SciForschen
Open HUB for Scientific Research

ISSN 2470-9948

International Journal of Vaccines and Immunization

Editorial Volume: 3.1 Open Access

Closing the Immunization Gaps through Community Empowerment and Private Sector Collaboration

Stanley K Diamenu*

Immunization officer, WHO Country Office for Ghana

***Corresponding author:** Stanley K. Diamenu, Immunization officer, WHO Country Office for Ghana, **E-mail:** diamenus@who.int

Received date: 04 Jul 2016; **Accepted date:** 05 Jan 2017; **Published date:** 10 Jan 2017.

Citation: Diamenu SK (2017) Closing the Immunization Gaps through Community Empowerment and Private Sector Collaboration. Int J Vaccine Immunizat 3(1): doi http://dx.doi.org/10.16966/2470-9948.e105

Immunization has reduced significantly morbidity and mortality due to vaccine preventable diseases in many countries. For example through the immunization programme, there has not been any measles death in Ghana since 2003. The country interrupted transmission of wild poliovirus since November 2008. In addition, Ghana also achieved maternal and neonatal tetanus (MNT) elimination in 2011 among others [1].

Immunization programme in Ghana has been used as the engine of integration to deliver other child survival interventions such vitamin A supplementation, growth monitoring, distribution of long lasting insecticide treated nets for malaria control and sometimes the registration of Births during routine immunization services and vaccination campaign activities.

In spite of the many achievements recorded through immunization programmes and resources available for delivery of immunization services, coverage gaps (low achievements as against expected targets) still exist in many developing countries that need attention and conceited efforts. In some countries, many eligible children do not complete their immunization schedules resulting in high dropout (unable to complete expected doses of multi-dose vaccines like DPT-HepB-Hib, oral Polio etc which have more than one dose) rates. About 12,000 eligible children (representing an average of 8% of the annual target) do not receive their third dose of the multiple dose antigens such as Oral Polio, DPT-HepB-Hib etc every year in Ghana. The situation is similar in some other developing countries.

Many factors contribute to the low immunization coverage in many developing countries. Notable among the factors are (i) limited funding for regular vaccine supply and operational activities, (ii) poor vaccine management resulting in high wastage and stock outs affecting immunization service delivery. A lot has been documented on the need to improve on vaccine management as vaccines are expensive and scarce [2], (iii) increasing cost of vaccines. There have been calls for cooperation between the vaccine manufacturing community and countries to offer low and affordable prices for vaccines for poor countries. This is one way of repositioning immunization and vaccines to close the immunization gap between the low income and high income countries [3]. Some schools of thought have called for production of vaccines that can stand the test of hot climates. Others have expressed need for moderate vaccine vial sizes (5 or 10 doses per vial) so that vaccine wastage rates and other operational costs that involve transportation, storage and waste management can all be manageable. [4].

The first ever African continental conference on immunization held in Addis Ababa, Ethiopia from 25-28 February 2016 is one major step to reposition immunization and vaccines with the view to improving immunization coverage in Africa. It is expected that the decision from the conference will facilitate country specific strategic decisions to achieve desired results [5].

In addition to the factors already discussed above there are two factors that immunization managers in low income countries need to consider as potential to increase immunization coverage. These are (i) community empowerment for immunization and (ii) collaboration with the private sector on immunization. These factors are briefly discussed below:

i) Community empowerment

Empowering the community to contribute meaningfully to immunization service decision-making and utilization has not been fully enhanced though community participation is one of the core principles of primary health care declaration (PHC) of Alma Ata in1978 [6]. Increase in immunization service utilization can fully be achieved in areas where community members recognize the benefits of immunization and the consequences they face for failure to get their children immunized. Community participation can only be effective if traditional rulers, opinion leaders and community interest groups who are custodians of the health of their traditional areas are actively engaged in the immunization decision making process. Currently the confidence level of people in vaccines and vaccination has gone up significantly and days when people refused vaccines and vaccination on beliefs from religion, culture and traditions are almost over. It is therefore important to strengthen community social mechanisms to encourage massive participation in immunization service delivery and utilization to increase coverage and also reduce dropout rates. Some of the ways by which community engagement can be effective are (i) through opinion pools on the benefits of immunization, (ii) involvement of local health authorities in immunization services planning, assessment and evaluation of immunization programmes, (iii) using some of the community leaders as immunization ambassadors, (iv) engaging them in regular social mobilization activities such as durbars, drama on immunization, fun games etc. A review of literature has shown that effective community participation has contributed to health improvements in some low income or poor communities [7-10].

