Closing the Gap

The pivotal role of community health in the Middle East and North Africa Region

Regional Report

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Regional Report

December 2024

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BHSP	Basic Health Services Package
CBHP	community-based health programme
CCM	country coordination mechanism
CHW	community health worker
CHNV	community health and nutrition volunteer
CMW	community midwife
CPD	continued professional development
CSO	civil society organizations
DAO	Dar Al Oumouma
DSC	Dispositif de Santé Communautaire
EPI	Expanded Programme on Immunization
GAC	Global Affairs Canada
GBV	gender-based violence
GF	Global Fund
HMIS	health management information system
HIV	human immunodeficiency virus
iCCM	integrated community case management
IDP	internally displaced persons
IMCI	integrated management of childhood illness
IEC	information, education and communication
IOM	International Organization for Migration
LMIS	logistic management information system
MENA	Middle East and North Africa
MNH	maternal and newborn health
MoH	Ministry of Health
MoPH	Ministry of Public Health
MPS	minimum package of services
MUAC	mid-upper arm circumference

NCD	non-communicable disease
NCDC	National Centre for Disease Control
NW Syria	Northwest Syria
PHC	primary health care
PHCC	primary health care centre
PHCI	primary health care institute
PPE	personal protective equipment
PSEA	protection from sexual exploitation and abuse
SOP	standard operating procedures
STI	sexually transmitted infections
ToC	theory of change
ToT	training of trainers
TWG	technical working group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UPHI	Universal Public Health Insurance
WHO	World Health Organization

Executive summary

This report presents a **mapping of community health** across the Middle East and North Africa (MENA) region, commissioned by the UNICEF MENA Regional Office. Covering 12 countries — **Algeria**, **Djibouti**, **Egypt**, the **Islamic Republic of Iran**, **Iraq**, **Jordan**, **Lebanon**, **Libya**, **Morocco**, **Tunisia**, **Sudan**, **Yemen** — and the subnational area of **Northwest Syria** (NW Syria). This mapping offers a baseline snapshot of existing community health resources, policies and infrastructure in each country or area. The mapping, carried out between August 2023 and November 2024, aims to support policymakers and multisectoral stakeholders, including civil society organizations (CSOs) and donors in identifying systemic gaps, setting strategic directions and responding to specific country needs for strengthening community health to achieve better outcomes for children.

Objectives and scope

The primary aim of this mapping is to show the availability of community health components across the selected MENA countries, rather than to assess their quality. This mapping provides an inventory of policies, structures and community health workers (CHWs), establishing a neutral reference point for future actions. The scope of the study encompasses **key health system pillars** — governance and accountability including community engagement, health management information systems (HMIS), health workforce, service delivery, medicines and health commodities, partnerships and financing and cross-cutting issues including gender, emergency response and internally displaced persons (IDPs) and refugees.

Methodology

Data collection involved desk reviews, surveys, key informant interviews and co-creation workshops held with national ministries and other stakeholders. Findings are synthesized into this report and an interactive **MENA Region Community Health Dashboard**, offering a tool for regional stakeholders to visualize current structures and track updates over time. This tool is intended to aid policymakers and stakeholders in monitoring the evolution of community health, should data be updated in future years.

Key findings

The mapping exercise reveals both challenges and opportunities within community health across the MENA region. Countries exhibit varying levels of development in their community health frameworks, workforce integration, service delivery models and data management practices, with distinct strengths and areas for improvement emerging across the health system pillars:

Governance and accountability

Community health governance varies widely. Half of the mapped countries have established formal policies and frameworks. In other countries, community health operates within broader primary health care (PHC) frameworks. Private sector involvement remains generally minimal, though **Lebanon** demonstrates more structured engagement, integrating private entities within public health outreach, training and service delivery. Community engagement mechanisms exist in all countries, but formal social accountability

structures are underdeveloped. Governance structures in the region reveal an emerging recognition of the importance of CHS and there are opportunities to integrate community health as a critical pillar of national health strategies. Formalizing the roles of CHWs within governance structures and decision-making processes presents a clear pathway to enhancing accountability.

Priority policy directions

1. Develop legal frameworks to formalize CHWs' roles and responsibilities.
2. Develop governance and oversight mechanisms to ensure integration and coordination of community health.
3. Promote public-private partnerships to enhance governance and resource mobilization.
4. Foster stakeholder engagement, including involving CHWs in programme design and policymaking, strengthening community engagement systems and institutionalizing social accountability mechanisms for stronger community involvement.

Health management information systems (HMIS)

Overall, there is limited integration of community health data into national HMIS in most countries. Some countries rely on paper-based systems, limiting the timeliness and accessibility of data, while others, such as the **Islamic Republic of Iran**, use digital platforms for more efficient data management. Parallel systems are occasionally in place, presenting an opportunity for integration and streamlining. There are also opportunities to develop standardized indicators across the region, which could enhance data consistency, cross-country comparisons and data-driven decision-making for community health.

Priority policy directions

1. Digitize and integrate community health information by investing in digital infrastructure and standardized data collection tools. Integrate community health data into national HIS, including behavioural data and social feedback.
2. Improve monitoring, evaluation and data quality by creating standardized indicators, and strengthening capacity for data analysis and for use in evidence-based decision-making.
3. Establish coordination and feedback mechanisms between community health programmes and health facilities. Ensure national databases register and track CHWs and key health personnel involved in community health initiatives.

Health workforce

CHWs are an essential part of health service delivery in the MENA region and their roles, training, and compensation vary according to context. Some countries have formalized CHW roles, while others depend on temporary or volunteer-based work, leading to variability in workforce stability. This presents an opportunity to standardize recruitment, training and accreditation across the region, which would foster a more skilled, supported and reliable CHW workforce. Formalizing employment pathways could enable CHWs to reach rural and underserved communities with a more structured, sustainable approach.

Priority policy directions

1. Unify the definition of CHWs and recognize them as part of the national health workforce.
2. Establish national accreditation systems and standardized CHW training curricula.
3. Compile CHW master lists that are disaggregated by key socio-demographic characteristics.

Service delivery

Community-based service delivery models are present in most mapped countries, yet the specific services offered by CHWs differ significantly. Core services include maternal health, immunizations, disease surveillance and health promotion. However, there are considerable differences in how integrated these services are within the PHC system, with some countries like **Algeria** and the **Islamic Republic of Iran** achieving high levels of integration, while others operate through parallel systems or vertical programmes, reducing the effectiveness and sustainability of CHW contributions.

Priority policy directions

1. Develop a predefined national package of services that is country-specific and that reflects community health priorities and aligns with national health strategies.
2. Strengthen formal linkages for the provision of more holistic services, including ensuring multisectoral collaboration to avoid duplication of efforts.

Medicines and health commodities

Countries like **Egypt**, the **Islamic Republic of Iran** and **Yemen** have set a precedent by establishing national standards for CHW supplies, providing a model for others. Countries reliant on CSO-driven supply chains, such as those in conflict-affected areas, have shown adaptability by utilizing these flexible, responsive models. Leveraging regional best practices in supply chain management offers a promising approach to ensuring reliable access to essential health commodities, even in challenging environments.

Priority policy directions

1. Develop standardized supply lists for CHWs and align them with national PHC priorities.
2. Expand LMIS to community levels and ensure alignment with national systems. This will help build resilience in supply chains to reduce stockouts, particularly in conflict-affected areas.

Partnerships and financing

Existing partnerships with international organizations and CSOs have proven invaluable in supporting community health in resource-constrained settings. These partnerships offer a foundation to build on through structured public-private partnerships, as seen in **Lebanon**, which could serve as models for other countries. The presence of dedicated budget lines for community health in some countries suggests that integrating community health into national health financing is achievable and can reduce reliance on external funding, promoting sustainability.

Priority policy directions

1. Ensure appropriate budget allocation and financial planning, including advocating for dedicated domestic funding for CHS and shifting allocation towards preventative care.
2. Develop innovative and diversified financing models, including by fostering partnerships with private sector or by developing community-based health insurance schemes to diversify funding sources.
3. Ensure collaboration and resource sharing through partnerships between government agencies, CSOs and external donors.

Cross-cutting issues

Gender-sensitive policies, emergency preparedness and support for IDPs and refugees are increasingly being incorporated into community health strategies. For example, **Sudan**'s inclusion of CHWs in emergency response and the integration of refugee services in Jordan highlight pathways to scale these efforts regionally. Countries have a strong opportunity to leverage CHW roles in delivering tailored services to vulnerable populations and expanding gender-sensitive policies will foster inclusivity and strengthen health equity across the MENA region.

Priority policy directions

1. Include gender sensitivity throughout community health policies and programmes, including training and recruitment processes.
2. Integrate CHWs into national emergency preparedness plans with a focus on rapid deployment and resilience.
3. Ensure additional training is provided to CHWs deployed in emergency situations and provide additional security measures as needed.
4. Ensure CHWs are based in their own communities to allow for rapid and efficient response processes.
5. Include refugees and IDPs as CHWs in the national health workforce.
6. Integrate refugee/IDP community health services into the national public health system.

Conclusion

The MENA region exhibits considerable variation in the development and operationalization of CHS. While some countries have made significant progress, gaps remain in governance, workforce development, data integration and financing. By addressing these gaps and leveraging identified opportunities, policymakers and regional stakeholders can strengthen community health as a cornerstone of equitable and resilient health in the region. As next steps policymakers, community health workers and local stakeholders, with support from UNICEF and partners, look forward to taking these actionable policy directions together to achieve this vision.


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1. Introduction

1.1 Background

Middle East and North Africa (MENA) is a diverse region with considerable variations in demography, dynamics and economic status.[1] The region contains low-, middle- and high-income countries with a range of health outcomes and disparities in health coverage and provision of care.[2][3][4][5] Over the years, countries in the MENA region have faced long conflicts and protracted complex crises, including political and climate crises and continue to face major development challenges such as gender inequality, high unemployment rates, rapid population growth with a large youth demographic bulge and growing misinformation and disinformation fuelling mistrust in service delivery systems. These challenges have significantly impacted the health systems in these countries.[6] Damage to infrastructure, disruption of essential health services and displacement of health care professionals have all contributed to the fragility of these systems, exacerbating the challenges faced in delivering comprehensive health care and rendering these countries vulnerable to health emergencies and threats of infectious diseases.

In such a context, strengthening the health system to deliver quality, equitable and affordable health care for all and enhancing health system resilience is key to achieving global health security.[7] High quality, accessible and equitable primary health care (PHC) that reaches the last mile is paramount to improve health outcomes of the population. Within the health system, the community level offers a critical and strategic entry point to deliver cost-effective, essential health services to the last mile. Community health, including community health workers (CHWs) have a vitally important role within this system and greatly contribute to emergency responses while mitigating health and economic consequences.[8]

Recognizing the need to strengthen the health system at community level and invest in one of its most fundamental assets – the health workforce – the Monrovia Call to Action[9] launched in March 2023, called upon leaders to invest in country-led community health strategies. It called for professionalizing CHWs, integrating them into health sector plans, securing political support and establishing accountability frameworks to track progress.

To realize the potential of the Monrovia Call to Action for improved primary health care, it is imperative to identify and address gaps related to pillars of community health: governance, financing, health management information systems, infrastructure and supplies, service delivery and the health workforce. By considering all these factors and their interdependencies, countries can develop strategies and interventions that address the entire spectrum of challenges and create resilient and sustainable community health that effectively serve the needs of the population. By establishing resilient community health, countries will be capable of responding more effectively to health crises and enhancing the overall well-being and health outcomes of populations.

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1 Plus, S. (2018). *Health Trends in the Middle East and North Africa: A Regional Overview of Health Financing and the Private Health Sector*. Rockville, MD: ABT Associates Inc. Retrieved from https://www.hfgproject.org/health-trends-in-the-middle-east-and-north-africa/

2 Mate K, Bryan C, Deen N, and McCall J. (2017). Review of health systems of the Middle East and North Africa region. *Int Encyclopaedia Public Health*. (2017) 4:347–56. 10.1016/B978-0-12-803678-5.00303-9

3 Ama, P.L, Ayodeji, F., and Hadia Samaha, K. (2004). Public Health in the Middle East and North Africa: Meeting the Challenges of the Twenty-first Century. *WBI Learning Resources Series*. Washington, DC: The World Bank.

4 Mate, K., Bryan, C., Deen, N., and McCall, J. (2017). Review of health systems of the Middle East and North Africa region. *Int Encyclopaedia Public Health*. 4, 347–56. Doi:10.1016/B978-0-12-803678-5.00303-9

5 Ama, P.L, Ayodeji, F., and Hadia Samaha, K. (2004). Public Health in the Middle East and North Africa: Meeting the Challenges of the Twenty-first Century. *WBI Learning Resources Series*. Washington, DC: The World Bank.

6 UNICEF. Health in Middle East and North Africa. UNICEF MENARO. Retrieved from https://www.unicef.org/mena/health

7 Plus, S. (2018). *Health Trends in the Middle East and North Africa: A Regional Overview of Health Financing and the Private Health Sector*. Rockville, MD: ABT Associates Inc.

8 Sirleaf, E. J., and Clark, H. (2021). Report of the Independent Panel for Pandemic Preparedness and Response: making COVID-19 the last pandemic. *The Lancet*, 398(10295), 101-103.

9 CHW Symposium and Monrovia CTA. (2023). Community Health Impact Coalition. Retrieved from https://chwsymposiumliberia2023.org/2023/03/27/the-monrovia-call-to-action-launched-by-the-liberia-ministry-of-health-at-2023-chw-symposium/

1.2 Development of this report

This initiative was commissioned by the UNICEF MENA Regional Office to provide a **mapping of community health**, with a specific focus on documenting the presence or absence of essential community health components. The mapping exercise aimed to capture a **snapshot of the current landscape** of community health across the region, detailing the availability, types and structures of policies, services and health workforce resources that support community health at the local level.

Unlike an assessment, this mapping does not measure, score, or evaluate the functionality or quality of community health delivery, but instead documents their existence and scope within selected countries. The mapping also outlines future priority policy directions to support strengthening and scaling community health in the region. For the purposes of this mapping, *CHWs are understood as health workers who have at least some training or education and are based in communities, either conducting outreach beyond PHC facilities, or being based at peripheral health posts that are not staffed by other health professionals* (e.g., doctors or nurses).[10] The mapping was conducted between August 2023 and November 2024.

The report synthesizes findings from 12 countries in the region, providing a summary of community health in **Algeria**, **Djibouti**, **Egypt**, the **Islamic Republic of Iran**, **Iraq**, **Jordan**, **Lebanon**, **Libya**, **Morocco**, **Tunisia**, **Sudan** and **Yemen** as well as the subnational area of **Northwest Syria** (NW Syria). A survey was conducted in the 12 countries,[11] gathering data from desk reviews as well as insights from key informant interviews. The survey covered results from pre-defined key indicators related to health system pillars and cross-cutting issues (see section 1.4). In addition, co-creation workshops were held at country level to validate findings and formulate future policy directions with relevant stakeholders with significant inputs from national ministries of health as well as other ministries and partners.

This mapping contributed to three key outputs a) the country briefs, b) MENA Region Community Health Dashboard and c) the regional report. **Country briefs** were developed for each country, as well as for the subnational area of NW Syria, based on the findings from the survey, desk review and interviews to further understand the existing situation.

The **MENA Region Community Health Dashboard**,[12] consolidates findings into a digital, interactive format. Designed as a practical resource for stakeholders, the dashboard offers an accessible platform to track community health components across the region. With the potential to be updated in coming years, the dashboard enables stakeholders to visualize changes, review longitudinal data and assess trends in the availability and integration of community health. This dashboard thus provides both a current overview and a mechanism for tracking progress toward more resilient and inclusive health systems as data updates are incorporated over time. Accompanying the dashboard are the country briefs and the regional report which serve as resources for advocacy and strategic planning, providing national and regional stakeholders with a baseline to inform community health efforts.

In terms of structure, the regional report is divided into seven main sections, according to the WHO health system pillars: 1) governance and accountability, including community engagement, 2) health management information systems (HMIS), 3) health workforce, 4) service delivery, 5) partnerships and financing, 6) medicines and health commodities, as well as 7) cross-cutting issues, including gender considerations, emergency response as well as internally displaced persons (IDPs) and refugees. It provides, as a conclusion, an overview of suggested priority policy directions to strengthen PHC through community health in the MENA region.

10 UNICEF. (2021). Guidance for community health worker strategic information and service monitoring, UNICEF, New York. Retrieved from https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/_recycler_/210305_UNICEF_CHW_Guidance_EN.pdf

11 Because the survey looked at national level indicators, the subnational context of NW Syria was not included in the survey.

12 The English version of the Dashboard can be found here. The French version can be found here.

1.3 Limitations

Several limitations should be acknowledged in association with the development of this report:

1. **Scope of countries and generalizability:** The mapping includes 12 countries and one sub-national area (NW Syria), which represents a diverse range of political, socio-economic and health system contexts. The findings may not be fully generalizable to all MENA countries. Differences in governance structures, health policies and service delivery models could mean that some of the challenges and opportunities identified may not be directly applicable to countries not included in this mapping.
2. **Data availability and quality:** The mapping relies on a combination of desk reviews, key informant interviews and co-creation workshops. However, the quality and comprehensiveness of available data varied across countries. Some countries may have more robust health information systems or better-documented policies, while others lacked detailed or up-to-date information. This disparity in data availability may have affected the level of detail provided for some countries.
3. **Political instability and conflict:** Several countries included in this mapping, such as **Lebanon**, **Sudan** and **Yemen** as well as the subnational area of **NW Syria**, are experiencing ongoing political instability and conflict. These challenging environments made it difficult in some instances to gather data or conduct interviews and workshops effectively. Findings therefore varied based on accessibility of data in countries currently facing conflict situations.

By acknowledging these limitations, this regional report aims to present a balanced and realistic view of the community health in the MENA region, while also identifying areas for future efforts. UNICEF, in collaboration with governments and partners, will take forward the recommendations and priority policy directions in 2025 and beyond.

1.4 Community health indicators

For each country participating in this mapping, a set of indicators were developed in collaboration with UNICEF, which informed the data collection for this assignment. The set includes indicators for each of the health system pillars, as well as for cross-cutting issues.

Table 1. Indicators for health system pillars and cross-cutting issues

	Main health system pillars	Indicators for country profiles/dashboards
1	Governance and accountability, including community engagement	1. Existence of an overarching community health policy or strategy 2. Existence of an overarching national CHW policy or strategy that explicitly stipulates the roles, qualifications and competencies of CHWs 3. CHWs recognized as part of the formal national health workforce in the country 4. Existence of a policy document stipulating that CHWs are compensated through government wage bills 5. Reference to community health services in PHC policy/strategy (e.g., referral protocols) • Level of integration of community health into PHC e.g., referral protocols) • Date of official integration of community health services in the PHC policy/strategy 6. Existence of community health services at community level provided by the private sector • Level of engagement of the private sector in provision of health services at community level 7. Type of community engagement mechanisms (e.g., health committees) 8. Existence of mechanisms that allow for CHW participation in decision making (e.g., participation in community health advisory committee, community health planning committee, community health promotion committee, community health emergency response committee) 9. Type of social accountability mechanisms (e.g., community score card, complaint and feedback system, meetings between community representatives and health workers at community level)

Table 1. (continued)

	Main health system pillars	Indicators for country profiles/dashboards
2	Health management information systems	1. Existence of a national health management information system (HMIS) • Existence of a component for management of community-based health data within the national HMIS • Type of platforms • Inclusion of social and behavioural health data in Community-HMIS (C-HMIS) 2. Means for community health data collection (e.g., digital, paper based, other) 3. Existence of a standardized set of indicators on community health 4. Existence of regular reporting on services provided by CHW
3	Health workforce	1. Total targeted number or health workers (overall workforce) as per national policy • Existence of (up to date) age and sex-disaggregated workforce data 2. Current coverage of health workers (based on population) vs target coverage, total and sex disaggregated. 3. Total targeted number of CHWs as per national policy 4. Total national population to be reached by CHWs as per national policy 5. Current coverage of CHWs (based on population) vs target coverage, total and sex disaggregated. 6. Geographical coverage of CHWs, total and sex-disaggregated 7. Geographic work area of CHWs: own community or elsewhere 8. Official cadres of CHWs (e.g., CHW, community midwife, health assistant, health volunteer) • Number of CHWs against each cadre, total and sex-disaggregated 9. Existence of CHW master list (CHWML) • Type of CHWML (e.g., Community Health Workers Master List, Management information system for Human Resources for health) • Existence of options for sex- and age disaggregation 10. Age distribution of CHWs • Number of CHWs against each age category, total and sex-disaggregated 11. Number of CHWs living with any kind of disability, total and sex-disaggregated 12. Existence of predefined criteria for to select CHW 13. Existence of a training curricula for CHW (e.g., pre-service training and opportunities for Continuous professional development (CPD)) 14. Existence of accreditation of CHW (knowledge and competencies are assessed and (re)certified) 15. Type of remuneration for CHW (e.g., salary, non-financial compensation), sex-disaggregated 16. Provision of supportive supervision of CHW • Type of supervision (e.g., through regular skill development, problem solving, performance review and data auditing, integrated) • Frequency of supervision • Number of supervisors, total and sex-disaggregated
4	Service delivery	1. Type of community-based service delivery models and platforms (list the different types) 2. Existence of standardized processes and/or guidelines for enhancing quality of care at community level 3. Existence of referral pathway to ensure continuity of care involving CHWs 4. CHW service delivery package as per national policy/strategy • **Specify:** Social and Behaviour Change Communication (SBCC); Health promotion and education; Environmental health, hygiene and sanitation; Malaria prevention and control; Integrated Community Case Management (iCCM)/Integrated management of childhood illness, Prevention and control of NCDs, including disability; Immunization/vaccination related services; Prevention and control of NTDs; Nutrition related services; HIV/TB related services; Adolescent Sexual and reproductive health services; Sexual and reproductive health services, Gender Based Violence services; Prevention of harmful practices, such as child marriage, female genital mutilation (FGM); Maternal and newborn health related services; Psychosocial support; Community disease surveillance and reporting; Vital events reporting including promoting birth registration; Verbal autopsy; Preventing/responding to public health emergencies; Early childhood development; School health; Infant and Young Child Feeding (IYCF); Other • **Specify:** integrated package of PHC services or vertical provision of services through vertical programmes 5. Existence of formal linkages with other sectors at community level (e.g., education, WASH, Child Protection/Social Welfare)

