

AFRICA COMMUNITY HEALTH PROGRAMME

CONTINENTAL LANDSCAPE SURVEY REPORT 2024/5





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Africa CDC is a continental autonomous health agency of the African Union established to support public health initiatives of Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.

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FOREWORD

Community health stands at the heart of Africa's health security and sovereignty (AHSS) agenda and is the backbone of resilient primary health care (PHC) systems. Across the continent, Community Health Workers (CHWs) continue to be the trusted bridge between communities and health systems, bringing care, hope, and dignity to millions of families, including during health emergencies.

This 2024 Continental Community Health Landscape Report, conducted by Africa CDC in partnership with UNICEF and in collaboration with the African Union Commission, marks a major milestone, providing the most comprehensive picture to date of Africa's community health systems. The results testify to Africa's progress: over 1 million CHWs are now deployed across 48 countries, reaching more than halfway toward the African Union's 2030 target of two million. Moreover, 84% of Member States have national community health strategies, and most have established coordination mechanisms that strengthen governance, accountability, and alignment with national priorities.

These achievements deserve celebration. Yet the report also highlights urgent challenges that must focus our collective attention. Financing remains the greatest bottleneck: the median annual per capita spending on community health stands at just USD 1.66, and over 80% of Member States still depend on external funding to sustain their programs. As official development assistance continues to decline globally, Member States must lead a new era of domestic resource mobilization, innovative financing, partner alignment, and program integration to secure the future of Africa's health workforce.

The road ahead demands political leadership, predictable investment, and accountability. Governments must establish dedicated budget lines for community health, integrate CHWs into the formal health workforce, and strengthen training, data systems, and digital infrastructure. Development partners must align behind country-led priorities and invest in Africa's capacity to sustain and scale what works.

Africa CDC, UNICEF and partners reaffirm their commitment to supporting Member States in building professional, polyvalent, digitally empowered, and equitably financed community health systems that anchor PHC, pandemic preparedness, and health security.

We invite policymakers, partners, researchers and advocates to use this report as a reference point and a tool for accountability.

We dedicate this report to Africa's community health workers, the women and men who form the frontline of our collective defense and the foundation of our vision for a healthier, more self-reliant Africa.

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CONTRIBUTORS

This landmark Continental Community Health Landscape Survey Report is the result of a highly successful collaboration between the 55 Member States in Africa, Africa CDC, UNICEF and partners. Africa CDC and UNICEF extend their deepest appreciation to the Ministries of Health of all African Union Member States, whose leadership, time and contributions are central to the richness of this report. The results of this comprehensive baseline survey are not only historic but also serve as the first of its kind. They point to the status of community health programs on the continent, highlighting opportunities to accelerate progress and enhance accountability.

Most notably, we recognize and applaud the hard work and unwavering commitments of the Community Health Workers on the continent who deliver life-saving, essential health services to their communities and form the backbone of the primary health care system. Their lived experiences and daily service to communities inspire the work captured in this report. This survey is dedicated to strengthening their role and ensuring that community health remains at the center of Africa's health systems transformation.

The report was prepared by Professor Uta Lehmann-Grube at the request of Africa CDC and UNICEF, with technical leadership and strategic direction from: UNICEF: Dr. Maureen Kerubo Momanyi, Megan Christensen; Africa CDC - Dr. James Guwani (immediate past head of division), Dr. Meggie Gabida. Member States, Africa CDC and UNICEF, along with partners of the Community Health Continental Coordination Mechanism (CCM) and Community Health Delivery Partnership (CHDP), provided strategic and technical guidance throughout the survey process and finalization of the report. We are grateful to the leadership at Africa CDC and UNICEF for their unwavering support and thanks to the many colleagues including: Dr. Landry Dongmo Tsague, Helga Fogstad, Dr. Fouzia Shafique, and Maria Muñiz.

A special thanks and recognition go to the technical teams of Africa CDC's Division of Community Health and UNICEF's Community Health and Data and Analytics Teams, who worked tirelessly to ensure the quality, accuracy and completeness of the findings: Africa CDC: Massengo Nsongola, Dr. Barnabas Kwame Yeboah, and Thaddee Niyoyitungira; UNICEF: Dr. Chris Ngwa, Tashrik Ahmed, Khaing Soe, Qiaolong Lin, and Felix Schwebel.

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We would also like to recognize the tremendous talent and contributions of Big Yellow Taxi who provided the overall graphic design and copy-editing for this report.



ACRONYMS

AHS	Africa Health Strategy
AHWs	Auxiliary Health Workers
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
APEs	Agentes Polivalentes Elementares
ASC	Agent de Santé Communautaire (Community Health Agent)
AU	African Union
AUC	African Union Commission
BHW	Boma Health Worker
CBC	Community Health Companion
CbSV	Community-based Surveillance Volunteer
CBVs	Community Based Volunteers
CHA	Community Health Assistant
CHEW	Community Health Extension Workers
CHOs	Community Health Officers
CHSS	Community Health Services Supervisor
CHVs-I	Community Health Volunteers-Intermittent
CHVs-R	Community Health Volunteers-Regular
CHW	Community Health Worker
CCM	Continental Coordination Mechanism
COVID	Coronavirus disease of 2019
DESDOM	Dispensateur de soins à domicile
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
HEP	Health Extension Programme

HEWs	Health Extension Worker
HIV	Human Immunodeficiency Virus
HSAs	Health Surveillance Assistants
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of New-born and Childhood Illness
JCHEW	Junior Community Health Extension Workers
LMICs	Low- and middle-income countries
MOH	Ministry of Health
NPHCDA	National PHC Development Agency
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHCU	PHC Unit
RECO	Relais Communautaire (Community Relay)
SDGs	Sustainable Development Goals
TBA	Traditional Birth Attendant
TTM	Trained Traditional Midwives
UHC	Universal Health Coverage
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children’s Emergency Fund
USAID	U.S. Agency for International Development
VHT	Village Health Team
VHW	Village Health Worker
WASH	Water, Sanitation and Hygiene
WDA	Women’s Development Army
WFP	World Food Programme
WHO	World Health Organisation
WHO/Afro	WHO Africa Region

GLOSSARY¹

Community: a group of people who live in a well-defined setting, share distinctive characteristics, have common interests, experiences and culture or are identified and governed by common regulations, norms, values and organizations.

Community Health: community health refers to the state of the health and well-being of individuals, families, and communities achieved by addressing determinants of health.

Community Health System: a subset of the health systems, that consist of a set of community and institutional actors, institutions and resources, bound by established policies and guidelines, to facilitate continuous delivery of accessible, affordable, effective, integrated, gender-sensitive and resilient health services to communities in a geographic setting, while responding to people’s legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose ultimate intent is to improve health outcomes.

1 Source: AU & ACDC (2024). **Community Health Systems: Concepts and Terminologies**. Division of Community Health System and Integrated Service Delivery. Africa Centres for Disease Control and Prevention (Africa CDC) Addis Ababa, Ethiopia.

Community Health Worker: a person who is selected and accepted by the community, recognized, trained, remunerated, equipped, supervised, and deployed to perform a well-defined scope of work within the national standardised minimum package of services.

Professionalized Community Health Workers

(Pro-CHWs): a trusted community resident, selected by their community, aged (18–60 years), of sound mind and officially recruited with a well-defined role and scope, who is trained, supervised and remunerated based on experience and qualification and adequately equipped with supplies and logistics required to deliver and/or facilitate the delivery of quality health, related psycho-social and other support services and recognized within the national public health system.

Community Health Volunteers (CHVs): a person who avails themselves, and/or chosen and accepted by the community to provide specific health services with or without incentives.

Community Health Committee (CHC): a community-based, voluntary, informal advisory gender-equitable membership group formed to create a link between the community and the formal health care system. They are to act in the interest of their communities, especially in decision-making, resource mobilization, conflict resolution, and also supervise the activities of community health volunteers.

Community Health Workers Package of Service

(CHW-PS): a set of services approved by the government in alignment with continental standardised package of services and guidelines that is delivered by CHWs in the community.

Integration of Community Health Service Delivery:

an approach that incorporates a community-based health service delivery package into the broader health service delivery systems.

Community-Based Health Intervention (CBHI): a

community-led multi-component action designed to improve the health and well-being of a community by addressing specific health issues within their unique social and environmental contexts.

Community Mobilization (CM): a process through which community members, groups, or organizations, often led and/or stimulated by community health workers and Health Committees plan, carry out, and evaluate their health needs and demands on a participatory and sustained basis to improve their health and other conditions, either on their own initiative or stimulated by others.

Integration of community health program: an approach that outlines a process by which a new set of norms or actions (e.g., community health interventions) are identified, introduced, refined, and become an integral part of a broader health system, backed by investments across competence, governance, and appropriate stakeholder engagement and support.

Community Score Card (CSC): a person-driven accountability approach where groups of people or civil society organizations (CSOs) hold public officials, service providers and governments responsible for meeting their obligations to protect and fulfill people's rights and needs.

Community-Event Based Surveillance (CEBS): the systematic detection and reporting of signals of public health significance within a community, by community members.

Sustainability of Community Health Programs:

sustainability of CHW programs refers to the full integration of community health programs into the formal health system, supported by long-term plans for governance, management, and financing. It requires predictable funding flows, clear budget lines, increased government investment to reduce reliance on external funding, adequate management and operational capacity from the government, and sustained political commitment to ensure the continuity and effectiveness of CHW programs at the country level.



EXECUTIVE SUMMARY

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Community health systems, grounded in trust, local participation and culturally responsive service delivery, are central to achieving universal health coverage (UHC), enhancing Primary Health Care (PHC) and ensuring public health security across the African continent. Community Health Workers (CHWs), as the anchors of these systems, extend lifesaving services to remote and underserved populations, serving as frontline responders in both routine care and emergency contexts.

In November 2024, the Africa Centres for Disease Control and Prevention (Africa CDC), in collaboration with UNICEF, conducted a continent-wide survey on the status of community health in Africa. This survey presents a comprehensive overview of the state of community health on the continent, as well as the existing challenges and opportunities. Additionally, the survey offers a snapshot of national progress and gaps related to community health. As a foundational step towards regular monitoring and tracking of continental and country progress, the survey results will be visualized through a dashboard and scorecard that will be routinely updated to improve stakeholder accountability and inform the Africa CDC's strategic interventions in achieving UHC and supporting resilient health systems in Africa.

1.1 SURVEY METHODOLOGY

Launched in November 2024 and validated in 2025, the survey constitutes a foundational milestone in

the development of Africa CDC's Community Health Data Platform and the Community Health Delivery Partnership's (CHDP) global community health dashboard, aimed at enabling dynamic monitoring and decision-making, tracking progress, and improving stakeholder accountability. The data collection instrument was co-designed with technical experts from the African Union, Africa CDC, UNICEF, Member States, and other partners of the Community Health Continental Coordination Mechanism (CCM) Technical Working Group, aligned with the Africa CDC Community Health Workforce Strategic Priorities, WHO guidance, and UNICEF benchmarks.



It consisted of quantitative and qualitative questions across seven domains:

-  **1. Policy, Strategy and Governance**
-  **2. Finance and Sustainability**
-  **3. Community Health Workforce**
-  **4. Service Provision (delivery)**
-  **5. Supplies and Equipment**
-  **6. Health Information Systems and Digitization**
-  **7. Community Engagement**

All 55 African Union Member States were invited to complete and submit the survey through a note verbal, and 51 Member States (93 per cent) responded. Data was triangulated with existing regional sources, and there were several rounds of follow-up with all countries to ensure accuracy, clarity and completeness. Additionally, a consultation meeting was held in Abuja, Nigeria, 5–8 August 2025, with community health focal points from ministries of health from Member States to validate their data. Country profiles were also prepared for each Member State, highlighting selected community health indicators.

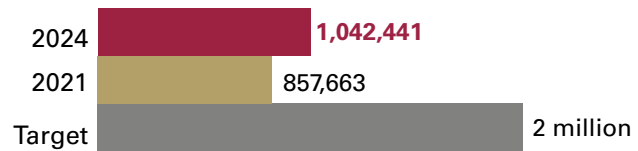
1.2 FINDINGS

1.2.1 COMMUNITY HEALTH WORKFORCE: SCALE, SCOPE AND GAPS

As of 2024, 51 AU Member States report a total of 1,042,441 CHWs deployed – marking a significant increase from 857,663 in 2021. This represents a 52 per cent improvement toward the continental target of two million CHWs. However, deployment remains uneven, with some countries like Rwanda and Kenya nearing national targets while others lag behind significantly.

Overall, the CHW density is one (1) CHW per 1,358 population with wide variability across countries. Some countries have more than six CHWs per 1,000 population and others well below one CHW per 1,000. Moreover, information about the distribution of

Total CHWs deployed (against targets)



CHWs by sex remains incomplete, reflecting systemic gaps in data collection and workforce planning. While 90 per cent of Member States define CHWs within their policy frameworks, only 69 per cent formally recognize them as part of the national health workforce, indicating ongoing challenges in full institutional integration.

1.2.2 GOVERNANCE AND COMMUNITY ENGAGEMENT

Governance is a central determinant of community health system effectiveness. In 2024, 84 per cent of AU Member States reported having national community health strategies, up from 47 per cent in 2022. However, many of these strategies are outdated or lack implementation frameworks.

Notably, 96 per cent of countries now have designated entities responsible for CHWs, and 84 per cent report the existence of national coordination platforms. These structures are essential for multisectoral collaboration, policy coherence, and accountability.

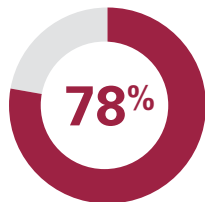
Community ownership and engagement are critical governance pathways and enablers of sustainability. The survey reveals that most countries report moderate to high levels of community involvement in CHW selection, service delivery and health promotion. However, engagement remains uneven, with gaps in awareness, empowerment and participatory governance.

1.2.3 FINANCING AND SUSTAINABILITY

The continent's health financing landscape is at a crossroads. External funding – while catalytic – remains volatile and unsustainable. Most countries (80 per cent) still rely on donor support for over half of their community health budgets.

Median per capita spending on community health is just US\$1.66 (unless otherwise noted, all monetary figures are in US\$), with wide variability across countries (US\$0.005-US\$33). Despite this, only 78 per

Percent of countries with costed community health strategy



cent of countries have a costed community health strategy, and 37 per cent of countries have developed investment cases for community health, and just 21 per cent have financial sustainability plans.

There is an estimated annual funding gap of US\$3.65 billion for community health, which calls for a paradigm shift towards domestic resource mobilisation, innovative financing mechanisms and strategic investment. The Lusaka Agenda and the Africa Health Financing in a New Era concept paper provide a roadmap for building resilient, sovereign health systems and three key financing options that serve African populations sustainably and equitably.

1.2.4 SCOPE OF SERVICES

Survey results reflect the wide and often very comprehensive range of services rendered by CHWs in most Member States, covering community health surveillance, health promotion and prevention, diagnostics and referrals, as well as basic curative services. While some Member States, particularly in the north of the continent, still focus primarily on health education, many additionally include contact tracing, full iCCM, mental health, gender-based violence support, identification and treatment of non-communicable diseases, and public health emergencies in their scope.

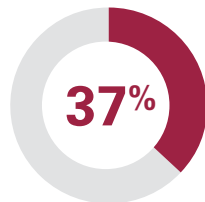
1.2.5 MANAGEMENT OF THE COMMUNITY HEALTH WORKFORCE

SELECTION PROCESSES AND CRITERIA

Community ownership remains a core pillar of workforce legitimacy. In most Member States, CHWs are selected jointly by Health facilities, Community leaders, Government actors, and development partners.

Selection criteria commonly include literacy (basic or secondary education), community trust, local

Percent of countries with developed investment cases for community health



residency, motivation, and gender representation. Increasingly, Member States are introducing formal age limits (often 18–45 years) and physical capacity assessments, signalling a shift toward a more professional recruitment process.

TRAINING AND PROFESSIONAL DEVELOPMENT

The success of community health programs hinges on the quality of training and the importance of refresher training. It is a major step towards mainstreaming and strengthening these programs that 86 per cent of AU Member States now have standardised training programs and 65 per cent report the existence of refresher training. Of those CHW receiving pre-service training, 67 per cent are deployed following their training.

However, only 31 per cent of Member States currently offer career advancement pathways. This gap limits retention, motivation, and CHWs' professional recognition. Addressing this is critical for workforce sustainability.

SUPERVISION

Effective supervision boosts CHW performance and accountability and can improve the quality of care. The recognition of the importance of supervision is reflected in the fact that 92 per cent of Member States reported having supervisory structures in place. In most cases supervision is offered either weekly (11 Member States) or monthly (33 Member States), and is organized through health facilities, and in some cases through senior community health supervisors.

EQUIPMENT AND SUPPLY CHAIN

Over 90 per cent of Member States provide supply kits to CHWs. Common items include: Mid-Upper Arm Circumference (MUAC) tapes (88 per cent of

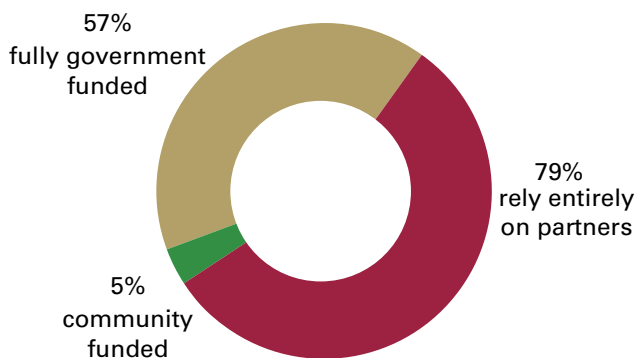
Member States), gloves (86 per cent of Member States), Information, Education, and Communication (IEC) materials (88 per cent of Member States), thermometers (75 per cent of Member States), Rapid Diagnostic Tests (RDTs) (76 per cent of Member States), smartphones/tablets (63 per cent of Member States), basic medicines and protective gear.

However, stock replenishment is inconsistent: only 30 Member States (59 per cent) report regular resupplies. Irregular supply chains undermine community trust and service effectiveness.

COMPENSATION AND INCENTIVES

The majority of Member States now acknowledge the importance of fair compensation. While 73 per cent report having a regular payment system for CHWs, only 51 per cent report provisions for paying CHWs through the government wage bill. Furthermore, salaries vary dramatically across Member States, from a minimum of US\$10 to a maximum of US\$432 per month. There was no substantial difference in payment between male and female CHWs reported, but only 27 per cent of Member States keep sex-aggregated data.

Funding sources are diverse:



Additionally, 49 per cent of Member States offer non-financial incentives (e.g., transport, airtime, insurance, and public recognition).

1.2.6 DATA AND INFORMATION SYSTEMS

Survey results suggest that health information systems in Member States are improving and transitioning to digital systems. 41 Member States (80 per cent)

indicated that they have a community-based health management information system (C-HMIS), 35 Member States (69 per cent) have a master register of CHWs, and 39 Member States (77 per cent) indicated that the data collected by CHWs is integrated into the national health information system. However, fragmentation due to multiple parallel tools, lack of interoperability between systems, and lack of government ownership remains a challenge which needs to be addressed.

1.3 CONCLUSIONS

The 2024/5 Community Health Landscape Survey highlights progress, resilience, and ambition across African health systems. In many places, community health workers have grown from under-supported volunteers into semi-professional occupational groups embedded in national health strategies.

However, despite increased deployment, formal recognition, and community engagement, major challenges persist – particularly around sustainable financing, professionalization, and performance management. Africa CDC’s and UNICEF’s leadership has been pivotal in curating a continental vision, policy, and strategy and supporting Member States to accelerate progress in their community health programmes.

Moving forward, the strategic priorities must focus on closing equity gaps, formalizing CHW status, expanding service capacity, and institutionalizing sustainable systems. Achieving this vision will require coordinated action between governments, partners, and communities to embed community health as a cornerstone of universal health coverage and pandemic preparedness in Africa.

As Dr. Jean Kaseya, Director General of Africa CDC, notes:

“Investing in community health workers is not only ethically right but strategically sound. It delivers long-term returns in health, equity, security and development.”

1. INTRODUCTION



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Community health systems, along with the community health workers (CHWs) who form their foundation, are crucial for ensuring sustainable and equitable access to healthcare, as well as for maintaining global health security. In the context of enhancing Primary Health Care and addressing Africa's complex chronic health workforce challenges, CHWs play a pivotal role in delivering a comprehensive array of preventive, promotional, curative, nutritional, and rehabilitative services. They are indispensable in detecting disease outbreaks, responding to pandemics and natural disasters, ensuring health security, and serving as frontline workers to facilitate access to health services.

