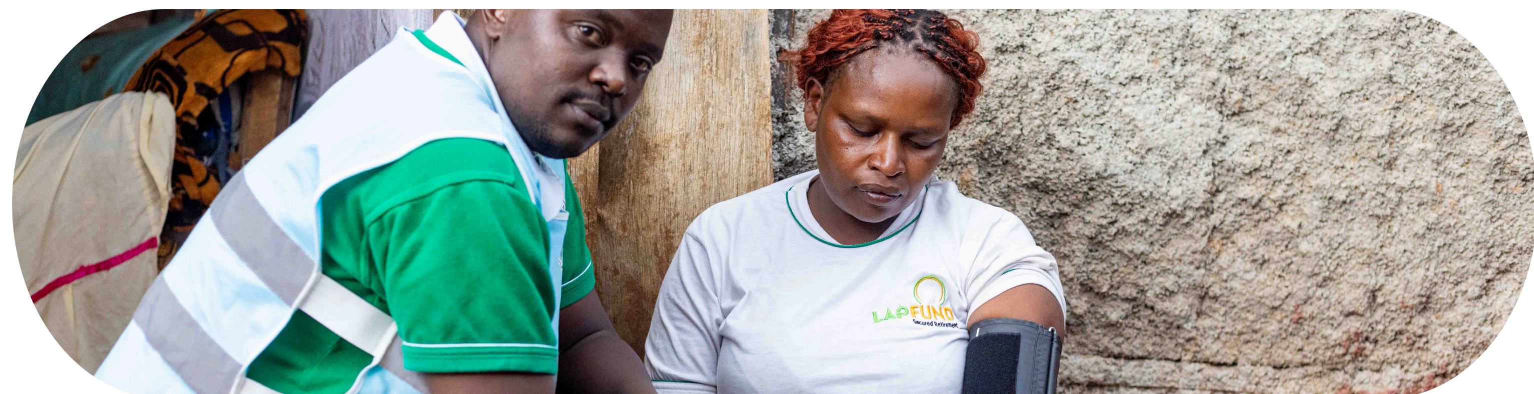
Health Systems and Financing Accelerator Fellowship Program (HSFAFP)

The Health Systems and Financing Accelerator Fellowship Program (HSFAFP) is FAH's flagship initiative for **strengthening government-led health system reforms**. Launched to build **durable in-country technical and leadership capacity,** the Fellowship targets government officials at the intersection of policy, budgeting and implementation - the people already best placed to translate a well-designed strategy into a budget allocation, and a budget allocation into services that reach communities. Active in Senegal, Sierra Leone, Zambia, the Central African Republic (CAR), and Kenya, the 2025 Fellowship **evolved beyond a capacity-building program into a structured reform residency that equips government leaders to design, finance, and implement high-impact reforms in Primary Health Care (PHC), Sexual and Reproductive Health and Rights (SRHR), and Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH).**

Over the course of nine-months, government fellows are **mentored** to design and operationalize a policy reform which they are already in the right government position to lead; chosen to specifically target some of the most pressing health financing challenges to health outcomes in their country. Host governments are able to maintain government staff in their positions as the fellowship program combines **self-paced online learning, intensive in-person bootcamps, mentorship, peer exchange, and cross-country exposure.**

HSFAFP Cohort 2 Participating in a Cross-Learning Exchange Field Trip in Nyeri County, Kenya

The Fellowship is a **"social innovation"** which
(1) puts equal emphasis on "policies" through advancing a real-world policy reform, and **on "people"** by building their hard skills (e.g. on health financing) and on soft skills (e.g. political economy and change management) necessary to lead reforms to completion.
(2) builds an ecosystem of in-country reform champions across Ministries of Health and Ministries of Finance across Africa; across **"vertical" units** (e.g. MNCH directorates) and **"horizontal" units** (e.g. PHC or Health financing units"
(3) allows for South-South learning, creating a safe space for government staff to share their lived experiences and problem-solve together on their real challenges to operationalizing reforms from within.