Table 1. (continued)

	Main health system pillars	Indicators for country profiles/dashboards
5	Medicines and health commodities	1. Existence of a national standard list of supplies for use by CHWs 2. Inclusion of supplies required for care provided at community level in mainstream public health national supply system 3. Existence of Logistics Management Information System (LMIS) in place at community level as part of the national LMIS • Type of platform
6	Partnerships and financing	1. Means for data collection (e.g., digital, paper based, other) 2. Proportion of domestic funding for community health (vs external funding) • **Specify:** Name of ministry responsible for funding CHW 3. Existence of a specific budget line in the national health budget for community health 4. Existence of a costed national community health policy/strategy • Proportion of costs for implementation of community health strategy that is funded 5. Main external funders of CHW related activities (e.g., government, Global Fund, Gavi, World Bank, Bill and Melinda Gates Foundation/BMGF) 6. Type of support provided by funders (e.g., provision of supplies, training/capacity building, remuneration/motivation/salaries, documentation, other)
7	Cross-cutting issues	**Gender considerations** 1. Existence of training for CHWs on gender considerations 2. Existence of gender sensitive CHW policies and programmes, including Protection from Sexual Exploitation and Abuse (PSEA) mechanisms 3. Existence of gender sensitive recruitment and selection processes **Emergency preparedness and response** 4. Incorporation of CHWs and supervisors in emergency preparedness plans (existing/established or newly recruited CHWs) • Provision of additional training • CHWs work within their own communities (if not, it could affect access to services during times of emergencies) • Existence of security measures for CHWs in emergency situations (insurance, security training – particularly for female CHW) **Refugees/IDP settings** 5. Level of integration of refugees/IDPs into existing community health programmes 6. Level of involvement of refugees/IDPs in CHW workforce for those communities 7. level of integration of refugee/IDP community health services into national public health system

2. Health systems pillars

2.1 Governance and accountability, including community engagement

Key findings

- Five out of 12 countries in the MENA region have established national frameworks for CHWs with dedicated policies and departments. For countries without a dedicated community health programme in place, community health is addressed in three ways: 1) Community health activities are incorporated within their PHC systems, 2) community health is delivered through specific vertical programmes or 3) as a combination of both.
- Five out of 12 countries officially recognize CHWs as part of the national workforce, as civil servants and/or on governmental payroll, while six do not. Countries recognizing CHWs as part of the national health workforce have dedicated legal frameworks or national strategies in place that clearly delineate the roles of CHWs, with some ad hoc challenges also addressed.
- There is a limited engagement of CHWs in decision-making, with decisions related to community health often being made at higher governance levels, whether interventions are led by governments or humanitarian organizations.
- Seven out of 12 mapped countries show some level of private sector involvement, which has been characterized as "partial involvement". Private sector engagement often lacks formal legal frameworks or organized public-private partnerships.
- MENA region countries have made significant progress in establishing and operationalizing community engagement mechanisms. All participating countries reported having at least some form of community engagement mechanisms in place, primarily through training on key health topics and health promotion and lifestyle activities.
- There is limited involvement of community members in social accountability mechanisms in the participating MENA region countries, with the exception of the Islamic Republic of Iran, Jordan and Sudan.

Existing strategies/policies on community health

Community health service delivery is vital in all contexts but especially where the health system at other levels is disrupted, temporarily weakened, or have reduced functionality,[13] [14] as is the case in many MENA countries experiencing conflict (e.g., Sudan, Yemen, etc.), fragmented health system governance (e.g., Lebanon),[15] and natural disasters (e.g., Libya, etc.). Establishing robust legal frameworks is essential for optimizing community health planning, service delivery, resource mobilization and the effective training and supervision of health care workers, ensuring sustainable and equitable health outcomes. This mapping highlights the diverse legal frameworks for community health across the 12 selected countries as well as the region of **NW Syria**, showing different levels of development and integration. As seen in Table 2, five of the mapped countries have established national frameworks with dedicated policies and departments.

13 Miller, N.P., Zunong, N., Al-Sorouri, T.A.A., *et al*. (2020). Implementing integrated community case management during conflict in Yemen. *J Glob Health;* 10:1–10.

14 Mullany, L.C., Lee, C.I., Paw, P., *et al*. (2008). The MOM project: delivering maternal health services among internally displaced populations in Eastern Burma. *Reprod Health Matters*, 16:44–56.

15 Moussallem, M., Zein-El-Din, A., Hamra, R., Rady, A., Kosremelli Asmar, M., and Bou-Orm, I.R. (2022). Evaluating the governance and preparedness of the Lebanese health system for the COVID-19 pandemic: a qualitative study. *BMJ Open*, 12(6): e058622. doi: 10.1136/bmjopen-2021-058622. PMID: 35649616; PMCID: PMC9160591.

Table 2. Countries with overarching community health policy or strategy

Countries	Existence of an overarching community health policy		
	Yes	No	Other*
Algeria			
Djibouti			
Egypt			
Islamic Republic of Iran			
Iraq			
Jordan			
Lebanon			
Libya			
Morocco			
Sudan			
Tunisia			
Yemen		[16]	

* **Other:** Alternative policy or strategy is available in the country.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Countries like **Djibouti** and **Egypt** have established clear policies and strategies to support community health programmes. **Djibouti**, for example, recently developed a National Community Health Policy in 2023, followed by a strategic plan for 2024–2028 and even created a dedicated Department for Community Health within the Ministry of Health (MoH) to oversee its implementation.

Egypt has a long-standing community health initiative, the "Raidat Rifiats Programme", launched in 1996[17] to promote family planning and population development, which has since evolved into a comprehensive national strategy and is now being managed by various ministries and NGOs.[18]

In **Morocco**, a national strategy emphasizing community health services was developed in 2019, known as the *Interventions en santé communautaire*[19] strategy, but it is untested and underfunded. The country has taken steps through initiatives like *Comités locaux de santé* (local health committees) and the *Dispositif de santé Communautaire* (DSC) (community health mechanism)- launched in 2019 – highlighting a growing recognition of community health.

16 A taskforce was recently formed to develop the National Community-Based Strategy. Further details are still under development and the strategy document is expected to be finalized by the end of 2024.

17 Folz, R., and Ali, M. (2018). Overview of community health worker programmes in Afghanistan, Egypt and Pakistan., *La Revue de Sante de La Mediterranee Orientale [Eastern Mediterranean Health Journal]*, 24(9), p. 940–950.

18 Maternal and Child Survival Programme. (2019). Development of Egypt's National Community Health Worker Strategy Optimising a Historical Programme for the Future. Retrieved from: https://pdf.usaid.gov/pdf_docs/PA00TXG5.pdf [Accessed August 2024]

19 MSPC. (2019). *Interventions en santé communautaire : Document de stratégie nationale.*

As for **Yemen**, key initiatives include the CHW Network established in 2017, which aims to expand to 15,000 CHWs by 2025 and the National Midwifery Strategy (2024-2026) designed to improve maternal and newborn health services through the training of community midwives. Also, a National Community-Based Strategy is under development, with a focus on involving CHWs in decision-making processes.

Establishing robust legal frameworks is essential for optimizing community health planning, service delivery, resource mobilization and the effective training and supervision of health care workers, ensuring sustainable and equitable health outcomes.

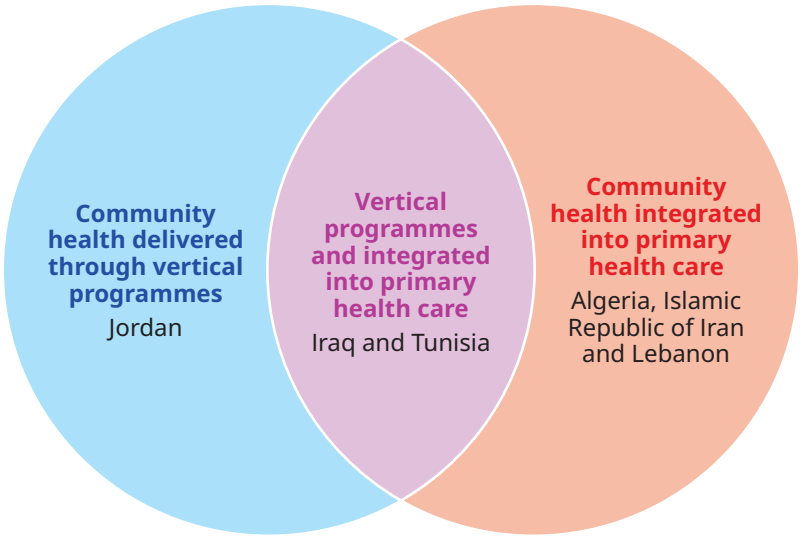
Furthermore, a Community Health Worker Investment Case, developed in 2022, aims to integrate community health efforts with primary health care, promoting a multi-sectoral approach to health system strengthening.

Sudan has a long history of commitment to community health and was finalizing its overarching community health policy at the time of this mapping (2024).

In addition to strong vertical programmes and strategies (e.g., Reproductive Health [RH], Expanded Programme on Immunization (EPI) and Malaria programmes, among others), the country can also build on its Primary Health care Expansion project and its integrated community case management (iCCM) strategy, both of which have strong community health integration components.

For countries without a dedicated department in place, community health is addressed at national level in three ways: 1) Community health activities are incorporated within their PHC systems (Algeria, the Islamic Republic of Iran and Lebanon), 2) community health is delivered through specific vertical programmes (Jordan), or 3) as a combination of the two (Iraq and Tunisia). See Figure 1.

Figure 1. Community health modalities in countries with no dedicated departments in place



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In **Algeria**, community health has long been established through their *santé de proximité* or *services de soins de base*, which encompass interventions at the population level. It is also mentioned and integrated through policies promoting prevention and bringing health services closer to the population, involving associations and representatives of users and patients.

In the **Islamic Republic of Iran**, CHWs have been officially integrated into PHC for decades. The General Policy of Health (2013) provides the overarching framework for community health in the country and community health services are an integral part of numerous primary health care policies and strategies.

Lebanon has embedded community outreach within its national primary health care (PHC) accreditation programme.[20] CSOs play a crucial role in this regard, organizing community health activities as part of their broader efforts to reach vulnerable populations[21] These initiatives are often driven by project-based needs rather than a national framework.

Jordan's 2008 Public Health Law, although not specifically addressing community health, regulates health promotion, disease prevention and community-based activities like immunization and non-communicable disease (NCD).

In **Iraq**, the National Health Policy (2014-2023) and the Basic Health Services Package (BHSP) mention the establishment of "community health houses" staffed by male and female CHWs to support immunization, growth monitoring, contraception distribution and other preventive services. Although this initiative has not yet been operationalized due to security concerns and other challenges, it represents an important step towards recognizing the role of community health in broader health care strategies. The country has also incorporated community health-like initiatives under broader health efforts or through partnerships with CSOs. Examples include efforts of the "health promoters" who are integrated into primary health care clinics and are responsible for health education, outreach and community engagement, bridging the gap between formal health care services and community needs. In addition, international organizations working on community health align their interventions with MoH requirements and efforts at the community level.

In **Tunisia**, the community health approach, though not formalized under a specific policy, is integrated into various health programmes, including PHC, Public Health, multisectoral collaboration and Family Medicine. The comprehensive model implemented in **Tunisia** covers preventive, curative and promotional health services. In addition, community health initiatives are currently being mainstreamed in the country's health efforts and reforms. In fact, the country is currently revising its national strategic plan for risk communication and community engagement, emphasizing the need for stronger community involvement in health risk management.

In addition to the aforementioned examples, the subnational area of **NW Syria** has its own model. The health system is dependent on cross-border international support and humanitarian funding due to the political situation in the region. Since 2015, CHWs have been introduced in the subnational region of **NW Syria** through international interventions and in 2017, they were included as part of the essential PHC package developed by the World Health Organization (WHO). A "Unified CHW Curriculum" was later created in 2018 to coordinate these efforts and a Technical Working Group (TWG) was established to provide guidance to community health interventions.[22] [23] The governance of community health interventions remains fragmented due to the humanitarian situation, resulting in dependence on international actors with little involvement of local authorities and inconsistent integration of CHWs into the health system. Despite these challenges, community health in the subnational area of **NW Syria** has shown resilience, particularly during emergencies such as the cholera outbreak, when coordinated efforts through the TWG proved effective.

20 Primary health care systems (PRIMASYS): case study from Lebanon, abridged version. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.

21 Hemadeh, R., Kdouh, O., Hammoud, R., Jaber, T., and Khalek, L.A. (2020). The primary healthcare network in Lebanon: a national facility assessment. Eastern Mediterranean Health Journal, 26 (6), 700–707. World Health Organization. Regional Office for the Eastern Mediterranean. https://doi.org/10.26719/emhj.20.003 License: CC BY-NC-SA 3.0 IGO

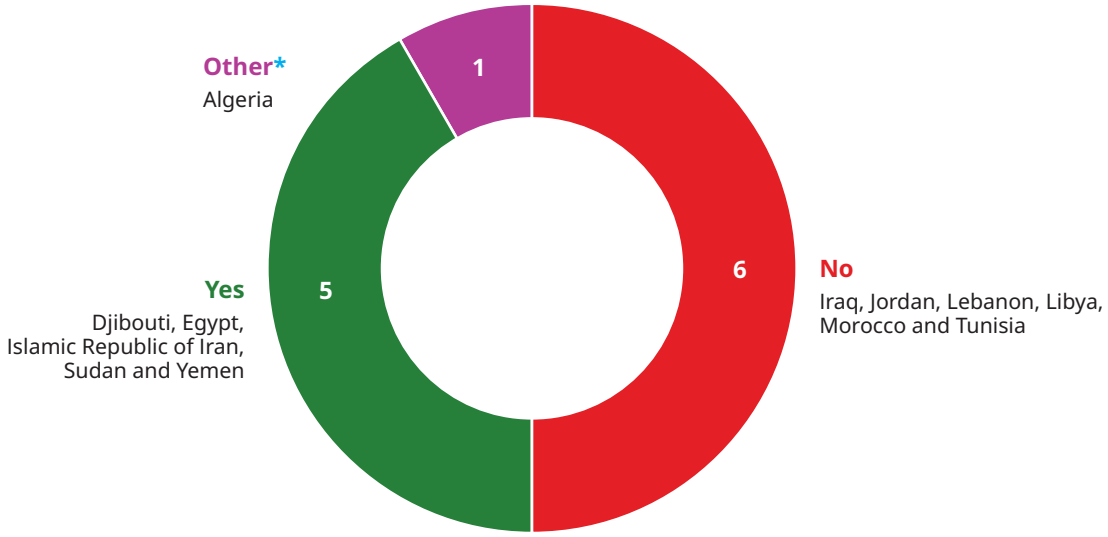
22 MSH. (2017). The Cost of an Essential Health Service Package for Northern Syria. [Online]. Retrieved from: https://msh.org/resources/the-cost-of-an-essential-health-service-package-for-northern-syria/ [Accessed August 2024]

23 Habboush, A., *et al*. (2023). A framework for community health worker optimisation in conflict settings: prerequisites and possibilities from Northwest Syria, *BMJ Glob Health*.

Existing strategies/policies related to CHWs

The variability in the integration of community health into legal frameworks is similarly reflected in the institutionalization of CHWs (having them as civil servants and/or on government payroll). Figure 2 shows the recognition of CHWs in the national health workforce, which varies significantly across the mapped countries: five out of 12 recognize CHWs as part of the national workforce (Djibouti, Egypt, Islamic Republic of Iran, Sudan and Yemen) and six do not. It has been reported that countries without formal integration face significant challenges in sustaining community health initiatives, as these programmes remain largely dependent on CSO-driven efforts and lack the governmental support required for long-term success.

Figure 2. Countries with CHWs recognized as part of national workforce (n=12)



* In Algeria, health care professionals in *Santé de Proximité* centres are full-time workers providing community-level services.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Strategies and policies related to CHWs vary from one country to another, as follows:

Countries like **Djibouti**, **Egypt**, the **Islamic Republic of Iran**, **Sudan** and **Yemen** have made strides in recognizing and integrating CHWs into their national health systems. In 2024, **Djibouti** established regulations to recruit CHWs and integrate them into the national PHC system, with a focus on fostering community engagement. In **Egypt**, CHWs, known nationally as *Raedat Rifiat*, was established by the government as part of the community health programme in 1996. The **Islamic Republic of Iran** has also fully integrated CHWs as part of its formal health workforce, where they play a key role in delivering services to both rural and urban populations. In **Sudan**, CHWs and community midwives are formally recognized at the state level and receive government salaries with employment rates varying by State and resources available. **Yemen** also recognizes CHWs as part of the national health workforce and efforts are underway to revise the legal framework to further solidify their roles.

The integration varies in form, with diverse approaches observed across countries, particularly in **Algeria**, **Tunisia** and **Morocco**. In **Algeria**, all health care professionals working in *Santé de Proximité* centres are full-time formal workers who provide services at the community level. They are integrated into the health system without differentiation based on their community interventions.

There is a necessity for stronger legal frameworks that clearly define the roles and qualifications of CHWs in many MENA countries, ensuring their effective integration into national health systems while granting them the recognition and support essential for their community health work.

There is no official definition of the roles, qualifications and specific competencies for CHWs, but their roles and importance are recognized, particularly in programmes addressing HIV, communicable and NCDs (such as cancer, disabilities, etc.). As for **Morocco**, its 2019 community health national strategy mentions CHWs, but their roles and qualifications are not clearly defined and they are not formally recognized within the national health workforce. **Tunisia** also does not have a formal status for CHWs, relying instead on "community liaisons" who are mostly volunteers working with CSOs.

In **Iraq**, health promoters within the MoH's Health Promotion Department engage in community work, but there is limited integration with other ministries such as education and youth. As for the CHWs employed by international organizations working closely with primary health care centres (PHCCs), they are not formally part of the national health workforce.

In countries like **Jordan**, **Lebanon** and **Libya**, CHWs are not formally integrated into the national health workforce. In **Jordan**, two types of health workers are involved in community health activities: primary health care workers (or "health promoters") and community health volunteers. The Health Promoters, with backgrounds in nursing or midwifery, deliver varied health promotion and disease prevention services, although they do not fully meet the definition of CHWs. The community health volunteers operate within community health committees to support the MoH's health messaging efforts in local communities. In **Libya**, CHWs are deployed by NGOs and recruited to work on specific NGO initiatives, with financial support being provided by NGOs and for the duration of the project. The CHWs therefore remain outside of the formal health workforce. As for **Lebanon**, despite the presence of numerous community outreach programmes led by CSOs, CHWs are not recognized as part of the national health workforce and do not have any official status or legal framework to support their role within the health system.

Integration of community health into PHC

There is a need to establish mechanisms for CHWs to actively participate in shaping the initiatives and services they provide to ensure these are fit for purpose and sustainable.

The integration of community health into PHC is uneven across the mapped countries in the MENA region, with some achieving significant progress in integration, while others continue to face challenges in fully incorporating community health into their national systems. See Table 3. The **Islamic Republic of Iran** reiterated its commitment to integration through the "General Policy of Health" (2013) which considers CHWs as an essential part of the PHC service package in the country, with clearly defined roles, qualifications and competencies.

In **Sudan**, there has been significant progress in integrating CHWs into the PHC system through the "PHC Expansion Project" which has focused on increasing PHC coverage. The project has expanded the role of CHWs and community midwives (CMWs), who are now recognized as formal health care providers. Additionally, commitment for integration is reiterated in the "National Health Policy (2017–2030)" which emphasizes integrating community health efforts into PHC service delivery. In **Algeria**, all services under *santé de proximité*, are primarily focused on prevention, managed by the state (governance, funding, organization, service delivery, etc.) and include community-level services, such as those provided by medical caravans and mobile vaccination campaigns.

Table 3. Countries integrating community health services into primary health care

Countries	CH services mentioned in the PHC policy/strategy	Level of integration
Algeria	Other*	Fully integrated
Djibouti	Other	Other
Egypt	No information/unclear	Other
Islamic Republic of Iran	Yes	Partially integrated
Iraq	Yes	Other
Jordan	No	Partially integrated
Lebanon	Yes	Other
Libya	Yes	Partially integrated
Morocco	Other	No information/unclear
Sudan	Yes	Partially integrated
Tunisia	Yes	Partially integrated
Yemen	Yes	Fully integrated

* **Other:** Alternative mechanism available in country.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

PHC Expansion project in Sudan

Sudan has made a significant effort to strengthen community health through its PHC Expansion Project. This project started in 2012 and aims to increase PHC coverage and move away from a hospital-centric model. Through this project, the scope of services offered has expanded with a significant increase in the total number of formal CHWs and community midwives (CMWs) trained and deployed.