In recent years, significant progress has been made in advancing global, continental, and national agendas aimed at strengthening sustainable systems development to achieve improved health outcomes. To effectively monitor this progress and identify necessary actions, robust data systems and evidence are essential. To this end, the Africa CDC and UNICEF in 2024 launched a continental survey on the state of community health on the continent, which included availability and management of CHWs, as well as the current situation regarding policy development, financing and governance. The findings of this survey, which also aims to establish the groundwork for dashboards, scorecards, and annually updated surveys in future years, are presented here.

The document commences by providing background information on the role, significance and current state of community health systems and the community health workforce, and offers an overview of recent strategic developments. It then explains the survey's methodology and presents its findings, concluding with considerations for actions and strategies to further strengthen community health on the continent.



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2. BACKGROUND

2.1 THE ROLE OF COMMUNITY HEALTH SYSTEMS

Community health systems are increasingly recognized as being foundational to health systems, serving as critical bedrocks and conduits for improving access to primary health care (PHC) and advancing the goal of universal health coverage (UHC) (Sacks et al. 2020). These systems are rooted in the community and built on a foundation of trust, participation, and local engagement. Their primary function is to extend the reach of primary health care (PHC) by providing culturally appropriate, accessible, and continuous care at the community level. In doing so, community health systems significantly contribute to the realization of universal health coverage (UHC), ensuring that all individuals and communities receive the health services they need without suffering financial hardship (Mupara et al. 2023; H. Schneider and Lehmann 2016). By embedding health services within the community and empowering local stakeholders - including public health officials, civil society, and community health leaders - community health systems foster greater ownership, accountability, and responsiveness to local health challenges (Sacks et al. 2020). This context-sensitive approach is particularly vital for reaching marginalized, rural, and underserved populations, who often face significant barriers to accessing facility-based care due to distance, cost, or cultural factors. Evidence consistently shows that facility-based services, which are anchored in well-functioning community systems, are effective in improving health outcomes and resilience through health promotion, prevention and curative services. Community embeddedness is thus not merely a tangential supplement to health systems but a cornerstone for equitable, people-centred, and comprehensive primary health care (Perry and Hodgins 2021; Ballard et al. 2025).

Central to these systems is the community health workforce, particularly community health workers (CHWs). They play a pivotal role in delivering a spectrum of essential health services, including maternal and child health care, infectious disease prevention, health

education, and support for chronic disease management (Glenton, Javadi, and Perry 2021). CHWs act as trusted liaisons between health systems and the communities they serve, leveraging their deep understanding of local contexts to educate, advocate, and connect individuals with essential health and social services (Cometto et al. 2018; Olaniran et al. 2017). In many settings, CHWs are the first - and sometimes only - point of regular contact with the health system, providing ongoing care and monitoring that extends the continuum of care beyond sporadic facility visits. This proximity enables them to identify unmet health needs early, promote preventive practices, and facilitate timely referrals, thereby reducing unnecessary hospital admissions and health care costs (Perry, Zulliger, and Rogers 2014). In recent years they have also played pivotal roles in detecting disease outbreaks, responding to pandemics and natural disasters, enhancing health security and acting as frontline workers to aid recovery and resilience (Wiah et al. 2020; Ballard et al. 2022; Werner et al. 2023).

2.2 THE CURRENT STATE OF COMMUNITY HEALTH SYSTEMS IN AFRICA

However, despite the pervasive acknowledgement of their importance and substantial progress in recent years, community health systems and the community health workforce often remain under-resourced and insufficiently integrated into formal health systems, thereby limiting their potential impact. Member States that have successfully integrated CHWs into their national health strategies demonstrate that achieving sustainable change towards UHC requires not only scaling up the community health workforce but also their integration into the formal health system, adequate training, supervision, remuneration, and systemic support for CHWs (Perry and Hodgins 2021).

The following offers a brief overview of the principal themes related to the current status of community health systems in Africa, which provides the backdrop to this survey's detailed findings.

2.2.1 NUMBERS AND DENSITY

While the African Union set a target of deploying two million CHWs on the continent, ideal numbers and density vary, as they depend on a range of other factors, such as the concurrent availability of other health care cadres (e.g., nurses and doctors), population density, workloads and scopes of practice. Quality of training and support also play important roles (Asamani, Okoroafor, and Mwinga 2025).

The WHO Guidelines explain the close interrelationship between CHW density (numbers per capita), scopes of tasks and workloads, and performance. Systematic reviews commissioned for the guidelines found that “decisions about catchment area population should be based on a variety of considerations: frequency of contact required; nature of the services provided; expected weekly time commitment from the CHW; and local geography (including proximity of households), weather and transport availability” (WHO 2018, 53).

Recent work conducted by WHO Regional Office for Africa examined *Community Health Worker Requirements to Accelerate Progress Towards Universal Health Coverage in Africa* (Asamani, Okoroafor, and Mwinga 2025). Using recent data and modelling techniques to analyze CHW workforce requirements under varying scenarios of full-time and part-time work, they found that needs-based estimates of CHW density range widely - from 11.2 to 59.5 per 10,000 people - depending on how much time CHWs dedicate to health work. If all CHWs worked full-time, the workforce gap would be approximately 210,000. However, under part-time scenarios (e.g., 30 per cent – 65 per cent time spent on health duties), the shortage could rise to between 580,000 and 954,500.

Similarly, the Africa CDC health workforce investment case conducted in 2024 revealed that the continent needs a density of 25.34 CHWs per 10,000 people to achieve 70 per cent UHC service coverage and 36.20 CHWs per 10,000 people to achieve 100 per cent UHC service coverage.

So, while the target of 2 million CHWs is an important continental target, AU Member States have to conduct national and sub-national needs assessments and scenario planning to establish context specific targets. Africa CDC and partners play an important role in

supporting Member States in these endeavours. This survey sheds light on the current (2024/5) status of numbers, density and management of the community health workforce.

2.2.2 GOVERNANCE

Community health systems governance, defined as the processes, relations, structures, and institutions that guide and oversee the management of community-level health systems, is consistently identified as a crucial factor to achieve systems functionality and improved health outcomes. Key policy documents, such as the *Africa Health Strategy 2016–2030*, the *WHO Guidelines on Health Policy and System Support to Optimize Community Health Worker Programmes*, and increasingly the academic literature (See, for example: Pascal Saint-Firmin et al. 2018; Angwenyi et al. 2018; Lewin, Lehmann, and Perry 2021; Helen Schneider 2019), emphasize the need to strengthen governance through the institutionalization of community health programs, in order to improve accountability, stewardship and management of programs, and to develop sustainable funding mechanisms. Indicators of good governance, which will be elucidated in this report’s findings, include the existence of community health policies and strategies, investment and sustainability plans, the incorporation of the community health workforce into national health plans and budgets, the integration of community health information systems, as well as structures and processes that ensure multi-stakeholder and community engagement (Lewin, Lehmann, and Perry 2021; Helen Schneider and Lehmann 2016).

2.2.3 FUNDING AND FINANCIAL SUSTAINABILITY

The recent concept paper published by Africa CDC on *Africa’s Health Financing in a New Era (Africa Centres for Disease Control and Prevention 2025)* highlights the Continent’s financial crisis in light of the dramatic contraction on official development assistance (ODA), high levels of debt, low domestic investment in health, and surging health emergencies. The paper gives expression to the **Lusaka Agenda**, which provides a foundation for coordinated action to support systemic shift towards a domestically financed health systems and UHC that leaves no one behind (FGHI 2023). It

proposes a comprehensive three-pillar strategy focused on domestic resource mobilization, innovative financing, and blended finance.

The existential crisis in health financing generally is mirrored, and in some cases aggravated, in community health programs, which have historically relied heavily, and sometimes entirely on external (donor) funding. Estimates of the current funding gaps to reach continental targets vary. The recent *Community Health Workforce Strategic Priorities (Africa Centres for Disease Control and Prevention 2023)*, published by Africa CDC, estimates a US\$4.4 billion annual funding gap for community health.

Slightly older estimates, by Gichaga et al, calculate a funding gap of approximately US\$5.4 billion for scaling community health worker (CHW) programs in Sub-Saharan Africa. But despite this gap, the authors argue, community health programs remain a cost-effective strategy, with a low cost per capita ranging from US\$1.50 to US\$13.00 (Gichaga et al. 2021). The financing of health systems in general, and the community-based foundations of these systems in particular is thus a bedrock of reaching UHC goals investing in “the Africa we want”.

To advance and support strategic investments in health financing, it is essential to track budgets and expenditures and engage in robust short-, medium- and long-term planning. This necessity is emphasized in the aforementioned policy documents and the academic literature (Kumar et al. 2020; Masis et al. 2021; Ballard et al. 2021). This survey provides an overview of the current state of financial stocks and strategies in Member States.

2.3 ADVANCING COMMUNITY HEALTH POLICY, STRATEGY AND COLLABORATION SINCE 2017

2.3.1 THE AFRICAN POLICY AGENDA

Recognizing the critical importance of community health systems, global, continental and national leaders have spearheaded the development of numerous policies, guidelines, and strategic support initiatives to enhance community health across the continent in recent years.



Building on Africa’s *Agenda 2063* and *Africa Health Strategy 2016 – 2030*, in 2017, the Heads of State and Government of the African Union called on the African Union Commission (AUC), alongside UNAIDS, WHO, and other partners, to urgently **recruit, train, and deploy 2 million community health workers (CHWs) across Africa** (Assembly/AU/Dec.649 (XXIX)).

In 2019, the World Health Assembly passed a historic resolution emphasizing the need for CHWs to ensure universal health coverage and to provide comprehensive health services, particularly to underserved populations. The Assembly called on Member States to optimize CHW programs as part of the global strategy to achieve universal health coverage (UHC), Sustainable Development Goal (SDG) 3, and strengthening health security.

Since then, health emergencies like the COVID-19 pandemic, the recent Mpox outbreak and humanitarian crises, further highlighted the importance of building community health systems, not as short-term solutions to emergencies, but as foundational elements for achieving UHC. In 2018, the World Health Organization published its ***Guideline on health policy and system support to optimize community health***

worker programmes (WHO 2018), which calls for the integration of community health workers in health systems and communities.

Since then, important milestones in advancing the community health agenda on the African continent have been the **Monrovia Call to Action** at the 3rd International Community Health Workers (CHW) Symposium in 2023, and the **Community Health Delivery Partnership** between key national, regional and global partners, established “to support country-led plans, budgets and priorities to promote the community health agenda and accelerate progress toward national health goals”.

This increasing convergence of the policy agenda, particularly on the African continent, has been accompanied by efforts by Africa CDC, in collaboration with UNICEF and other partners to support AU Member States in the development of policies and operational plans which will facilitate the recruitment, training, deployment of two million CHWs and improving national community health programs.

2.3.2 STRENGTHENING CONTINENTAL COLLABORATION AND PARTNERSHIPS

AU Member States have furthermore recognized the need for a robust coordination platform to align and strengthen continental and national efforts, and to provide mutual support on the continent. This recognition and several high-level meetings culminated in the call for the establishment of the Continental Coordination Mechanism (CCM) for Community Health in November 2023 during the 2nd High Level Meeting on Community Health Systems. The CCM, which is the continental arm of the global CHDP partnership, has three levels: Taskforce chaired by the Director General of Africa CDC, the Technical Working Group chaired by Member State (Uganda) and the three subgroups (Policies & SOPs, Financing & Sustainability and Monitoring and Evaluation), all chaired and co-chaired by Member States and partners.

The *Africa CDC Strategic Plan 2023 – 2027*, informed by the outcomes of these meetings, evidence reviews and preceding policy directions, identifies integrated health systems as its first priority, and recognizes a strong

public health workforce, as well as “coordinated, respectful and action-oriented public health partnerships and strengthened engagements with communities on public health needs” as key enablers.

At the most recent high-level meeting on community health in Addis Ababa (November 20–22, 2024), senior officials from over 42 African Union Member States, representatives from Ministries of Health, the *Department of Health, Humanitarian Affairs, and Social Development of the African Union Commission*, key partners, and relevant stakeholders endorsed the *Africa CDC Community Health Workforce Strategic Priorities (2023–2027)*, which outline the goals, roles, and outcomes for strengthening CHW programs.

In the foreword to the document Africa CDC Director General, Dr Jean Kaseya emphasizes that

“Community health forms the cornerstone of our collective vision for a healthier Africa. [...] The recent trajectory of disease outbreaks, including COVID-19, Ebola, Marburg, and Mpxv, has revealed the need for more robust public health systems to address such challenges. Investing in community health workers is not only ethically right but also strategically sound. It delivers significant long-term returns, including enhanced productivity from a healthier population, reduced risks of future global and public health crises, increased employment opportunities, and women’s economic empowerment.”

The strategy provides a roadmap for scaling up integrated, sustainable CHW programs to achieve UHC and resilient health systems in Africa and identifies five strategic priorities (*see Figure 1*).

Figure 1: Africa CDC Community Health Strategic Priorities for 2023–2027 and Flagship Activities



Source: Africa CDC Community Health Strategic Priorities for 2023–2027 and Flagship Activities

2.3.4 DATA AND INFORMATION SYSTEMS FOR PLANNING AND MONITORING

To effectively monitor progress and signpost policy and strategic actions towards the Lusaka agenda and the Monrovia Call to Action, urgent evidence on the state of community health in Africa is needed.

To address this need, Africa CDC, in partnership with UNICEF, conducted the *Continental Community Health Landscape Survey* reported in this document across all 55 African Union Member States. This survey, building on previous surveys in 2020 and 2022, provides valuable insights into community health governance, policies, financing,

workforce, health information systems, and service delivery. This survey provides the basis for the implementation of annual surveys, and the development of national fact sheets, a continental community health dashboard and scorecard, alongside *WHO's National Health Workforce Accounts* and the already existing *Community Health Delivery Partnership's*² community health dashboard. The data will be publicly available and will serve as a valuable resource for global, regional and national stakeholders, helping to track progress and inform annual reports on the status of community health across the continent.

² <https://www.communityhealthdeliverypartnership.org/community-health-dashboard>

3. METHODOLOGY

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3.1 OVERVIEW

This survey, conducted in 2024/5, employed a cross-sectional, descriptive design to assess the status, capacity and maturity of community health and community health worker (CHW) programs across all AU Member States. It aimed to generate comprehensive, policy-relevant data to inform stakeholders at multiple levels. The survey was designed to provide information on:

- The state of the community health workforce, including numbers, density, integration into the national health workforce, compensation, aspects of management (selection, training, supervision, supplies), services rendered.
- Governance arrangements, including existence of national policies, strategies, partnerships and community participation.
- Funding and financial arrangements, such as costing of programs, available budgets, investment cases and sustainability plans.
- Data and information systems.
- Challenges and improvement plans.

The survey followed the definitions and terminology recently adopted by the African Union and Africa CDC (see glossary).

Each member state provided a single, country-wide comprehensive response through designated focal points within the ministry of health or relevant government agency responsible for community health, working in close collaboration with UNICEF and Africa CDC country focal points. The primary respondent coordinated inputs from all relevant departments and stakeholders.

The survey was shared with all 55 Member States of the African Union, and focal points for community health or another focal point from within the ministries of health were encouraged and supported by Africa CDC and UNICEF staff to respond: 51 (93 per cent) Member States responded.



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Figure 2: AU Member States who responded to survey



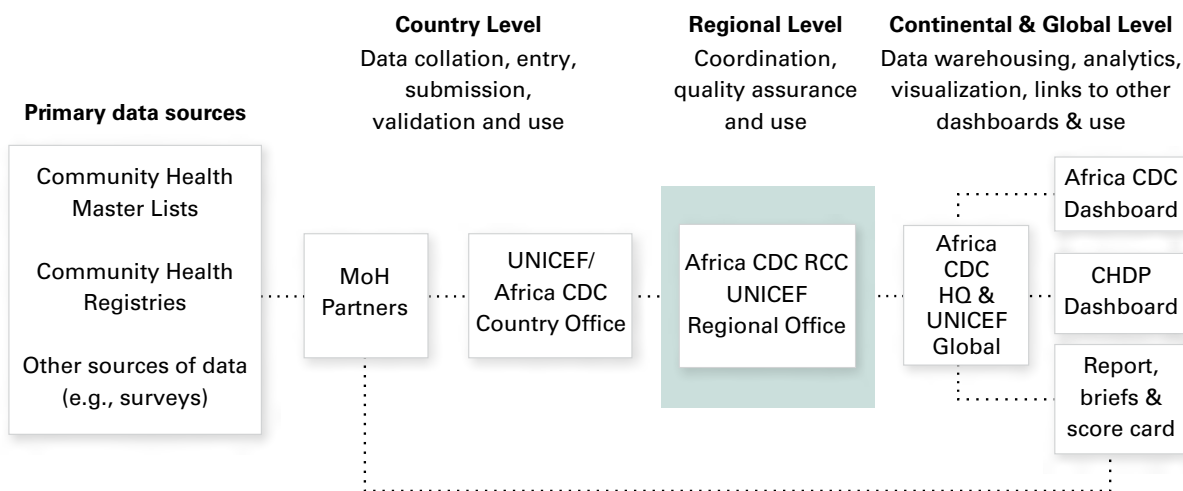
3.1.1 DATA COLLECTION

A structured questionnaire developed based on existing national strategies, policies, costing data, workforce registries, training plans and health information systems was jointly developed by Africa CDC and UNICEF and communicated to national ministries of health through a note verbale.

Member States were encouraged to ensure reference is made to information within their respective policy documents, budgets, workforce registries, training curricula, supply chain information, community health

information systems and implementation guides. The focal point compiled data with input from relevant departments, stakeholders and partners, and completed questionnaires and supporting documents were submitted electronically through a secure Jotform platform to ensure data integrity and confidentiality. This centralized national approach ensured consistency, comparability and comprehensive coverage of national community health systems, minimizing duplication and maximizing resource efficiency.

Figure 3: Survey methodology



To ensure data quality, pre-survey briefing to ensure understanding of questions was conducted with focal persons from Africa CDC Regional Coordinating Centres and UNICEF Regional Offices. A step-by-step guide was also provided to Member States. Validation checks for completeness and consistency were conducted including follow-up with respondents to clarify discrepancies or incomplete data, with data cleaning and verification before analysis.

The data collection period took three months from November 2024 to January 2025, with a response rate of 92.7 per cent (51 out of 55 Member States).

3.1.2 DATA ANALYSIS

Descriptive analysis was employed to quantify the status of community health programs, including the number and distribution of CHWs by cadre, age, sex and disability; coverage of community health policies and strategies; and training coverage and scope of work for CHWs. Financial investments, budgets and expenditures related to community health were analysed to identify gaps and opportunities. Qualitative analysis of open-ended questions, exploring strategic priorities, common challenges and solutions, complemented the quantitative results.

Country profiles, regional summaries and an overarching continental report to inform policy decisions and program development will be developed.

3.1.3 DATA VALIDATION PROCESS

Data was triangulated with existing regional sources, and there were several rounds of follow-up with all Member States to ensure accuracy and clarity. Additionally, a consultation meeting was held in Abuja, Nigeria, 5–8 August 2025, with community health focal points from ministries of health from Member States to validate their data. Country profiles were prepared for each Member State, highlighting selected community health indicators.

3.1.4 ETHICAL CONSIDERATIONS

The designated focal point provided informed consent on behalf of their country, acknowledging the purpose, scope and use of the data. No sensitive data was collected, and access was restricted to authorized personnel involved in analysis and reporting. Data was collected and managed in compliance with national and international ethical standards. Data will be used solely for the intended purpose of assessing and improving community health programs, and shared in anonymized, aggregated forms for public dissemination.



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3.1.5 LIMITATIONS

First, the quality of the mapping results (both in terms of correctness and completeness of data submitted) relied on each country's submission, and on the availability of data and documentation within Member States. As the institutionalization of community health policy and planning, as well as community health information systems are still in their infancy in many Member States data completeness and quality was uneven, and the identification of data gaps constitutes a significant outcome of the survey in itself. Fifty-one (51) Member States submitted survey responses, which is a substantial improvement from previous surveys, signaling the increasing recognition afforded to this topic in Member States.

Second, it should be noted that this report reflects information and evidence as submitted by Member States in their surveys and policy documents. In line with the aim of the mapping exercise, it deliberately does not draw on other published literature, to retain the fidelity of information as presented by Member States.

Third, the survey was geared to large, national-level programmes. However, it is well known that many Member States have numerous small, region-specific projects or programmes funded by non-governmental agencies, either in addition to or instead of national programmes. Due to the structure of the survey, information about these smaller projects was not captured, and may need to be followed up within Member States at a later stage.

4. FINDINGS



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The findings section reports survey results, starting with an overview of progress made in the community health workforce, reporting financial and governance arrangements, and then providing more detail of service delivery and management of the workforce, before reporting key challenges and how AU Member States have addressed these in their respective countries.

