

Carruurteenna "our children"

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More effort needed to enhance child survival in Somalia

By
UNICEF and the World Health
Organization (WHO), Somalia

Progress towards meeting the UN Millennium Development Goals (MDG) for reducing child and a maternal death in Somalia is slow. Child and maternal mortality remain high while coverage of the most basic cost-effective public health interventions remains very low and resilient to longer term change. With only six years to go before the MDG target year of 2015, major new efforts are urgently needed to raise and sustain coverage and impact of essential interventions in health, water, sanitation and nutrition.

The UNICEF and WHO Joint Programme on Accelerating Young Child Survival for Somalia for 2008-09, represented the start of such a commitment. It is based on global scientific evidence and years of hands-on experience of the realities in Somalia. The Joint Programme outlines a set of basic cost-effective interventions to be delivered through various tested strategies in order to reach every child in all districts of Somalia.

This programme is outcome-oriented and



A girl gets a protective jab during the Child Health Days campaign in Somalia. © UNICEF Somalia/2009.

multi-sectoral (health, water, sanitation, nutrition inputs).

It is a conscious effort to minimize duplication and maximize use of scarce resources and past experience; it consolidates financial and human capacities to significantly reduce under-five mortality in Somalia and support the development of health systems that will make reaching the goal of reducing child mortality possible and sustainable.

Children represent our future – and their survival, well-being and development is key for a promising future. Somalia is home to millions of children who have limited access to basic health and education and who continue to suffer from preventable diseases such as diarrhoea, measles, malaria and pneumonia; and malnutrition. In Somalia, one in seven children under five years still continues to die. Children do not have to die when inexpensive and proven interventions are known and if delivered can effectively save lives.

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Why do children die in Somalia?

There are estimated to be about 8.5 million people living in Somalia – but no one knows for sure given that the last census was completed in the 1970s! The population is spread out over a vast country and is one of the lowest population density countries in the world. Many of the people are concentrated in a few urban centres – but a significant proportion remains spread out in rural areas.

After many years of conflict, the population is impoverished and highly vulnerable to shocks—drought, financial crisis, rising food and fuel prices. Furthermore there is a complete collapse of normal public institutions and functions – so there is very poor development of infrastructure and a public health system that is in shambles.

UNDP's 2000 Human Development Report ranked Somalia lowest in all health indicators except life expectancy. In the latest Human Development Report, the country is not even ranked, due to the lack of reliable data. As a result, it was noted that "most Somalis spend most of their time trying to stay alive and keep their families alive" (UN, 2005). Extreme poverty in Somalia is estimated to be 43% with large disparities between the urban population at 23% and the rural and nomadic populations at 53% (UNICEF, 2001). At least 80% of the population is estimated to be illiterate (65% urban and 89% rural).

The causes of child mortality are therefore expected to be similar to those in many extremely under-developed contexts: diarrhoea, pneumonia, measles, malaria and under nutrition – as well as others such as asphyxia, premature delivery, sepsis and tetanus. The evidence base in Somalia is weak, but health records indicate that the major causes of child morbidity relate to under-nutrition, diarrhoeal diseases, respiratory tract infections (especially pneumonia), vaccine preventable diseases and injuries.

The years of war and institutional decline have resulted in very poor health status of the population. The population is largely destitute and totally dependent on remittances and international aid flows – and has limited access to the health system.

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Child and maternal mortality remain high in Somalia...

About Child Health Days (CHDs)

In partnership with local authorities, UNICEF and the World Health Organization (WHO) have been carrying out Child Health Days in Somalia to protect children under five from preventable diseases and water-borne illnesses. They are also working to reduce malnutrition and safeguard women against neonatal tetanus in child delivery. The interventions include immunizations against measles, diphtheria, whooping cough, tetanus and polio as well as Vitamin A supplementation, de-worming, among others. During the Child Health Days (CHDs) hundreds of field teams take the campaign to urban and rural areas setting up immunization posts in prominent community areas as well as in schools, health centres and around mosques. See map and table on Page 8 for statistics and coverage.

Challenges of providing healthcare to children and women in Somalia

It is difficult and expensive to provide health care in Somalia. The insecurity and unpredictable operating environment in most parts of the country, poor infrastructure, scattered population including nomads, limited number of trained human resources and poor functional health clinics are among the challenges faced in providing services.

