Community Health

Policy and Implementation Landscape Mapping in the Middle East and North Africa Region 2024

Yemen Country Brief

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THE REPUBLIC OF YEMEN
Ministry of Public Health & Population

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1. Community health in Yemen

Existence of a community health policy in place	Recognition of CHWs as part of the national health workforce	Number of CHWs currently deployed	Inclusion of CHWS in emergency preparedness plans	Domestic funding available	Community engagement mechanisms in place	Formal linkages between community health and other sectors available
No	Yes	36,300	Yes	No	Yes	Yes

1.1 Country context

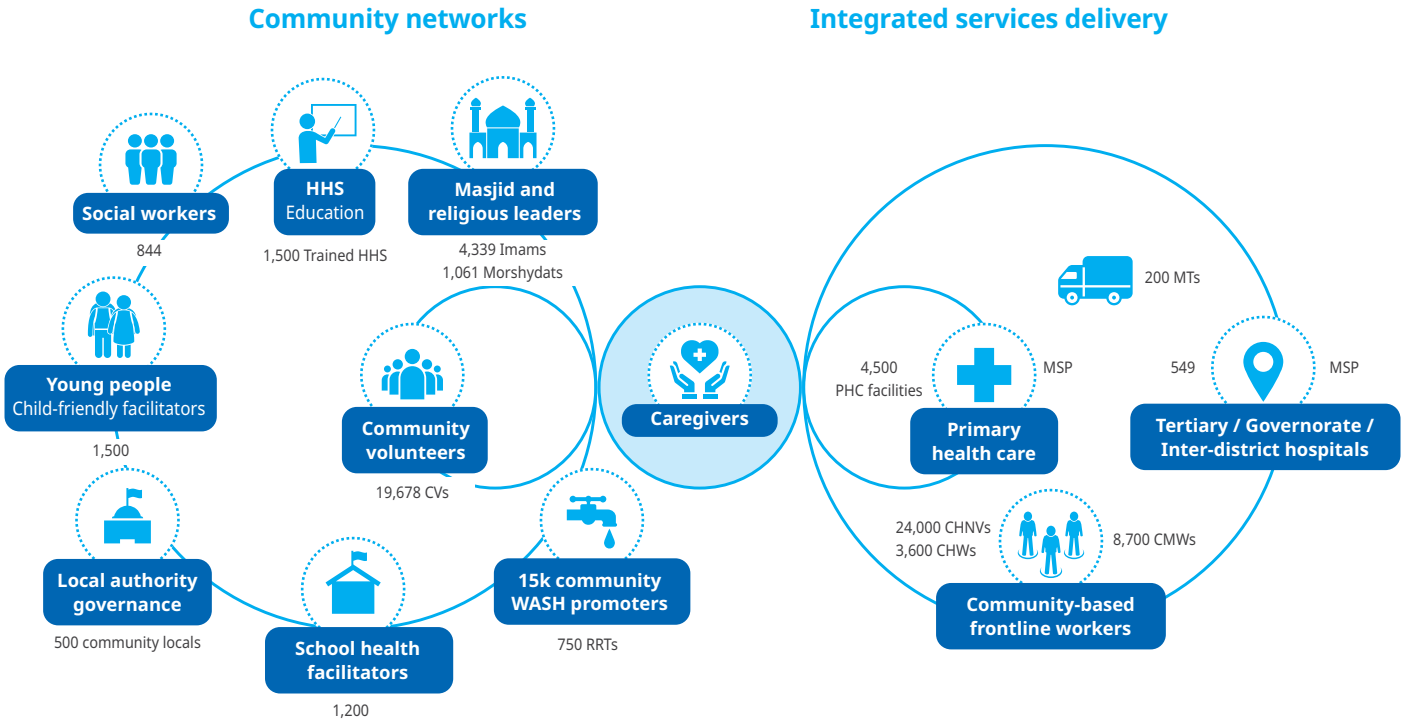
Yemen is a nation in the Middle East and North Africa region with a total population of 35.8 million.[1] In 2014, conflict erupted, and the country has been enduring a humanitarian crisis since. Ongoing conflict has devastated Yemen's economy and society, plunging millions into poverty and hunger. Disruptions to aid, trade, and remittances have worsened the crisis. Insufficient humanitarian funding limits aid reach, leaving many in dire need.[2] In 2024, 18.2 million people are in need of humanitarian assistance and protection services, more than half of whom are children.[3] Recurrent disease outbreaks also pose a challenge.

