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The Nexus Center for Health and Peace

"Peace is a prerequisite for Health"
(The Ottawa Charter for health Promotion, 21 November 1986)

The Nexus Center for Health and Peace

The world is changing at an **unprecedented speed**. Due to demographic shifts, the planet is becoming more crowded. Urbanization is exploding to the point that now more than half of the world's population lives in cities. Demand for food and water is out-stripping supply. Natural disasters are becoming more frequent and more severe. Rapid advances in technology are shrinking time and space. These fast and dramatic changes are creating **new challenges** as well as **new opportunities**. Realizing those opportunities requires **peace and security arrangements** which are essential for **health** which in turn is a prerequisite for social and economic development, and the well-being of humanity in general.

In an inter-connected world, many of these **challenges are inter-linked**. They re-enforce and exacerbate each other. For example, **polio** in Pakistan, Nigeria Somalia and Syria and its recent spillover to Iraq, Ethiopia, Cameroon and Equatorial Guinea demonstrate in the starkest terms how zones of instability are vulnerable to disease and its spillover. By better understanding the linkages or **nexus** between various factors, it is easier to identify areas of risk or vulnerability and, on that basis, to seek more effective remedial solutions. The key is to replace vicious circles with **virtuous ones**, and to strengthen **resilience** in order to reduce vulnerability.

In the case of polio the **security situation is seen as the biggest barrier** to the disease's global eradication. New ways to enable mass immunization need to be developed and implemented in remote areas which sometimes are not controlled by the central government. **Diplomacy, strategic coordination and advocacy** in combination with a broad range of health care services will be the key to access previously inaccessible regions.

To better **understand the nexus of factors** that creates instability and to **improve the nexus of knowledge and promote action** to resolve these problems, the International Peace Institute (IPI) has decided to establish the **Nexus Centre for Health and Peace** in Vienna. This Centre of excellence will analyze the factors that contribute to conflict and – working closely with key decision-makers – seek new solutions in order to reduce the threat of instability that can harm health, development, and social harmony.

The Centre will take a **structured, multi-disciplinary** approach to enable health and peace:

Primary activities will include (i) analysis of the security and healthcare situation in affected countries, its drivers and interdependencies, (ii) development of strategies in order to improve the security and healthcare situation and (iii) track II diplomacy and strategic coordination to enable the implementation of the strategies.

Supporting activities will bring together experts from diverse backgrounds including the private sector, academic institutions, think tanks, civil society, as well as governments and

multi-lateral organizations. This will **strengthen networks** among experts from around the world across a wide area of disciplines.

The aim is to proactively **provide and implement solutions** as well as encourage **adaptive leadership** in order to reduce the potential harm caused by conflict and instability, to enable policy makers to be better prepared to cope with these crises, and to face the challenges of the future – even the unexpected ones. It will be a **"do tank"** and not just a "think tank".

Areas of Focus

The focus areas of health and peace can be further broken down into subcategories. There are complex interdependencies among the subcategories; therefore an institutionalized multidisciplinary approach is necessary in order to coordinate the efforts to ultimately improve peace and health.

The topics that the Nexus Centre will focus on are:

- Health
    - Enable childhood immunization in conflict zones
    - Decrease child and maternal deaths in conflict and post conflict states
    - Increase government's healthcare expenditure
    - Improve healthcare infrastructure
    - Support activities to avoid food shortages
    - Improve disaster prevention and relief
- Peace
    - Promote conflict prevention and resolution
    - Increase resilience to transnational threats
    - Enable peacebuilding and statebuilding

Methodology

The Nexus Centre for Health and Peace will **map global trends**, collect and analyze information on **health care and security issues**, drawing on IPI's strategic assessments, the Global Observatory, and mapping skills. In a second step IPI will **engage with regional and thematic experts** in order to develop **mitigation strategies**. Finally, it will coordinate the implementation of these strategies through **facilitation, track II diplomacy** and **strategic coordination**.

For each issue area, the Nexus Centre will look at **good practices** and **positive case studies** in order to identify **factors that promote resilience**. The aim is to carry out **evidence-based research** and assist policy makers in order to have an **impact on policy**. It will also look at how **technology** can be used to reduce health and security threats and enhance resilience.

Added Value

Short-term independent initiatives are necessary but not sufficient. In order to be sustainable, preventive and remedial measures need to be part of a **coordinated, comprehensive and long-term global process** that unites all stakeholders and ensures a multi-disciplinary and evidence-based approach. To be effective and sustainable, this process should be **centralized and institutionalized**. That is the logic behind creating the Centre.

Outcomes

Working with a wide range of experts from the private sector, academic institutions, think-tanks, civil society, specialized institutions, inter-governmental organizations as well as all levels of government, IPI will develop a series of **operational recommendations** on how to strengthen health and peace globally and **coordinate the implementation** of these. In the process, it will help strengthen networks among actors from a cross-section of backgrounds. These connections can enable more effective prevention and a quicker response during times of crisis.

Health

The planet is facing challenges to biological security, including pandemic diseases (like malaria, polio, tuberculosis and HIV/AIDS), resurgent diseases (like SARS), or accidental or deliberately perpetrated outbreaks. Several regions suffer from hunger caused by food insecurity or conflict. Some of the world's most vulnerable people face double jeopardy by falling victim to counterfeit medicines.

Areas where there is instability and weak governance are particularly vulnerable. Polio was limited to a few isolated regions of Afghanistan, Nigeria, Pakistan, Somalia and Syria but due to intensifying conflict and low immunization levels the disease was able to spillover to neighboring states Ethiopia, Cameroon, Equatorial Guinea and Iraq. This development shows the link between instability and disease and highlights the need for coordinated action. Therefore, to improve health it is essential to reduce violence and promote peace. As stated in the World Health Organization's Ottawa Charter for Health Promotion (1986), peace is the primary condition for health.

Armed conflict, instability, and state fragility claim lives, disrupt livelihoods, and halt delivery of essential services, such as health and education. The relationship among these factors is established, but remains complex. First of all, armed conflict and public health interact in many different ways. Besides the obvious but important fact that people are killed, injured, disabled, abused or traumatized due to armed conflict, it can be said that in most countries indirect and nonviolent deaths far outnumber violent ones. In Darfur, 87 percent of civilian deaths between 2003 and 2008 were nonviolent.[1] Some **indirect effects of armed conflict on global health** include:

- impeding access of health professionals and humanitarian agencies to populations in need (conflict-affected countries have on average less than one health professional per 10,000 people);
- "flight" of health professionals from conflict zones for safety issues (health workers are often targeted by government security forces as well);
- lack of supplies and basic equipment in hospitals and clinics in conflict zones, as well as uneasy access to health facilities for populations in needs, also due to deterioration of infrastructure and transportation;
- decrease in government expenditure on healthcare;
- food shortages, even famine, due to damaged agricultural structures, collapse of the economy, aid deliberately withheld, and disruption of the family unit.
- three to four times higher under-age five mortality rates in conflict zones than the rest of the world;

[1] Olivier Degomme and Debarati Guha-Sapir, "Patterns of Mortality Rates in Darfur Conflict," *The Lancet* 375, No. 9711 (2010), pp. 294-300.

- sharp decline in basic childhood immunization in conflict zones (decline of routine immunization level in Syria from 83% in 2010 to 52% in 2012[2]);
- highest rates of maternal deaths due to childbirth complications and other debilitating conditions in conflict-ridden or post-conflict states;
- increased incidents of sexual violence towards women and children, with greater numbers of sexually transmitted diseases, as well physical and psychological trauma;
- increased incidence of infectious diseases (polio, malaria, cholera, measles) during conflict due to malnutrition, unsanitary conditions, lack of clean water, etc.

Not only can these diseases travel across borders, but they can also create such a high number of victims in conflict-affected countries that vulnerability to further political and military instability as well as state failure are increased.

States characterized as **fragile or failed** tend to have far worse population health indicators than states at comparable levels of development.[3] As of today, for example, no low-income fragile or conflict-affected country has yet achieved a single Millennium Development Goal (MDGs).[4] Poor health indicators are a product of inadequate governance and service development. Moreover, fragile states tend to be affected by humanitarian crises that extend for years. In other words, a context of continuing crises and emergencies, combined with weak or non-existent local and national institutions, can undermine health improvements or nullify health investments and programs in the long-term.

While armed conflict and instability undermine health goals, the opposite is also true. Investments in health, conflict resolution and statebuilding can be **mutually reinforcing**. Conflict resolution and peacebuilding measures can help prevent or lessen the impact of the above negative outcomes of armed conflict on public health. At the same time, the position of medical professionals in society, given their neutrality, credibility, and equality, can be a precious resource during negotiations, as are health-related cease-fires. The fact that health issues are of interest to all warring parties can contribute to this advantage.

Moreover, health investment can contribute to the well-being of the state and its population. In the long term, stronger health systems can improve the health of the population, leading to greater productivity, stronger economies, less violence, and state stability. Evidence also indicates that improved health services can increase trust in state institutions, thus contributing to the authority and legitimacy of the government.[5]

In its effort to support the Bill & Melinda Gates Foundation and the Polio Eradication Initiative, IPI follows a proactive approach of strategic analysis, development of operational

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[2] Unicef & World Health Organization, *Middle East Polio Outbreak Response Review*, 2014, p. 6

[3] Rohini Jonnalagadda Haar and Leonard S. Rubenstein, *Health in Postconflict and Fragile States* (US Institute of Peace, January 2012), p. 2.

[4] World Bank, *World Development Report*, 2011, p. 2

[5] Margaret Kruk, Lynn Freedman, Grace Anglin, and Ronald Waldman, "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Postconflict Countries: A Theoretical Framework and Research Agenda," *Social Science Medicine* 70 (2010), pp. 89-97.

recommendations and track II diplomacy to enable implementation. The strategic analysis includes (i) **public opinion surveys** on **health care and security**, (ii) analysis **of militant groups** opposing the vaccination campaign, (iii) **mapping of accessible and inaccessible regions** and (vi) **socio-political research** in order to identify the **key barriers to polio eradication**. IPI has thereafter **developed mitigation strategies** for each of the identified barriers and implementation strategies in each of the affected countries. In parallel IPI gained access to key political and religious decision-makers in order to coordinate and enable **successful vaccination rounds in previously inaccessible areas**.

Case studies of IPI's work in Nigeria and Somalia are attached (see Appendix).Short briefing reports on the barriers to polio eradication in Pakistan and Afghanistan are attached as separate files. Confidential information is also available upon request.

The Nexus Centre for Conflict Resolution will look at how peace can contribute to health, and health to peace.

Humanitarian issues

Natural disasters like droughts, floods, earthquakes, tsunamis, and forest fires can lead to **loss of life, displacement**, and situations in which **diseases (like polio) can spread quickly**. Famine is often the result of complex factors – not only drought. Displacement can also **negatively affect health**: refugees and internally displaced persons suffer from increased mortality, disability and psychological distress. Therefore the links between health and humanitarian issues need to be better understood.

The dimensions, frequency and complexity of natural disasters are increasing. Extreme weather conditions are creating mega-storms that are causing damage on a massive scale. Climate change, as well as environmental degradation and rapid urbanization, make the likelihood of such disasters, and the destructiveness of their impact, even greater. In the 21st century, the world will have to become better prepared to cope with this challenge.

This necessitates innovative steps to enhance the ability of the humanitarian community and governments to use all available means -including military assets- as quickly and efficiently as possible to meet the needs of victims. People who have had their lives turned upside-down by disasters, need basic shelter, water, food, and medicine in order to survive. In the aftermath of large-scale natural disasters, quickly deploying military and civil defence assets (MCDA) in support of humanitarian relief efforts can mean the difference between life and death.

When disaster strikes, there is an explosion of needs, out of proportion with normal capacity, and often under conditions where the national emergency relief services are overwhelmed or massively disrupted – causing chaos, collapse of infrastructure, breakdown of communications, and disruption of public services and security. In major disasters, where the magnitude is enormous and destruction extremely heavy, national capacities are quickly exceeded, while international humanitarian assistance needs time to build up.

Military and civil defence assets, prepared for responding to disasters, can fill the gap quickly. These assets (like i.e. airlift, airdrop, water decontamination, communications, logistics, search and rescue, reconnaissance, land and sea transport) which may not be available in the traditional emergency response system, can make an important difference in the immediate aftermath of a disaster. They can enable traditional humanitarian assistance providers to leverage their resources, and provide a surge of the volume of assistance. Indeed, in the past fifteen years, relief operations have increasingly called on military assets. There has also been an increased use satellites – and other technologies – to improve disaster relief.

The Nexus Centre for Health and Peace will focus on what steps can be taken to improve disaster prevention and relief in order to reduce the health risks to the population at large, particularly the most vulnerable. It will also look at the factors that contribute to famine, as well as the special needs of displaced persons.

Conflict Prevention and Resolution

IPI has been working to prevent and resolve conflicts for more than forty years. It regards conflict resolution as an essential end in itself, and a prerequisite for improving health, development and governance.

The best way of resolving conflicts is to prevent them from erupting in the first place. It is therefore essential to promote a **culture of prevention**, for example by promoting integration in culturally diverse societies, and to promote **inter-religious dialogue**. IPI has considerable experience in these fields.

More must also be done encourage non-military **confidence-building measures** (CBMs), including inter-community contacts, joint projects (for example in relation to health and humanitarian assistance), sporting events, dialogue among peer groups (i.e. women, young people, business leaders), as well as economic and environmental CBMs.

Conflict prevention includes **early warning** and **preventive diplomacy**. Lessons need to be learned from successful preventive tools at international as well as at local levels. Furthermore, mediators should intervene at an early stage in order to prevent disagreements (e.g. in relation to land, language, ethnic issues, water, or governance) from erupting into conflict. There is a wealth of knowledge and expertise within countries that are or have been affected by conflict. However, while local knowledge, research, and analysis exist in conflict-affected regions, they are under-represented in the international policymaking circles. It is time to connect these two levels of analysis and intervention—local and international—and to move local knowledge from the bottom-up.

When conflicts have broken out, **conflict resolution** is essential. Track II diplomacy can play a key role to put new suggestions on the table and to open back channels of communication. IPI has many years of experience in facilitating high-level and discreet meetings on vexed issues, while many of its senior staff have direct **mediation expertise**.

After a conflict situation **reconciliation** is vital. Transitional justice, dealing with the past, and seeking accommodation to move ahead peacefully can all help to build sustainable peace.

The Nexus Centre for Health and Peace will promote conflict prevention and resolution with a particular focus on reducing the impact of conflict on health and development.

Transnational threats

Over the past twenty years, states and international organizations have largely failed to anticipate the evolution of transnational organized crime (TOC) from a localized problem into a strategic threat to governments, societies and economies. The problem manifests itself in a number of ways: trafficking of persons, drugs and weapons, piracy, illegal exploitation of timber and wildlife, cyber-crime, economic crime and money laundering, illegal dumping of hazardous waste, and counterfeiting. As a result of the mismatch between well-funded and adaptive criminal groups on one hand and slow-moving, uncooperative bureaucracies on the other, the detrimental impact of organized crime has grown significantly to the point where **cities, states and even entire regions are under threat**.

Organized crime can have an impact on stability, the rule of law, and development. It can also have an **impact on public health**. This includes death or injury from those caught in the cross fire. **More people die from non-conflict deaths – including criminal violence – than from conflicts.** El Salvador ranks higher than Iraq in terms of violent death rates per 100,000 population, and two dozen countries (mostly in Central America and Africa) rank above Afghanistan.[6] Crime-related violence can also affect mental health, particularly among victims of crime. Furthermore, drug trafficking enables drug use which is a major cause of suffering and death for millions of drug dependent people worldwide.

Organized crime threatens health in other ways. The **unregulated dumping of hazardous waste** causes ecological damage (like poisoned ground water). One of the most callous crimes is the **counterfeiting of medicine**. Many of those in most need of medication – particularly retroviral drugs – are sold fake medicine. This not only make the most vulnerable even sicker or even kills them, it can contribute to the generation of drug-resistant strains of the most deadly pathogens. Organized crime can also lead to **devastation of the environment**, for example through illegal logging or fishing.

Other transnational threats include the ones posed by **biological and toxin weapons, as well as radiological incidents**. Greater attention is needed to ensure that the positive advances of biotechnology can be shared by mankind, while safeguarding against misuse and unintended negative implications. Furthermore, the peaceful uses of nuclear energy should be encouraged while reducing the risk of nuclear accidents and the smuggling of radiological materials.

The Nexus Centre for Health and Peace will look at what steps can be taken to reduce the threat posed to public health and human security by organized crime as well as biological and toxin weapons and radiological incidents.

[6] Global Burden of Armed Violence 2011, p. 53.

Peacebuilding and Statebuilding

In the areas of peacebuilding and statebuilding, IPI has a long-standing reputation for enhancing knowledge and policy development. More recently, IPI has provided direct support to UN officials and Member States on the challenges facing the **UN peacebuilding architecture**. These new institutions are a step forward in coordinating the various actors and activities in peacebuilding, but major gaps, both at strategic level and operational, still persist. These gaps include: 1) insufficient attention to the political dynamics of post-conflict situations; 2) lack of coordination among diverging actors' viewpoints, interests, and objectives that hamper the development and implementation of coherent peacebuilding strategies; and 3) failed support toward reestablishing national capacities for governance and service delivery. All of these gaps point to the fact that each post-conflict situation is unique, defying general theories and blueprints for action.

Through strategic partnerships, IPI has provided policy analysis to enhance understanding of **state fragility** and to support bilateral and multilateral donor efforts to promote **aid effectiveness and sustainable development in conflict-affected and fragile states**. This is a particularly important area to focus global efforts, since, as mentioned above, no low-income fragile or conflict-affected country has yet achieved a single MDG and poverty rates are, on average, more than 20 percent higher in countries where violence is protracted than in other countries.[7] IPI also recently examined how international actors analyze the local context and dynamics in the countries where they work and asked whether and how this analysis feeds into decision-making and strategic planning. This study stressed, in particular, the need to "promote a culture of analysis" and "cultivate multiple sources of information and analysis locally and internationally."[8]

The Nexus Centre for Peace and Health will look at what factors can strengthen resilience in post-conflict settings, and promote new thinking on how to build peace and statehood in countries in transition.

[7] World Bank, *Ibid.*

[8] Jenna Slotin, Vanessa Wyeth, and Paul Romita, *Power, Politics, and Change: How International Actors Assess Local Context* (New York: International Peace Institute, 2010), p.19.

Appendix

Barriers to Polio Eradication in Nigeria

A Situation Assessment

Prepared for The Bill & Melinda Gates Foundation

April 2014

Executive Summary

Existing Barriers and emerging Challenges to Polio Eradication

A) Healthcare Infrastructure

Nigeria's governance structures are highly decentralized making health service delivery a multi layered process with complicated and unclear division of responsibilities. Funding flows are unclear and unpredictable, while accountability is almost non-existent. In northern states people are highly dissatisfied with health care facilities and access to them.

B) Negative public Opinion

Refusal of polio vaccination based on a negative perception of "Western" and "American" aid, particularly vaccinations from Western pharmaceutical companies, as well as the government siphoning funds from foreign organizations. Few people see polio as the biggest health threat and therefore do not understand the overemphasis on polio compared to malaria, typhoid and diarrhea.

C) Unstable political and Security Situation

In northern states, such as Borno and Yobe, the security situation is the primary concern of families and poses a key challenge to vaccination teams. Attacks by Boko Haram on polio workers and vaccination facilities as well as lack of information and feedback about the development of the situation add to the difficulty for polio teams to plan vaccinations. The situation has deteriorated in the first quarter of 2014. Elections in 2015 are expected to slow down polio eradication efforts.

D) Operational Issues

Lack of monitoring and coverage of vaccination campaigns have resulted in the same children and households being consistently missed in immunization rounds. In addition, lack of financial oversight and overabundance of cash has distorted the public health market. Some organizations might purposely fail to monitor their work so eradication campaigns and funding will continue.

Recommendations on overcoming Barriers of Polio Eradication

Based on the initial assessment of the situation, the following mitigation strategies are suggested in order to address the issues associated with polio eradication:

A) Improvement of overall **healthcare infrastructure** and services
   1) Improvement of overall healthcare services: Polio vaccination campaigns should be part of a broader push for better governance and better delivery of health services. This would strengthen the credibility of polio and health workers and potentially reduce "polio fatigue" and vaccine rejections.
   2) Targeted healthcare infrastructure improvements: Development and maintenance work of facilities could be undertaken as well as improvement of medical equipment and supply of medication in affected regions. These measures would improve the health care infrastructure in particularly distrustful communities.

B) Changing **public opinion** and maintaining stakeholder involvement
   3) Assessment of public opinion on community level: Determining the public opinion on community level will be necessary in order to review and reassess current communication strategies and campaigns for different regions.
   4) Participatory polio campaigns: Immunization programs should involve state and local governments, community leaders and traditional rulers such as emirs, political and religious leaders. The merits of polio vaccines should continue to be broadcast through formal and

informal networks, such as community radio television, pamphlets, religious ceremonies and cultural events.

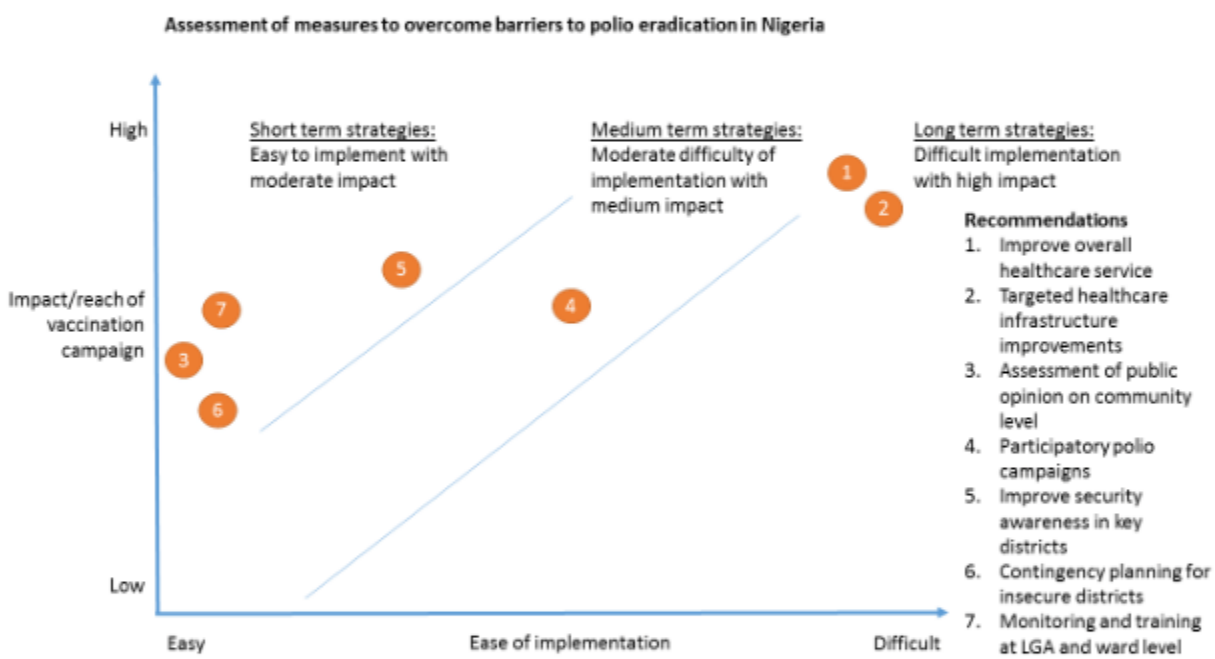
C) Raising awareness of the **security context** & performing scenario analysis

5) Improve security awareness in key districts: Setting up a network to gather information about the security situation on LGA and ward level would help mitigate the risk of attacks on future vaccination campaigns.

6) Contingency planning for insecure districts: GPEI should develop contingency plans for each LGA on how to operate in a crisis environment. In addition, public health professionals need to be educated about political and security issues in the areas in which they work.

D) Mitigating **operational inefficiencies**

7) Monitoring and training for vaccination staff: Staff should be trained in order to perform more robust monitoring at the LGA and ward level to facilitate efficient use of funds and resources.



In the graph above, the various strategies laid out have been clustered according to their likely impact on the polio eradication campaign, as well as on their ease of implementation. Ease of implementation was assessed along three criteria: cost, time and risk. In particular, the issue of risk is pertinent for those interventions seeking to have impact in Boko Haram controlled regions.

Introduction

At the start of the campaign in 1988, there were an estimated 350,000 cases of polio worldwide, with 125 countries classified as polio-endemic. By the start of 2012, only 222 cases were reported worldwide and the number of polio-endemic countries had been reduced to three: Afghanistan, Nigeria and Pakistan. In total, polio has disappeared by 99.9%, but the remaining .1% of eradication has proven to be the most difficult, the most expensive — and the most important.[9]

Nigeria rests on the front lines of the global fight to eradicate poliovirus. In 2013, 53 new cases of polio were detected[10] while the first weeks of 2014 saw dozens of clinics close and hundreds of doctors flee amid continuing attacks by Islamist sect Boko Harm in the country's north.[11] Nigeria remains the only polio-endemic country in Africa, and one of the few countries in the world where children are still at risk of paralysis or death from polio.[12]

These grim realities come despite a coordinated push by the Nigerian Federal Government (FG), state and local governments, and the international community to eradicate polio in northern Nigeria. As one of the last polio-endemic countries in the world, Nigeria represents not only one of the last pieces of the global polio eradication puzzle, but a puzzle in its own right.

Regional insecurity recently lead to a spillover of polio to Cameroon. In March 2014 three new cases of polio have been reported with a total of 7 since 2013, making it the first outbreak since 2009. The World Health Organization stated that the virus is at high risk of crossing borders. The same strain as in Cameroon has just been confirmed in Equatorial Guinea, making it the first case since 1999.[13]

The persistence of polio in Nigeria has global implications. In 2003, for example, several states in northern Nigeria banned federally sponsored polio immunization campaigns amid the "discovery" that the vaccine was contaminated with drugs intended to sterilize young Muslim girls. This decision led to a global outbreak accounting for the spread of polio into 20 countries across Africa, the Middle East, and Asia, causing 80 percent of the worlds' cases of paralytic poliomyelitis. In addition to effectively ending any hopes of eradicating polio by the revised goal of 2010, the vaccine boycott eventually led to an estimated $500 million in costs to control the outbreak.[14]

Within its own borders, polio eradication in Nigeria represents much more than a public health issue. It sits at the center of a complex web of incentives which are shaped by cultural concerns, structural constraints, and political calculations amid an environment of insecurity.