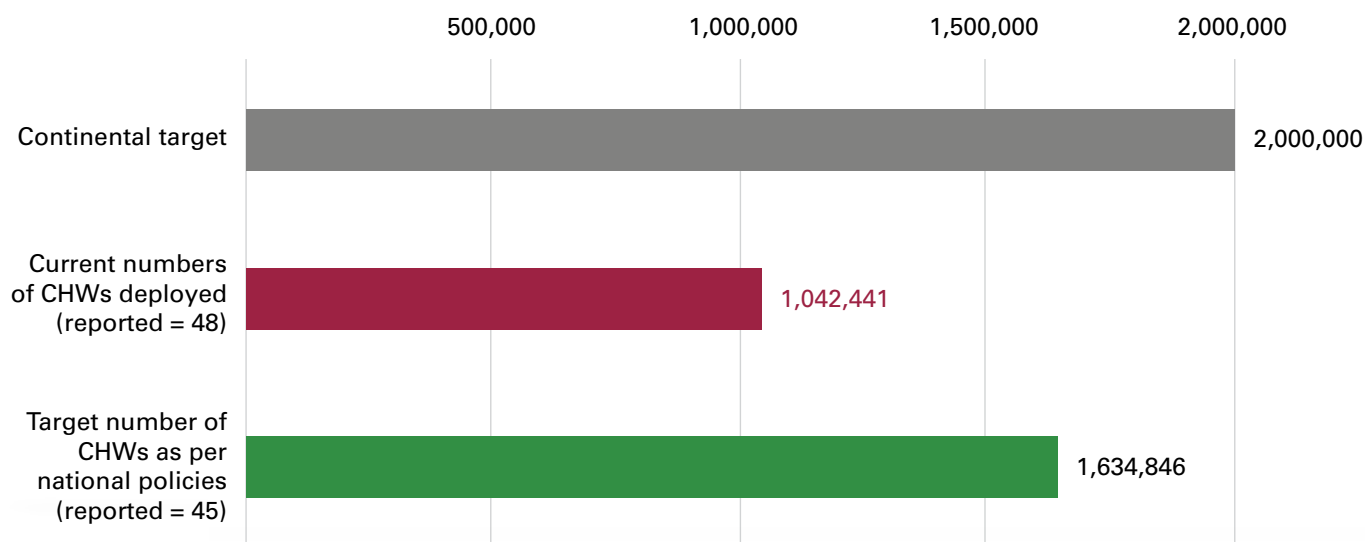
4.1 COMMUNITY HEALTH WORKFORCE

4.1.1 NUMBERS AND DENSITY

AU Member States (n=48) in 2024 reported a total of **1,042,441 CHWs**, crossing the 50 per cent mark

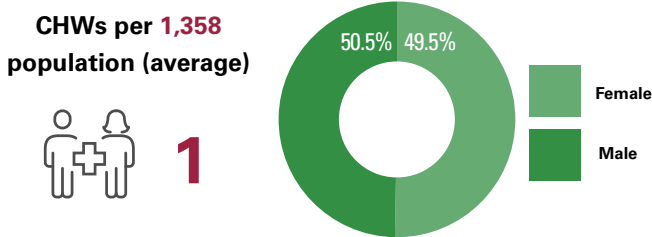
toward meeting the continental target of 2 million CHWs and reflecting a substantial increase since the AU-led survey conducted in 2021, which reported a stock of 857,663 CHWs. Forty-five Member States reported national targets for deployment of CHWs, which altogether amount to **1,634,846** (see Appendix G). While some Member States have reached their target numbers already (such as Rwanda) or are close (such as Kenya and Guinea-Bissau), in most countries, actual deployment lies well below national targets.

Figure 4: CHW numbers



This means that on average there is one CHW per 1,358 population, although this figure hides very substantial variability between Member States, from 4.8 CHWs per 1,000 population in Zambia to 0.01 CHWs per 1,000 in the Democratic Republic of the Congo.

Figure 5: CHWs per population (average)



Sex-disaggregated data were reported by 37 Member States, suggesting an almost even split between female (50.47 per cent) and male (49.53 per cent) CHWs.

Forty-three Member States (84 per cent) have identified the total population to be targeted by CHWs, and a few have also identified specific geographic areas to be prioritized for CHW support. In 45 Member States, CHWs are deployed throughout the country, while 6 deploy their CHWs in specific geographic areas.

4.1.2 LEGAL AND REGULATORY FRAMEWORKS

Over two-thirds of Member States now recognize CHWs as formal members of the health workforce, in line with the WHO guideline on health policy and system support to optimize CHW programs (WHO 2018; “The Monrovia Call to Action” 2023), signalling increasing integration and a long-term commitment to sustaining CHW programs and protecting CHWs across political cycles.

Figure 6: CHWs recognized as part of the formal health workforce

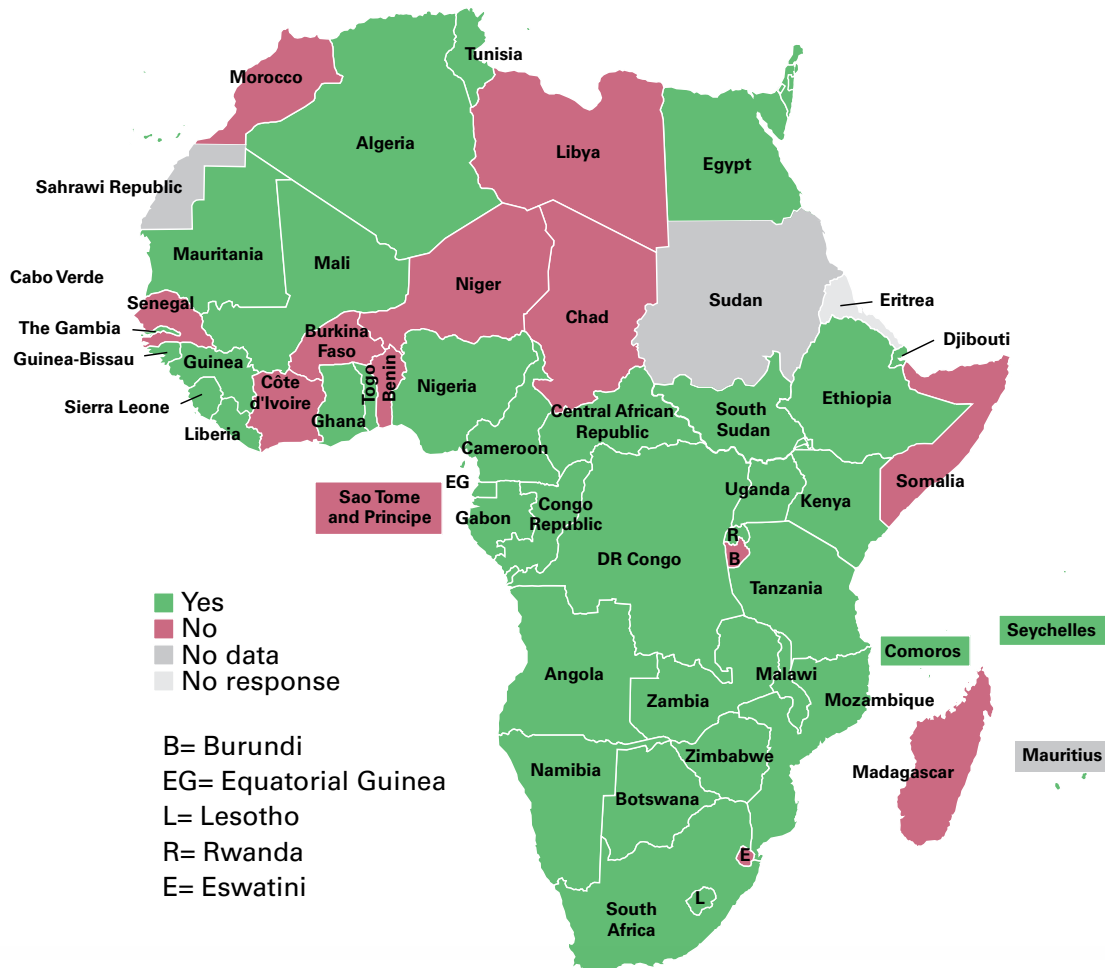


Figure 7: Legal frameworks for CHWs

Member States who have a formal definition of CHWs



Member States recognizing CHWs as a formal cadre in the health workforce



Indicators of formal recognition include integration into or alignment with ministries' employment and salary structures. Some Member States have developed national laws and statutory provisions that support and define CHWs and their roles and mandates, while some

referenced policies, strategies, or operational guidelines as the mechanism for formalization.

While many Member States have made great progress in the institutionalization and protection of programs, some responses reflected the absence of a clear mechanism, or that the process was still under development, signalling a need for strategic support.

4.2 GOVERNANCE

4.2.1 STATUS OF COMMUNITY HEALTH STRATEGIES

This survey utilized the existence of community health strategies, as well as mechanisms for the coordination and management of programs, as indicators of functioning governance.

Figure 8: Member States reporting existence of a national community health strategy



43 (n=51) AU Member States (84 per cent) reported the existence of a community health strategy, which is a dramatic improvement from a previous survey conducted in 2022. However, strategies in several Member States have lapsed and need to be reviewed and updated.

In 35 Member States (78 per cent of those who returned results) these strategies have also been costed, compared to 47 per cent in 2022.

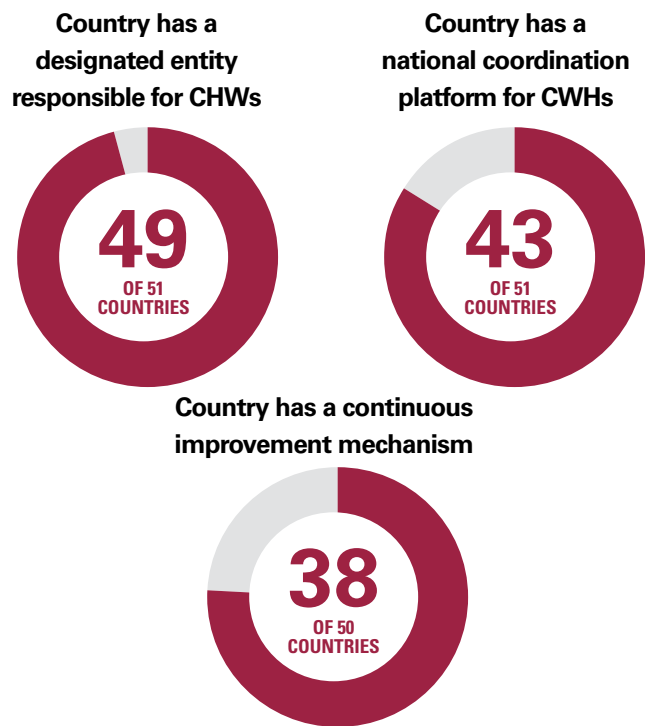
4.2.2 GOVERNANCE STRUCTURES AND COORDINATION

Figure 9: Governance structures for community health



96 per cent of Member States have designated entities with responsibility for community health, and more than three quarters indicated the presence of a national coordinating platform for their community health system.

Figure 10: Oversight mechanism for community health

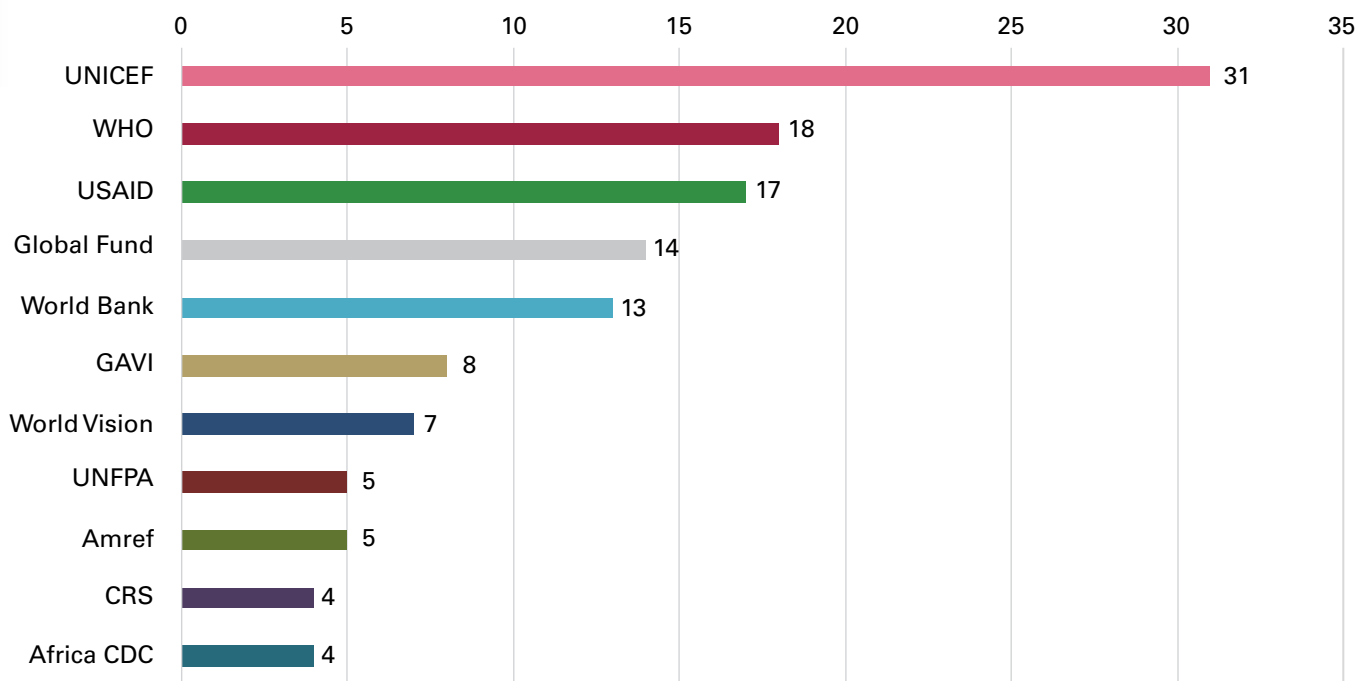


Many Member States have assigned responsibility for community health and CHWs to units within Primary Health Care (PHC) or Public Health departments (see, for example, “Community Health Program under Primary Health Care Department” or “Service de Coordination et du Suivi des Soins de Santé Primaires”, while several responses specify specialized divisions dedicated solely to community health, such as “Direction de la Santé Communautaire”. A few units are also lodged within ministries’ health promotion and prevention departments. The variation in naming conventions also highlights how community health is positioned within broader health governance structures.

4.2.3 PARTNERSHIPS

Most Member States continue to work closely with numerous external partners in the running and financing of community health programs. UNICEF is present in most Member States, highlighting its pivotal role in strengthening community health on the continent. Figure 11 reflects the external partners listed in four or more Member States. The full list of partners records 200 organizations.

Figure 11: Partner organizations supporting CHWs in four or more Member States



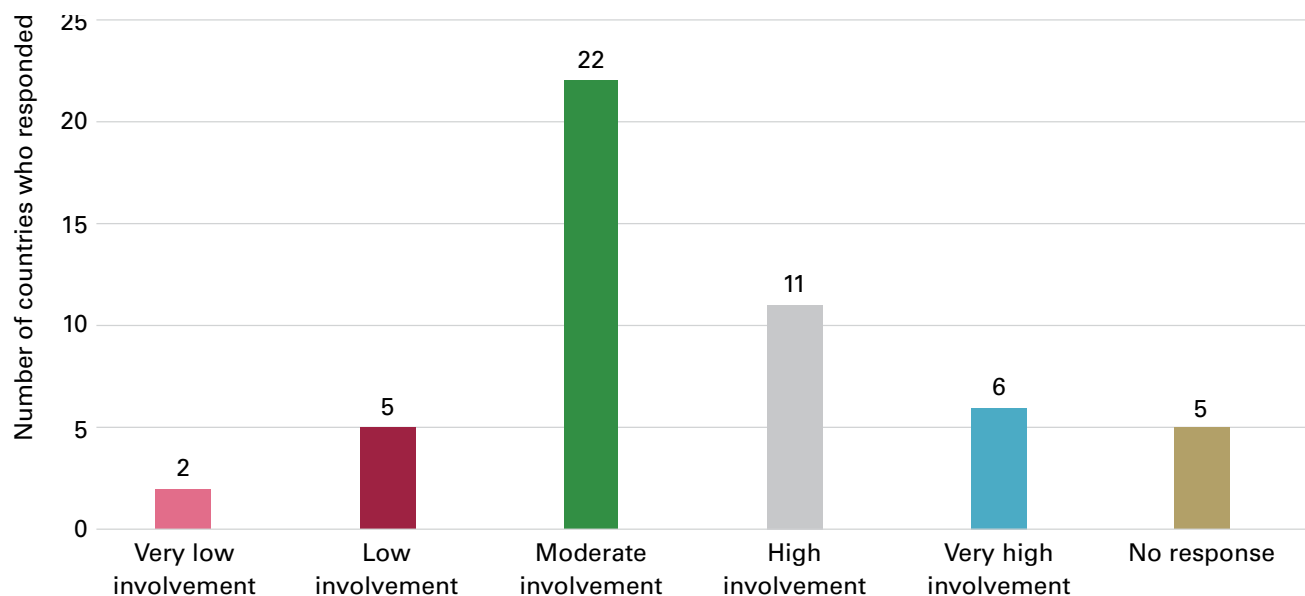
4.2.4 COMMUNITY ENGAGEMENT

Community engagement is not often discussed as a governance issue. However, with the growing recognition of the importance of alignment between community and health systems, processes and structures, which facilitate this alignment, community

engagement become an important governance topic.

Member States were asked to rank the involvement of communities in their countries' community health programs from very high to very low. The results show appreciable involvements and contributions:

Figure 12: Level of community involvement in community health programs



Responses listed a wide range of community contributions including, selection, social mobilization, cultural acceptance, non-financial motivation, active health promotion, advocacy and political support. The data reflects a deepening of community ownership

in several Member States, although some responses also highlight gaps in awareness or engagement. A minority of responses indicate limited knowledge or no identifiable contributions, which points to areas needing better community integration.

Table 1: Types of community contributions to community health programs

COMMUNITY CONTRIBUTIONS
Community Participation in CHW Selection
Communities are actively involved in the recruitment or election of CHWs, ensuring local trust and alignment with social dynamics.
Non-Financial Motivation and Social Recognition
Many responses highlight non-monetary incentives such as public recognition, social status or moral support as key contributions from communities.
Health Promotion and Behavior Change
Communities support early health-seeking behaviors, participate in promotion and education activities, and engage in referral processes.
Social Mobilization and Peer Support
There is widespread mention of community mobilization for health campaigns, peer support groups (e.g., mother-to-mother) and community feedback mechanisms.
Support for Broader Determinants of Health
Some communities also provide support for water, hygiene and sanitation improvements, reflecting a holistic view of health.
Advocacy and Political Support
Community members help with advocacy efforts that influence policy decisions and secure resources for CHW programs.

4.3 FINANCING COMMUNITY HEALTH PROGRAMS

4.3.1 FUNDING AND ALLOCATION OF RESOURCES

The survey results reflect both the continuing vulnerability of community health systems as the foundation of national health systems, as well as increasing efforts to increase domestic resources.

Table 2 to the right shows the enormous variability in dedicated community health expenditure per capita across the continent.