1.2 Overview of community health

In Yemen, health services are delivered through public, private and charitable sectors. According to the Public Health Law, the Ministry of Public Health and Population (MoPHP) is responsible for providing services across primary, secondary, tertiary and specialized levels of care. The primary health care network includes various health units and centres that are integrated with community networks.[4] Access to health care remains constrained.[3] To address these issues, the MoPHP has envisioned an integrated service delivery model with interventions at facility- and community level.[5] Health services in the community are currently provided by community health nutrition volunteers (CHNV), community midwives (CMW), community health workers (CHW).[5] Each of these community-based cadre possesses unique profiles, skill sets, and provides distinct services. Historically, these cadres have been affiliated with specific vertical programmes within the health sector. As Yemen transitions towards development programming, the MoPHP is currently developing a new national community-based Primary Health Care (PHC) strategy. This strategy aims to integrate all cadres and mitigate fragmentation within the health sector.

1 Ministry of Health and Environment. Population Estimates for the Expanded Programme on Immunization, 2024.
2 World Bank. (2024). The World Bank in Yemen. Overview. 25 January 2024. https://www.worldbank.org/en/country/yemen/overview
3 OCHA (2024). Humanitarian Needs Overview Yemen, 2024. https://reliefweb.int/report/yemen/yemen-humanitarian-needs-overview-2024-january-2024-enar
4 MoPHP (2010). National Health Strategy 2010-2025. Retrieved from https://faolex.fao.org/docs/pdf/yem175174.pdf
5 MoPHP (2022). CHW Investment case.

Figure 1. Yemen's health service modality: Community networks for integrated services delivery



Source: CHW Investment Case, MoPHP (2022).

2. Health systems pillars

2.1 Governance and accountability

- The MoPHP recognizes current health system gaps and has made community health a priority across MoPHP policies and strategies.
- The MoPHP is currently developing a national a community-based PHC strategy that will facilitate standardization, institutionalization, and further integration of the network of community workforce into the PHC system. This strategy will provide the enabling environment and bring all partners together to scale up the community based PHC services.
- A *National Midwifery Strategy 2024-2026* was recently developed by MoPHP, UNICEF and UNFPA. It aims to prepare and qualify community midwives through a three-year programme to enhance the coverage of maternal and newborn health services and to meet community needs.
- A national taskforce, led by the MoPHP, was recently formed to develop the National Community-Based Strategy and coordinate its implementation. The strategy is expected to be finalized by the end of 2024, and its implementation will start early in 2025.
- The MOPHP structure in the north is being updated to include the Community-Based Initiatives Unit (CBI) under the primary health care (PHC) sector.

- A *Community Health Worker Investment Case* was developed in 2022 and includes the rationale, structure, tasks, expected outcomes, and a package of services. It aims for strong multi-sectorial community health initiatives that will integrate with PHC and contribute to strengthening the health system. With the new national strategy being developed, the MoPHP intends to update investment case.

2.1.1 Community engagement

- Community leaders, in collaboration with local health leaders, participate in the selection of the CHWs. This ensures the acceptance of the CHWs by their communities once ready for deployment.
- The new CBI unit under the PHC sector will include community health advisory commissions and community health planning committees for participation of CHWs in decision-making processes.
- Community engagement mechanisms currently in place include health committees, training on key health topics, consultations for health interventions and regular meetings between community representatives and health workers at community level.