Insecurity and physical access remained the major constraint in achieving results for children. UNICEF and WHO national and international staff supervised the training and implementation of CHDs wherever access allowed from Awdal and Togdheer in the northwest up to Galkayo and Garowe in the northeast, and Buale, Baidoa, Jowhar and Wajid in Central/Southern Somalia. Although UNICEF staff was mobilized from all programmes to support the CHDs in any way possible, access to the field remained a challenge.

Inadequate or late **financing of the CHDs** will impact its scheduled delivery every six months. It is envisaged that after the completion of the first round of implementation in all zones (Northwest, Northeast and Central/South) of Somalia, UNICEF and WHO will be able to review the actual costing for categories and units of cost for all three zones and have a through understanding of cost of delivery of CHDs per child. Timely funding for CHDs is required to ensure supply pipeline, micro planning and training and social mobilization. **Lack of accurate population data** is a challenge that hampered effective micro planning and resource allocation. The CHDs is a population-based programme aiming to reach every child regardless of their status and socio economic characteristic (internally displaced persons and host communities, urban and rural, girls and boys, nomads and pastoralists). The success of the CHDs depends on an effective micro planning at district level that counts every child

and every woman in each of the villages. The polio National Immunization Days (NIDs) population estimates was used for the CHDs micro planning. The active involvement of the WHO polio programme staff at all levels, particularly the region and district level where CHD micro planning and implementation happens, was very instrumental for the successful implementation of the CHDs. The team used their experience in polio and worked very closely with the Ministries of Health in Somaliland and Puntland. In South/Central Somalia where the Ministry of Health structure is not that much functional, the polio team and UNICEF staff coordinated with NGO partners at district level. The strong partnership of WHO and UNICEF Somalia was demonstrated again as was done in the polio eradication efforts.

The **shortage of human resources** especially vaccinators and the **limited capacity of vaccine storage** were addressed through strategies like a phased approach in implementation or mobilizing large number of trained staff not only from the health sector but also outside the sector who participated as recorders or social mobilizers for administration of Vitamin A and de worming during the CHDs. The phasing made it possible to move the cold chain for vaccine storage from one district to another to ensure vaccine safety. On the technical side, although the overall programme reached a good number of women for tetanus vaccination, CHD teams faced **TT vaccine refusal** among women and girls in some places. This was partly due to lack of awareness that TT is for all women of child-bearing age even those who are not married and those who are not pregnant at the time of vaccination. This underlines the need for a comprehensive and continuous behavioural change communication and social mobilization targeting both men and women on the benefits of TT vaccination.

Why do children die in Somalia?

From Page 1

The public health system

The health system is poorly resourced and unevenly distributed. The public health system struggles to provide services to a limited number of Somalis against crushing constraints: insecurity; geographical challenges and nomadic populations; an unstructured and limited workforce constrained by lack of motivation; uncertainty about the political future and administrative settings; financial and operational fragmentation and poor information and surveillance. Physical and financial barriers exist to accessing health services— cost and time for transport as well as distance to often poor quality services. This leads to low demand for basic services and late health seeking behaviour in times of urgent need. In particular demand is extremely low for preventive and other services including immunization. Furthermore due to poor staffing, inadequate supervision and supplies, and limited options for referral – the public health system provides very poor quality of services – and hence does not engender much trust from the population.

An analysis of 2007 health data returns indicates that utilisation rates are 0.13 per person per year OR the average Somali visits a public health facility once every eight years! Various other surveys indicate that between 50 and 75% of the population use private pharmacies and private health services if and when they do use modern health care services – and less than 20% of the population use public sector services .

The current humanitarian crisis

Fighting between the government and opposition forces has intensified since early May 2009. While Mogadishu has seen the worst violence, fighting also spread to several other areas and towns in southern and central Somalia, leading to increased civilian casualties, human rights abuses, renewed large scale population displacement, the destruction and confiscation of livelihood assets, and disruptions to economic activities and trade - further aggravating the humanitarian crisis.

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There is need for more sensitization on the benefits of tetanus vaccination...