Upon our return [from the fellowship cross-country exchange], we quickly adapted the best practices to our own context [in Sierra Leone], leading to the rapid adoption of a new Ministry of Health organizational structure and the formalization of community engagement and primary health care as a recognized service. This experience not only inspired us but it directly strengthened and standardized how we deliver care in our country.

- Mrs Elizabeth Musa, National Coordinator, CHW Program, Sierra Leone

Through this fellowship, I gained profound knowledge in equity, gender, health investment costing, leadership, public speaking, and strategy: the very foundations needed to drive meaningful, sustainable change. Not only did I benefit from this opportunity. My entire country the Central African Republic benefitted as well.

Dr. Mack-Allan Gbayanguele, Director of Community Engagement, Ministry of Health Central African Republic.

FELLOWSHIP PROGRAMME

AT A GLANCE

5 countries with active Fellowship programmes: Kenya, Zambia, Sierra Leone, Senegal, CAR

14 Alumni government fellows across 5 countries

15 senior MoH officials completed 9-month Health Systems Accelerator Fellowship, building long-term reform leadership

2 PHC and health financing reforms designed by Fellows operationalised in 2025 in Kenya & Zambia

FROM GOVERNMENT FELLOWS TO SYSTEM LEADERS

The Fellowship's impact extends beyond the individual reforms that were led during the fellowship. Alumni are **increasingly occupying influential positions within Ministries of Health, translating technical capacity into sustained policy leadership.**

In Sierra Leone, alumni have assumed pivotal roles: e.g. one alumnus was promoted to National Planning Officer now leading the development of the National Health Sector Strategic Plan 2026-2030 and the other alumni as Senior Monitoring and Evaluation Officer within the Ministry of Health is now heading the MEARL department. In Senegal, an alumnus joined the Delivery Unit supporting Community Health transformation (appointed directly by the Ministry of Health), continuing to apply Fellowship expertise to operationalize national reforms. These fellows are now directly influencing national priorities and performance oversight at more senior and strategic roles withing their governments.

These career trajectories demonstrate the Fellowship's multiplier effect: **leadership development translates into institutional capability, improved reform stewardship, and durable system change.** By strengthening officials responsible for budgeting, planning, and program management, the Fellowship increases the likelihood that PHC and RMNCAH reforms are not only well designed, but effectively implemented, monitored, and adapted through routine government processes.

A Growing Continental Community of Reform Leaders

The Fellowship has **cultivated a vibrant and expanding Alumni network** that serves as a cross-country community of practice. This network supports **peer accountability, knowledge exchange,** and the **advancement of Health Compacts across Africa.** Alumni consistently report **strengthened leadership confidence, enhanced technical credibility,** and **increased professional visibility**, outcomes that have contributed to promotions and expanded reform mandates within government.

Strengthening the Ecosystem with Evidence

Thought Leadership and Advocacy to Shift the Field of Health Financing towards prioritizing community-led PHC and PFM

2025 was the year community health financing in Africa visibly fractured. External aid fell, climate shocks hit, and fiscal space tightened exactly when demand surged. FAH's Evidence, Policy & Advocacy (EPA) work was built for this moment: to give decision-makers the evidence, tools and reform instruments needed to shift from donor dependency to resilient, domestically financed PHC systems.

2025 IMPACT

AT A GLANCE

REACH & INFLUENCE

4,255 People
Reached via webinars & thought leadership.

3 Countries
Countries with **4+ government-owned** policy evidence produced with FAH technical support.

75 experts in **25+ countries** requested CHFA Toolkit.

1 landmark BMJ Global Health paper (20 years of CHW financing analyzed).

28 blogs, op-eds & thought leadership pieces published
Translating financing evidence into accessible arguments for practitioners, advocates and policymakers across the continent.

1 Afrca CHIP Dashboard
giving governments, funders and partners a single interface to see how financing flows are shaping community health systems across sub-Saharan Africa.

14 Convenings, digital broadcasts and on-the-ground storytelling that brought FAH's financing evidence to life - from continental policy stages to community health workers in the field.

KEY FINDINGS

82% of community health financing in sub-Saharan Africa is externally sourced.