In its own self-assessments, the GPEI Independent Monitoring Board has expressed concern as recently as 2011 that polio will not be "eradicated on the current trajectory" asserting that "important changes in style, commitment and accountability are essential."[15]

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[9] Polio Global Eradication Initiative, http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx
[10] See: Polio Global Eradication Initiative, http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx
It is worth noting that the 53 cases in 2013 are down from 122 in 2012, a 57% drop.
[11] "Violence grinds healthcare to a halt in Nigeria's Borno State," IRIN, 5 February 2014
http://www.irinnews.org/report/99595/violence-grinds-healthcare-to-a-halt-in-nigeria-s-borno-state
[12] "Polio endemic" is the term used to describe a region or country with naturally circulating poliovirus and where polio transmission has never been interrupted. Nigeria is the only polio endemic country in Africa.
[13] "Regional insecurity fuels polio in Cameroon" IRIN, 26 March 2014
http://www.irinnews.org/report.aspx?ReportID=99841
[14] WHO Global Alert and Response, "Poliomyelitis in Nigeria and West Africa," January 6, 2009,
http://www.who.int/csr/don/2009_01_06/en/index.html.
[15] Independent Monitoring Board of the Global Polio Eradication Initiative, "Report, October 2011,"
http://www.polioeradication.org/Portals/0/Document/Aboutus/Governance/IMB/4IMBMeeting/IMBReportOctober2011.pdf.

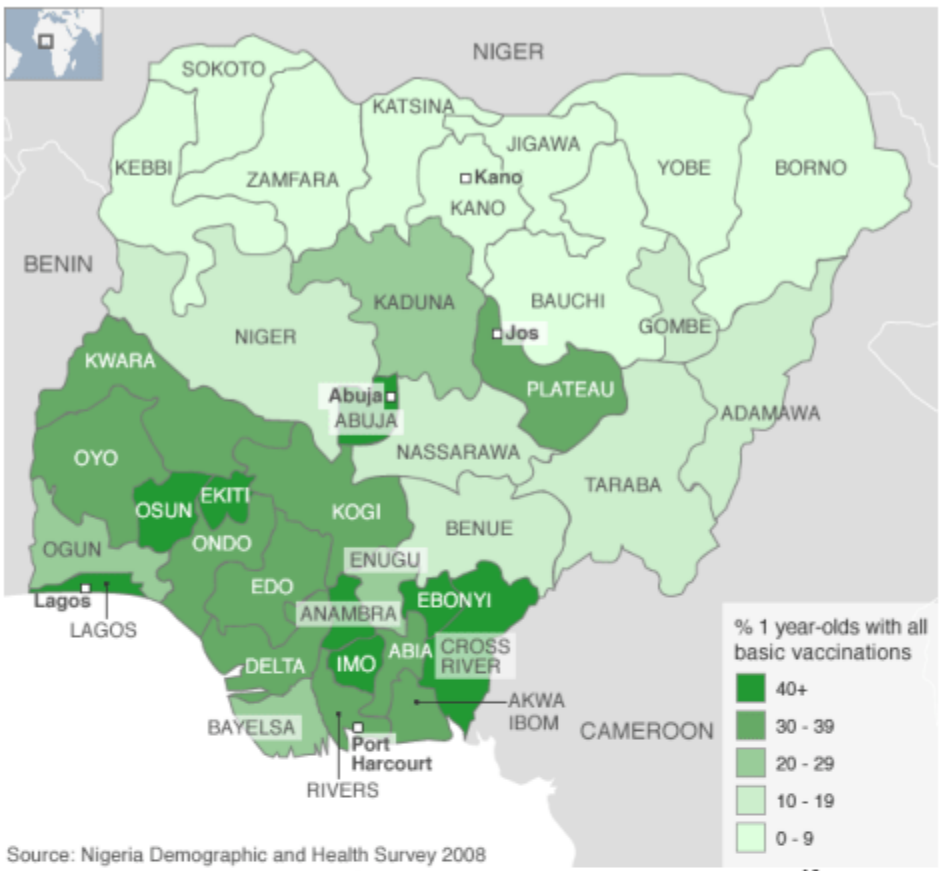


Figure 1: Percent of 1 year-old with all basic vaccinations[16]

These warnings are still applicable today. Divisive national elections that are all but guaranteed to exacerbate existing political, ethnic, and religious tensions at the national and local levels are scheduled for February 2015. Meanwhile, the Federal Government finds itself bogged down in an intractable war against an Islamist insurgency that is escalating by the day, leaving the lives of hundreds of thousand, if not millions of northern Nigerians hanging in the balance.

While elections and ongoing security concerns in the north are sure to divert critical attention and resources away from vaccination efforts, they also increase the risk of further politicizing, or even militarizing the already controversial issue of polio eradication.

The stalemate in the battle against polio in Nigeria also comes at a time when public health experts, as researchers Jennifer G. Cooke and Farha Tahir have noted, "are beginning to express concern about the opportunity costs of continuing a campaign with a price tag of $1 billion annually to eradicate a disease that, however, devastating, is not among the top 20 killers in the developing world."[17]

Put another way, the poliovirus and efforts to eradicate it do not exist in a vacuum. The considerable progress that has been made over the last decade in eradicating polio in Nigeria remains as reversible as ever, due in large part to dynamics such as "polio fatigue," continued gaps and failures in governance, and an increasingly precarious security situation in the country's north.

[16] BBC, "Nigeria's National Conference starts in Abuja", 17 March 2014 http://www.bbc.com/news/world-africa-26613962

[17] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.

Polio eradication is a political issue, and comprehending the socio-political context in which these vaccination campaigns must operate is critical not only to identifying barriers to polio eradication, but to understanding why consolidating gains to date has proved so challenging.

This report investigates the nature of these barriers to polio eradication in northern Nigeria by placing them within their proper socio-political context. It identifies several types of barriers and emerging challenges to polio eradication, and aims to offer a nuanced analysis of the way in which various dynamics work against consolidating the gains of polio eradication in a symbiotic, cyclical and often self-sustaining manner.

Polio eradication efforts have made considerable strides over the last decade in northern Nigeria, and the global public health community has shown an admirable commitment to self-evaluation. The challenge of polio, however, is that unless transmission is interrupted entirely, dramatic reversals remain a strong possibility.[18]

While incorporating the lessons of past shortcomings into future activities is a critical component of effective programming, GPEI efforts could be further enhanced by improving its ability to think "strategically" about polio eradication within Nigeria's shifting socio-political and security contexts. A better understanding of "human terrain" might allow GPEI to anticipate problems before they occur and to better mitigate the negative impact of events that are outside of its control.

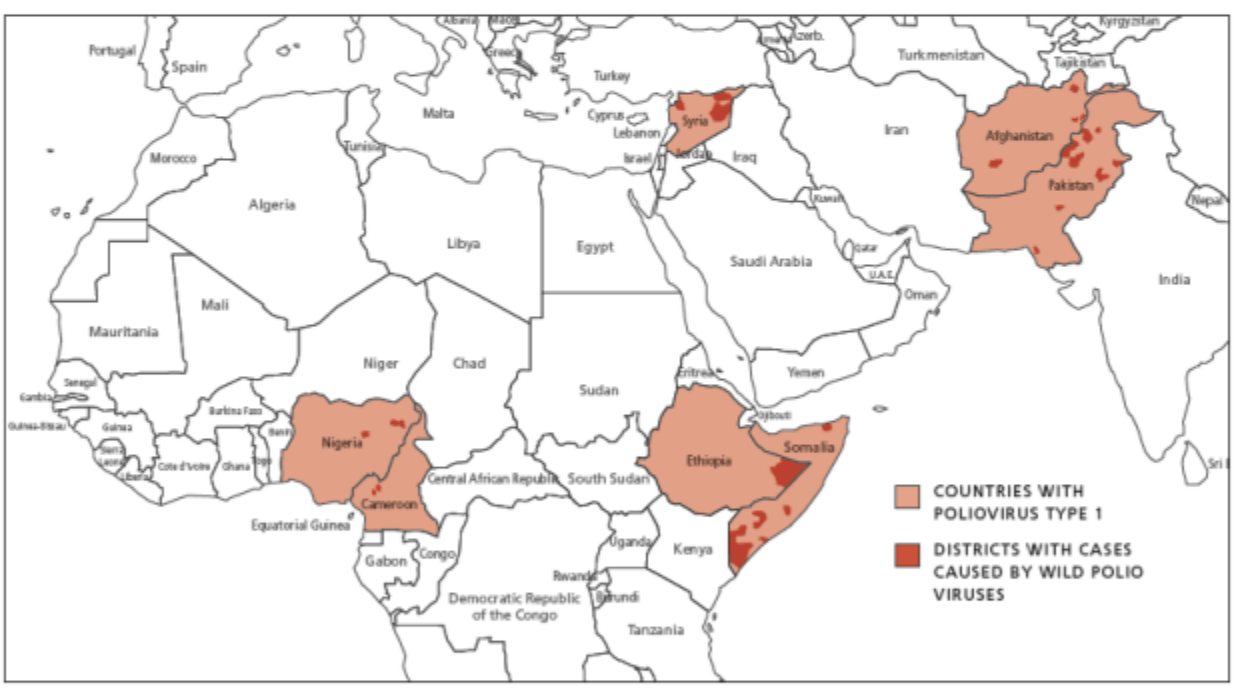


Figure 2: Map of Worldwide Polio Cases (19 August 203-18 February 2014)[19]

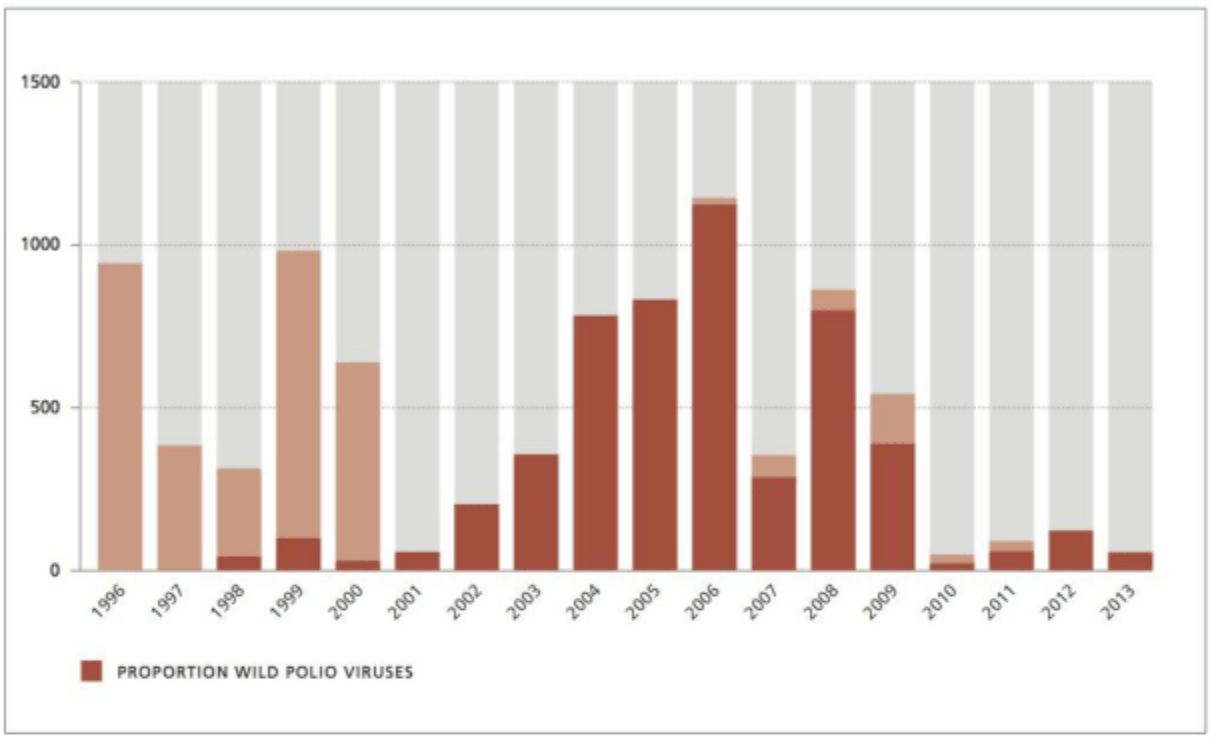
Methodology

In order to gain a more strategic understanding of the barriers to polio vaccination within northern Nigeria's current political and security environment, the authors of this paper conducted a rapid-assessment consisting of a comprehensive review of pertinent works of scholarship, international

[18] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012. Also see: Charles Kenny, "The Eradication Calculation," Foreign Policy, 17 January 2011, http://www.foreignpolicy.com/articles/2012/01/17/the_eradication_calculation

[19] Global Polio Eradication Campaign, with modifications by the author: http://www.polioeradication.org/Dataandmonitoring/Poliothisweek/Polioinfecteddistricts.aspx

and national reports, press articles, and six weeks of field work across 10 states in northern Nigeria.



These states include Borno, Yobe, Bauchi, Jigawa, Kano, Katsina, Kaduna, Zamfara, Sokoto and Kebbi.

The field work for this report was carried out by local journalists and interlocutors who could safely and responsibly navigate the risks involved in arranging and conducting interviews in northern Nigeria given its current security environment. Due to the sensitive nature of the subject at hand, interviewers relied on long, semi-structured interviews in order to approach the subject of polio discretely. This interview format also provided ample space for wider discussions about development, health services, governance and security, all of which are crucial to better understanding the socio-political context in which polio eradication efforts succeed and fail.

Figure 3: Number of Polio Cases in Nigeria, 1996-2013[20]

In an effort to consult a broad and diverse set of perspectives on these issues, over sixty interviews were carried out with men and women from a range of backgrounds. The authors sought opinions from local government officials, doctors, healthcare providers, religious leaders, traditional leaders, school teachers, business people, community organizers and much more. Though the authors are confident that this methodology is the most appropriate for the questions this paper seeks to engage, it is worth emphasizing that this is a qualitative approach and the underlying research that supports the paper's conclusions should be treated as such.

Northern Nigeria in Context

Nigeria is a country of paradox, representing the best and worst of how African states are perceived by the broader international community.[21] It is an economic giant, an intellectual hub, and a regional leader. At close to 175 million people, it is by far the most populous country in Africa. Its large area

[20] Figure 2 sources, WHO and GPEI

[21] Clarence J Bouchat, "The Causes of Instability in Nigeria and Implications for the United States," Strategic Studies Institute, 19 August 2013.

holds productive agricultural land and immense deposits of oil and natural gas.[22] With an urbanization rate of close to 50% and a population whose median age is 17.9 years, Nigeria seems poised for economic prosperity.[23] Already the largest oil producer in Africa, Nigeria's economy has been growing at a rate of 6 to 7 percent per year and is well placed to soon overtake South Africa as Africa's largest economy.[24]

Nigeria also views itself as the natural leader of the African continent, in part due to these demographic and economic realities. It possess one of Africa's strongest and most capable militaries which regularly plays an active role in peace operations abroad. At the international level, Nigeria has been recognized for its leadership in major organizations such as the Organization of the Islamic Conference (OIC), the Organization of Petroleum Exporting Countries (OPEC), the African Union (AU) and the Economic Community for West African States.[25]

All of these accomplishments come despite endemic corruption, grinding poverty, and sectarian violence that has plagued Nigeria for decades.[26] In fact, the roots of Nigeria's dysfunction, and the fault lines along which Nigeria may be torn apart can be traced to the very process of its formation.[27] As McLoughlin and Bouchat explain:

> Like most post-colonial African states, Nigeria is both a mosaic of tribes, related or allied ethnic or ideological groups, and nations now linked economically and politically under a common government in a colonially imposed territorial unit. The British colonial government created a unified Nigeria in 1914 to demarcate its area of control from those of its European competitors and because its northern protectorate was too poorly resourced to stand on its own. It was therefore created as a state by externally imposted fiat, not for any internal, organic reason. Before the British arrived, there was no shared national consciousness, culture, or language in Nigeria, nor was there any sentiment to coalesce its peoples into a coherent nation under colonial rule.[28]

History

53 years into independence, it is no small wonder that Nigeria remains a single state. While the Biafran war of the late 1960s is the most high-profile manifestation of regionalist and sectarian impulses in post-colonial Nigeria, it is by no means the only one. Even today, the Federal Government continues to face challenges to its authority from a number of armed groups based on regional, ethnic, ideological and religious identity. These movements include the Movement for the Actualization of the Sovereign State of Biafra (MASSOB) in the south-east, the Movement for the Survival of the Ogoni People (MOSOP) and the Movement for the Emancipation of the Niger Delta (MEND) in the south, and an Islamist insurgency in the north all of which are fighting in different ways to wrest control of territory away from the central government in Abuja.[29]

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[22] Central Intelligence Agency (CIA), The 2012 World Factbook, 2012, Nigeria. https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html
[23] Central Intelligence Agency (CIA), The 2012 World Factbook, 2012, Nigeria. https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html
[24] Todd J. Moss, "BRICN? When Will Nigeria Pass South Africa?" Center for Global Development: Views from the Center, 8 August 2013. http://www.cgdev.org/blog/bricn-when-will-nigeria-pass-south-africa
[25] Clarence J Bouchat, "The Causes of Instability in Nigeria and Implications for the United States," Strategic Studies Institute, 19 August 2013.
[26] See: Clarence J Bouchat, "The Causes of Instability in Nigeria and Implications for the United States," Strategic Studies Institute, 19 August 2013.
[27] Gerald McLoughlin and Clarence J. Bouchat, "Nigerian Unity In The Balance," Strategic Studies Institute, June 2013.
[28] Gerald McLoughlin and Clarence J. Bouchat, "Nigerian Unity In The Balance," Strategic Studies Institute, June 2013.
[29] Jonathan N.C. Hill, "Sufism In Northern Nigeria: Force For Counter-Radicalization?" Strategic Studies Institute, May 2010.

Many of the difficulties confronting Nigeria are at least partly of its own making.[30] Governing such a divided state was never going to be an easy undertaking. The roster of military juntas that ran the country into the ground only gave way to democracy in 1999, but Nigeria's current government has done little to inspire confidence.[31] Decades of corruption, abuse, and inept government have alienated large portions of the Nigerian population and left a chasm between the government and the governed.[32]

Government & Administration

Nigeria's government is designed as a Federal Republic. Executive power resides with the President who is the head of state and head of government. Legislative power is divided among two chambers, a democratically elected House of Representatives and the Senate, which together form the law-making body known as the National Assembly. The Supreme Court of Nigeria acts as the country's highest judiciary.[33]

Administratively, Nigeria is divided into 36 states that elect a governor and 1 territory (the capital, Abuja). Each state is further divided into 774 Local Government Areas known as LGAs. In turn, each LGA is divided into wards.

Religion

Islam was first introduced to northern Nigeria in the 11th century, becoming well established in the major urban centers across the north and gradually spreading south into what today is referred to as the "middle belt" of Nigeria by the 16th century.[34] Today, about half of Nigeria's population is Muslim, the majority of whom live in northern Nigeria. 12 states in northern Nigeria have had sharia law codified within their legal code since 2000. Though the vast majority are Sunni Muslim, there is a significant Shia minority, and a wide array of brotherhoods and sects who preach various violent and non-violent forms of fundamentalist, conservative and moderate Islam.

Northern Nigeria has a long tradition as a center of Islamist thought, including fundamentalist strands of Islam- One of the first and most famous instances of armed Islamist uprisings against the state came in the early 19th century when religious scholar Usman Dan Fodio led a group of Muslims from the Fulani tribe to revolt against the dominant Hausa sultanates and the sultanate of Borno.[35]

At the heart of Dan Fodio's political and social revolution stood the belief that the rulers of northern Nigeria were corrupt and were not true adherents to sharia because they allowed the practice of Islam to be mixed with traditional beliefs. After leading his followers into exile, Dan Fodio called for jihad and returned to launch a successful attack that would go on to establish the Sokoto Caliphate, stretching across northern Nigeria and its environs. The Caliphate represented an Islamic banner of resistance to colonial conquest, and a rejection of secular government.[36] To this day, the Sultan of Sokoto remains one of the most important and influential religious leaders in northern Nigeria.

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[30] Jonathan N.C. Hill, "Sufism In Northern Nigeria: Force For Counter-Radicalization?" Strategic Studies Institute, May 2010.
[31] Carlo Davis, "Boko Haram: Africa's homegrown Terror Network," World Policy Journal 12 June 2012.
[32] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[33] "Nigeria," CIA World Factbook, 28 January 2014. https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html
[34] Emilie Oftedal, "Boko Haram: An Overview," Norwegian Defense Research Establishment (FFI) 31 May 2013.
[35] Emilie Oftedal, "Boko Haram: An Overview," Norwegian Defense Research Establishment (FFI) 31 May 2013.
[36] Abimbola Adesoji, "The Boko Haram Uprising and Islamic Revivalism in Nigeria," Africa Spectrum 45, no. 2 (2010)

Colonialism

In the early 1900s, the British Empire extended its colonial control northward from the Nigerian coast, eventually gaining control of the Sokoto Caliphate. Initially, the British decided to maintain northern and southern Nigeria as two separate protectorates due to their cultural differences. Economic calculations persuaded the British to merge the two in 1914.

But even after unifying northern and southern Nigeria, Britain pursued a colonial system of indirect rule in the north, choosing to govern the area through hand-picked indigenous rulers. This policy institutionalized existing north-south divisions, the effects of which are prevalent to this day.

Present Situation

Nigeria's economic decline since independence has hit the north particularly hard. Per capita public expenditure on health in the north was less than half that in the country's south as recently as 2003.[37] Development indicators remain lower than in the south where there is far more public and private investment, infrastructure and health services.

Nigeria's transition to democracy in 1999 saw the election of Olusegun Obasanjo, making him the first Christian and southerner to lead the federal government since his own tenure as a military ruler from 1976 to 1979. This shift in political power from northern political elites to southern political elites, combined with widening economic disparities between north and south, fueled a sense of political marginalization throughout much of northern Nigeria.[38]

With little faith left in government and politicians, hundreds of thousands, perhaps millions, of Nigerians have found themselves drawn to individuals and groups who advocate a radical alternative to the status quo, often expressed in religious or moral terms. Within Christian communities, which are predominantly but not exclusively based in southern Nigeria and constitute roughly 40% of the population, disillusionment with government has tracked with the rise of evangelical Christian movements advocating faith as an alternative means to health and economic prosperity. Among Nigerian Muslims, who make up approximately 50% of the population, there has been a surge in support for sharia law as an alternative to a corrupt and ineffectual secular judiciary.[39]

Researcher Peter Chalk identifies three main streams of Islamic thought in contemporary Nigeria: conservatism, modernism and fundamentalism. Fundamentalism in the Nigerian context, according to Chalk, focuses on "anti-system movements that articulate vehement opposition to the existing political (secular) status quo, the federal government, established (and perceived ineffectual) religious elites, modern-oriented Muslim identity, and foreign -- mainly Western -- influences."[40] In other words, the fundamentalist strand of Islamist thinking in the north of the country says that the continued failures of the Nigerian government are evidence of inherent flaws with secular government. In recent years, a group called Boko Haram has emerged as the most salient and destructive manifestation of this philosophy.

Boko Haram

Boko Haram is an Islamist sect in northern Nigeria. Initially established as a religious movement in the late 1990s or early 2000s that sought to purify northern Nigeria from the corrupting influences of

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[37] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[38] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[39] Jonathan N.C. Hill, "Sufism In Northern Nigeria: Force For Counter-Radicalization?" Strategic Studies Institute, May 2010.
[40] Peter Chalk, "Islam in West Africa: The Case of Nigeria," in The Muslim World after 9/11, ed. Angel M. Rabasa et al. (Santa Monica, CA: RAND, 2004).

Western culture, Boko Haram has since transformed into an armed insurgency determined to transform Nigeria into an Islamic state.

Though the group had been carrying out violent attacks for the better part of a decade, Boko Haram burst onto the international scene in 2010 and 2011 when it carried out a string of deadly attacks against the Nigerian government and detonated a car bomb after crashing into a United Nations building in Abuja, killing 23 people in the process.

Nigerian President Goodluck Jonathan has sought to crush Boko Haram through the enlistment of civilian vigilante groups and the deployment of some 8,000 soldiers supported by fighter jets and helicopter gunships to northern Nigeria. Due to a virtual media blackout northeast Nigeria, where a state of emergency has been in place since May 2013, very little information can be independently verified. Consequently, it is difficult to assess the effectiveness of the Nigerians government's heavy-handed tactics, and the effects of fighting between the government and Boko Haram on the civilian population.

As a result of the upsurge in violence, Nigerian citizens are openly wondering if their country is on the brink of a civil war. Amid checkpoints and constant security warnings, an air of apprehension pervades daily life throughout much of northern Nigeria, with social and economic activities in some northern states grinding to a halt and and bringing previously peaceful communities to the verge of fracture.[41]

The relative strength of Boko Haram is unclear. While Boko Haram appears to be growing more lethal -- the group is thought to have killed thousands since 2009 and carried out several audacious large scale attacks on heavily fortified military targets in the last few months -- precious little is known about its leadership, organizational structure, funding streams, and membership. At any given time, a patchwork of armed groups or individuals in northern Nigeria may be carrying out attacks under the banner of Boko Haram.

Even its name, "Boko Haram" -- a phrase borrowed from the Hausa language native to northern Nigeria -- is an unofficial moniker ascribed from the outside that the group's core members do not use, preferring its official Arabic name of "Jamā'a Ahl al-sunnah li-da'wa wa al-jihād" instead.

Despite its Hausa name, the majority of its initial membership is believed to be ethnic Kanuri, from northeastern Nigeria. But over the course of the last decade, the group has metastasized, spreading throughout northern Nigeria and inserting itself within longstanding conflicts in the "middle-belt."

Boko Haram has deployed suicide bombs and coordinated assaults aimed at an array of targets, including markets, schools, hospitals, clinics, banks, churches, mosques, police stations and military installations. And while the scope and intensity of Boko Haram's terror campaign is breathtaking, the movement is not without its antecedents.

The previously discussed Sokoto Caliphate was an armed movement against what was perceived at the time to be the illegitimate rule of powerful elites who were misappropriating Islam. In fact, Dan Fodio's legacy of a purifying withdrawal from society in order to wage a righteous jihad against corrupting influences is seen by many northern Nigerian Muslims, including Boko Haram, as a template for a more just, prosperous and equitable northern Nigeria.[42]

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[41] Michael Olufemi Sodipo, "Mitigating Radicalism in Northern Nigeria, African Center for Strategic Studies, No. 26, August 2013.

[42] David Cook, "The Rise of Boko Haram in Nigeria", CTC Sentinel 4, no. 9 (2011).

More recently, there was the Maitatsine movement, which was led by a Cameroonian preacher named Mohammed Marwa who took up the teachings of Dan Fodio after arriving in the northern Nigerian city of Kano in 1945. Marwa's preaching, predicated on the belief that he himself was a prophet, earned him the name Maitatsine, which translates from Hausa to mean "he who curses" or "the one who damns." Much like Dan Fodio, Marwa's movement stood against Nigeria's corrupt secular government and its allies within the "moderate" religious establishment. Marwa was eventually forced into exile by the British colonial government, but returned to Kano shortly after independence.