Following extensive refresher trainings for CMWs in 2019, antenatal care blood pressure measurement and urine tests increased. The project also saw an increase in post-natal care uptake in project sites and a reduction in waiting times for patients at pilot hospitals. Community health committees were engaged to develop action plans for improvement of health outcomes as well as being engaged in health and hygiene promotion activities.

In **Libya**, while the "Primary Health Care Institute (PHCI) Strategy 2023"[24] emphasizes community engagement, community health integration with PHC services is through short-term projects funded by CSOs, which limit sustainability beyond the project's duration. As for **Iraq**, health promoters within the MoH, are involved in the PHC system, conducting community work. Their full integration remains limited, particularly as CHWs employed by international organizations do not typically receive recognition within the national health workforce. In **Yemen**, community health has been partially integrated into PHC since 2017, with some ownership at the programme level. The vertical nature of these programmes limits full integration and there is little coordination between different CHW cadres, resulting in a lack of a cohesive strategy.

In **Lebanon**, the mapping identified political commitment (with the MOPH Vision 2030) as well as some tangible efforts led by UNICEF toward better integration of community health within its PHC network.

24 The Primary Healthcare Institute (2023). Primary Health Care Strategy 2023, PHCI.

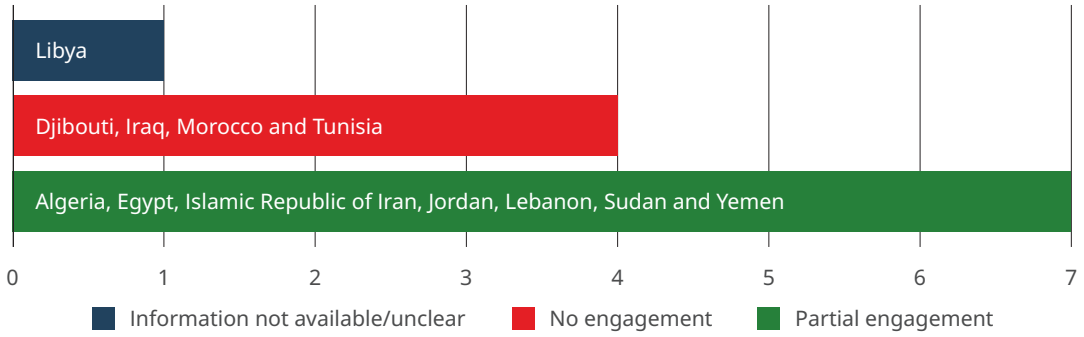
In 2023, UNICEF collaborated with the Ministry of Public Health (MOPH) to pilot an integrated model within 50 PHC centres, where CHWs work alongside nurses and midwives. Further steps are also being taken to involve performance-based incentives through the "Asalameh programme".

As for the subnational area of **NW Syria**, the integration of community health into PHC remains fragmented. While the roles of CHWs were clarified in 2018, implementation has been hindered by insufficient training, funding and coordination. As a result, CHW integration continues to face obstacles and a more cohesive policy and stronger commitment from PHC directors and supporting organizations are needed to achieve meaningful progress.

Engagement of the private sector

The private sector encompasses individual service providers (including alternative healers) and for-profit entities that are privately owned and operated. It excludes CSOs and faith-based organizations.
The involvement of the private sector in community health service funding, planning, or provision across the mapped countries in the MENA region remains minimal. Seven of the mapped countries – including **Algeria**, **Egypt**, the **Islamic Republic of Iran**, **Jordan**, **Lebanon**, **Sudan** and **Yemen** – show some level of involvement, which has been characterized as "partial involvement" (see Figure 3). Even when such involvement exists, it often lacks formal legal frameworks or organized public-private partnerships.

Figure 3. Countries with private sector engagement (n=12)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Where present, private sector contributions are limited to disease-specific associations (e.g., cancer patient associations), volunteer health personnel, or corporate social responsibility initiatives, with minimal coordination with relevant government ministries or public stakeholders. Partial engagement of the private sector has been noted in seven countries: **Algeria**, **Egypt**, the **Islamic Republic of Iran**, **Jordan**, **Lebanon**, **Sudan** and **Yemen**, as well as in the subnational region of **NW Syria**. In **Jordan**, the "National Health Strategy (2023-2025)" acknowledges the potential role of the private sector in health promotion and disease prevention. In the **Islamic Republic of Iran**, there is promising private sector involvement, with ongoing initiatives aimed at increasing engagement in family medicine services across 200 districts. In **Lebanon**, the private sector — highly dominant in the health care system and providing a significant share of health services with more advanced capacities and resources than the public sector— and civil society actively contribute to community health, especially in areas where the government lacks expertise or resources. Also in **Lebanon**, private entities lead awareness campaigns, conduct outreach activities, develop guidebooks and provide training for CHWs, playing a significant role in public health efforts. In **Sudan**, while the country does not have an official public-private engagement framework, there is some regulation at State level. This regulation is not fully enforced due to capacity issues. Overall, while there is some engagement at community level regulated by States in Sudan, it is limited. As for the subnational region of **NW Syria**, there has been some success in coordinating private sector health initiatives, such as the "Expanded Programme on Immunization (EPI)" cluster, where paediatricians referred defaulters and zero-dose children to vaccination teams, improving immunization rates.

For the remaining countries, either no engagement was observed, or the information regarding private sector involvement was unclear. In **Libya**, for example, it is unclear the extent to which the private sector is engaged at community level. While there was some private sector involvement during **Libya**'s COVID-19 response, particularly in vaccination campaigns, it was not sustained.

Private sector engagement in Lebanon

In **Lebanon**, the primary health care network is structured through a public-private partnership. The MoH provides technical support, but the actual ownership, management, operational costs and capital expenses of PHC are handled by private entities, namely NGOs.

These NGOs have a contract with the MoH and are mandated to maintain staff necessary to implement private health care activities. They are asked as part of the contract to conduct community outreach activities. The PHC receives a monthly incentive to make sure that they engage with stakeholders and reach out to the gatekeepers in the community to facilitate the work of CHWs at the community level.

In conclusion, while there are isolated examples of private sector engagement, the involvement of private entities in community health for service delivery beyond broader health information dissemination and health promotion, remains limited and unorganized across much of the region and there are opportunities for strengthening this engagement.

Existing community engagement mechanism

Strengthening community engagement platforms and mechanisms is crucial for fostering dialogue around demand, access and utilization of quality health services, as well as catalysing practice of life saving or risk reduction household behaviours for improved health and social well-being. Critically, community engagement mechanisms are necessary for ensuring the inclusion of community voices in decision-making related to community health, making health care systems more responsive and accountable to local needs. Some of the MENA region countries have made significant progress in establishing and operationalizing community engagement mechanisms. An overview of types of community engagement mechanisms by country can be seen in Table 4 below.

In **Algeria**, while community engagement is largely informal, it is nonetheless very active in the provision of community health services. For services provided by the government under the *Santé de proximité*, such as mobile caravans, collaboration between public health services and community leaders has fostered a sense of shared responsibility, particularly in health outreach. Other forms of community engagement are reflected in the participation of local actors, including volunteers, patients, families of patients and health personnel volunteers from the private sector, who actively participate in public health initiatives and service provision, especially at the community level. This participation remains sporadic and is limited to vertical programmes and specific diseases. Local associations and CSOs play a significant role in **Algeria**'s fight against HIV, working to raise awareness, provide screenings and support vulnerable populations, including migrants, as part of the National HIV Plan.

In **Djibouti**, recent efforts have led to the decentralization of decision-making by establishing focal points for communication, social mobilization and community involvement at primary and secondary health care facilities, aiming to better coordinate community activities at the facility level. In **Egypt**, where CHWs are ideally recruited from the communities they serve, community leaders have always played a key role in encouraging community members to apply for various CHW positions, ensuring that health workers are well-integrated and trusted by the local population.[25] In the **Islamic Republic of Iran**, regular meetings are held between community representatives and community health care providers, with ongoing efforts aimed at expanding these engagement mechanisms nationwide.

25 Folz, R., and Ali, M., (2018). Overview of community health worker programmes in Afghanistan, Egypt and Pakistan. *La Revue de Sante de La Mediterranee Orientale [Eastern Mediterranean Health Journal]*. 24(9), 940–950.

Table 4. Countries with community engagement mechanisms

Countries	Community engagement mechanisms
Algeria	Informal but active community engagement in health services; collaboration in *Santé de proximité* initiatives; active role of CSOs in HIV support.
Djibouti	Decentralization through focal points for communication, social mobilization, and community involvement at health care facilities.
Egypt	Community leaders encourage local recruitment of CHWs, enhancing trust and integration.
Islamic Republic of Iran	Regular meetings between community representatives and health care providers; efforts to expand engagement nationwide.
Iraq	Health committees at PHC level involve religious and community leaders; support from UNICEF for national health committee; varied approaches by ministry.
Jordan	Structured engagement led by the 'Health Communication and Awareness Directorate' through health committees with around 3,000 volunteers providing consultative feedback.
Lebanon	Private sector and civil society fill gaps with awareness campaigns, training, and development of guidebooks.
Libya	Community engagement tied to specific interventions, CHW involvement foreseen in Strategic Directions (2018), but limited intersectoral mechanisms.
Morocco	Local health committees supported by UNICEF, integration of CHWs through DSC, involvement of CCM in HIV and TB, and regional AIDS committees.
Sudan*	NHRR-SP 2022-2024 aims to improve PHC via a family health approach, focus on strengthening community systems through health dialogues and health committees.
Tunisia	National Health Policy 2030 promotes community participation, providing opportunities to develop engagement mechanisms.
Yemen	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.

* Not operationalized yet.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In **Iraq**, some community engagement occurs through health committees at the PHC level and include religious and community leaders. Effectiveness of these depend on the committee members and the PHC manager. Vertical community health programmes initiated by international organizations use various mechanisms (e.g., regular meetings, training, community consultation sessions) to engage communities in their work. The types of mechanisms differ by organization and are not streamlined via the government. Those focal points also facilitate community engagement as part of their duties to respond to health epidemics or provide overall social behaviour change on key health priorities. **Jordan** offers a structured approach, where the "Health Communication and Awareness Directorate" at the MoH leads community engagement through mechanisms like community health committees and health promotion activities. These committees, composed of approximately 3,000 volunteers, hold regular meetings with local and national health officials to provide feedback. The role of these committees is primarily consultative, with no formal involvement in decision-making processes.

Community engagement mechanisms have played a crucial role in fostering trust between health workers and the communities across countries in the region.

In **Lebanon**, the private sector and civil society have been highly active in filling gaps where the state lacks resources or expertise. The contributions of these sectors to community health, range from awareness campaigns and outreach activities to providing training and developing guidebooks for community health actors.

In **Libya**, community engagement activities tend to be limited to the duration of the associated intervention. The document, "Strategic Directions for Establishing CHWs" (2018), foresees participation of CHWs in decision-making processes as well as linkages with the food, nutrition, water and sanitation sectors. While such an initiative exists, there are currently no mechanisms in place to allow for this participation and it is unclear the extent to which intersectoral linkages are operational.

In **Morocco**, several community engagement mechanisms exist, such as "Local health committees" established with UNICEF support and the *Dispositif de Santé Communautaire* (DSC) a system that integrates community health workers *(Personne relais Communautaire)* with *Dar Al Oumouma* (DAO) (Maternity Waiting Homes) and health centres. Additionally, the Morocco Country Coordinating Mechanism (CCM) for the Fight Against AIDS and Tuberculosis in the context of the Global Fund, is a multisectoral body that includes -among other stakeholders- various ministerial departments, CSOs, as well as representatives of people living with HIV and key populations. At the regional level, the CCM is mirrored by Regional Committees for the Fight Against AIDS, which also involve local governments and other representatives.

In **Sudan**, the "National Health Recovery" and "Reform Strategic Plan (NHRR-SP) 2022–2024" (NHRR-SP 2022–2024) aims to enhance PHC through a family health approach, focusing on strengthening community systems by establishing community health dialogues and community health committees. The Strategic Plan also proposes accountability mechanisms, such as a Periodic Health Assembly, although it lacks specific accountability measures for CHWs. However, these objectives have not yet been fully operationalized, with limited community involvement in the planning, implementation and oversight of national health policies and services.

In **Tunisia**, the "National Health Policy 2030" emphasizes the importance of community participation, which provides opportunities for the further development of associated mechanisms. As for **Yemen**, 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.

In the subnational area of **NW Syria**, community engagement mechanisms have played a crucial role in fostering trust between health care workers and local populations. These include organization of awareness sessions at community level, coordination between CHWs, private doctors and midwives, organization of dialogue sessions with community leaders and religious leaders to foster acceptance of CHWs services at community level. The involvement of mosques in disseminating health messages and coordination with local councils have further strengthened these efforts.

The pivotal role of social and behaviour change in robust community health

At the heart of building an equitable, inclusive and resilient community health is the role that social and behaviour change (SBC) plays in improving services and promoting the uptake of healthy practices among communities.

SBC strategies have been used across the region to *study and understand* behavioural bottlenecks and barriers such as public misperceptions and adverse gender norms, to the utilization of maternal, child and family health services; *build* capacity of health service providers including frontline community health workers; *address* rumours and misinformation around disease outbreaks such as COVID, polio, cholera and measles among others; *improve* and *sustain* knowledge and practice of life-saving and risk reduction health behaviours which includes abandonment of harmful social practices; *advocate with* and *mobilize* local influencers, community leaders and key stakeholders to enable better health decision making at family level; *empower* parents, caregivers and communities to seek and demand quality health services; *foster* accountability of the health system through community feedback and social listening; and critically, to *build trust* between communities and health systems through improved service provider and client interaction.

SBC plays a particularly critical role in enhancing the capacity of community health workers. Additional cadres of frontline volunteers and community groups such as youth, mothers and fathers, have been mobilized to amplify health promotion messages especially during public health emergencies as for example during cholera outbreaks in **Yemen** or during COVID-19 response in **Algeria** and **Tunisia**. Social listening insights and community feedback were used to update training for health volunteers and midwives in **Sudan** to address concerns of women around vaccinations, without bias. Training packages on interpersonal communication, participatory appraisal and action, as well as human-centred design techniques have been integrated within pre-service and in service training curricula in several countries across the region such as **Iraq** and **Lebanon**.

More information available: here

Involvement and participation of CHWs in decision making

The participation of CHWs in decision-making processes is essential for fostering collaborative governance, ensuring that policies and interventions are informed by the practical insights of those working directly in the field and are designed to genuinely address the needs of the communities they serve. This mapping has revealed a limited engagement of CHWs in decision-making, resulting in decisions related to community health being made primarily at higher governance levels, whether interventions are led by governments or humanitarian organizations.

The general trend revealed limited opportunities for CHWs to actively participate in shaping the initiatives and services they provide, yet a few notable examples where CHWs play a more active role in decision-making emerged. In **Egypt**, for instance, focus group discussions with CHWs and their supervisors were organized during the development of national strategies, allowing CHWs to share feedback and recommendations.[26]

Similarly, in the **Islamic Republic of Iran**, community health advisory commissions provide a platform for CHWs to contribute to decision-making, helping to align health policies with community needs. In **Iraq**, health promoters within the MoH have some level of participation in decision-making. This involvement remains inconsistent, with CHWs employed by NGOs often excluded from such processes.

26 Maternal and Child Survival Programme. (2019). Development of Egypt's National Community Health Worker Strategy Optimising a Historical Programme for the Future. Retrieved from: https://pdf.usaid.gov/pdf_docs/PA00TXG5.pdf [Accessed August 2024]

Social accountability mechanisms

Participation of communities in social accountability mechanisms is vital for assessing the performance of CHWs and community health services, ensuring accountability, improving service quality and fostering a health system that truly reflects the needs and priorities of the local population. This mapping revealed limited involvement of community members in the mapped MENA region countries, underscoring the need for stronger accountability systems to enhance service delivery and responsiveness of community health programmes. While a few countries have implemented social accountability systems, others lack formal structures.

Best practice countries include the Islamic Republic of Iran, Jordan and Sudan:

- The **Islamic Republic of Iran** has developed a wide range of social accountability mechanisms for community health service provision. These include a "complaint and feedback system", "regular community meetings", "community-based monitoring", a "hotline" and a "community-linked maternal death review", allowing for continuous community input and oversight ensuring that community members have avenues to voice their concerns and contribute to improving health services.
- **Jordan**, through the MoH, offers a 24/7 hotline for complaints and suggestions related to community health services. Additionally, regular meetings between "Community Health Committees" and the Ministry are facilitated through Health Care Directorates in each governorate, providing a communication channel that enables monitoring and accountability of health services at the community level.
- In **Sudan**, the "National Health Recovery" and "Reform Strategic Plan (NHRR-SP) 2022–2024" emphasize the importance of strengthening social accountability in community health through the development of "Periodic Health Assemblies" and other community health dialogues.

Other countries, including **Algeria**, **Libya**, **Morocco**, the subnational region of **NW Syria** and **Tunisia**, currently lack formal social accountability mechanisms within their community health frameworks.

Lastly, in the MENA region, UNICEF-supported frontline volunteer networks are integral to social accountability mechanisms, strengthening feedback systems and ensuring community-driven improvements in health and social outcomes during public health emergencies and beyond.

Summary: Governance and accountability, including community engagement

Stronger accountability mechanisms are needed in order to enhance service delivery and responsiveness of community health programmes.

The governance of community health across the MENA region is characterized by a mix of challenges and opportunities. While many countries struggle with formal recognition of CHWs, fragmentation and resource limitations, the commitment to developing national strategies, existing CHW networks and the active engagement of civil society provide a solid foundation for improvement.

Strengthening coordination, increasing community engagement, investing in accountability mechanisms and ensuring adequate resources will be key to advancing the governance and sustainability of community health across the region.

2.2 Health management information systems

Key findings

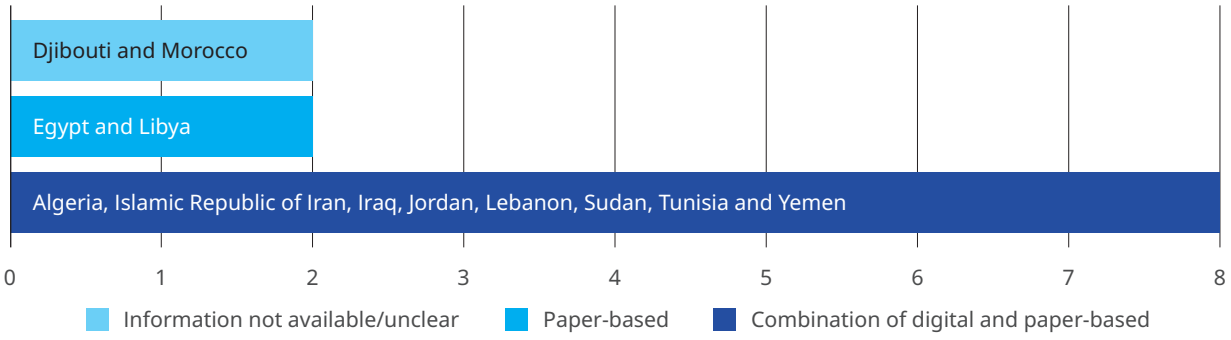
- In general, countries face challenges with fragmented data, which is often confined to vertical programmes.
- In some cases, countries have parallel systems for collecting community health data, while others have the infrastructure to collect it but do not integrate this data into their HMIS.
- In terms of means of data collection, some CHWs use tablets and specific software and many still rely on paper-based reporting.
- There is a lack of standardized indicators on community health – particularly around behavioural data, community feedback and social listening trends and insights – integrated at national level.
- CSOs collecting data often operate independently or outside of the national system.

Effective data collection is vital for optimizing community health, as it supports informed decision-making, efficient resource allocation and the development of targeted interventions that enhance health outcomes in the populations they serve. The mapping has identified a significant gap in the availability of community-based health management information systems (C-HMIS) across the MENA region. In fact, only one of the participating countries has integrated community health data within their national HMIS (see Table 4). The remaining countries still face challenges in this area, leaving community health-related data fragmented and often confined to vertical programmes. In some cases, countries have parallel systems for collecting community health data, while others have the infrastructure to collect it but do not integrate this data into their HMIS. In several countries, community health data is collected only by CSOs, or specially commissioned research agencies (for behavioural data) and never transferred to relevant ministries for integration. Integration of behavioural data within HMIS systems is also complicated by the nature and characteristics of the data type, costs, as well as the frequency and methodologies for data collection.

Challenges in data for community health stem from a lack of standardized indicators and insufficient integration of community health into national HMIS.

Data collection methods also differ between countries and within the same country, with **Algeria**, **Islamic Republic of Iran**, **Iraq**, **Jordan**, **Lebanon**, **Sudan**, **Tunisia** and **Yemen** using a combination of digital and paper-based methods. As for **Egypt** and **Libya**, they use paper-based data collection methods.