Life-saving nutrition interventions for vulnerable Somali children

EL-BERDE, Somalia, 24 June 2009 – From early in the morning, the outpatient therapeutic programme (OTP) in El-Berde is crowded with women and their children seeking its services. The OTP is set up inside the town's maternal and child health centre to treat children suffering from severe acute malnutrition – a life-threatening condition.

The staff at the OTP are busy attending to the long queue of mothers carrying their babies. They measure each child's height, weight and arm circumference to assess nutritional status and progress of treatment. Physical check-ups to determine medical conditions are also conducted.

El-Berde, located near the border with Ethiopia in the Bakool region of southern Somalia, is one of the towns that has been receiving an increasing number of people displaced by armed conflict.



A child is weighed at the outpatient therapeutic centre in El-Berde, Somalia. © UNICEF Somalia/2009

Expanding nutrition interventions

"Despite the deterioration of the security situation in Somalia, UNICEF's nutrition interventions have been expanding during the past two years as the high malnutrition rates among children persist and we identify new pockets of very high acute malnutrition," says Nutrition Specialist for UNICEF Somalia Fitsum Assefa.

Ms. Assefa notes that UNICEF has expanded the number of OTPs it supports from 40 to close to 200. The organization is aiming to reach more than 50,000 children suffering from severe acute malnutrition during 2009.

"The good news is that we are able to reach children in desperate need of this life-saving intervention," said Ms. Assefa.

"But also the needs are great and there are very critical pockets of vulnerabilities that are not reached because of the insecurity and lack of humanitarian access."

Therapeutic feeding and care

At the front of the queue, a mother named Dahaba says she came to the OTP to have her one-year-old son Ali examined. Ali was referred to this OTP, run by the non-governmental organization International Medical Corps with UNICEF's support, when he was found to be severely malnourished and in need of immediate treatment. Dahaba notes that her son was in a state of complete frailty just a few months ago.

"Ali was so weak and sick when I first came here," she recalls. "He was very thin. I was so worried that he wasn't going to make it. But he is now doing better and even looks totally different. The staff told me today that next week will be the last day for us to come here for a check-up."

Having provided Ali with weekly follow-ups, rations of Plumpy'nut (a therapeutic food product specially formulated to treat severe acute malnutrition), vitamin A and other medicines, the OTP staff decided that Ali is cured and ready to be discharged. To prevent reversal of his condition, Ali will be transferred to a UNICEF-supported supplementary feeding programme where he will receive a monthly ration of blended foods and his condition will be monitored on monthly basis for at least three months.



Dahaba, a visitor to the OTP in El-Berde with her one-year-old son, Ali. © UNICEF Somalia/2009

Critical help from partners

UNICEF and partners are responding to Somali children's nutrition needs with a package of interventions that includes blanket feeding for the prevention of malnutrition among vulnerable children, in addition to the treatment of severe and moderate acute malnutrition

through OTPs, in-patient stabilization centres and supplementary feeding programmes set up across the country.

Thanks to generous contributions by the European Commission Humanitarian Aid Department, the French Committee for UNICEF and the Governments of the United Kingdom, the United States, Spain and Norway, UNICEF is able to provide treatment for tens of thousands of Somali children with severe acute malnutrition.

Vulnerable children

Children like Ali are the most vulnerable to the impact of poverty, food insecurity, lack of safe drinking water and conflict in Somalia. "My son had bad diarrhoea and his body was swollen, so I brought him to ... the OTP," said Halima, mother of one-year-old Ahmed.

The young boy was suffering from oedema, a condition of excess storage of fluid in the body caused by severe malnutrition and infection. Having gone through treatment and made visible improvement, Ahmed will soon be discharged from the OTP.

FUNDING and PARTNERSHIPS

UNICEF acknowledges contribution from SIDA, OFDA, Denmark, Japan, DfID, GAVI, UN Foundation, Norway and CIDA for their support to the overall Child Survival in Somalia. At least 50 local and international partner organizations have been involved in the Child Health Days campaign with about 40 of them being in the Central/Southern Somalia regions of Gedo, Bay, Bakool, Middle Jubba and Lower Jubba and the others being involved in activities that include social mobilization in Northeast Somalia ("Puntland").