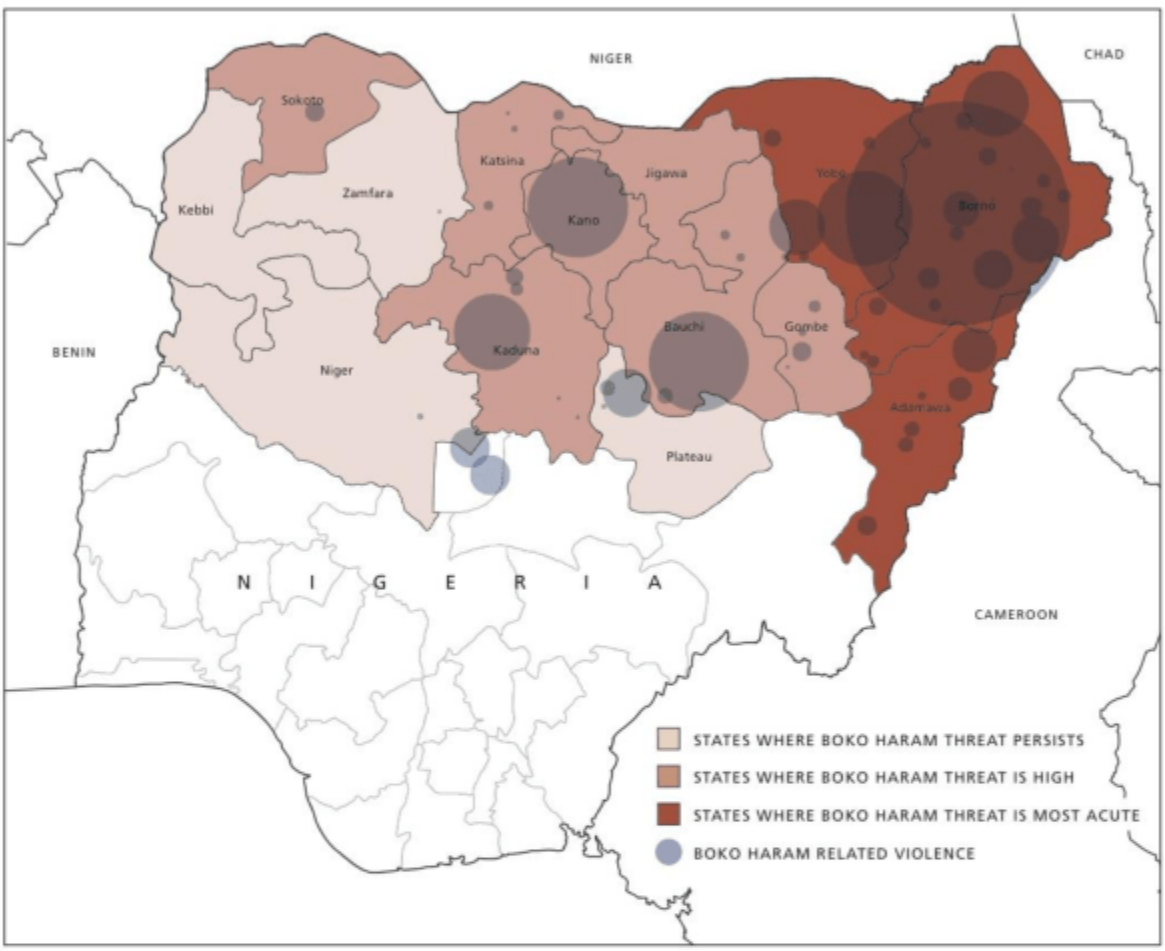
The Maitatsine message resonated with the young, poor and unemployed in the slums of Kano. Throughout the 1970s, the Maitatsine movement gradually turned violent, leading to clashes with police. Marwa was killed in 1980 during a confrontation with police, but even after his death, riots spread throughout northern Nigeria, claiming the lives of between 4,000 and 5,000 people.[43] The movement never quite recovered, but isolated pockets of extremism remained, and Maitatsine teachings are thought to be a source of ideological inspiration for Boko Haram.[44]

The Maitatsine movement introduced many of the tactics that would become common in northern Nigeria's current wave of Islamic radicalization (both violent and non-violent), particularly the mobilization of poor communities against established, urban Muslim elites perceived to be colluding with a corrupt, secular government.[45]

[43] Abimbola Adesoji, "The Boko Haram Uprising and Islamic Revivalism in Nigeria," Africa Spectrum 45, no. 2 (2010)
[44] Abimbola Adesoji, "The Boko Haram Uprising and Islamic Revivalism in Nigeria," Africa Spectrum 45, no. 2 (2010)
[45] Abimbola Adesoji, "The Boko Haram Uprising and Islamic Revivalism in Nigeria," Africa Spectrum 45, no. 2 (2010)

The Nigerian government successfully crushed the Maitatsine movement with brute force.[46] The success of these heavy handed tactics may have given the Nigerian government a false sense that Boko Haram was merely the latest manifestation of a violent Islamist undercurrent that could be stemmed through similar means.

Figure 4: Areas where access is limited due to security concerns[47]



But all accounts, attempts to crush Boko Haram through military might have proved unsuccessful, even counterproductive. Nigerian security forces cracked down on Boko Haram during mass uprisings in 2003-2004 and thought the problem had been dealt with, only to see Boko Haram re-emerge.[48] A 2009 attempt to deliver a decisive blow to Boko Haram in their stronghold of Maiduguri led to the death of at least 700 people. Boko Haram's then leader, Mohammed Yusuf, was captured by police and summarily executed.[49] After that episode, Boko Haram faded from public view for close to a year, only to come back more determined and lethal than before.[50]

[46] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[47] Figure 3 source, Council on Foreign Relations, with modifications by the author
http://www.cfr.org/nigeria/nigeria-security-tracker/p2948
[48] Alex Thurston, "Nigeria: An Ephemeral Peace," The Revealer, 22 June 2013.
[49] Rom Bhandari, "Boko Haram Infiltrates Government," Think Africa Press, 10 January 2012.
[50] Alex Thurston, "Nigeria: An Ephemeral Peace," The Revealer, 22 June 2013.

As part of its operations against Boko Haram since 2009, the Nigerian government has allegedly killed hundreds of suspected militants and sympathizers, and have stood accused of extrajudicial killings as well as using Boko Haram as a cover for attacks on political rivals or as pretext for score-settling.[51]

During raids on suspected Boko Haram strongholds, the military has burned homes and summarily executed suspected Boko Haram members in front of their families. Nigerian authorities have cast a wide dragnet, arresting thousands of people across northern Nigeria, holding many of these prisoners incommunicado without charge or trial for months or even years. In some cases, prisoners have been detained in inhuman conditions, tortured or even killed.[52] Amnesty International reported receiving credible evidence that over 950 people have died in military custody in the first six months of 2013 alone.[53] The ongoing violence and abuse by government forces may even be driving new recruits into Boko Haram's arms.[54]

In the wake of an escalation of violence, Boko Haram and its followers are all the more driven by a desire for vengeance against politicians, police, and Islamic authorities aligned with the state. Furthermore, Boko Haram has proved itself to be very adaptable, evolving its tactics swiftly and changing its targets at the behest of a charismatic, if opaque leadership.[55]

Part of what makes understanding and defining Boko Haram so difficult is the fact that it may very well be several different things at once. As former US ambassador to Nigeria John Campbell told reporter Andrew Walker, Boko Haram is certainly a grassroots movement that taps into anger over poor governance and a lack of development in northern Nigeria, but it is also a core of Mohammed Yusuf's followers who have reconvened around Abubakar Shekau to exact revenge on the Nigerian state. At the same time, it can be viewed as a kind of personality cult, an Islamic millenarianist sect inspired by a charismatic preacher.[56]

Boko Haram's increased deadliness and the sophistication of its attacks are widely cited as evidence that they are collaborating with foreign groups. Its violent campaign has expanded in scope and capability, and its membership is believed to have diversified, with anecdotal evidence suggesting that foreign fighters from Chad, Mauritania, Niger, Somalia and Sudan may be in Boko Haram's ranks.[57]

In recent years, northern Nigeria has also seen the formation of splinter groups emerging from Boko Haram, the most prominent being a group commonly referred to as Ansaru, though its full Arabic name Juma'atu Ansarul Muslimina Fi Biladis Sudan, translates to "Vanguards for the Protection of Muslims in Black Africa."[58]

Formed in January 2012, Ansaru explicitly targets Westerners in Nigeria and neighboring countries. Some analysts cite this goal as possible evidence that the once parochial ambitions of Boko Haram, or factions within Boko Haram, may now be international. In fact, since 2011, there have been

[51] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[52] Human Rights Watch, "Nigeria: Massive Destruction, Deaths From Military Raid," 1 May 2013.
[53] Amnesty International, "Nigeria: Deaths of hundreds of Boko Haram supsects in custody requires investigation," 15 October 2013.
[54] Alex Thurston, "Nigeria: An Ephemeral Peace," The Revealer, 22 June 2013.
[55] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[56] See John Campbell's quotes in Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[57] Abimbola Adesoji, "The Boko Haram Uprising and Islamic Revivalism in Nigeria," Africa Spectrum 45, no. 2 (2010)
[58] Abimbola Adesoji, "The Boko Haram Uprising and Islamic Revivalism in Nigeria," Africa Spectrum 45, no. 2 (2010)

increasing signs of international collaboration between Boko Haram and militants from Niger, Mali, the broader Sahel, Somalia and other countries throughout the Muslim world.[59]

In tandem with its deployment of security forces to crush Boko Haram, the Nigerian government has simultaneously attempted to negotiate with the group.

In 2011, democracy activist Shehu Sani attempted to broker exploratory talks between the former president Olusegun Obasanjo and Mohammed Yusuf's brother-in-law, Babakura Fugu. Soon after the meeting, gunmen stormed into Fugu's house and shot him dead. Boko Haram denied the killing and the assassins have not been identified.[60]

In January 2012, a group claiming to be a moderate breakaway faction of Boko Haram sent a tape to the National Television Authority saying it was ready to negotiate. Four days later a dozen people were publicly beheaded in Maiduguri by people claiming to be Boko Haram.[61]

Despite these setbacks, the administration of President Goodluck Jonathan has shown intermittent interest in the idea of dialogue with Boko Haram. The formation of the Committee on Dialogue and Peaceful Resolution of Security Challenges in the North of Nigeria, formed on April 24, 2013 is probably the most ambitious overture to date.[62] But there are several practical and political barriers to productive negotiations taking place.

To start with some of Boko Haram's stated demands are practically impossible to realize, and often contradictory.[63] The demand that Nigeria implement Islamic law nationwide, for example, is a non-starter. Second, finding credible representatives of Boko Haram who are serious about negotiations may not be possible, and even if it were, it is unclear that these representatives or interlocutors would be able to control other wings or factions within Boko Haram.[64]

There are some demands from Boko Haram which might be up for discussion, such as the release of senior members who are in captivity, the return of property taken from its members, and bring the people responsible for the extra-judicial execution of Mohammed Yusuf to justice.[65] But it is unclear what exactly Boko Haram has to offer the government short of dropping its core demands in the first place.

Second, offers of amnesty and calls for negotiations with Boko Haram may be politically unpopular with Christians and the vast majority of Muslims in Nigeria who oppose the group. The fact that previous ceasefires and attempts at negotiations have collapsed, and that communities affected by the crisis are growing impatient, may strengthen the hand of those who prefer a military solution to the crisis. As researcher Alex Thurston writes, "the limitations of military approaches may soon lead Nigeria back to the hope of dialogue, and the difficult question of how to break the cycle of ineffective crackdowns and inconclusive negotiations."[66]

The Polio Epidemic in Context

Despite an array of political and economic challenges, Nigeria had made significant strides in eradicating polio from 1996 to 2001, with a dramatic expansion of coverage via National and Subnational Immunization days. In the wake of a significant drop in reported cases, there was

[59] Jacob Zenn, "Boko Haram's International Connections," CTC Monitor, 14 January 2013.
[60] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[61] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[62] Alex Thurston, "An Ephemeral Peace," The Revealer, 22 June 2013.
[63] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[64] Alex Thurston, "Nigeria: An Ephemeral Peace," The Revealer, 22 June 2013.
[65] Andrew Walker, "Special Report: What is Boko Haram?" United States Institute of Peace, June 2012.
[66] Alex Thurston, "Nigeria: An Ephemeral Peace," The Revealer, 22 June 2013.

increasing optimism that the 2005 global eradication target might be met.[67] Hopes of meeting that target, however, were subsequently dashed with the onset of a vaccination boycott throughout much of Nigeria.

The 2003 Boycott

In 2003, the political and religious leadership of Kano, Zamfara and Kaduna states in northern Nigeria brought the immunization campaign to a halt, urging parents not to immunize their children. Among the initial reasons listed for the boycott were allegations that the vaccine had been contaminated with anti-fertility agents, HIV, and could cause cancer.[68]

Local media at the time reported that the formal boycott began at a July 2003 meeting of an influential network of Muslim organizations called Jama'atul Nasril Islam (JNI), in which one of the Emirs in northern Nigeria "presented a memo on the concerns and apprehensions of his people on the allegations that the polio vaccination campaign was being used for the purposes of depopulating developing countries and especially Muslim countries."[69]

At the forefront of the boycott was Datti Ahmed, a physician based in Kano who heads a prominent Muslim group called the Supreme Council for Sharia in Nigeria (SCSN). At the time of the boycott, Ahmed was quoted in a South African news outlet asserting that vaccines were "corrupted and tainted by evildoers from America and their Western allies."[70] Dr. Ahmed, who had only a year earlier called for a boycott of the Miss World pageant in Abuja on religious grounds, voiced his opposition to the polio vaccination in stark terms. "We believe that modern-day Hitlers have deliberately adulterated the oral polio vaccines with anti-fertility drugs and contaminated it with certain viruses which are known to cause HIV and AIDS."[71]

The ban quickly divided Muslim leaders, many of whom were embarrassed by the political undertone of the boycott.[72] Prominent Islamic scholar Sheikh Yusuf Qaradawi was quoted as saying, "I was completely astonished about the attitude of our fellow scholars of Kano towards polio vaccine. I disapprove of their opinion, for the lawfulness of such vaccine in the point of view of Islam is as clear as sunlight." Citing the fact that the vaccine was administered in over 50 Muslim countries, Sheikh Qaradawi accused the SCSN of creating a negative images of Islam which "make it appear as if it contradicts science and medical practice."[73]

Despite widespread criticism of the ban, many local political, community and religious leaders began fueling rumors that the vaccines were unsafe, encouraging their followers and constituents to boycott. Kano's then-governor Ibrahim Sekarau suspended the administration of the vaccine, and state governments in Bauchi, Kaduna and Zamfara soon followed.

This was not the first time that rumors about safety have plagued immunization campaigns, nor is skepticism about them confined to non-western countries. But the initial assumption that these

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[67] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[68] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[69] "Nigeria Polio Vaccine: Controversy Over or Renewed?" Weekly Trust, 6 March 2004. http://allafrica.com/stories/200403080451.html
[70] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[71] Laurie Garret and Scott Rosenstein, "Polio's Return," The American Interest, 1 March 2006. http://www.the-american-interest.com/articles/2006/03/01/polios-return/#footer
[72] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[73] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/

baseless rumors would be short-lived demonstrated a fundamental lack of understanding of the context within which these vaccination campaigns were taking place.

The Nigerian director of the United Nations Children's Fund (UNICEF) told researchers Judith R. Kaufmann and Harley Feldbaum, "Our own Western-oriented...background tells us if vaccine is found to be good, then it's scientifically good, that's it. ...Instead, the population who rejected it was thinking in other terms, and we didn't realize the power of that and how disruptive that could have been. ...We didn't see it coming, and unfortunately that is quite normal."[74]

It soon became abundantly clear that the polio vaccination boycott was due to a combination of political, ethnic, and religious tensions brought to the fore by the April 2003 re-election of President Olusegun Obasanjo.

A born-again Baptists Christian from southern Nigeria, Obasanjo's election to a second term over retired General Muhammadu Buhari, a Muslim from northern Nigeria, exacerbated existing tensions over regional disparities over government services, including health services.[75]

Upon losing the election, General Buhari's All Nigeria People's Party (ANPP) challenged the victory of President Obasanjo's People's Democratic Party (PDP) in Nigeria's Supreme Court. Kano, for example, was a state under the control of the ANPP challenged the polio vaccination exercise organized by the PDP-controlled federal government.[76] Some observers suspected that northern political leaders calling for the boycott did so less out of concerns for community safety, and more as a means of the federal "southern" government.[77]

It is also important to take into account the fact that comparative rates of using health services in southern Nigeria versus northern Nigeria differ dramatically. In 1990, the comparative rates between north and south were 50% versus 18%. In 1999, the disparity had grown to 60% versus 11%. By 2003, at the time of the boycott, the gap had widened to 64% versus 8%.[78]

Nigeria's health system decentralizes administrative control over primary and secondary health to states, while the federal government maintains control of care at the tertiary level. As a result, states like Kano, Zamfara, Bauchi and Kaduna were able to halt immunization exercises planned by the federal government.[79]

As reports of the vaccine boycott spread, parents began actively refusing vaccination when health workers came to their homes, some going so far as to mark the doors of their homes to falsely signal that a health worker had already visited, and putting nail polish on their children's fingers to mimic the ink that signifies that a child has been vaccinated.[80]

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[74] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[75] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[76] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[77] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[78] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[79] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[80] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.

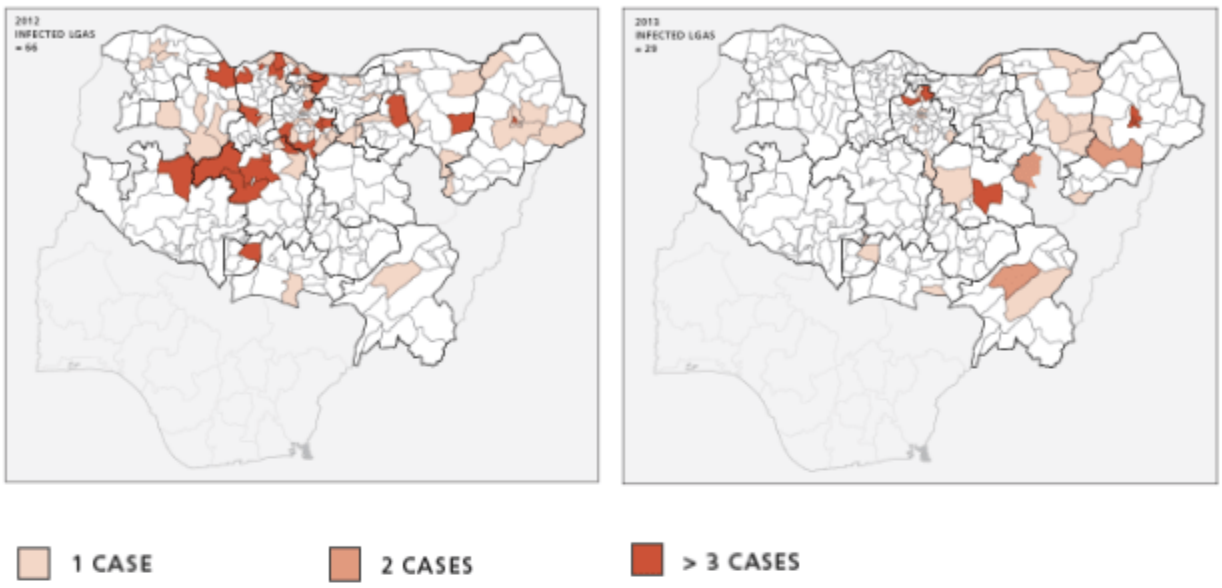

Figure 5: Restriction of wild polio virus spread in 2013, compared to 2012[81]

There is also an important historical and social context in which the boycott should be viewed.

In 2000, Alhaji Najib Hussain Adamu, the Emir of Kazuare in Jigawa state in northern Nigeria and one of the first leaders to spearhead the anti-vaccination campaign in northern Nigeria, began taking notice of confusion within his community stemming from the arrival of outsiders coming to houses to vaccinate children with drops of oral polio vaccine. Relatively few people were afflicted with polio, whereas other health concerns, namely malaria, were widespread in their communities.[82]

It is not hard to imagine that an aggressive, mass immunization program based on door-to-door visits by strangers might illicit suspicion, especially in a context in which access to basic healthcare is not easily available.[83] As John Murphy of the Baltimore Sun wrote at the time:

> The aggressive door-to-door mass immunizations that have slashed polio infections around the world also raise suspicions. From a Nigerian's perspective, to be offered free medicine is about as unusual as a stranger's going door to door in America and handing over $100 bills. It does not make any sense in a country where people struggle to obtain the most basic medicines and treatment at local clinics"[84]

A lawyer by training, Emir Adamu began to do research on the vaccine on the internet, where he found a variety of sources and documents offering "evidence" of an ulterior motive behind polio vaccine campaigns. One such claim suggested that that the oral vaccine, which was created using monkey cells, was contaminated with a host of monkey viruses, including a close relative to HIV, thus supporting the theory that the polio vaccine spawned the modern AIDS pandemic.[85]

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[81] GPEI, http://www.polioeradication.org/Portals/0/Document/InfectedCountries/Nigeria/Nigeria_NationalPolioEradicationEmergencyPlan_2014.pdf

[82] Laurie Garret and Scott Rosenstein, "Polio's Return," The American Interest, 1 March 2006. http://www.the-american-interest.com/articles/2006/03/01/polios-return/#footer

[83] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/

[84] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/

[85] Laurie Garret and Scott Rosenstein, "Polio's Return," The American Interest, 1 March 2006. http://www.the-american-interest.com/articles/2006/03/01/polios-return/#footer

Another document which caught the Emir's attention, which is not related to vaccination campaigns or HIV/AIDS, was the National Security Study Memorandum 200, authored in 1974 by then U.S. Secretary of State and National Security Advisor Henry Kissinger. The obscure memorandum suggests that rapid population increases in the developing world can generate threats to national security through regional destabilization and resource scarcity. The memo, which suggests that the U.S. promote family planning in certain countries, including Nigeria, has since gained notoriety in certain circles in Nigeria and is cited as evidence of a stealth policy by the U.S. to reduce Nigeria's population.[86]

Distrust of Western health interventions in northern Nigeria, however, predate the "investigative" work of Emir Adamu and Dr. Datti Ahmed. In 1996, the American pharmaceutical giant Pfizer began testing its drug Trovan on children in Kano during a bacterial meningitis outbreak in northern Nigeria. Years later, a suit filed on behalf of those children at the Federal District Court in Manhattan alleged that parents were not informed that the drug was experimental, nor that they could refuse the drug if they chose, or that another organization was offering an internationally approved treatment for free at the same site.[87]

The same suit also accused Pfizer of administering low dosages of the meningitis treatment ceftriaxone to improve the relative effectiveness of Trovan, and that these low doses of ceftriaxone were responsible for injuries and death, while Trovan was responsible for cases of brain damage, loss of motor skills and death of several of the participants of the study.[88]
Current polio eradication efforts should be sensitive to the legacy of distrust that many Nigerians have because of the Memorandum 200 affaire. When they cite Memorandum 200, even if they are misinterpreting its meaning, that document, which says that curbing Nigeria's population growth is in the U.S. national interest, actually exists. To dismiss the concerns of those who cite these examples outright is to fundamentally ignore the context within which vaccination campaigns in northern Nigeria must take place. It also fails to empathize with the northern Nigerian parent who, in the face of conflicting information from a range of sources, just wants to do what is best for his children and may err on the side of not letting a foreigner or outsider vaccinate them.

In response to the public outcry about the polio vaccine, the Nigerian federal government set up a technical committee to assess the safety of the polio vaccine. A key component of the committee's work was to send samples of the vaccine for laboratory tests abroad to prove its safety. The results were rejected by the SCSN, however, on the grounds that the Muslim community was not adequately represented on the committee.[89]

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[86] For more on this subject, see: Laurie Garret and Scott Rosenstein, "Polio's Return," The American Interest, 1 March 2006. http://www.the-american-interest.com/articles/2006/03/01/polios-return/#footer

[87] Laurie Garret and Scott Rosenstein, "Polio's Return," The American Interest, 1 March 2006. http://www.the-american-interest.com/articles/2006/03/01/polios-return/#footer

[88] Laurie Garret and Scott Rosenstein, "Polio's Return," The American Interest, 1 March 2006. http://www.the-american-interest.com/articles/2006/03/01/polios-return/#footer For more on the investigation, see: Joe Stephens, "Panel Faults Pfizer in '96 Clinical Trial in Nigeria," The Washington Post, 7 May 2006. http://www.washingtonpost.com/wp-dyn/content/article/2006/05/06/AR2006050601338.html; Joe Stephens, "Pfizer Faces Criminal Charges in Nigeria," The Washington Post, 30 May 2007 http://www.washingtonpost.com/wp-dyn/content/article/2007/05/29/AR2007052902107.html; Joe Stephens "Pfizer to Pay $75 Million to Settle Nigerian Tovan Suit," The Washington Post, 31 July 2009 http://www.washingtonpost.com/wp-dyn/content/article/2009/07/30/AR2009073001847.html; and Donald G. McNeil Jr., "Nigerians Receive First Payments for Children Who Died in 1996 Meningitis Drug Trial," The New York Times, 11 August 2011 http://www.nytimes.com/2011/08/12/world/africa/12nigeria.html?gwh=CB2E73B8DBDC9A6FB7FBEA57C47A851A&gwt=pay

[89] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/

The federal government responded by forming another technical committee, which this time included members of JNI -- the Muslim group that initially spearheaded the boycott -- but the SCSN again rejected the committee, asking for the inclusion of its own nominees.[90]

Despite the fact that Kano saw a 30% increase in polio during this time, the Kano State Government justified its opposition at the time, arguing that it was the "lesser of two evils, to sacrifice two, three, four, five even ten children to polio than allow hundreds of thousands or possibly millions of girl-children likely to be rendered infertile."[91]

The deadlock was eventually resolved in July 2004 when religious leaders were recruited to engage SCSN and those who opposed the vaccine. These meetings led to a consensus in February 2004 to test the vaccine independently in a Muslim country.[92] Kano state governor Ibrahim Sekarau finally decided to end the 11-month boycott after the vaccine obtained a seal of approval from Biopharma, an Indonesian company which, thanks to the fact that Indonesia is a Muslim country, was recommended to become the new supplier of polio vaccines for the predominantly Muslim states in northern Nigeria.[93]

In retrospect, the major breakthroughs in ending the impasse had much more to do with diplomacy than the triumph of science. In the midst of the boycott, for example, U.S. Secretary of State Colin Powell and UNICEF headquarters suggested to UN Secretary-General Kofi Annan that he send Ibrahim Gambari, the secretary-general's advisor for African affairs, to Nigeria as a special envoy. As researcher's Judith R. Kaufman and Harley Feldbaum explain:

> Normally, the UN Secretariat would not send a national of a country to negotiate in his or her country of origin, for fear of conflict of interest or pressure being put on the individual. However, in this case, most felt that Gambari was uniquely qualified. Gambari's father was a Muslim northerner and Emir of Ilorin, and his mother was a southerner. Gambari has served under virtually all of the surviving former Nigerian presidents, including those with presumed influence in the North, and had managed President Obasanjo's 1991 campaign to be UN secretary-general.[94]

Gambari was dispatched by Obasanjo to meet with the Sultan of Sokoto, the Emir of Kano, several high-profile traditional Muslim leaders, prominent politicians such as General Buhari, and even Datti Ahmed. During these trips, the complexity of the issue at hand became apparent.

