POLICY BRIEF•22

SIDRA INSTITUTE

TOWARDS AN EVIDENCE-BASED AND EQUITABLE CHILDHOOD VACCINATION IN FRAGILE AND PROTRACTED HUMANITARIAN SETTING OF SOMALIA

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Key Messages

- A significant proportion (60 percent) of Somali children under two years of age remain zero-dose and have not received any dose of the four basic routine childhood vaccines.
- Nomadic populations, internally displaced persons, and populations living in remote and Al-shabaab controlled areas remain vulnerable and neglected population groups with high proportion of zero-dose children and missed communities.
- The five main health and immunization policies and guiding documents in Somalia do not consider zero-dose children and missed subpopulations for specific, tailored interventions and service delivery models.
- Fragmented immunization service delivery, incomplete and poor-quality immunization coverage data due to limited demographic and health data sources, insecurity, low availability of immunization services, and insufficient funding are some of the bottlenecks in the health system responsiveness and effectiveness to reach zero-dose children and missed communities.
- Sociocultural and economic factors such as misinformation and beliefs about immunization, inequality, poverty and livelihood challenges and low parental education are related to higher risk of non-immunization or under-immunization of children in Somalia.
- Somalia Federal and Federal Member State Ministries of Health (FMoH, FMS MoHs), Gavi, WHO, UNICEF, World Bank and other health partners need to work together and improve immunization governance, policies and service delivery.
- Innovative and effective approaches to delivery of immunization services such as geospatial tracking of nomadic population, integration and co-delivery of immunizations with other human health and veterinary services, increased engagement with affected communities (nomadic, IDPs) and alternative routes of delivery for areas that the government is not present remain critical.
- Somalia has a huge untapped potential of human resources for health, given its young and entrepreneurial population, both in the country and diaspora. Strategic prioritization and meaningful partnership with local stakeholders and members of the community could reduce vulnerability and increase resilience in the health system.

Background and Context

Somalia is classified as the most extremely fragile country in the world (OECD, 2022). According to OECD (2016), "fragility is the combination of exposure to risk and insufficient coping capacities of the state, system and/or communities to manage, absorb and mitigate those risks." (OECD, 2016). A multitude of crisis, shocks and uncertainties such as persistent conflicts and violence, political deadlock, recurrent droughts and floods, and fragmented and weak state institutions have turned the country into one of the most challenging operating environments in the world and left it in dysfunctional state of fragility.

State coping capacities reflect the governance and strength of its institutions. Decades of conflict has left the state institutions with a fragmented and weak governance and decision-making structures and shortage of critical resources. The health system has particularly bore the brunt of the state collapse and suffered from fractured governance, low service availability, poor health infrastructure, severe shortage of health workers and limited reliable and quality health data.

Today's Federal Somalia accommodates two levels of health authorities; Ministry of Health at the Federal level (FMoH) and Ministries of Health at each of the Federal Member States (FMS MoH). These MoHs are responsible for leading and coordinating the health sector programmes and activities at national, state, regional and district levels.

Multiple external and internal actors such as the UN agencies (WHO, UNICEF, UNFPA, World Bank) and international and local Non-governmental Organization (NGOs) are also involved in the health service planning financing and service delivery in different locations. Poor governance, coordination, insufficient funding and limited capacity for service delivery have been idenfied as the main drivers of the ineffective planning and responsiveness, overlapping of interventions and poor performance of the health system (MoH Somalia, 2021).

Somalia is one of 20 countries in the world with the highest numbers of zero-dose children (UNICEF, 2023). More than 60 percent of children under two years of age have not received any dose of the four basic routine childhood vaccines. Most of these children are in the poorest and most vulnerable segments of the population with low level of formal education and access to routine primary health care services living in remote locations and in nomadic and internally displaced communities.