From immunization villain to TT hero

Fifty-three-year old Farah Mohammed, alias 'Shacks' is a general worker at a local private clinic on the outskirts of Garowe, Puntland. Married with eight children, including 3 under five children, 'Shacks' has a history of being a core-non compliant parent to immunization in the area. During one of the 2008 polio campaigns, Farah resisted several attempts by local polio vaccination teams and influential leadership that visited him to have his children immunized. However, this time around, Farah was seen leading the rapid response team of the just ended CHDS in Garowe, talking to fellow husbands after evening prayers and explaining to them about Tetanus Toxoid (TT) vaccine for women and the need for mothers and under five years old children to benefit from Child Health Days. Read on below about Farah and his experience...

"I first heard about Child Health Days through Ibrahim, my neighbour who does voluntary work for Amin Women and Child Organization [AWOC], a local NGO engaged by UNICEF and partners to undertake advocacy and community mobilization activities in our area. The context within which Ibrahim informed me about the CHDs was that this was going to be for children only. As we were having a chat, Radio Daljir, a local radio station aired a jingle about the CHDs. After listening to the jingle it became apparent what this was going to be about: a health campaign targeting mothers and children and that the package included several interventions.

As the jingle faded away, there we were arguing with Ibrahim about the CHD package especially about Tetanus Toxoid (T.T) vaccine, also in the package. Recalling the message about TT, Ibrahim started off by telling me that his wife had never received TT vaccination because of the story he heard about how one health facility had made several women in one community un-reproductive. When I asked him the source of the story, Ibrahim didn't have facts to argue with. He simply said, he couldn't remember exactly who told him the story but asserted that it was true and he swore to that. It is then that I explained to him how important the TT vaccine was to women of child bearing age group. I explained exactly the way Dr. Saffi, my supervisor explained to me when I argued with her about a similar negative story about TT. My story was that the vaccine made women to bear female children only. When I explained to Dr Saffi, she wondered just how possible that could be done through the TT vaccine. Although I hesitantly asked my wife to go for the TT vaccinations a few years back, she recently delivered a healthy baby and we have had no problems with the baby. Dr. Saffi told me that the TT vaccine protects the mother and the baby from getting Tetanus. According to her, in many countries immunization against tetanus is routinely given to pregnant women, usually during the ante-natal care contacts. Unfortunately, we don't have adequate ante-natal care facilities in Somalia. She further said that for women who did not receive any dose earlier in life, or had no documentation of such immunization, a total of five doses were recommended: two one month apart in the first pregnancy, and one in every subsequent pregnancy (or at relevant intervals), up to a total of five doses.

When given to women of childbearing age, vaccines that contain tetanus toxoid (TT) not only protect women against tetanus, but also prevent neonatal tetanus in their newborn infants, I said to Ibrahim. When TT vaccine is given to a woman who is or who becomes pregnant, the antibodies that form in her body are passed to the baby in the womb. These antibodies protect the baby against tetanus during birth and for a few months afterwards. They also protect the woman against tetanus. A three-dose course of TT provides protection against maternal and neonatal tetanus for at least five years. A maximum of five doses will protect women throughout their childbearing years.

After this lengthy discussion with Ibrahim, he openly mentioned to me that based on the information from Dr. Saffi, he was going to spread the word in the community about the need for women of child bearing age group to receive TT vaccinations. He also said the need for under five children to receive CHD packages was necessary as he was really saddened by the pictures he saw about children who had died as a result of not having been vaccinated against measles in one of the towns in southern Somalia. A few days later, I linked up with Ibrahim and we planned to go into the community to spread the TT vaccination word to fellow husbands about the need for mothers to receive TT.

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Measles mortality reduction campaign

Measles has knocked on many doors in Somalia claiming its share of mortality from many households in the past. However, through the joint WHO/UNICEF programme for measles elimination, massive deaths from Measles have become a thing of the past. The measles mortality reduction campaign of 2005-2007 conducted by UNICEF, WHO, local authorities and partners was successful in reaching more than 3,000,000 (more than 90% of the children aged 9 months to 15 years old. These and previous efforts have resulted in a reduction of measles cases from 12,008 cases in 2004 to 1,081 cases in 2008. The latest campaign was conducted in three phases over a period of 20 months by UNICEF, WHO, Ministries of Health and NGOs.