&

76% flows to vertical, disease-specific programs.

A system structurally dependent on donors, not designed for resilience.

STRATEGIC ACTIONS
THAT SHIFTED THE FIELD

1. BUILDING THE ANALYTICAL FOUNDATION: THE BMJ PAPER THAT CHANGED THE CONVERSATION

FAH Published Trends in Government and Donor Financing for CHW Programmes in sub-Saharan Africa in BMJ Global Health, the most comprehensive analysis of CHW financing to date, covering two decades (2002–2022), bringing domestic financing into view for the first time, and classifying vertical vs. horizontal CHW programs.

The paper landed exactly when global health financing contracted. It reframed the debate from "Is there enough money?" to "Is the way money flows building resilient systems or locking countries into fragmented dependency?"

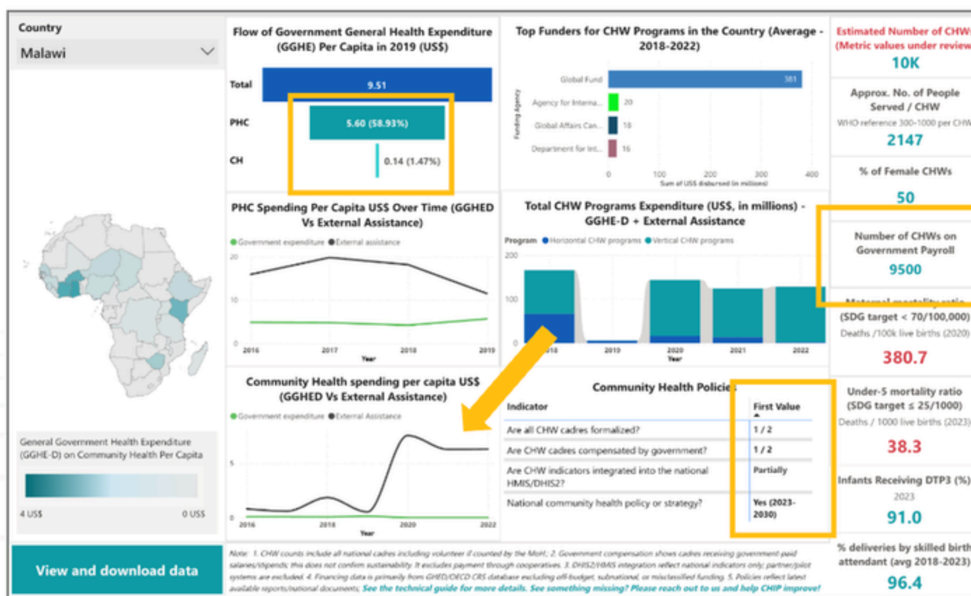
The evidence:

- **~82% of community health financing** was externally funded
- **~76% of programmes** were structured as vertical, disease-specific initiatives
- **Financing volatility** is a structural feature, not a bug

2. MAKING FINANCING VISIBLE AND ACTIONABLE: THE AFRICA COMMUNITY HEALTH INVESTMENTS FOR PRIMARY HEALTHCARE (CHIP) DASHBOARD AND THE COMMUNITY HEALTH FINANCING ASSESSMENT (CHFA) TOOLKIT

The Africa CHIP Dashboard is a single platform consolidating financing flows, workforce data, systems readiness and health outcomes across sub-Saharan Africa. Unlike other tools, CHIP shows what kind of system money is building, and whether it's building one at all.

The dashboard helped reveal three patterns:



1. **Commitment ≠ spending** - payroll figures look strong, but domestic CH spending per capita tells a fuller story
2. **CHW density≠ performance** - where outcomes stall despite strong coverage, the data often points to supply gaps, not CHW failure
3. **Financing risks become visible early** - declining external assistance alongside flat domestic spending can be seen in time to act

The African CHIP Dashboard makes these dynamics visible early, while there is still time to respond. It enables governments to shift from reactive to anticipatory decision-making and supports development partners to direct resources toward the highest-impact system constraints.