2.2 Health management information systems

- The DHIS2 is the information system applied nationwide.
- Community health and nutrition volunteers (CHNVs) and community health workers (CHWs) are providing data on a monthly basis to the PHCs with which they are affiliated. The PHC manager then submits these reports together with the PHC report to the district level coordinator to be added in the DHIS2. There are preparations to further decentralize the DHIS 2 data entry to the PHC and CHW levels.
- Currently, standardized indicators on community health exist for services that CHWs, CHNVs and CMWs provide, including MNH, Malaria, the Expanded Programme on Immunization (EPI) and Integrated Management of Childhood Illness (IMCI). The MoPHP is working on further strengthening information systems as part of the community strategy.

2.3 Medicines and health commodities

- CMWs and CHWs provide a range of essential medicines for the services they provide, including ANC, PNC, SBA (for CMWs only) and IMCI. CHNVs provide only preventive care, and hence only supplementation of Vitamin A which was recently introduced into their role.
- The community health workforce receives their supply of essential medicines from the PHCs with which they are affiliated.
- Evidence shows several challenges exist with medicines and supplies for the community health workforce: 1) drugs ordered from international sources experienced delays; 2) drugs provided to health facilities meant to supply CHWs were consumed in the facility before reaching CHWs; 3) conflict and insecurity caused drug stockouts.
- The new strategy under development is expected to facilitate an establishment of a robust supply chain system for the community health workforce.

2.4 Health workforce

- Yemen has different types of community health workforce cadres, each with different and unique profiles, skill sets and mandates. CHWs and CMWs are recognized as part of the national health workforce and the Ministry of Legal Affairs is revising the organogram.
- Currently, there are 3,607 CHWs deployed across 108 districts (26 per cent of all districts) in 45 per cent of Yemen's governorates (10 governorates). More than 24,000 CHNVs covering 48 per cent of the villages in tier 2 and tier 3 settings. More than 8,700 CMWs exist in all governorates.
- All community health workforce personnel are women and selected and deployed from their own communities. However, it can be difficult to find qualified candidates in every village.
- Community midwives are highly trusted by women and ensure skilled care during pregnancy, childbirth, and post-pregnancy and immunizations.[6]
- Training curricula for CHWs run for three months and certification is provided by the MoPHP. This is an integrated and comprehensive training curriculum that covers different programmatic areas, including MNH, EPI, Nutrition, Malaria, IMCI, and community-based surveillance.
- Incentives are provided on monthly basis and meetings are quarterly convened. MOPHP is not authorized to take decisions on official employment or salaries. The first is under the Ministry of Civil Servants and the latter under the Ministry of Finance.
- Payments to CHWs are made solely from external sources at $100 per month. Payments are made in bimonthly cycles and are linked to the submission of monthly reports by each CHW.
- The new strategy is expected to redefine the role of the community health workforce, including training, linkages, supervisory mechanisms and renumerations.

2.5 Service delivery

- The different community-based cadres provide different services. The CMWs, after attending three years of pre-service training, provide comprehensive maternal, newborn and child health services, including attending deliveries at health facilities and at home.
- CHWs provide ANC, PNC, ICCM/MCI and Nutrition services, in addition to raising health awareness to generate demand and uptake for health services. Currently, they do not attend deliveries and provide injectables.[7]
- A referral system is in place that links CHWs with primary health care facilities. In some instances, the referral system remains underdeveloped. This is the case for referral systems for CMWs and CHNVs, for example.
- Travel is the primary threat to the safety of CHWs and supervisors. Measures taken to protect them include pairing males and females, only serving in one's home village, security training and coordinating with community leaders to ensure their safety.