The number of reported measles cases following the campaign has drastically dropped by about 90 per cent. The campaign was successful in preventing measles outbreaks and massive death, putting a smile on the face of parents. Shortly after the measles campaign, a mother in Baidoa had this to say: "**Thank God, we are relieved from measles deaths**". To ensure more smiles from mothers and their children, UNICEF and WHO along with other partners are determined to do all it takes for this relief to continue through CHDs and improved routine immunization. However, worth noting is that low routine immunization coverage has led to a growing cohort of children born after the 2005-07 measles campaign that is susceptible to measles if they do not get measles vaccination.. The recent increase in suspected measles cases in Togheer region (in late 2008) and Bari and Kakar regions (in early 2009) was an indication of the need for immediate and large scale measles vaccination for Somali children.

There is need for immediate and large scale measles vaccination for children...

The child survival revolution

New technologies to reduce under 5 mortality (<5MR) began to revolutionize health care systems in developing countries from the 1960s. The first child survival “revolution” was launched by James Grant (then executive director of UNICEF) in 1982. The strategy aimed at promoting growth monitoring, oral rehydration, breast feeding and immunization.

The Child Survival revolution was extremely successful in organising collective political will, raising resources and directing capacities to the development of an evidence base for effective and appropriate health interventions, and finally rolling out tested technologies into national public health and welfare systems to promote child survival. So much so, critics were concerned with the diversion of resources and efforts away from building resilient and sustainable national health care systems (towards a “myopic” focus on specific outputs).

However, the initial gains made were extraordinary – with reductions in under-five mortality rates (<5MR) of roughly 2/3rds. In 1960, there were estimated to be 18.9 million annual deaths in under fives; this number was reduced to 9.7 million annually by 2005.

To improve child survival new determination was acknowledged with the formulation of a specific Millenium Development Goal (4) of reducing child mortality further garnering international political attention towards working together to reach a major reduction in child mortality by 2/3rds on 1990 rates, by the year 2015. Compared to the start of the original child survival revolution there is a wider scientific literature on the extent of need (including for example the realisation that to significantly enhance child survival, we have to address infant mortality and that these efforts are necessarily connected to reductions in maternal mortality).

There have also been major advances in nutrition and hygiene – exponentially expanding our understanding of the critical role of the need for sanitary and hygiene interventions as well as micro-nutrients and special lipid supplementation as a means to reduce nutrition related mortality and morbidity/disability.

Hence the child survival revolution has become a true public health agenda and expanded beyond the remit of the medical sector to encompass an agenda for action to address determinants of poor health. Comprehensive evidence based reviews have been conducted to define the “tool kit” for child survival, infant and child nutrition and maternal and infant survival and published in the Lancet.

In addition to the evidence base which has provided us with a list of priority interventions – there are a host of new commodities and services as well as programme delivery experiences that form the research agenda for the future and extend our capacity to radically impact on maternal, newborn and child survival.

The picture is now clear – we know the major causes of mortality – we know how to review the country specifics to tailor what strategies would be most cost effective - and we have a range of programme service delivery options. But despite major advances in the knowledge base, there is low coverage of

utilization (for earlier we mentioned strong improvements in mortality rates) for many of these basic interventions in the 42 countries home to 90% of child deaths – and increasing gaps in survival chances between the children of the rich and poor.

It is now an imperative and a responsibility to show we can turn this hard won knowledge into effective action and radically reduce young child mortality, morbidity and disability – and at low cost. Only real, varied and widespread success can sustain political commitment and resource flows over time.

There is need; there are effective and feasible interventions options; they can be delivered at low cost and these interventions have not reached adequate coverage - hence there is an agenda for action!

Why do children die?

