

Strengthening demand creation for immunization*

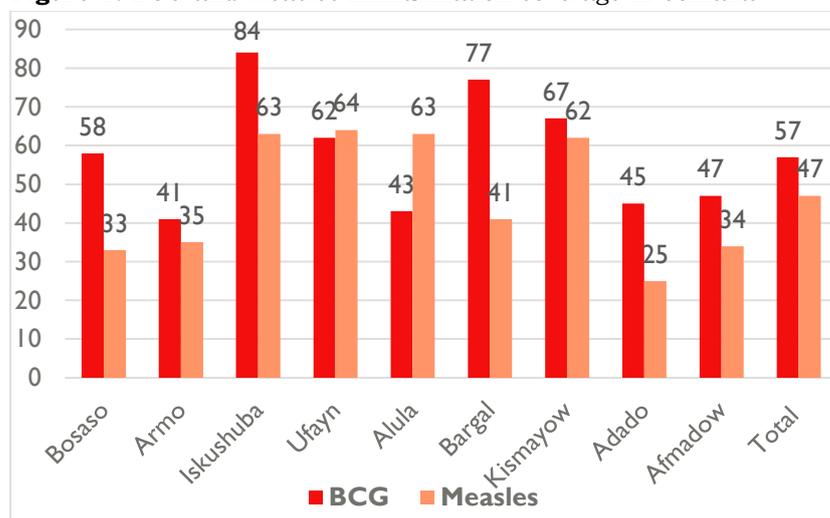
Immunization is one of the most cost effective public health strategies utilized to promote health.¹ Annually, vaccines prevent an estimated 2.5 million deaths as well as severe morbidity from vaccine preventable diseases (VPD).² GAVI projects that vaccinations administered between 2011 and 2020 will help to avert more than 23 million future deaths.³ However, globally, reports show that 19.4 million infants are still missing out on getting immunised with the basic vaccines, particularly in low and middle income countries.^{4,5} The unfavourable health context in Somalia has left the nation with some of the most critical levels in health indicators in the world with still a long way ahead until national and international goals of health, such as the Sustainable Development Goals (SDG) are met.⁶ This fact sheet draws on a baseline survey conducted for a Community Health and Social Accountability Project (CHASP) and secondary literature to suggest strengthening demand creation for immunization.

In Somalia, the EPI coverage aims to ensure that all children have access to vaccines. However, EPI coverage, like all other health indicators, lags behind.⁷ Although Polio has been successfully combated in the past 3 years in Somalia, diseases like Measles are still prevalent in many parts of the country. Somalia has a DPT1 coverage as an access indicator of 25%, which is far behind the goal in A World Fit for Children of 90 per cent nationally and with a minimum coverage of 80 per cent in every region.⁸ In Somalia, immunization coverage is estimated at only 30-40% against six major childhood diseases- tuberculosis, diphtheria, pertussis, tetanus, polio, and measles⁹ – even though there are close to 40 International NGOs supporting immunization activities. The trend of low childhood immunization coverage was evident during the baseline survey conducted in Nov 2017 where we accessed the immunization coverage for the four basic vaccines namely BCG (57%), Measles (47%), Polio (14%), and Pentavalent (28%) vaccines in 9 districts i.e. Kismayo, Adado, Afmadow, Iskushuban, Armo, Alula, Bosaso, Barga and Ufayn.

However, we find big regional variation in immunization coverage where the districts in Puntland have higher coverage than those in Afmadow and Adado (figure 1). This could be due to long-term existence of Essential package of health services (EPHS). On the contrary, Kismayo is one of the district in Lower Juba region that was doing better than Afmadow in the same region of Lower Juba and Adado in the neighbour region of Galgaduud and had not benefitted from EPHS. This could be attributed by the availability of outreach immunization services at the primary health units (PHU).

In Somalia, the PHU has the most outreach and is meant to offer lifesaving support for mothers, children and community at large including child immunization services. However, districts like Adado had 80% of the PHU not offering child immunization services including outreach services, suggesting possibility of increasing outreach immunization coverage through PHUs.

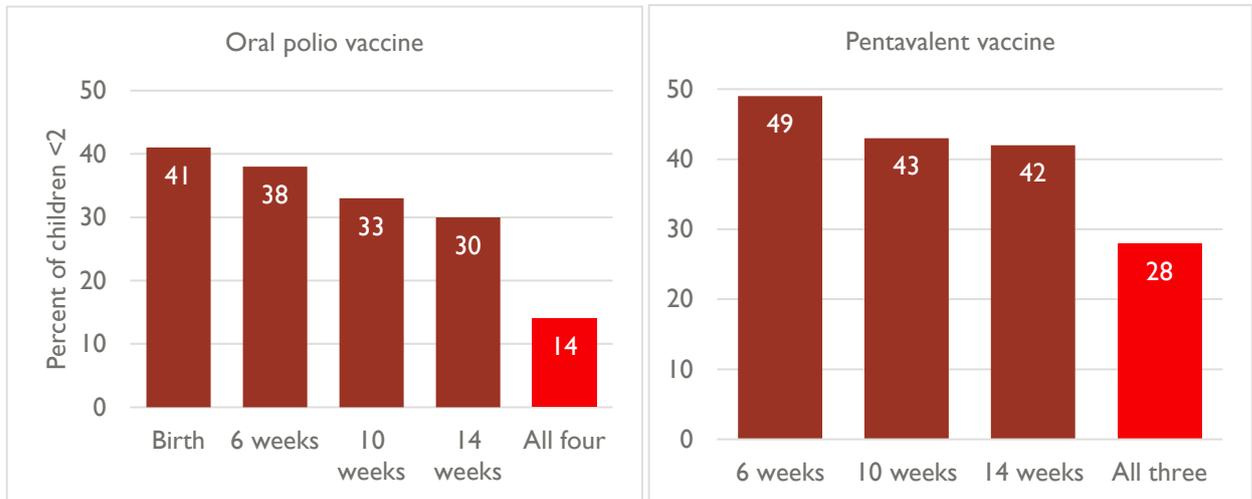
Figure 1: BCG and Measles Immunization coverage in Somalia



* This fact sheet is based on literature review, household survey and qualitative interviews conducted as part of CHASP baseline. For further details, please contact Leila.Abdullahi@savethechildren.org

Another important aspect we observed was dropout rates in immunization after the first dose. Some vaccines like Polio and Pentavalent vaccines need more than one dose and the drop out from the first dose to the last dose were more than 2-3 folds. The project should consider child specific follow-up for reducing dropout, which is more manageable to implement at PHU level. The drop out on follow up vaccines was observed equally in all the 9 districts without any exception

Figure 2: Polio and pentavalent Immunization coverage in Somalia



In conclusion, given the low vaccination coverage the project suggest investigating further and strengthening the demand creation for immunization. Additionally, the project should consider child specific follow-up for reducing dropout, which is more manageable to implement at PHU level.

References

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