Table 2: Average per capita budget on community health in US\$

AVERAGE PER CAPITA BUDGET (US\$) FOR COMMUNITY HEALTH (N=38)	
Mean	US\$4.77
Median	US\$1.66
Minimum	US\$0.005
Maximum	US\$33.61

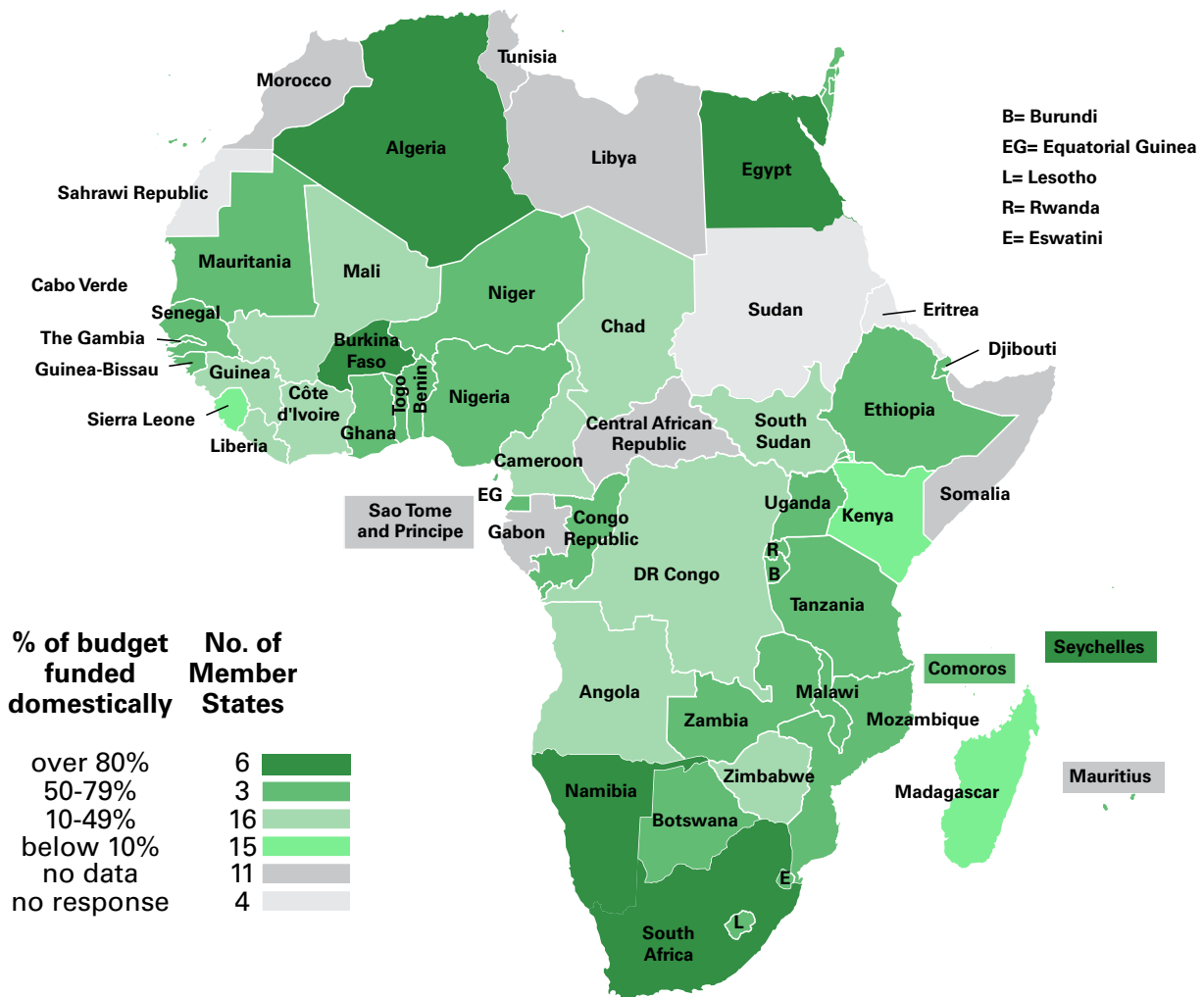
Per capita budgets, as well as total annual budgets by country can be found in Appendix A.

Increasing domestic funding is a strategic priority and target to strengthen sustainability and integration of community health programs. Several Member States lead the way. Algeria, Egypt, Burkina Faso, Namibia, Seychelles and South Africa reported that more than 80 per cent of their budgets are funded domestically, while Kenya, Lesotho and Niger have reached a 50 per

cent benchmark. However, most Member States (34 out of 40, or 85 per cent) rely on donor funding for 49 per cent or more of their community health budgets, and 15 Member States domestic funding falls below 10 per cent (see Figure 13 below).

The list of partners funding community health programs is again led by UNICEF, while the full list of funders comprises 122 organizations.

Figure 13: Percentage of community health budget funded domestically

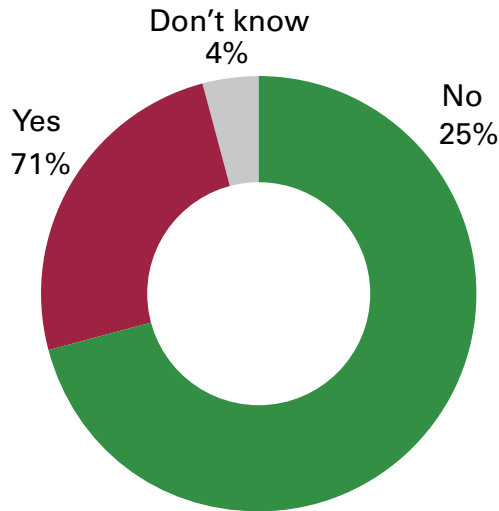


4.3.2 FINANCIAL TRACKING AND PLANNING

Seventy-one per cent of Member States (36) map their community health budgets and expenditures to priorities articulated in their national health strategy, reflecting increasing alignment of community health with national priorities and plans (see Figure 14). However, only 23 Member States (45 per cent) reported

established processes to track budget allocations and expenditures for community health, suggesting a need for strengthening fiscal management and oversight, both to improve accountability and efficiencies, and to provide better foundations for financial planning and the rational allocation of resources.

Figure 14: Community health budget allocation and expenditure mapped to priorities in the national health strategy (n=51)



The weakness in tracking systems is mirrored in financial planning indicators: only 19 Member States currently have an investment case and 21 have a financial sustainability plan for community health (full list of Member States can be found in Appendix B). This highlights the urgency to strengthen financial planning and management capacities in ministries of health.

4.4 MANAGEMENT OF THE COMMUNITY HEALTH WORKFORCE

The management of the community health workforce encompasses a wide array of human resource functions, including aspects of cadre definitions and differentiation, selection, training and supervision; scopes of service packages provided; equipment and supplies; and finally forms of financial and non-financial compensation. Survey findings under these headings will in turn be presented below. In summary they show that, despite differences in nomenclature, training, and employment status, the defining

features of CHWs across Africa are their community embeddedness, their function as trusted health intermediaries, and their ability to deliver essential health services at the grassroots level, making them indispensable to primary health care and the pursuit of universal health coverage.

7.1.1 CADRE DEFINITIONS

Africa CDC recently adopted a continental definition of CHW³, which is reflected in the glossary at the beginning of this document:

Male or female community members who are selected by the communities they reside and serve, and are trained, paid, equipped and protected to perform critical work to prevent, detect, promote and respond to disease outbreaks, and are occasionally supervised and tasked by health professionals to support delivery of continuous, effective, affordable, available, integrated, resilient, culturally appropriate and gender-sensitive health services.

The document furthermore provides additional definitions for *Professionalized CHWs* (Pro-CHWs) and *Community Health Volunteers* (CHVs), also reflected in the glossary.

This guidance on concepts and terminologies will greatly assist clarification and alignment of appellations and definitions in future.

Currently, CHWs are known by many different names across the continent, and many Member States have more than one category of CHW.

³ AU & ACDC (2024). **Community Health Systems: Concepts and Terminologies**. Division of Community Health System and Integrated Service Delivery. Africa Center for Disease Control and Prevention (Africa CDC) Addis Ababa, Ethiopia

Figure 15: Appellations of CHWs



Across Member States, the definitional characteristics of CHWs reveal both shared core elements and notable contextual adaptations. Importantly, CHWs are members of the communities they serve, often selected by the community itself based on trust, commitment, and sometimes specific criteria such as literacy, age, or gender preference. Their primary role is to bridge the gap between communities and the formal health system, delivering a spectrum of services that include health promotion, disease prevention, basic curative care, and support or referral services. Increasingly CHWs are formal, salaried cadres and are remunerated in some form.

In some contexts, CHWs are stratified into different types or cadres, such as “community relays,” “health extension workers,” or “multi-purpose health agents,” each with distinct training levels and scopes of work. Supervision and integration into the health system are emphasized, with CHWs often working under the technical oversight of health personnel and community leaders.

The full list of definitions provided by AU Member States can be found in appendix C.

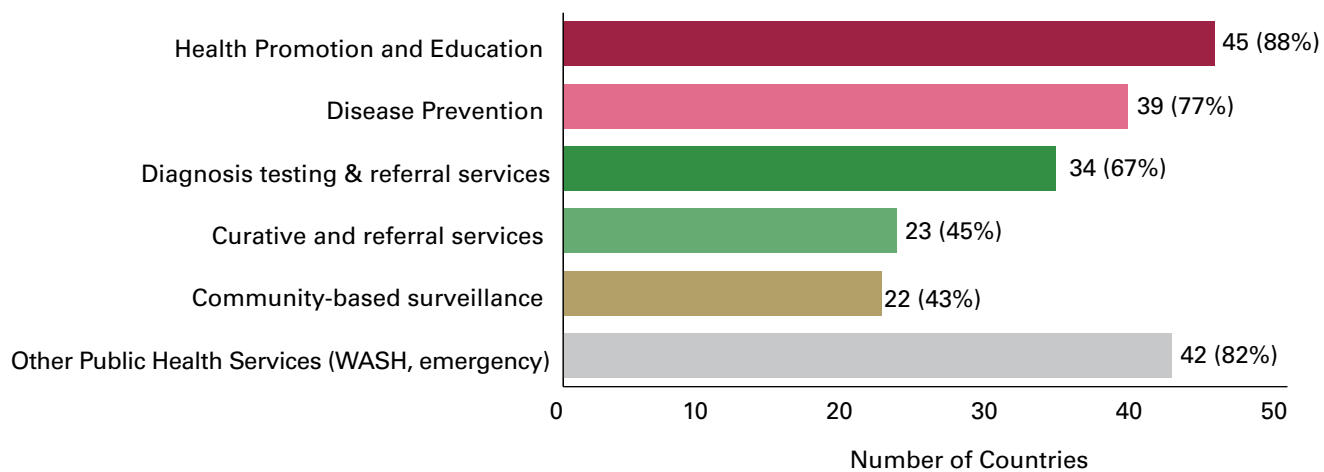
4.4.2 SERVICE PACKAGE

Survey results reflect the wide and often very comprehensive range of services rendered by CHWs in most Member States, covering community health surveillance, health promotion and prevention, diagnostics and referrals, as well as curative simple services. Table 6 summarizes which service packages are provided across Member States. While some, particularly in the north of the continent, still focus primarily on health education, many Member States additionally include contact tracing, full Integrated Management of Childhood Illness (IMCI), mental health, gender based violence support, identification and treatment of non-communicable diseases, and public health emergencies in their scope. As their scope of work has widened due to increased needs and chronic HR shortages in most Member States, the recognition of CHWs as an essential and foundational part of the health workforce has grown, in turn leading to the alignment of support, finance and governance arrangements currently under way. The detailed breakdown of services provided can be found in appendix D.



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Figure 16: Service packages provided by CHWs

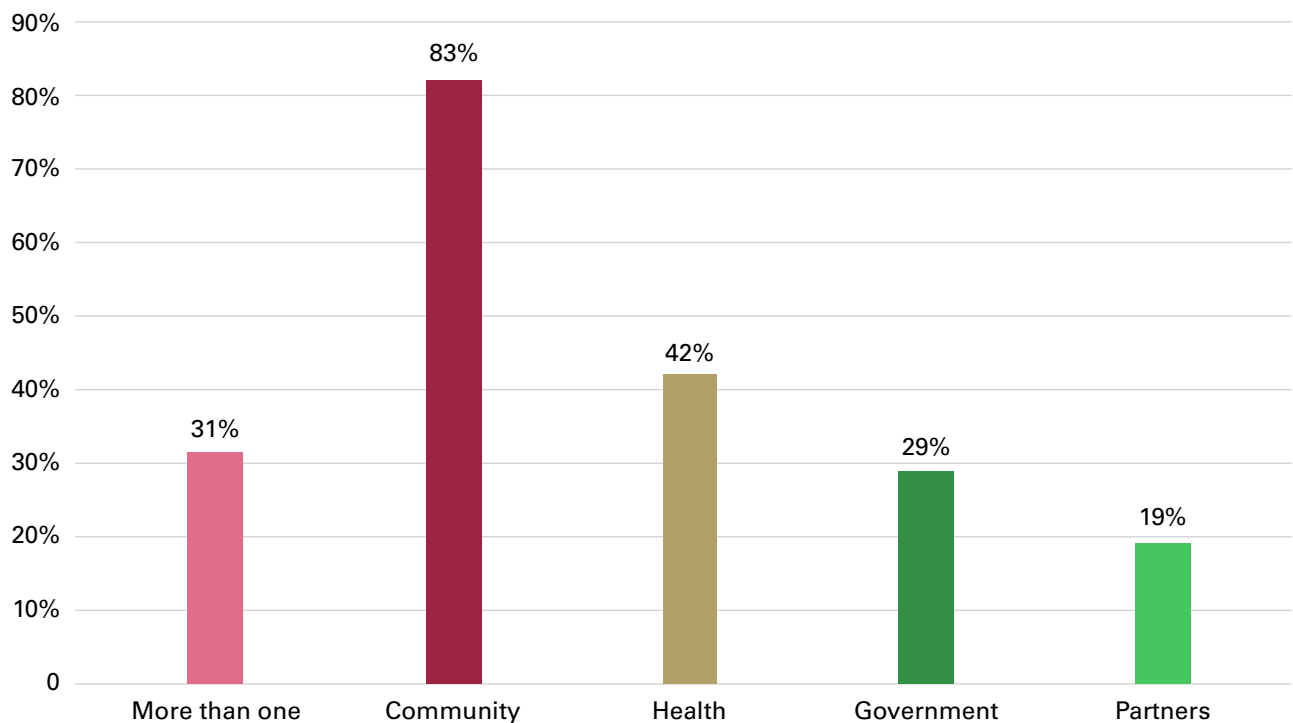


4.4.3 SELECTION PROCESS AND CRITERIA

In most Member States CHWs are selected by communities and health facilities in the area they serve.

Very often, more than one stakeholder group is involved in selection, as reflected in figure 17 below.

Figure 17: Stakeholder groups involved in CHW selection



Community involvement in selection processes takes different forms:

- **Nomination and voting:** In several Member States, community members nominate candidates and vote to select CHWs through consensus or elections.
- **Selection committees:** Some Member States form selection committees that include community representatives, local leaders, and health officials.
- **Criteria-based selection:** Communities often use predetermined criteria to identify suitable candidates, such as literacy, local knowledge, and commitment to serve.
- **Public meetings:** Many Member States organize public gatherings or assemblies where candidates are presented and selected by the community.
- **Verification and endorsement:** In some cases, communities verify and endorse the selected CHWs.
- **Traditional leadership involvement:** Traditional leaders like chiefs often play a key role in facilitating the selection process.
- **Local governance structures:** Existing local governance structures, such as village development committees, are sometimes involved in the selection.
- **Gender considerations:** some Member States emphasize selecting both male and female CHWs to ensure gender balance.
- **Transparency and consensus:** Many Member States stress the importance of a transparent and consensual selection process to build community trust and collaboration.

The most commonly cited selection criterion is minimum educational attainment. Many Member States today require CHWs to have either basic literacy and numeracy skills, or to have completed primary or secondary school. There is a discernible trend towards higher educational requirement compared to years when CHWs were only expected to be able to read and write in their local language⁴.

Some Member States have explicit upper and lower age limits (often between 18 and 45 years of age), while others speak about physical and emotional maturity to handle health responsibilities as a criterion.

Importantly, many Member States specify that CHWs must be nominated or selected by the community and known to be trustworthy, respected, and engaged in local affairs.

Other criteria mentioned include:

- Motivation and voluntarism (interest in helping the community)
- Previous health experience or basic training in health services
- Residency within the area of assignment

4.4.4 TRAINING AND PROFESSIONAL DEVELOPMENT

The academic literature is replete with evidence emphasizing that the success of community health programs hinges on the quality of training and the importance of refresher training. It is a major step towards mainstreaming and strengthening these programs that 86 per cent of AU Member States now have standardised training programs and 65 per cent report the existence of refresher training.

Table 3: Training and career advancement

TRAINING AND CAREER ADVANCEMENT	
Standardised training curriculum available (n=51)	44 (86%)
Refresher training available (n=51)	33 (65%)
CHWs deployed after pre-service training (n=41)	67%
% of Member States that have mechanisms for career advancement for CHWs (n=51)	16 (31%)

Although the evidence is less complete (only 41 Member States responded), 67 per cent of CHWs receiving pre-service training were also deployed. This gap between training and deployment should be explored further, as it indicates some gaps in deployment effectiveness.

Detailed data on refresher training did not provide clear trends. While 33 Member States reported that refresher training had been offered in the previous year, the numbers attending varied from just a few hundred in some countries to 50,000 and more CHWs in others.

Providing opportunity for career advancement to CHWs is another well-established predictor of program success and sustainability as the opportunity for career advancement is closely linked to CHW motivation, job satisfaction and turn-over. Currently only 16 Member States make provision for career advancement, flagging another topic for attention and improvement.

4.4.5 SUPERVISION

Like training, supervision is considered crucial for optimizing the performance and impact of community health worker programs. While there is no universal “best practice,” the evidence points to the importance of supportive, regular, and skills-based supervision that is well-integrated with local health systems.

4 For comparison see WHO (2007). *Community Health Workers. What do we know about them?* Geneva.



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Table 4: Supervisory structure in place (n=47 (92%) Member States)

SUPERVISORY STRUCTURE IN PLACE (NO. OF MEMBER STATES)	N = 47 (92%)
Weekly	11
Monthly	33
Irregular or unknown	3

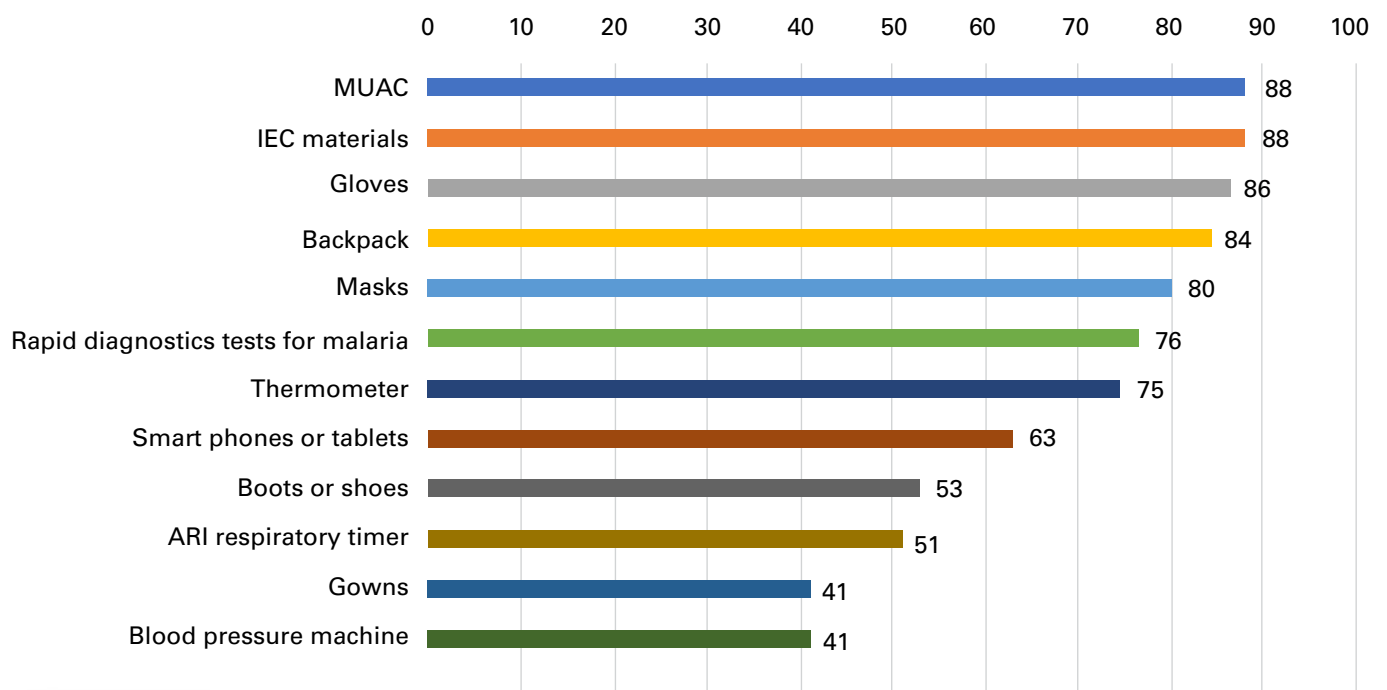
The recognition of the importance of supervision is reflected in the fact that 92 per cent of Member States reported having supervisory structures

in place. In most cases supervision is organized through health facilities, and in some cases through senior community health supervisors. The entities responsible for supervision are listed in appendix F.

