Community Health

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

North West Syria Brief

unicef for every child

World Health Organization

UNFPA

WFP World Food Programme

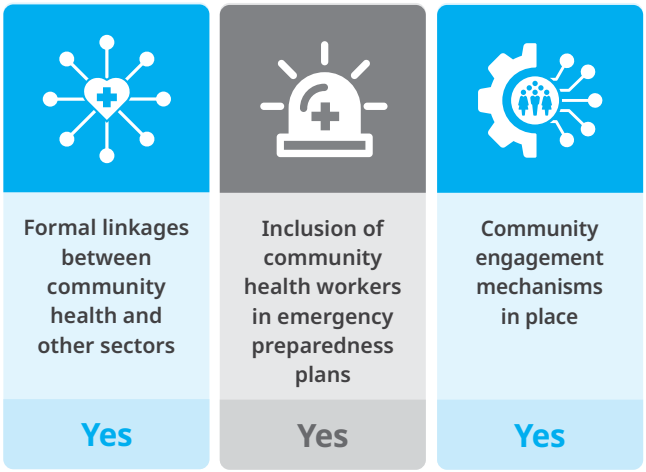
NW Syria NUTRITION CLUSTER

HEALTH CLUSTER

WASH Cluster

© UNICEF/UN0401429/Syria

1. Community health in North West Syria



1.1 Context

In North West Syria (NWS), a civil movement that began in 2011 has developed into a prolonged armed conflict, resulting in a significant humanitarian crisis. The region's conditions have worsened in recent years due to an economic crisis compounded by forced displacement, the COVID-19 pandemic, a cholera outbreak, and a destructive earthquake in February 2023. This situation affects over 4.5 million people, including more than 2.8 million internally displaced individuals, predominantly women and children (79 per cent). Many displaced persons live in overcrowded camps with limited access to essential services.[1]

The humanitarian crisis is deepening, and cross-border aid is under pressure to meet long-term needs. There is a severe funding shortage, which caused essential services at nine hospitals to be temporarily halted last year. In addition, half of the health facilities have been destroyed and 70 per cent of health care providers have fled, leading to a significantly weakened health sector in the region. Challenges related to access, equity, continuity, and utilization of services persist amid the ongoing conflict.

In 2015, international organizations introduced the concept of community health workers in NWS. Although a unified package of services was successfully developed, implementation has faced challenges, and there have been inconsistencies in approaches both between and within different clusters.

1.2 Methodology

This mapping provides an overview/snapshot of the community health currently in place in NWS. It followed a mixed methods approach, combining (1) a document review of publicly available documents and internal reports and evaluations shared by stakeholders, (2) 10 key informant interviews conducted virtually with representatives from the health, Expanded Programme on Immunization (EPI), nutrition, and Water, Sanitation and Hygiene (WASH) clusters and their partners, as well as community health workers (CHWs), and (3) a validation workshop conducted with 36 key stakeholders. The interviews and the workshop were recorded (after obtaining consent of informants and participants) and transcribed. Data was then coded using Dedoose software, focusing on health system pillars considered for this mapping, including governance and accountability, health management information system (HMIS), health workforce, service delivery, medicines and commodities, partnerships, and financing. Some insights related to cross-cutting themes, such as gender considerations, emergency preparedness, and integration of internally displaced persons (IDPs) in community health, were also extracted. All primary and secondary data were then triangulated and summarized in this brief.

2. Health systems pillars

2.1 Governance and accountability

Since 2015, international organizations have introduced interventions by CHWs in NWS, with limited involvement from local authorities possessing executive power. Then, in 2017, CHWs were included in the essential primary health care (PHC) package created by the World Health Organization (WHO) for NWS as an auxiliary component linked to PHC, but their roles and integration within the health care system were not clearly outlined. Additionally, governance and implementation of initiatives were highly fragmented, leading to community fatigue and high turnover. To address this issue, a **"Unified CHW Curriculum" was developed by the WHO in collaboration with non-governmental organizations (NGOs) in 2018, and a "Technical Working Group (TWG) for CHW" was established to guide the overall direction of interventions**.[2, 3] This initiative was considered highly successful in coordinating community health efforts, particularly in 2018 and 2019. While mixed feedback was received regarding the current level of activity of the TWG, all informants agreed that it is actively engaged during emergencies, such as the cholera outbreak. As for the governance of community health interventions related to the EPI cluster, the Syrian Immunization Group (SIG) is responsible for the technical aspects of the work, while the NGOs and INGOs partners are responsible for the administrative and financial aspects (each partner being responsible for a defined number of vaccination centres). With regards to the nutrition cluster, coordination is centralized at the cluster level with no dedicated working group to oversee community interventions. Additionally, many partners of the nutrition cluster are working closely with the health cluster. Hence, **community health is still functioning in NWS but lacks adequate central coordination.**

Community health in NWS was also considered to be heavily dependent on external humanitarian funding, with international actors typically dictating the implementation details in a top-down manner. **This top-down decision-making method** is seen as a challenge that hinders optimal outcomes, as a bottom-up approach would likely be more effective. This has been evidenced, for example, by the "Corona Coordination Mechanism," which utilized a bottom-up strategy by incorporating feedback from grassroots levels to refine COVID-19 related messaging to ensure that health communications were clear and comprehensible to the target audience. Overall, this process was found to have led to more impactful and widely understood public health messages.