Figure 4. Countries with type of community health data collection mechanisms (n=12)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Furthermore, health information systems for community health remain underdeveloped in many countries, lacking clear metrics and indicators. Existing data is often limited to vertical programmes and focuses more on achievements, such as "the number of referred patients", with no indicators reflecting on the broader impact of interventions, e.g., percentage of successful referrals. This gap hampers the measurement of intervention outcomes, limits evidence-based decision-making, hinders the assessment of CHW competencies and training needs and most critically, makes it difficult to present compelling, evidence-based arguments to government leaders and external donors regarding the importance of CHW support interventions as well as their contribution to the CH interventions' achievements.

Table 5. Countries with C-HMIS integrated into the national HMIS (n=12)

Countries	C-HMIS included in national HMIS			
	Yes	No	Other	No info/unclear
Algeria				
Djibouti				
Egypt				
Islamic Republic of Iran				
Iraq				
Jordan				
Lebanon				
Libya				
Morocco				
Sudan				
Tunisia				
Yemen				

* **Other:** Alternative mechanism available in country.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In the subnational area of **NW Syria**, where different clusters (health, nutrition, etc.) are involved in the humanitarian response and maintain their own reporting systems, there are rare instances of data compilation across clusters. However, the need for transparency in humanitarian operations and reporting to donors has compelled these organizations to implement clear reporting mechanisms.

There are various challenges related to community health data across the MENA region. Chief among these is the lack of standardized indicators, which results in inconsistent and non-comparable data across countries. This, combined with the insufficient integration of community health data, including behavioural data, into national HMIS, creates a fragmented data landscape that hinders comprehensive decision-making. In fact, the absence of policy frameworks, resulting in reduced resources for CHS also negatively affects C-HMIS development and effectiveness. Additionally, the reliance on vertical programmes like immunization limits the broader applicability of collected data to overall community health needs. Fragmented data collection efforts by CSOs or research agencies, which often operate independently of national systems, further exacerbate this problem by making it difficult to capture a unified picture of community health services and outcomes.

Another key challenge is the poor quality and irregularity of reporting, often driven by inadequate training, limited capacity and the lack of proper infrastructure, particularly in rural and underserved regions.

This has a direct impact on the usability of the data, reducing its value for evidence-based decision-making. Leveraging community health data is also a common challenge across the region, with countries acknowledging that collected data is primarily driven by external donors in many countries and is rarely analysed fully, triangulated, or used for decision-making.

This is particularly prevalent in the region, as donor funding plays an important role in supporting community health services. The limited analysis, triangulation and utilization of the available community health data in policymaking also results from the fact that the existing data is often incomplete or fragmented, which hinders its use for health planning, designing and monitoring of interventions.

2.3 Health workforce

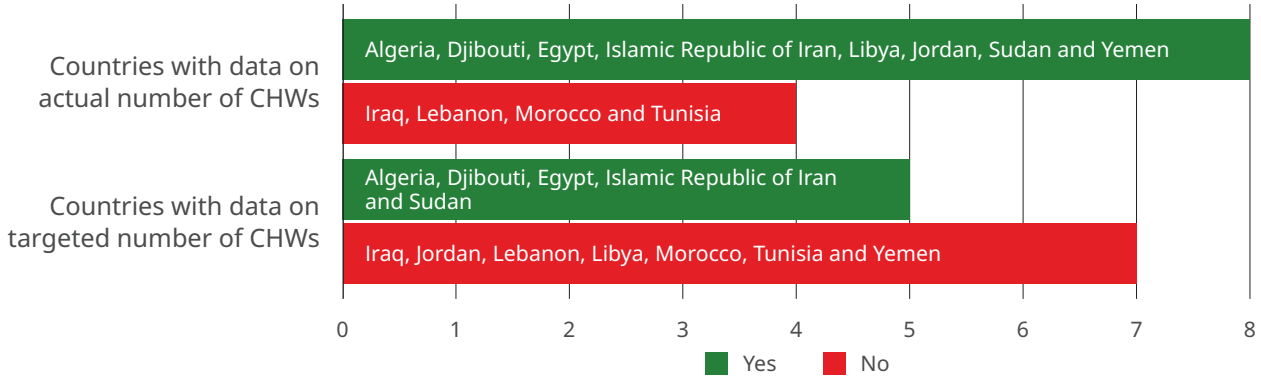
Key findings

- The information available on the community health workforce in terms of their number, characteristics, selection criteria, cadres, training, remuneration, accreditation and supervision varies from country to country within the MENA region.
- Countries with a national policy for community health tend to have more detailed information pertaining to CHWs compared to countries where most of the community health activities are managed by CSOs.
- Five out of the 12 participating countries have set targets for total number of CHWs deployed in the country, and eight have data on current CHW numbers. Some countries have made progress toward these targets, though many fall short. Actual CHW numbers are only known for a few countries, with others relying on estimates.
- Sex-disaggregated data on total CHWs are currently only available for three of the participating 12 countries in the region.
- Less than half of participating countries in the MENA region have a master list or predefined criteria for recruiting CHWs. Selection criteria vary significantly, with a preference for community residents or existing health workers. In countries where CHWs are employed by community organizations, selection is often tailored to specific programmes, resulting in variability in roles and responsibilities.
- Most countries have training programmes in place, while only a few have accreditation opportunities.
- CHWs in MENA receive salaries, temporary financial support from CSOs or other incentives. The type of remuneration often depends on the cadre.

Number and geographic distribution of CHWs

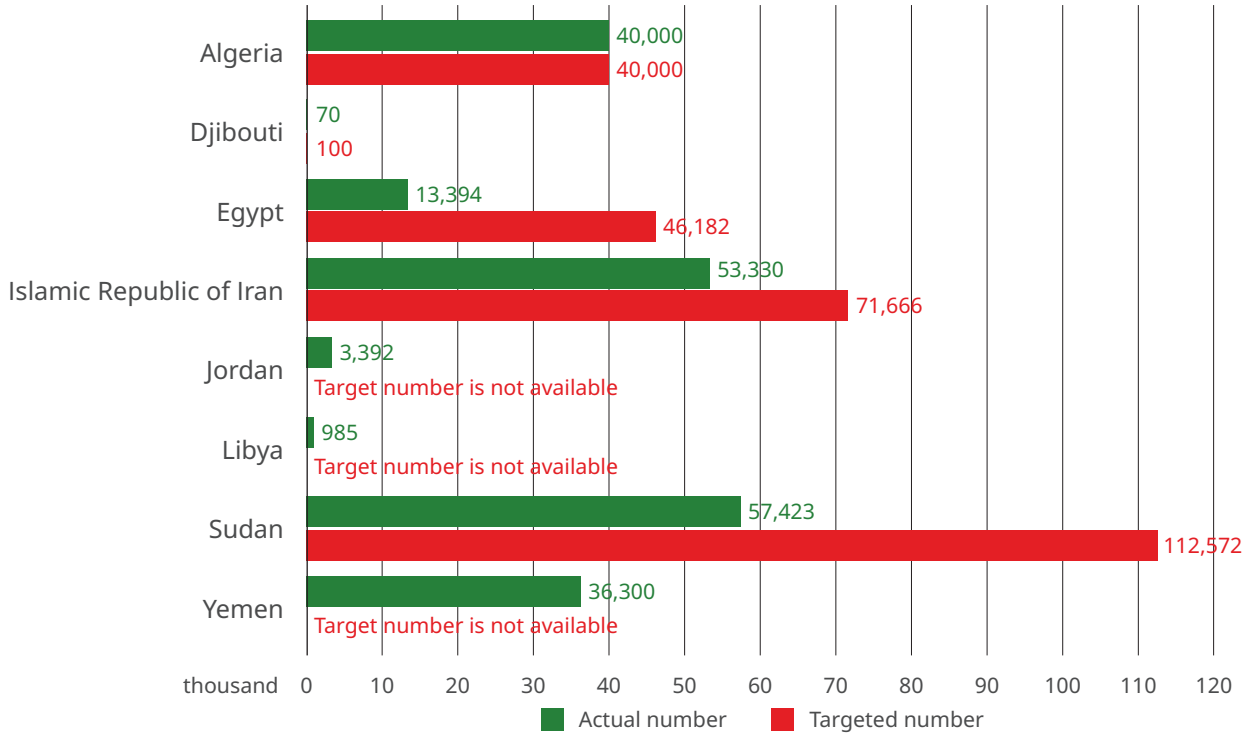
More than half of the countries in the MENA region have data on the actual number of CHWs operating in their country and half have identified the targeted number of CHWs in their national policy. **Algeria**, **Djibouti**, **Egypt**, the **Islamic Republic of Iran** and **Sudan**, have data on both the targeted and actual numbers.

Figure 5. Countries with data on the targeted and actual number of CHWs in their national policy (n=12)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Figure 6. Countries with available data on actual and targeted number of CHWs (n=8)



Note: Data on Targeted number' of CHWs is not available for Jordan, Libya and Yemen.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In Figure 6, the total **targeted number** of CHWs as per the national policy is available for **Algeria**, **Djibouti**, **Egypt**, the **Islamic Republic of Iran** and **Sudan**. In **Djibouti**, for example, the plan, as stated in the National Strategic Plan for Community Health (PSNSC), is to hire and train 100 CHWs per year while in **Egypt**, the targeted number of CHWs at the country level is equal to 46,182.[27] In the **Islamic Republic of Iran**, the targeted number of CHWs is 71,666 and a CHW is expected to provide services to between 100 and 1,500 persons in a rural area. In **Lebanon**, a UNICEF-led initiative to promote CHWs proposes to train two CHWs per PHCCs that are part of the national PHC network.

The **actual number** of CHWs available per country is known for **Algeria**, **Djibouti**, **Egypt**, the **Islamic Republic of Iran**, **Jordan**, **Libya**, **Sudan** and **Yemen**. In **Egypt**, for example, the total current number of CHWs (including population educators) is around 13,394,[28] while in the **Islamic Republic of Iran** there are 53,330. Moreover, according to the Africa Centres for Disease Control and Prevention (CDC) it is estimated that there are 985 CHWs (covering around 10 per cent of the country's population)[29] in **Libya**. The evaluation of CHW Programme in 2022 estimated that there are over 57,423 CHWs currently deployed in **Sudan**, a number that has most likely been impacted by the ongoing war since April 2023. In **Jordan**, there are 3,392 community health volunteers in Jordan's 155 Community Health Committees who help with MoH's health messaging in local communities and 392 health promoters. However, since most of the latter have professional degrees, these workers do not meet all criteria of the CHW definition. In **Iraq**, CHWs are not officially recognized but there are currently 3,000 health promoters in the country. For **Algeria**, *santé de proximité* employees involved in community health activities number 40,000 currently deployed. However, the exact number of other types of CHWs remains unclear. In **Djibouti**, there are currently 70 CHWs.

27 Head of Central Administration of Family Planning and Director of National Programme of CHW. (2023). Presentation of the Head of Central Administration of Family Planning and Director of National Programme of CHWs. [Workshop] In Country Consultation Workshop for Stronger, More Equitable Primary Health Care and Emergency Preparedness and Response.

28 Folz, R., and Ali, M. (2018). Overview of community health worker programmes in Afghanistan, Egypt and Pakistan. *La Revue de Sante de La Mediterranee Orientale [Eastern Mediterranean Health Journal]*. 24(9), 940–950.

29 Africa Centres for Disease Control. (2024). Country Consultation Workshop for Stronger, More Equitable PHC and Emergency Preparedness and Response [PPT], Africa CDC.

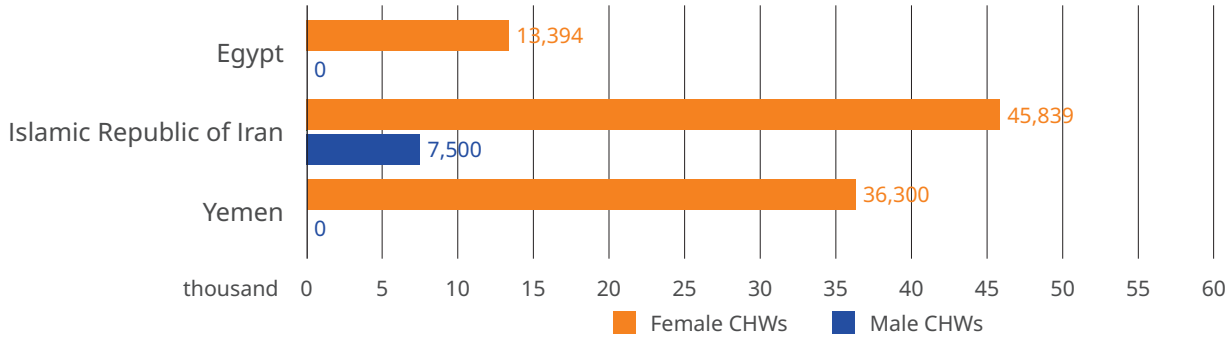
For other countries like **Lebanon** where CHWs are usually volunteers working for CSOs, their numbers are estimated by each CSO separately. As for the subnational area of **NW Syria**, the most recent Health Resources Availability Mapping System (HeRAMS) report from 2023 indicates that there are 927 CHWs in the region, the majority being linked to PHCs.[30]

Sex-disaggregated data on total CHWs are currently only available for three countries in the MENA region.

Participating stakeholders stated that many individuals are labelled as CHWs but may not be actively practicing in that capacity. Still for other countries like **Morocco** and **Tunisia** there are no figures on the number of CHWs. In Figure 7, it should be noted that sex-disaggregated data on the CHW workforce is currently only available for three countries: **Egypt**, the **Islamic Republic of Iran** and **Yemen**.

In **Egypt** and **Yemen**, there are only female CHWs. In the **Islamic Republic of Iran**, while there are substantially more female (45,839) CHWs than male (7,500), there are slightly more male CHW supervisors[31] than females (16,000 compared to 11,000). In general, there is a tendency to hire women as CHWs in the region (see section on cross-cutting issues). The community midwife (CMW) cadres (e.g., in Yemen and Sudan) also recruit exclusively women.

Figure 7. Countries with available data on total number of CHWs (sex-disaggregated) (n=3)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

National standards for the targeted geographical coverage of CHWs vary in the region.

National standards for the targeted geographical coverage of CHWs vary in the region. For example, the **Islamic Republic of Iran**, **Jordan** and **Sudan** are expecting full coverage. In **Yemen**, they operate in 50 per cent of governorates or 30 per cent of its districts. In **Egypt**, coverage varies by governorate ranging from <2 per 10,000 population to >50 per 10,000 population.[32]

In **Iraq** and **Lebanon**, since CHWs are hired by CSOs, they work in specific areas covered by the CSOs such as camps for **Iraq** and PHCC catchment areas in **Lebanon**. In **Djibouti**, community actors are spread throughout the country. Furthermore, not all CHWs are expected to work in their own communities.

30 WHO. (2023). Health resources and services availability monitoring system Herams – third quarter, 2023 report Türkiye health cluster for northwest of Syria, Jul–Sep 2023. [Online]. Retrieved from: https://reliefweb.int/report/syrian-arab-republic/health-resources-and-services-availability-monitoring-system-herams-third-quarter-2023-report-turkiye-health-cluster-northwest-syria-jul-sep-2023. [Accessed August 2024].

31 A CHW supervisor is an individual who provides supervision, coaching and direct support to the CHW.

32 Head of Central Administration of Family Planning and Director of National Programme of CHW. (2023). Presentation of the Head of Central Administration of Family Planning and Director of National Programme of CHWs. [Workshop] In Country Consultation Workshop for Stronger, More Equitable Primary Health Care and Emergency Preparedness and Response.

In **Jordan** and the **Islamic Republic of Iran**, most CHWs work within their communities. Other CHWs that stay within their communities include peer educators working with migrants or volunteers from the medical sector in **Algeria** and the *Behvarz*[33] in the **Islamic Republic of Iran** who are expected to stay and work in the village for fifteen years after completing their study programme.[34] In **Yemen**, the preference is for female CHWs, such as community midwives and community reproductive health volunteers, to remain in their own communities as they are highly trusted by the women and therefore able to provide skilled care during pregnancy, childbirth and post-pregnancy and for immunizations.[35]

In summary, more than half of the MENA countries have data on actual CHW numbers, while less than half have national targets (see Figure 7). Some countries have made progress toward these targets, though many fall short. Sex-disaggregated data is limited and coverage varies, with some aiming for full national reach while others focus on specific regions, often influenced by CSOs. CHW roles and locations also differ, with some working within their own communities and others operating in broader areas.

Official cadres and roles of CHWs

There is a variety of official cadres and community level actors in each country in the region, some of which are country specific. Table 6 below provides an overview of the different types of cadres across countries in the MENA region.

Table 6. Different types of community level cadres by country

Countries	CHW	Community midwife	Community health volunteer	Other*	No official cadres
Algeria				■	
Djibouti				■	
Egypt	■			■	
Islamic Republic of Iran				■	
Iraq					■
Jordan			■	■	
Lebanon					■
Libya					■
Morocco					■
Sudan	■	■	■		
Tunisia					■
Yemen	■	■	■		

* **Other:** Indicates alternative cadres available in country.

As noted in sections above, the roles and responsibilities of CHWs differ between countries. This variation is also seen in the types of cadres available. That stated, official cadres can generally be grouped into three broad categories: CHWs, CMWs and community health volunteers.

33 Community health workers based in rural areas in Iran are called *Behvarz*.

34 Perry, H. and Crigler, L. (Eds). (2014). Developing and Strengthening Community Health Worker Programmes at Scale: A Reference Guide and Case Studies for Programme Managers and Policymakers. USAID/MCHIP. Retrieved from http://bit.ly/1AUBjtS

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

Countries with CHWs who are officially recognized and employed include **Egypt**, the **Islamic Republic of Iran**, **Sudan** and **Yemen**. In other countries, there is a mix of CHW cadres (employed by the government) and volunteer cadres who conduct ad hoc work with specific programmes (as in the case of Sudan). Official volunteers are also seen in **Yemen** (where they work specifically on nutrition) and Jordan. Still other countries have a different way of defining and grouping CHWs altogether. For example, in the **Islamic Republic of Iran**, CHWs are grouped based on whether they work in urban *(Moraghebe-Salamat)* or rural *(Behvarz)* settings.

Cadres of CHWs vary across the region but often include formal CHWs, community midwives and community volunteers.

This is also often seen in the case of countries with alternative systems in place, such as **Algeria**, whose *santé de proximité* workers are responsible for primary and community health. Alongside these health workers, **Algeria** also has various types of community actors who contribute to community health initiatives. These include voluntary health professionals working in public or private sectors and engaged in health associations (e.g., health professionals volunteering in NGOs), organized patient groups negotiating with authorities (e.g., associations for diabetics, cancer patients, or individuals with kidney failure), relatives of patients advocating for their needs (e.g., associations for children with Down syndrome, spina bifida, or autism) and individuals motivated by personal convictions, such as medical and pharmacy students (e.g., students volunteering to help those in need). Peer educators also play a key role in supporting key populations under the National AIDS Plan (e.g., sex workers, men who have sex with men, people who inject drugs and migrants).

In countries other types of CHWs include the following:

1. In **Djibouti** under the national plan, the country plans to recruit and hire official CHWs. The country also has community actors who are periodically engaged in implementation of community health programmes according to needs (these include *mères conseillères* or mothers' advisors for nutrition and *relais communautaires* or community relays). Finally, there are plans to hire and train 100 official CHWs per year with 70 already engaged.
2. In **Jordan**, there are two types of health workers who conduct community health-related activities namely, primary health care workers or health promoters who usually have a nursing or midwifery background and community health volunteers.

In countries with no official cadres, alternative community actors are present:

3. **Iraq** has several types of workers who conduct community health related activities. These include health promoters working for the Health Promotion unit at the MoH who perform community work in an ad hoc manner and CHWs hired by CSOs and international organizations for short-term projects, especially within IDP and refugee camps, CHWs, junior CHWs, community health volunteers (e.g., during COVID-19).
4. In **Lebanon**, to date, most of the health-related activities at the community level have been undertaken by different health/social professionals at the PHCC level or through volunteers that are recruited and trained by NGOs for specific activities.
5. In **Libya**, while there are no official cadres, different types of CHW are defined and deployed by CSOs according to the aims of their projects. The only commonly accepted cadre that operates without restriction in Libya is the health promotion/education cadre.

6. In **Morocco**, CHWs are mentioned in the national strategy but they are not recognized as part of the national workforce and their roles and qualifications are not well defined.
7. In **Tunisia**, there is no defined status for CHWs, but there are *relais communautaires* who are essentially volunteers who devote part of their free time to taking part in community activities (often as part of association projects). There are also health personnel profiles within the MoH such as *infirmiers des centres de santé de base* and *éducatrices de l'Office National de la Famille et de la Population* whose role is similar to that of the CHW.[36] These professionals have the role of promoting health, preventing disease and, more generally, reducing social inequalities linked to health.

The MENA region features a variety of official CHW cadres, with roles differing based on the type of worker and country. In many instances, CHWs lack formal recognition and their roles remain unclear or undefined within national health systems. In some cases, even where CHWs are not officially recognized, community-level health work is carried out by volunteers or through local health professionals.

Early breast cancer detection at community level in Lebanon

In **Lebanon**, social health workers responsible for community health in participating PHCCs and their volunteer teams have played an important role in the early detection of breast cancer in their catchment areas. The social health workers receive training on the information that they need to share with women in the community on breast cancer. The social health workers then return to the PHCC where they send out volunteers who then organize awareness raising activities at the community level.