4.4.6 EQUIPMENT AND SUPPLY CHAIN

Forty-six Member States reported providing their CHWs with supply packages, which contain the following items:

Figure 18: Items included in the standard supply package provided to CHW by % of reporting Member States

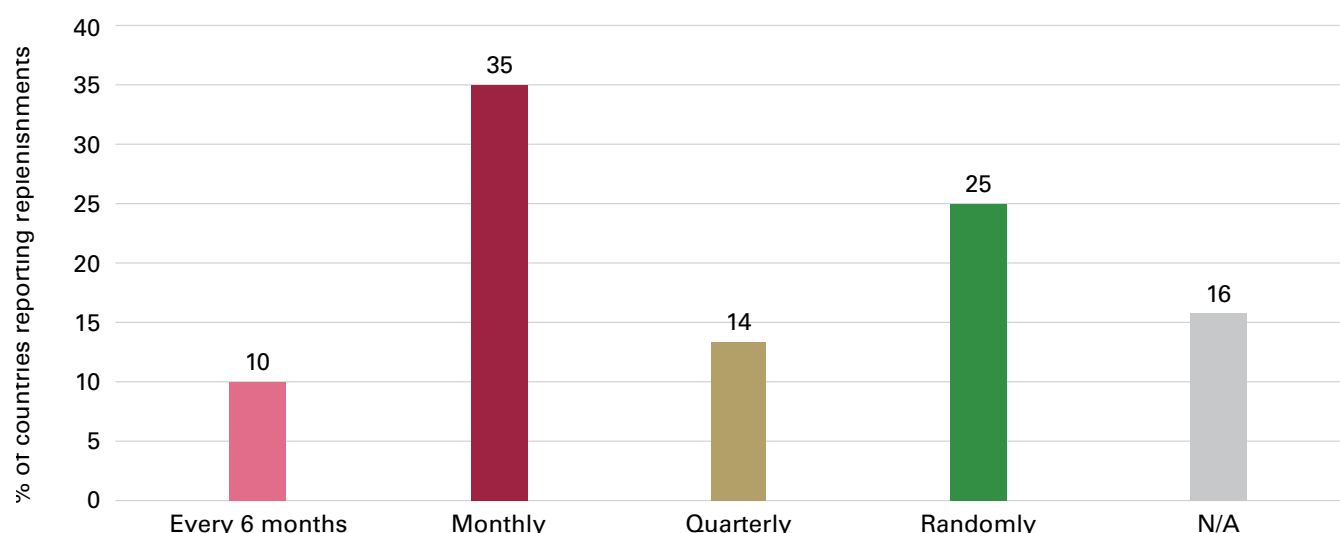


Seventeen Member States provided detailed open-ended responses listing a wide range of supply items. These include:

Table 5: Details of items included in supply packages

ITEMS INCLUDED IN SUPPLY PACKAGES	
1. Medical Equipment and Tools	Stethoscope, fetoscope, glucometer, specula, sphygmomanometer, delivery kits, dressing sets, pregnancy test kits, weighing scales, instrument trays, first aid boxes, timers, couches, examination lights, kidney dishes, PPE items: gloves, plastic aprons, face masks, biohazard containers and hand sanitizers
2. Medicines and Commodities	Antimalarials (e.g., ACT/Coartem), ORS, zinc, amoxicillin, folic acid, paracetamol, chloroquine, tetracycline and misoprostol, micronutrients: Vitamin A, iron-folate, albendazole, family planning supplies: Depo-Provera, condoms, pills, Implanon, Vaccine carriers, ice packs and cold boxes for immunization support
3. Reporting and Documentation Tools	Job aids, flipcharts, advice cards, monitoring workbooks, mobile phones for digital reporting via platforms such as cEMR (community electronic medical records)
4. Transport and Storage	Bicycles, motorbikes, backpacks for transport, Medicine cabinets, metallic boxes and lockable storage units
5. Protective and Weather Gear	Raincoats, umbrellas, gumboots, torches, solar lamps, hats, plastic aprons, uniforms, badges and reflective vests/gilets
6. Health Promotion and Educational Materials	Health education flipcharts, key message booklets, IEC/CCC materials, manuals for community relays, counting beads, jugs, cups for ORS preparation

Figure 19: Frequency of stock replenishments





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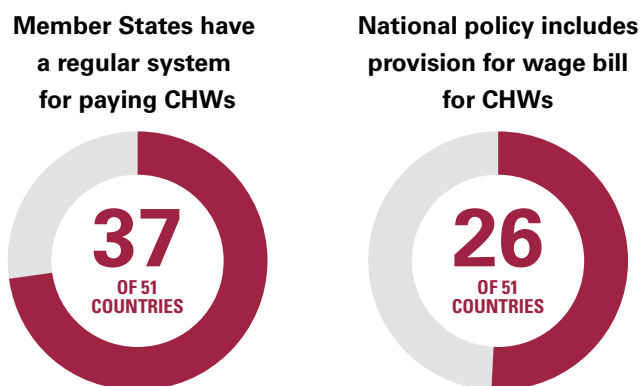
Stock availability is known to play an important role not only in effective service provision, but also in strengthening community embeddedness and trust: communities lose faith, if CHWs cannot perform their duties because they do not have equipment and supplies. While 30 Member States (59 per cent) reported regular stock replenishments, a substantial number (13) reported random replenishments, flagging an area where improved coordination and oversight could improve program performance and effectiveness.

4.4.7 COMPENSATION

The WHO Guidelines recommend “remunerating practicing CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they

undertake”. The need to pay CHWs for their services has become more widely accepted in recent years, as is evidenced in this survey. 73 per cent of Member States (n=37) report having a regular payment system for CHWs, and 51 per cent (n=26) report provisions for paying CHWs through the government wage bill.

Figure 21: Remuneration systems



However, salaries vary dramatically across Member States, from a minimum of US\$10 to a maximum of US\$432 per month (and it should be noted that only 37 (73 per cent) Member States provided data on payment amounts). There was no substantial difference in payment between male and female CHWs reported, but only 27 per cent of Member States keep sex-aggregated data.

Member States also employ different payment modalities: 89 per cent provide all or some of their compensation as fixed payments; 57 per cent employ performance-based modalities; 22 Member States reported a mix of fixed and performance-based payment modalities.

Figure 20: Payment modalities

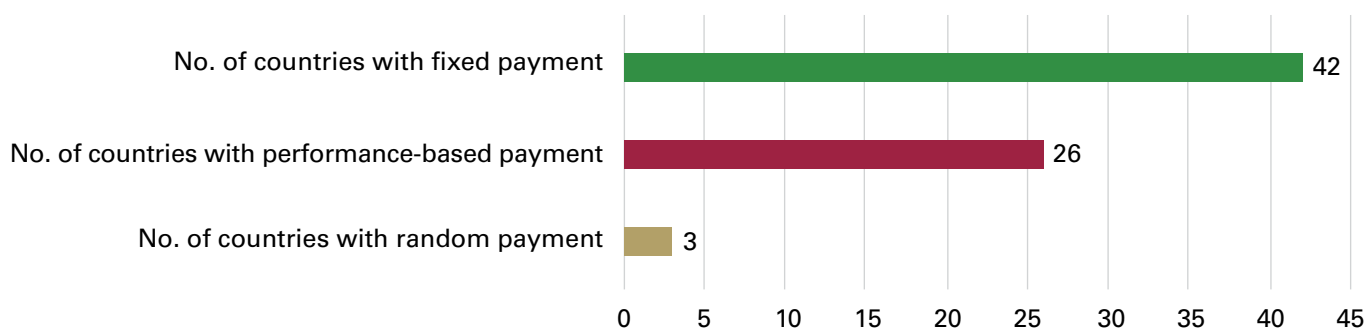
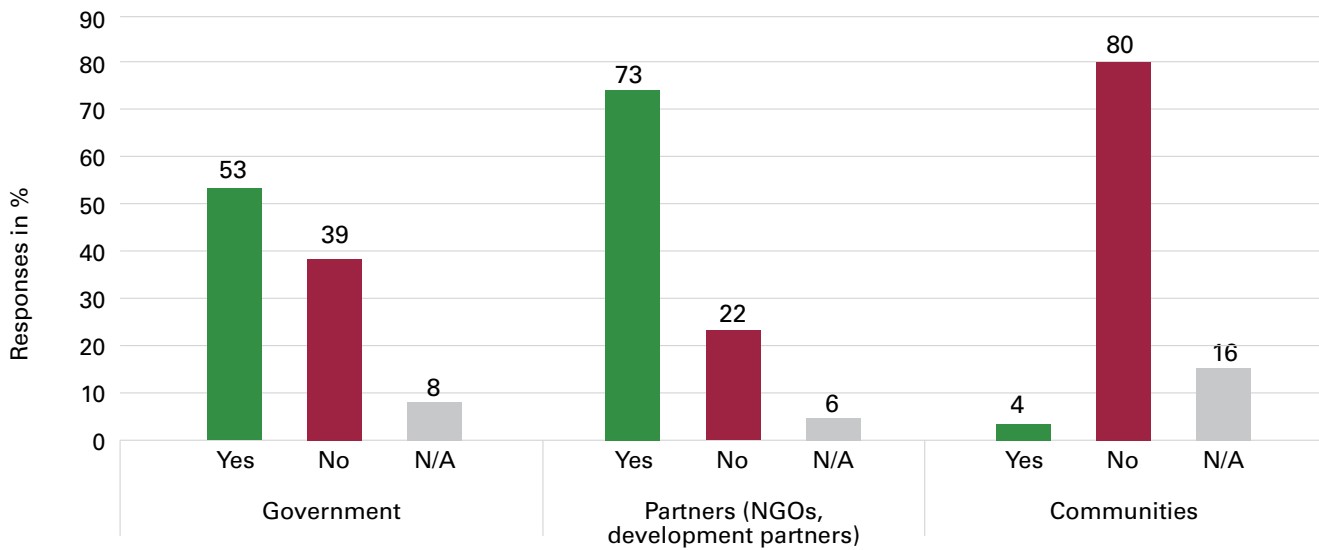


Figure 22: Funding sources of CHW salaries



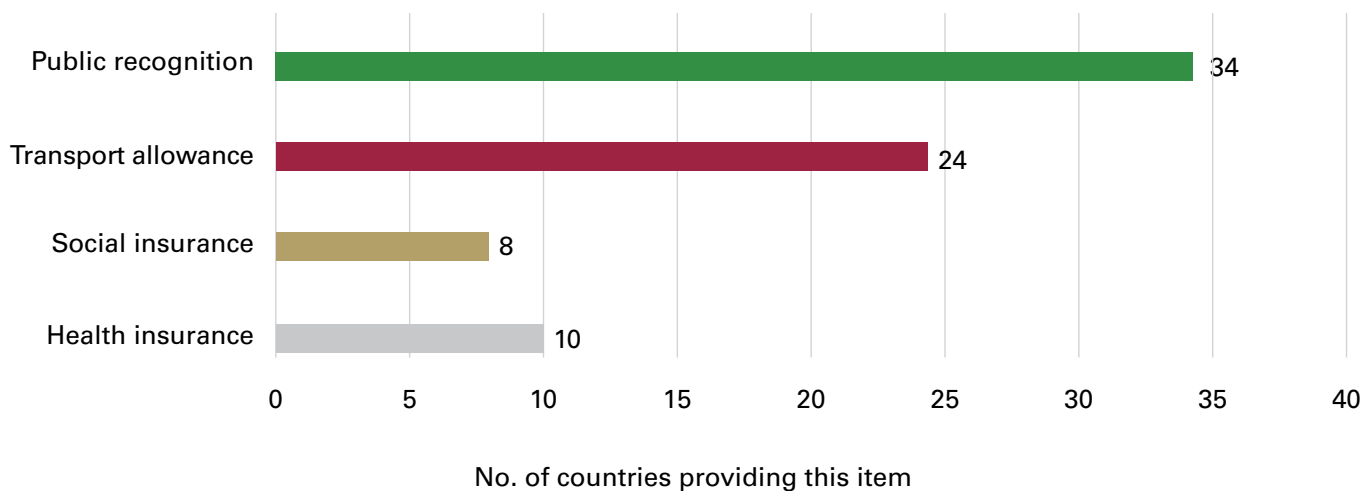
Note: (n=47)

Funding sources are diverse:

- 43% rely entirely on partners
- 36% use a mixed model
- 20% are fully government-funded

Twenty-five Member States reported also providing non-financial compensation, but few have disaggregated these by gender. Non-financial compensation may come in a variety of forms, but typically includes transport allowances, health and social insurance. Many Member States also mentioned public recognition as a non-financial incentive.

Figure 23: Types of non-financial compensation provided

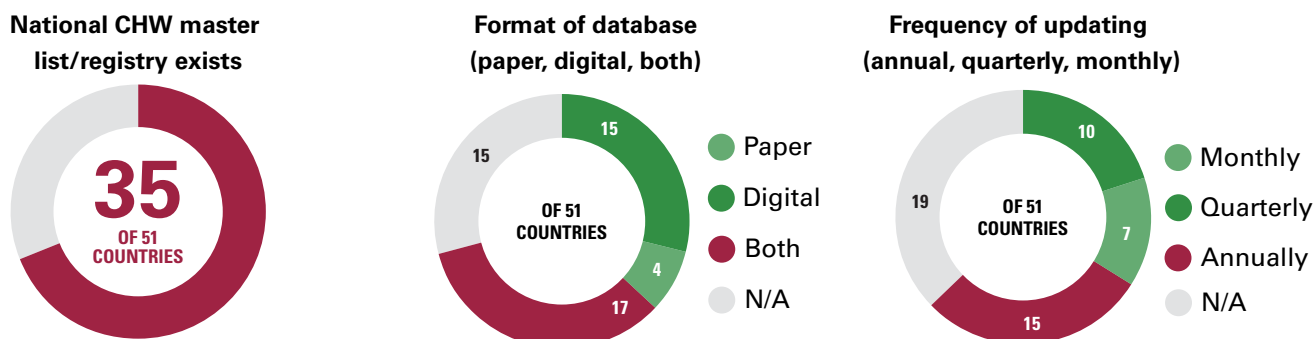


4.5 HEALTH INFORMATION SYSTEMS AND DIGITIZATION

4.5.1 DATABASE FOR CHWS

Most Member States (69 per cent) today have a master register of CHWs, which in many countries is updated annually or quarterly (see Figure 24 below).

Figure 24: Availability of CHW database and master register



Thirty-one Member States reported that their database captures the geographical distribution of CHWs, and 23 Member States capture CHW training needs.

4.5.2 DATA AVAILABILITY AND USE

Results in this survey suggested that the information systems situation is improving. Forty Member States (78 per cent) indicated that they have a community-based health management information system (C-HMIS), and 39 Member States (77 per cent) indicated that the data collected by CHWs is integrated into the national health information system (such as DHIS2).

Table 6: Existence of C-HMIS in Member States

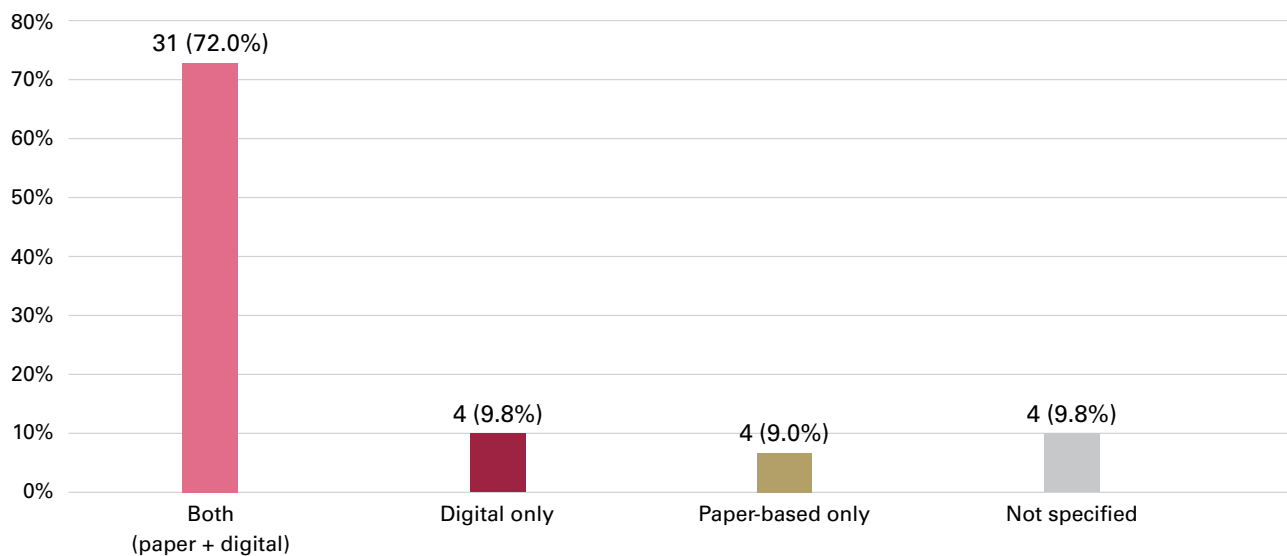
EXISTENCE OF COMMUNITY-BASED HEALTH MANAGEMENT INFORMATION SYSTEM (C-HMIS) IN MEMBER STATES		
	No. of Member States responded	Percentage
No	11	39
Yes	40	78

Table 7: Community health information integrated into national HIS

COMMUNITY HEALTH INFORMATION INTEGRATED INTO NATIONAL HIS		
	No. of Member States responded	Percentage
No	12	24
Yes	39	76

Member States are rapidly transitioning to digital information systems like eCHIS, DHIS2, or mHealth applications, though many face scaling and uptake challenges. Most Member States describe using hybrid systems, where frontline health workers collect data using paper forms, which are later compiled and digitized at district or national levels. Fragmentation due to multiple parallel tools, lack of interoperability between systems, and lack of government ownership remains a challenge, although some Member States have made substantial progress with integration, e.g., into DHIS2.

Figure 25: Formats of C-HMIS (n=43)



In further elaborating the state of c-HMIS systems, many Member States describe the use of hybrid systems, where frontline health workers collect data using paper forms, which are later compiled and digitized at district or national levels. Several Member States are shifting toward digital platforms like DHIS2, COMMCARE, and custom applications like ALAFIACOM for real-time data access and mobile-based reporting. This shows innovation in digitizing community data collection, validation, and real-time access.

Common challenges reported include data accuracy, limited trained personnel, and insufficient digital infrastructure, as well as fragmentation due to multiple parallel tools and lack of interoperability between systems.

Many Member States emphasized the need for stronger government ownership and oversight, particularly where systems are still managed by development partners and NGOs

Asked how the data within the community-based HMIS systems is used, a few key themes emerged:

- 1. Decision-making and health system planning**
 - A dominant theme was the use of CHMIS data to guide national and local planning, intervention design, and advocacy.
- 2. Donor reporting and accountability**
 - Some Member States specifically highlighted the role of CHMIS in donor reporting, reflecting its value in global health partnerships.
- 3. Data validation and multilevel oversight**
 - Regular monthly or quarterly validation of community health data by health centers and districts was emphasized.
- 4. Monitoring and performance feedback**
 - Tools such as community scorecards are used to follow up on data anomalies and ensure service accountability.

4.6 COMMUNITY HEALTH BOTTLENECKS AND SOLUTIONS

4.6.1 CHALLENGES IDENTIFIED

African governments face a wide range of challenges in implementing effective community health programs. These challenges, documented across numerous Member States, can be broadly categorized into issues of financing, governance, workforce, infrastructure, data management, and community engagement.

FINANCIAL CONSTRAINTS:

The most recurrent challenge is inadequate and unsustainable financing. Many Member States, such as Angola, Chad, Liberia, and Zimbabwe, rely heavily on donor funding to sustain their community health programs. This dependency makes programs vulnerable to disruptions if external support diminishes. Even in Member States with government support, like Uganda and Ghana, the allocation is often insufficient. Inadequate domestic investment limits the ability to pay salaries, procure essential supplies, and maintain supervision and logistics systems.

WORKFORCE CHALLENGES:

A severe shortage of trained and motivated CHWs affects nearly all Member States. Recruitment, training, retention, and compensation of CHWs are critical issues. For example, Ethiopia reports high attrition and declining motivation among Health Extension Workers (HEWs), while Egypt cites retirement and halted hiring. In many nations, such as Djibouti, CHWs lack clear career paths, and in others like Kenya, South Africa, and Malawi, training is inadequate or non-accredited. Low pay, volunteer-based models (as in Comoros and The Gambia), and poor working conditions exacerbate attrition.

WEAK GOVERNANCE AND COORDINATION:

Fragmented governance structures, overlapping roles of stakeholders, and lack of clear regulatory frameworks hinder program implementation. Somalia and South Sudan exemplify how weak coordination between partners and ministries leads to inefficiencies and duplication of efforts. In Tunisia and Cameroon, the absence of clear legal

recognition for CHWs adds to the ambiguity. Poor leadership at sub-national levels also undermines accountability and program oversight.

INFRASTRUCTURE AND LOGISTICS:

Inadequate logistical support and weak supply chains impede service delivery. Member States like Egypt, Uganda and Sierra Leone struggle to deliver supplies to remote areas and manage inventories efficiently. Transportation issues (Eritrea, Ethiopia, South Sudan), limited health posts (Malawi, Ethiopia), and poor roads (South Sudan) further restrict outreach.

DATA AND DIGITALIZATION DEFICIENCIES:

While digital health is increasingly recognized as essential, many Member States lack the infrastructure, tools, and training for effective data collection and utilization. Egypt and Uganda highlight low digital literacy among CHWs and poor interoperability between systems. Benin, Madagascar, and Guinea report challenges with digital data collection and system integration. This hampers evidence-based decision-making, monitoring, and evaluation.