From Page 2

There is a huge population of internally displaced persons with over 211,000 people displaced from Mogadishu alone between May 2009 and July which places the total number of new IDPs in Somalia at more than 1.3 million people. The drought in the central regions is intensifying, following five consecutive seasons of rain failure. Already, roughly 60% of the population in the central regions (Galgadud and Mudug) is classified either in Acute Food and Livelihood Crisis or Humanitarian Emergency due to drought, hyperinflation, and conflict, which have affected rural, urban and IDP populations. Nutrition surveys as of May 2009 confirmed that the nutrition situation remained above the emergency threshold for all groups, with global acute malnutrition (GAM) rates of between 15.3% and 18.0% and severe acute malnutrition (SAM) rates between 2.6% and 5.5%. There is an emerging drought in the north in the regions of Sool, Sanaag and northeastern Toghdeer, due to recent rain failure, which is compounded by three previous seasons of relatively poor and patchy rainfall. The following are conclusions:

- ◆ The Somali population has faced long periods of destitution and social decline. Additionally, it currently faces increasing political, financial and natural disasters creating immediate crisis and longer term continuation of the chronic crisis. The result is that Somali women and children are dying in unacceptably large numbers from the most basic of health problems.
- ◆ There are very few public resources to develop functional public health systems.
- ◆ The public health facilities that do exist operate at sub-standard levels and therefore do not provide sufficient quality of services – sufficiently accessible to offer real service options to all Somalis.
- ◆ In order to deliver a comprehensive child survival programme delivery options are required that can achieve real coverage – the public health system does not offer this opportunity at the current time or foreseeable future.

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Physical and financial barriers are a major barrier to health service provision...

Using interpersonal communication skills to mobilize communities for Child Health Days

Aisha, aged thirty-seven, is chief mobilizer of a local community mobilization group, HODMAN Relief & Development Organization which has been engaged by UNICEF to undertake community mobilization for Child Health Days in Northeast Somalia ('Puntland'). Her group's experiences in the use of Interpersonal Communication Skills to mobilize people in Bossaso, Puntland's commercial capital are highlighted below.

On a hot sunny day, forty-seven year old Ifrah Mohammed joins a group of women trekking to a local Child Health Day [CHD] site in their community. Some of the women carry children on their backs and some walk them along. As they walk to the site, some are humming the local CHD radio jingle that has since hitting the radio waves a few weeks ago become a popular tune on everybody's lips in Bossaso.

The tune asks mothers and children to visit the local CHD sites to receive a CHD package during the forthcoming CHD. The radio jingle was developed by UNICEF and a local media partner, Horsed media. The CHD jingles had messages from a Sheik, a parent, a child and a mother among others, all related to the CHD package asking various participant audiences to go to the nearest CHD site for a CHD package.

As Ifrah and her colleagues get closer to a CHD site, they meet a group of community mobilisers on a community mobilization assignment. The mobilizers are walking about as they make announcements using mega phones about the CHDs. They are from a local NGO, HODMAN. The chief mobilizer of the group is Aisha, Ifrah's niece who lives in a nearby compound.

"We have been visiting members of this community in the last two weeks talking to people and making announcements about the forthcoming Child Health Days," says Aisha. "Some community members initially didn't seem to understand the whole idea of CHDs because they thought it was a polio campaign but after explaining about the package and reasons why this is being conducted, they understood and agreed to attend the CHDs."

Aisha further says that their group's excellent interpersonal communication skills have made her group's assignment easy having received orientation from UNICEF about CHDs and how to strengthen mobilization through interpersonal skills.

"Talking to community members who do not seem to understand the need for such a life-saving intervention has not been easy. Our main focus has been on communities that were non-compliant during previous similar campaigns. Among our activities has been to dispel the notions that some life saving intervention such as vaccination has some negative effects," says Aisha.

"When we go to a household and share the data we received during the orientation at UNICEF, they are able to understand the numbers of children and women dying from preventable diseases in simple language."

One commonly used interpersonal skill is that of using *probing questions* to encourage caregivers and guardians to give further information where needed to clarify issues raised during conversations. This technique requires tact in wording and tone so as to avoid being judgmental.

Since it involves Somalis who know their culture, they are able to use their tone and voice adequately. This technique has



Social mobilizers at work to support the Child Health Days (CHDs) in Somalia. © UNICEF Somalia/2009

helped to bring out perceptions about health interventions, hence guiding mobilizers in their explanations of the intentions of CHDs.

"Currently, we have child caregivers who once convinced agree to join mobilization teams to act as advocates.

They join teams to give talks to community leaders and to institutions about CHDs, in some instances citing examples of their sad experiences of losing loved ones in cases that should have been prevented," says Aisha.