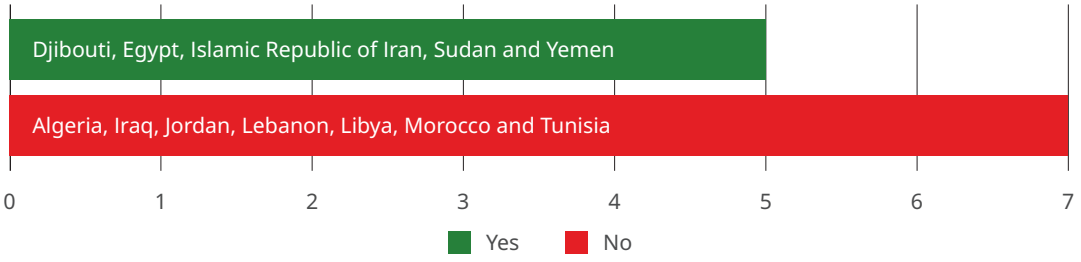
These activities are conducted through community or household visits where volunteers inform the women about breast cancer danger signs and the benefits of screening. They encourage women to follow the screening guidelines and direct them toward the PHCCs for mammographies or ultrasounds and then follow up directly with them on results and recommendations. PHCCs offer a 50 per cent to 60 per cent discount for these services to incentivize women to come in for screening.

In 2024, 1,500 women came in for screening and over 30 cases of cancer were detected. All these cases were detected early and the women were not aware of their condition prior to the community health intervention.

Predefined selection criteria and existence of a CHWs master list

Most countries in the MENA region do not have a CHWs master list (Figure 8) or predefined selection criteria on which to base the recruitment of CHWs (Figure 9). Exceptions to this include **Djibouti**, **Egypt**, the **Islamic Republic of Iran**, **Sudan** and **Yemen**, which have both a CHW master list and an established set of predefined criteria to select and recruit CHWs. These criteria vary from country to country but seem to be mostly articulated around the definition of a CHW.

Figure 8. Countries with a CHW master list (n=12)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

36 PSI (2020). La situation des agents de santé communautaires en Afrique: une étude présentant les documents disponibles sur les initiatives en matière de soins de santé primaires. Retrieved from https://pop-umbrella.s3.amazonaws.com/uploads/f745819f-5744-4a71-a5d7-50703ec455b1_PSI_CHWs_In_Africa_French_02.pdf

In the **Islamic Republic of Iran**, for example, CHW recruitment is managed by recruitment committees at the level of the district health centres. CHWs are required to sit for a written examination and an interview prior to selection. They should also have an associate or bachelor's degree in family health, general hygiene, nursing, midwifery and/or disease control for men. Additionally, there is criteria for *Behvarz* recruitment to be in rural areas and *Moraghebe-Salamat* in urban areas

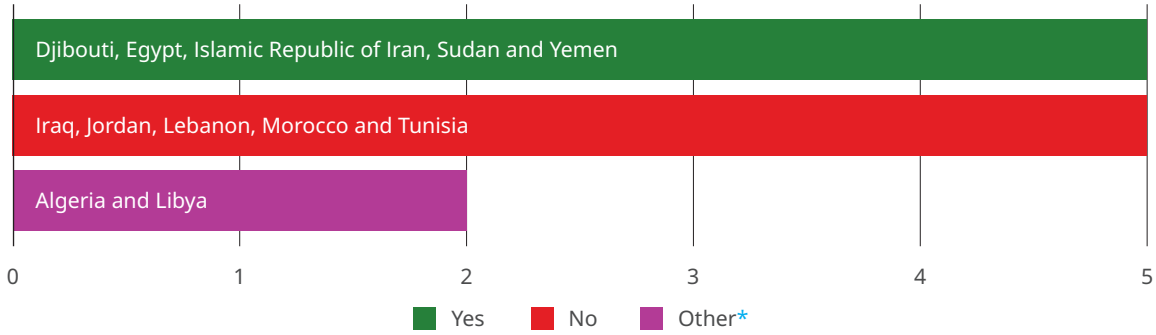
In general, there is a preference in MENA for CHWs to reside in the community and to be from an existing health worker cadre.

Egypt has predefined criteria for selection of CHWs (Figure 9), which include being residents of the community they are serving, having an education level higher than the community average, having less than three children and, if married, obtaining their husband's permission to work.

Moreover, the newly adopted "Egypt's National Community Health Worker Strategy" includes a set of predefined criteria to select CHWs, a revised CHW job description, qualifications and scope of practice.[37]

Although **Libya** does not have predefined criteria for the selection of CHWs, there is a tendency in the country to choose CHWs from among other health workers, such as pharmacists or dentists. In **Lebanon** and **Iraq**, CHWs are selected by CSOs that define their own selection criteria and roles and responsibilities for CHWs which vary depending on the programme with some being integrated with primary health care services.

Figure 9. Countries with a predefined selection criteria for CHWs (n=12)



* **Other:** Indicates countries that have either unofficial or preferential selection criteria or that have selection criteria as a part of an alternative system (i.e. *santé de proximité*).

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Most countries in the MENA region do not have a master list or predefined criteria for recruiting CHWs. In some areas, selection criteria vary significantly, with a preference for community residents or existing health workers. In others, discussions on criteria are ongoing following the introduction of national community health policies. In regions where CHWs are employed by community organizations, selection is often tailored to specific programmes, resulting in variability in roles and responsibilities.

Training, supervision and accreditation of CHWs

The availability of training programmes, supportive supervision and an accreditation process for CHWs in the region, varies by country with most of them having training options while only a few have accreditation opportunities (Table 7).

37 Maternal and Child Survival Programme. (2019). Development of Egypt's National Community Health Worker Strategy Optimising a Historical Programme for the Future. Retrieved from: https://pdf.usaid.gov/pdf_docs/PA00TXG5.pdf [Accessed August 2024]

Table 7. Availability of training, supervision and accreditation programmes by country

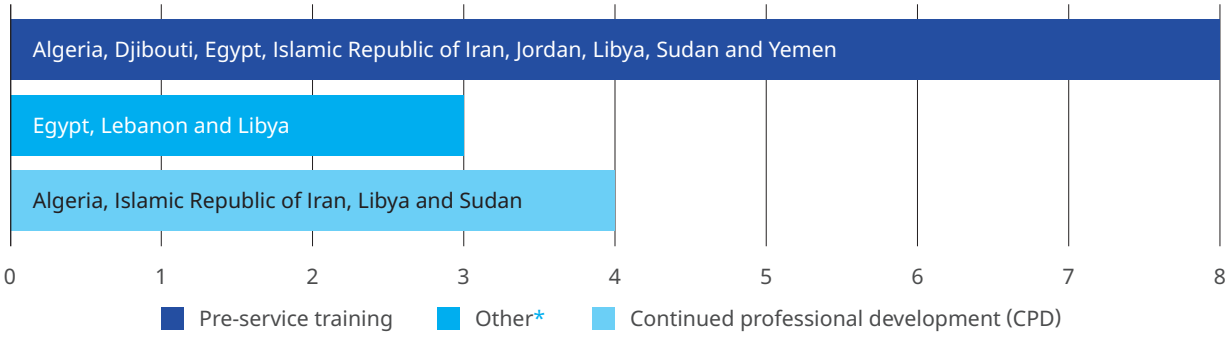
	Countries											
	Algeria	Djibouti	Egypt	Islamic Republic of Iran	Iraq	Jordan	Lebanon	Libya	Morocco	Sudan	Tunisia	Yemen
Training												
Supervision												
Accreditation												

Legend Yes No Other Information not available/unclear

* **Other:** Includes countries where alternatives to accreditation or training provided by other sources are in place.

Further, nine out of the 12 countries in the MENA region (Algeria, Egypt, Djibouti, the Islamic Republic of Iran, Jordan, Lebanon, Libya, Sudan and Yemen) have put in place training programmes for CHWs (Table 7). Training programmes for community actors differ by country based on their status, roles and employers. However, most of these countries offer pre-service training (Algeria, Djibouti, Egypt, the Islamic Republic of Iran, Jordan, Libya, Sudan, Yemen) and a couple (Algeria, the Islamic Republic of Iran, Libya and Sudan) additionally provide continued professional development (CPD) (Figure 10).

Figure 10. Countries with available data on type of training (n=9)[38]



* **Other:** Includes countries who have developed a new curriculum or where training modules were prepared by CSOs and approved by the government.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In the **Islamic Republic of Iran**, CHW training includes both pre-service and in-service training. For *Behvarz*, the course work, which is conducted over two years, is divided into three grades and consists of both theoretical and practical components, including clinical placements in Health Houses and rural health centres. The *Moraghebe-Salamat* who are graduates of the University of Medical Sciences and Health Services, are also required to complete 174 hours of mandatory pre-service training. All health promoters and community health volunteers in **Jordan** receive pre-service training which includes gender considerations. **Sudan** has developed both pre-service and in-service formal trainings for CHWs and CMWs. CHWs are required to complete a 9-months training and accreditation is received upon completion.

38 Applicable to countries who reported having any training in place. More than one type of training can apply to a country.

An updated version was created but has yet to be fully endorsed and adopted due to the political instability in the country. CMWs are trained in midwifery schools through a 15-month curriculum outlined by the International Confederation of Midwives (ICM). Moreover, health volunteers attend short-term training courses through PHC programmes with support from CSOs. These courses are programme specific and last from a few days to weeks. In-service training for CMWs and formal CHWs is carried out by doctors, midwives and nurses who underwent training of trainers (TOT) programmes and is supported by the government or CSOs depending on the programme. Yemen has an integrated and comprehensive training curriculum certified by the MoPH that covers different programmatic areas, including MNH, EPI, Malaria and IMCI.

Egypt, **Lebanon** and **Libya** have proposed other types of training. In **Egypt** government-employed CHWs typically undergo a 5-day course focusing on family planning, record keeping and communication skills.[39] Moreover, the country has also developed a new CHW curriculum, which consists of five thematic training modules: operational manual, newborn and child health, reproductive health, communicable and NCDs, and nutrition.[40] In **Libya**, on the other hand, CSOs use a training module for CHWs that was endorsed by PHCI in 2019.[41] Similarly, in **Lebanon**, CHWs are using a community guidebook for CHWs developed by the International Medical Corps and approved by the MoPH. In addition, the American University of Beirut, as part of a consultancy for UNICEF, has developed an operationalization toolkit that covers the organizational policies and procedures that govern the work of CHWs in **Lebanon** including unifying the definition of CHWs along with their selection criteria, role, function, certification and supervision.[42] The toolkit is in the process of being approved by the MoPH. Although **Iraq** does not have formal training programmes in place they offer some training programmes for community actors, for example, community health volunteers are trained on an ad hoc basis in certain situations including during emergencies. **Morocco** is in the process of investigating various training options. Currently, CSOs offer trainings to their CHWs and nurses have been trained in family and community health at the *Instituts supérieurs des professions infirmières et techniques de santé* (ISPITS) since 2016.

Five countries namely **Egypt**, the **Islamic Republic of Iran**, **Jordan**, **Sudan** and **Yemen**, provide supportive supervision to CHWs in their countries (Figure 11). In **Egypt**, for example, this includes quarterly mentorship visits and biannual supportive supervision meetings, which are conducted by central supervisors, quarterly programme review meetings, which are conducted by central and governorate supervisors and (3) biannual Community-Based Health Programme (CBHP) stakeholder meetings, which are conducted by district and governorate supervisors. Supervision meetings are standardized and occur monthly.[43] In the **Islamic Republic of Iran**, CHWs are under close monthly supervision with on average 60 supervisors per district health centre. Moreover, staff from the rural health centres regularly plan and perform supervisory visits to *Behvarz* in Health Houses. The evaluation of a programme's effectiveness and the quality of care provided is performed at the district, province and national levels. In **Sudan**, supportive supervision is carried out to CHWs as programmatic components, although this is sometimes irregular. Supervision is provided through PHC programmes by associated facilitators or by monitoring and evaluation officers of specific programmes. In **Iraq**, health promoters are assessed by MoH staff. In **Lebanon** and **Morocco** CHWs are supervised and evaluated by the CSOs for which they work. **Algeria** also provides supervision for CHWs working with key populations within CSOs funded by the Global Fund. This supervision varies according to each CSO.

39 Folz, R., and Ali, M. (2018). Overview of community health worker programmes in Afghanistan, Egypt and Pakistan., *La Revue de Sante de La Mediterranee Orientale [Eastern Mediterranean Health Journal]*, 24(9), p. 940–950.

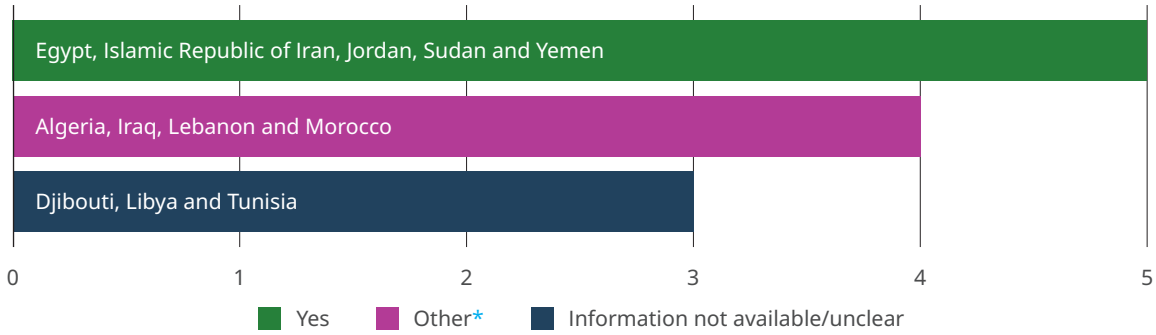
40 Maternal and Child Survival Programme. (2019). Development of Egypt's National Community Health Worker Strategy Optimising a Historical Programme for the Future. Retrieved from: https://pdf.usaid.gov/pdf_docs/PA00TXG5.pdf [Accessed August 2024].

41 The Primary Healthcare Institute. (2019). CHW Basic Training Module, PHCI.

42 American University of Beirut (2023). Operationalising toolkit community health workers – Lebanon: Qualifications, recruitment, management, supervision, education, certification, outreach (community and home visits), networking and coordination tools., Department of Family Medicine, WHO Collaborating Centre for Family Practice. [Draft toolkit, under review].

43 Folz, R., and Ali, M. (2018). Overview of community health worker programmes in Afghanistan, Egypt and Pakistan., *La Revue de Sante de La Mediterranee Orientale [Eastern Mediterranean Health Journal]*, 24(9), p. 940–950.

Figure 11. Countries providing supportive supervision for CHWs (n=12)



* **Other:** Includes countries with alternative supervisory activities, often led by CSOs, in place.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In the subnational area of **NW Syria**, WHO, in collaboration with CSOs, developed a "Unified CHW Curriculum" in 2018 and established a TWG to guide interventions.[44] [45] The curriculum covers core health topics, with additional modules introduced as needed. Successful training programmes included a "21-day initiative", but there are funding issues for continuation of refresher trainings. Supervision of CHWs, outlined in WHO guidelines, includes field visits and coaching but often occurs irregularly with inconsistent monitoring.[46]

As a result of conflicts and wars, there is fear among the families. They were wondering, who are these people and what is their job? That was at the beginning of our work, as we were new on the ground. But after the training we received and after continuous communication with the families, today, we have direct communication with all individuals. We communicate directly with the families through various activities, especially home visits. We conduct home visits daily. These visits aim to build trust between community health workers and community members. We listen to the community's concerns, address their questions and at the same time, we provide accurate and truthful information about the importance and necessity of vaccines.

CHW in the subnational area of NW Syria

Finally, most countries in the region do not have a clearly defined accreditation system for CHWs in place (Figure 12). In fact, only four countries, **Djibouti**, **Egypt**, **Sudan** and **Yemen**, have such a system in place.

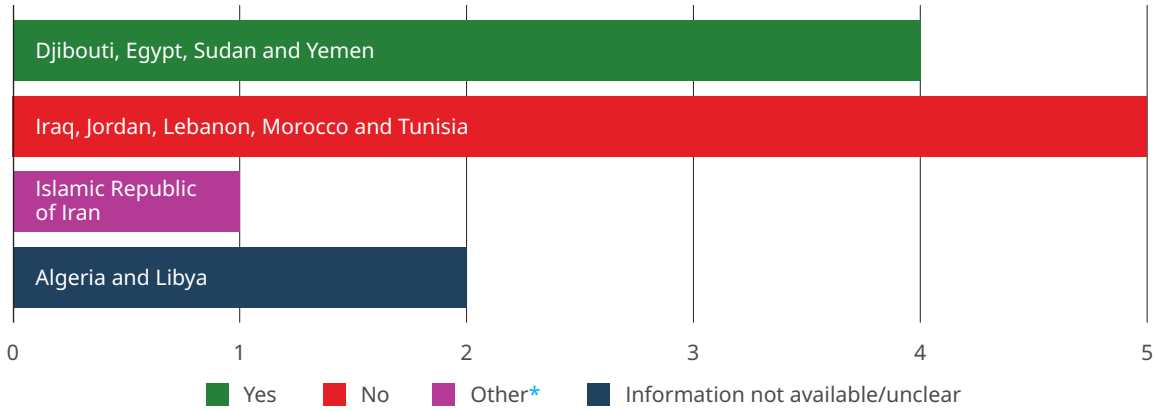
In summary, in the MENA region, while several countries have implemented training programmes and supportive supervision for CHWs, significant variations exist in the structure and frequency of these initiatives. Most countries provide pre-service training, often coupled with in-service training, although some lack a standardized approach to supervision and accreditation. There are challenges associated with inconsistencies in training, supervision and the absence of clearly defined accreditation systems.

44 MSH. (2017). The Cost of an Essential Health Service Package for Northern Syria. [Online]. Retrieved from https://msh.org/resources/the-cost-of-an-essential-health-service-package-for-northern-syria/ [Accessed August 2024].

45 Habboush, A., et al. (2023). A framework for community health worker optimisation in conflict settings: prerequisites and possibilities from Northwest Syria. *BMJ Glob Health*.

46 UDER. (2020). Assessment of community health programmes in Northwest Syria.

Figure 12. Countries with an accreditation system for CHWs (n=12)



* **Other:** Includes countries with an alternative to official accreditation systems (for example, through regular competency assessments).
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Remuneration

Remuneration schemes vary by country depending on whether CHWs are recognized as part of the national health workforce in the country. In **Algeria**, **Djibouti**, **Egypt**, the **Islamic Republic of Iran**, **Sudan** and **Yemen** CHWs are considered government employees and receive monthly salaries. In **Libya** and **Morocco**, CHWs are deployed by CSOs who provide financial support for the duration of their projects. In **Lebanon** and **Tunisia**, CHWs are mostly volunteers who receive incentives rather than salaries.

CHWs in MENA receive salaries, temporary financial support from CSOs or other incentives. The type of remuneration often depends on the cadre.

However, in **Lebanon**, under the integrated approach piloted by UNICEF in collaboration with MoPH and partner ICSOs/CSOs, 100 CHWs were incorporated within PHCCs as part of a team that included two CHWs who were salaried, trained and supervised by the PHCC. These CHWs were trained and remunerated by UNICEF as a first step but the plan is that they will be renumerated by the PHCC and incentivized by UNICEF in the future.

Regarding **Algeria**, health care professionals operating in their *Santé de Proximité* facilities are full-time health care professionals who receive a monthly salary based on a scale defined by the MoH. In contrast, volunteers from associations do not receive a salary but may be given a per diem by certain organizations. As for the subnational area of **NW Syria**, the approximate salary for CHWs is $270 per month.

Overall, remuneration schemes for CHWs in the region vary, reflecting different levels of integration into national health systems. While some countries provide regular salaries, others rely on temporary financial support from CSOs, or they incentivize volunteers. In general, there is a need for more standardized and sustainable approaches to compensating CHWs.

2.4 Service delivery

Key findings

- Most countries in MENA have adopted more than one type of service delivery model and most often include extensions of health facility systems.
- Many countries in the MENA region have established referral pathways to enhance continuity of care provided by CHWs. There are challenges related to implementation and resource availability for implementation of referral systems.
- Five out of 12 participating countries in the MENA region have a predefined service delivery package in place. Despite not always being standardized, a wide range of community health services is still being provided, often led by CSOs.
- Most countries have developed formal linkages with several sectors at the community level. The most common sectors are water, sanitation and hygiene, education, as well as food and nutrition.

Community-based service delivery models

The most common community-based service delivery models among participating countries in the MENA region were those where CHWs were extensions of health facility systems – PHCs (7) or were managed through community-based non-profit organizations (6) (Table 8). **Yemen** is the only country in the region that has implemented an integrated care model. In **Iraq**, services provided by international organizations in IDP/refugee camps have been halted with the closing of the camps in June 2024.

Most countries have adopted more than one service delivery model with services being provided as extensions of health facility systems, as part of CSO efforts, as well as having specific community-based services available (e.g., home health, mobile clinics, community clinics, etc.). For example, in **Yemen** there are five models. In the subnational area of **NW Syria** there is also a variety of models namely, community-based, health facility-based, programme-specific teams (for example nutrition or COVID-19), mobile clinics and rapid response teams that emerged after the earthquake to provide therapeutic services for malnourished patients.

Most countries in MENA have adopted more than one type of service delivery model, and most often include extensions of health facility systems.

The landscape of community-based service delivery models in the MENA region is diverse, with some countries employing multiple frameworks to enhance access to health care. Predominant models consist of extensions of health facility systems and services provided through non-profit organizations. Additionally, various countries are in the process of establishing community health strategies, highlighting ongoing efforts to adapt and optimize service delivery.