COMMUNITY ENGAGEMENT AND TRUST:

Many governments struggle to meaningfully involve communities in health programs. Structural barriers, as seen in Angola and Tunisia, and cultural factors, like in Sierra Leone, limit the effectiveness of CHWs. Where CHWs are not residents or lack community acceptance, outreach and health promotion are weakened.

PROGRAM SCALE AND EQUITY:

Scaling programs to achieve universal coverage remains elusive. South Sudan and Uganda report low national coverage of CHWs relative to their populations. Marginalized and rural communities often remain underserved due to infrastructure limitations and resource constraints.

In summary, African community health programs face systemic, logistical, and human resource challenges that require coordinated investments in financing, governance, digital systems, and CHW professionalization to achieve lasting impact.

4.6.2 SOLUTIONS IMPLEMENTED TO ADDRESS CHALLENGES

AU Member States have adopted a wide array of solutions to address the significant challenges in implementing community health programs. These solutions target financing, workforce development, governance, digitalization, community involvement, and health system integration.

STRENGTHENING GOVERNANCE AND POLICY FRAMEWORKS:

Several Member States have taken strategic steps to institutionalize community health. Djibouti, for instance, established a dedicated community health division within its health ministry and developed its first national community health policy and strategic plan. Similarly, South Africa is updating its CHW policy framework and finalizing a business case to justify funding. Somalia and South Sudan are harmonizing fragmented community health programs through revised strategies and integration frameworks, aiming to consolidate services and reduce inefficiencies.

EXPANDING AND FORMALIZING CHW CADRES:

To address workforce shortages, Member States like Egypt and South Sudan are extending contracts for retired health workers and integrating diverse community health cadres into unified programs. Rwanda has implemented a new salaried CHW cadre and performance-based incentives to improve retention. Kenya, Uganda, and Ghana are focusing on professionalizing CHWs through standard training curricula, occupational standards and updated implementation guidelines.

IMPROVING FINANCING AND RESOURCE MOBILIZATION:

Many governments are working to reduce dependence on donors by increasing domestic financing. Ethiopia introduced Community-Based Health Insurance (CBHI) to generate local revenue, while Member States like Madagascar and Senegal are integrating community health priorities into broader health sector grants from organizations like the Global Fund and World Bank. Côte d'Ivoire and Zimbabwe have launched national investment compacts and budget frameworks that include explicit provisions for community health.

ENHANCING SUPERVISION, MOTIVATION AND CAREER DEVELOPMENT:

Training, supervision, and career development have been prioritized. For instance, Congo developed a national supervision guide, while Guinea-Bissau and Lesotho focus on fair compensation and role definition. Liberia created an e-learning platform for continuous professional development. Sierra Leone and South Sudan are introducing biometric registration and standardised training materials to ensure consistent supervision and performance tracking.

DIGITALIZATION AND DATA INTEGRATION:

Several governments are embracing digital solutions to enhance monitoring and service delivery. Egypt, Malawi, and Côte d'Ivoire have pilot digitalization projects underway. Kenya and Uganda are enhancing their electronic community health information systems (e-CHIS) and training CHWs in digital literacy. Rwanda and Guinea-Bissau are rolling out integrated digital data platforms to streamline service delivery and enable real-time decision-making.

COMMUNITY ENGAGEMENT AND LOCAL GOVERNANCE:

Local ownership and community engagement are central to many reform efforts. Angola and Côte d'Ivoire are advocating for municipal involvement and establishing forums to engage mayors and local leaders. Seychelles has launched public health campaigns to raise awareness of personal health responsibilities, while Sierra Leone and Ethiopia emphasize community mobilization to build trust and accountability.

SUPPLY CHAIN AND INFRASTRUCTURE IMPROVEMENTS:

Improving logistics is another focus area. Eritrea has innovatively used camels and donkeys for rural transport, while Sierra Leone and Liberia are enhancing procurement systems to maintain supply chain continuity. Namibia and Zambia are investing in essential equipment and transportation to support CHWs in the field.

In conclusion, African governments are employing multifaceted and country-specific approaches to improve community health programs, with increasing emphasis on sustainability, integration, and local empowerment.



5. DISCUSSION

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The 2024/5 Community Health Landscape Survey affirms that community health systems (CHS) in Africa have evolved from fragmented, often project or disease-driven programs into increasingly institutionalized, policy-driven components of national health systems. These shifts mirror and support Africa CDC's strategic vision as outlined in its ***Community Health Workforce Strategic Priorities (2023–2027)***, which emphasize integrated, resilient, and people-centered health systems built on a foundation of community engagement and data-driven policy implementation.

A central achievement highlighted in the survey is the deployment of just over one million community health workers (CHWs) across 48 Member States – 50 per cent of the AU's 2-million target. This expansion aligns with Africa CDC's strategic emphasis on strengthening the public health workforce as a first-order priority. However, country-level discrepancies in CHW density (ranging from over 6 per 1,000 population to well under 1 per 1,000) suggest that workforce scale-up alone is insufficient. Rather, contextual workforce modeling – accounting for geography, workforce composition, scope of work, and local disease burden – must be prioritized, keeping in mind WHO and Africa CDC modeling, which shows that a density of 25.34 CHWs per 10,000 people is needed to achieve 70 per cent UHC service coverage and 36.20 CHWs per 10,000 people would achieve 100 per cent UHC service coverage.

Governance improvements, including the establishment of designated CHW oversight entities in 96 per cent of Member States and community health strategies in 84 per cent, reflect strong national commitment to institutionalizing CHS. However, too many strategies remain outdated or uncosted. While Africa CDC has supported this policy infrastructure, there is now a need to ensure that such strategies are not only current but actionable, aligned with broader national health plans, and equipped with robust implementation and monitoring mechanisms.

Community engagement, a foundational principle of Africa CDC's people-centered approach, also shows notable progress. Most Member States report high levels of community involvement in CHW recruitment, supervision, and social mobilization. This embeddedness ensures cultural acceptability and facilitates trust. Nonetheless, some Member States exhibit weak or inconsistent mechanisms for sustained engagement, indicating a need for more formalized community governance structures that foster two-way accountability.

The financial landscape, too, shows great variability across the continent. Several Member States have developed strong fiscal environments, providing continental learning opportunities, but the majority remain fragile. The median annual per capita expenditure on community health is only US\$1.66 (mean=US\$4.77), with significant disparities across

Member States. Despite 71 per cent of Member States mapping CHW expenditures to national strategies, only 45 per cent track allocations, 37 per cent have investment plans, and 41 per cent have sustainability frameworks. Six Member States now fund 80 per cent or more of the community health budget domestically, but the great majority continue to rely on donor funding for more than half of their CHW budgets, underscoring the sector's vulnerability to shifting external priorities. These findings reinforce the urgency of domestic resource mobilization, improved financial tracking, integration into national fiscal frameworks, and innovative co-financing mechanisms such as pooled funding or community-based insurance as outlined in Africa CDC's "Africa's Health Financing in a New Era" concept.

The professionalization of CHWs remains uneven. While 68 per cent of Member States recognize CHWs as a formal cadre, significant gaps remain in legal protections, salary integration, and career pathways. Africa CDC's standardization of terminology – differentiating Pro-CHWs from CHVs – is a welcome development that can help Member States clarify roles, training, and employment terms. Still, training remains highly variable in duration and scope, and refresher programs are often absent. Standardised regional competencies, peer learning platforms, and accreditation mechanisms can help align CHW quality while allowing for local flexibility. Again, there are great continental learning opportunities, by highlighting and disseminating lessons from Member States that have developed strong policies and practices in institutionalizing and aligning remuneration, strengthening training and creating career pathways for CHWs.

The scope of CHW services continues to expand. Nearly all surveyed programs deliver maternal, newborn, and child health services, with many also provide in mental health, gender-based violence response, and chronic disease care. This widening mandate reflects both community needs and health system pressures. However, it necessitates investment in role clarification and cadre differentiation, expanded training, retooling, differentiated supervision models, and tailored service delivery packages to embed polyvalence, while avoiding overburdening CHWs.

Digital innovation presents a promising frontier. While CHW registries and data systems are growing, many Member States remain in nascent stages of digitization. Africa CDC's priority of enhancing data systems through national scorecards and dashboards can support real-time decision-making, performance monitoring, and evidence-led planning. Integrating CHW data into broader health information systems also enables improved resource allocation, surveillance, and community-level impact measurement.

Finally, the survey showcases Member States' resilience and innovation. Localized solutions – such as community engagement platforms, supply chain enhancements, and mobile data collection tools – underscore the adaptability of CHS. These innovations provide opportunities for continental learning, peer support, and South-South technical collaboration – pillars emphasized in Africa CDC's strategic orientation.

Overall, the 2024/5 survey underscores that strong structural and policy foundations have been laid, which can now be built upon and accelerated. The transformation of community health in Africa depends not only on increasing numbers but also on improving quality, ensuring financial sustainability, and strengthening systems of support. These imperatives resonate deeply with Africa CDC's commitment to UHC and its vision of empowered CHWs as frontline defenders of health security and equity.





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6. RECOMMENDATIONS

6.1 RECOMMENDATIONS FOR AU MEMBER STATES:

6.1.1 LEADERSHIP AND GOVERNANCE:

Across the continent, governments have taken important steps in affirming the centrality of community health within national health agendas. The presence of community health strategies in more than four-fifths of AU Member States reflects a decisive shift toward stronger institutional foundations. Yet, as the 2024/5 Community Health Landscape Survey highlights, too many of these strategies remain outdated or uncosted. Sustained efforts to update and cost these strategies – anchoring them in broader health sector plans, national fiscal frameworks, universal health coverage (UHC) priorities, and pandemic preparedness – will provide clarity on targets and timelines, while also guiding investment and accountability.

The momentum of political commitment remains a key driver of progress. Ministries of Health and Finance, when working in concert, can ensure that community health systems are positioned as national priorities. Sustained high-level engagement and advocacy – through policy dialogues, presentations of evidence on community health worker (CHW) contributions, and sharing of successful country models – can help support programs across political cycles.

In this evolving landscape, governance structures within Ministries of Health carry particular weight. The

establishment of dedicated community health units or divisions, equipped with clear authority and adequate resources, has already improved coordination in many Member States. Strengthening these units further, and empowering them to convene stakeholders, manage planning and training, and provide oversight, can transform them into the backbone of national community health systems. As Africa moves toward the AU’s target of 2 million CHWs by 2030, strong governance will remain the anchor for ensuring scale-up, integration, and accountability.

6.1.2 INSTITUTIONALIZATION AND INTEGRATION:

Community health workers are increasingly recognized as essential members of the health workforce, but gaps remain in formal integration. Roughly two-thirds of Member States now provide such recognition in policy, yet inconsistencies persist across remuneration, training, and supervision. When CHWs are formally embedded in national systems – backed by regulatory frameworks, job classifications, and financing structures – their contributions become more sustainable, their protections stronger, and their role more visible to communities.

Policies that harmonize recruitment, training, remuneration, and career development can reduce fragmentation and strengthen consistency across programs and partners. Without such harmonization, CHWs risk being pulled into vertical, donor-driven initiatives that dilute their role as Primary Health Care providers. Aligning CHW functions with national

health priorities and service delivery models ensures that their daily work responds to the real needs of communities while advancing system-wide goals such as UHC and health security.

The institutionalization of CHWs also requires a shift in perception: from volunteers or temporary solutions toward skilled, professionalized cadres who represent the frontline of health system resilience. This requires the establishment of regulatory bodies and associations for CHWs, as well as dialogue and alignment with other cadres working at community and primary levels, especially nurses. When fully integrated, CHWs can act as trusted community anchors, connecting households with health systems, while also supporting surveillance, prevention, and response to both endemic diseases and emerging threats.

6.1.3 FINANCING AND SUSTAINABILITY

There is an urgent need to establish or increase dedicated domestic budget lines for community health programs. While several countries have made strides to develop investment cases and financial sustainability plans and have increased domestic funding for community health programs, most Member States still depend on donors for more than half of their community health budgets. Expanding efforts to build the case for domestic financing, demonstrate cost-effectiveness, and strengthen advocacy with ministries of finance will be crucial.

Predictable financing can be achieved by integrating CHW remuneration into national wage bills, thereby embedding community health in the recurrent budget rather than leaving it dependent on external cycles. Investment in strong financial tracking systems and fiscal management processes and capabilities will also enhance accountability and ensure that scarce resources are used effectively.

Innovative approaches to financing are also gaining traction. Mechanisms such as community-based health insurance, pooled funds, or the integration of community health into broader sectoral grants can create diversified and sustainable funding streams. These models also foster resilience, enabling governments to protect CHW programs during times of fiscal stress. As Member States move toward the

AU's shared goal of 2 million CHWs and reaching their own national goals, sustainable financing will be the determining factor for long-term viability.

6.1.4 COMMUNITY HEALTH WORKFORCE DEVELOPMENT:

The professionalization of the community health workforce is advancing, though unevenly, across the continent. Defining distinct CHW cadres, with clearly articulated competencies and responsibilities, provides the basis for a more coherent workforce structure. Standardised, competency-based training curricula – designed to meet local contexts but anchored in continental guidelines – can elevate the quality of service-provision and create confidence in CHWs as skilled providers.

Career development pathways remain limited, with only a handful of Member States offering structured progression opportunities. Expanding such pathways, including links to tertiary education institutions, can motivate CHWs, improve retention, and foster a pipeline of leadership from within the cadre itself. Continuous professional development, including refresher courses and supervisory support, ensures that CHWs remain equipped to respond to evolving health challenges.

Workforce development must also remain attentive to equity. Gender-sensitive recruitment and support systems can empower women, who already make up the majority of CHWs, while also creating opportunities for youth employment. Such inclusive approaches advance both health outcomes and broader social development, in line with Agenda 2063's people-driven vision.

6.1.5 COMMUNITY HEALTH INFORMATION SYSTEMS AND DIGITIZATION:

Growing investments in health information systems provide a strong foundation for community health data integration. Expanding the use of digital tools can enhance real-time data collection and decision-making. National CHW registries – linked to human resources for health systems – can improve workforce management. Developing robust data governance frameworks, while building analytics and visualization capacity, can ensure community health data is used effectively and responsibly for planning and monitoring.

6.1.6 SERVICE DELIVERY AND COMMUNITY ENGAGEMENT

The scope of CHW services is expanding, reflecting both community demand and health system priorities. From maternal and child health to non-communicable disease management, emergency preparedness, and mental health, CHWs are increasingly expected to deliver a broad package of care. This requires ongoing retraining and retooling. Regular reviews of scopes of practice and ensuring the availability of refresher training – linked to evolving disease burdens and population needs – help ensure that CHWs remain focused, effective, and adequately supported.

Service delivery models also need to adapt to diverse contexts. Differentiated approaches, tailored to rural, peri-urban, or marginalized communities, allow CHWs to deliver care in ways that are both accessible and culturally acceptable. These models should be supported by adequate supervision, supply chain reliability, and referral linkages to ensure continuity of care.

At the heart of community health lies community engagement. Communities are not only recipients of services but active partners in CHW programs. Strengthening community governance structures, formalizing participation in CHW recruitment and supervision, and embedding accountability mechanisms deepen trust and foster sustainability. Where CHWs are seen as both providers and neighbors, community health programs achieve greater legitimacy and effectiveness.

6.2 RECOMMENDATIONS FOR AFRICA CDC AND AU ORGANS:

6.2.1 TECHNICAL SUPPORT AND CAPACITY BUILDING:

Providing continuous technical assistance to Member States in developing, costing and implementing national strategies and operational plans aligned with the continental framework constitutes a core function of Africa CDC. Developing and disseminating regional guidelines, standardised training modules, and monitoring and evaluation tools informed by

African best practices and contextual realities could significantly strengthen program quality and consistency. Facilitating cross-country learning and South-South collaboration through technical working groups, peer-learning exchanges, and communities of practice will help disseminate innovation rapidly and adapt successful approaches to diverse contexts.

6.2.2 RESEARCH AND EVIDENCE GENERATION:

Africa CDC is uniquely placed to champion a continental research agenda on community health. Coordinated research – focusing on effectiveness, cost-effectiveness, and broader social and economic impact – can fill persistent knowledge gaps and provide a robust evidence base for policymaking.

Establishing a continental evidence hub, hosted by Africa CDC in collaboration with academic and government partners, would enable rapid synthesis and dissemination of findings. Such a hub could serve as the central repository for lessons learned, case studies, and operational insights, ensuring that evidence is not siloed but shared across Member States. Building regional research capacity will also allow Africa to generate and own the evidence that shapes its community health future

6.2.3 ADVOCACY AND RESOURCE MOBILIZATION:

Africa CDC's continental mandate positions it as a key advocate for community health at both African and global levels. Continued advocacy can help elevate community health on political and financing agendas, ensuring sustained attention even amidst competing



priorities. Supporting Member States in developing investment cases, coordinating donor contributions, and exploring innovative financing mechanisms will be essential to secure the resources required for scaling and sustaining CHW programs.

6.2.4 POLICY HARMONIZATION AND REGIONAL COORDINATION:

The African Union plays a unique role in fostering collaboration among Member States and ensuring coherence in approaches. Facilitating high-level dialogues, technical consultations, and ministerial platforms enables governments to align policies and share experiences. By strengthening continental coordination mechanisms, the AU can reduce duplication, promote coherence, and leverage economies of scale in investments.

6.2.5 MONITORING AND ACCOUNTABILITY:

The AU's leadership, in establishing the continental acceleration framework, provides an opportunity to energize the integration and strengthening of community health as part of national health systems. The Continental Community Health Programs Scorecard, when aligned with the AU Accountability Framework for Health, can serve as a powerful tool for tracking progress, highlighting success stories, and identifying areas for improvement.

Peer review mechanisms, built into AU platforms, can foster mutual accountability among Member States while also encouraging cross-country learning. Shared indicators, aligned with SDGs and Agenda 2063, provide the foundation for assessing progress at national, regional, and continental levels.

6.3 RECOMMENDATIONS FOR DEVELOPMENT PARTNERS:

6.3.1 ALIGNMENT AND HARMONIZATION:

Development partners have played an essential role in supporting community health programs, but alignment with national strategies remains critical. Coordinated approaches – anchored in national priorities rather than vertical programs – strengthen

community health systems as a whole and reduce duplication. Joint planning, pooled funding, and coordinated technical support maximize the efficiency and impact of investments. The Community Health Delivery Partnership (CHDP), a country-driven collaboration of global, regional, and national stakeholders committed to increasing access to equitable, high-quality essential health services through community-based primary health care, is one such initiative, which should be supported, expanded and replicated.

6.3.2 SUSTAINABLE FINANCING:

Providing technical assistance for costing, financial tracking and sustainability planning remains vital for building national capacity. Using funding modalities that support national budgets and help embed CHW programs into domestic financing structures will enhance long-term program viability and country ownership. Partners might consider more flexible, long-term funding commitments that allow for systemic investments rather than short-term project support.

6.3.3 CAPACITY BUILDING AND KNOWLEDGE SHARING:

Investments in training institutions, curriculum development, and faculty strengthening remain essential for sustaining CHW programs. Partners can also foster operational research, support peer learning, and facilitate South-South exchanges that showcase African innovations and solutions. Sharing context-specific evidence ensures that programs are grounded in local realities and can adapt to changing circumstances.

6.3.4 INNOVATION AND TECHNOLOGY:

Supporting the scale-up of digital solutions aligned with national digital health strategies can enhance CHW effectiveness and program efficiency. However, technology investments should be accompanied by commensurate investments in building the digital literacy of CHWs and managers to ensure these tools translate into improved performance and health outcomes rather than becoming additional burdens.



6.4 SUMMARY OF RECOMMENDATIONS

The landscape survey, in conjunction with subsequent engagements with Member States and global partners, points the way forward to address challenges and accelerate, embed progress, and entrench community health as a cornerstone for achieving UHC and the aspirations of Agenda 2063. It calls on Member States as primary drivers and owners, and on the AU and Africa CDC, and partners as crucial supporters of Member States, to work together on the following priorities:

1. Community health workforce development

a. Scaling up workforce numbers and density:

Accelerate recruitment, training, and deployment of community health workers (CHWs) to reach the continental target of **2 million CHWs by 2030**, requiring at least **200,000 annually**, while addressing current inequities within and across Member States.

b. Strengthening and professionalizing the community health workforce by

- i. upskilling new and already deployed CHWs as polyvalent health workers, capable of responding to existing and emerging health challenges;
- ii. Clarifying and differentiating roles across community health cadres;
- iii. developing unified and standardized curricula and training programs, including regular opportunities for upskilling and continuing education, and clearly defined career pathways;

2. Leadership and Governance

- a. Ensuring sustained **high-level leadership and advocacy** —through policy dialogues, presentations of evidence on community health worker (CHW) contributions, and sharing of successful country models— to safeguard programs across political cycles.