FAH deployed the CHFA Toolkit v2.0 in Zambia and Senegal, surfacing hidden constraints: outdated costing, fragmented funding streams, weak MoH–MoF coordination, gender barriers in CHW leadership.

Impact:

- **Zambia:** government-owned Action Plan linked to national frameworks, informing 2027–2031 strategy.
- **Senegal**: findings informed a government-led policy brief in 2025 which shaped the National Community Health Strategy (2025–29), including financing, professionalization & performance mechanisms.

Beyond these two countries, the CHFA Toolkit's reach in 2025 extended well beyond FAH's direct portfolio.

- **75 experts in 25+ countries** requested the toolkit—proof it's moved from FAH tool to field standard.

3. TURNING ANALYSIS INTO ACTION: 8+ GOVERNMENT-OWNED POLICY BRIEFS

FAH co-developed **8+ policy briefs** with ministries (Sierra Leone, Zambia, Senegal, CAR) on community health financing, DRM, gender equity, insurance reform, subnational tracking and MNCH, designed to be **carried by governments into budget rooms,** not delivered as external recommendations.

FOUR EXAMPLES:

Country	Brief	Key Argument	Impact
Sierra Leone	*Enhancing Investments in PHC for UHC*	Currently PHC <5% of health expenditure; OOP >50%; donors fund most preventive care. **Shift Needed:** increase PHC to 12%, establish SHI, introduce sin taxes & mining levies	Used in budget & health sector planning
Zambia	*CBVs & National Health Insurance*	~80% workforce (informal sector) uncovered despite near-complete formal enrollment. **Shift Needed:** roadmap for 90,000+ CBVs to support NHIS expansion	Operational tool for insurance reform
Senegal	*Gender & CH Governance*	CHWs (majority women) systematically excluded from planning structures **Shift Needed:** mandate CHW representation, dedicated budget line	Informed national gender & CH strategies
Senegal	*Subnational CH Financing (2023–24)*	First granular map of regional financing flows **Shift Needed:** Evidence base for addressing geographic inequities	Used by government & partners

4. WHEN CLIMATE SHOCKS STRUCK AFRICA, FISCAL SCISSORS CRUSHED HEALTH SYSTEMS: FAH PROPOSED FOUR SHIFTS IN PHC FINANCING TO ADAPT

THE CRISIS:

- **Zambia:**
  - Worst drought in **20 years**
  - Cereal yields **−43%**
  - ~**52,000 children under 5** at risk of severe wasting;
  - ~**112,000** pregnant/breastfeeding women at risk.

- **Kenya:**
  - Flooding (March–May) killed hundreds, displaced **700,000+**;
  - **Cut off ANC access**, facility deliveries;
  - **Mothers lost medicines**, supplements.

The structural failure: PHC financing systems: budget lines, disbursements, insurance, PFM rules are designed for stability, not volatility. Climate shocks raise demand and disrupt supply simultaneously. CHWs, the last line of care, are financed through the most fragile mechanisms and lose funding first when donors contract.

FAH's response: The Price of Volatility analysis + docuseries (Kenya & Zambia) proposed four financing shifts:

1. Climate adaptation finance for PHC
2. Shock-responsive insurance & adaptive social protection
3. Climate risk-adjusted capitation
4. Flexible PFM & contingency funding

5. BRINGING EVIDENCE TO CONTINENTAL PLATFORMS: AFHEA, CPHIA & THE DURBAN PROMISE

At **AfHEA (Kigali, March 2025)** FAH organized a side event dubbed Strengthening CH Systems for UHC in Low-Resource Settings. Discussions featured country experience from Kenya and Senegal - not as case studies presented by FAH, but as evidence carried and presented by government officials themselves - illustrating how reforms in formalising and financing community health workers translate into systemic change at national level.

CPHIA (Durban, October 2025) Theme: Moving Towards Self-Reliance to Achieve UHC and Health Security in Africa, described as a continental reckoning.

