

Case Study: UNICEF, SOMALIA

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Area of work (Outcome Area): Demand Generation and Service Delivery for Polio and Routine Immunisation

Country: Somalia

Title: Fostering Community Participation Through Influential Leaders for Zero-Dosed/Defaulter Tracing and Sustainability Through an HCD Approach in Somalia

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Abstract

Somalia has made enormous progress against polio but faces the world's longest-running outbreak of circulating variant poliovirus type 2 (cVDPV2). Despite stopping wild poliovirus transmission in 2014, insecurity, weak health systems and population movement have left approximately 1.5 million Somali children under 5 being zero-dose. The country has made big strides through the Big Catch-Up (BCU) accelerated initiatives in which nearly 700,000 zero-dose children received their first dose of pentavalent vaccine (UNICEF 2025). The country's admin data for Penta 3 coverage stands at 78% as of July 2025.

The Influential Leaders Project is a collaborative initiative led by Somalia's Federal Ministry of Health (FMoH), state ministries, UNICEF and the Gates Foundation. Using a human-centred design (HCD) approach, it engages community elders, women and youth leaders in vulnerable populations to co-create zero-dose and defaulter tracing strategies to build trust and ownership, strengthen routine immunization (RI) and integrate cold-chain and service delivery improvements. Early results that spanned over 2 months from 17 districts show that over 21,509 zero-dose/defaulters children were traced and 94 per cent received vaccinations, with 63 per cent of cases resolved through leader involvement. Re-operationalisation of health facilities reached previously underserved communities, boosting routine immunization uptake while fostering accountability and sustainability. The case study documents the project's rationale, design, implementation, results, lessons learned and recommended next steps for replication.

1. Issue (Background)

1.1. Outbreak context and immunization gaps:

Somalia successfully halted wild poliovirus transmission in 2014 but continues to battle cVDPV2, with recurring outbreaks since 2017 (Frontiers 2025). Outbreaks of measles, cholera, diphtheria, whooping cough and neonatal tetanus further strained the health system. Somalia Emergency Action Plan (SEAP) emphasize community engagement and advocacy, improved service coverage and cross-border coordination. However, the context remains challenging, around 17 per cent of targeted children live in inaccessible areas and only 62 per cent of public hospitals and 68 per cent of health centres offer immunization. Less than half of the population lives within

10 kilometres of a vaccination facility, forcing reliance on outreach campaigns that are expensive and often unsustainable services (Frontiers 2025).

1.2. Demand-side barriers: Demand-side barriers to immunization in Somalia continue to significantly influence caregivers' ability and willingness to seek services. Many parents and caregivers have limited awareness of vaccination schedules and the benefits of completing the full series, while entrenched social norms and daily survival priorities often place health-seeking behind other urgent needs. In several communities, mistrust and broader insecurity, particularly in areas affected by chronic conflict, further undermine confidence in vaccines and health services. Gender-related constraints add an additional layer of vulnerability: women's restricted mobility, limited decision-making power within households, and concerns about safety all reduce their ability to access immunization services for their children. Together, these interconnected factors shape a complex demand-side environment that must be addressed through targeted engagement, tailored communication, and community-driven solutions (UNICEF 2023). A recent scoping review on strategies to reach zero-dose and under-immunized children highlights that interventions such as vaccination registries, household-level tracing tools, and caregiver reminder approaches, when paired with targeted community engagement, are effective in increasing coverage and reducing missed children (Johns Hopkins Bloomberg School of Public Health, 2024). Trusted figures such as clan elders, women's groups, youth leaders and religious leaders are effective in dispelling misinformation and convincing hesitant families [UNICEF 2024].

1.3. Opportunity for innovation: Somalia's polio programme historically relied on Social Mobilization Networks (SOMNET) for house-to-house outreach. While SOMNET has achieved notable results, it is stretched thin and has limited capacity for zero-dosed and defaulter tracing in remote or insecure areas. The Influential Leaders Project was conceived in 2023 as a complementary approach that leverages a Human Centered Design Approach (HCD) and shared accountability. It aims to link zero-dose and routine immunization efforts, integrate supply chain improvements and strengthen community ownership.