Funding is often earmarked for specific activities or regions, which limits the influence of local actors, who are primarily responsible for carrying out community health programmes but have little power in the decision-making process.

Efforts to **integrate community health services at the PHC** level in NWS have faced significant challenges. In 2016, integration efforts were minimal and primarily focused on obtaining additional funding rather than true implementation. By 2018, the roles of community health workers were clarified, but practical implementation remained weak. This highlighted the need for proper training and coordination to ensure effective integration. Informants stated that a considerable gap remains in the integration of services, underscoring the necessity for a clear policy and commitment from PHC directors and supporting organizations to achieve meaningful integration within the health care system.

The private sector involvement in community health initiatives in NWS is present but remains limited and has received mixed feedback. There has been effective coordination between the EPI cluster and paediatricians to refer identified defaulters and zero-dose children (ZDC) to Vaccination Teams (VT), resulting in an increase in vaccination rates in certain areas. Another example of successful private sector engagement involved collaboration with influencers, who helped spread awareness about the importance of COVID-19 vaccines through their social media platforms, thereby increasing vaccination uptake in targeted communities.

However, within the nutrition cluster, there is hesitation to engage with the private sector due to concerns about the promotion of breastfeeding substitutes. This caution stems from fears that the private sector may prioritize commercial interests over public health goals, particularly regarding infant nutrition. As a result, while some areas have seen benefits from private sector involvement, others remain wary, highlighting the need for careful management and collaboration to ensure alignment with public health objectives.

> *"In January 2024, 153 paediatricians offered their time to collaborate with SIG teams, and 36 ZDC have been reported to SIG teams by 22 doctors in January 2024."* [4]

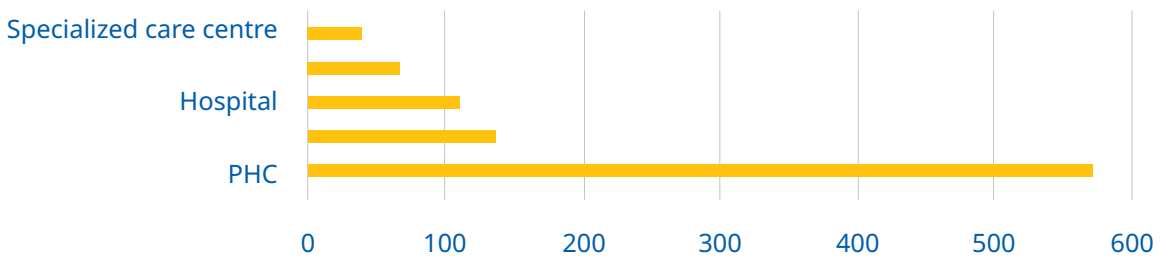
Community engagement mechanisms in NWS exist and have been crucial for improving public health outcomes and fostering trust between health workers and local populations. These mechanisms also involve some limited engagement with the private sector. Existing mechanisms include the following:

- Organization of awareness sessions in schools, hospitals, etc.
- Coordination with private doctors and midwives.
- Pharmacy coordination visits.
- Local council coordination visits.
- Dissemination of messages through mosques announcements.
- Organization of dialogue sessions with influential community members, community leaders and religious leaders.

2.2 Health workforce

Although **exact count of CHWs in North West Syria is not available,** 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 (see Figure 1).[5] That stated, informants reported that many individuals are labelled as CHWs but may not be actively practicing in that capacity.

Figure 1. **Distribution of CHW per type of facility in NWS, 2023**[5]



The Standard Operating Procedures (SOP) for CHWs' household visits, developed by WHO, outlines four types of CHWs along with their hiring requirements and responsibilities, as shown in Table 1.[6] However, significant inconsistencies exist **regarding the available positions of CHWs** and their implementation, with recruitment not standardized among partners. Titles for CHWs in North West Syria are also not standardized. Examples include Nutritionist, Protection Worker, TB Support Worker, Referral Facilitator, and Rapid Response Team (RRT) Worker,[7] or a mixed structure according to each project. Moreover, some CHWs have different titles yet perform similar tasks. Lastly, not all supervision team members are dedicated CHW staff; some hold other programmatic positions, such as Assistant, Officer, Coordinator, Manager, and Supervisor.