6 USAID (2022). Helping a Couple Achieve the Dream of Parenthood. https://medium.com/usaid-2030/helping-a-couple-achieve-the-dream-of-parenthood-bd80855f3573

7 UNICEF (2024). Community Health Workers Network: A life-saving initiative for mothers and children in rural Yemen. https://www.unicef.org/yemen/stories/community-health-workers-network-life-saving-initiative-mothers-and-children-rural-yemen

2.6 Partnerships and financing

- Community health is mainly supported through partnerships and external aid, including from bilateral and multilateral donors (e.g., UNICEF, WHO, European Union, USAID, World Bank, Save the Children, etc.). The type of support provided includes training, supplies, equipment, job aids, supervision, remunderation, M&E, data collection and reporting.
- Expenditure on health as a percentage of GDP is 4.25 per cent (WHO, 2015) and the budget allocated to health was 2.23 per cent in 2015.[8]
- Despite the commitment of the MoPHP to community based PHC, the socio-economic challenges have not allowed for allocation of domestic resources. Partners are involved in the development of the new strategy, and this is expected to facilitate ownership of the strategy, potentially facilitating future funding. However, a sustainable financing mechanisms has to be established.

2.7 Cross-cutting issues

2.7.1 Gender

- Gender considerations are not currently incorporated into CHW trainings and there are no gender sensitive policies or programmes in place.
- All personnel in the community health workforce in Yemen are women.

2.7.2 Emergency preparedness

- CHWs are currently included in emergency preparedness plans in Yemen.
- There are safety measures in place, however, for CHWs. These include, for example, pairing men and women together to travel to remote areas; only serving in home village; security training and coordinating with community leaders to ensure CHWs safety.

2.7.3 IDPs and refugees

- IDPs can receive services if they reside within the catchment area that the community health workforce serves. The community health workforce visited IDP camps regularly to deliver services, although the influx of more IDPs strained the work.

8 WHO (2015). WHO Global Data Observatory Data Repository. https://apps.who.int/gho/data/view.main.GHEDGGHEDGGESHA2011v?lang=en

3. Conclusions

3.1 Challenges

- Social mobilization, supply chain and regular supervision is difficult during heightened conflict and insecurity.
- Departure of health care professionals moving into private sector or abroad.
- Current community health programming is dependent on external aid, which leads to poor sustainability.
- Service delivery challenges related to both a weak health system and the conflict.
- Short-term donor funding for interventions that are not integrated in PHC are unsustainable.
- Frequent drug supply interruptions and gaps.

3.2 Enablers

- Community health is well supported by MoPHP's primary health care policies and strategies.
- Existence of several national policy documents and programmes that can serve as a foundation for formalizing community health.
- There is a strong demand for a community health workforce, especially in hard-to-reach areas that are removed from PHC facilities.
- Mobile networks (i.e. phones, mobile applications, or emails) have been successfully used for CHW supervision.

3.3 Priority policy directions

- Develop, review, update and endorse key national policies and strategies related to community health (e.g., Community Primary Health Strategy).
- For the development of the Community Health Strategy:
  - Ensure that community health workforce cadres are harmonized and aligned with clear strategic direction on roles, package of services, coverage, geographic prioritization and remuneration.
  - Prioritize career development pathways for community health workforce personnel and linkages with community midwifery programmes.
  - Formalize capacity building programmes for the community health workforce to ensure quality of trainings and academic recognition.
  - Consider provision of mental health and psychosocial support to the community health workforce under this strategy.
- Ensure adequate and sustainable financing for the scale-up of the community health workforce. Ensure integration of donor support into these initiatives and advocate for increased multi-sectoral government ownership and financial commitment.
- Given the current health professional shortages and travel difficulties, shift health service delivery tasks where possible to the community health workforce and enable them to take on more responsibilities and tasks.

- Strengthen monitoring and feedback within community health. This includes sensitizing health facilities on community health work support.
- Ensure community health workforce personnel and supervisors can continue their work amidst travel difficulties due to conflict by ensuring access to mobile networks.

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