CASE STUDY • 6/6

Delivery System for Scale

Mobile Clinics Paving the Way for Enhanced Community-Based Nutrition Programing

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Photo credit: UNICEF Yemen

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Overview

This case study is part of a compendium of country-level case studies produced by the Delivery System for Scale[1] project that explore promising, context-specific approaches to scale prevention and treatment of wasting for children under five. In Yemen, where acute food insecurity affects 17 million people, approximately 3 million children under five face the risk of acute malnutrition, with 540,000 at risk of severe acute malnutrition (SAM). Mobile clinics have proven successful as a strategy for delivering essential primary healthcare and nutrition services in hard-to-reach and crisis-affected areas. Nevertheless, recent funding cuts resulting in fewer operational mobile clinics have compromised these services. Ensuring continuous access to and availability of nutrition services remains a significant challenge. This case study describes the evolution of mobile clinics and their role in scaling up prevention and treatment nutrition services in Southern Yemen. It also offers recommendations based on a recent 'Assessment of the current state of service delivery for the prevention and treatment of child wasting in high-burden governorates'[2] on how treatment efforts could be expanded in northern Yemen and through community cadres, thereby enhancing both access and the sustainability of treatment countrywide.

Introduction

Child wasting rates in Yemen are among the highest in the world and continue to increase as the humanitarian crisis worsens and aid becomes increasingly limited.[3] The latest Integrated Phase Classification (IPC) analysis[4] revealed that out of the 17 million people living in areas affected by acute food insecurity, an estimated 3 million children under five are at risk of developing acute malnutrition and 540,000 are at risk of developing life-threatening severe acute malnutrition (SAM).

In the first six months of 2023, the Yemen Ministry of Public Health and Population (MoPHP) and UNICEF, together with other implementing partners, implemented several activities focused on accelerating the scale-up of integrated management of acute malnutrition (IMAM) programming. These efforts resulted in support to over 4,655 outpatient therapeutic programs (OTPs) to treat SAM, a network of 24,447 active community health nutrition volunteers to screen for and refer acutely malnourished children, and 203 mobile clinic teams to extend the reach of static nutrition sites into hard-to-reach areas of the country.

Despite recent progress, maintaining consistent access to nutrition services and expanding outreach face significant challenges, attributed to various factors, including:

- **Inadequate functioning of the health system.** Less than half of the country's health facilities are fully functional and recent reductions in funding have forced the United Nations and other international partners to suspend aid to an additional 300 health centers.
- **Insecurity and instability.** Even where health facilities are available, accessing health services seems a nearly impossible challenge. The ongoing conflict – especially in governorates that share a boundary between North and South Yemen – adds additional hurdles to access and exacerbates health needs. These areas have the highest recorded number of landmines and are also areas where health facilities, themselves, are also targets of attack.

- **Remote, hard-to-reach areas.** Many areas with the highest burden of acute malnutrition are also those with mountainous terrain and/or a lack of serviceable roads. The financial cost and opportunity costs of travel to the nearest available health center often disincentivize or are prohibitive of health seeking behaviors.
- **Operational cost of mobile clinics.** Despite their effectiveness in delivering primary healthcare in areas with infrastructure challenges, mobile clinics services and teams are hindered by their high operating costs, averaging seven to nine thousand USD per month.

Current health and nutrition services in hard-to-reach-areas

Mobile clinic services

In Yemen, mobile clinics are organized as one-stop shops, typically composed of 5 to 7 team members including a team leader, nurse, midwife, laboratory technician, vaccinators, pharmacists, and a nutrition/medical assistant.

Roving teams deliver both preventive and curative health and nutrition services and provide laboratory services and essential medications for approximately 500 patients each month. The scope of available health services has expanded over the years to include communicable and non-communicable disease treatment, immunization for young children, basic maternal health including antenatal care and post-natal care, mental health consultations and family planning. Nutrition services include screening of all children under five and PLW for acute malnutrition, treatment of uncomplicated severe and moderate acute malnutrition and offering infant and young child feeding counseling sessions. Importantly, mobile clinics also provide a venue to address non-health issues such as gender-based violence. Teams may deliver education sessions and refer cases for further support.

Over the last decade, the mobile clinic approach has been well established by MoPHP and several implementing partners in Southern Yemen. Unfortunately, humanitarian aid funding cuts are compelling many partners to end or significantly reduce their current operations.

A day at a mobile clinic

Upon arrival, patients register with community health volunteers (CHVs) who arrive to support the mobile clinic team or the team nurse. Children undergo a physical examination where their height, weight and vitals are taken (e.g. blood pressure and oxygen saturation levels). A nurse reviews their medical history, investigates their existing conditions, and assesses their current condition. Health concerns are managed by the mobile clinic team and when necessary, medication is prescribed and provided for free. Patients are also referred to consult with the on-site physician as needed.

Children under five are screened for acute malnutrition and further assessed for any medical complications. If a child is diagnosed with uncomplicated severe acute malnutrition (SAM) or moderate acute malnutrition (MAM), the mobile clinic team may administer treatment as part of their service offerings. Alternatively, the child may be referred to the closest outpatient treatment site for appropriate care.

Any patient with a serious medical condition that cannot be managed through the mobile clinic or who is diagnosed with complicated SAM is referred to the nearest static health facility or stabilization center.