Table 1. **Types, hiring requirements and responsibilities (as per the SOP) for CHWs' household visits**

Position and hiring requirements	Responsibilities
Community health worker / CHW Must be a member of the targeted community and to be recruited from the same community	Identifying and assessing health needs Health education and promotion Referral facilitation Follow-up and monitoring
Community health field team leader Must have completed university/high education	Supervision and support Quality assurance Coordination and collaboration Reporting and documentation Training and capacity building
Community health general supervisor Must be certified in any sort of health sciences	Overall management and coordination Policy development and implementation Resource allocation and management Monitoring and evaluation Stakeholder engagement
Community health trainer Must have prior experience working as/with CHWs or have medical background	Responsible for delivering the knowledge and building the skills of the selected CHWs in six areas

The **Unified CHW Training Manual, developed in 2018 by WHO and its partners, provides training for CHWs covering six core modules:** family health, communicable diseases, non-communicable diseases, healthy lifestyle (addressing obesity, smoking, and elderly care), nutrition, and a basic module.[8] Additional modules have occasionally been added, covering specific health topics (e.g., cholera). An assessment of the CH programme in NWS conducted in 2020, revealed that approximately 50 per cent of CHWs have received training on the comprehensive package and the six-module curriculum. The training programme was also found to face several challenges, including limited number of qualified trainers, insufficient training duration, and poor effectiveness of online training and inadequate practical scenarios. There is also a need for training completion certificates. Technical issues, such as poor internet and electricity for online training, and logistical issues, such as difficult transportation for CHWs in remote areas, security concerns, poor weather conditions, and lack of childcare services for the children of women CHWs, further complicate training efforts. The need for refresher training has been raised to address these issues.[7]

As for the supervision, the WHO SOP for CHWs' household visits outlines a clear monitoring and supervision process.[6] According to these guidelines, CHWs should be supervised through field visits, on-the-job coaching, and weekly meetings or visits to discuss and evaluate work plans. Monitoring and supervision involve several structured activities: the general supervisor designates one day per week to meet with each team leader

and their team members, which includes ten CHWs, to discuss activities, evaluate cases requiring referrals to health services, and address challenges. Additionally, the general supervisor meets weekly with team leaders to assess the team's work and review reports and work plans. CH team leaders are responsible for monitoring and evaluating each CH team's performance by conducting weekly site visits with the team as part of on-the-job training using a 'supportive supervision form.' The team leader also evaluates the team's performance within the community on a monthly basis by conducting spot-check interview visits to five previously visited households.[6] **While supervision and regular evaluation of CHWs do occur, they often take place outside the recommended schedule of visits, which can lead to inconsistencies in the monitoring process**.[7]

Therefore, the health workforce of community health in NWS faces significant challenges that affect the effectiveness and sustainability of community health programmes. Firstly, despite successful training programmes, such as the 21-day initiative, a lack of refresher training remains a challenge due to funding constraints. Secondly, there is a lack of capacity to effectively monitor and supervise health teams, resulting in insufficient oversight and accountability. The COVID-19 response highlighted this, with the rapid expansion of health workers focusing on coverage rather than on maintaining quality standards. Thirdly, many CHWs are well-educated, but financial instability, security concerns, and difficult working conditions deter potential recruits. Additionally, the high rates of service providers leaving their positions due to dissatisfaction with financial compensation, displacement, and raised employment standards further strain the workforce.

Table 2. **Specificities of the EPI and nutrition clusters with regards to their CH workforce, training and supervision**

	EPI	Nutrition
CHWs	Each team consists of one social mobilizer, one female vaccinator, and one male vaccinator. There are two levels of social mobilizers: those identifying zero-dose cases and those mobilizing the teams. Vaccinators must be certified nurses. *As of January 2024: 92 functioning facilities and 132 VTs.*	Each team consists of two nutritionists and two CHW or nutrition community workers, with one member dedicated to data entry. Rapid Response Teams handle cases with medical complications.
Training	One or two training courses are conducted per year, covering communication, EPI components (such as effective vaccine management and cold chain training), and learning from doing.	Various training initiatives are conducted in coordination with WHO or other partners. Teams receive training to conduct screenings, identify nutrition cases, and provide treatment.
Supervision	Weekly meetings are organized for social mobilizers at the regional and district levels. Supervisors conduct supervisory visits to routine vaccination centres and submit reports in DHIS2. The priority for these visits is given to centres with a relatively low performance.	Supervision visits are conducted regularly to monitor and maintain the quality of services.

IDPs in NWS are integrated into and mixed with the host population, facilitating a cohesive approach to service provision. Also, since CHWs are predominantly recruited from within the communities they serve - ensuring cultural sensitivity and effective service delivery- and that the recruitment strategy is based on qualifications and experience, the **community health workforce is a diverse one that includes both host community members and IDPs and does not make the distinction between the two.** Informants reported that this approach not only promotes inclusivity but also enhances the understanding and responsiveness of health services to the unique needs of each community.

2.3 Service delivery

According to the SOP for CHWs' household visits,[6] the **primary role of a CHW is to effectively disseminate information aimed at improving prophylaxis and health promotion, identifying risk factors and symptoms, and facilitating access to health services.** Key activities outlined by the WHO for CHWs during these visits include building a trustful relationship with the community, assessing common health problems, sharing and disseminating health information, promoting healthy behaviours and environments, and preventing diseases within the community. Information sharing covers newborn and child health care, reproductive health services, antenatal and post-natal care, breastfeeding and nutrition advice, and promoting hygiene and healthy lifestyles. This includes raising awareness about cardiovascular diseases, diabetes, chronic respiratory diseases, cancer, and addressing psychosocial well-being and basic mental health issues. Informants also reported high reactivity and proactivity in these interventions, noting that they adapt to community needs and address emerging issues, such as providing information related to COVID-19, cholera, and other health concerns. CHWs are also responsible for identifying symptoms and risk factors for common diseases, referring cases when necessary, and conducting follow-ups upon the patient's return to the community. Additionally, they are tasked with recording morbidity and mortality data according to health programme needs. More details are presented in Table 3.