In Sokoto, for example, Gambari realized that although the Sultan of Sokoto is traditionally the spokesman for the Muslims of the region, he is also the head of JNI. The secretary-general of the JNI, however, was one of the earliest and most steadfast opponents of polio immunization. Though Gambari left Sokoto with assurances from the Sultan that he agreed the boycott was harmful to the population, it was possible that others within the religious establishment would continue to oppose polio vaccines.[95]

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[90] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[91] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[92] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[93] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/
[94] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[95] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101

Gambari's trip to Kano proved more difficult, and highlighted the political aspect of the boycott. The governor of Kano was a member of General Buhari's party and had political incentives to oppose President Obasanjo.[96]

In tandem with Gambari's shuttle diplomacy in northern Nigeria, the DPEI Secretariat reached out to the Organization of the Islamic Conference (OIC) to "defuse the idea that GPEI and WHO were controlled by Western donors."[97] This engagement eventually led to the OIC passing a resolution urging the remaining polio-endemic OIC countries to accelerate their efforts to eradicate polio.[98] At the same time, the U.S. began putting diplomatic pressure on Nigeria by raising the profile of polio in its bilateral discussions, and having its ambassadors reach out to their counterparts in other countries to do the same.[99]

By April 2004, the governor of Kano was the sole government official opposing immunization, and it is impossible to know what exactly led to his decision to finally end the boycott. There may have been an internal Nigerian deal, or it could be that the official boycott had outlived its political usefulness. Another possibility could be Kano's negative image worldwide. The WHO reported that 80% of global cases of polio paralysis in the world originated from Kano, and several countries were considering placing travel restrictions on travelers from Kano, which would have precluded those from Kano from participating in the Hajj (pilgrimage to Mecca) in Saudi Arabia unless they were vaccinated at the airport.[100]

The external diplomatic efforts eventually helped bolster efforts from within Nigeria. Within a year of the formal end to the boycott, many of the same religious and political leaders who had questioned the safety of the vaccine became vocal proponents of polio vaccination.[101] In 2004, both the governor and emir of Kano participated in national immunization drives, with Governor Shekarau even allowing President Obasanjo to publicly administer the drops to his one-year-old daughter. In 2006, the newly appointed Sultan of Sokoto also became a champion of polio immunization, working to convince local and traditional leaders of the merits of the campaign.[102]

Lessons and Outcomes from the Boycott

The vaccine boycott in northern Nigeria was the result of a complex nexus of factors, including a lack of trust in modern medicine, political and religious motives, strained north-south relations, a history of perceived betrayal by the federal government, the medical establishment and big business, and a conceivably genuine, even if misguided attempt by the local leaders to protect their people.[103]

One of the key lessons of the boycott is that while public health officials might normally view polio eradication as a "technical" problem to be solved by science, innovation and effective program

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[96] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[97] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[98] "Resolution N. 14/31-S&T on Global Cooperation In Polio Eradication Programme Among OIC Member States" Organization of the Islamic Conference, 14-16 June 2004. http://www.polioeradication.org/content/publications/OIC_resolution_0604.pdf
[99] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[100] Judith R. Kaufmann and Harley Feldbaum, "Diplomacy And The Polio Immunization Boycott In Northern Nigeria," Health Affairs, 28, no.4 (2009):1091-1101
[101] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[102] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[103] A.S. Jegede, "What Led to the Nigerian Boycott of the Polio Vaccination Campaign?" PLoS Medicine 4, no. 3 (2007) : e73; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/

implementation, in Nigeria, polio eradication is a political endeavor. It is also affected by an increasingly unstable security situation in the north.

An outgrowth of this lesson was the realization that because the issue of polio eradication in northern Nigeria is a political issue as much as it is scientific one, diplomacy needs to be an essential component of eradication efforts.

Though the boycott began at the subnational level in Nigeria, it has global ramifications and set back eradication efforts in other countries. It took a network of international organizations and NGOs, pressure from diplomats, and the enlistment of groups like the OIC that are not normally considered within the purview of global health to solve the crisis.

The global public health community has since done an admirable job of taking the spread of false information seriously, and understanding that these rumors are often grounded in assertions that are either partially true, or make sense within their own context. Public health officials have become much better at engaging communities and coming to grips with the socio-political nature of this campaign. They have thought outside the box, reaching out to religious organizations, women's organizations, even artists to develop campaigns.

Overall, far greater care has been taken to understand and respond to the concerns of communities at the micro-level and to work with and through those interlocutors who are best positioned to reach and persuade potentially reluctant families to participate. Efforts have been linked to incentives for parents, including cash transfers, vitamin A provisions, de-worming tablets, antimalarial bed nets.[104]

National authorities have also reaffirmed their commitment to eradicating polio, offering vocal advocacy and pledging considerable federal funds to eradication efforts. In recent years, there has been an increased, if intermittent, state-level commitment from governors who have become more energized and supportive of the campaign. Some states have even introduced elements of coercion. In mid-2011, three states threatened to fine or imprison parents who refuse to vaccinate their children and to prosecute public health workers who fail to report refusals.[105]

[104] IRIN News, "Nigeria: Vitamin A Handouts Boost Polio Eradication Efforts," June 14, 2010, http://www.irinnews.org/report.aspx?reportid=89470.
[105] IRIN News, "Nigeria: Jail Threat for Polio Vaccination Refuseniks," August 11, 2011, http://www.irinnews.org/report.aspx?ReportId=93480.

Findings from the Field: Existing Barriers, Emerging Challenges

The field interviews carried out for this paper suggest that while the public health community has made considerable strides since the 2003 boycott, several barriers to polio eradication persist and new challenges to polio eradication in northern Nigeria are emerging.

Health Care Infrastructure

Overall dissatisfaction with the healthcare system

One key finding that was evident across all of the states in northern Nigeria is broad dissatisfaction with the healthcare system. Most of those interviewed maintained that access to healthcare facilities are in poor condition and not keeping pace with population growth. Several of those interviewed suggested that health-workers and doctors seemed more trained and qualified than in previous years, but still lacked the equipment and facilities necessary to carry out their work.[106]

Poor health care Infrastructure

While many governments in West Africa are nominally decentralized, Nigeria's governance structures are highly decentralized in a way that makes politics, and therefore health service delivery, a multi-layered process with a complicated and unclear division of responsibilities. Funding flows are unclear and unpredictable, while accountability is almost non-existent.[107]

Working in the health sector requires engaging the Federal Government, State Government and lower levels such as LGAs and wards. At every level, government officials are entirely capable of blocking programs that they either do not approve of or feel were not sufficiently channeled through them. A considerable amount of time and energy is spent working with local governments and keeping them sufficiently satisfied. [108]

Every layer of government represents a potential new blockage, as many office holders and administrators view it as a legitimate right to hold processes up for personal gain. Matters are further complicated by deeply entrenched party politics and patronage networks. The GPEI must operate within these systems where patronage and corruption are not only endemic, but systemic. They are present at every level vertically, and sprawl horizontally.[109]

Negative public opinion

Public opinion about vaccinations leading to refusal

Refusal of vaccinations, or "non-compliance," was also widely cited as a major roadblock to polio eradication. However, some of the motivation commonly attributed to why people refuse to vaccinate their children did not come up in the interviews. Rumors of pork being in the vaccine or that the CIA uses health workers as spies (as was the case in Pakistan in the hunt for Osama Bin Laden) were not mentioned.

The most common reason provided for non-compliance were that they believed that the polio vaccine was a "Western" or "American" attempt to sterilize Muslim children, so as to diminish the Muslim population.

"We are meant to understand that it can make girls barren. They said it can also be used to transmit deadly disease so that our populations can be reduced," said a 45-year-old businessman and father of eight from Katsina state.[110]

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[106] Interviews in northern Nigeria. January, 2014.
[107] Interviews with health-sector NGO workers in Abuja. December 2013.
[108] Interviews with health-sector NGO workers in Abuja. December 2013.
[109] Interviews with health-sector NGO workers in Abuja. December 2013.
[110] Interview in Katsina, northern Nigeria. January 2014.

A 55-year-old Islamic cleric in Bauchi state, for example, claimed that polio is a "Western creations" and described the vaccine as "un-Islamic," but couched his opposition in slightly different terms, highlighting the aspect of foreign imposition. "Polio campaign will still be 100% unsuccessful in northern Nigeria until and unless the issue is done with sincerity and honesty. It is a plan to undermine Muslims and our own values," he said.[111]

Field interviews also suggested that opposition to polio vaccination does not necessarily go hand in hand with opposition to modern medicine. Another man from Kano, for example, said that he trusts health workers, but not if they are working with polio campaigns. He asserts that polio is a "jinn related disease" (brought on by spiritual entities) and that the government is only championing polio because it is "another way of siphoning funds by government from foreign bodies."He does not vaccinate his children because he does not believe in the same way that "the government and white-man are thinking."[112]

Another interviewee in Kano state, expressed similar beliefs. He trusts healthcare workers, but not when they come with polio vaccines. "I was of the opinion that it was a jinn-related health problem. But I am beginning to be confused with the aggressive government media campaign about it."[113] Several interviewees suggested that those who oppose the vaccine don't necessarily believe that polio does not exist, but that it does not exist in the way that the government and health care providers believe it does.

A 32-year old father of six from Tudun Fulani, Kano, stated his opposition in more concrete terms. "Polio campaigns," Mr. Musa said, "is only government that is trying to deceive public with its campaign against the disease." When asked why he does not vaccinate his children, Mr. Musa offered a straight forward response. "It is against my culture," he said.[114]

Other respondents who oppose the vaccine cited the fact that they do not trust putting the well-being of their children in the hands of vaccinators. "I will not accept anything (sic) polio from anybody. They are my children so nobody has authority over them above me," said a 45 year-old civil servant from Kano.

Another interviewee from Eudun Wada, Gusau, Zamfara state, also said he was suspicious about vaccinators. "Most of the workers are not friendly and there is a shortage of drugs," he explained, saying that "no concrete convincing explanation" has been given about polio vaccines.[115]

Though field interviews suggested that polio vaccination campaigns have a unique stigma, it is not an anomaly. Access to healthcare and delivery of healthcare services is nowhere near adequate in northern Nigeria. It is important to remember that GPEI is trying to eradicate polio within a healthcare framework that is failing to deliver even the most basic services. Improving over-all quality and capacity is necessary. Polio is a much bigger healthcare problem.

<u>Overemphasis on polio vaccinations fuels conspiracy theories</u>

Another key finding of the field interviews is the role that an disproportionate focus on polio within the context of a failing public health system plays in reinforcing conspiracy theories. None of the people interviewed listed polio as their number one health priority or health concern. Instead, the majority of respondents listed malaria typhoid and water sanitation as their main preoccupations.

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[111] Interview in Bauchi, northern Nigeria, January, 2014.
[112] Interview in Kano. January, 2014.
[113] Interview in Kano. January, 2014.
[114] Interview in Kano. January, 2014.
[115] Interview in Zamfara, northern Nigeria. January 2014.

Another interviewee who opposes polio vaccines, cited the government's obsession with polio as evidence of a probably ulterior motive. "We also hear that countries like USA give [the vaccines to] Nigeria free. Why not give us drugs on malaria which is very prevalent," he asked.[116]

This line of thinking also translates to non-compliance for political, rather than religious or cultural reasons. Marginalized communities, who feel left behind by the state, are experiencing "eradication fatigue," and the perceived obsession by outsiders with vaccinations has alienated some communities, who view vaccinations as the only thing they ever get from the their government.

The narrative coming out of some of these communities is that they ask for wells, they get vaccinations. They ask for paved roads, they get vaccinations. They ask for cash transfers, they get vaccinations. To that end, non-compliance is often a political statement rather than an expression of culture or religion. It is an act of protest born out of the fact that for some of these communities, it is the only opportunity they get to interact with and express displeasure with their government.[117]

The risk of continued politicization of the issue is particularly acute in the run-up to and in the wake of elections.

Negative public opinion about polio vaccinations has different reasons

In 8 of the 10 states where fieldwork was carried out for this report, those who refuse to vaccinate their children were almost always described as rural, undereducated or illiterate who were simply misinformed or following the guidance of misguided Imams. But in Borno state, interviews suggested a different narrative.

According to officials at the Emergency Operation Centre (otherwise known as Child Survival Centre) within the Metropolis of MMC and Jere, "the highest level of resistance being recorded is in elite communities like the University of Maiduguri and other tertiary institutions of learning." In these settings, "elites still propagate the so-called conspiracy theory within the university environment and or the academics there look down on the local immunizers as not capable, given their little educational background, to administer any form of vaccine in their wards."[118]

Throughout Borno state, a range of barriers to polio eradication were cited by interviewees. In the city of Maiduguri, as stated above, resistance appears to stem from elites in academia, who are suspicious of the polio campaign.

[116] Interview in Katsina, northern Nigeria. January 2014.
[117] Interview with diplomat in Abuja, December 2013.
[118] Interview in Borno, January 2014.

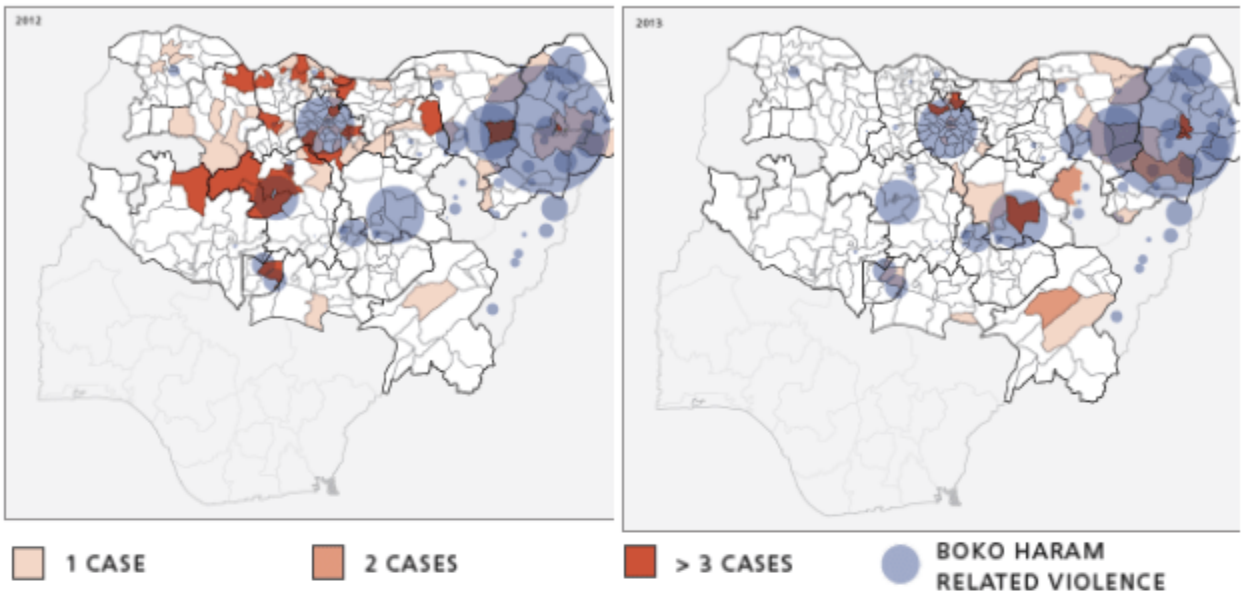

Figure 6: Comparing the Intersection of polio cases with Boko Haram related violence, 2012-13[119]

Ongoing security challenges also limit the mobility of vaccinators, as shown clearly in the diagram above. In Jere, non-compliance is more often attributed to beliefs that the vaccine is a form of birth control. In Bama, extreme insecurity and ongoing violence prevent immunization rounds from taking place, whereas in Damboa and Dikwa, insecurity remains a serious barrier, in tandem with high rates of refusal as a means of protesting over the basic lack of health and social amenities.[120]

"They want to know why polio vaccine is being given free while they have to pay for drugs for malaria, typhoid, diabetics, diarrhea, cold etc," said one local journalist. "They would want to know why the government is paying so much, going into nooks and cranny to eradicate a disease that is, to them, not visible or verifiable or even very common when they have more pressing needs like potable water, roads, dispensaries, and schools which have not been provided by the government."[121]

Another interviewee described the motives behind non-compliance in much more blunt, political terms referring to the local government. "You don't patronize us when you share food items during Sallah or Christmas celebrations, except your party followers," he said. "Now because this is polio, which will not fill our stomachs, you come knocking and begging us to take it in order to please America."[122]

In Yobe state, which has also been hit hard by the ongoing war between Boko Haram and state security services, resistance to polio vaccines is thought to be less pronounced than in Borno, with high areas of non-compliance concentrated by the frontier towns near the border with the Republic of Niger.[123]

Taken together, the interviews conducted across all ten states indicate that awareness campaigns, community outreach, enlistment of religious leaders and micro-plans have significantly reduced rates of non-compliance. Several people interviewed claimed that they once opposed vaccinated their children, but have since become advocates.[124] This is undoubtedly good news.

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[119] Figure 6 overlays GPEI data shown in figure 4, with security data found in figure 3.
[120] Interview in Borno, January 2014.
[121] Interview in Borno, January 2014.
[122] Interview in Borno, January 2014.
[123] Interviews in Yobe, January 2014.
[124] Interviews across northern Nigeria, December 2013 andJanuary 2014.

But it is important to keep in mind that Boko Haram challenges the legitimacy of not only the state, but also the traditional religious hierarchy within northern Nigeria which they see as corrupted by the political system. Their ideology is inherently subversive, and could potentially make the enlistment of prominent leaders such as the Sultan of Sokoto or Emir of Kano less effective in the future.[125]

Unstable political and security situation

Elections in 2015 are anticipated to slow polio eradication efforts down

Several interviewees, including health workers, local politicians, and diplomats cited "2015," when hotly contested Presidential as well as a host of other national and local elections are slated to take place, as a potential problem for polio eradication. There remains a serious risk that north-south and state-federal battles may play out again in the public health arena.[126]

The Federal Government is on board with efforts to eradicate polio. In fact, it considers failures to eradicate polio an embarrassment. Political will at the level of local governments, however, remains a roadblock. With the February 2015 campaign just around the corner, eradication is likely to become a lower priority, with energy and resources diverted elsewhere. Disruptions in health-services delivery due to post-election violence is considered all but inevitable.[127]

Security situation making regions inaccessible for vaccinations

In Borno state and Yobe state, where the war against Boko Haram has rendered entire swaths of territory off limits, the challenge of eradicating polio is has an added security dimension.[128] Almost everyone interviewed in Borno and Yobe state listed security as their primary concern for themselves and their families, and worried that the security situation is likely to continue deteriorating.[129]

As one journalist in Maiduguri, the capital of Borno state explained, "Borno state is presently the epicenter of the Boko Haram terrorism... There is high tension and insecurity challenges have hampered development especially in the above mentioned areas [Maiduguri, Jere, Bama, Damboa and Dikwa] where there is a high rate of resistance to polio vaccines. The economy of the state which revolves around subsistence agriculture, fishing and commerce, has been nearly crippled due to the insurgency. In terms of development, government has not done very well in providing amenities like water, electricity, healthcare facilities, job for the youths, good roads, education facilities and security."[130]

"The security issue is even more disturbing," he continued, "as the major security agencies like the policy and army lack manpower to cover remote areas of the state; this also gives enough ground for the Boko Haram insurgency to thrive."[131]

Lack of information and feedback about the security situation

Health workers have to rely on day to day assessments from the civilian Joint Task Force (JTF), an ostensible state sanctioned militia for up to date security information. Some donors and implementers are reluctant to integrate their work with vigilante groups, as it may increase the chances that health workers will be targeted.[132]

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[125] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[126] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.
[127] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.
[128] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.
[129] Interviews in Borno, January 2013. Interviews in Yobe, January 2013.
[130] Interview in Borno, January 2013.
[131] Interview in Borno, January 2013.
[132] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.

This fear is almost certainly warranted. In December, Boko Haram reportedly bombed the offices of the Borno State National Program on Immunization in the state capital of Maiduguri. Motives for the attack are not clear, but it highlight the fact that Boko Haram, or at least factions within it, view any government building as a legitimate target.[133] There are also rumblings that the Nigerian government might seek to have the military or civilian JTF carry out polio vaccinations.[134]

Operational issues

Lack of coverage and monitoring of vaccination campaigns

Evidence from interviews, in conjunction with existing literature and reports on the subject, suggest that rather than randomly missing some children each year, vaccination campaigns are consistently missing the same children and households with each round of immunizations.[135] GPEI has stepped up efforts to strengthen micro-plans that drill down to individual households to ensure all children are vaccinated and are increasingly incorporating GPS and GIS technology to track the movement of vaccination teams and identify areas, communities, and even individual homes that have been missed.[136]

But despite these efforts, there are glaring weaknesses in monitoring and evaluation. A preference for frequent, almost continual rounds of vaccinations by influential donors and implementers might be hindering overall abilities to evaluate programs. The "shotgun approach," while understandable given the desire to eradicate polio as soon as possible, runs counter to the goal of targeted interventions.[137] Interventions need to be precise, but collecting the requisite information that would allow for precision has not been done and probably cannot be done unless vaccination rounds are carried out less frequently.[138]

Limited financial oversight and overabundance of cash is distorting the healthcare market

Both NGO representatives in Abuja and interlocutors in the field warned that despite the persistence of polio in northern Nigeria, there is probably more money being poured into Nigeria than is necessary for eradicating polio. This overabundance of cash may be distorting the "public health market" and allowing local governments to misappropriate funds while still carrying out polio eradication programs at a minimum. The release of funds are regularly delayed, which in turn disrupts planning and implementation. It may very well be that local governments and NGOs view polio eradication as a funding mechanism rather than an actual goal.[139]

In its most extreme form, the abundance of money tied to polio eradication efforts may be providing perverse incentives. At this point, polio eradication is a full-scale, multi-million dollar industry. There are offices and NGOs that exist only because of the campaign. There are drivers, cooks, and cleaning staff and perhaps entire patronage networks who depend on the continuation of polio eradication campaigns. It is an open secret that some organizations might purposely fail to monitor their work so that polio eradication campaigns will continue. For this reason, levels of non-compliance might be

[133] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[134] Interview with diplomat in Abuja, December 2013.
[135] Interview with NGO officials and diplomats in Abuja, December 2013. See also: Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[136] Jennifer G. Cooke and Farha Tahir, "Polio Eradication in Nigeria: The Race to Eradication," CSIS Global Health Policy Center, February 2012.
[137] Several interviewees in the public health sector referred to initiatives that encouraged wide-ranging, near constant rounds of routine immunizations as the "shotgun approach," in contrast to more precise targeting of certain communities.
[138] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.
[139] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.

inflated and households missed by immunization rounds may be over-reported, so as to ensure that funding streams continue. In this sense, there are some perverse incentives to not eradicate polio[140]

[140] Interviews in Abuja, December 2013. Interviews in northern Nigeria, January 2014.

Recommendations

Healthcare Infrastructure

Improvement of overall healthcare service through polio vaccination campaigns

1. Improvement of overall healthcare services: Polio vaccination campaigns need to be part of a broader push for better governance and better health service delivery**.** This does not mean that immunization rounds need to be put on hold, but it does require that polio vaccination campaigns have to be embedded within efforts to bridge gaps between the government and the governed. Absent these efforts, frustrations with translate into "polio fatigue" and vaccine rejection. One option would be to provide additional healthcare services (medication for diarrhea, malaria etc.) through vaccination personal in order provide broader health care service.

2. Targeted healthtcare infrastructure improvements: For a higher impact strategy, **targeted improvements can be made of healthcare infrastructure** in communities that are distrustful of the state, though this runs the risk of exacerbating suspicions of motives, and creating new tensions between districts.

Public Opinion

Involvement of stakeholders & communication strategy

3. Assessment of public opinion on community level: Determining the public opinion on community level will be necessary in order to **review and reassess current communication strategies** and campaigns for different regions.

4. Participatory polio campaigns: Immunization programs should **continue to be participatory and involve state and local governments**, community leaders, and traditional rulers such as emirs, political leaders who are elected and religious leaders. Civil society groups, even those outside the purview of health should be mobilized. In some areas, Polio eradication is on the right trajectory. Continued efforts in sensitization should be maintained and a radical rethink of strategy is not required. The merits of polio vaccines should continue to be diffused through these formal and informal networks, such as community radio, television, pamphlets, religious ceremonies and cultural events.

Security Context & Scenario Analysis

Setting up a network to gather information about the security situation on LGA and ward level

5. Improve security awareness in key districts: In much of northern Nigeria, but specifically Borno and Yobe states, **polio eradication needs to be placed in a security context.** Polio eradication is not a neutral enterprise. Though eradication efforts have made great strides in realizing that "being right is not enough," within the context of politics and culture, perhaps it is time to start thinking where polio eradication and public health fall within the security sector. Attacks by Boko Haram, as haphazard and nihilistic as they seem, are not random. Local interlocutors should be found who are able to navigate this terrain and provide GPEI with real-time information.

Working with the police and the army is unlikely to yield actionable intelligence. They have their own motives and agendas and have demonstrated a stunning inability to know much about the socio-cultural terrain in which Boko Haram operates. Reaching out to JTF poses a different

problem all-together, as healthcare providers are likely to be targeted if they are seen as in an extension of JTF. The global health community needs to find a way to gain real-time information about shifts in the socio-cultural terrain without "militarizing" the issue.

One avenue that should be explored is **reaching out to civil society groups, local journalist organizations and NGOs that are familiar with these dynamics**, though not necessarily healthcare specialists. Setting up a network of groups that can provide information on the political and security situation at the LGA or even ward level would go a long way in helping the polio eradication efforts forecast and plan for external shocks.

Scenario analysis and contingency plans in a crisis environment

6. **GPEI should have strong contingency plans for each LGA for how to operate in a crisis environment.** This is potentially dangerous work, but the dangers are not entirely unpredictable. For the foreseeable future, contingency plans must be put in place to deal with refugees who flow into Niger, Chad and Cameroon. They should also be in place to deal with IDP flows as a result of violence stemming from Boko Haram, and election-related violence. A "wait and see" approach will not suffice. The health community, including donors, need to be more proactive in preparing to mitigate the impact of insecurity and violence in northern Nigeria.