This variety underscores the importance of tailoring health models to meet the unique needs of communities across the region, ultimately aiming for improved health outcomes.

Table 8. Different types of community-based service delivery models implemented by country (n=12)

Community-based service delivery model	Countries											
	Algeria	Djibouti	Egypt	Islamic Republic of Iran	Iraq	Jordan	Lebanon	Libya	Morocco	Sudan	Tunisia	Yemen
Extensions of health facility systems, PHC	■			■		■	■	■		■		■
Non-profit organizations	■	■		■		■	■		■		■	
Other organizations operating in the intersection between health systems and communities (religious organizations, etc.)	■							■	■		■	
Mobile health units	■	■										■
Home health services		■		■					■			■
Community health clinics				■		■						■
Integrated care model (coordinated across facilities/professionals)												■
Other*					■							
information not available			■									

* **Other:** Includes countries that have not yet developed their community-based services or where services have stopped.

Standardized processes/guidelines for enhancing quality of care

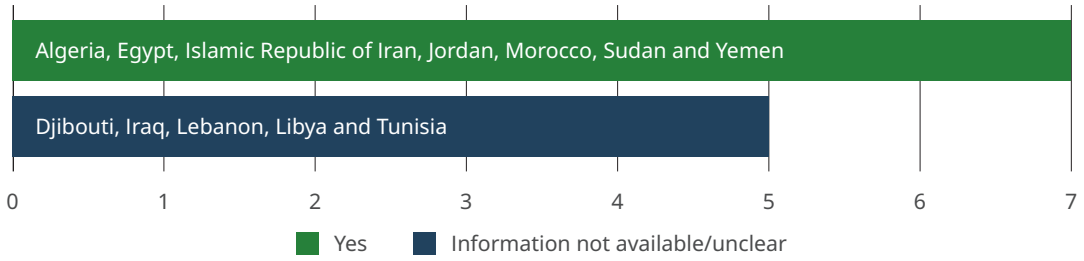
Limited information was available on the extent to which participating countries in the MENA region have processes and/or guidelines for enhancing quality of care at the community level. **Egypt**, the **Islamic Republic of Iran**, **Lebanon**, **Morocco**, **Tunisia** and **Yemen** reported having some processes or guidelines in place, but it is unclear to what extent these are standardized. In **Sudan**, the guidelines for improvement of quality of care at the community level are outlined for specific programmes (for example iCCM).
In the subnational area of **NW Syria**, CHWs largely followed the WHO Standard Operating Procedures (SOP) for household visits. **Djibouti**, **Iraq**, **Jordan** and **Libya** do not have developed processes.

Referral pathways for continuity of care

To ensure the continuity of care provided by CHWs, seven countries (Algeria, Egypt, Islamic Republic of Iran, Jordan, Morocco, Sudan and Yemen) in the MENA region that participated in this mapping have established clearly outlined referral pathways from community to health facility levels (Figure 13).

In **Egypt**, for example, writing of referrals are included within the service delivery package and in Yemen and Jordan, CHWs or CMWs identify individuals who need care and refer them to appropriate services.
In the case of **Jordan**, the referrals are to the health care facilities of the MoH and are subsequently followed up by the local community health committee members. For **Yemen**, the referrals are to the PHCCs. Some referral mechanisms remain underdeveloped as is the case for CMWs and Community Health Nutrition Volunteers (CHNVs). **Morocco** and **Algeria** have referral systems for specific services. In **Morocco** the *personnes de relais communautaire* guide expectant mothers to *Dar Al Oumouma* for childbirth or to health centres for pre- and post-natal visits. **Algeria** has put in place referral systems for CHWs recruited by CSOs working on themes related to key populations. The **Islamic Republic of Iran** has put in place a multi-tiered referral system whereby CHWs refer people to rural health centres or secondary level facilities

Figure 13. Countries with established referral pathways to ensure continuity of care involving CHWs (n=12)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

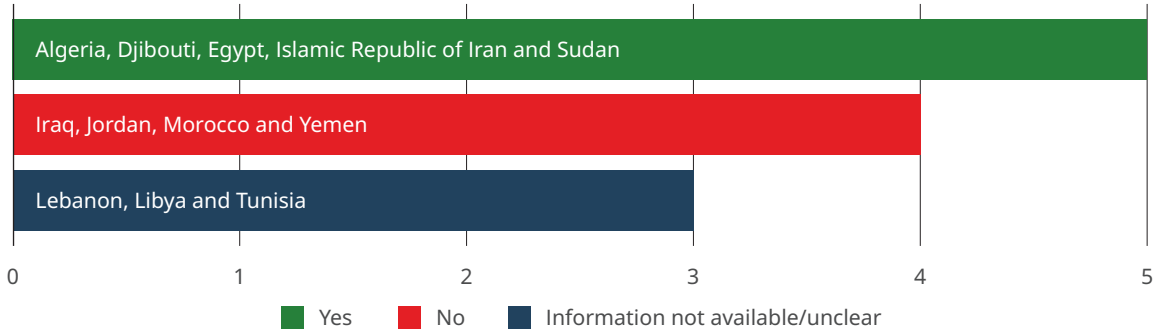
for primary care services or specialized care. Urban areas also have a referral system in place between health posts, health centres and district hospitals.[47] In **Sudan**, referral pathways are further coordinated in line with the PHC expansion project and are available to higher level care facilities. However, these face suboptimal implementation due to a lack of resources. No clear information is available on the referral systems for **Djibouti**, **Iraq**, **Lebanon**, **Libya**, **Tunisia**. In the subnational area of **NW Syria**, according to WHO SOPs for household visits, CHWs are responsible for referring cases when necessary. They also conduct follow-up visits upon the patient›s return to the community.

Many countries in the MENA region have established referral pathways to enhance continuity of care provided by CHWs. Despite effective practices in some areas, challenges related to implementation and resource availability persist. Overall, further development is needed in the region to ensure that CHWs can successfully connect individuals to essential health services.

National predefined CHW service delivery package

Countries in the MENA region were evenly divided when it came to the existence of a predefined service delivery package (Figure 14). Of the twelve participating countries, in addition to the subnational area of NW Syria, five had a package (Algeria, Djibouti, Egypt, Islamic Republic of Iran, Sudan), four did not (Iraq, Jordan, Morocco, Yemen) and it was not clear whether such a package was predefined as part of the policy/strategy in **Lebanon**, **Libya** and **Tunisia**. **Djibouti** established a Community Minimum Package of Services (MPS) in 2012 and it has not been updated since.

Figure 14. Countries with national predefined CHW service delivery package (n=12)



Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

47 Kalroozi, F., *et al*. (2020). A critical analysis of Iran health system reform plan. *J Educ Health Promot*, 9:364. doi: 10.4103/jehp.jehp_493_20.

Where it exists, areas defined by the national CHW service deliverable package vary from country to country, but all countries include health promotion and education, environmental health, hygiene and sanitation, prevention and control of NCDs, immunization and vaccination-related services, nutrition-related services, sexual and reproductive health services, maternal and newborn health related service (Table 9). CHWs play a critical role in vaccinations, including by mobilizing communities (especially in hard-to-reach areas), recalling of zero dose for routine immunizations and defaulters of vaccine doses, as well as raising awareness among pregnant women on the importance of vaccine schedules. Example of other services include HIV/TB- related services in **Algeria**, **Djibouti**, the **Islamic Republic of Iran** and **Sudan**, community disease surveillance and reporting and young child feeding in **Djibouti** and the **Islamic Republic of Iran** and malaria control in **Djibouti**, **Egypt**, the **Islamic Republic of Iran** and **Sudan** and psychosocial support in **Algeria**, **Djibouti**, the **Islamic Republic of Iran** and **Sudan**. The service delivery package in **Egypt** and the **Islamic Republic of Iran** also includes some administrative roles such as the collection of demographic data for catchment areas and record keeping in **Egypt**[48] [49] and conducting a census of their own community at the beginning of each year to classify community members according to the services they provide in the **Islamic Republic of Iran**. Moreover, in the **Islamic Republic of Iran**, services are delivered by a multidisciplinary health team according to set guidelines established by the government through health network service delivery points and home health services that are an integral part of the PHC system.[50] For **Algeria**, the provided interventions cover maternal and newborn health, vaccination, nutrition, and psychosocial support. As for the CSOs, they are involved in the prevention of NCDs and HIV/AIDS.

I took part in an anti-scorpionic programme for two years starting in 1992. At the start, we were given 15 days' training at the hospital in the use of syringes and how to react to each situation. If the patient felt unwell, I accompanied him to the emergency room. I covered a very specific region. If I remember, the total number [served] was around three thousand... The coordination and follow-up was done directly with the nurse at the basic health centre... There was a register in which we entered all the data (first and last name, age, procedure, etc.) and at the end we gave this register to the nurse...
In my opinion, this programme needs to be restarted, because there's always a need for immediate intervention with people who've been bitten. Victims take a long time to reach health facilities and there are regular reports of complications, including one death during a transfer 4 or 5 years ago.
The programme is a long-standing one and the inhabitants have found it highly relevant.

CHW from Tunisia

48 Folz, R., and Ali, M. (2018). Overview of community health worker programmes in Afghanistan, Egypt and Pakistan., *La Revue de Sante de La Mediterranee Orientale [Eastern Mediterranean Health Journal]*, 24(9), p. 940–950.

49 Head of Central Administration of Family Planning and Director of National Programme of CHW. (2023). Presentation of the Head of Central Administration of Family Planning and Director of National Programme of CHWs. [Workshop] In Country Consultation Workshop for Stronger, More Equitable Primary Health Care and Emergency Preparedness and Response.

50 Allen, L. N., Plummer, M. L., Gupta, A., Venema, M., Khalid, F., Toro Polanco, N., and Reynolds, T. (2024) PHC-oriented models of care. In D. Rajan, K. Rouleau, J. Winkelmann, D. KriCSOs, M. Jakab, and F. Khalid (Eds.), Implementing the Primary Health Care approach: A primer. Geneva: World Health Organization; 2024 (Global report on primary health care). Licence: CC BY-NC-SA 3.0 IGO.

Table 9. Different types of national CHW service delivery package implemented by country (n=12)

National CHW service delivery package	Countries											
	Algeria	Djibouti	Egypt	Islamic Republic of Iran	Iraq	Jordan	Lebanon	Libya	Morocco	Sudan	Tunisia	Yemen
Social and behavioural change		■		■								
Communication		■		■								
Health promotion and education		■	■	■						■		
Environmental health, hygiene and sanitation		■		■						■		
Malaria prevention and control		■	■	■						■		
Integrated Community Case Management (iCCM)/Integrated management of childhood illness		■								■		
Prevention and control of NCDs, including disability	■	■		■						■		
Immunization/vaccination related services	■	■		■						■		
Prevention and control of NTDs		■										
Nutrition related services	■	■		■						■		
HIV/TB related services	■	■	■	■						■		
Adolescent sexual and reproductive health services		■										
Sexual and reproductive health services		■								■		
Gender-based violence services		■								■		
Maternal and newborn health related services	■	■		■						■		
Psychosocial support	■	■		■						■		
Community disease surveillance and reporting		■		■								
Vital events reporting including promoting birth registration		■		■								
Verbal autopsy		■		■								
Preventing/responding to public health emergencies		■		■								
Early childhood development				■								
School health		■		■								
Infant and young child feeding (IYCF)		■		■								
No predefined package					■	■			■			■
Information not available/unclear							■	■			■	

Regardless of the availability of a predefined national CHW service delivery package, a wide range of community services are provided at the community level by community actors. In most cases, these are

delivered as vertical programmes led by various CSOs rather than a comprehensive state implemented package. In **Iraq**, for example, health promoters engage with communities to raise awareness about health issues, promote healthy behaviours and educate people on disease prevention based on the emerging needs of the population rather than on a specific package of health messages. In **Algeria**, **Jordan**, **Lebanon**, **Libya**, **Morocco** and **Tunisia**, CSOs provide various community health services for which they recruit and manage volunteers, CHWs or other community actors. In the subnational area of **NW Syria**, CHWs mostly adopt the WHO SOPs for household visits that define their role, the number of household visits they should make and the key activities that take place during them. Accordingly, household visits of 20-30 minutes are conducted in teams of two to ensure safety and acceptance. During these visits CHWs work on building trust with the community, identifying symptoms and risk factors for common diseases and promoting hygiene and healthy lifestyles. CHWs share and disseminate health information on newborn and child health care, reproductive health services, antenatal and post-natal care, breastfeeding and nutrition. Moreover, CHWs have the administrative task of recording morbidity and mortality data. However, there are cases where some partners, rather than adopting the comprehensive package developed by WHO, focus on vertical programmes.[51]

Overall, while some countries have successfully established service delivery packages, others remain without clear or predefined ones. Despite not always being standardized, a wide range of community health services is still being provided, often led by CSOs.

Formal linkages at the community level

Most countries have developed formal linkages with several sectors at the community level (Table 10, Figure 15). The most common sectors are water, sanitation and hygiene, education, as well as food and nutrition, while the sectors with the least linkages are shelter and non-food items, safety and security and human rights (Figure 15). For some countries such as **Lebanon** there was evidence of multisectoral collaboration, but it was not clear if the links were formalized. In **Yemen**, linkages are not yet established.

Table 10. Formal linkages with other sectors at community level by country (n=12)

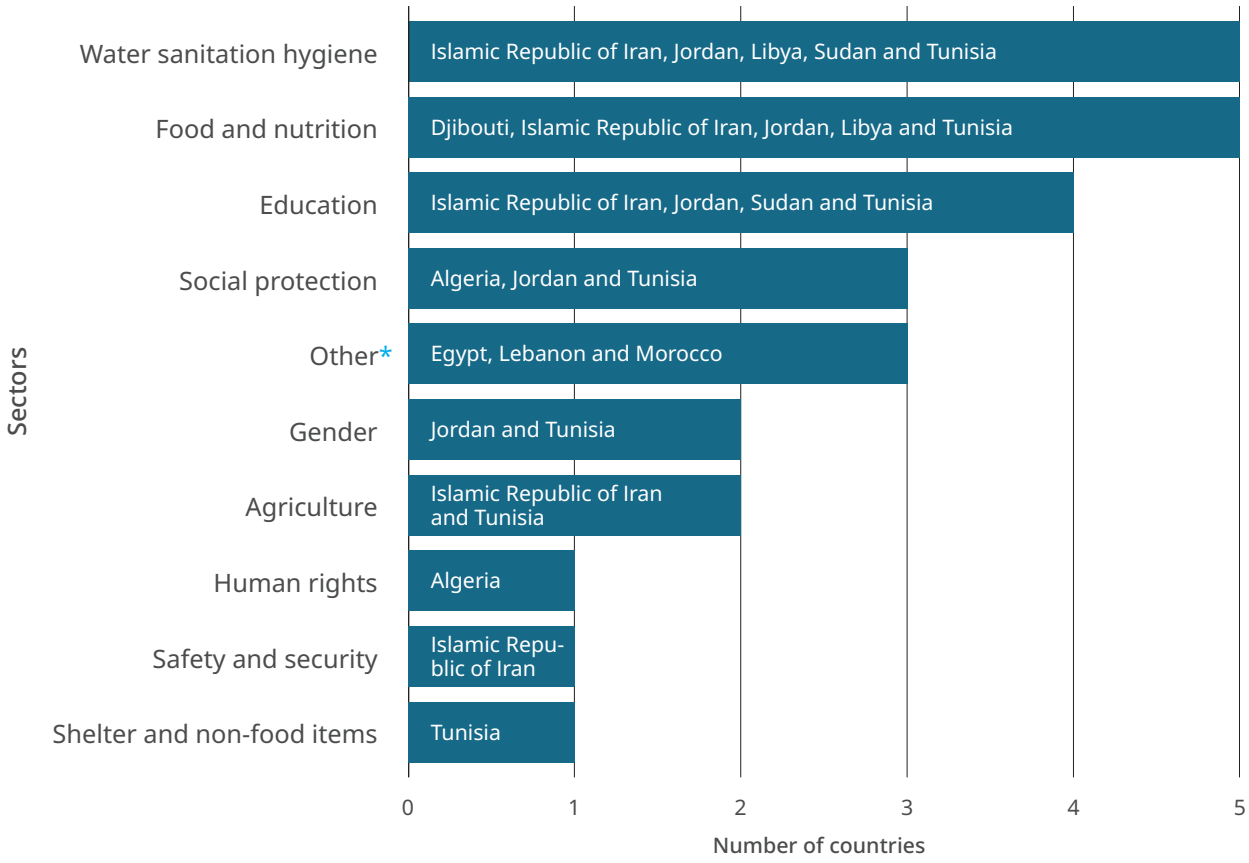
Sectors	Countries											
	Algeria	Djibouti	Egypt	Islamic Republic of Iran	Iraq	Jordan	Lebanon	Libya	Morocco	Sudan	Tunisia	Yemen
Agriculture				■							■	
Education				■		■				■	■	
Food and nutrition		■		■		■		■			■	
Gender						■					■	
Human rights	■											
Safety and security				■								
Shelter and non-food items											■	
Social protection	■					■					■	
Water sanitation hygiene				■		■		■		■	■	
Other*			■				■		■			

* **Other:** Includes countries where linkages have not been established, or linkages have been established for punctual projects, or it is not clear if they have been formalized.

51 WHO–Health cluster. (2019). Standard Operating Procedures for Community Health Workers household visits.

Despite the presence of multisectoral collaboration in some countries, there is often a lack of formalization in these partnerships or unclear information as to the extent to which they are operationalized. This highlights the need for a more coordinated approach across countries in the region.

Figure 15. Countries with formal linkages at community level by sector (n=10)[52]



* **Other:** Includes countries where linkages have not been established, or linkages have been established for punctual projects, or it is not clear if they have been formalized.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

52 Applicable to countries who reported having linkages in place (10 total). Multiple types of linkages can apply to a country.

2.5 Medicines and health commodities

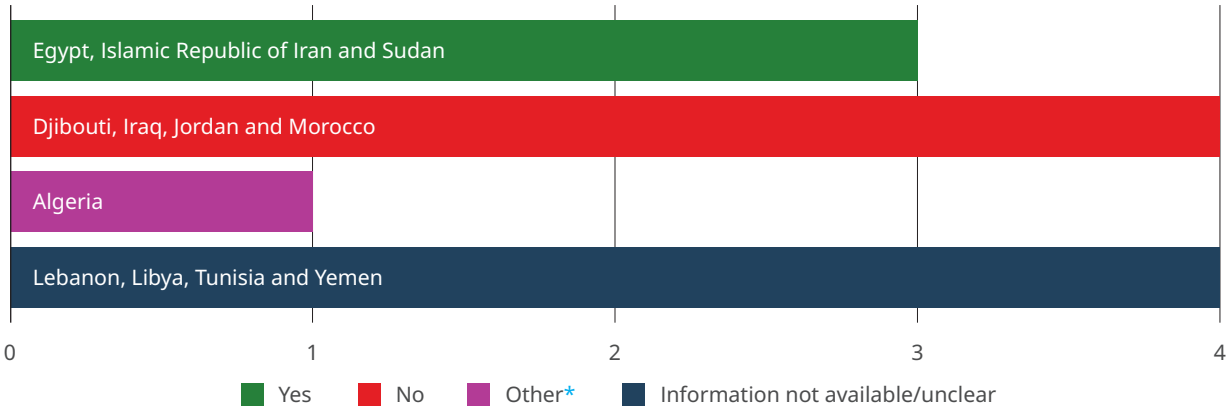
Key findings

- Three countries across the region have developed national lists of supplies for use by CHWs.
- Most countries have mechanisms in place to ensure that supplies are distributed through government systems, PHCs, or CSOs.
- Part of the reason for not having a clearly formulated list specific to CHWs in some countries could be that CHWs are not officially recognized in these countries or even that in some of them CHWs are not allowed to prescribe and dispense medication.
- Challenges such as supply shortages, stockouts, transportation issues and conflict-related disruptions continue to hinder consistent access to essential health commodities in several countries.
- Three countries have an LMIS at community level in place as part of the national level LMIS.

National standard list of supplies for CHWs

Countries in the MENA region that have participated in this mapping are evenly divided when it comes to the existence of a national standard list of supplies for use by CHWs (Figure 16). Three countries (Egypt, the Islamic Republic of Iran and Sudan) have a list that is used by all CHWs, while four (Djibouti, Iraq, Jordan and Morocco) do not have one and the information on the existence of a list is not available or not clear for four countries (Lebanon, Libya, Tunisia and Yemen). **Algeria** has a standard list available for CSOs working with key populations within the national strategic plan to fight against STIs, HIV and AIDS. Part of the reason for not having a clearly formulated list specific to CHWs in some countries could be that CHWs are not officially recognized in these countries or even that in some of them CHWs are not allowed to prescribe and dispense medication.

Figure 16. Countries with a national standard list of supplies for use by CHWs (n=12)



* **Other:** Indicates alternative system for financing and funding for community health available in country.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Egypt, the **Islamic Republic of Iran** and **Sudan** have a clearly defined national standard list of supplies for use by CHWs.[53] **Djibouti**, **Iraq**, **Jordan** and **Morocco** do not have one. In **Djibouti**, for example, the list of products authorized for community activities has not been standardized and in **Jordan**, supplies are available upon request through the Ministry of Health's Central Tenders Directorate.