The WHO SOP also specifies that CHW household visits are conducted in teams of two to ensure safety and improve household acceptance. Each visit lasts between 20 and 30 minutes, with follow-up visits continuing up to 12 months after the initial visit. Each team visits a household at least once every 2 to 3 months, covering an average of 7 households per day. A CHW team is responsible for a group of families containing between 1,000 and 1,400 individuals, ensuring the number of families does not exceed 250.

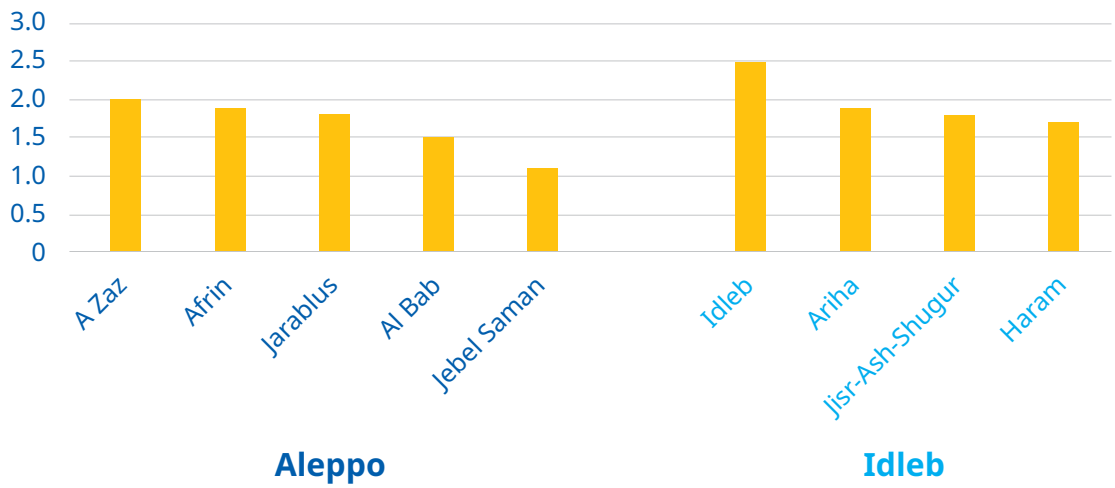
However, inconsistencies have been reported at the implementation level among various partners within the health cluster. Some partners focus on vertical programmes rather than adopting the comprehensive package developed by WHO. This approach leads to community fatigue and reduces trust in CHWs, as many questions remain unanswered by teams that concentrate on single-programme or disease-specific messaging. Beyond the health cluster, the EPI has its own service delivery model, focusing on immunization through a mixed strategy of fixed sessions and outreach sessions. Fixed sessions provide vaccinations in health centres, PHC centres, specialized clinics, hospitals, and immunization centres, while outreach sessions follow micro plans to cover the community in designated areas. In both strategies, social mobilizers and vaccinators work together in the field to vaccinate identified zero-dose children on the spot. Social mobilizers identify these children and share their data with vaccinators, who then follow up to ensure vaccination. Additionally, the EPI cluster has been implementing school vaccination campaigns in NWS for several years. As for the nutrition cluster, it also employs various modalities, such as rapid response teams and CHWs as part of nutrition teams. Some teams focus solely on nutrition-related tasks, while others address multiple health aspects. This variety has also led to the development of different types of CHWs in NWS, such as community-based CHWs, health facility-based CHWs, CHWs as part of nutrition teams, COVID-19 CHWs, CHWs as part of mobile clinics, and CHWs as part of rapid response teams. Rapid response teams mainly emerged after the earthquake to provide therapeutic services for malnutrition patients. Mobile clinic teams differ from traditional CHWs in that they include doctors, midwives, nurses, pharmacists, and possibly an administrator for supervision, with additional roles like psychologists added as needed. Feedback on these shifts in community service provision is mixed. Some consider these roles important in hard-to-reach regions, near frontline areas, and areas exposed to shelling and bombardment, despite diverging from the known role of CHWs. Others have expressed concerns that these approaches limit demand for PHC services instead of referring patients to and linking them with the health system. Some informants believe that CHWs themselves (as defined by the WHO SOP for household visits) can be further trained to provide basic curative services, an approach that has been successfully applied in many other settings.