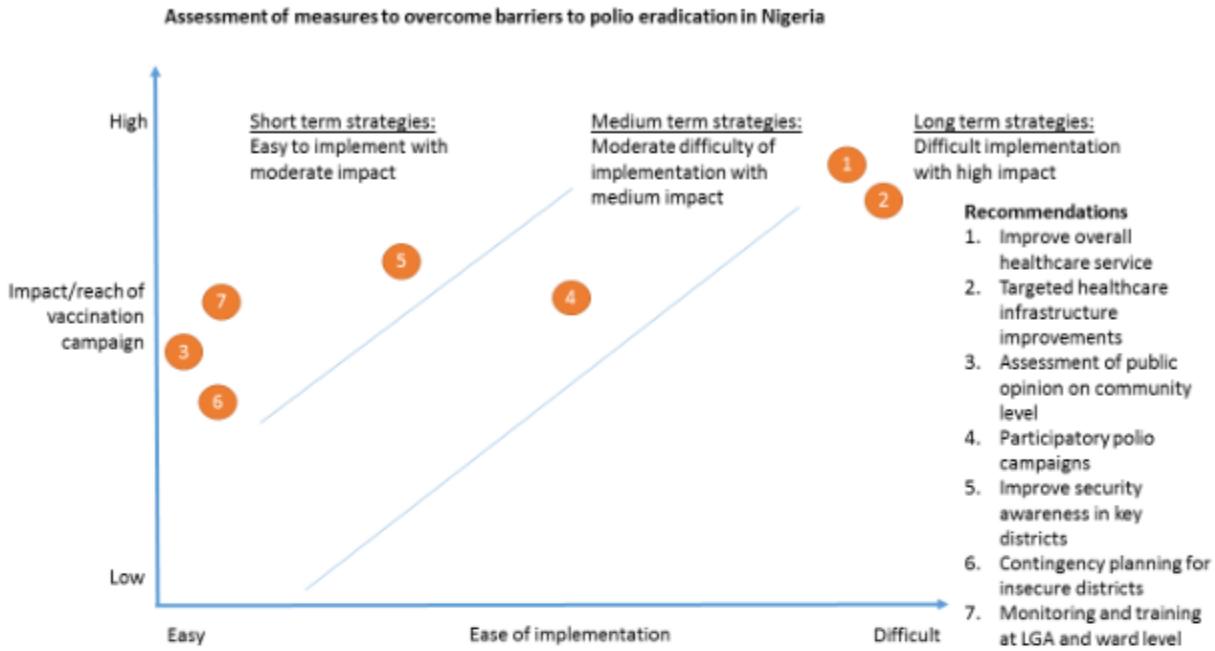
The GPEI has done a good job making technical assistance and advice readily available to program implementers, but it should work to develop ways to give "strategic" advice, which would include feedback loops that would better anticipate the effects of instability, whether they stem from political or security events. **Public health professionals need to be educated on political and security issues of the areas in which they work,** perhaps seconded to other organizations, where they can be trained to be able to approach diplomats, ministries of foreign affairs, military officers, local leaders, religious leaders and a range of other actors to better understand the broader conditions in which they must operate, and to mobilize the appropriate support in the face of new or emerging challenges. Flexibility and an ability to respond to realities on the ground are essential. This means coordinating with multiple actors and requires a willingness to mix politics, public health, and diplomacy. The toolbox needs to be diversified to enable a better understanding of how insecurity effects public health.

Monitoring & Feedback

Monitoring training for vaccination staff#

7. **Monitoring and training for vaccination staff: More robust monitoring needs to take place at the LGA and ward level.** This means training staff to be able to carry out monitoring activities, as well as having independent actors who can verify or "audit" the work being carried out. A cost benefit analysis of diverting resources, time and energy toward monitoring rather than constant routine immunization rounds should be conducted. Near constant immunization rounds, or the "shotgun" approach may yield results and might eradicate polio in spite of the poor quality of the underlying public health infrastructure in northern Nigeria, but getting past the finish line is not enough, staying past the finish is the end goal.

In the graph below, the various strategies laid out have been clustered according to their likely impact on the polio eradication campaign, as well as on their ease of implementation. Ease of implementation was assessed along three criteria: cost, time and risk. In particular, the issue of risk is pertinent for those interventions seeking to have impact in Boko Haram controlled regions.



Many of the recommendations, however, should be considered as basic pre-requisites for continuing to operate in Boko Haram controlled areas of Nigeria. The tensions in these regions are escalating high, and the risks to health workers, community members and considerable.

Barriers to Polio Eradication in Somalia

A Situation Assessment

Prepared for The Bill & Melinda Gates Foundation

April 2014

Executive Summary

This report is an assessment of barriers to polio eradication and potential mitigation strategies in order to overcome these.

Barriers to Polio Eradication

A) Poor Healthcare Infrastructure

Availability of and access to health care services is very limited in Somalia leading to vaccination levels of <50%. In rural areas distribution of health care facilities is extremely scarce. Most of basic health care services are provided by private institutions and NGOs. There is limited involvement of the government and little local ownership of vaccination campaigns.

B) Unfavorable social Perception:

Most of the people in Somalia do not see polio as one of the biggest health threats. Instead they highlight malaria, typhoid and diarrhea as the biggest threats and would prefer medication or treatment for these diseases. The general public's knowledge about polio has improved after the awareness campaign in 2010. However, Al Shabaab's recent public messaging effort has fostered the belief that polio vaccinations can cause sterility, paralysis and even HIV.

C) Unstable political Situation

Somalia's political dysfunction has long been a barrier to the development of an effective health care system. Limited territorial control, assaults on civilians by military forces as well as low levels of health care and vaccination support highlight some of the weaknesses of the current government. In addition, a power vacuum and a multitude of stakeholders (government officials, clan elders, militias and Al Shabaab) increase logistical and financial complexity for NGOs and polio workers in order to get access to certain areas.

D) Unstable Security Situation

Al Shabaab poses the biggest barrier to polio eradication in the country. Al Shabaab's strength is diminishing, but its tactics and commanders are becoming more violent. The group is sabotaging vaccination campaigns, denying polio teams access to Al Shabaab controlled regions and launching anti-polio vaccination messaging campaigns to change the public's opinion. The reasons for Al Shabaab's anti-polio position are believed to be a general objection to western aid organizations, fears of insurgency and espionage as well as political bargaining power.

Mitigation Strategies

Based on the initial assessment of the situation, the following mitigation strategies are suggested in order to address the issues associated with polio eradication:

A) Improving overall public healthcare by closing the urban rural health care divide and strengthening local governance

Polio eradication should be framed in the broader context of strengthening local governance, development and access to healthcare.

(1) Information/Attraction/Access: Pursuing an information strategy targeting rural dwellers would help to raise awareness of polio and demand for vaccinations.
(2) Improving overall Healthcare services: Mobile health care units could be used to facilitate better healthcare availability in rural areas for the short and medium term while the government should develop a long term health care infrastructure plan.

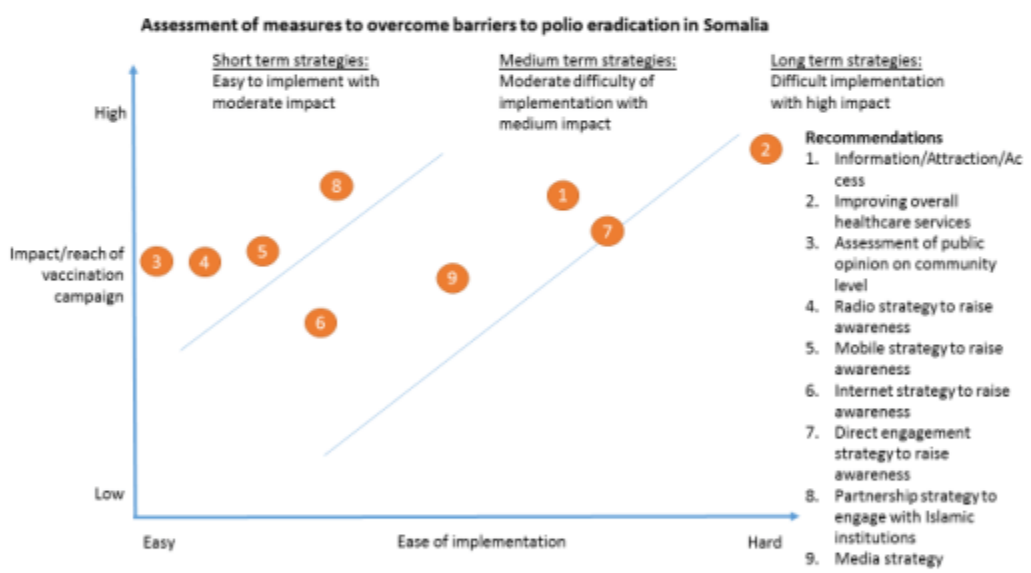
B) Changing the Public Opinion

Because the situation in Somalia is still in flux and (unlike in Nigeria) interests around the eradication economy are not entrenched, there is still an opportunity to shift opinions in favor of polio eradication with targeted campaigning.

(3) Assessment of Public Opinion on Community Level: Determining the public opinion on community level will be necessary in order to review and reassess current communication strategies and campaigns for different regions.
(4) Radio Strategy: Sponsor a continuing series of radio in order to raise awareness about health care and polio in rural and urban areas.
(5) Mobile Health Information Strategy: Craft mobile health programs through reverse SMS efforts in order to push out information and health alerts to mobile users.
(6) Internet Strategy: Develop a Somali language web presence that raises awareness of polio and seeks to clarify rumors.
(7) Direct Engagement Strategy: Engage with clan and religious leaders in order to change their opinion and the opinion of their followers.

C) & D) Overcoming political and security issues

(8) Partnership Strategy: Engagement of Islamic NGOs and pharmaceutical companies while continuing "western" NGO work would help deemphasize the western conspiracy connotation of polio work and emphasize its religious legitimacy.
(9) Media Strategy: Start open discussions with conservative clerics and religious leaders in order to soften Al Shabaab's position regarding polio vaccinations.



In the graph above, the various strategies laid out have been clustered according to their likely impact on the polio eradication campaign, as well as on their ease of implementation. Ease of implementation was assessed along three criteria: cost, time and risk.

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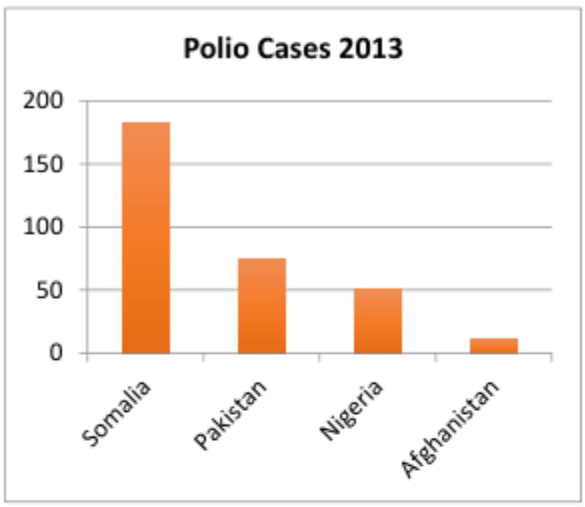
Introduction

Somalia is ground zero in the global fight against poliovirus. Beginning with a single case in Banaadir region in April 2013, the current epidemic had claimed 194 victims in Somalia by April of 2014.[141] Another 24 victims have been recorded in neighboring Kenya and Ethiopia. Fifty six per cent of poliovirus cases worldwide in 2013 were attributable to the Horn of Africa epidemic. While the epidemic seemed to have peaked in October, a small number of residual cases have been identified. The large un-vaccinated and under-vaccinated population in the country heightens the possibility that the disease will continue to circulate. In turn, a pernicious epidemic in Somalia raises the risk that adjacent countries could experience outbreaks.



The outbreak of polio in Somalia is not just indicative of poor public health; it is directly related to the nation's deeply dysfunctional politics. Despite the inauguration of an internationally recognized Federal Government in August 2012, the nation has not had a government capable of exercising control over the entire territory since 1991. Rather, Somalia has been a zone of persistent war and insecurity, dominated by warlords, insurgents, and foreign military forces. Social service delivery – including health, nutrition, and education – has been left to a host of national and international NGOs. The complex and at times antagonistic relationship between political actors and service providers in Somalia has impeded aid delivery, propelled famine, and resulted in vaccination rates that fall well below both regional and international norms.

Nonetheless, while the re-eradication of poliovirus in Somalia presents an enormous challenge, it is achievable. Somalia has eradicated wild poliovirus twice before, despite high levels of insecurity and violence. For many, success in such a context is a test of the international community's ability to adequately address polio vaccination under extreme circumstances. As former UNICEF Executive Director remarked in 2004, "If polio can be stopped in Somalia, it can be stopped anywhere."[142]

This report investigates the nature of barriers to polio vaccination in Somalia. Three types of barriers are explored: structural, social, and political. Structural barriers revolve around the lack of effective healthcare facilities in Somalia. Much of the healthcare infrastructure was destroyed or looted during the conflict, while endemic violence and threats have led some healthcare providers, such as *Médecins Sans Frontières*, to leave the country. The second type of barrier involves societal perceptions. Somalis do not seem to hold the ideological aversion to polio vaccinations seen in countries such as Nigeria and Pakistan, where the disease is endemic. However, negative rumors about the vaccine abound in Somalia, complicating public messaging efforts and sparking vaccination refusals. Islamist groups in south and central Somalia contribute to and benefit from these rumors, promoting them through a vigorous public messaging campaign linking the vaccine with sterility and HIV/AIDS. Additionally, the social perception that polio is a disease that poses only a minimal threat has diminished vaccination demand. Finally, the research analyzes political barriers to polio vaccination are analysed. The most overt barrier to vaccination in Somalia is Al-Shabaab, which has exerted control over large segments of south and central Somalia for the last five years. The group has impeded and at times completely halted aid activity, including vaccinations, in its territory. While

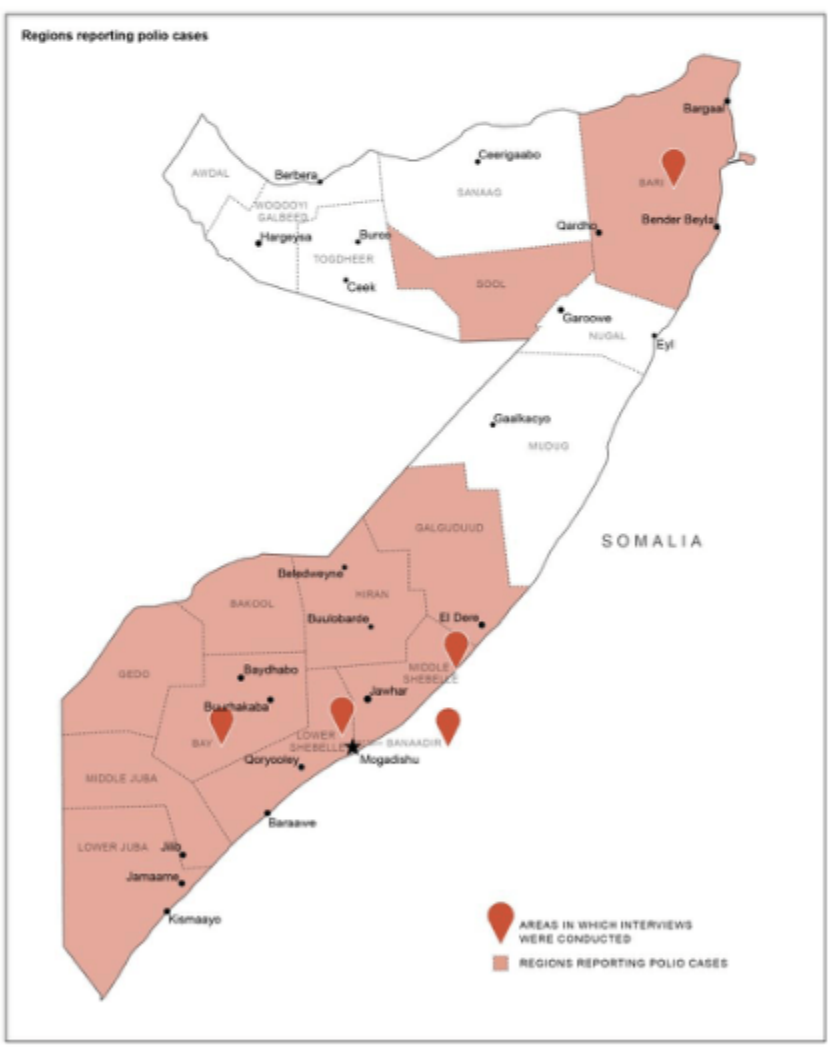
[141] Global Polio Eradication Initiative, Polio This Week in Somalia, Posted http://www.polioeradication.org/Infectdcountries/Importationcountries/Somalia.aspx, 15 April, 2014

142 Conflict-Ridden Somalia Conquers Polio, Starts New Vaccination Campaign, UNICEF Africa News March 29, 2004

Al-Shabaab has lost ground over the last two years, the group is remarkably resilient; making it prudent to assume it will continue to play key a military and political role in south and central Somalia in the future. Finally, the Federal Government of Somalia, backed by the African Union Mission in Somalia is an important political actor. However, it faces serious political and administrative challenges, while security in the areas under its control continues to spiral downwards. The report will conclude by offering some tentative mitigation strategies and identifying future avenues for analysis.

This report aims to convey a nuanced understanding of the barriers that have impeded vaccination efforts and disincentivized families from protecting their children from poliovirus. Few analytic reports exist on healthcare issues in Somalia, and none touch upon the 2013 poliovirus epidemic. Therefore, this report fills a gap, sketching out an initial picture of what factors contributed to, and which continue to impact, the spread of poliovirus in Somalia. Without a better understanding of what Somalis believe about polio, a robust comprehension of how political dynamics in Somalia impede vaccination efforts, and an identification of the gaps in medical infrastructure, it will be difficult to definitively eradicate polio in the country.

Methodology



In order to identify the barriers to polio vaccination in Somalia, a rapid-assessment was carried out between October 2013 and January 2014. First, an information review was conducted, involving a comprehensive assessment of all international and nationally available reports, media articles and other documents regarding Somalia's historical approach to polio vaccination, the current epidemic, and international responses. Statistical data on health, economic issues, and demographic trends in Somalia was also compiled and analyzed.

Second, eight weeks of field research were undertaken in Somalia and Kenya. Due to the dangers of conducting field research in some areas of Somalia, interviews were not conducted in locales under the exclusive control of Al-Shabaab. Rather, the interviews were conducted in regions in which polio has re-occurred which have recently experienced some degree of Al-Shabaab presence. Regions surveyed included Bari, Bay, Middle Shabelle, Lower Shabelle, and Banaadir. Interviews on healthcare and political issues were conducted

with several dozen community leaders, religious leaders, businessmen, and health care professionals. The interviews were semi-structured, in order to allow for comparison. Concurrent with activities in Somalia, interviews were conducted in Kenya, focused on gaining a deep understanding of international efforts to stem the polio epidemic in Somalia, as well as gathering information on the political dynamics in Somalia. Interviewees were drawn from UNICEF, WHO, FAO, EU ECHO, EU Commission, Conflict Dynamics International, the Rift Valley Institute, current and former members of Somalia's federal government, Somali journalists, and independent researchers.

All interviews were conducted in confidence and there was no attribution to the Bill & Melinda Gates Foundation.

In addition to the situation assessment ´Barriers to Polio Eradication in Somalia` similar assessments have been conducted for Nigeria, Afghanistan and Pakistan.

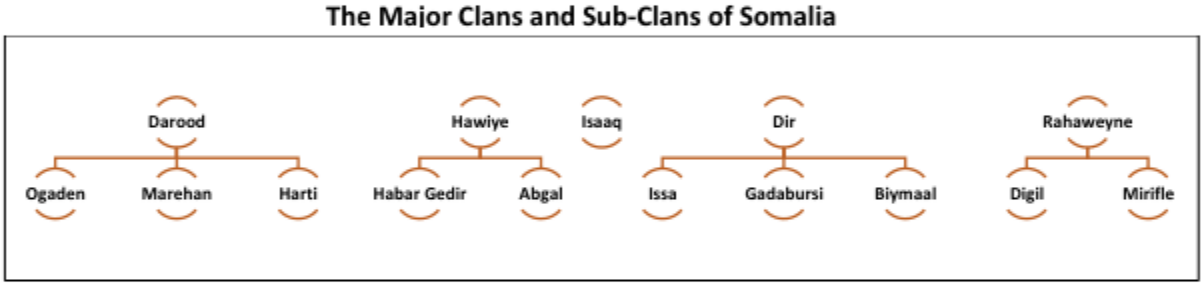
Background

Sprawling over 637,657 square kilometers, Somalia encompasses most, though not all, of the ethnically Somali zones in the Horn of Africa. While the last census was conducted in the mid-1980s, the World Bank estimates that Somalia's population is slightly more than 10 million.[143] Forty four per cent of the population are aged fourteen or younger.[144] Life expectancy stands at around 51 years.

Somalia is still a profoundly rural society, with sixty two per cent of the population located in the countryside. However, urbanization has increased over the last 20 years, driven in part by conflict related displacement amongst the rural population. Forty one per cent of the urban dwellers live in Mogadishu, the capital and the largest urban area in the country. Roughly twenty per cent of the population are either internally displaced, or are refugees in surrounding countries.[145]

Poverty, exascerbated by continuing civil unrest, is a reality for most Somalis. Eighty one per cent of the population lives in poverty, a percentage which rises to ninety four per cent amongst the rural population.[146] Over half of all Somalis are unemployed, with youth unemployment often considerably higher.[147] Many interviewees in Somalia highlighted a lack of jobs, especially amongst the youth, as one of the key threats facing the nation. A community leader in Baidoa indicated: "I think the greatest threats in Bay region are a lack of economic opportunities. The people are very poor and they don't have a lot of livelihood means. Most depend on hand outs from family and friends."[148]

The Major Clans and Sub-Clans of Somalia



Conflict in Somalia is primarily conducted amongst the patrilineal clans and sub-clans to which nearly all Somalis belong. The five major clans are Darood, Hawiye, Dir, Isaaq, and the Rahanweyn (Digil and Mirifle). The major clans in turn are subdivided in sub-clans, with some, such as the Ogadeni and Habar Gedir wielding significant influence over national politics. In addition to the major clans, a number of minor clans exist. Clans represent a major political force within Somalia, with clanism often determining access to resources and jobs. The violence and anarchy of the last quarter century has increased their salience, becoming, in the words of one interviewee, "the one thing you could rely on."[149] However, the clans have also proved to be a divisive political force. Clan rivalries and grievances have driven many of the conflicts – physical and political – that have savaged Somalia since the mid-1970s. Such conflict continues in the present day, with one interviewee noting "The greatest challenge to the government is bad politics, with every clan wanting to dominate; the prime minister was ousted because he is from a different clan to the president. The same can be said about all politics in Somalia."[150]

While clannism is not a conflict driver per se, since 1991, Somalia's clan politics have resulted in a political economy convened along clan lines. Clannism has become the organising principle around

[143] The World Bank, Somalia Data, Accessible at: http://data.worldbank.org/country/somalia
[144] CIA World Factbook – Somalia, Accessible at: https://www.cia.gov/library/publications/the-world-factbook/geos/so.html
[145] 2014 UNHCR country operations profile – Somalia, Accessible at: http://www.unhcr.org/pages/49e483ad6.html
[146] Human Development Report Somalia 2012, UN Development Program, Pp. 63
[7] Ibid.
[148] Interview, Community Leader, Bay
[149] Interview, Think Tank Researcher, Nairobi
[150] Interview, Religious Leader, Banaadir

which the state has coalesced, triggering a highly volatile greed and grievance cycle of lawlessness and disorder centred around the control of resources, including international aid.[151]

Somalia: A Political History

Somalia has been embroiled in civil war since the late 1970s. By 1991, a coalition of rebel groups managed to wrest control of the country away from President Mohamed Siad Barre, leading his government to collapse, and forcing him to flee. In quick order, the rebel groups – which were organized along competing clan and sub-clan lines – turned on each other. While some areas of Somalia, such as the northern quasi-states of Somaliland and Puntland – remained peaceful, clan and warlord based violence convulsed the southern and central regions of the country.[152] By mid-1992, the international community had mobilized a United Nations peacekeeping force for the country, tasked with ensuring the delivery of aid to the desperately needy civilians impacted by the conflict. This force and the two additional international military forces that followed it were generally regarded as ineffectual. The forces of the final mission, UNOSOM II, were withdrawn from Mogadishu by 1995.

The disengagement of the international community from Somalia led to a period of low-grade violence throughout the late 1990s. Local governance initiatives, many based around clans and sub-clans, appeared throughout Somalia. Many were encouraged by Somalia's neighbours; few lasted. The only two polities that have succeeded to any degree are Somaliland, based around the Isaaq clan, and Puntland, dominated by the Darood clan.

In 2000, the Somalia National Peace Conference resulted in the formation of the Transitional Federal Government (TFG).[153] Despite international support, the TFG proved to be an inept, weak, and corrupt institution.[154] Real power in Mogadishu and other areas of the south was wielded by a group of predatory warlords, whose rapaciousness hobbled efforts to create a functional economy and provide aid to the many Somalis in need. The Union of Islamic Courts emerged in this vacuum. A disparate alliance of Islamist, business, and Hawiye clan interests, the courts promised stability and an end to warlordism. To accomplish this, they fielded a potent militia, including a little known group know as Al-Shabaab (The Youth). Al-Shabaab was formed by a small group of fighters who had previously been associated with Al-Itihaad al-Islamiya, a Salafist group that had dissolved in the early 2000s. Many of the group's founding members had trained or spent time in Afghanistan.[155] Their grudge with the warlords was largely personal, as many of the warlords, acting at the behest of the U.S. Central Intelligence Agency, had sought to kidnap or kill the Afghan trained Somalis.

By 2006, the Islamic Courts had defeated the warlords and taken control of Mogadishu, as well as most of south and central Somalia.[156] The TFG was confined to Baidoa, in Bay region, protected by Ethiopian military forces.[157] Under the Courts' control, Mogadishu was calm and relatively safe for the first time in a generation. A new wave of foreign fighters arrived in Somalia in this era, responding to an open invitation from Al-Shabaab. The group maintained strong connections with Al-Qaeda operatives in East Africa, relying on them for training and other support activities. During this period, Al-Shabaab's role within the courts grew, commiserate with its increasingly potent military strength, including the novel utilization of Improvised Explosive Devices (IEDs) and suicide attacks.

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[151] Tuesday Reitano, "What hope for peace? Greed, grievance and protracted conflict in Somalia", Yale Journal for International Affairs, April 2013

[152] Mark Bradbury and Sally Healy, Endless war: A brief history of the Somali conflict, ACCORD, Issue 21, Pp. 10

[153] The International Crisis Group, Somalia: The Tough Part Is Ahead, 26 January 2007, Pp. 3

[154] The International Crisis Group, Somalia: The Transitional Government On Life Support, 21 Feb 2011, Pp. I

[155] Stig Jarle Hansen, *Al-Shabaab in Somalia: The History and Ideology of a Militant Islamist Group*, Oxford University Press 2013, New York, pp. 20

[156] The International Crisis Group, Somalia: The Tough Part Is Ahead, 26 January 2007, Pp. 1

[157] Ibid.

Elements of the Islamic Courts attacked the Ethiopian forces on December 8th 2006, prompting the Ethiopians to launch a full-scale offensive against them. The superior firepower of the Ethiopian forces devastated the Courts' militias, leading to a rapid disintegration of the organization. On December 28th, the Ethiopians entered Mogadishu and continued south, demolishing the Courts' military and political structure. Al-Shabaab was one of the few units to avoid annihilation, a feat accomplished by its rapid retreat into the countryside of southern Somalia. While not destroyed, the previously formidable organization was driven underground, harried by withering Ethiopian and U.S. airstrikes. By the beginning of 2007, Al-Shabaab was at the nadir of its power, far more profoundly defeated and vulnerable than at any other time in its history, including in the present period.