There are five main policies, guidelines and framework documents for health and immunization services in Somalia: Somalia Health Sector Strategic Plan (HSSP), Somali National Immunization Policy, Expanded Programme on Immunization (EPI) policy, the Essential Packages of Health Services (EPHS) framework and the Roadmap to Universal Health Coverage (UHC) (MoH Somalia, 2018; MoH Somalia, 2020; MoH Somalia, 2020).

These policies and guiding documents do not consider zero-dose children and missed subpopulations for specific, tailored interventions and service delivery approaches. Specifically, the Somali immunization policy has not identified zero-dose and under immunized and has not laid out strategic approaches in locating, engaging and delivering services for these missed communities.

In Somalia, the quality, completeness and reliability of immunization coverage data is poor partly due to the limited demographic and health data sources which makes the generation of robust evidence and information very urgent. Without good quality data and evidence from research on the characteristics of zero-dose and missed communities, it will be very challenging to develop innovative targeted policies, interventions and service delivery strategies.

Given current global call and efforts to reach zero-dose and under immunized children as part of the global Immunization Agenda 2030 (IA30) and the ambition of leaving no one behind (WHO, 2020), this policy brief aims to contribute towards an evidence-based and effective approach to context-specific, policy-oriented and result-driven immunization programming in Somalia.

This brief draws evidence from two studies on zero-dose and under-immunized communities in Somalia. The first study assessed the prevalence and determinants of unvaccinated (zero-dose) children in Somalia using the demographic and health data (DHS) (Mohamoud et al, 2023).

The second study explored who and where the zero-dose and under-immunized children live, and how or the strategies used to reach zero-dose children, using the GAVI Vaccine Alliance IRMMA framework (GAVI, n.d). The overarching objective of this policy brief is to shed light on vulnerable and at-risk zero-dose and under-immunized children in the fragile context of Somalia and provide short-term as well as long-term actionable recommendations and policy options for improved and equitable childhood vaccination coverage (Bile et al, 2023). The two studies presented in this brief are part of a larger research project (RAISE) on zero-vaccine dose communities in crisis-affected populations (LSHTM, n.d).

The first paper in this policy brief used secondary data from 2020 health and demographic survey to determine vaccination coverage in children under two years of age and particularly children who had not received any dose of the four basic routine vaccines (BCG, Polio, DPT, Measles), so called zero-dose children. Sociodemographic, household and health seeking behaviour were extracted from the DHS data. Variables that were shown to be significantly associated with zero dose children at $p< 0.05$ in the single logistic regression analysis were identified and included in a final multiple logistic regression analysis. The second paper was a qualitative study with key informant interviews with Government officials, UN agencies and NGO staff (international and local) and focus group discussions with vaccinators and community members designed to understand current vaccine delivery practices.

The two studies were conducted in three geographically and socioeconomically diverse regions (Puntland, Jubbaland, Galmudug) and populations (rural/remote, nomadic/pastoralists, IDPs, and urban poor population) in Somalia.

Puntland State	
General	The largest, oldest (est. 1998) and relatively most stable State in Somalia
Geographic locations	Densely populated cities and towns, sparsely populated districts, rural villages and "hard to reach" remote coastal areas.
Population	Estimated to 4.9 million
Subgroups	Urban and nomadic populations, fishing communities and internally displaced people (IDPs
Galmudug State (SNBS, 2021)	
General	The State, located in central Somalia, is the smallest State and was formally established as a Federal Member State in 2015
Geographical location	Densely populated cities and towns and sparsely populated rural and coastal areas.
Population	Estimated to be 1.3 million
Subgroups	Large urban and nomadic population (44% and 31% respectively) and fishing communities.
Jubaland State (SNBS, 2021)	
General	The State is situated in Southern Somalia and was formally established as a Federal Member State in 2013.
Geographical location	The densely populated coastal city of Kismayo, several towns along the border with Kenya and Ethiopia and large fertile agricultural areas along Jubba River.
Population	Estimated to be 1.36 million.
Subgroups	Sedentary communities (urban, farming and fishing communities), pastoralist, internally displaced people, and refugee returnees.