- b. Strengthening dedicated community health units or divisions**, equipped with clear authority and adequate resources, and empowering them to convene stakeholders, manage planning and training, and provide oversight.
- c. Enhancing governance, ownership and coordination** through the development of comprehensive national community health policies and costed strategies that drive the operationalization of the One Budget, One Implementation Plan and One M & E.
- d. Reinforcing community governance structures**, ensuring formal participation in CHW recruitment and supervision, while embedding accountability mechanisms that deepen community trust and ownership.

3. Institutionalization and integration

- a. Fully embedding the community health workforce in national health systems**, through regulatory frameworks and bodies, certification and accreditation, and the establishment of national association.
- b. Aligning CHW roles and functions with national health priorities and service delivery goals**, ensuring coherence and responsiveness.
- c. Harmonizing standards** for recruitment, training, remuneration, and career development across Member States.
- d. Reframing CHWs as a permanent and professionalized cadre**, recognized as the frontline of resilient health systems rather than temporary solutions

4. Financing and sustainability

- a. Strengthening sustainable financing for community health** by prioritizing domestic funding strategies, investments, and sustainability plans, that incorporate the costs of community health programs into national recurring budgets. This should include
 - i.** integrating the remuneration of CHWs into national wage bills;

- ii.** exploring innovative financing options; and
- iii.** improving fiscal planning and management functionalities within ministries.

5. Service delivery and support

- a. Aligning service delivery packages** with community health needs, pandemic preparedness, and national health priorities.
- b. Standardizing and upgrading scopes of practice** and ensuring continuous upskilling of the existing workforce. Service delivery models should be **differentiated and context-sensitive**, adapted to rural, peri-urban, and marginalized populations, ensuring accessibility and cultural acceptability.
- c. Strengthening support systems** including supervision, supply chain reliability, and effective referral linkages to guarantee continuity and quality of care.

6. Information systems and M&E

- a. Strengthening information systems and M&E frameworks** to track progress and allow evidence-led decision-making and targeted support
- b. Expanding the establishment and use of digital information systems** to enhance real-time data collection.
- c. Establishing and maintaining national CHW registries** to enable accurate planning, deployment and management of the community health workforce.
- d. Developing robust data governance frameworks**, and building national and regional capacity for analytics and visualization, ensuring data is used effectively, ethically, and responsibly.
- e. Facilitating knowledge exchange and learning platforms** across and between countries to advance continental solidarity and shared progress.



7. CONCLUSIONS

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The 2024/5 Community Health Landscape Survey presents a powerful reflection of progress, resilience, and ambition across African health systems. In many places, community health workers have grown from under-supported volunteers into semi-professional cadres embedded in national health strategies.

However, despite increased deployment, formal recognition, and community engagement, major challenges persist – particularly around sustainable financing, professionalization,

and performance management. Africa CDC's leadership has been pivotal in aligning continental vision, policy, and strategy.

Moving forward, the strategic priorities must focus on closing equity gaps, formalizing CHW status, expanding service capacity, and institutionalizing sustainable systems. Achieving this vision will require coordinated action between governments, partners and communities to embed community health as a cornerstone of universal health coverage and pandemic preparedness in Africa.

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9. APPENDICES

APPENDIX A: TOTAL ANNUAL AND PER CAPITA SPENDING ON COMMUNITY HEALTH IN US\$

COUNTRY	TOTAL ANNUAL BUDGET FOR COMMUNITY HEALTH (US\$)	PER CAPITA (US\$)
Algeria		
Angola	35,100,000	0.926467294
Benin	23,636,364	1.830844672
Botswana		
Burkina Faso	411,808,717	17.48747491
Burundi	23,000,000	1.864947326
Cameroon	6,262,203	0.215020534
Central African Republic	26,226,426	4.919893297
Chad	10,691,404	0.526692902
Comoros	838,080	0.962138085
Congo	5,681,124	0.896255875
Côte d'Ivoire	406,650,405	12.34163459
Democratic Republic of the Congo	166,180,685	1.356455216
Djibouti	5,000,000	4.686874595
Egypt		
Equatorial Guinea		
Eritrea		
Ethiopia	1,264,392,993	9.333238728
Gabon		
Ghana	495,458,857	15.01043962
Guinea	33,813,084	2.41698192
Guinea-Bissau		
Kenya	90,000,000	1.60018656
Lesotho	30,731,536	13.00351666
Liberia	21,000,000	3.999857529
Libya		

COUNTRY	TOTAL ANNUAL BUDGET FOR COMMUNITY HEALTH (US\$)	PER CAPITA (US\$)
Madagascar		
Malawi	142,776,000	6.88599382
Mali	10,000,000	0.408496732
Mauritania	8,937,672.733	1.725479738
Morocco		
Mozambique	93,000,000	2.797462455
Namibia	101,589,014	33.61202369
Niger	18,526,684	0.704114528
Nigeria	53,188,235	0.228569983
Rwanda	71,400	0.005173855
São Tomé and Príncipe		
Senegal	14,344,667	0.771498303
Seychelles		
Sierra Leone	11,100,000	1.284421632
Somalia	3,000,000	0.152284264
South Africa	170,349,779	9.106997171
South Sudan	46,963,942	0.769606295
Eswatini	8,401,744.52	7.010585054
Tanzania	39,871,328	0.645782389
The Gambia	1,800,000	0.75
Togo	2,042,972	0.220449205
Tunisia		
Uganda	66,563,380.6	1.450011457
Zambia	350,000,000	16.56040721
Zimbabwe	45,000,000	2.643983094

APPENDIX B: PRESENCE OF INVESTMENT AND SUSTAINABILITY PLANS BY COUNTRY

	COUNTRY HAS AN INVESTMENT CASE FOR COMMUNITY HEALTH	COUNTRY HAS PLAN FOR FINANCIAL SUSTAINABILITY
Algeria	Yes	Yes
Angola	No	No
Benin	No	Yes
Botswana	No	Yes
Burkina Faso	Yes	Yes
Burundi	No	No
Cameroon	Yes	No
Central African Republic	No	No
Chad	No	No
Comoros	Yes	Yes
Congo	No	No
Côte d'Ivoire	Yes	No
Democratic Republic of the Congo	No	No
Djibouti	No	No
Egypt	No	No
Equatorial Guinea	No	No
Eritrea	No	No
Ethiopia	Yes	Yes
Gabon	No	No
Ghana	Yes	Yes
Guinea	No	No
Guinea-Bissau	No	No
Kenya	Yes	No
Lesotho	No	Yes
Liberia	No	Yes
Libya	No	No

	COUNTRY HAS AN INVESTMENT CASE FOR COMMUNITY HEALTH	COUNTRY HAS PLAN FOR FINANCIAL SUSTAINABILITY
Madagascar	No	No
Malawi	No	Yes
Mali	Yes	No
Mauritania	No	No
Morocco	No	No
Mozambique	Yes	Yes
Namibia	No	Yes
Niger	Yes	No
Nigeria	No	Yes
Rwanda	Yes	Yes
São Tomé and Príncipe	No	No
Senegal	No	No
Seychelles	No	Yes
Sierra Leone	Yes	Yes
Somalia	No	No
South Africa	Yes	Yes
South Sudan	Yes	No
Eswatini	No	Yes
Tanzania	No	Yes
The Gambia	No	No
Togo	Yes	No
Tunisia	No	No
Uganda	Yes	Yes
Zambia	Yes	No
Zimbabwe	Yes	Yes

APPENDIX C: CADRE DEFINITIONS

	DEFINITIONS OF CHWS
Algeria	
Angola	CHW are all community actors involved in health and social determinants of health, such as Health Promoters, ADECOS, Mentor Mothers, Traditional Birth Attendants, volunteers, activists from NGOs and CBOs, Traditional Healers and practitioners of Natural and Homeopathic Medicine.
Benin	Il existe deux types d'agents de santé communautaires: 1- Le Relais communautaire est une personne de sexe masculin ou féminin ; âgée d'au moins 25 ans au moment de la désignation ; sachant lire et écrire en français ; résident dans le milieu et ayant une bonne maîtrise de la langue du milieu. 2- L'agent de santé communautaire qualifié est une personne de sexe masculin ou féminin ; âgée d'au moins 20 ans et de 45 ans au maximum au moment du recrutement ; titulaire d'une licence en soins infirmiers ou en obstétrique.
Botswana	CHW 1 is a permanent employee with specific certificate training for CHWs CHW 2 is a person recruited within their locality with the involvement community leadership selected based on their trust and then trained on a minimum health package
Burkina Faso	L'ASBC est une femme ou un homme sélectionné(e) dans et par sa communauté conformément à des critères définis, ayant reçu une formation de base sur les SBC, pour offrir localement des services promotionnels, préventifs, curatifs de base et de soutien, sous l'encadrement technique du personnel de santé. Il est installé par l'autorité communale.
Burundi	C'est une femme ou un homme choisi par les membres de sa communauté, selon des critères précis pour s'occuper des problèmes de santé des individus et de la collectivité sous la supervision des services de santé. Il est chargé de sensibiliser la communauté sur les questions de santé et d'effectuer certaines prestations au niveau communautaire.
Cameroon	Un agent de santé communautaire polyvalent est un homme ou une femme qui vit dans la communauté sachant lire et écrire l'une des langues officielles, le français ou l'anglais, en plus du dialecte local, et qui a été formé par le programme pendant 12 jours sur 20 modules.
Central African Republic	Un agent de santé communautaire est une personne (femme ou homme), volontaire, sélectionnée dans et par sa communauté conformément aux critères définis, ayant reçu une formation de base sur un paquet d'activités communautaires pour offrir dans sa communauté des services préventifs, promotionnels, curatifs de base et de réadaptation, sous l'encadrement technique du personnel de santé qualifié et avec l'appui du leader de la communauté.
Chad	Un membre d'une communauté, choisi par celle-ci selon des critères bien précis pour la servir.
Comoros	
Congo	Un agent de santé communautaire est toute personne (homme ou femme), issue de la communauté, résidant de façon permanente dans cette communauté, jouissant d'une bonne moralité, sachant lire et écrire et qui accepte de façon volontaire de se rendre disponible après avoir reçu une formation pour assurer les interventions à base communautaire. Les relais communautaires sont identifiés au cours des réunions communautaires du comité de santé (COSA), présidées par un représentant de l'autorité politico administrative (sous-préfet, maire, ou leurs représentants), avec l'appui de l'équipe cadre du district sanitaire concerné. Les agents associatifs relèvent d'organisations de la société civile et présentent actuellement des profils différents en fonction de leurs domaines d'intervention.
Côte d'Ivoire	Un agent de santé communautaire (ASC) est un homme ou une femme volontaire, sélectionné(e) dans et par sa communauté selon des critères précis, ayant reçu une formation de base pour offrir un paquet intégré de services préventifs, promotionnels, curatifs de base et de soutien sous la supervision du personnel de santé. Il est chargé de sensibiliser la communauté sur les questions de santé et d'effectuer certaines prestations au niveau communautaire. Cette définition prend en compte les éducateurs de pairs et les conseillers communautaires.

DEFINITIONS OF CHWS

Democratic Republic of the Congo	
Djibouti	Il s'agit d'un homme ou d'une femme volontaire, sélectionné(e) dans et par sa communauté selon des critères précis, ayant été formé(e) pour offrir un ensemble de services préventifs, promotionnels, curatifs de base et de soutien sous l'encadrement technique du personnel de santé. Il est chargé de sensibiliser la communauté aux questions de santé et d'effectuer certaines prestations au niveau communautaire.
Egypt	A CHW is a member of the health team. Carefully selected from the community around the catchment area of the PHC with a highly professional training, she is equipped to be the expressive voice within the health unit and to be a guide for the health team about the renewed needs of community members.
Equatorial Guinea	Es una persona elegida y reconocida por su comunidad, que se encarga de acercar los servicios de salud a la población, de promover la salud y de prevenir enfermedades.
Eritrea	Barefoot Doctors are CHW who are trained for six months (three months theoretical and three months practical) and aim to prevent and treat common illnesses in the communities. While the other volunteer CHWs are given short programatic training on such topics as Malaria, TB, Reproductive Health and Community IMNCI. They provide health education, advice on when to seek treatment, and on how to treat common programatic illnesses.
Ethiopia	<p>Ethiopia launched the Health Extension Program (HEP) in 2003. Health Extension Workers (HEWs), the Ethiopian version of CHWs, are females with some males in pastoral areas, trained, government-employed and salaried frontline health workers that implement the HEP. Close to 43,000 HEWs implement 18 service packages of health promotion, disease prevention, and basic curative services at the health post level or by going house to house. The HEP enabled Ethiopia to achieve significant improvements in maternal and child health, communicable diseases, hygiene, sanitation, and health care seeking. The HEP is a community-based approach and designed as the main vehicle to achieve universal coverage of PHC, particularly among rural, pastoralist populations & less privileged urban communities. The focus of HEP is disease prevention, health promotion, with selected curative care health services at the community level: implementing several prevention & treatment services categorized.</p> <p>The HEP is a community-based health service delivery program whose educational approach is based on the diffusion model, which holds that community behavior is changed step by step: training early adopters first, then moving to the next group that is ready to change. Those resistant to change would gradually be conditioned to change because of changes in their environment. HEP assumes that health behavior can be enhanced in communities by creating model families that others will admire and emulate. HEP has four health subprograms: disease prevention, family health, environmental hygiene and sanitation, and health education and communication; these correspond to the elements of primary health care coverage as defined in the Alma Ata Declaration. Every village with 5000 residents (3000 population to pastoral areas) builds a health post. At least two HEWs who have completed tenth grade are recruited from the same community and trained in HEP modules for one year, after which they return home as salaried frontline health care staff. The HEP is a flagship of the Ethiopian Health Sector Development Program: an innovative intervention marked by institutionalization of primary health care, government leadership, and the alignment and substantial support of development partners. The program has brought nearly universal basic health care to the country's largely rural population, helping increase demand for services and deliver a wide range of preventive and curative services. The HEWs are a formally recognized cadre that has strong political support. HEWs are formal employees and are paid a salary. HEWs are full-time employees who are meant to split their time between health posts and the community. These expectations have changed considerably since the HEW program was initiated. HEWs were originally conceived as links between their local community and the formal health services. Over the course of a week, HEWs divide their time between the health post (51 per cent); the community and outreach services (37 per cent), with the remaining 11 per cent of their time spent elsewhere such as Household visits, School, service delivery at Health Post, visits at social settings such as household, church, market, school. 3000 – 5000 population per a village (= 2 Health Extension Workers per 3000 – 5000 population: 500 – 1000 Household].</p>

	DEFINITIONS OF CHWS
Gabon	
Ghana	<p>Health Assistant Preventives are trained for a period of two years, pass the licensure exams and are licensed to practice in the community.</p> <p>CHV are elected by the community in which they reside in and trained for a short period of two weeks to three months and attached to the Health Assistant Preventive to support service delivery activities in the community.</p> <p>CHWs have senior high school certificates, are trained for a period of three months, and they are engaged by the Youth Employment Agency to support health service delivery activities in CHPS zones and supervised by Health Assistants Preventive.</p>
Guinea	<p>ASC désigne un agent de santé formé dans le cadre de la santé communautaire et qui dispose d'un contrat avec la commune pour exercer ce rôle. L'ASC est le superviseur du RECO.</p> <p>RECO désigne la personne qui est choisie et formée sur le paquet intégré.</p>
Guinea-Bissau	<p>A/O ASC é uma mulher ou homem voluntária/o selecionada/o, de acordo com um processo e critérios definidos, tendo recebido a formação e equipamentos básicos, para oferecer um pacote integrado de atividades curativas, preventivas e promocionais na sua comunidade, sob supervisão e supervisão técnica de pessoal de saúde.</p>
Kenya	<p>A Community Health Officer is a trained health professional who is assigned to supervise the community health promoters under their community health unit.</p> <p>A Community Health Promoter is a member of the community who is selected and appointed in accordance with section 9 of this Act or a community health volunteer or a Community Health Worker who is deemed to be a community health promoter under section 22(3) of this Act and who is trained to provide community health services to defined households.</p>
Lesotho	<p>Community Health Worker (CHW) is a front-line public health worker who is trained and engaged by the formal system (MOH), other line ministries, development partners, private sector or other implementing agencies to serve or provide essential health services at the community level and link communities with health care systems.</p> <p>Village Health Worker (VHW) is a member of a community elected by community members to provide basic curative, preventive, promotive and rehabilitative health services to the community.</p> <p>Village Health Worker Supervisor (VHWS) is a VHW with five years' working experience, selected from cohort of Village Health Workers and demonstrating high standards of work based on an annual performance review.</p> <p>Village Health Worker Coordinator is a VHW with five years' working experience, selected from a cohort of Village Health Worker Supervisors, and s/he has a COSC pass with three credits and demonstrates high standards of work based on an annual performance review.</p>
Liberia	<p>In the context of the Liberian National Community Health Program, a Community Health Worker, called the community health workforce, is defined as:</p> <ol style="list-style-type: none"> 1. Anyone who lives in a community, selected by the community through an interactive community engagement process, trained in the NCHP competency-based curriculum, equipped, supervised and incentivized by the Ministry of Health through its Community Health Services Division to provide the essential package of community health services in their community as outlined in this policy. <p>OR</p> <ol style="list-style-type: none"> 2. A professionally trained and licensed health care provider (Physician Assistant, Nurse or Midwife) who is recruited and trained by the Ministry of Health through its Community Health Services Division, in the NCHP competency-based curriculum, equipped, deployed, incentivized and supervised by the Ministry of Health to supervise and deliver the essential package of community health service as outlined in this policy. <p>No community members actively serving in key positions in a community (for example, City Mayor, Commissioner, Chief, Teacher, etc.), shall be recruited to serve as a CHW in the first or second categories.</p>

	DEFINITIONS OF CHWS
Libya	
Madagascar	Personne issue de la communauté, ayant reçu des formations de courte durée pour promouvoir le bien-être intégral de la population. Son rôle consiste à sensibiliser et à offrir des prestations pour la prise en charge des enfants de moins de cinq ans et des femmes dans leurs communautés.
Malawi	Formal cadre who is on a government salary and provides health services at the community level. Informal cadre who is not on a government salary, such as community health volunteers.
Mali	L'agent de santé communautaire (ASC) est une personne chargée d'offrir un paquet de soins et de services de santé essentiels sensibles au genre et comprenant des activités préventives, curatives et promotionnelles au niveau d'un ou plusieurs villages, fractions, quartiers ou secteurs de quartiers éloignés du Centre de santé communautaire ou d'accès difficile.
Mauritania	L'agent de santé communautaire est une personne choisie par la communauté et en fait partie. Il est désigné par la communauté selon les critères d'engagement et de motivation, d'âge (20–45 ans) et de préférence des femmes. Au sein de la communauté, il contribue à faire connaître et à encourager le recours aux services de santé. Au niveau du système de santé, il est tenu d'organiser des campagnes de sensibilisation sur la santé, de fournir des soins, d'assurer la prise en charge de certaines maladies et de suivre des maladies graves.
Morocco	Une personne relais communautaire (PRC), selon le programme dans lequel il opère, fournit des activités de promotion de la santé, de sensibilisation de la population à l'adoption de comportements sains et d'orientation. Pour le VIH, il peut faire le dépistage communautaire.
Mozambique	Agentes Polivalentes de saúde (APS) e outros
Namibia	A Community Health Worker (CHW) is a member of a community who provides basic health care within their community and is capable of providing preventive and promotional/health education to that community and also provides referrals to the nearest clinic for further management. A CHW doesn't have a formal education equal to that of a nurse, CHO or doctor. They are chosen within the community to assist a train personnel community health extension worker who is going to be trained to be a CHW.
Niger	Relais Communautaire Paquet Complet : (services curatifs, préventifs et promotionnels) au-delà d'un rayon de cinq km des formations sanitaires dont les enfants de 2 à 59 mois constituent la cible principale pour les services curatifs. Le paquet curatif comprend entre autres la prise en charge du paludisme, de la pneumonie et de la diarrhée, le dépistage/référence vers les formations sanitaires des cas de malnutrition, la référence et le suivi des femmes enceintes et des nouveau-nés, la surveillance des maladies et la surveillance des décès maternels et périnataux. Relais Communautaire Paquet Partiel (services promotionnels et préventifs) dans un rayon de cinq km des formations sanitaires. Le paquet préventif et promotionnel fait respectivement la promotion de 13 pratiques familiales essentielles (PFE) et permet d'appuyer la mise en place des groupes de soutien pour l'alimentation du nourrisson et du jeune enfant (ANJE) et l'amélioration de l'utilisation des services.