However, Al-Shabaab was able to rebound rapidly. Between 2007 and 2008 it engaged in a vigorous insurgency in the countryside, while its forces menaced urban centers through bombings and other terrorist attacks. The group has proven adept at using fear instrumentally, both as a tactic and a goal in its own right, deterring popular cooperation with the TFG via targeted assassinations, bombings, and other attacks.[158] Many Somalis, including a large section of the diaspora, viewed Ethiopia as an occupying power, and rallied to support Al-Shabaab's insurgency. Additionally, the group's popularity was buttressed by the serious failures of the TFG, which had been reinstalled in Mogadishu. Successive administrations had proved themselves feckless and often venal, spending staggering sums of money without achieving visible benefit for average Somalis.

Another potent military actor emerged during this period, as the African Union deployed a military peacekeeping force to Mogadishu in March 2007. The military component of the African Union Mission in Somalia (AMISOM) was composed of heavily armed units from Uganda and Burundi. Initially, AMISOM provided security for the TFG and its facilities, enabling the Somali Armed Forces (SAF) to concentrate on battling Al-Shabaab.

These efforts were ultimately unsuccessful. Ethiopia withdrew its military in late 2008, as a new iteration of the TFG, one based on Islamist principles, took power in Mogadishu. Like its predecessor, this transitional government proved, again, inept and powerless, unable to provide services to its citizenry or to rally military opposition against Al-Shabaab. The Ethiopian withdrawal facilitated the takeover of south and central Somalia by Al-Shabaab. The TFG maintained a beachhead in Mogadishu, protected by a sizable AMISOM force.[159] However, its writ extended only as far as the AMISOM frontline.

Throughout 2009 and 2010 Al-Shabaab proved an able and effective administrator of the south and center of the country. A sharia-based criminal justice system was created, and succeeded in providing a degree of law and order. Bureaucratic agencies were created to deal with international organizations, both enabling and at times impeding efforts to provide aid to Somalis living in areas under the group's control.

Al-Shabaab's power was based on both military might as well as an ability to manipulate local grievances to their benefit. The group's post-clannist ideology proved attractive to Somalis exhausted by decades of internecine conflict, enabling it to attract new recruits from areas under its control. Security improved as Al-Shabaab suppressed inter-clan violence and banditry. This in particular led to increased public support for the movement. Nonetheless, Al-Shabaab's policies – including a ban on music, movies, and the popular stimulant *khat* – were not well received in the areas under their control, and increased popular discontent.

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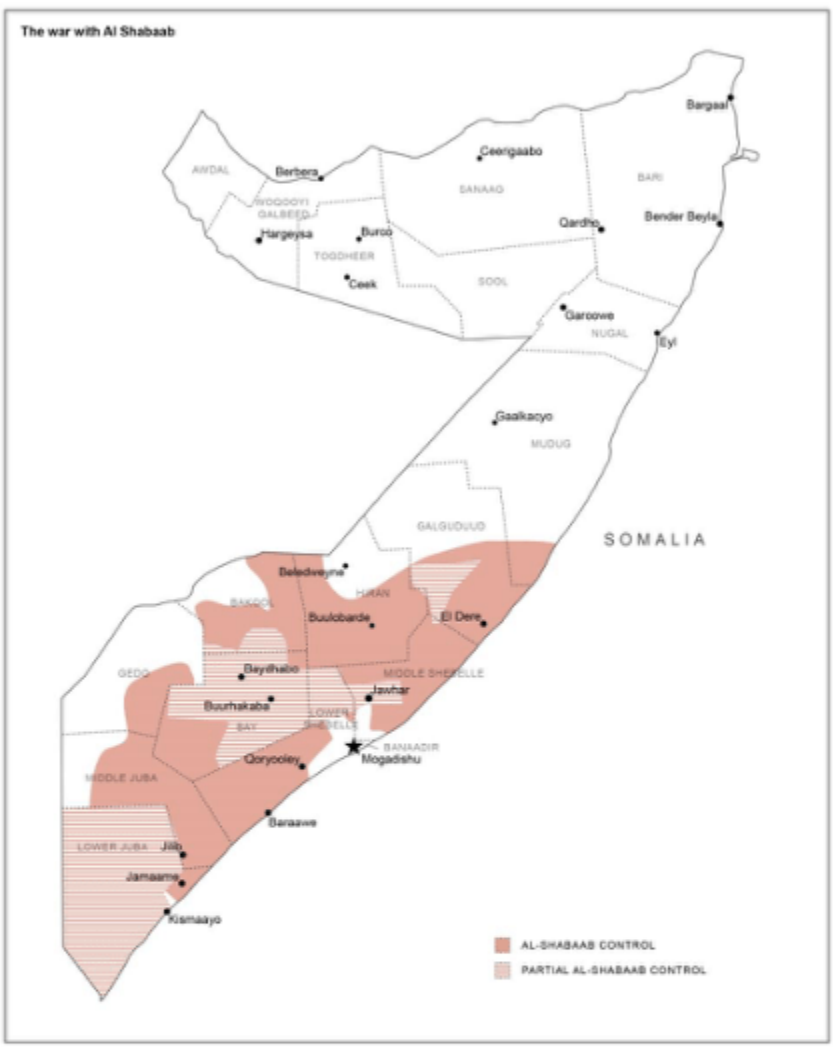
[158] Stig Jarle Hansen, *Al-Shabaab in Somalia: The History and Ideology of a Militant Islamist Group*, Oxford University Press 2013, New York, pp. 55

[159] Ibid., pp. 100

In August 2011, Al-Shabaab initiated an offensive in Mogadishu, aimed at conquering the city. The group lost decisively to AMISOM and TFG forces. The defeat signaled the beginning of a period of decline for Al-Shabaab. In October 2011, Kenya invaded southern Somalia, eventually seizing control of the southern city of Kismaayo. In February 2012, Al-Shabaab solidified its relationship with Al-Qaeda, formally merging itself into the group.[160] By late 2012, the group had withdrawn from Mogadishu and other major towns in the south and center of the country, though it continued to hold a few urban areas. It should be noted that while Al-Shabaab was forced out Mogadishu and Kismayoo under military pressure, it was not militarily defeated. Rather the withdrawals seem to have been part of a calibrated strategy aimed at force protection.



Somalia's first internationally recognized government since 1991 was established in the summer of 2012. President Hassan Sheikh Mohamud was elected on September 12th, amongst great international and national optimism about his ability to navigate the multiplicity of challenges that face modern day Somalia. Despite the efforts of the Federal Government of Somalia (FGS) to increase its capacity, it remains cloistered within Mogadishu and a few urban areas in the south and center of the country, and highly dependent on AMISOM for military protection.

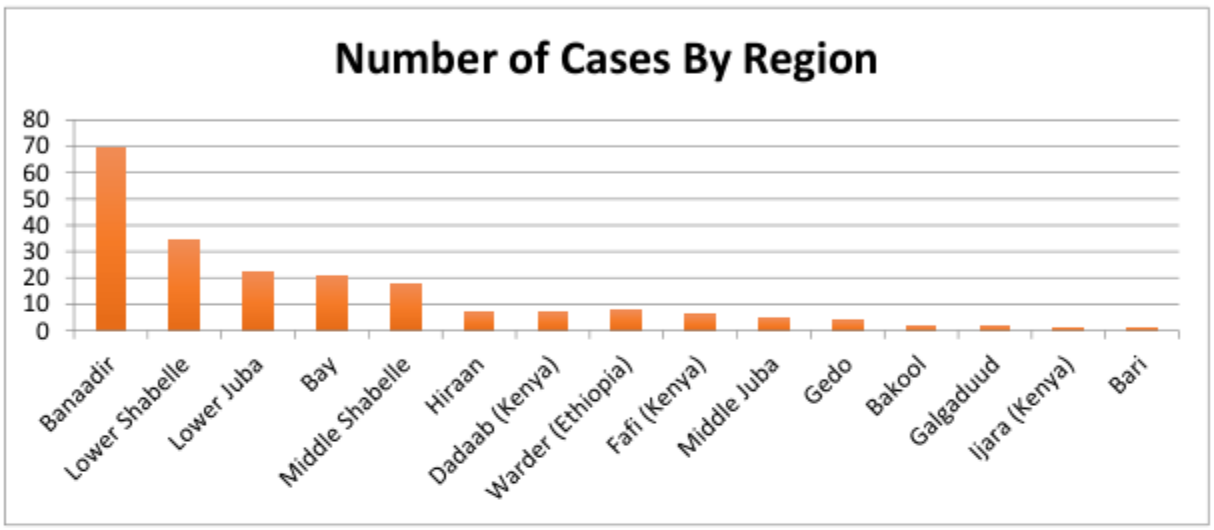
Al-Shabaab remains in control of large swaths of the countryside in south and central Somalia. At least 1.5 million Somalis live in Al-Shabaab controlled areas, while another 1.8 million live in districts in which Al-Shabaab has some presence.[161] Since withdrawing from the urban areas the group has systematically avoided direct combat with AMISOM forces, instead relying on guerrilla and terrorist attacks to wear down its enemies. It has again begun to use fear actively to dissuade cooperation with the FGS and AMISOM. As one analyst observed, the group is biding its time and waiting.[162]Epidemic Background

[160] BBC News, Somalia's al-Shabab join al-Qaeda, Posted 10 February 2012, Accessible at: http://www.bbc.co.uk/news/world-africa-16979440

[161] Calculations based on Rural Population Estimates by Region/District, UNDP Somalia, August 1, 2005.

[162] Stig Jarle Hansen, *Al-Shabaab in Somalia: The History and Ideology of a Militant Islamist Group*, Oxford University Press 2013, New York, pp. 53

It is in this chaotic situation that the 2013 poliovirus epidemic emerged. On Thursday April 18th, a 32-month-old child in Somalia's Banaadir region came down with sudden onset paralysis. Within the month, another case of paralysis was reported in Dadaab, a refugee camp in Kenya that houses an estimated 423,496 Somali refugees. On May 9th, the Banaadir case was confirmed as wild poliomyelitis (WPV1), genetically similar to strains found in West Africa. Health authorities moved rapidly to mitigate the emerging epidemic, initiating a vaccination drive using oral polio vaccine (OPV) in Banaadir and some areas of the Lower Shabelle region on May 14th.[163]



Data from the Global Polio Eradication Initiative, January 2014

Despite these efforts, the epidemic surged. Cases increased in Banaadir throughout May, while sporadic cases were reported in other districts. This pattern began to change in late May, as the epidemic took root in Lower Shabelle, Lower Juba, and Bay. The epidemic's peak seems to have come in early June, when 47 cases were recorded over a two-week stretch.[164] In accessible districts, most of those paralyzed were under the age of two. However, a surprising minority of cases involved children between two and ten, as well as two outlier cases who were in their teens, hinting at long existent gaps in vaccination coverage.

Health authorities, led by the World Health Organization (WHO) and UNICEF mustered a robust response to the epidemic. Commencing with the May 10th vaccination drive, 10 vaccination rounds were conducted, targeting south and central Somalia, Puntland, and Somaliland. Most of the drives were targeted at children under 10, however, three vaccination rounds targeted all ages. Additionally, an all ages' vaccination drive was instituted in Dadaab.[165] A robust public awareness campaign was also undertaken, with 1,356 mosque announcements, 46,337 community meetings, 48,000 public service announcements broadcast over the radio, and 1,300,000 SMS messages sent.[166] Somali political officials were high profile proponents of vaccination; the President, Prime Minister, and Speaker of the Parliament all received the polio vaccine in a highly publicized event at Villa Somalia in Mogadishu. Interviews indicate that many vaccination teams engaged in similar public vaccinations on themselves, and on their children. President Hassan Sheikh Mohamud highlighted the important goal of these publicized efforts, noting, "We do not want taboos to prevent people from taking the polio vaccine."[167]

However, not all Somali political forces supported the vaccination efforts. Al-Shabaab engaged in a high profile campaign against the vaccination process. The group had stymied efforts at door-to-door

[163] Somalia Ministry of Health WHO/UNICEF Somalia, Somalia polio outbreak update - October 2013
[164] Ibid.
[165] The Star (Nairobi), State U.S Fight Against Polio, June 28, 2013
[166] Somalia Ministry of Health WHO/UNICEF Somalia, Somalia polio outbreak update - October 2013
[167] Four Million Targeted in Somali Polio Campaign, Garowe Online (Garowe), June 11, 2013

vaccination in the areas under its control since 2010, due to concerns that vaccination efforts may be a cover for intelligence gathering activities. By 2013, 600,000-1,000,000 unvaccinated individuals were believed to reside in the areas under Al-Shabaab control.[168] Interviews in Somalia indicate that Al-Shabaab's ability to impede door-to-door vaccination efforts extends even into areas under government control, with one interview respondent in a district firmly under Government control noting that the vaccinators "are also afraid [of Al-Shabaab] and they only cover the very small areas where they feel safe."[169] Nonetheless, in some areas under the control or influence of Al-Shabaab, vaccinators were able to work. Interviewees and media reports indicated that low-level commanders at times allowed localized access for vaccination teams. Such derivation from Al-Shabaab policy has reportedly become less common as the movement centralizes, but as of 2013 was still possible.

Al-Shabaab's centralization and increasing conservatism has propelled a new and more vehement opposition to the polio vaccination, in addition to its long-standing opposition to the vaccination process. Interviews and media reports indicate that Al-Shabaab engaged in an active public messaging campaign aimed at stirring up public fear against the vaccine itself. Most messaging by Al-Shabaab revolved around the rumors that the vaccine causes sterility or HIV/AIDS. Al-Shabaab's employment of the rumors pre-dates the 2013 epidemic, but the group's public messaging against the vaccine seems to have become far more common during the spring and summer of 2013. Underlying these messages is an attempt by Al-Shabaab to tap into and politically benefit from the distrust by Somalis of the international community's actions and motives.

Health authorities sought to mitigate Al-Shabaab's impact on the vaccination campaign by vaccinating all children who came to health and nutrituion posts in denied areas and by stationing vaccination teams at 289 key travel points. Reportedly, these efforts were successful, with the transit teams alone vaccinating some 70,000 children per week.[170]

By late June, cases were declining in Banaadir, even while they increased in other regions in south and central Somalia. Additional infection clusters occurred in Kenyan and Ethiopian border areas that hosted large numbers of ethnic Somalis and refugees from Somalia. Reports of poliovirus tapered off in the fall of 2013, with the last confirmed case in mid-January, in Somali region in Ethiopia. In April 2014, the tally of paralytic victims stands at 218. In Somalia, thirty three per cent of cases were registered in Banaadir province, followed by Lower Shabelle with seventeen per cent.[171] The vast majority of cases in the 2013 epidemic, sixty per cent, occurred in areas that have been partially or fully controlled by the FGS and AMISOM for over a year.[172] The dearth of reported cases in Al-Shabaab territory despite with the large unvaccinated population in those areas, heightens the probability that the number of paralytic cases may be higher than what has been recorded. However, the distribution of recorded cases also indicates that expanded FGS control alone will not mitigate Somali's vulnerability to the disease.

Despite the halt in recorded cases, there is reason to be cautious in declaring the epidemic over. Somalia has the second lowest polio vaccination coverage in the world, estimated at over 800,000 children. The 600,000-1,000,000 unvaccinated people living in areas under Al-Shabaab control alone are a potent reservoir for the continued circulation of the virus. Compounding the difficulty, much of the population in Al-Shabaab territory reside in rural areas, where healthcare services have historically been poor and information on health issues difficult to access. Rural dwellers in government-controlled areas – under-reached by information awareness and vaccination efforts – are another potential reservoir propelling a continuation of the epidemic.

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[168] Interview with WHO personnel, and Somalia Ministry of Health WHO/UNICEF Somalia, Somalia polio outbreak update - October 2013

[169] Interview, Religious Leader, Banaadir

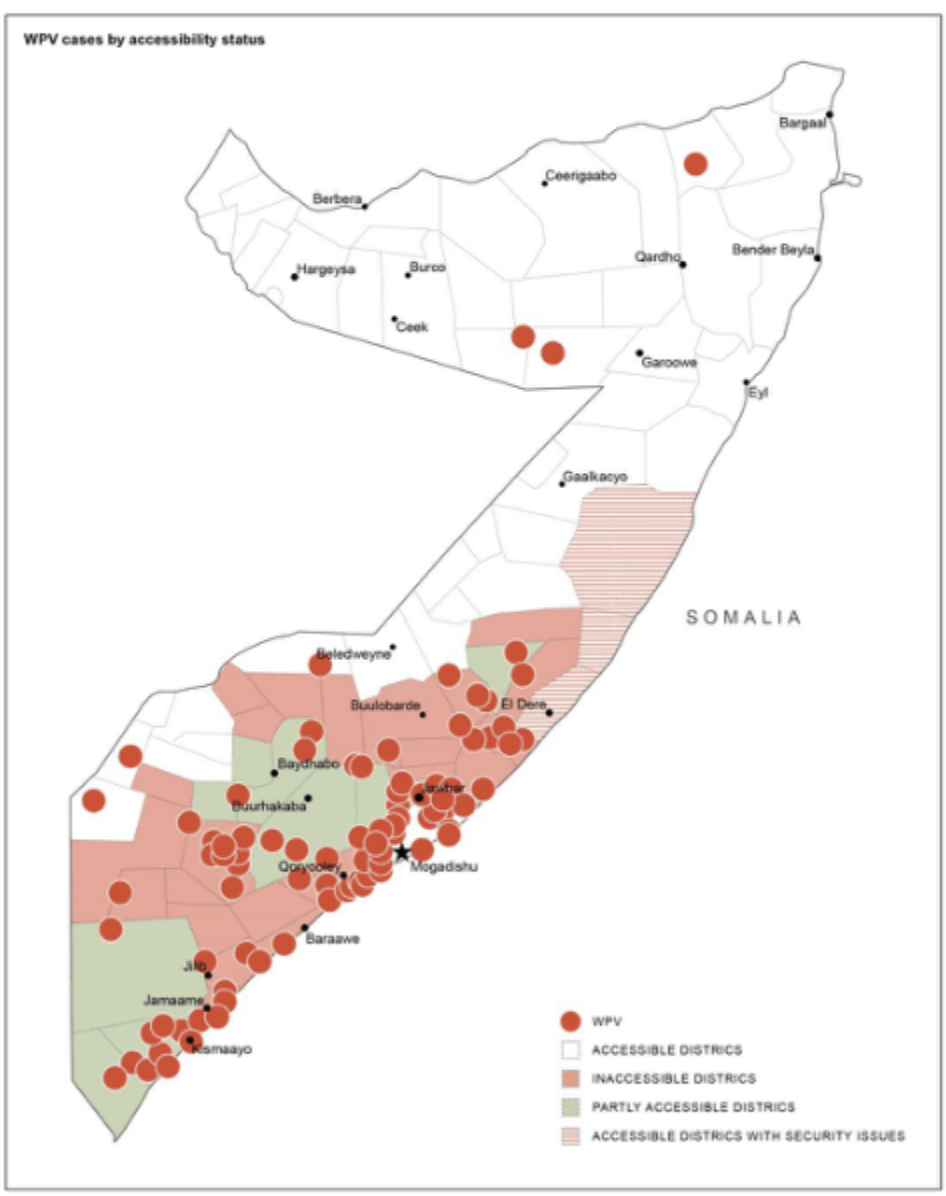
[170] Interview, WHO Personnel, Nairobi

[171] Calculations based on Rural Population Estimates by Region/District, UNDP Somalia, August 1, 2005

[172] Independent Monitoring Board of the Global Polio Eradication Initiative, Eight Report, October 2013

The last time Somalia confronted a polio outbreak, between 2005 and 2007, the trajectory was similar to the current epidemic. An initial outbreak, concentrated in Banaadir province, led to a high number of paralysis cases over the first six months. Case levels declined dramatically after that point, though it took another year and a half before the circulation of the disease was fully interrupted. It should be noted that in many ways the security and political environments during the 2005-2007 epidemic were far more conducive to vaccination efforts than those in the present day.

Nonetheless, polio eradication in Somalia is possible. Interviews indicated that vaccine demand and knowledge of polio are increasing rapidly. Public and private health infrastructure is also expanding, delivering cheaper, more professional and more effective services. While both the social and infrastructural variables are subject to a glaring urban-rural divide, they display a positive trajectory. However, the final variable, politics and stability, is a far more pernicious challenge.

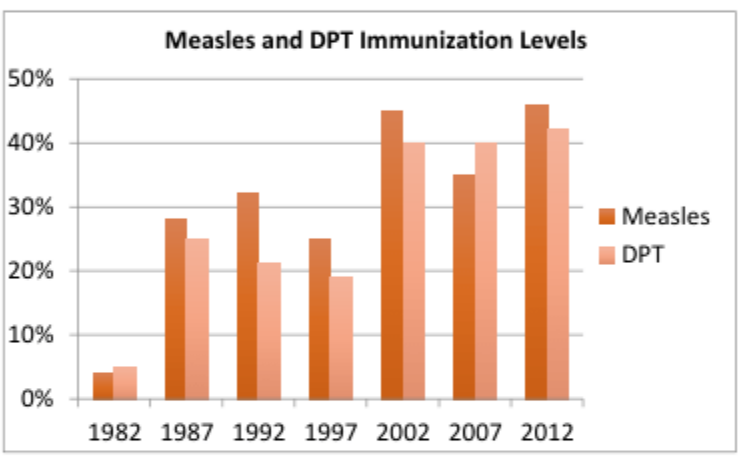


Barriers to Polio Vaccination

Research indicates that three broad barriers have impeded vaccination efforts in those countries in which polio is endemic. These include infrastructural barriers (healthcare), social barriers (perceptions of polio and the vaccine), and political barriers (the existence of spoilers and governmental weakness). Each of these barriers will now be analyzed, identifying the salient challenges, and how they are evolving.

Healthcare Infrastructure

Somalia's polio epidemic is indicative of a deeply dysfunctional health sector. The dearth of healthcare is not new, having been a persistent challenge since the waning days of President Siad Barre's regime. By that point, healthcare spending had been declining since the mid-1970s, and by 1991, only twenty per cent of Somalis had access to basic health services.[173] There was a strong urban bias in healthcare provision, a divide that persists to the present day. The ensuing civil war wrecked the minimal public health system that did exist, leaving those in south and central Somalia with little choice but to pay for private services or turn to clinics run by non-governmental organizations.



Currently, Somalia faces one of the greatest gaps between healthcare availability and healthcare needs in the world. Somalia has an estimated four physicians per 100,000 people, far lower than the regional average.[174] A similar asymmetry exists with nurses and other healthcare workers. In part because of limited availability, it is estimated that on average Somalis visit a health post once every eight years.[175] This has resulted in disease and mortality levels far above both regional and international norms. Vaccination coverage, for polio and other diseases is often well below fifty per cent, though there has been gradual improvement over the last decade. Coverage rates are often far lower in rural and remote areas.

Previous research on Somalia's health sector has found that the key impediments to service delivery revolve around availability and accessibility.[176] Each of these issues is analyzed in turn, as well as the professionalization of services, to identify the challenges that exist, the improvement or deterioration of the situation, and the impact on polio vaccination efforts.

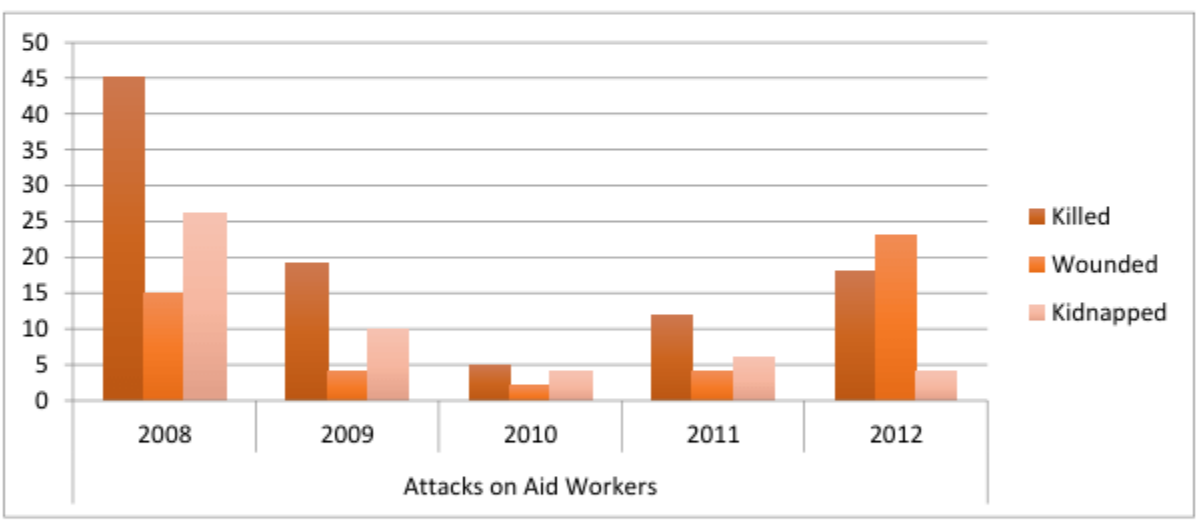
The availability of healthcare in Somalia is extremely limited, despite some signs of a gradual increase in options. Healthcare in Somalia is provided by non-governmental organizations or private facilities. Treatment via traditional and religious methods is common, though interviewees were less reliant on these methods than in years past. However, religious leaders are still sought out by parents worried about the religious permissibility of Western medicine.

The private health facilities are the most widespread and accessible form of healthcare in Somalia, however they offer a highly uneven level of care. Some private health facilities are staffed by doctors and nurses and offer decent medical services. However, the most common type of private health facilities are local pharmacies, which double as clinics. Interviewees were pessimistic about the level

[173] Caitlin Mazzilli and Austen Davis, Health Care Seeking Behavior in Somalia: A Literature Review, UNICEF, PP. 6
[174] World Health Organization, Somalia: Health Profile, May 2013
[175] Caitlin Mazzilli and Austen Davis, Health Care Seeking Behavior in Somalia: A Literature Review, UNICEF, PP. 15
[176] Ibid., PP. 19

of care offered by these facilities. One community leader in Bay region remarked, "The chemists treating people and giving medicines are untrained and unprofessional."[177] Another respondent indicated that the pharmacies are often first and foremost business ventures "run by untrained and unprofessional individuals."[178] Many interviewees did note, however, that the quality of the medicine offered at these facilities had improved in recent years, with counterfeit medicines perceived to be less common.