2. Strategy and Implementation

2.1. Human-centred design and participatory planning:

2.2. To begin the project, a literature review was conducted to gain a better understanding of the clan structure and communities. This included community needs assessments for additional insights. A thorough analysis of data (RI and polio campaign data) was completed to help determine key priority districts in consequential geographic locations, and an audience analysis (rural, urban poor, nomadic, IDP populations, minority and dominant groups). The project applied a four-phase HCD methodology:

2.3.

Phase 1: Listening and reviewing – multisectoral teams conducted community needs assessments and mapping in 17 high-risk districts across Galmudug, Hirshabelle, South-West, Jubbaland and Banadir). They identified 1,090 influential individuals (clan elders, women leaders and youth representatives) and held 60 HCD sessions to explore barriers and co-create solutions. Feedback from these sessions informed the programme design and emphasised shared leadership and accountability. Phase 2: Co-designing – community members, health workers, state ministries and UNICEF jointly developed interventions such as household defaulter-tracking lists, digital referral tools, appointment reminders and support groups. Phase 3: Scale-up – evidence-based solutions were piloted and then expanded to all 17 targeted districts. Phase 4: Service delivery – the project re-operationalised 38 health facilities and supported an additional 62 facilities, allowing 138 villages to receive routine immunization services for the first time. Multi-antigen sessions delivered oral polio vaccine (OPV1), pentavalent vaccine and other EPI antigens,

integrated with cold-chain support and community engagement.

2.4. Roles and partnerships: The project delineated clear roles to ensure accountability and sustainability. Elders and women leaders advocate for vaccination, build trust, facilitate dialogue and mobilize households. Youth leaders support zero-dose/defaulters tracing and community exercises. Social mobilizers and health workers conduct house-to-house visits, administer vaccinations and collect real-time data using Open Data Kit (ODK). District and state EPI coordinators supervise activities and ensure data quality. UNICEF and Gates Foundation provide technical assistance, supplies and funding, while the FMoH and state ministries lead implementation. Community mobilizers partner with local leaders to reach remote settlements; in Dhusamareeb, for example, vaccinators have built rapport with families and work tirelessly door-to-door, collaborating with local leaders to reach remote villages (UNICEF 2025). Training workshops oriented SMs and health workers on respectful care, digital tools and data use.

2.5. Integration with routine services and digital tracking: Mapping exercises matched families to the nearest health facility and flagged zero-dose children. ODK-based forms capture GPS coordinates, contact details and vaccination status during house-to-house visits. Data was synchronised with dashboards to monitor progress, identify defaulters and send follow-up alerts. Support groups and accountability forums encouraged dialogue between community leaders, health workers and families. The project integrated routine immunization into polio outbreak response, enabling children to receive multiple antigens at once and reducing drop-out rates.

3. Progress and Results

3.1. Reach and vaccination outcomes: By September 2025 the project was rolled out in 17 districts. Mapping identified 1,090 influential leaders who conducted community engagement exercises, and after a two-month roll-out period, 21,509 children who were zero-dose or defaulters were traced. Of these, 20,198 (94 per cent) received vaccinations after following-up, demonstrating high effectiveness of leader-driven tracing. Leader involvement resolved 13,551 cases (63 per cent). Only 6 per cent of traced children required further follow-up, often due to migration, insecurity or vaccine hesitancy. Gender distribution among traced children was roughly equal (52 % boys, 48 % girls), reflecting equitable reach.