A child receives a dose of vaccine at MCH Gambol in Garowe, Puntland, Somalia. Photo: SIDRA Institute/Abdi Omar Bile.

The three subgroups of nomadic populations, internally displaced persons, and populations living in remote and Al-shabaab controlled areas were found to be vulnerable and neglected population groups with highest proportion of zero-dose and under-immunized communities. despite sharing certain vulnerabilities, these group are contextually, demographically and socioeconomically diverse.
The studies have highlighted the limited consideration for context, population characteristics and socioeconomic factors in Somalia's health and immunization policies, decision making and service delivery approaches for these most vulnerable and neglected populations.

Short-term recommendations and programmatic actions

- Somalia MoHs, WHO, UNICEF, World Bank and other relevant stakeholders need to work together and establish appropriate immunization governance structure such as the National Immunization Coordination Committee (NICC) and/or other steering working groups.

- Somali MoHs and their partners need to ensure greater participation of all stakeholder in such governance structure and decision-making spaces in order to ensure effective mechanism that can

  - coordinate programmes, interventions and facilitate sharing of knowledge, expertise and experience
  - realize sufficient funding and equitable resource allocation
  - support the planning and management of vaccine supplies, cold chains and logistics
  - improve communication and social mobilization
  - and monitor and measure performance and results

- The MoHs, Gavi, WHO, UNICEF, World Bank and other relevant partners need to support the generation and use of research and evidence on i) how to "localize" decisions and governance structure for health, nutrition, and immunization in fragile and protracted humanitarian settings, ii) innovative approaches for service delivery (i.e., geospatial tracking of nomadic populations), iii) attitudes to childhood vaccinations and immunization services among vulnerable population groups; and iv) performance measurement of the expanded program on immunization in Somalia.

- MoHs need to expand inclusion and meaningful participation of local community members and organisations in the design, implementation, and evaluation of immunisation services for hard-to-reach population groups. One way to achieve this action is to collaborate with local NGOs and civil society groups and to establish immunization service user focus groups in different States and regions of Somalia.

- There is an urgent need to review immunization policies and guidelines in Somalia. Using the growing evidence about the importance of giving greater consideration to context and subpopulation characteristics, the MoHs and their partners need to design population-specific and targeted strategies and interventions to reach vulnerable and neglected populations such as nomadic, internally displaced communities and populations in remote and Al-Shabaab controlled areas.

- The MoHs need to strengthen the timely collection, reporting and analysis of the routine immunization data through DHIS2.

Long-term recommendations and policy options

- WHO, UNICEF, World Bank and UNFPA need to support the MoHs and the other relevant government Ministries and departments to develop a long-term plan for strategic investment in sustainable immunization programme including strengthening the infrastructure, capacity and resources for immunization.

- The MoHs in collaboration with their partners needs to promote the culture of information and evidence handling and use such as

    - the collection and use of systematic and routine quality health and immunization data
    - improving the estimation of catchment population size and denominators
    - implementing civil registrations
    - Conducting targeted immunization coverage surveys
    - and embedding research in the health and immunization programmes

- The MoHs need to take the ownership and leadership of the immunization governance and service delivery by develop mechanisms where stakeholders can contribute to an effective coordination, decision-making, funding and accountability at local, regional, and national level.

- The MoHs, WHO, UNICEF and World Bank and other relevant stakeholders need to use the existing evidence of and develop strategies for a coherent and integrated mechanisms for planning and co-delivery of immunization services, veterinary care, nutrition and other health services.

- The MoHs need to explore the potential to mobile and create enabling conditions for effective engagement of diaspora, harnessing their skills and capacities and attracting financing for health, nutrition, and immunization services.

- The MoHs and relevant stakeholders need to consider the scale up of initiatives like REACH (Reaching Every Child in Humanitarian in the Horn of Africa) engaging local actors in reaching zero-dose children in challenging settings.

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