Non-Governmental Organizations (NGOs) are the other large provider of healthcare services in Somalia. Since the collapse of the Siade Barre regime, NGOs such as *Médecins Sans Frontières*, *CARE*, *Intersos*, and *OXFAM* – to name only a few – have operated throughout Somalia. Interviewees generally preferred NGO medical facilities, noting that they provided a moderate to high level of care. However, some interviewees highlighted concerns over the capacity and level of care provided by newly opened facilities. One health official noted, "More health facilities supported by International and local NGOs like ICRC have been opened but they lack capacity. Some do not even have the right staff; they have no training in handling the sick."[179] Another observed that, "The local health post has medical staff and nurses who are with the Red Cross. However, they are very small and inadequate so the bulk of medical help is provided by private pharmacies."[180] Multiple interviewees from regions outside of Banaadir indicated that for serious health concerns they typically eschewed local options, and instead travelled to medical facilities in Mogadishu, which they perceived to be more professional.



In terms of access, the availability of NGO-provided healthcare is tightly tied to the shifting battle lines of Somalia's civil war. Many NGOs providing service have been banned from Al-Shabaab controlled areas, or restricted in the types of services they can provide. Such bans and restrictions stem from Al-Shabaab's belief that humanitarian activity is being used to spy on the group. Given this restrictive operating environment, Al-Shabaab's expulsion from a district is often linked to increased healthcare access. Additionally, the chaos and banditry that is rife throughout south and central Somalia have led to kidnappings, attacks, and other physical threats that have caused some health related NGOs to withdraw from the country, including *Médecins Sans Frontières* in 2013. After several years of declining attacks, violence against NGO personnel rebounded in 2012. If the number

[177] Interview, Community Leader, Bay
[178] Interview, Religious Leader, Middle Shabelle
[179] Interview, Health Official, Middle Shabelle
[180] Interview, Businessman, Middle Shabelle

of attacks continues to mount, it may impede or halt the operations of the NGOs operating in the south and central part of the country. Such a cessation of activities can have a crippling impact on Somalis in need of affordable and effective healthcare.

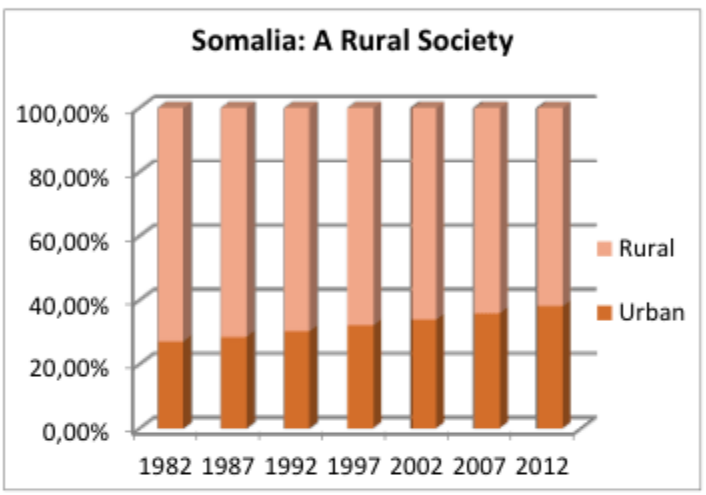
The overdependence on NGOs for health services and lack of local ownership of the healthcare situation is a key long term challenge in Somalia. While international NGOs are committed and courageous in their provision of health services, often in the face of great personal risk and adversity, their actions ultimately depend upon organizational willingness to continue operating in Somalia. *Médecins Sans Frontières'* (MSF) withdrawal from Somalia in August of 2013, after 22 years of operations in the country, exemplifies the danger of Somalia's reliance on NGOs. MSF made the difficult decision to withdraw due to attacks on and kidnappings of its staff members. While the withdrawal ensured the physical security of MSF personnel, it left Somalis who had come to depend on the organization for health services in a difficult position. As one interviewee observed, "since MSF left we have had no doctors and for any complications we have to go to Mogadishu."[181] As long as Somalis are dependent on external entities for their health services, the surety of accessible care is literally out of their hands. Therefore, increasing the capacity of the ministries charged with healthcare provision in Somalia and boosting their ability to plan, provide, and evaluate health needs in the country should be a key medium term goal.

Additionally, the shortage of local medical personnel in Somalia was flagged by many health officials as a key problem in the polio vaccination campaign. Some noted that the vaccinators in their area were badly trained, and mishandled the vaccine. One remarked that "According to my experience, many professionals and learned people are not confident with vaccines storage, the people who dispense of the vaccines and lay people are they tend to mishandle the delicate vaccines. This erodes the people's confidence in the process and undermines the whole campaign."[182] Another health official observed that when confronted with a vaccinator, parents would ask "you are not a doctor, why should I entrust you with my child's health?"[183] Other health officials noted concerns that members of a single clan in their area were tasked with vaccinating the community. This reportedly led to vaccine refusals by members of rival clans. Finally, concerns were voiced that the vaccination drive was leveraged as a money making endeavor by local individuals, leading them to employ untrained members of the community. A doctor in Middle Shabelle indicated "the [polio] vaccination process is done by a man from a popular clan, who has used his influence and politics to get the tender to carry out the vaccination here. The man is not a medic and has no medical background. He employs his clansmen and -women without considering qualification and training. The WHO and UNICEF use him to gain access where they cannot go. The people handling the vaccines are uneducated and unprofessional."[184]

The health officials interviewed represented the largest bloc of critics of the vaccination efforts in their communities. Many of the criticisms are intimately linked with Somalia's health capacity challenge; after two decades of conflict there are simply not enough trained medical professionals to oversee and implement a mass-vaccination campaign. Epidemic entrepreneurs have exploited this, providing vaccinators and offering international health officials the ability to access otherwise denied areas. However, in at least some cases this has led to the employment of minimally trained vaccination teams and impacted on the willingness of some to accede to the inoculation of their families.

[181] Interview, Community Leader, Middle Shabelle
[182] Interview, Health Official, Bay
[183] Interview, Somalia Federal Government Health Official, Nairobi
[184] Interview, Doctor, Middle Shabelle

Finally, a large challenge for both healthcare and the vaccination efforts is the spatial distribution of healthcare facilities. As noted earlier, for decades there has been a pronounced urban-rural divide in healthcare availability. The current iteration of Somalia's civil war has exacerbated this, as urban areas are now primarily under government control while rural areas are controlled by Al-Shabaab, and are thus extremely difficult to access. Rural areas also contain the vast majority of Somalia's population, making the shortage of healthcare options in those zones a matter of pressing importance. This shortage is further magnified by the expense and difficulty of traveling for rural dwellers.[185] Research has found that in many cases the cost of traveling to a healthcare facility often outpaces the actual cost of medical care.[186] The poorest, those in rural areas, are thus doubly disadvantaged by low levels of healthcare availability and a financial inability to travel to a location where such services are available. This lack of of medical options has reportedly fed into a general skepticism of western medecine in the countryside, as well as fatalism over the possibility of recovery. The inaccessibility and lack of health care facilities in rural areas has led to a continuing reliance on traditional medecinal techniques.[187]



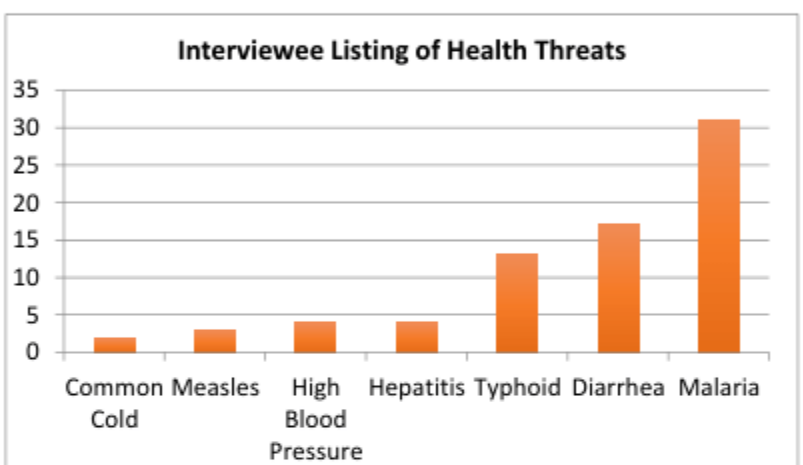
The challenges posed to Somalia's healthcare system do not have an easy fix. Capacity building, increased availability of facilities, and novel solutions to the challenge of rural healthcare accessibility may all play a role. However, it is abundantly clear that the current status quo is not adequate. Without improvements in Somalia's health system, there is little possibility that vaccination levels will increase in the long term. While the surge in vaccination efforts that occurred during the 2013 epidemic is effective in mitigating an acute outbreak of disease, it is not a durable fix.

[185] Caitlin Mazzilli and Austen Davis, Health Care Seeking Behavior in Somalia: A Literature Review, UNICEF, PP. 19
[186] Ibid., PP. 20
[187] Interview , Former BBC Somalia Journalist, Nairobi

Social Perceptions

Full vaccination coverage often hinges upon social buy-in to the vaccination program. In areas where this does not occur – such as Nigeria, Pakistan, and Afghanistan – vaccination efforts face considerable challenges. Three aspects of Somali society salient to the vaccination program were investigated: perceptions of disease risk, knowledge polio, and views on the vaccine. In each of these areas, the potential for change was focused upon.

Polio research in northern Nigeria indicates that a challenge in that context is the gap between the urgency that national and international health authorities place on the eradication of polio and the level of concern that the disease evokes amongst the population. Simply put, the incidence of polio is so infrequent that other diseases are seen as far more pressing threats to the health of the population. In turn, this tends to disincentivize demand for the vaccine. A similar dynamic seems to exist in Somalia.



Interviews indicate that Somalis do not rank polio amongst the most dangerous health threats that they or their families face. Only one in forty respondents flagged polio as a threat. Rather, diseases such as malaria, diarrhea, and typhoid are seen as challenges that are far more acute and damaging. There seems to be little variation amongst the different regions, though reports of malaria did seem marginally higher in areas close to the Shabelle River. Findings from the interviews are born out in WHO statistics. Both malaria and typhoid occur in Somalia at levels far above regional and international norms.[188] In 2010, malaria accounted for seven per cent of deaths for children under five, while diarrhea accounted for sixteen per cent. By comparison, the 185 cases of paralysis caused by the poliovirus represent an extremely small sliver of childhood illnesses in Somalia. Therefore, entities tasked with eradicating the disease face the challenge not only of reaching a large, rural population, but also of stimulating demand for the vaccine by heightening Somali's threat perception of poliovirus.

While Somalis view other diseases as more acute threats than polio, they are certainly aware of the disease. Termed daebeyl in Somali, the acute flaccid paralysis caused by polio is traditionally viewed as a bad omen caused spirit possession (as one interviewee noted, it is a situation in which "someone collided with a Jinn").[189] A minority of respondents also indicated that in some cases the paralysis was thought to be an inherited condition. To "cure" daebeyl, Somalis traditionally confined the paralyzed individual to a room and summoned an exorcist. The exorcist, often a religious leader, would attempt to dispel the possessing spirits from the victim's body by reciting passages from the Quran and burning herbs. One respondent also observed that in some cases healers resorted to "burning", a traditional form of Somali acupuncture using hot coals. Religious authorities contacted for this report indicated that such traditional "cures" are still used, though far less frequently than in years past. However, interviews suggest that there is a pronounced urban-rural information asymmetry; with rural dwellers believed to be far more likely to ascribe to traditional beliefs about supposed cures for daebeyl.

[188] World Health Organization, Somalia: Health Profile, May 2013
[189] Interviews in south and central Somalia and Puntland

Interviews suggest that the last five years have seen a dramatic change in Somali's knowledge of polio and their willingness to rely on modern medicine to prevent it. The urban dwellers interviewed were nearly unanimous in noting that their views on polio had undergone a shift. None of those interviewed, including religious leaders, viewed the diseases as spiritual in nature. Rather, respondents perceived it to be a medical disease which could be prevented. Most of the credit for this shift in knowledge is due to the information awareness campaigns conducted by local and international NGOs. One respondent remarked, "Now we take [infected kids] to the hospitals in Mogadishu. This is due to the information and the awareness that we have been given by the radio and through the dialogues we have had in the community."[190] Even though few of those interviewed had encountered someone stricken with acute flaccid paralysis, nearly all felt comfortable that they would recognize the paralysis as polio, and seek appropriate medical care. However, a large number of respondents indicated that they generally did not know the symptoms of non-paralytic polio, suggesting a possible avenue for future awareness building.

A third perceptual barrier faced by health officials tasked with eradicating polio revolves around vaccinations. Concern about the permissibility and safety of the polio vaccine and the way in which the vaccination campaigns have been conducted has hampered disease eradication efforts in other countries. While the social environment in Somali seems more conducive to vaccination efforts, challenges remain. As described earlier, Al-Shabaab has sought to impede vaccination efforts by claiming the vaccine is tainted, and will negatively impact the recipient - causing sterility or HIV/AIDS. While the group's public messaging effort against the vaccination campaign involves rumors commonly utilized by Islamic extremist groups in other countries, it does not seem that Al-Shabaab has adopted global rhetoric and employed it in the local context. Rather, rumors that the OPV causes sterility and HIV/AIDS are common in Somalia, both in areas previously controlled by Al-Shabaab and areas, such as Puntland, where the group has historically had a limited presence. A religious leader in Middle Shabelle observed, "Years ago people would revolt against the vaccination campaign and be hostile to anybody who attempted to vaccinate them. This was because they believed the vaccines were viruses being spread by foreign powers and that they would cause such diseases like HIV to our population."[191] More broadly rumors about sterility and HIV/AIDS relate to a profound cynicism towards the actions and intentions of international actors in Somalia. One Somali political candidate remarked, "People in Somalia are suspicious about almost everything, especially if coming from the West. Al-Shabaab adds to this. People do not expect anything good from the U.S."[192]

Additionally, some interviewees highlighted the belief that the polio vaccine drive is actually a secret drug trial by a pharmaceutical company. Reported by a health official in Bay and an interviewee in Bari, the rumor is reportedly promulgated by religious leaders and non-medical professionals. According to the health official, the intent of the rumor is to "make people think that the organizations doing the vaccination don't care about them."[193] It is unclear how widely this rumor has spread.

Interestingly, the belief that vaccinations cause autism, increasingly common in the U.S. and Western Europe, has also spread to Somalia. Reportedly, a member of the diaspora who returned to Somaliland has been active in promulgating the rumored link.[194] There is little indication that the rumor is widely repeated or believed, with none of the interviewees in Somalia flagging the rumor as common in their communities. Nevertheless, the existence of the rumor is troubling, and it should be monitored for future spread.

Finally, interviewees indicated that some Somalis view OPV as responsible for their children becoming sick. A Somali journalist explained, "Over the last three years, people didn't like [the

[190] Interview, Health Official, Middle Shabelle
[191] Interview, Religious Leader, Middle Shabelle
[192] Interview, Somali Political Candidate, Nairobi
[193] Interview, Health Official, Bay
[194] Interviews, UN and NGO officials, Nairobi

vaccine]. They ran away from polio vaccination, after their children received the vaccine and felt a fever and headache. They realized that the vaccination itself is a virus."[195] These concerns can present remarkably durable barriers, with one religious leader in Bari noting that he had refused to vaccinate his family because "my wife said her niece died after being prescribed vaccination 7 years ago in their village. She was adamant and I began getting a little worried because I knew the country's health system was in a chaos and there may have been a mistake."[196] Other interviews indicated that some believed that the vaccine itself caused polio. This concern is not wholly without merit. Between 2007 and 2013, a number of circulating vaccine-derived poliovirus (cVDPV) cases were reported in Somalia. Given the dearth of wild poliovirus in Somalia during this time, the reports of vaccine-derived cases likely become a potent argument against utilization of the vaccine, further suppressing demand for it.

The advent of the 2013 epidemic and the associated awareness campaign seem to have succeeded in minimizing concerns about the vaccine. Interviewees in Somalia were emphatic that in urban areas few still believed the rumors. Nearly all respondents had, when offered the chance, vaccinated their families. More broadly, data from the UN on vaccination acceptance and media reports seem to bear this out. Attempts by the UN and international NGOs to stimulate demand for the vaccine seem to have succeeded. One Somali healthcare worker stated "People come voluntarily to my health facility and ask for the OPV even though it is not available at my facility because I have not been provided with it. This was unheard of some years back when people did not used to trust the vaccines."[197]

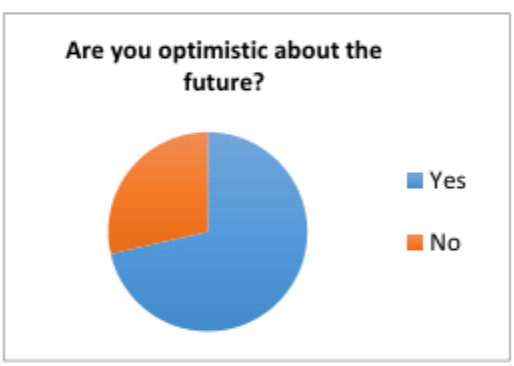
Promisingly, interviews indicate that knowledge of polio and demand for the vaccine improves rapidly once adequate information on the disease is available. Al-Shabaab's ability to harden attitudes against vaccination by trumpeting rumors about the vaccine are effectiv only as long as the group is in control of an area previously cut off from adequate information and able to dictate the types of medical care and information available. It is likely that concerns about Somalis irrevocably turning against vaccination efforts due to Al-Shabaab's messaging campaigns are, while legitimate, likely overblown. Nonetheless, as we will see in the final section, political barriers form the most intractable of the challenges faced by the vaccination teams in Somalia.

[195] Interview, Somali Freelance Journalist, Mogadishu
[196] Interview, Religious Leader, Bari
[197] Interview, Health Official, Middle Shabelle

Political Barriers

Somalia's political dysfunction and widespread instability have long been potent barriers to effective healthcare. For vaccinators, the difficulties attendant with working in a war zone have been magnified by the vehemence with which Al-Shabaab has publicly opposed their activities. Al-Shabaab's efforts to erect barriers to vaccination have succeeded in producing one of the largest unvaccinated population groups in the region, estimated conservatively at 600,000. Despite losing significant territory and key urban centers since 2012, Al-Shabaab is far from a defeated entity. The group is still a powerful political and military force, a reality that is unlikely to change in the near future. Additionally, Al-Shabaab is not the only barrier to vaccination provision in south and central Somalia. The newly established Federal Government of Somalia (FGS) has proven to be a functional, yet still weak entity. The absence of effective governance in areas under the control of the FGS has led to re-emergence of banditry and clan-based conflict. This predation impedes and increases the cost of service delivery, as well as potentially foreshadowing increased conflict in areas of Somalia now thought to be secure. This section will explore the current political realities and security situation faced by the Federal Government of Somalia and Al-Shabaab, highlight the salient political dynamics, and identify the impact on health and vaccination provision.

Federal Government of Somalia



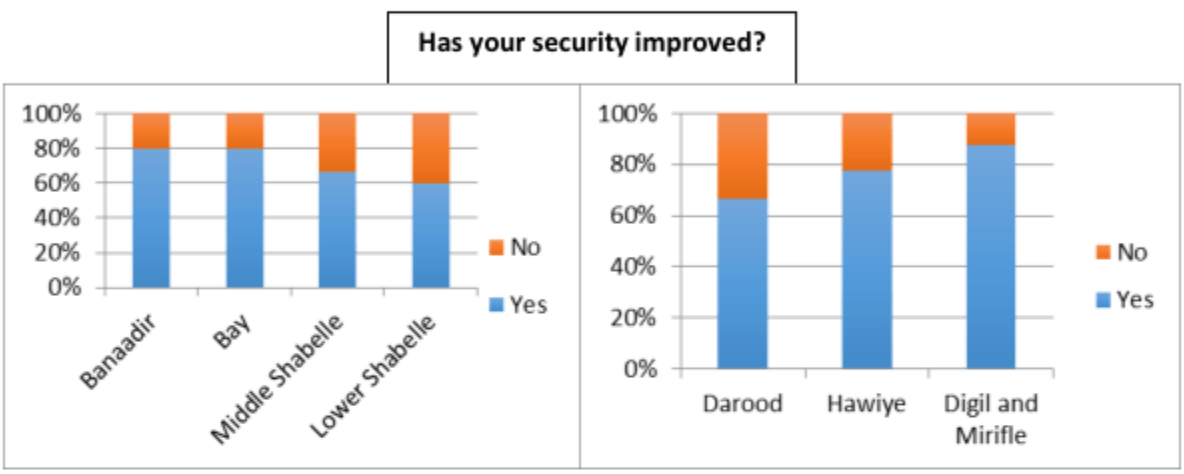
The Federal Government of President Hassan Sheikh Mohamud is viewed as the most effective government Somalia has had in decades. The FGS is the first internationally recognized Somali government since 1991, and it enjoys *de facto* control over many of the urban areas in south and central Somalia. Many interviewees were optimistic about the path the country was on, regardless of whether they supported the FGS or not. However, the FGS remains challenged by its limited territorial control and power, continued violence, low levels of support, and key political questions which remain unresolved. Each of these issues individually could hobble the effectiveness and durability of the FGS; collectively they make it difficult if not impossible to run the state.

A key challenge for the FGS is that its writ does not extend particularly far. Though the Government claims *de jure* control of all of Somalia, its *de facto* control is limited to Mogadishu and some urban areas in the south and center of the country.[198] The Federal Government/AMISOM gained significant territory in 2012, seizing most major urban areas in the south and center of the country, however, there were few territorial gains in 2013. At present, AMISOM and the Somali Armed Forces (SAF) do not have the manpower to significantly alter the military status quo.

A second challenge is that the FGS does not "own" the security situation. While a great deal of effort has been put into the development of a new Somali army, the current force has serious desertion and morale problems. SAF soldiers reportedly do not receive their salaries on a regular basis, and, according to one former TFG national security advisor, there is reliable information that soldiers have resorted to selling weapons and ammunitions to Al-Shabaab in order to support themselves and their families. Additionally, the national military has reportedly been recruited along clan lines, which raises the spectre that the force will come to be seen as robustly equipped clan militia, and thus an army of occupation in those areas dominated by rival clans.

[198] Daniel Kebede, Somalia: Still in Transition?, Africa UP Close, Woodrow Wilson International Center for Scholars

Unable to provide security in Somalia, the FGS depends heavily on AMISOM's presence to keep Al-Shabaab from re-taking areas currently under government control.[199] Interviewees were often emphatically positive about the role played by AMISOM, even while their perception of the security provided by SAF forces was generally mixed to negative. However, reliance upon AMISOM is a double-edged sword for the Government. While the FGS would be militarily hobbled without it, the force could be a political liability. If Somalis come to perceive AMISOM as acting to advance foreign interests in their country, they could turn dramatically against both AMISOM and the FGS. Some analysts have flagged the recent incorporation of Kenyan and Ethiopian military forces into AMISOM as posing just such a danger.[200]



Third, the physical security of average Somalis is improving, but significant challenges remain. The majority of interviewees perceived their security as having improved. This ranged from a high of eighty per cent of respondents in Banaadir to a low of sixty per cent in Lower Shabelle. Broken down along clan lines, the Digil and Mirifle clans were most likely to view the situation as improving, while the Darood were the least likely to see a general bettering of the situation. It should be noted that President Hassan Sheikh Mohamud is Hawiye, as indeed are much of the political class in Mogadishu.

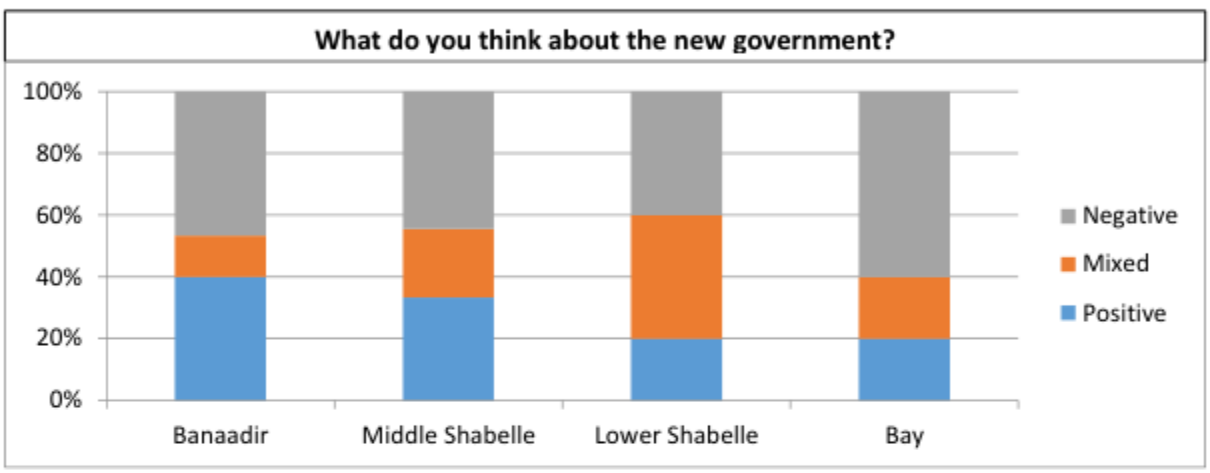
While these numbers are optimistic, the qualitative interviews indicated that the security situation remains extremely precarious. One businesswoman in Lower Shabelle remarked on an increased incidence of robbery and rape, perpetrated by SAF units. She stated, "The threat to me is the constant insecurity and violence. There are explosions in Afgoi on a daily basis. There are a lot of women who are being raped by the government soldiers who are just militias and robbers."[201] Similar sentiments were voiced frequently in Middle Shabelle, especially regarding robbery by SAF soldiers. One businessman stated "the local authority and their militias are extorting business people by force in the name of taxation. There is no accountability."[202] There has been a reported increase in roadblocks, used by government forces and militias to extort travelers. According to one report, tariffs in one area of Hiran "have increased from $50 under Al-Shabaab control to almost $700 per livestock truck."[203]

In addition to predation by FGS forces, politicized, polarized and violent conflicts are systematically resurfacing and spreading in many parts of the country. Reports from Hiran, Middle Shabelle, and

[199] Matt Bryden, Somalia Redux? Assessing the New Somali Federal Government, CSIS Africa Program, August 2013, PP. 4
[200] Bronwyn E. Bruton, speaking at "*The al-Shabab Threat After Westgate*", held at the Carnegie Endowment for International Peace, December 17, 2013
[201] Interview, Businesswoman, Lower Shabelle
[202] Interview, Businessman, Middle Shabelle
[203] Somali CEWERU, From the bottom-up: Perspectives through Conflict Analysis and Key Political Actors' Mapping for the Central Regions of Hiran, Galgaduud, and Middle Shabelle, Pp. 8

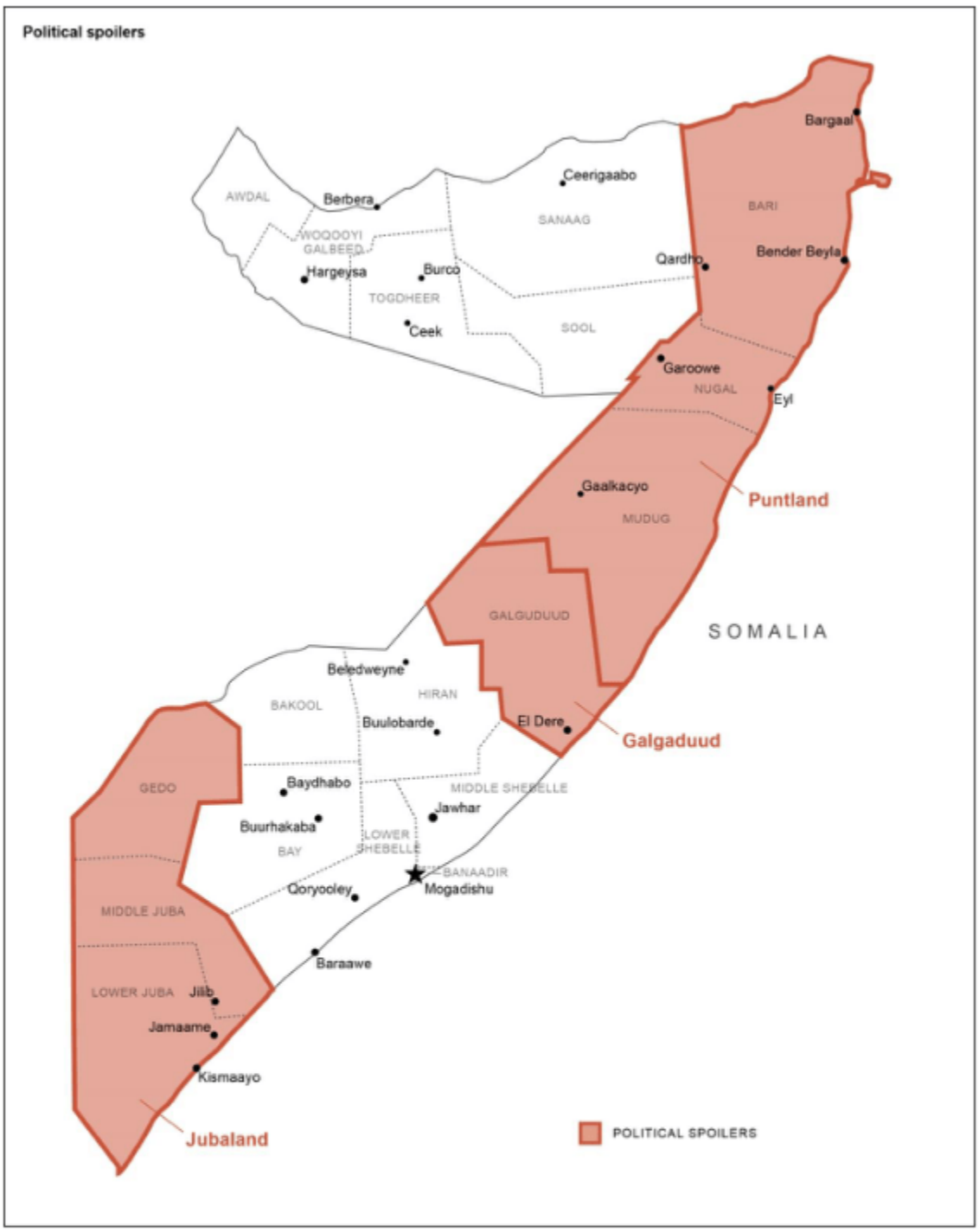
Lower Shabelle indicate that clan-based conflicts are increasingly common.[204] The national election scheduled for September 2016 may further exacerbate local level clan violence.