Table 3. **Key activities provided by CHWs**[6]

	Details
Specific information for the household and family members	New-born care, child health, reproductive health, antenatal care, post-natal care, breastfeeding and nutrition, hygiene, healthy lifestyle and awareness raising on cardiovascular diseases, diabetes, chronic respiratory diseases, and cancer, psychosocial well-being and basic mental health issues
Immunization programmes	Covers polio, measles, rubella, tetanus
Basic examination	• Weight and height of new-born and children, if possible • Screening children under 5 years for acute malnutrition
Follow-up on NCD patients and their medications	• Blood pressure measurement by a digital sphygmomanometer • Glucose level measurement by glucometer
Distribution of items	• Chlorine tabs, lice shampoo, and scabies lotions • Oral rehydration solution (ORS) • Nail cutters, toothbrushes, pastes, and soaps • Micronutrients and PlumpyDoz when available and in coordination with nutrition programmes in the served area
Identification of symptoms of disease without diagnosis	• Risk signs and symptoms during gestation and birth delivery • Identify patients at risk of NCDs for awareness raising purposes • Identify cases of moderate and severe malnutrition by MUAC screening and oedema detection • Screening of medicinal danger signs for children under 5 years and pregnant women • Identify suspected cases of communicable diseases such as COVID-19, measles, cholera, polio, etc.
Referrals	• Register and refer individuals to an appropriate health facility according to its available services • Provide referred individuals with referral slips to ensure appropriate tracking of referrals • Follow-up on patients through household visits after the referral and service reception

Regarding service coverage in NWS, there is an average of 1.8 CHWs per 10,000 population, indicating under-coverage compared to the benchmark of at least 10 CHWs per 10,000 population (see Figure 2).[5] However, slightly better coverage was reported for EPI teams based on an assessment conducted by the EPI cluster. Despite this, the EPI assessment reiterated insights from informants about the underserved nature of hard-to-reach communities near conflict areas or under government control areas. To address this challenge, the EPI cluster is seeking safe locations to provide vaccination services. Informants reported other challenges impeding optimal coverage for CHWs, including Turkish control in certain areas, donor funds being earmarked for specific regions, and limited coordination within the CH TWG and among different partners. Beyond these challenges, planning difficulties for CHWs were noted, such as the difficulty in accurately assessing the size of target communities due to population mobility, leading to varied performance across different districts and organizations. In fact, although it increases the relevance of CHWs, the frequent displacement of IDPs complicates planning, follow-up, and community trust-building.

Figure 2. **Coverage of CHWs per district expressed as number of CHW per 10,000 population**



NWS' coverage: 1.8 CHW for 10,000 population

Informants also raised concerns about factors reducing the effectiveness of service delivery, particularly related to referrals. One major issue is the lack of a comprehensive map of services, which makes it difficult for CHWs to identify and utilize all available options for patients. Additionally, transportation challenges complicate the referral process; ambulances are predominantly used for transfers between health facilities, leaving few resources for patient transportation to other services. This situation is further exacerbated by the fact that many individuals cannot afford the cost of transport, significantly hindering their access to necessary health care services. Follow-up effectiveness was also raised as a concern with a need for better coordination between CHWs and health facilities. It is also important to note that despite the high relevance and significant achievements of community health in service provision, coverage, and community trust-building, community priorities in such a complex context (i.e. residents being more focused on urgent issues like security, shelter, and basic survival) often overshadow health prevention efforts, leading to lower acceptance of CHW services.

2.4 Partnerships and financing

Like the entire health care system's financing, **community health in NWS heavily relies on external funding from various donors.** Main donors include, but are not limited to, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Qatar Red Crescent (QRC), Global Alliance for Vaccines and Immunization (GAVI), Bill and Melinda Gates Foundation, United Nations International Children's Emergency Fund (UNICEF), WHO, World Food Programme (WFP), World Vision, and Cooperative for Assistance and Relief Everywhere (CARE). This external support has ensured funding to cover costs for running teams, including salaries (approximately $270 per month for CHW), transportation, purchasing supplies, and equipment, as well as in-kind support through training and provision of supplies. However, key informants reported that the current funding crisis for NWS, described as the largest in more than a decade, has deeply affected community health services. These services are considered the most susceptible to funding shortages and the first to be canceled when resources are scarce. This has led to programme interruptions, loss of trust with communities, and reduced workforce retention, as CHW seek more stable job opportunities. Additionally, the short-term nature of funding exacerbates programme interruptions and limits the sustainability of interventions. Additionally, the earmarking of funds for specific programmes, interventions, or regions is further hindering optimal coordination and the complementarity of efforts among different donors and their partners. Inefficient use of financial resources, such as buying certain supplies already procured by UNICEF instead of covering other budget lines related to community health interventions, was also mentioned as a challenge limiting efficient use of resources. Therefore, participants reported an urgent need for information sharing regarding proposals developed by partners (which should be shared with cluster representatives) and investments among donors and between donors and cluster representatives to achieve more coordinated and complementary interventions and investments.

Lastly, a significant concern is the misconception among donors regarding the limited effectiveness of community health interventions in NWS, which is due to (1) inadequate monitoring and evaluation processes that result in limited evidence of the cost-effectiveness of CHW interventions and (2) the fact that many organizations hire staff labelled as CHWs but do not employ them in those roles, leading to a perception that funding for these activities is not cost-effective. To address these issues, informants suggested an alternative approach based on previous experience, which involves collecting data that reflects the effectiveness and impact of interventions (such as the appropriateness of referrals) rather than just basic achievement indicators. This would highlight the cost-effectiveness of community health interventions, enhance the credibility of implementing partners towards donors and improve donors' responsiveness.