53 World Health Organization. Pharmaceuticals Unit. (1986). WHO model list of essential drugs: Model drug information sheets for community health workers, Rev.1. World Health Organization. https://iris.who.int/handle/10665/61124

Part of the reason for not having a clearly formulated list specific to CHWs in some countries could be that CHWs are not officially recognized in these countries or even that in some of them CHWs are not allowed to prescribe and dispense medication.

For the other countries the situation is not as clear given that there is limited information available on supply systems for medicines and health commodities for community health programmes. Regardless, most countries have mechanisms to ensure that the needed supplies are provided to the communities either through the government and/or PHCCs like in **Algeria**, **Jordan**, **Lebanon** and **Morocco** or through international organizations and/or local CSOs for which CHWs work like in **Iraq**, **Jordan**, **Lebanon**, **Libya**, **Morocco** and **Tunisia**.

These arrangements work well in situations where CSOs hold stocks of health products and have effective management mechanisms resulting from the successful training provided to volunteer managers (Algeria), while other countries face challenges of stockouts due to delays in reception (Yemen), shortages in supplies (Djibouti, Yemen), lack of funding (subnational area of NW Syria), transportation difficulties (Djibouti) as well as conflict and insecurity issues (Yemen).

Medicines and health commodities distributed to CHWs varied by country and purpose. For example, items distributed in the subnational area of **NW Syria** as part of household field visits to ensure community health and hygiene included chlorine tablets, lice shampoo, scabies lotions, oral rehydration solution (ORS), nail cutters, toothbrushes, toothpaste, soaps and when available, micronutrients and PlumpyDoz. Additionally, equipment and supplies for household visits consisted of Mid-Upper Arm Circumference (MUAC) tape, Information-Education and Communication (IEC) materials, glucometers, sphygmomanometers or electronic blood pressure monitors, oximeters and thermometers (for CHWs assigned to COVID-19 surveillance). In **Tunisia**, **Algeria** and **Morocco**, CSOs working with the national programme to combat AIDS and STIs were supplied with condoms and screening tests based on needs they submitted in advance.

In summary, only a few countries across the region have developed national lists of supplies for use by CHWs. Despite this, most countries have mechanisms in place to ensure that supplies are distributed through government systems, PHCs, or CSOs. However, challenges such as supply shortages, stockouts, transportation issues and conflict-related disruptions continue to hinder consistent access to essential health commodities in several countries.

Logistics management information system (LMIS) at community level

A LMIS is a system of records and reports – whether paper-based or electronic – used to aggregate, analyse, validate and display data (from all levels of the logistics system) that can be used to manage the supply chain. LMIS data elements include stock on hand, losses and adjustments, consumption, demand, issues, shipment status and information about the cost of commodities managed in the system. Participating countries reported on whether a LMIS is in place at community level as part of the national LMIS, as well as the platform and means of data collection.

Having an LMIS at community level as part of the national level LMIS, helps to ensure rapid response and preparedness during emergencies by enabling real-time tracking and mobilization of essential health supplies. Monitoring supply levels of commodities at community level also improves visibility and coordination across all levels of the health system, minimizing delays, reducing stockouts and preventing waste. Three countries (Egypt, the Islamic Republic of Iran and Yemen) reported having a LMIS in place at community level as part of the national level LMIS (Table 11).

Table 11. Integration of community level LMIS into the national supply systems by country (n=12)

Countries	LMIS at community level as part of national level LMIS			
	Yes	No	Other*	Information not available/unclear
Algeria			■	
Djibouti		■		
Egypt	■			
Islamic Republic of Iran	■			
Iraq				■
Jordan				■
Lebanon			■	
Libya				■
Morocco				■
Sudan			■	
Tunisia				■
Yemen	■			

* **Other:** Indicates countries where LMIS systems are managed by other actors (e.g., CSOs) or where an alternative system is in place.

In the **Islamic Republic of Iran**, the CHWs collect the data digitally while in **Yemen** they use a paper based LMIS for vertical programmes on maternal and newborn health (MNH), Malaria, EPI and integrated management of childhood illness (IMCI). In the case of **Algeria**, some CSOs working on the fight against HIV/AIDS and other STIs have their own highly effective LMIS and have been trained to use it. In **Sudan**, procurement and supply management is provided through a unified supply system known as the National Medical Supply Fund (NMSF), which is regulated by the NMPB and integrated as part of the PHC package.[54] This is the case, for example, for the procurement and distribution of midwifery bags and clean delivery kits for CMWs. Therefore, while the kits are distributed according to the RH programme distribution plan at state and, in some cases, locality levels, the actual distribution of the kits to the midwives is undertaken by the chief midwives of the state and locality. The NMSF distributes commodities in accordance with the given programme's distribution plan and places supplies as per agreement with that programme. The means of data collection varies by programme but is mostly paper based.

As seen in Table 11, for five of the countries, it is not clear whether a LMIS system exists or to what extent it is integrated in the national supply system. In **Morocco**, for example, specific software is used to manage the inventory of testing kits and condoms used by CSOs working in HIV prevention and some data is being integrated within the DHIS 2. In **Libya**, there are recommendations in the "Strategic Directions for Establishing CHWs (2018)" for community health programmes to use existing systems for logistics support of medicines and supplies to the facilities that should be recorded in a monthly report outlining the stock position of medicines and supplies. However, there is no evidence of any integration with the national supply system, including the LMIS.

In conclusion, only a few countries in the MENA region, have implemented systems for CHWs to manage supply data. In many cases, the presence and integration of LMIS with national supply systems is absent or unclear, leading to gaps in efficient supply management.

54 Mohamed, A. M. (2023). Challenges of Primary Health Care in Sudan and the Role of the Health System Building Blocks as Contributing Factors: Rethinking Primary Health Care in Sudan's Journey to Universal Health Coverage, *KIT Royal Tropical Institute*.

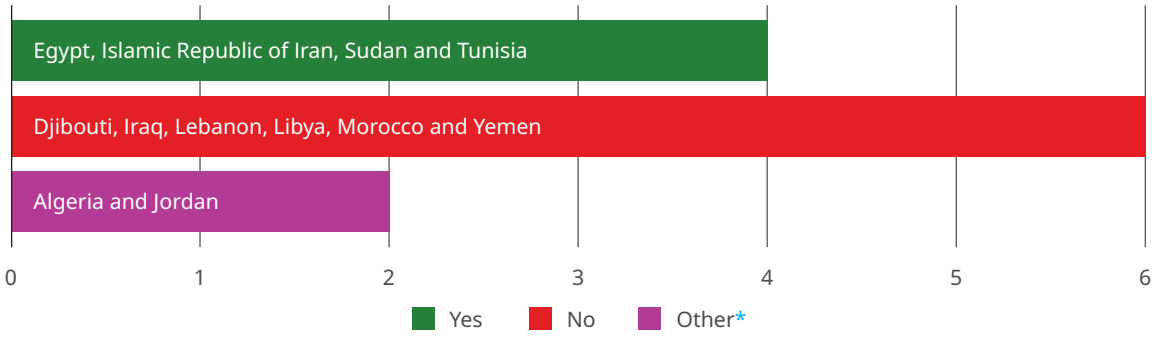
2.6 Partnerships and financing

Key findings

- Four out of the 12 participating countries have domestic funding for community health and two out of 12 have a budget line for community health in their national health budget.
- External funding remains prevalent in many countries, with the financing of community health often reliant on external donors.
- Domestic funding is often insufficient, ad hoc and linked to broader PHC budgets, diluting its use for community health.

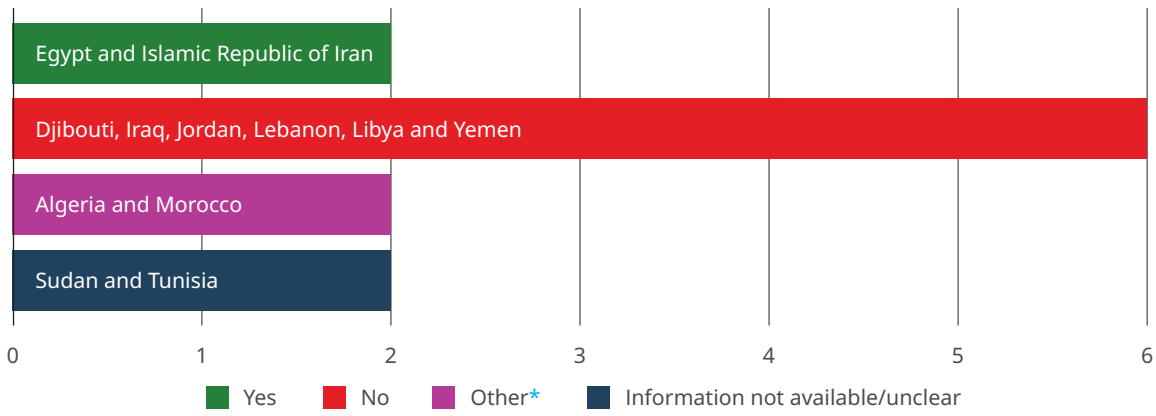
Community health in the MENA region is largely shaped by a combination of domestic and external financing mechanisms, with significant variation across countries in terms of funding allocation, coordination and sustainability. External funding (from various donors) remains prevalent in many countries, with the financing of community health often reliant on external donors. The survey results show that four out of the 12 (Egypt, the Islamic Republic of Iran, Sudan and Tunisia) mapped countries have domestic funding for community health (Figure 17) and two out of 12 (Egypt and the Islamic Republic of Iran) have a budget line for community health in their national health budget (Figure 18).

Figure 17. Countries with availability of domestic funding for community health (n=12)



* **Other:** Indicates alternative system for financing and funding for community health available in country.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

Figure 18. Countries with availability of a budget line for community health in the national health budget (n=12)



* **Other:** Indicates alternative system for financing and funding for community health available in country.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In some countries, funding for community services is often absorbed into the general health budget or more specifically the PHC budget, which can be insufficient to meet needs.

In other instances, domestic funding is available for community health, but it does not always cover all the necessary costs. In **Algeria**, the health system is primarily state funded, with community health funding integrated into the national health budget. In 2024 alone, US$1.77 billion* (238 billion Algerian Dinars) were allocated, with US$335 million* (45 billion Algerian Dinars) specifically earmarked for improving health services, particularly at the community level. Additional financing for community-level activities – including those implemented by CSOs – is provided by various ministries, including Health, Social Affairs, Family, and Interior. There remains a need for additional funding for public subsidies of active associations and there are challenges with funding coordination.

External financing plays a crucial role in sustaining community health services in most MENA countries. Major international donors such as UNICEF, the Global Fund (GF), WHO and various CSOs provide significant financial and technical support to community health programmes. In countries like **Libya** and **Yemen**, external funding is often the primary source for supporting CHW salaries, training, supplies and operational costs. In the subnational area of **NW Syria**, due to the humanitarian situation, the community health is exclusively financed by external donors who provide financial support for team operations, including salaries, transportation, purchasing supplies and equipment, as well as in-kind support through training and provision of supplies.

There is a need for additional funding that is independent of broader PHC budgets to avoid dilution of its use for community health.

The discussion on funding mechanisms for community health highlights challenges, both in terms of domestic and external funding sources. Domestic funding, when it exists, is often insufficient, or ad hoc, diluting its use for community health and leads to issues in funds utilization. In almost all countries, domestic funding is supplemented by external donor funding.

These external funds come in two main forms: Financial and in-kind support. Financial support is typically channelled through CSOs via competitive requests for proposals. Successful applicants receive funding to implement activities that align with donor priorities, such as HIV and STI prevention initiatives, often funded by entities like Expertise France and the Global Fund. In-kind support, such as the provision of supplies, is also common. For example, in the subnational area of **NW Syria**, UNICEF supplies essential materials like MUAC tapes and PLUMPS to CHWs working under the nutrition cluster.

Available funding primarily covers salaries and incentives for CHWs, particularly in countries where CHWs are not integrated into the national human resources for health systems (e.g., Lebanon). Other key areas of support include training and capacity building, provision of medical supplies, data collection tools, and operational costs like transportation and communication.

In many cases, external funding is short-term, earmarked for specific vertical programmes, or contingent on geopolitical factors, making it unpredictable and often insufficient to cover all community health needs. This overdependence on external financing is a challenge, where limited domestic investment threatens the continuity of community health services when donor funding runs out. The short-term nature of donor funding can lead to programme interruptions and instability. In addition to the sustainability issue, the region is facing major funding challenges due to various emergencies, such as conflicts, earthquakes and other natural disasters. These crises have weakened health systems, increased pressure on available resources and shifted priorities towards more urgent matters, leading to a severe funding crisis, with community health emerging as the most vulnerable sector.

* Exchange rates are based on the rates as of December 3, 2024.

Lastly, challenges are related to the fact that some funds intended for community health are diverted to other interventions. This misallocation leads to a reduced impact of community health interventions, further discouraging donor investment in this area. The absence of reliable data on community health also hampers proper monitoring, evaluation and advocacy efforts, making it difficult to demonstrate the value of CHWs› work and secure continued donor support.

In conclusion, while external donor funding plays a crucial role in supporting community health, the short-term, fragmented and often misdirected nature of this funding presents obstacles. The dependence on external financing, coupled with insufficient domestic investment, complicates the sustainability of community health. Improved coordination, long-term financial commitments and enhanced data collection are necessary to ensure the continuity, sustainability and effectiveness of community health interventions.

2.7 Cross-cutting issues

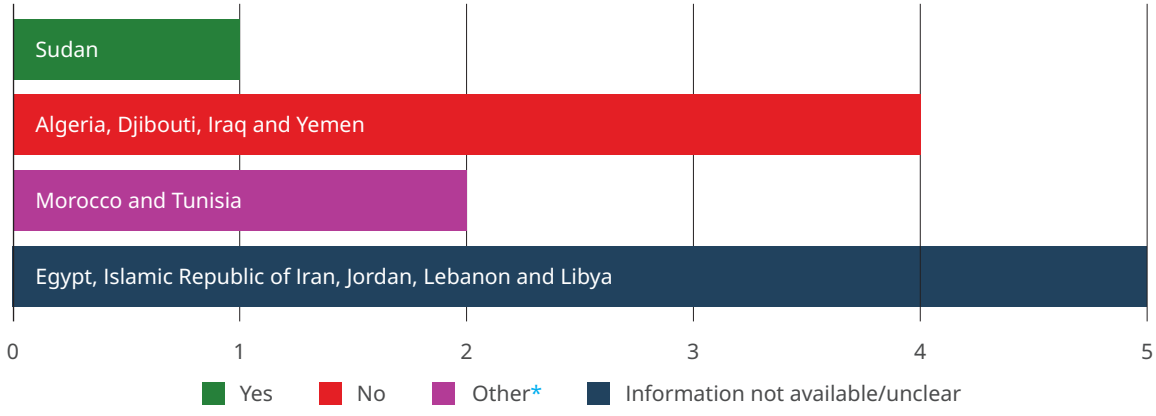
Key findings

- Gender sensitive programmes or trainings were developed and integrated at the level of CSO efforts in the country, but not at national level. There is also a tendency for a gendered division of labour in community health work across the region.
- Less than half of participating countries have CHWs integrated into emergency preparedness plans. Even when not formally integrated, however, CHWs play an important role in emergency situations across the region.
- Most countries reported at least some integration of refugees and IDPs into existing community health programmes. For refugees, this was mainly presented as access to services, as there were challenges noted in recruiting refugees as CHWs due to legal status at country level.

Gender considerations

Among MENA countries, **Sudan** has gender-based violence (GBV) programmes being implemented at community level. **Morocco** and **Tunisia** reported that gender sensitive programmes or trainings were developed and integrated at the level of CSO efforts in the country, but not at national level. No country reported the existence of Protection from Sexual Exploitation and Abuse (PSEA) mechanisms in the context of CHW policies and programmes.

Figure 19. Countries with gender sensitive CHW policies and programmes (n=12)



* **Other:** Includes countries with an alternative to official accreditation systems (for example, through regular competency assessments).
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In terms of recruitment and selection processes, gender is often considered by countries in the context of programmatic areas. It was reported, for example, that due to social and cultural norms, women are selected or recruited to work in specific programmes, such as reproductive health.

In some countries, such as **Egypt** and **Yemen**, only women are recruited to be CHWs. In other countries, such as the **Islamic Republic of Iran**, it was noted that men are also recruited for specific thematic programmes (such as disease control), while in **Lebanon**, there are plans to have equal representation in each of the PHCCs with a team consisting of one male and one female CHW. It was also reported that, in instances involving home visits for female community members and where male household members are absent, it is preferable for CHWs to be women. In the subnational area of **NW Syria**, there is a tendency towards recruiting women to be CHWs, but men to be team leaders. Having men as team leaders is thought to facilitate interactions with local authorities due to cultural dynamics, while women are perceived as better able to engage at household level with other women. In the subnational area of **NW Syria**, women CHWs are also sometimes paired with male relatives to mitigate concerns regarding female mobility. It was also noted that women are sometimes selected to be CHWs as they are more willing to work on a voluntary basis. Therefore, there is a tendency for a gendered division of labour in community health work across the region. These dynamics emphasize the need for equitable recruitment processes and for adequate pay and compensation for CHW efforts.

In terms of gender-sensitive training for CHWs, **Jordan** and **Djibouti** reported including this as a regular topic in pre-service training curricula. Some countries, such as **Sudan**, also have community health programmes focused on certain gender topics, such as GBV. This is particularly important in the context of emergencies and armed conflict, where rates of GBV increase.[55] [56] In some countries, additional GBV training is also provided in the case of emergencies. In the subnational area of **NW Syria**, some organizations provide training on GBV to CHWs to enhance their ability to identify, respond to, and support individuals affected by GBV and to protect the CHWs themselves. In **Sudan**, CMWs received additional GBV training after armed conflict broke out in Khartoum at the start of the war in April 2023. The focus of the training was on identification and referral of cases.

In terms of security measures, some countries noted that there were security challenges for women CHWs. For example, in the subnational area of **NW Syria**, some organizations working on community health reported that recruiting women CHWs poses challenges for safe transport. The solution was therefore to include a mixed male/female CHW team to ensure safety within communities and to avoid having women CHWs enter houses alone.

The lack of gender-sensitive policies and programmes for CHWs across the participating countries highlights gaps in addressing gender dynamics within health systems. There is a need for comprehensive, equitable recruitment processes and enhanced training that focus on gender issues, particularly in contexts affected by emergencies.

55 Health Cluster (2021). Gender-based violence in health emergencies. Retrieved from https://healthcluster.who.int/our-work/thematic-collaborations/gender-based-violence-in-health-emergencies#:~:text=In%20humanitarian%20crises%2C%20levels%20of,women%20are%20at%20acute%20risk

56 UNICEF (2022). Gender based violence in emergencies. Retrieved from https://www.unicef.org/protection/gender-based-violence-in-emergencies

Case study from Sudan: Transformative role of frontline female workers

In **Sudan**, where crises continue to unfold, women-led and girl-centred groups have played a pivotal role in ensuring that emergency support is inclusive and effective. These groups, in partnership with UNICEF, provide psychosocial support, safe spaces, recreational activities and dignity kits to displaced populations, meeting both immediate needs and long-term recovery goals. Their leadership not only delivers essential services but also fosters trust, safety and community resilience.

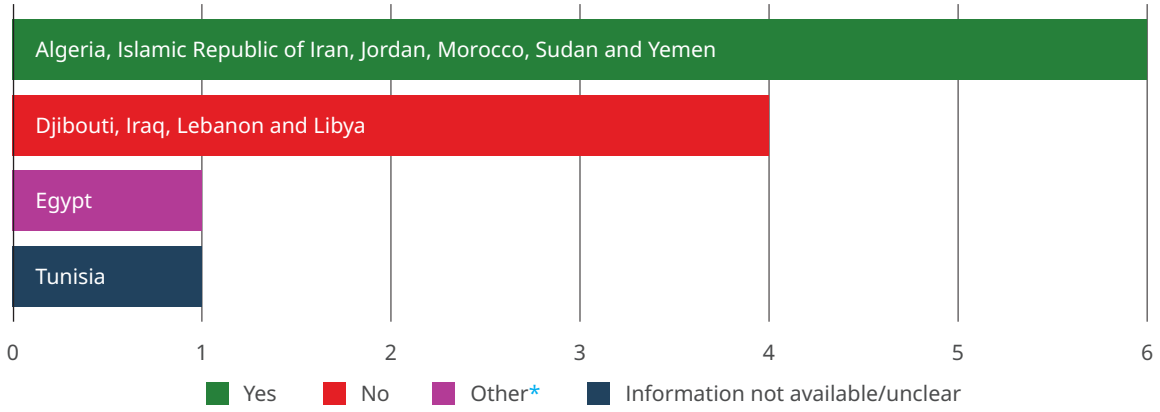
Women-led and girl-centred groups have been instrumental in supporting internally displaced persons (IDPs), volunteering at IDP centres and leading efforts to address protection from sexual exploitation and abuse (PSEA) through targeted training. Their work exemplifies a transformative approach, empowering women and girls to take on leadership roles and influence decision-making. Such initiatives promote equity and social justice.

Ongoing mapping and updates of grassroots initiatives ensure that these efforts remain responsive to the volatile situation on the ground. Through their resilience and dedication, women-led efforts in Sudan are not only providing lifesaving support but also paving the way for a more equitable future, placing women and girls at the heart of recovery and rebuilding.