Community-based nutrition services

Community-level nutrition services are crucial complements to OTP, TSFP (static sites), and mobile clinic teams. Community Health Workers (CHWs) and Community Health Volunteers (CHVs) play a pivotal role in health screening and awareness activities, especially when mobile clinics are not scheduled in the area. This involves actively identifying cases through MUAC (Mid-Upper Arm Circumference) measurements and checking for edema in children under five and pregnant and lactating women (PLW) during home visits and screening campaigns. Cases are then referred to the mobile clinic or OTP/TSFP. For children admitted to OTP or TSFP and in communities with a high malnutrition burden, CHWs provide Infant and Young Child Feeding (IYCF) counseling, while CHVs assist in defaulter tracing.

Community-based cadres receive nutrition training and supervision support from MoPHP, implementing partners, and/or UNICEF. However, they typically do not administer treatment for Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM), even though some Community Health Workers (CHWs) are trained and equipped to provide curative treatment for other childhood illnesses through integrated community case management (iCCM) for malaria, diarrhea, and acute respiratory infections.

Opportunities to scale

Since their introduction by the International Rescue Committee in Abayan Governorate in 2012, mobile clinics have remained a primary approach for delivering health and nutrition services in hard-to-reach areas in Southern Yemen. Since then, the scale and scope of mobile clinics has expanded to various governorates of the country where several agencies (UN and INGOs) support operationalization. According to the 2022 to 2023 national health information management system (HMIS) indicators on consultations and beneficiary reach of mobile clinics, data show comparable coverage and reach between static health facilities and mobile health teams.

In 2018, Save the Children introduced a mobile health team in Hajjah in Northern Yemen to provide healthcare, water, and food to the most vulnerable families. However, attempts at replication by partners and the Ministry of Public Health and Population (MoPHP) have not been as successful. The lack of clear policy or guidelines on the use and adoption of mobile health clinics has impacted their uptake and use in the North.

Respondents to the 'assessment of the current state of service delivery for the prevention and treatment of child wasting in high-burden governorates' reflected on the mobile clinic approach and community-based services, sharing the following reflections and recommendations.

Based on respondents' current experience with community-based nutrition services, they believe that empowering community health cadres such as CHWs and CHVs to provide treatment would be a more cost-effective and sustainable option compared to maintaining mobile clinic teams for malnutrition treatment. They noted that operating one mobile clinic costs between seven to nine thousand USD per month, while community-based nutrition services cost less than 2000 USD per month.

Respondents generally recommended redirecting the current mobile clinic approach to function as technical supervision for community-based programming instead of providing comprehensive primary care services. However, they acknowledged the importance of securing the necessary political commitment, policies,

and guidelines for the function, structure, and required wages to operate the dual system of community-based nutrition treatment services and mobile health clinics.

Respondents suggested reallocating part of the operational cost to maintain the mobile health clinic, with a portion reinvested in static health units or facilities and the remainder allocated to operational costs for community-based nutrition services. They observed that investment in recruiting and training community cadres (Community health and nutrition volunteers, community health workers or SBCC counselors) to deliver services in the farthest areas and those communities located in the secondary and territory zones has become the new norm and could be replicated elsewhere.

Summary and implications

The utilization of mobile clinics has proven effective in addressing nutrition crises in the southern governorates of Yemen. However, the operational costs associated with mobile clinics have led to an increasing suspension of services, resulting in a lack of treatment options in the most remote areas. Nevertheless, the core of the strategy, which involves extending treatment services from static health facilities into the community via mobile services, can offer valuable insights for introducing community-based nutrition treatment. Empowering community-based cadres to broaden their responsibilities from screening and counseling to delivering curative treatment offers a potentially more effective strategy for improving access to nutrition treatment in challenging operational contexts.

- Since 2012, mobile clinics have effectively delivered primary health and nutrition services in areas with infrastructure challenges, reaching communities in the farthest corners of districts and governorates, particularly in the south.
- The success of mobile clinic operations has spurred expansion and coordination of community-based nutrition programming. Empowering community-based cadres is recognized by stakeholders as a potentially more sustainable way to decentralize nutrition treatment. Fewer mobile clinics could prioritize primary care outreach and technical supervision of community-based services, rather than providing all nutrition services.
- The mobile clinic approach has been successful in Southern Yemen, but challenges persist in replicating it in the North due to funding and policy issues. To expand community-based nutrition treatment, the MoPHP should provide clear policy guidelines for mobile clinics and the use and adoption of community-based cadres to deliver nutrition treatment.
- Restoring and sustaining access to health and nutrition services should be a priority and opportunity for the Ministry of Public Health and Population, especially as Yemen transitions into a period of relative peace. Governmental and MoPHP commitment and guidance are crucial to harmonize service delivery universally in both Southern and Northern Yemen territories.

Endnotes

1 The Delivery System for Scale project was implemented from 2022-2023 by the International Rescue Committee, Action Against Hunger and Save the Children, with the support of UNICEF. The project provided technical and operational support to UNICEF country offices in high-burden countries, aiming to accelerate efforts to bring child wasting treatment to scale.

2 An 'Assessment of the current state of service delivery for the prevention and treatment of child wasting in high-burden governorates' online survey and series of KIIs was conducted in July 2023 as part of the DSFS project Terms of Reference (TOR) for Yemen.

3 https://doi.org/10.3390/children6060077

4 Yemen: Acute Food Insecurity Situation January - May 2023 and Projection for June – December 2023 (partial analysis) https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1156365/?iso3=YEM