- FAH was in in **6 high-level sessions + 2 abstracts**
- **FAH organized a side event:** *Securing the Future of PHC: Innovative & Sustainable Financing Pathways*
- Kenya MoH presented Primary Care Networks & facility financing reforms
- **FAH abstracts:** 20 years CHW financing trends + SHA early implementation

The significance of CPHIA 2025 extended beyond FAH's individual sessions. The conference produced the **Durban Promise - a continental commitment to health sovereignty anchored in domestically financed, resilient primary health care systems.**

The framing FAH has advanced throughout 2025 - **that health financing architecture, not just funding volumes, determines whether PHC delivers** - was reflected in the conference's core declarations. That alignment was not coincidental. It **reflected years of FAH positioning** the same analytical argument in the rooms where continental health policy is shaped.

THE THROUGH-LINE:

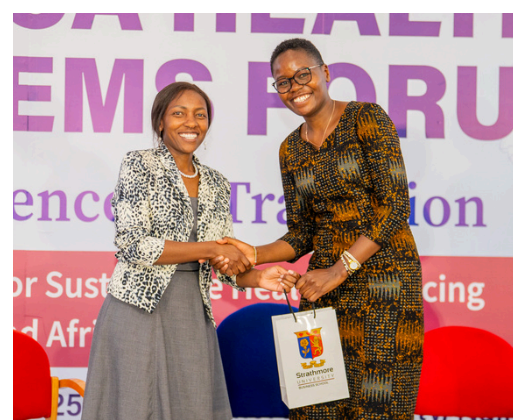
FROM EVIDENCE TO SYSTEMS CHANGE

FAH's EPA work in 2025 operated on two levels simultaneously:

1. **Country-level:** Generating rigorous evidence, translating it into tools (CHIP, CHFA), co-creating reform instruments (policy briefs) governments can carry into budget rooms.
2. **Continental-level**: Ensuring those lessons reach the platforms (AfHEA, CPHIA) where health financing rules are set and political conditions for reform are created.

Each step made the next possible:

The result:
A common analytical foundation for a harder, more important conversation:
Not how to plug the gap, but how to build systems that don't depend on donors.



Bridging Donor Dollars to Local Lifelines:
How FAH's Fiscal Sponsorship Unlocks Funding for Community Health Across Africa

Across Africa, **grassroots health initiatives** that know their communities best are **routinely shut out of major funding streams** not for lack of impact, but for lack of **formal legal status, robust financial systems,** and the **compliance structures** donors usually require.

Recent donor reforms and tightened risk appetites have created a funding bottleneck: promising local organizations stall, lifesaving community health programs are delayed, and fragile primary health systems remain dependent on fragmented, short-term support. The result is predictable and tragic: **missed opportunities to prevent maternal and child deaths, unmet needs for family planning,** and **communities left vulnerable** because the right money can't reach the right people at the right time.

FAH provides a practical, trusted solution. Acting as a fiscal sponsor under a dual registration model (as a 501(c)(3) and as an African entity), FAH **receives** and **manages donor funds** on behalf of locally led initiatives, handling **due diligence, compliance, financial management, reporting**, and **audits**, so community partners can focus on delivery.

This bridge **reduces administrative friction** and **donor perceived risk, speeds disbursement, strengthens governance,** and **ensures every dollar is transparent and tied to impact**. FAH **couples fiduciary stewardship with capacity building**, embedding tools like digital resource mapping and routine fiscal briefs so **partners strengthen their systems and move toward direct funding over time.**

FISCAL SPONSORSHIP
AT A GLANCE

4 Organisations currently sponsored under our Fiscal Sponsorship program

6+ million total contracted amount under our Fiscal Sponsorship portfolio

For donors and organizations seeking measurable, equitable impact: fiscal sponsorship is leverage. By pairing donor compliance with local leadership, FAH creates a faster, lower cost pathway to scale proven interventions, derisk investments, and catalyze blended finance.

PARTNERSHIP HIGHLIGHTS

FAH's in-country programmes are complemented by technical partnerships with specialised implementing organisations working in community health. In Ethiopia and Mali, FAH provided technical and financing support to primary implementing partners Muso and Last Mile Health. These contributions are reported here as partnership highlights to accurately reflect the attribution of results.