ii) Collaborating with the private sector on immunization

Encouraging private sector participation is crucial to increase coverage and reduce the burden of vaccine preventable diseases in deprived areas. One group of the private sector that can be of benefit to the immunization programme especially in the rural areas is the private midwives. They are qualified midwives who operate private maternity homes in most deprived communities where there are no public health facilities. They provide ante-natal, delivery and post-natal services to the community. In Ghana the government in collaboration with World Health Organization

(WHO) initiated a plan to engage private midwives in immunization service delivery in 2003. Thirty-three private midwives in 19 districts in 4 regions namely Volta, Central, Western and Brong Ahafo were trained in immunization basics to deliver immunization services at their clinics. They were provided with cold chain equipment and supplied regularly with vaccines from the district health office. They submitted monthly activity reports to the district health office. The initial plan was to scale up the training of the private midwives in all the districts in the country but unfortunately the plan had to be abandoned later due to financial constraints.

As part of efforts to revive the collaboration with the private midwives again, an evaluation was conducted in 2010 to determine the contributions of the 33 trained to the total immunization coverage of the districts in the 4 regions. Immunization data at the private maternity facilities and the district health offices for the third quarter (Oct-Dec 2009) were reviewed. Checklists were used to interview (i) the 33 private midwives, (ii) selected members of district health management and (iii) the regional health management teams. Data was available in Western and Brong Ahafo regions from 13 midwives in the two regions. The evaluation showed that (i) Seven of the private midwives from 5 districts in the Brong Ahafo region, recorded penta3 immunization coverage of 285 (11%) out of the total 2590 children immunized for the period under review (Oct-Dec 2009). (ii) Six of the private midwives from 6 districts in the Western region recorded penta3 immunization coverage of 115 (1.6%) out of 7067 children immunized during the same period. The evaluation has shown that 400 children in the two regions were immunized by private midwives with the third dose of the pentavalent vaccine just in the third quarter (Oct-Dec) of 2009. This revelation has shown that the 400 children would have missed the immunization service if the private midwives in the 13 districts were not involved in the immunization programme [7]. It is therefore a call for strengthening collaboration with the private midwives to improve access to immunization services especially in the rural and challenged communities. Generally district health teams or local health authorities can collaborate effectively with the private midwives by mapping out all the private maternity homes in their catchment areas and provide them with the requisite support (training, supervision, supply of vaccines etc) to deliver immunization services as was initiated in Ghana.

References

1. Ministry of Health/Ghana Health Service (2014) Expanded programme on immunization, Report on post introduction evaluation of MCV2, PCV and Rotavirus vaccines in Ghana.
2. Diamenu S, Bosnu G, Abots F, Amponsa-Achiano K, Sarpong F, et al. (2015) Why conduct Effective Vaccine Management (EVM) assessment? Int J Vaccine Immunizat 1.
3. Diamenu S (2017) Vaccine vial size proposal.
4. Medicines Sans Frontiers (2015) The right shot: Bringing down barriers to affordable and adapted vaccines. 2nd edition.
5. Sabin Vaccine Institute (2016) First Ever African Continental Conference on Immunization - Immunization Financing News. 8.1.
6. Alma Ata (1978) Primary Health Care: Report of the International Conference on Primary Health Care Alma-Ata, USSR. WHO.
7. Kyei-Faried S, Diamenu S (2010) Report on assessment of Private midwives involvement in immunization in Ghana.
8. Sule SS (2004) Community participation in health and development. Niger J Med 13: 276-281.
9. Rifkin S (2009) Lessons from community participation in health programmes: a review of the post Alma Ata experience. Int Health 1: 31-36.
10. Kironde S, Kahirimbanyi M (2002) Community participation in primary health care (PHC) programmes: Lessons from tuberculosis treatment delivery in South Africa. Afr Health Sci 2: 16-23.