> *"In 2021, as part of a project, one of our main goals was to improve coordination and integration within the health care system. To achieve this, we piloted a new system that clarified roles by providing a clear job description for the supervisor within each health facility. The supervisor's role was to review cases handled by doctors, provide feedback on the types of cases seen, assess their appropriateness, and identify any weaknesses.*
> *Feedback was collected from doctors through the supervisors, who then conducted training sessions to address these weaknesses, including guidance on when to refer patients.*
> *We observed significant improvements through this new approach. Over a three-month period in 2021, we used a proxy indicator to measure integration by tracking the percentage of referrals from primary health centres to hospitals. Initially, there were 43 referrals, but none were recorded at the hospitals. After implementing our approach, the number of referrals increased to 248 in June, with 37 being recorded at hospitals.*
> *This demonstrated a significant improvement. By July, 14.9 per cent of the cases were correctly referred and recorded, and by August, this figure rose to 91 per cent. Month by month, we observed continuous improvements in the referral process."*
>
> Key informant

2.5 Medicines and health commodities

As per WHO SOP for household field visits, a range of items is distributed to ensure community health and hygiene. These include chlorine tablets, lice shampoo, scabies lotions, oral rehydration solution (ORS), nail cutters, toothbrushes, toothpaste, soaps, and, when available, micronutrients and PlumpyDoz, coordinated with nutrition programmes in the area.

Equipment and supplies for household visits consist 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).

Informants reported the availability of these supplies, though there were some short-term interruptions mainly due to funding disruptions. However, no accurate data on the availability of these items was collected under this mapping's scope.

2.6 Health management information system

The WHO SOP for CHWs' household visits[6] clearly outlines the reporting process, which includes the following steps:

1. I**nitial demographic inventory:** CHWs conduct a demographic inventory and record the information on dedicated forms. A report is then prepared and submitted to the team leader. This step occurs once at the commencement of teamwork.

2. **Data entry:** For each visit, CHWs enter data and procedures into electronic forms.

3. **Daily data upload:** At the end of each day, CHWs upload the entered data to a server whenever an internet connection is available at their gathering centres.

4. **Daily inventory:** At the end of each day, CH teams perform an inventory of the number of visits and activities conducted, the items and materials distributed, and the cases referred during that day, then deliver this inventory to the team leader.

5. **Weekly report compilation:** CH team leaders compile, review, and approve all CH teams' reports on a weekly basis to be shared with the general supervisor.

6. **Bi-weekly comprehensive report:** The general supervisor compiles the reports from team leaders on a weekly basis for review and integration into a bi-weekly comprehensive report to the programme manager.

CHWs primarily report indicators reflecting coverage and workload, such as the number of households visited, beneficiaries attending awareness sessions, and referrals, without capturing the impact and outcomes of the interventions. Efforts to add granularity to indicators (e.g., type of service) and to introduce impact-related indicators (e.g., success of referrals) have faced challenges. As of May 2024, three types of indicators were being collected and reported to WHO by different implementing partners via the 4Ws platform:

1. Number of households reached by CHW teams
2. Number of referral cases from the community to facilities
3. Number of CHWs trained per month


© UNICEF/UNI193647/Rashidi

Although regular data collection from partners was initially successful between 2018 and 2019, data is now more fragmented with very limited use in monitoring and evaluation. Different clusters have varying data collection methods and sources. Additionally, the presentation of data provides limited visibility on community health activities.[9] In fact,

- The EPI dashboard, which clearly delineates interventions by mobile teams, offers the best visibility. EPI reports on doses provided by gender and age are developed and sent via WhatsApp to the operational district data officer, who then enters the data into DHIS2. Data for zero-dose and defaulters are entered, with children assigned an ID and barcode for data sharing between vaccination centres. Newborn data, including the first hepatitis B dose, are entered in the hospital. The tracker system facilitates easy follow-up if a child does not return within two months, overcoming previous tracking challenges.[10]
- For the nutrition cluster, data on screened children, recipients of infant and young child feeding, breastfeeding messages, and referred mothers are entered directly into a KoboTool and compiled into Excel sheets, feeding into the system for real-time tracking. Information is regularly shared by cluster partners, with monthly reports prepared and shared with UNICEF and the cluster.[11]
- As for the means of data entry also differ among partners, with some using tablets for direct entry and others using paper forms for later electronic input. Other internal reporting systems exist for some donors.[7]

In conclusion, the lack of centralization and compilation of data limits overall visibility on community health interventions, targeted communities, and coverage, hindering coordination of activities and evidence-based decision-making and planning. Additionally, many implementing partners work separately with different clusters, leading to duplications further limiting the accuracy of data.