Why do children die in Somalia? — Continued From Page 5

- ◆ There is a general lack of knowledge about how to promote child health and when to seek health care among the Somali population – there is a lack of demand particularly for effective preventive health services such as immunisation.

The way ahead

UNICEF has developed a strategic plan to maximize the impact in reducing maternal, infant and child mortality, morbidity and disability. It involves the following components:

- (1) Mass communication for the promotion of enhanced knowledge among the Somali population to allow them to improve behaviours to promote infant and child survival and to promote higher demand for and better use of health services.
- (2) Investment in better health information to promote evidence-based decision making.
- (3) The delivery of a package of low-cost effective and logistically simple child survival interventions (medical, nutrition and hygiene) through service delivery campaigns down to the village level and mass social mobilisation to promote attendance and uptake (coverage cannot be achieved through the facility-based health care alone). This strategy is effected through the Child Health Days.
- (4) Focussed attention to a smaller number of public health facilities to be able to upgrade them (staff, services, drugs) to ensure they offer sufficient quality services at low enough costs that they can serve the needs of the population (at least in those catchment areas) and a focus on referral links to higher level local facilities.
- (5) A prioritised plan of operational research to refine our understanding of the highest priority feasible/deliverable interventions in the context of Somalia.

Somalia — child health days coverage

Somalia – one of the harshest places on the planet—provides an extreme environment that presents huge challenges to its people in terms of simple survival. The combination of a predominantly arid environment, difficult terrain and low population density, with settlements scattered over vast distances, coupled with in-existent infrastructure (roads, electricity and potable water supplies) mean that the population is desperately under-served.

In spite of these difficulties, there have been success stories. Somalia has been able to contain the polio virus since March 2007 and bring down measles cases among children under five from 12,008 in 2004 to 1,081 in 2008. Most of these achievements have been reached through direct service provision to communities for instance the measles campaigns reaching millions of children and the polio national immunization days which contributed to the attainment of a polio free status in Somalia, a remarkable achievement given the realities in Somalia. Within the overall joint programme of UNICEF and WHO in Somalia for Accelerating Young Child Survival, both agencies with support from Ministries of Health and local authorities and in collaboration with NGOs launched the Child Health Days (CHDs) in December 2008.

The Child Health Days – a periodic intensification of routine immunization plus nutrition- is a renewal of efforts to increase coverage of key high-impact health interventions to as many children as can be reached using campaign type strategies. CHD packages include high impact core child survival interventions such as immunization (measles, Diphtheria, Pertussis and Tetanus and oral polio vaccine), Vitamin A, de-worming, oral rehydration salts, water disinfection tablets, and nutritional screening targeting children under five years as well as tetanus toxoid vaccination for women of child-bearing age.

The first round of the Child Health Days (CHDs) started in the last week of December 2008 in Northwest Somalia (“Somaliland”) where it continued until mid-February 2009. In Central/Southern Somalia the CHDs took place from March to early May 2009 (except Benadir and Lower Shabelle regions and Kismayo district) and in Northeast Somalia (“Puntland) dur-

ing May and June 2009.

So far, more than one million children and around 800,000 women of child-bearing age have been reached by the CHDs. The table on Page 8 reflects coverage figures of Somaliland, Central/Southern Somalia (excluding Benadir, Lower Shabelle regions, and Kismayo district) and Puntland.

The table shows a remarkable achievement which is much higher than what the programme achieved through routine expanded programme on immunization (EPI) activities in 2008. For example, the measles coverage in the CHDs from December 2008 to July 2009 is almost 10 times the coverage achieved for measles vaccination through the routine EPI programme at health facility level in the entire 2008. Thus, this comparison clearly highlights the thousands of additional children and women who are being reached through the CHDs. These figures are just indicators – each of the children and women reached through CHDs received a package of services and not just measles or TT vaccines!

To maintain the coverage and make an impact on child morbidity and mortality, the CHDs will be conducted every six-months. While CHDs are planned every six months, UNICEF and WHO will ensure appropriate support to the EPI routine programme and facility-based care including the vaccine storage infrastructure, training of staff and supervision, effective social mobilization and communication to increase the coverage of core child survival interventions for children and families.