STRENGTHENING PHC FINANCING AND ACCOUNTABILITY IN ETHIOPIA WITH LAST MILE HEALTH

In 2025, as global funding cuts reshaped the health financing landscape, in Ethiopia, FAH's partner LMH continued to provide **technical support to the Ministry of Health to secure catalytic resources.** These efforts helped unlock **USD 417,685** to finance targeted interventions that included Quarterly Monitoring Reviews of Community Health investments, revision of the national scope of practice and training package for PHC workforce development and dissemination of the Community-led Monitoring Framework.

These efforts aimed to strengthen tracking of health investments, enhance capacity of the workforce and ensure accountability at every level of the system.

STRENGTHENING ETHIOPIA'S FRONTLINE THROUGH THE SCALABLE BLENDED LEARNING APPROACH WITH LAST MILE HEALTH

In Ethiopia, the health extension program (HEP) forms the foundation of universal health coverage with Health Extension Workers (HEWs) delivering essential health services directly to communities. In 2025, Last Mile Health deepened their partnership with Ethiopia's Ministry of Health by scaling a government-led, gender-responsive blended learning approach focused on strengthening HEW's skills for quality Reproductive, maternal, newborn, and child health (RMNCH) services.

Working in close coordination with Regional Health Bureaus, LMH equipped 713 Health Extension Workers and **supervisors - of which 80% are women - with critical skills** in RMNCH. The results were striking with **over 90%** of trained HEWs **demonstrating improved knowledge in key RMNCH** areas while a**verage skills scores jumped from 59% to 83%**. To ensure government ownership and sustainability, LMH supported Regional Health Bureaus to lead implementation, trainee selection, logistics and preparation of continuous professional development (CPD) centres. FAH and LMH are **using this evidence of impact and cost-effectiveness to advocate for this innovative approach scale-up to other African countries.**

Strengthening community health and investing in CHWs to improve malaria detection and treatment in Mali with Muso

In Mali, malaria remains the leading cause of illness and death, accounting for **27% of deaths** within facilities. Mali is thus amongst the **10 highest burden malaria countries** globally. To address these challenges, the Ministry of Health relies on integrated Community Health Workers who are critical in supporting early diagnosis, treatment, and referral to PHC facilities for a range of health conditions and needs. However, CHWs face **challenges** that include s**hortage of supplies, irregular supervision, and support** undermining their work in delivering quality malaria services to communities.

In response to these challenges in community health funding, FAH's partner Muso provided technical assistance to MoH to **unlock USD 12.5 million for CHW** training and supervision, integrating SRHR and gender into CHW programs, and boosting community engagement to reach zero-dose children. This investment contributed to stronger CHW systems.

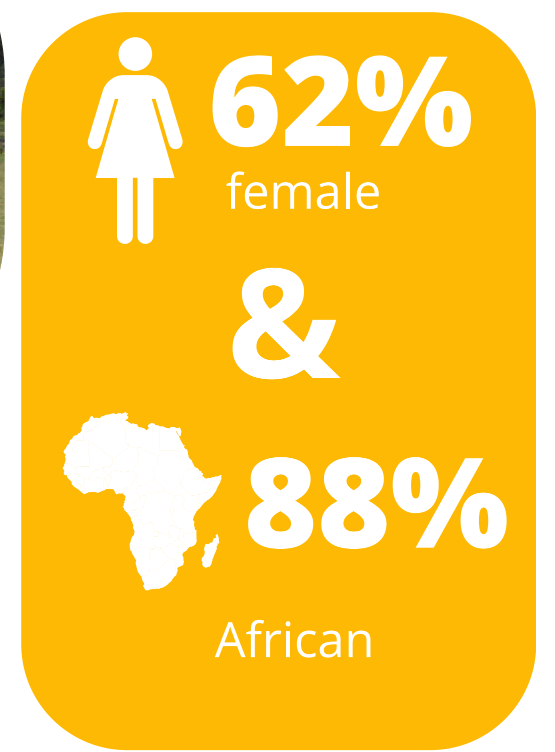
These improvements translated to improved service delivery outcomes which include an increase in under five children and pregnant women receiving treatment for uncomplicated malaria.