2.7 Cross-cutting issues

Gender considerations

Cultural norms and security concerns impact gender considerations and shape community activities in NWS, leading to a variety of approaches among partners to address these considerations and ensure the proper implementation and acceptance of activities. These considerations are more prominent in rural, conservative communities compared to urban settings, where there are fewer gender-related restrictions. In terms of implementation:

- Some partners have composed CHWs' teams of two individuals, often with a mix of genders, to ensure safety and acceptance within communities and to avoid having female CHWs enter houses alone. Also, in conservative areas, cultural sensitivities may necessitate avoiding female CHWs, or pairing them with male relatives to mitigate concerns and improve team effectiveness.
- There is also a noted tendency towards having female CHWs and male team leaders. Female CHWs are essential for engaging with women, especially in households where male members are absent, while male CHWs and team leaders are perceived as facilitators in interactions with local authorities. Nonetheless, male CHWs are also essential in regions with critical security contexts and for activities like father support groups.
- Some partners reported that recruiting female CHWs poses challenges due to security and transportation issues, particularly for roles requiring house-to-house visits.
- Some organizations provided training on gender-based violence (GBV) to CHWs in an effort to enhance their ability to identify, respond to, and support individuals affected by GBV, and to protect the CHWs themselves.

Overall, gender considerations are vital for successful community health interventions, requiring careful attention to team composition and role allocation to enhance effectiveness and cultural acceptance.

Emergency preparedness and response

CHWs have played a crucial role in emergency situations in NWS. Several experiences reported by informants highlight how partners have leveraged the skills, expertise, and availability of CHWs to support health system responses to emergencies, spanning from the COVID-19 pandemic to the cholera outbreak and the earthquake.

Despite initial disruptions caused by the earthquake affecting Gaziantep, CHWs adapted by participating in the deployment of mobile teams to affected areas and assisting with immediate relief efforts. They also played a pivotal role in supporting nutrition services through screening and treatment for malnutrition. Their involvement further extended to distributing essential materials, including personal protective equipment (PPE) and high-energy biscuits. Also, their familiarity with the community has been instrumental in aiding distribution and identifying needs during crises. Furthermore, they played a crucial role in addressing the indirect impacts of the earthquake by raising awareness about diseases that might emerge due to destroyed infrastructure and compromised hygiene and promoting preventive measures.

During infectious disease outbreaks, CHWs were promptly deployed, and their activities were tailored or adapted to address emerging needs. They received focused training on new skills tailored to the specific challenges of each crisis (e.g., cholera outbreak, COVID-19 pandemic) rather than undergoing a complete training programme. This targeted approach enabled them to deliver effective health promotion, facilitate referrals for treatment, and encourage demand for vaccinations. Beyond conducting sessions, CHWs collected insights, such as topics discussed and other relevant details, amassing 20,000 entries during the COVID-19 period. This data was crucial for understanding community attitudes and beliefs, helping tailor messages for more cultural appropriateness. For example, such insights helped adjust strategies, showing that distributing flyers and brochures was ineffective, prompting a diversification of communication methods.

Furthermore, a notable experience emphasizing the role of CHWs beyond health messaging and referrals, which can further mitigate the scarcity of health system resources during emergencies, was implemented during the COVID-19 pandemic. At this time, CHWs were trained and deployed to effectively conduct triage, reducing the burden on health facilities by providing initial assessments and guidance.

It should also be noted that additional incentives were provided to CHWs during the COVID-19 response to support their efforts considering the high-risk situations and recognizing the increased risks and workload they faced.

Overall, CHWs have been a vital component of emergency response efforts in NWS, contributing significantly to health service provision and community resilience during crises.

3. Suggestions for priority strategic direction

Governance and accountability

- Revive the TWG for CHWs and establish a comprehensive strategy, approach, and set of priorities that will guide community health initiatives effectively.
- Foster inter-cluster coordination by involving representatives from various clusters in the TWG for CHWs to optimize resource utilization and enhance the effectiveness of community health interventions.
- Create and maintain functional TWG structures at both district and sub-district levels to ensure efficient planning, implementation, and monitoring of community health activities.
- Designate focal points at the district and sub-district levels to enhance coordination and communication among stakeholders involved in community health efforts.
- Engage and coordinate with local authorities to ensure that community health strategies align with local needs and resources, fostering stronger support and collaboration.
- Revise the unified SOP that can be utilized by all partners to standardize practices, improve efficiency, and ensure consistency in community health interventions.

Health workforce

- Establish a coordinated recruitment process for CHWs where partners share information with each other to ensure optimal distribution and deployment of resources.
- Establish standardized recruitment processes across NGOs to ensure consistency in the selection and onboarding of CHWs, fostering a unified approach to community health worker deployment.
- Standardize CHW positions and responsibilities across programmes and partners to ensure clarity and consistency in roles and duties.
- Involve the community in the recruitment process of CHWs to ensure community engagement and address issues related to harassment, fostering a safer and more supportive working environment.
- Assign female CHWs in a manner that respects and accounts for cultural differences in each district, understanding the specific needs and dynamics of every community.
- Consider organizing gender sensitivity training to equip CHWs with the skills and awareness needed to navigate gender-related challenges effectively, promote gender equality, and ensure their safety and well-being while engaging with diverse communities.
- Develop and enforce harmonized salary scales for CHWs across all partners to ensure fair and gender equitable compensation.
- Create strategies to retain CHWs, particularly in high-risk areas, by offering incentives and support that address their unique challenges and encourage long-term commitment.
- Regularly assess and address the training needs of newly recruited CHWs, providing refresher or new training sessions as necessary to ensure they are well-prepared for their roles.