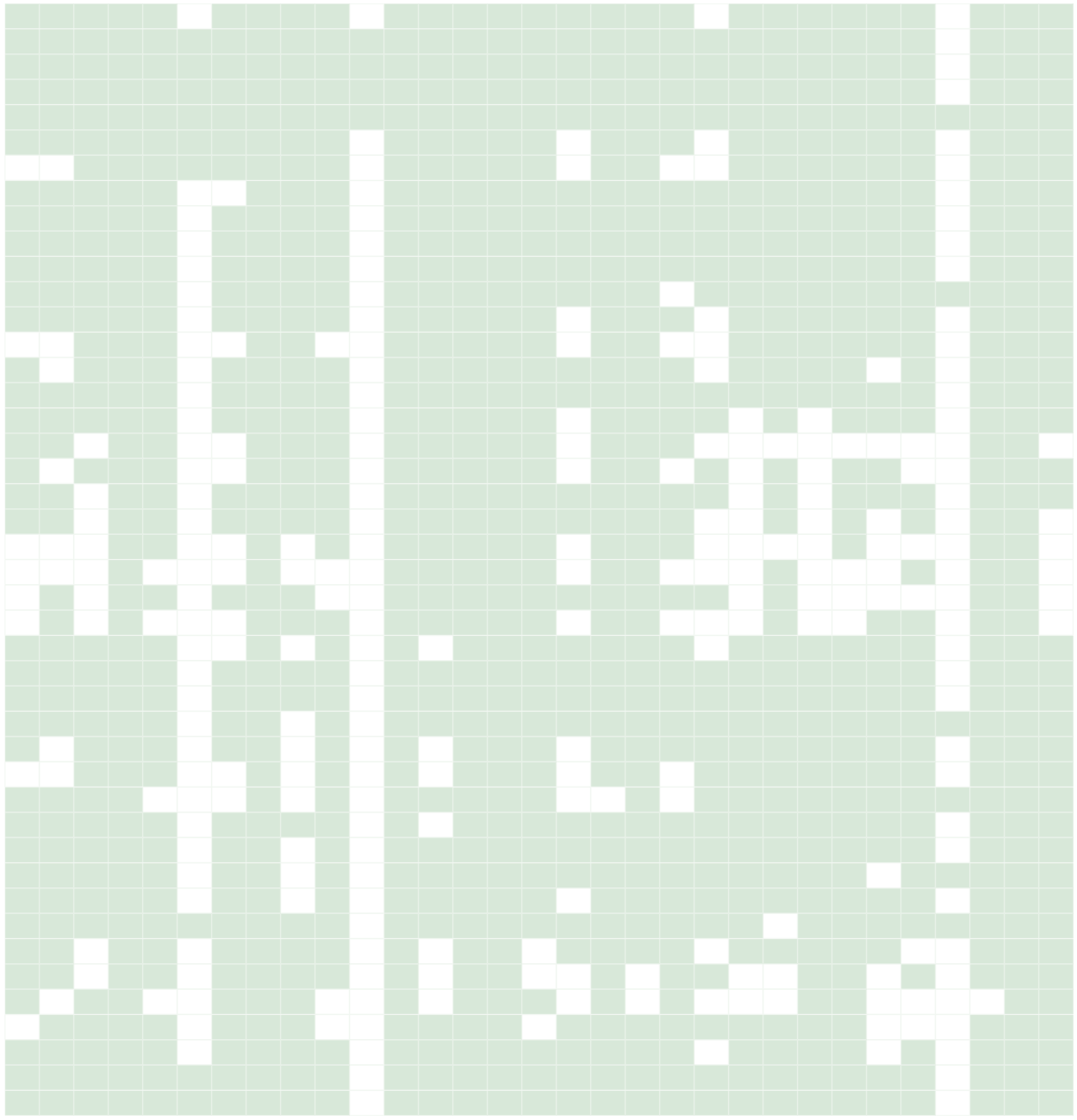
DEFINITIONS OF CHWS	
Nigeria	<p>The CHWs in Nigeria comprise two cadres of personnel consisting of auxiliary and formally trained community-based healthcare workers.</p> <ol style="list-style-type: none"> 1. The auxiliary CHWs comprise community health personnel who provide services at household and community levels; they live among the people all the time. This cadre of health workers must have attended at least primary school and have undergone the necessary service-based training. 2. Community-based health workers deliver services at facility and community levels. This cadre of health workers must possess the following basic qualifications from an accredited school of health technology: CHO, CHEW or JCHEW.
Rwanda	<p>A polyvalent community health worker (CHW) in Rwanda is a trained CHW who provides a minimum package of services comprising a wide range of health services at the community level including disease prevention, maternal and child health, health education and basic medical care. They are adaptable and capable of addressing various health needs, working with different sectors and forums to improve overall community health outcomes.</p>
São Tomé and Príncipe	<p>Volunteer agents trained in promoting health care in the communities in which they are located.</p>
Senegal	<p>Nous avons dans notre stratégie de santé communautaires les acteurs communautaire de santé (ACS), qui sont des volontaires communautaires qui participent actuellement à la mise en œuvre des activités de santé au niveau communautaire. Ils sont classés en deux catégories:</p> <ul style="list-style-type: none"> - Les acteurs communautaires de soins (ACs) : en charge de délivrer un paquet de services curatifs, préventifs et promotionnels. Il peut s'agir d'un homme ou d'une femme officiant dans une case de santé ou à domicile. Il a reçu une formation homologuée, centrée sur un paquet de services normés. - Les acteurs communautaires de promotion et de prévention (ACPP) : en charge de la création de la demande et de la diffusion des messages sanitaires. Ils sont composés d'hommes et de femmes officiant dans une case de santé ou un site et qui ont reçu une formation homologuée centrée sur un paquet normé.
Seychelles	<p>Any cadre of staff delivering any type of services in the community to address the needs of the community.</p>
Sierra Leone	<p>The Community Health Worker is a member who provides basic health and medical care within their communities and is capable of providing preventive, promotional and rehabilitation care to that community, typically without formal education equal to that of a nurse, Community Health Officer, or medical doctor.</p>
Somalia	
South Africa	<p>Refers to any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial wellbeing and provide ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.</p>

DEFINITIONS OF CHWS	
South Sudan	A Boma Health Worker refers to any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial wellbeing and provide ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.
Eswatini	The cadre who provides health services at the community level, primarily based and works in the community and has undergone training (based on the approved MOH community health services curriculum) to carry out a series of specified roles and functions, which are provided by the health system or health program.
Tanzania	A person providing health, nutrition and social welfare services outside of a health facility, discharging their services at the individual family or community level.
The Gambia	Community Health Nurses are formally trained nurses who supervise other community health workers. Village Health Workers are volunteers identified by the community who primarily perform health promotion activities and the treatment of minor ailments. Community Birth Companions are women identified by the community who support pregnant women from antenatal to delivery. They serve as advocates for the promotion of safe pregnancy and delivery.
Togo	Un agent de santé communautaire est un volontaire, homme ou femme, élu démocratiquement par sa communauté située au-delà de cinq km d'une formation sanitaire ou dans une zone difficile d'accès (obstacle naturel), afin de fournir des prestations de santé de base selon la responsabilité technique ou autre qui lui a été déléguée. Un relais communautaire est toute personne ne répondant pas à la définition d'agent de santé communautaire et qui collabore avec le personnel de santé qualifié ou l'ASC dans le cadre de la promotion de la santé est appelée « relais communautaire ».
Tunisia	
Uganda	Front-line non-professional health workers and aides selected by communities, trained and working in the communities from which they come from.
Zambia	Community Health Workers are trained frontline health provider who serve as a critical link between health facilities and communities. CHWs are recruited from within the communities they serve, enabling them to effectively address local health needs and cultural contexts.
Zimbabwe	A permanent resident of the community, aged 18 years and above selected by the community and having completed 12 weeks of competence-based pre-service training provided by the Ministry of Health and Child Care.

APPENDIX D: SERVICES PROVIDED BY CHWS

	Algeria	Angola	Benin	Botswana	Burkina Faso	Burundi	Cameroon	Central African Republic	Chad	Comoros	Congo	Cote D'Ivoire	Democratic Republic of the Congo	Djibouti	Egypt	Equatorial Guinea	Eritrea	Ethiopia	Gabon	Ghana
Health Promotion and Education on Sexual and Reproductive...																				
Health Promotion and Education on Maternal and Newborn...																				
Health Promotion and Education on Child Health																				
Health Promotion and Education on Nutrition																				
Health Promotion and Education on Communicable Diseases																				
Health Promotion and Education on Non-communicable Diseases...																				
Health Promotion and Education on Mental Health																				
Disease Prevention of Sexual and Reproductive Health																				
Disease Prevention of Maternal and Newborn Health Related...																				
Disease Prevention of Child Health Related Illnesses																				
Disease Prevention of Nutrition Related Diseases																				
Disease Prevention of Communicable Diseases																				
Disease Prevention of Non-communicable Diseases Including...																				
Disease Prevention of Mental Health Related Illness																				
Disease Prevention for Early Childhood Development																				
Disease Prevention for Immunization and Vaccination Related...																				
Curative and Referral Services Related to ICCM Integrated																				
Curative and Referral Services Related to Sexual and...																				
Curative and Referral Services Related to Minor Injuries																				
Curative and Referral Services Related to Nutrition																				
Curative and Referral Services Related to Communicable...																				
Curative and Referral Services Related to Non-communicable...																				
Curative and Referral Services Related to Mental Health and...																				
Curative and Referral Services Related to Maternal and...																				
Curative and Services Related to Gender Based...																				
Identifying Disease Conditions and Referral for Sexual and...																				
Identifying Disease Conditions and Referral for Child Health																				
Identifying Disease Conditions and Referral for Nutrition																				
Identifying Disease Conditions and Referral for Communicable...																				
Identifying Disease Conditions and Referral for Non-...																				
Identifying Disease Conditions and Referral for Mental...																				
Identifying Disease Conditions and Referral for Gender...																				
Identifying Disease Conditions and Referral for Malaria																				
Identifying Disease Conditions and Referral for TB																				
Identifying Disease Conditions and Referral for HIV																				
Identifying Disease Conditions and Referral for Pregnancy																				
Community Disease Surveillance and Disease Reporting																				
Community Disease Surveillance: Vital Events Reporting																				
Community Disease Surveillance: Birth Registration																				
Community Disease Surveillance: Verbal Autopsy																				
Community Disease Surveillance: Defaulter Tracing																				
Community Disease Surveillance: Contact Tracing																				
Water, Sanitation, and Hygiene																				
Preventing/Responding to Public Health Emergencies																				

Guinea
 Guinea-Bissau
 Kenya
 Lesotho
 Liberia
 Libya
 Madagascar
 Malawi
 Mali
 Mauritania
 Morocco
 Mozambique
 Namibia
 Niger
 Nigeria
 Rwanda
 São Tomé and Príncipe
 Senegal
 Seychelles
 Sierra Leone
 Somalia
 South Africa
 South Sudan
 Eswatini
 Tanzania
 The Gambia
 Togo
 Tunisia
 Uganda
 Zambia
 Zimbabwe



SERVICE PACKAGES PROVIDED BY CHWS

SERVICE PACKAGES PROVIDED BY CHWS			
SERVICE GROUP	SERVICE	% OF MEMBER STATES OFFERING SERVICE	NUMBERS
Health promotion and education	Sexual, reproductive and health	92	47
	Maternal and newborn health	98	50
	Child Health	94	48
	Nutrition	96	49
	Communicable diseases	100	51
	Non-communicable diseases & NTDs	90	46
	Mental health	69	35
Diagnosis, testing and referral	Sexual, reproductive and health	69	35
	Child health	86	44
	Nutrition	88	45
	Communicable diseases	82	42
	Non-communicable diseases	76	39
	Mental health	59	30
	Gender-based violence	69	35
	Malaria	86	44
	TB	78	40
	HIV	75	38
	Pregnancy	80	41
	Disease prevention	Sexual and reproductive health	90
Maternal and newborn health		92	47
Child health		92	47
Nutrition		92	47
Communicable diseases		92	47
Non-communicable diseases incl. disabilities		82	42
Mental health		61	31
Illnesses related to early childhood		80	41
Immunization & vaccines	92	47	

SERVICE PACKAGES PROVIDED BY CHWS

SERVICE GROUP	SERVICE	% OF MEMBER STATES OFFERING SERVICE	NUMBERS
Curative and referral	Integrated Community Case Management (iCCM)	84	43
	Sexual and reproductive health	47	24
	Minor injuries	61	31
	Nutrition	75	38
	Communicable diseases incl. TB	61	31
	Non-communicable diseases & disabilities	39	20
	Mental health & psychosocial support	35	18
	Maternal and newborn health	63	32
	Gender-based violence	51	26
	Community-based surveillance	Disease surveillance & reporting	90
Vital events reporting		78	40
Birth registration		73	37
Verbal autopsy		49	25
Defaulter tracing		55	28
Contact tracing		86	44
Others	Water, sanitation and hygiene (WASH)	94	48
	Palliative care	41	21
	Public health emergencies	90	46
	Adolescent health	69	35

APPENDIX E: STAKEHOLDER GROUPS INVOLVED IN CHW SELECTION

	HEALTH FACILITY	COMMUNITY	GOVERNMENT	DEVELOPMENT PARTNERS
Algeria	No	No	Yes	No
Angola	No	Yes	No	Yes
Benin	No	Yes	Yes	No
Botswana	Yes	Yes	Yes	Yes
Burkina Faso	No	Yes	Yes	No
Burundi	No	Yes	No	No
Cameroon	No	Yes	No	No
Central African Republic	No	Yes	No	No
Chad	Yes	No	No	Yes
Comoros	Yes	Yes	Yes	Yes
Congo	Yes	Yes	No	No
Côte d'Ivoire	No	Yes	No	No
Democratic Republic of the Congo	No	Yes	No	No
Djibouti	Yes	Yes	Yes	No
Egypt	No	No	Yes	No
Equatorial Guinea	No	No	Yes	No
Eritrea	No	Yes	Yes	No
Ethiopia	No	No	No	Yes
Gabon	Yes	Yes	No	Yes
Ghana	Yes	Yes	Yes	No
Guinea	No	Yes	No	No
Guinea-Bissau	No	Yes	No	No
Kenya	No	Yes	No	No
Lesotho	Yes	Yes	No	No
Liberia	No	Yes	No	No

	HEALTH FACILITY	COMMUNITY	GOVERNMENT	DEVELOPMENT PARTNERS
Libya	No	No	No	No
Madagascar	Yes	Yes	No	No
Malawi	No	Yes	Yes	No
Mali	Yes	Yes	No	No
Mauritania	Yes	Yes	No	No
Morocco	No	No	No	Yes
Mozambique	No	Yes	No	No
Namibia	No	Yes	No	No
Niger	Yes	Yes	No	No
Nigeria	No	Yes	Yes	No
Rwanda	No	Yes	No	No
São Tomé and Príncipe	Yes	Yes	No	Yes
Senegal	Yes	Yes	No	No
Seychelles	Yes	No	No	No
Sierra Leone	Yes	Yes	No	No
Somalia	Yes	Yes	Yes	Yes
South Africa	No	Yes	Yes	No
South Sudan	No	Yes	Yes	No
Eswatini	Yes	Yes	No	No
Tanzania	No	Yes	No	No
The Gambia	No	Yes	Yes	No
Togo	No	Yes	No	No
Tunisia	No	No	No	Yes
Uganda	No	Yes	No	No
Zambia	Yes	Yes	Yes	No
Zimbabwe	Yes	Yes	No	No

APPENDIX F: ENTITIES RESPONSIBLE FOR CHW SUPERVISION

	ENTITIES RESPONSIBLE FOR CHW SUPERVISION
Algeria	Directorate of Prevention and Promotion, District level – SERVICE SEMEP – Prevention focal point at District level
Angola	Currently NGOs supervise CHW. However, under the new policy it will be the health professional deployed in the health facility of the catchment area.
Benin	L'ASCQ supervise les relais communautaires. et ces 2 acteurs sont supervisés par la plateforme One health de la commune et les autres niveaux de la pyramide sanitaire
Botswana	Health promotion
Burkina Faso	les agents de santé de leur formation sanitaire de tutelle
Burundi	La direction de la Promotion de la santé, de la demande de soins, de la santé communautaire et Environnementale à travers les Cordonateur de la promotion de la santé au niveau provinciale et les Techniciens de promotion de la sante au niveau communautaire
Cameroon	Chef de l'aire de sante
Central African Republic	L'agent de santé chargé des ASC sur le plan technique et le Chef de village ou quartier sur le plan administratif
Chad	Le centre de santé
Comoros	infirmier ou sage du poste de la structure de sante plus proche
Congo	Les Centres de Sante
Côte d'Ivoire	Infirmiers et sage-femmes
Democratic Republic of the Congo	Les infirmiers titulaires
Djibouti	Quotidienne par le médecin et l'infirmier major. Communautaire par le comité de santé et COGES Supervision mensuelle par le niveau central
Egypt	Governorate Supervisor
Equatorial Guinea	Los distritos sanitarios y las areas comunitarias
Eritrea	Nearby health facilities
Ethiopia	By the cluster/catchment health centers.
Gabon	DISPENSARE ou CENTRE DE SANTE
Ghana	District Health Management Team
Guinea	les chefs de centre de santé
Guinea-Bissau	Ministério da saúde
Kenya	Community health officer
Lesotho	Central - DHMT - health facility - community
Liberia	Community health service supervisors (CHSS)

	ENTITIES RESPONSIBLE FOR CHW SUPERVISION
Libya	NGOs
Madagascar	Le chef d la formation sanitaire et le relais communautaires
Malawi	Assistant Environmental Health Officers
Mali	Centre de santé communautaire (CSCOM)
Mauritania	Les Infirmiers chef des poste et le responsable des SSP au niveau des Directions Regionales de Sante
Morocco	l'ONG dont il relève
Mozambique	Unidade sanitaria periferica
Namibia	Ministry of Health
Niger	Les Chefs des centres de santé
Nigeria	CHEWs
Rwanda	At health-center level
São Tomé and Príncipe	Delegados distritais
Senegal	Le poste de santé
Seychelles	Supervised by the in-charge of the cadre
Sierra Leone	District Health Management Team (PHU Facility)
Somalia	Female Community Health Supervisor
South Africa	Enrolled nurse and in some cases, professional nurse also known as Outreach Team Leader (OTL).
South Sudan	The overall supervision and oversight is by the Ministry of Health, Directorate for Primary Health Care led by Director General for Primary Health Care, National Ministry of Health. In the absence of the Director General, the Director for Boma Health Initiative leads the supervision and oversight at the national level. At the state level, overall supervision of the BHWs is by the Director General, State Ministry of Health supported by the state BHI supervisor. At the county level, overall supervision is provided by the county health director for the county health department, supported by county and Payam BHI supervisors.
Eswatini	Nearest health facility staff
Tanzania	Health facility and village office of a particular locality
The Gambia	Ministry of health, primary health care unit
Togo	Les responsables des formations sanitaires sont les premiers responsables de la supervision des ASC/RC
Tunisia	Not available
Uganda	The facility staff designated by the in-charge, often the assistant health educator or health assistant
Zambia	Environmental health officer
Zimbabwe	Health facility

APPENDIX G: CHW TARGET NUMBERS BY COUNTRY

	CURRENT NUMBERS DEPLOYED	TARGET NUMBER OF CHWS
Algeria	50,000	40,000
Angola	3,762	8,380
Benin	16,104	
Botswana	2,161	5,000
Burkina Faso	32,148	54,922
Burundi	12,495	
Cameroon	9,932	25,000
Central African Republic	3,734	20,440
Chad	8,077	40,000
Comoros	700	873
Congo	2,366	9,289
Côte d'Ivoire	12,498	47,231
Democratic Republic of the Congo	1,413	65,000
Djibouti	172	400
Egypt	13,467	46,182
Equatorial Guinea	218	
Eritrea	2,500	5,200
Ethiopia	45,298	62,661
Gabon		2,500
Ghana	41,054	35,000
Guinea	12,813	22,000
Guinea-Bissau	3,481	3,481
Kenya	107,831	107,831
Lesotho	7,515	
Liberia	4,904	17,800

	CURRENT NUMBERS DEPLOYED	TARGET NUMBER OF CHWS
Libya	1,200	
Madagascar	47,461	89,365
Malawi	15,000	21,000
Mali	5,415	10,679
Mauritania	456	3,700
Morocco		
Mozambique	9,477	22,124
Namibia	1,200	4,113
Niger	25,944	19,934
Nigeria	23,761	70,000
Rwanda	58,567	59
São Tomé and Príncipe	141	163
Senegal	52,185	
Seychelles	400	
Sierra Leone	8,558	8,700
Somalia	3,500	15,000
South Africa	43,781	100,000
South Sudan	10,244	35,688
Eswatini	3,051	5,000
Tanzania	54,321	137,294
The Gambia	942	1,889
Togo	7,948	12,000
Tunisia		
Uganda	147,382	374,330
Zambia	103,000	45,000
Zimbabwe	23,864	40,000



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