MEET THE TEAM

FAH is a locally rooted, globally connected organization powered by African health economists, public financial management and M&E experts.

Our core values

Our global expertise matched with global reach: a board and council spanning five continents, and a Government Advisory Group composed of former senior African officials. Together, they bring an exceptional blend of global experience and local insight, enabling FAH to partner with governments in a way that is both contextually relevant and globally informed.



Scaling Rwanda's Gains: From Government offices to Translating Lessons on Health Wins into Lifesaving, Community Centred Solutions

-Dr. Parfait Uwaliraye- Health Financing Lead for Francophone Africa

"Growing up in Rwanda, I learned that resilient, **well-financed health systems are not optional, they are the backbone of national recovery, keeping services running, protecting families,** and **turning a shared vision of prosperity and transformation into lived reality.**

From 2012 to 2023 I led **Planning, Monitoring & Evaluation and Health Financing at Rwanda's Ministry of Health, as the Director General of Policy & Planning**, a role that ,made me responsible for decisions with life-and-death consequences. I **drove financing reforms** that changed everyday realities: **introducing capitation, strengthening community-based health insurance to protect families from catastrophic costs,** and **building strategic purchasing frameworks** aligned with Rwanda's UHC goals.

I **chaired national technical committees** on health financing, research governance, private sector engagement, and human resources for health, bringing government, partners, and communities into **evidence-driven policie**s that translated into stocked clinics, functioning referral chains, and fewer families left behind. I have also served as the **country technical focal point for Global Financing Facility alignment working group** supporting countries to use One Plan, One budget and One report (1P1B1R) approach to assess their alignment maturity and helped shape the Lusaka Agenda for country-led, equity-focused health financing reform.

Those experiences reinforced a core lesson: **global commitments only matter when they bend to country realities and protect the most vulnerable.**

I joined FAH to share Rwanda's hard-won lessons and best practices with other African countries such as Senegal, the Central African Republic, and others, offering tools, humility, and a commitment to contextual adaptation, peer learning, and capacity building rather than one-size-fits-all blueprints. I now lead FAH's work across Francophone countries. I also represent **Global South civil society** on the **Pandemic Fund Board**, advocating for transparent, country-led financing that reaches frontline workers and communities living with fragility.

My work is driven by what I have seen: a mother's relief when care is affordable, a health worker's quiet pride with the supplies they need, and the lasting stability that follows."

A Personal Story of Purpose, Partnership, and Transformation

-Jemuge Kandie, Health Financing Technical Advisor

"My journey into global health began in the warm classrooms of my African community in Kenya, not on policy tables. I trained in **clinical medicine** to serve those around me and became a teacher, pouring my heart into **shaping compassionate, resilient clinicians.** The pride of preparing young health workers was profound, yet I soon saw that **individual skill could be swallowed by fractured, under-resourced systems** as delayed salaries, empty clinics, and unpaid CHWs undermined care and morale.

That realization shifted my focus to systems change. I moved into **health systems management** and **partnered with governments to design and implement financing reforms** that direct resources to the last mile. I led facility improvement financing and results-based mechanisms, strengthened PFM in facilities, and helped optimize revenue so services and the workers who deliver them, are supported and sustained.

Joining FAH let me scale this mission: costing and institutionalizing primary and community health, integrating it into national plans, and helping governments shift from donor dependence to domestic co-financing.

This work for me is deeply personal, rooted in the students I trained, the communities I call home, and a conviction that strong primary health care requires invested, professionalized community health."

Our
Partners

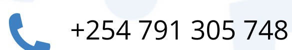
FAH's work is made possible through partnerships with governments, multilateral organisations, philanthropies, and implementing partners who share our conviction that well-financed, government-led primary health care is the most durable path to universal health coverage. We are grateful to every partner who invested in this work in 2025.

The Horace W. Goldsmith Foundation

Gates Foundation

Financing Alliance for Health

info@financingalliance.org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