3.2. Service delivery and routine immunization improvements: The project supported 100 health facilities across five states, including the re-opening of 38 facilities that had previously suspended routine immunization services. Outreach teams reached 138 villages for the first time with RI services. Between August and September 2025, 18,499 children received OPV1 and 18,230 received the first dose of pentavalent vaccine (27 per cent were over 12 months old). Penta1/Penta3 drop-out rates (DOR) declined from 19 per cent before the project to less than 10 per cent, suggesting improved adherence to the immunization schedule. Integration of OPV, pentavalent, pneumococcal and rotavirus vaccines reduced missed opportunities and optimized cold-chain use.

3.3. Qualitative changes: Community feedback indicates greater trust in vaccinators and increased awareness of vaccine schedules. Elders and women leaders report feeling empowered to hold health workers accountable, while youth leaders have gained leadership skills and digital literacy. State ministries and district coordinators note improved coordination with humanitarian partners. By fostering shared responsibility, the project has shifted perceptions of immunization from a purely external intervention to a community-owned initiative.

4. Lessons Learned

- **Community ownership is pivotal.** Engaging elders, women and youth leaders from the outset created trusted messengers who could address misinformation and advocate for vaccination. Local leaders were instrumental in persuading hesitant families and resolving refusals.
- **Human-centred design builds relevant solutions.** Participatory design sessions ensured interventions responded to the specific needs of different communities, leading to high uptake and sustainability.
- **Defaulter tracing and digital tools enhance efficiency.** Real-time registries, defaulter-tracing lists and reminder systems help identify and follow up on missed children, consistent with evidence that registries and defaulter tracing improve coverage (Johns Hopkins Bloomberg School of Public Health, 2024). Using ODK for data collection enabled rapid analysis and targeted follow-up.
- **Integrated service delivery strengthens routine immunization.** Bundling polio and other antigens during outreach reduced drop-outs and leveraged resources. Re-operationalising health facilities expanded RI access in previously underserved areas.
- **Shared accountability fosters sustainability.** Clear delineation of roles, supervision and support groups-built accountability across community leaders, health workers and government. When leaders were engaged, two-thirds of cases were resolved.
- **Challenges remain.** Some families lack awareness of vaccination schedules or remain hesitant; reasons for missed vaccinations include migration, insecurity and service gaps. Funding uncertainty beyond 2025 threatens continuity. Access challenges persist in conflict-affected or nomadic areas, where outreach remains costly. Ongoing training and supportive supervision are needed to maintain quality.

5. Potential Application

The Influential Leaders Project demonstrates that participatory approaches can complement existing social mobilization networks to reach zero-dose and defaulter children. Elements of this model (mapping and engaging influential leaders, conducting HCD sessions, using digital defaulter registries and integrating multiple vaccines) are transferable to other humanitarian or decentralised contexts. Countries dealing with vaccine-derived polio outbreaks or large numbers of zero-dose children can adapt the approach by identifying locally respected figures and co-designing interventions. Careful tailoring to cultural norms, gender dynamics and health system capacity is essential.

6. Next steps

- **Analyse reasons for missed vaccinations.** Conduct qualitative studies to understand why the 6 per cent of traced children remain unvaccinated and design targeted responses (e.g., addressing nomadic movement, caregiver awareness or security barriers).
- **Scale up to new districts and strengthen cross-border collaboration (Kenya and Ethiopia).** Expand the project to high-risk districts not yet covered and work with neighbouring countries at border points to harmonise tracing and vaccination strategies, as cross-border mobility contributes to cVDPV2 transmission.
- **Integrate with other health services.** Build on the platform to provide maternal, newborn and child health interventions (e.g., nutrition, antenatal care), aligning with evidence that community engagement strategies can improve multiple services simultaneously.
- **Institutionalise digital tools.** Embed ODK-based registries and dashboards within the Federal Ministry of Health systems to ensure continuity and data-driven decision making; provide training and mentorship to district staff.
- **Secure sustainable financing.** Advocate with donors, including the Gates Foundation and Gavi, to maintain funding through 2026 and beyond, mitigating the risk of programme disruption.