Service delivery

- Ensure that training modules are aligned among all partners to provide CHWs with a consistent and comprehensive understanding of all essential areas, such as the WHO training packages with the six modules.
- Promote adherence to SOPs among all NGOs working with health and nutrition clusters to ensure that community health services are provided effectively through outreach visits by CHWs, reducing accessibility barriers and maximizing health system coverage.
- Conduct a comprehensive mapping of CHWs and their proximity to the nearest health facilities to identify who is responsible for specific tasks in various areas, eliminate inconsistencies and prevent duplication of efforts, such as multiple CHWs visiting the same household.
- Implement periodic assessments of the CHW programme's impact after a few years of implementation to evaluate effectiveness, identify areas for improvement, and guide future programme development.

Partnerships and financing

- Enhance coordination and advocacy efforts with donors to ensure that they are aware of existing investments, the needs and challenges facing CHWs, and to build strong partnerships that support community health initiatives.
- Foster transparent and open communication with donors to keep them informed about the progress and outcomes of funded projects, building trust and securing ongoing support.
- Prioritize securing stable and sustainable funding sources for community health services. This will also ensure continuous employment and capacity-building opportunities for CHWs, allowing them to develop their skills and maintain their roles effectively.
- Promote the efficient use of available funds by encouraging partners to collaborate and share resources, maximizing the impact of financial investments in community health programmes.
- Allocate resources to equip CHWs with the necessary supplies and equipment, ensuring they have the tools required to perform their duties effectively and provide high-quality care.
- Allocate funding to partners and interventions that have demonstrated effectiveness and impact, ensuring that resources are directed toward initiatives that provide the greatest benefits to community health.

Health management information system

- Develop a centralized database to maintain a comprehensive, coordinated and sex-disaggregated CHW master list to improve tracking, management, and deployment of CHWs.
- Standardize and simplify indicators used across various programmes and clusters to ensure consistency and facilitate easier comparison and analysis of data.
- Re-evaluate and streamline existing reporting structures to improve efficiency and accuracy in data reporting and develop mechanisms to facilitate the sharing of information for more effective planning and resource allocation.
- Explore potential opportunities for data sharing and collaboration through digital platforms, building on existing systems like DHIS2 (e.g., kobotool).
- Utilize available data for monitoring and evaluation and promote evidence-informed decision-making.
- Consider including impact-related metrics (e.g., success rate of referrals), allowing for a deeper understanding of the effectiveness of services delivered and enabling more informed decision-making.

Endnotes

1 OCHA, "North-West Syria: Situation Report (15 Mar 2024)," 2024. [Online]. Available: https://reliefweb.int/report/syrian-arab-republic/north-west-syria-situation-report-15-mar-2024-enar. [Accessed August 2024].

2 MSH, "The Cost of an Essential Health Service Package for Northern Syria," 2017. [Online]. Available: https://msh.org/resources/the-cost-of-an-essential-health-service-package-for-northern-syria/. [Accessed August 2024].

3 Ahmad Habboush et al., "A framework for community health worker optimisation in conflict settings: prerequisites and possibilities from North West Syria," BMJ Glob Health, 2023.

4 SIG, "Routine immunization report, January 2024," 2024.

5 WHO, "Health resources and services availability monitoring system Herams – third quarter, 2023 report Türkiye health cluster for northwest of Syria, Jul- Sep 2023," 2023. [Online]. Available: 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].

6 WHO- Health cluster, "Standard Operating Procedures for Community Health Workers household visits," 2019.

7 UDER, "Assessment of community health programs in North West Syria," 2020.

8 WHO, "Unified Community Health Workers Training Manual," 2018.

9 WHO, "Health Cluster 4Ws dashboard," 2024. [Online]. Available: https://app.powerbi.com/view?r=eyJrIjoiNWUzZGYzODUtNTY0Yy00Y2RkLTk2NGUtYmExYjVlZjIwZDQ1IiwidCI6ImY2MTBjMGI3LWJkMjQtNGIzOS04MTBiLTNkYzI4MGFmYjU5MCIsImMiOjh9.

10 EPI, "EPI Dashboard," 2024. [Online]. Available: https://app.powerbi.com/view?r=eyJrIjoiMDQ1ODkwMjctZWE2YS00YjRiLWJmN2YtMDQyZWVjN2YzZGU0IiwidCI6ImQ4OTI4NjQwLWJiNzYtNDRlMi1iMzdkLWMxODhlNzVhMWZlNyIsImMiOjl9.

11 Nutrition Cluster- WoS, "WoS Nutrition Cluster Dashboard, 4W," 2024.

This brief was commissioned by UNICEF MENARO and was developed by hera – Right to Health and Development in collaboration with UNICEF MENARO. It was developed as part of the Community Health Policy and Implementation Landscape Mapping carried out in 12 countries in the MENA region as well as the region of North West Syria. We extend our gratitude to all contributors for their expertise and commitment to enhancing community health.

United Nations Children's Fund (UNICEF)

Regional Office for the Middle East and North Africa

15 Abdel Qader Al-Abed Street
P. O. Box 1551
Amman 11821 Jordan
Tel: +962-550-2400
menaro_Info@unicef.org
www.unicef.org/mena

Cover photo: © UNICEF/UN0581299/Almatar