Emergency preparedness and response

Emergency preparedness is particularly important in the MENA region given the ongoing conflicts and crises. There have been multiple emergencies in the region since 2023, including earthquakes in **Morocco** and in the subnational area of **NW Syria**, massive flooding in **Libya** and a war in **Sudan**, which has driven over 400,000 refugees into **Egypt** between April and December 2023.[57] More recently, the humanitarian crisis in **Lebanon** is having a significant impact on the health system. An integrated community health allows for a stronger and more resilient health response to crises. According to survey results, when asked whether CHWs and their supervisors were incorporated into emergency preparedness plans, countries were divided, with six out of 12 responding "yes" (Algeria, the Islamic Republic of Iran, Jordan, Morocco, Sudan and Yemen), four responding "no" (Djibouti, Iraq, Lebanon and Libya) and the remaining two as "other" (Egypt) and "information not available/unclear" (Tunisia).

Figure 20. Countries with CHWs and their supervisors included in national emergency preparedness plans (n=12)



* **Other:** Indicates related mechanism in place.

Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

57 UNHCR (2024). Global Report 2023: Middle East and North Africa Region. Retrieved from https://reporting.unhcr.org/global-report-2023/regional-overviews/middle-east-and-north-africa

Countries that have integration of community health in emergency preparedness include, the **Islamic Republic of Iran**, **Jordan** and **Sudan**. In the **Islamic Republic of Iran**, following the Bam earthquake in 2003, the government established and revised its emergency response plans. This included, for example, the establishment of emergency operation centres (EOCs), periodic vulnerability and hazard assessments and integration of disaster management and risk reduction (DMRR) into the national PHC network, which includes community level efforts.[58]

In some countries, community health is integrated into emergency response with a focus on surveillance. In **Egypt**, CHWs supported rapid detection of disease outbreak using a surveillance and preventative health system from the MoPH, which allowed for immediate action from the rapid response team corresponding to the outbreak.

In other countries, such as **Djibouti** and **Lebanon**, CHWs are not currently included in emergency response, but there are plans to integrate them in the future emergency preparedness models.

The availability of the CHWs and the strength of their response to the crises in the region highlight the potential of the community health workforce to be mobilized and rapidly deployed.

In countries with no formal integration of community health in emergency preparedness, some engagement can still be seen at the community level during emergencies. For example, in **Iraq**, community health volunteers are sometimes engaged by the MoH during emergencies to provide relevant services at community level.

Similarly, in **Libya** during the Covid-19 pandemic, the local government in **Libya** mobilized health committees at the municipal level. These municipal health committees coordinated with one another and worked together to engage directly with communities to provide services, such as facilitating access to the Covid-19 vaccine and conducting education and health promotion activities. After the Covid-19 pandemic ended, these committees were dissolved, but GIZ is currently working to reinstate and revitalize these health committees and further integrate them into existing mechanisms. In the subnational area of **NW Syria**, CHWs were trained and deployed to effectively conduct triage during the Covid-19 pandemic, reducing the burden on health facilities by providing initial assessments and guidance.

On additional training for CHWs, few countries had data on whether additional training for CHWs was provided in the context of emergencies. In the subnational area of **NW Syria**, CSOs provide targeted training focused on skills specific to the crisis at hand (e.g., cholera outbreak, Covid-19 pandemic). There was also limited information available on whether additional security measures are taken for CHWs in emergency situations. Some countries mentioned the use of personal protective equipment (PPE) in the context of disease outbreaks, other security measures were not frequently cited. In **Iraq**, CSOs have put security measures in place in IDP and refugee camps, which included provision of mobile technology to CHWs and their supervisors to allow for close supervision and monitoring in conflict scenarios.

In instances where there was no national level integration on emergency preparedness, CSOs sometimes filled this gap. This is the case, for example, of **Iraq** where CHWs are integrated into emergency response through specific CSO programmes and initiatives in IDP and refugee camps. While **Morocco** has integrated CHWs in their national emergency preparedness plans, as part of the response, CSOs regularly mobilize CHWs during emergencies, as was seen in the Covid-19 pandemic and following the Al Haouz earthquake in 2024. In the subnational area of **NW Syria**, CHWs have contributed to relief efforts following disruptions caused by the earthquake in Gaziantep. CHWs were deployed as part of mobile teams to assist with efforts and played a pivotal role in supporting nutrition services through screening and treatment for malnutrition.

58 Ardalan, A., Rajaei, M. H., Masoumi, G., Azin, A., Zonoobi, V., Sarvar, M., Eshkevari, V., Ahmadnezhad, E., and Jafari, G. (2012). 2021–2025 Roadmap of I.R. Iran's Disaster Health Management. PLoS Currents. DOI: 10.1371/4f93005fbcb34

During the earthquake, we assisted with rubble removal and other immediate aid, even though it's not our primary role. During the cholera outbreak, we took an active role in raising awareness about disease prevention, thanks to the community's trust in us.

CHW in the subnational area of NW Syria

Although not always formally integrated into emergency preparedness and response plans, CHWs play an important role in emergency situations across the region. The availability of the CHWs and strength of their response to crises highlight the potential of the community health workforce to be mobilized and rapidly deployed, especially if further integrated into emergency mechanisms in response to emergencies.

The role of community midwives in Sudan

In **Sudan**, community midwives (CMWs) have played a critical role in the ongoing war, particularly in Khartoum. In Khartoum State, over 60 per cent of deliveries occur in health facilities, which is the highest in the country. With the outbreak of war in 2023, all maternity hospitals were forced to close, leaving a severe deficit and maternal health crisis in its wake.

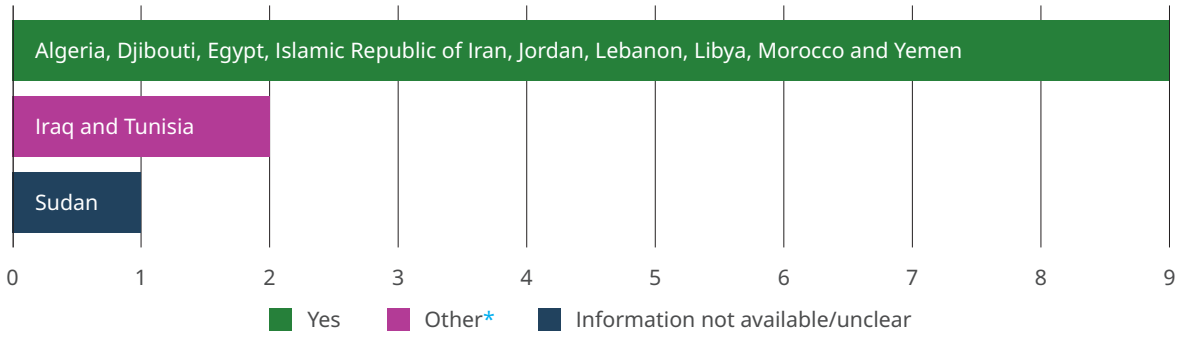
Using social media platforms, the MoH was able to mobilize CMWs in the area. With support from their supervisors, CMWs formed groups to respond to the crisis and safely conduct deliveries across localities in Khartoum. Deliveries are conducted at home or in makeshift labour rooms set up in PHC centres across the localities.

Additional training was provided to the CMWs at the outset of the war to better meet the emergent needs. This included a refresher training on maternal and neonatal warning signs. It also included an orientation on recognition and referral of cases of GBV. As frontline responders, CMWs took on the responsibility to ensure early referral to local health centres for appropriate case management.

Refugees and internally displaced persons (IDPs)

The findings from the mapping showed that nine of the 12 countries (Algeria, Djibouti, Egypt, Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco and Yemen) reported at least some integration of refugees and IDPs into existing community health programmes. It also highlights that the level of integration is not always known or fully documented.

Figure 21. Countries with refugees/IDPs included in existing community health programmes (n=12)



* **Other:** Indicates alternative mechanisms for engagement in place.
Source: Analysis from the Community Health Policy and Implementation Landscape Mapping in the Middle East and North Africa Region, 2024.

In many countries, refugees and IDPs receive equal access to community health services. In the **Islamic Republic of Iran**, for example, the government has allowed the inclusion of all registered refugees in the Universal Public Health Insurance (UPHI) scheme since 2015. Like Iranian citizens, migrants and refugees (including those who are undocumented) are therefore able to access PHC services free of charge.[59]
In **Algeria**, **Jordan** and the subnational area of **NW Syria**, there is also equal access to services for IDPs and refugees. In fact, in **Jordan**, it was further noted that camps are covered in most community health programmes, campaigns and services as well as including refugees/IDPs in the health workforce.
In **Yemen**, it was also noted that IDPs receive services if they reside within CHW catchment areas.

In **Djibouti**, IDPs and refugees are referenced in the National Community Health Policy (2023). The policy was developed in consultation with the International Organization for Migration (IOM) and United Nations High Commissioner for Refugees (UNHCR) and outlines the use of focal points who are already trained and engaged in the various camps in the region to facilitate community health service delivery.

It is to be noted that in several countries, it was reported that, due to national legislation, it was not possible to employ refugees as part of the health workforce (e.g., Lebanon, Libya, Yemen). In these instances, when refugees were engaged, it was as "volunteers". This is the case in **Libya**, for example, where community leaders of refugee communities were recruited as volunteers to facilitate access to these communities and to facilitate service provision. In **Lebanon**, it was also noted that there may be challenges in maintaining refugee CHWs due to the legal restrictions for employment. In some cases, therefore, CHWs serving refugee communities may not come from the communities themselves. This is also the case for IDPs in Yemen. In this instance, CHWs do not reside in IDP camps, but visit them regularly to deliver services (although the influx of more IDPs strained the work).

Refugees largely have access to community health services across countries in the region. There are sometimes challenges in engaging them in community health work due to legal status issues.

In some countries, community health for IDPs and refugees has been taken up by international organizations through vertical programmes, including by employing CHWs. In **Iraq**, the majority of community level work has occurred in the context of refugee and IDP health services through CSO initiatives.

Referral systems were also established to ensure that refugee and IDP communities were able to access services not only within camps, but also outside of them if emergency care was needed. Engagement is often seen in health promotion to support an uptake of services. This is the case, for example, in **Tunisia**, where CHWs are used for mobilization of peer educators in projects aimed at refugees and IDPs.

Overall, while refugees and IDPs can access services within the region, the levels of engagement in community health policies and programmes vary greatly. Ensuring that CHWs have ties to the communities they serve is important for the development of trust and for any subsequent uptake of services. External support through strategic partnerships, for example with IOM, United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) and UNHCR, were reported to be helpful in facilitating sufficient access to refugee and IDP communities both inside and outside camps.

59 Kiani, M., Khanjankhani, K., Takbiri, A., and Takian, A. (2021). Refugees and Sustainable Health Development in Iran. *Arch Iran Med*. Jan 1;24(1): 27-34. doi: 10.34172/aim.2021.05. PMID: 33588565.

3. Conclusions

The mapping of the community health policy and implementation landscape across the MENA region highlights significant opportunities for advancing community health for improvement of health outcomes. Despite the diverse political, economic and health contexts within the region, the findings demonstrate that community health is well-positioned to play a transformative role. Furthermore, experiences from countries like **Sudan** and the subnational area of **NW Syria** underscore the potential value of community health services during emergencies, offering a foundation for future resilience.

Legal frameworks supporting community health have proven to be enablers in some countries, strengthening governance, mobilizing resources and improving service delivery. These frameworks have helped clarify the roles of CHWs, enhance their training and supervision and contribute to better health outcomes. Expanding such frameworks across the region represents an opportunity to harmonize governance and reinforce the integration of CHWs within national health systems. Furthermore, while a few countries have made strides in **engaging CHWs in decision-making,** scaling up this inclusion presents an opportunity to ensure that health policies are more closely aligned with the needs and priorities of communities. Similarly, expanding **structured mechanisms for community engagement** — such as partnerships with local leaders, civil society and community members — can further amplify the voice of communities in health system design and delivery.

Data collection and management also hold significant potential for strengthening community health. Several countries have made progress in integrating community health into HMIS, enabling better decision-making and more effective resource allocation. Countries have an opportunity to standardize definitions and indicators, which would support evidence-based decision-making and improve the evaluation of health interventions. Strengthening data systems, even in challenging environments, can empower countries to better measure outcomes and advocate for continued investment in community health.

On the financing front, countries that have **secured domestic resources and budget lines for community health** demonstrate how national investment can reduce reliance on external donor funding and ensure programme continuity. Scaling this approach across the region presents a clear pathway to sustainable community health financing. Likewise, the diverse service delivery models emerging across the region offer valuable lessons. Countries are tailoring **community health strategies to meet the specific needs of their populations,** providing an opportunity to refine and adapt these models to maximize their impact.

Emergency preparedness is another area with strong potential for growth. The MENA region faces acute crises ranging from natural disasters and climate instability to disease outbreaks and political upheavals. These challenges emphasize the importance of **integrating community health into emergency preparedness efforts to build resilience and strengthen responses** during crises. Successful examples of community health integration during COVID-19 demonstrate how CHWs can be a cornerstone of crisis response, providing a robust framework that can be further developed to address future emergencies.

In conclusion, this mapping underscores the diversity of community health approaches in the region and the political commitment to prioritizing community health as a critical link between health systems and the communities they serve. These findings present an opportunity to build on progress already made while addressing gaps in governance, financing, data management, service delivery and emergency preparedness. By leveraging these opportunities, countries can create more resilient and sustainable community health, ensuring they meet the needs of all populations effectively and equitably.

4. Priority policy directions

Across the countries in the MENA region, there is a need to strengthen and better integrate community health; it is therefore essential to address several critical areas for improvement. The following recommendations outline practical steps to overcome challenges and capitalize on existing opportunities. For country specific recommendations, see Table 12 below.

4.1 Governance and accountability

- **Develop and implement appropriate policy and legal frameworks for community health:**
  - Institutionalize community health within the broader healthcare system, recognizing CHWs as part of the health workforce and unifying community health-related efforts under ministries of health.
  - Develop and implement comprehensive legal frameworks that recognize CHWs as part of the national health workforce, outlining clear roles, qualifications and pathways for professional development and ensuring adequate support, remuneration and recognition to sustain community health initiatives beyond CSO-driven efforts.
  - Where relevant, include CHWs within PHC systems to improve access, particularly in underserved areas.
- **Develop governance and oversight mechanisms:**
  - Establish formal oversight committees, composed of various stakeholders, including government, CSOs, funders and community representatives, to ensure horizontal integration and coordination of community health, coherence of interventions and promote long-term sustainability through shared responsibility and accountability.
  - Establish public-private partnerships to involve the private sector in funding, planning and delivering community health services.
- **Foster stakeholder engagement and participation:**
  - Encourage inclusive decision-making by involving CHWs in programme design and policymaking through consultations, advisory committees and feedback mechanisms, ensuring relevance and sustainability.
  - Strengthen community engagement systems, creating health committees that include community representatives, CHWs and healthcare providers to ensure community voices are part of healthcare planning and delivery.
  - Invest in formal social accountability mechanisms, allowing communities to provide feedback on CHWs and health services, monitor service quality and assess performance through structured feedback systems. The latter would ensure community health services are accountable, effective and aligned with the needs of the population.

4.2 HMIS

- **Digitize and integrate community health information:**
  - Expedite the digitization of community health information by implementing systems and software that enable online and offline data entry at the community level. This should include activities provided by various partners, including public and private entities, PHCCs, CSOs, etc.
  - Integrate C-HMIS into national HMIS for improved data centralization to allow for better decision-making and resource allocation.
  - Establish digital platforms and collaboration tools to streamline data sharing among implementing partners, government entities and other stakeholders to minimize duplication and optimize resource utilization.
- **Improve monitoring, evaluation and data quality:**
  - Create a set of indicators that reflect community health activities across a broad spectrum of programmes, rather than focusing solely on vertical initiatives. These indicators should assess not only workload and target achievements, but also impact of activities (e.g., success of referrals).
  - Invest in training and capacity building for CHWs, supervisors and data managers and equip them with skills necessary for data collection, entry, management and analysis. This will enhance data availability, data quality and improve reporting.
- **Establish coordination and feedback mechanisms:** Mechanisms should be established between community health programmes and health facilities to ensure that community-level efforts are recognized and integrated into broader health planning and strategy development.
  - Develop (or include in existing databases) national databases to register and track CHWs and other key personnel involved in community health initiatives. These databases should be **sex-disaggregated** and regularly updated to improve the management, deployment and coordination of CHWs across various programmes.

4.3 Health workforce

- **Unify the definition of CHWs and recognize them as part of the national health workforce:**
  - Acknowledge CHWs as a unique cadre with a well-defined role and specific selection criteria that are based on country-specific indicators.
  - Include CHWs among the national health human resources of a country. Ensure that CHWs are hired as employees with specific contract, wages and benefits.
- **Develop a unified training programme for CHWs with provisions for supervision, refresher courses and certification:**
  - Upon recruitment, ensure that CHWs undergo comprehensive and standardized training modules that include general and more specialized topics and culminate with official certification of CHWs by an accredited local body.
  - Provide opportunities for continuing development and advancement through more specialized courses, workshops or trainings that entail further certification.
  - In the trainings, ensure incorporation of mechanisms for supervision and evaluation and ensure that CHWs take refresher courses at regular intervals.
- **Compile a master list disaggregated by key socio-demographic characteristics:**
  - Ensure availability of a detailed list of trained and accredited CHWs available in the country indicating defining characteristics including age, sex, nationality, location and disability.

4.4 Service delivery

- **Develop a predefined national package of services that is specific to a country's needs:**
  - Ensure identification, planning and delivery of necessary basic services for all at the community level.
  - Ensure CHWs are trained to deliver these services and should be provided with the necessary tools and health commodities to be able to perform their jobs adequately.
- **Strengthen formal linkages for the provision of a more holistic service:**
  - Ensure multisectoral collaboration to deliver a more comprehensive service and avoid duplication of efforts. The presence of formal linkages will allow all parties to benefit from each other's expertise and work as a united front towards the improvement of the health of the community as a whole.

4.5 Medicines and health commodities

- **Develop a national standard list of supplies for use by CHWs:**
  - Identify a standard list of medicine and health commodities that would enable CHWs to perform their role efficiently and ensure that all items on the list are always readily available to CHWs.
- **Put in place a LMIS at community level that is integrated in the national level LMIS:**
  - Ensure that there is a functioning supply management system at the community level to enable the stocking and tracking of health supplies. This will ensure the availability of supplies and help avoid stockouts while at the same time providing a means of monitoring the performance of CHWs and maintaining transparency. This will also support building resilience, particularly in conflict affected areas.

4.6 Partnerships and financing

- **Ensure appropriate budget allocation and financial planning:**
  - Ensure that community health services are costed with allocation of specific and sufficient budget lines within national health budgets for community health to improve planning and resource allocation, reduce reliance on external donors and promote sustainability.
  - Shift a larger portion of health budgets towards preventive care rather than curative care, including services provided by CHWs and develop efficient domestic financing mechanisms to support CSOs with simplified administrative procedures and eligibility requirements.
  - Prioritize allocation of resources to community health programmes and interventions that have demonstrated effectiveness and impact.
- **Develop innovative and diversified financing models:**
  - Consider adopting innovative financing models such as public-private partnerships and community-based health insurance schemes to diversify funding sources and ensure the long-term sustainability of community health initiatives.
  - Seek new partners to enhance the financing of community health services and prioritize long-term, sustainable funding partnerships.

- **Ensure collaboration and resource sharing:**
  - Ensure collaboration through partnerships between government agencies, CSOs and external donors, promoting resource-sharing (e.g., data collection tools, training materials, medical supplies) among stakeholders to maximize the impact of financial investments in community health programmes.
- **Provide adequate compensation and support for CHWs:**
  - Prioritize fair compensation and incentives for CHWs, including performance-based bonuses, to reduce turnover and increase retention.
  - Allocate sufficient funds to equip CHWs with necessary supplies and equipment such as medical kits, communication tools, transportation and digital data collection devices.

4.7 Cross-cutting issues

4.7.1 Gender

- **Include gender sensitivity throughout community health policies and programmes:**
  - Ensure CHW recruitment policies are gender sensitive and that women are paid a fair and equal wage.
  - Ensure equal leadership and career progression opportunities for male and female CHWs.
  - Ensure training programmes include gender sensitivity training for all CHWs.
  - Ensure gender sensitive CHW policies and programmes are established, including protection from sexual exploitation and abuse (PSEA) mechanisms.

4.7.2 Emergency preparedness and response

- **Integrate community health into emergency preparedness plans:**
  - Incorporate CHWs as key actors in emergency response due to their proximity, knowledge of communities and connection with their members.
  - Ensure community health is included to improve surveillance mechanisms in emergency response. When integrated into emergency response mechanisms, CHWs have the ability be mobilized and rapidly deployed when the need arises.
- **Ensure additional training is provided to CHWs deployed in emergency situations and provide additional security measures as needed.** CHWs should be protected against health risks, violence and sexual assault.
- **Ensure CHWs are based in their own communities** to allow for rapid and efficient response processes.

4.7.3 Refugees and IDPs

- **Include refugees and IDPs as CHWs in the national health workforce:**
  - Refugee and IDP CHWs are key in gaining access to and promoting health in these communities. It is important to ensure refugee and IDP CHWs are well trained, supervised and paid a fair wage.
- **Integrate refugee/IDP community health services into the national public health system:**
  - Ensure equal access and targeted support for health services at community level for refugee and IDP populations.

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