The CHD activities were well received by local communities, families and health personnel. The authorities as well as communities were pleased to see real and tangible action for their people. Health personnel were motivated by the intense action and resultant high return on their investment and the population clearly welcomed the delivery of free and essential services, evident by the high turnout of families and children.

The next round of the CHDs is planned as follows: Somaliland in August 2009, Central/Southern Somalia in October/November 2009 and Puntland in December. 2009.

From Immunization villain to hero

From Page 4

Says Farah: “One of the strategies I and my team developed was to reach out to men after evening mosque prayers. We approached UNICEF to provide materials, about TT which we used in our discussions with the targeted participant groups. As part of our strategy, we identified spots near the central mosque where we sat and had discussions with individuals that we approached to discuss TT vaccination for women. One of the questions we asked during the initial discussions was to find out whether they were married, and for those that were married, we followed up with a question as to whether their wives were immunized against TT.

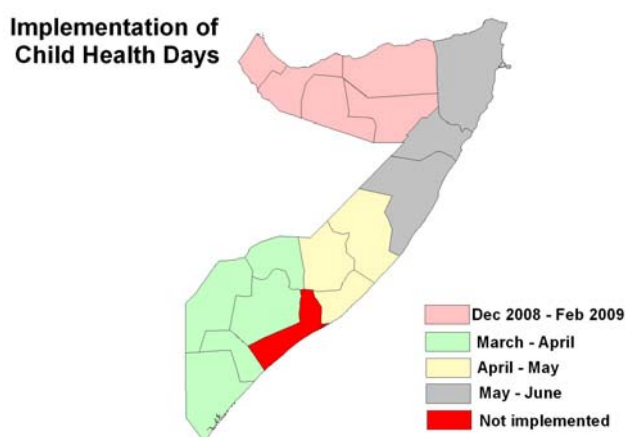
For those whose wives had not yet received TT vaccination we then went on to discuss the need to have them vaccinated. Some of the participants we spoke to mentioned that their wives were already pregnant and wondered whether it was not too late to receive the TT vaccine. We responded to queries continuously even during Child Health Days and our efforts surely added to the number of targeted child-bearing age women reached, but we still need to spread the word more by working much closely with UNICEF in order to have more receive TT.”



A woman gets TT vaccination during a CHD campaign in Somalia. © UNICEF Somalia/2009.

The CHDs will be conducted every six months to sustain their impact...

Implementation of Child Health Days in Somalia



Intervention	Age	Number reached*	Estimated Coverage (based on UNDP population)**
Polio vaccination (OPV)	Children 0-59 months	1,072,179	85%
Measles vaccination	Children 9-59 months	899,789	84%
DPT 1-3 vaccination	Children 6 weeks – 11 month	245,655	98%
Vitamin A supplementation	Children 6-59 months	937,184	83%
De-worming (Albendazol)	Children 12-59 months	839,512	83%
Tetanus Toxoid 1-5 vaccination	Women of Childbearing Age	802,142	55%
Oral Rehydration Salt (ORS)	Children 0-59 months	1,073,727	85%
Aquatabs	Children 0-59 months	1,082,063	86%

*This also includes two days mop-up coverage in Hargeisa, Northwest Somalia ('Somaliland').

**Percentage based on areas covered during CHDs, and excludes target population of Benadir, Lower Shabelle regions and Kisumu district, where CHD could not be implemented due to security reasons.

More effort needed to boost child survival in Somalia

From Page 1

This bulletin is dedicated to Child Survival issues and in particular focuses on Child Health Days (CHDs); the background and history, achievements made in the first round of CHDs in Somalia, the challenges and way forward. The Child Health Days are a demonstration of the fact that results can be achieved even in a difficult environment for children if we act together. We would like to take this opportunity to thank health authorities for their commitment and support to the CHDs, the NGO partners for their collaboration and the communities and parents who brought their children for vaccination and helped the teams to fulfill their duties. The CHDs would not have been possible without a joint effort and dedication demonstrated throughout. We would also like to thank the donors for their contribution that made the CHDs a reality in Somalia. It is with this spirit of cooperation that we assert that our joint efforts to reach every child with critical high impact interventions will continue!

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