The rise in predation and clan violence points to a central challenge faced by the Federal Government: its inability to ensure citizen security in the areas under its control. This is troubling not only for what it says about government security capacity, but also because it risks undermining support for the FGS. As noted earlier, Al-Shabaab's support was based primarily on its ability to guarantee day-to-day safety in the areas under its control.



The Federal Government is also struggling for support amongst Somalis. It is important to remember that the FGS was not voted into office via an election, but rather through a vote in the Somali parliament (itself unelected). Since coming into office, the Government has not done a good job at developing internal political capital, nor in fostering a constituency.[205] Interviewees were mainly pessimistic about the FGS. Many indicated that they viewed it as corrupt, interested primarily in politics, and beholden to clan interests. One businessman in Middle Shabelle observed, "The new government is made up of people who care a lot about their clans and their tribes. Most of them are politicking at the expense of their citizens."[206] Another interviewee underlined the danger of this approach, noting, "The greatest threat [for the Federal Government] is violence, because not all Somali clans are supporting the government. Some clans say that they are unfairly represented in the federal government and may rise up in arms at any moment if they are not watched carefully."[207]

[204] Somali CEWERU, From the bottom-up: Perspectives through Conflict Analysis and Key Political Actors' Mapping for the Central Regions of Hiran, Galgaduud, and Middle Shabelle, Pp. 7; Somali CEWERU, From the bottom-up: Perspectives through Conflict Analysis and Key Political Actors' Mapping for the Central Regions of Hiran, Galgaduud, and Middle Shabelle, Pp. 47
[205] Interview, Mark Bradbury, Rift Valley Institute, Nairobi
[206] Interview, Businessman, Middle Shabelle
[207] Interview, Health Official, Middle Shabelle



Rather than building a supportive constituency, the Federal Government is seen to be fixated upon the design of Somalia's new federalist system. Heavily supported by political leaders in Galgaduud, Jubaland, and Puntland, the federalist structure would involve the creation of one or more new political entities in the south of the country. The FGS has been lukewarm on the implementation of a federal system, and has instead focused its energies on centralizing political authority in Mogadishu. As one interviewee stated, "The whole federalism issue is about governance, autonomy, and accessing international resources."[208] The focus on the federalism question has diverted the Government's focus from the conflict with Al-Shabaab. Despite the slow increase in the capacity of SAF forces, there seems little political focus on expanding government control into the rural areas of

[208] Interview, Mark Bradbury, Rift Valley Institute, Nairobi

the south. As one Nairobi analyst indicated, "There is a parallel reality with Somali politicians, they deal with the future as if they've got control of the country and have beaten Al-Shabaab. They are miles away from that in the south."[209]

While the Federal Government has proven to be accommodating to the current vaccination campaigns, the government's weakness presents a challenge for near term and long term health provision. In the near term, the government's weakness has led to the "gatekeeper phenomenon."[210] Lower level officials have leveraged their physical control over local populations and IDPs to profit from the provision of aid in their area. The system is not new in Somalia, but according to the UN monitoring group it has become more sophisticated in recent years.[211] The diversion of aid by the gatekeepers prevents beneficiaries from receiving necessary supplies, as well as impeding efforts to monitor on the effectiveness of service delivery.

Additionally, the power vacuum in FGS-controlled areas has complicated negotiations by NGOs for access.[212] While Al-Shabaab can, and often does, bar aid agencies from accessing its area, it does present a uniform means of negotiating for access. The existence of multiple political actors in government-controlled areas – government officials, clan elders, militias, and Al-Shabaab – increases the logistical and financial complexity of accessing these areas for NGOs.

In the long term, the greatest danger to the vaccination efforts is the possibility that the current governance process, as weak as it is, will fall apart. The disintegration of the FGS would, at best, impede efforts by NGOs to provide vital services to Somalis. At worst, a flare up of violence along clan lines would lead to widespread death and destruction, increasing the vulnerability of the population to diseases such as typhoid, diarrhea, and polio.

Security Situation

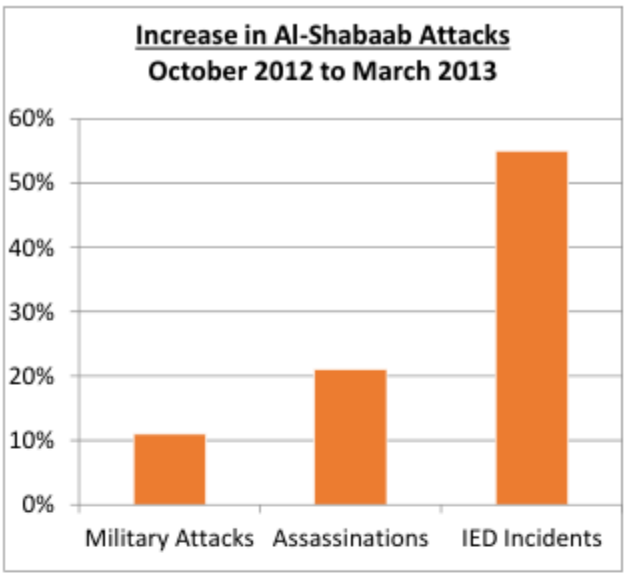
Stability and healthcare are a vicious circle in Somalia. Instability, and attendant destruction of infrastructure, pose one of the most significant barriers to health care for Somalis. In Government controlled areas, poor health care access can drive popular disillusionment and disgust with the Federal Government of Somalia, fueling grievances and instability. In areas controlled by Al-Shabaab, the situation is even more complex, as the country's poor security situation makes it difficult to bring vaccination and other health care services to the people in rural areas, while at the same time Al-Shabaab does not allow people to seek vaccination services at health care service stations.

Harakat Al-Shabaab Al-Mujahideen

Al-Shabaab is the most potent barrier to polio vaccination in Somalia. The group is the only large political actor that has sought to halt and sabotage vaccination efforts. Al-Shabaab's opposition to the vaccination campaign is motivated in part by ideological concerns, similar in many ways to the concerns voiced in Nigeria. The group is also motivated by fear, viewing the vaccination campaign as a ruse designed by Western intelligence agencies to gather information and identify the location of Al-Shabaab's leadership. The increasing use of drone strikes and special operations raids against the group have deepened their paranoia. The impact of Al-Shabaab's campaign against vaccination has been severe; between 600,000 and 1,000,000 individuals in the areas under their control are not vaccinated. It is likely that this large unvaccinated population will prolong the polio epidemic, leaving children paralyzed who could have been protected.

[209] Interview with Roger Middleton, Conflict Dynamics International, Nairobi
[210] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2012, pp. 9
[211] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2013, pp. 365
[212] Interview with Roger Middleton, Conflict Dynamics International, Nairobi

Al-Shabaab is the most resilient force in Somalia. Its history has been marked by cycles of success, overreach, and retreat. Despite frequent pronouncements of its destruction, the group has an impressive ability to learn from its failures, and rebound. While the group seems to be in a weak position at present, there is little chance that it is on the verge of collapse. Rather, it is playing a waiting game, wearing down AMISOM and the FGS through guerrilla action and terrorist attacks. Its history suggests that it will move rapidly to capitalize on any weaknesses shown by its rivals in south and central Somalia.



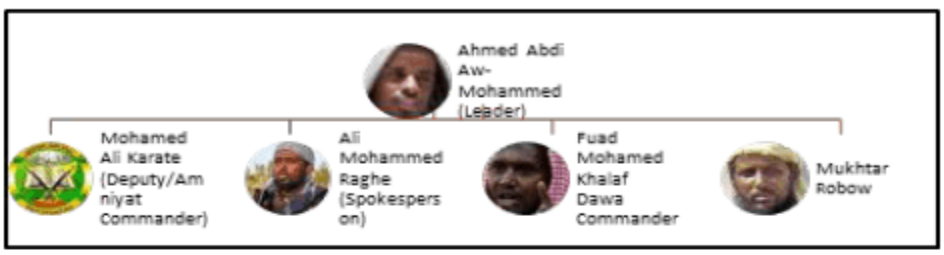
Ideology and Leadership

Al-Shabaab's ideology is a complex mix of Islamism, international jihadism, and nationalism. At its core, the group is united by Salafist ideology, an austere philosophy based on an exceeding narrow interpretation of the Quran. Traditionally, Somalis have not followed Salafist teachings, preferring instead various Sufi orders. However, Salafist movements, including Al-Shabaab, have gained adherents and support in the past by offering a non-clan-based, Somali identity. Their vision of a political system not dominated by clans has been extremely appealing for Somalis buffeted by three decades of clan-based conflict. Al-Shabaab's strategic evolution, however, has been driven by a constant struggle between those evincing an international jihadist view and those focused on purely national aspirations.

International jihadist ideology has existed within Al-Shabaab since the foundation of the organization. Many of the group's founders were either trained or fought in Afghanistan. Upon their return to Somalia, connections were forged with remnant members of Al-Qaeda's mostly defunct East African branch. The international jihadist strain within Al-Shabaab views its mission as protecting the Islamic Community worldwide, anywhere it is perceived to be under threat. In this view Somalia is just one battle ground amongst many. The most prominent proponent of this view is Sheikh Ahmed Abdi Aw-Mohamed (AKA Godane), the founder of Al-Shabaab, and its leader since 2007. Born in 1977 in Somaliland, Godane spent time in Afghanistan before his return to Somalia. He has sought to internationalize the organization in part by actively soliciting foreign fighters, and in part by declaring formal allegiance to Al-Qaeda in 2012.

The nationalist wing of Al-Shabaab has voraciously criticized these goals and actions. Associated with Mukhtar Robow (AKA Abu Mansur) and Fuad Mohamed Khalaf, themselves founding members of the group, the nationalist wing focuses far more on conflict and governance in Somalia. More rooted in local clans than Godane's wing, the goals of the nationalists are to win political control of Somalia.

Al-Shabaab Leadership



While perceived to be more moderate that the Salafists, it is perhaps more apt to describe the nationalists as practical. Their moderation, when it comes to issues such as vaccinations and aid, is driven by the desire to provide practical governance for their communities. Robow and others within the nationalist wing have been vehemently critical of Godane's decision to merge Al-Shabaab into Al-Qaeda, as well as the growing centralization of the group.

Al-Shabaab's leadership structure is currently in a state of flux. Since 2010, Sheikh Godane has been working to centralize the group's decision-making authority under his control.[213] For much of the group's history, decision-making involved the group's shura council, composed of key military and political leaders within the group. The executive shura brought together the sometimes fractious and disparate elements of the group, enabling criticism of Godane, discussion of strategy, and other disputes to be handled without threatening Al-Shabaab's unity.

Mukhtar Robow was one of the primary leaders to push back against this centralization drive. Hailing from the Bay region, Robow is seen as a pragmatic moderate, more focused on the conflict in Somalia than the larger jihadist struggle. He and Godane have repeatedly quarreled over ideology and tactical questions. The conflict between the two took a dark turn during the summer of 2013 when a military clash occurred in Barawe, Lower Shabelle. During the clash, two shura members (Ibrahim Haji Jama Mead and Abul Hamid Hashi Olhayi) were killed, and Robow fled. He is now believed to be in Bay region. His current association with the group is unclear, though reports of reconciliation between Robow and Godane emerged in November 2013.

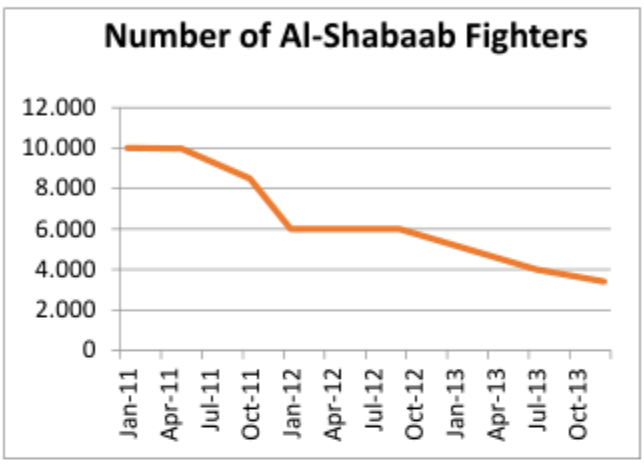
Al-Shabaab's commanders have quarreled before, with internal conflicts never impacting the group's operational capability. However, the killing of two senior leaders is unprecedented for the group. Robow and Hassan Dahir Aweys, another senior leader who fled after the clash, command significant clan-based constituencies. Robow's and Aweys' absence from the inner circle of the Al-Shabaab may well alienate their clans, impeding recruitment and other forms of support. Godane's attempt to wield unilateral control over the organization may well backfire. He enjoys little clan-based support, and is reportedly personally unpopular.[214] Unfortunately, there is little indication that the FGS has sought to leverage this split to politically splinter Al-Shabaab.

[213] Interviews with Al-Shabaab defectors in Mogadishu

[214] Bronwyn E. Bruton, speaking at "*The al-Shabab Threat After Westgate*", held at the Carnegie Endowment for International Peace, December 17, 2013

Organization and Recruitment

Al-Shabaab has three distinct components: a political/civil administrative apparatus, a traditional military force, and a secret service, the Maktabatu Amniyat. The first element, the civil administrative and political apparatus is an often-overlooked component of the group's success. During the 2009-2011 period when Al-Shabaab engaged in governing south and central Somalia it developed a well-functioning, though unofficial, governance structure. A look at the titles of the administrators during this time is instructive. Three different group leaders were tasked with finances (First deputy In Charge of Finance, Head of Finance, and Treasurer), another was Judge of Al-Shabaab, while, ominously, a third was head of Kidnapping Aid workers for Ransom.[215] Underneath these leaders, bureaucrats engaged in taxation, policing, and judicial activities. The latter especially was multi-tiered, and created the first effective, centralized court system Somalis had known in years. Al-Shabaab formed a Dawa department focused on promulgating the group's Salafi brand of Islam. A subcomponent of the Office for the Supervision of the Affairs of Foreign Agencies, the Humanitarian Coordination Office (HCO) was developed to regulate international aid agencies.[216] This office was also involved in negotiating access fees leveled on international aid organizations that wished to operate in Al-Shabaab territory. The governance apparatus was reportedly dismantled in many areas when Al-Shabaab returned to guerrilla warfare, however, some structures – such as tax and law enforcement units – are still believed to be operational.



While Al-Shabaab's service provision won public support, the group's potent military capacity has distinguished it in Somalia. The group's offensive capabilities are divided between two wings of the organization: the military and the Amninyat. The military component of Al-Shabaab is composed of close to 4,000 fighters, organized into 7-8 man squads.[217] This level has dropped dramatically over the last three years, due to battlefield attrition, desertions, and the defection of clan-based units. The group is distinctive in Somalia for paying its fighters, reportedly between $100-$500 per month. Fighters are usually recruited in areas under Al-Shabaab control, with many joining for economic rather than ideological reasons.[218] One analyst remarked that "its profitable to be a Shabaab in some regions. They provide livelihoods.[219] However, Al-Shabaab does hold an attraction for Somali youth. An interviewee observed, "Al-Shabaab are seen as having a strong vision, which helps to draw in youth. Al-Shabaab believes in its goals enough that they are committing suicide for it."[220] There are few reports of forced recruitment. Enlistees undergo three to six months of training in one of the 20 camps that Al-Shabaab operates.[221] Foreign fighters reportedly conduct much of the instruction.

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[215] Suna Times, Al-Qaeda foreign operatives dominate Al-Shabaab executive council, Posted May, 05 2011, Accessible at: http://www.sunatimes.com/view.php?id=392

[216] Ashley Jackson and Abdi Aynte, Talking to the Other Side: Humanitarian Negotiations with Al-Shabaab in Somalia, Humanitarian Policy Group, Overseas Development Institute, Pp. 14

[217] Interviews with Al-Shabaab defectors in Mogadishu

[218] Interviews with Al-Shabaab defectors in Mogadishu

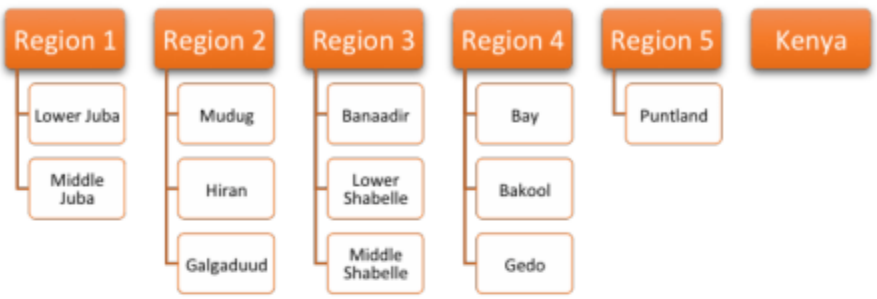
[219] Stig Jarle Hansen, speaking at "*The al-Shabab Threat After Westgate*", held at the Carnegie Endowment for International Peace, December 17, 2013

[220] Interview, Former BBC Journalist, Nairobi

[221] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2013, pp. 66

The military component of Al-Shabaab maintains a hierarchical, though largely opaque command structure. Al-Shabaab reportedly maintains five operational commands, most responsible for multiple regions. Each command is led by a regional commander, with commanders for each region

Military Command Structure



serving underneath him. One level down are district commanders, who have traditionally enjoyed broad autonomy. However, the centralization of the group has reportedly limited the operational discretion of lower level commanders.[222]

The other offensive component fielded is the Maktabatu Amniyat. The Amniyat is a clandestine "organization with an organization", tasked with intelligence, counter-intelligence, and terrorist attacks.[223] The group is also responsible for enforcing unity within Al-Shabaab, by, amongst other things, hunting down and killing defectors.[224] They are widely feared within Al-Shabaab. The Amniyat's total strength is unclear, though some reports claim that in 2013 there were 200 members operating in Mogadishu alone.[225]

The Amniyat is under the direct control of Ahmed Abdi Godane, through its nominal director is Mahad Mohamed Ali (AKA Karate).[226] Karate is an experienced militant who led the urban resistance against Ethiopia in Mogadishu after the fall of the Islamic courts. His control over the Amniyat is indicative of his increasingly important role within Al-Shabaab. Godane has reportedly used the Amniyat in his drive to centralize decision-making around him.

Maktabatu Amniyat Structure

The organization is structured "like a clandestine terrorist organization" utilizing a networked, cell based structure in order to minimize the group's vulnerability to penetration or arrest. The members of the Amniyat are specially selected, with many possessing specific linguistic or operational capabilities.[227] They receive higher salaries than regular Al-Shabaab forces, and often operate individually or in small teams. Given the operational similarities between attacks attributed to the Amniyat in Mogadishu and attacks claimed by Al-Shabaab in Uganda and Tanzania, it is logical to presume that the Amniyat maintains a foreign operations wing. Some observers have noted that the Amniyat is operationally viable even without Al-Shabaab's military support, raising the possibility that Godane has designed

[222] Ibid., pp. 315
[223] Interviews with Al-Shabaab defectors in Mogadishu
[224] Stig Jarle Hansen, *Al-Shabaab in Somalia: The History and Ideology of a Militant Islamist Group*, Oxford University Press 2013, New York, pps. 74 & 83
[225] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2013, pp. 58
[226] Ibid., pp. 56
[227] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2013, pp. 57

the group to "survive Al-Shabaab, in the event that the movement was deprived of any territorial control or clan and political support in Somalia, or if it split into its constituent factions."[228]

Foreign Fighters

Finally, foreign-born fighters constitute another distinct section within Al-Shabaab. Foreign fighters have been present in Somalia since the 1990s, including elements associated with Al-Qaeda in East Africa.[229] Reportedly, several hundred foreign fighters were serving alongside Al-Shabaab in 2006. Al-Shabaab actively promoted the immigration of foreign fighters to Somalia, inviting them to come and wage jihad in the country. There have also been some reports that jihadists from other conflict areas – such as Nigeria – have come to Somalia to gain training at Al-Shabaab camps. There are believed to be roughly 300 foreign fighters in Somalia at present – primarily Sudanese, Kenyan, and Yemeni, as well as an unknown number if diaspora Somalis.[230]

Increasingly, Al-Shabaab has also recruited fighters in East Africa. Kenya and Tanzania have been particularly fertile recruiting grounds. Recruits come not only from the Somali and from Muslim population groups in the region, but also from Muslim converts. Al-Shabaab has sought to further advance their recruitment efforts in East Africa by increasing their Swahili language outreach.

Finally, Al-Shabaab has recruited actively amongst the Somali diaspora. A significant number of diaspora members from the United States and Western Europe have responded to these calls. The motivations for most have revolved around nationalism, rather than jihadism. However, a number of diaspora volunteers have been utilized in suicide attacks, suggesting that some element of religious radicalization has occurred.

However, while Al-Shabaab has publically sought to attract international fighters to Somalia, the reality when they arrive is often far more difficult. The Amniyat keep close tabs on foreign fighters, with its intelligence agents posing as their drivers and the receptionists at foreign fighters' guesthouses.[231] Foreign fighters are often accused of spying, and/or mistreated in some other way. The withdrawal of Al-Shabaab from the cities seems to have catalyzed a feeling of vulnerability in the organization. This has manifested, in part, in an intense paranoia towards non-Somalis. Al-Shabaab's hostility towards foreign fighters has led many to leave Somalia, and a few to be killed by the group.[232]

Tactics

Despite withdrawing from most urban areas in 2012, Al-Shabaab continues to exert control over large swaths of central and south Somalia. According to the UN Monitoring Group on Somalia and Ethiopia, these include the regions of "Middle Juba, most of Hiran, Bay and Bakol regions, and sizeable parts of Galgadud, and Lower and Middle Shabelle."[233] At least 20 districts are controlled directly by Al-Shabaab.[234] As of 2005, the last time population estimates were published by the UN, 1.5 million people lived in those districts. At least 12 districts are contested, meaning the government

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[228] Ibid., pp. 59
[229] Stig Jarle Hansen, *Al-Shabaab in Somalia: The History and Ideology of a Militant Islamist Group*, Oxford University Press 2013, New York, pp. 43
[230] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2013, pp. 68
[231] Ibid., pp. 57-58
[232] Interviews with Al-Shabaab defectors in Mogadishu
[233] Report on Somalia of the Monitoring Group on Somalia and Eritrea, 2013, pp. 48
[234] Occupied districts include Tayeeglow, Waajid, Xudur, Dinsoor, Baardheere, Garbahaarey, Bulo Burto, Jalalaqsi, Bu'aale, Jilib, Saakow, Jamaame, Adan Yabaal, Cadale, Baraawe, Kurtunwaarey, Qoryooley, Sablaale, Ceel Buur, and Ceel Dheer.

controls the urban centers and main routes, while Al-Shabaab holds control of the countryside.[235] It is estimated another 1.8 million Somalis live in these areas. Additionally, the group expanded into northern Somalia in 2012, absorbing a militant force operating in western Puntland. Finally, the group retains a discrete though coercive presence in almost all of Somalia's urban areas. It maintains the ability to use fear coercively even in areas the government deems under its control. One community elder in Middle Shabelle observed that "security is getting worse; I have never witnessed such suicide attacks like I have seen in the last two years. Al-Shabaab is assassinating anybody. People are afraid of the darkness, they don't know when they are going to get bombed and this has never been in Somalia."[236]

Al-Shabaab has been defined by the employment of military tactics and operational capability that often far outstrip other Somali militia groups. For most of its history, Al-Shabaab has operated as a light irregular force. When matched against a heavily armed and well-trained military it has tended to fair poorly. Its defeat in large battles against militaries of Ethiopia, Kenya, and AMISOM highlights the group's weakness. However, Al-Shabaab has excelled when using asymmetric tactics and when facing lightly armed militia forces. One of the group's key strengths is its mobility. It is able to move its forces rapidly to swarm opponents, and to take advantage of tactical and strategic opportunities.[237]

Guerrilla and terrorist tactics are the group's forte. Its novel employment of IED and suicide attacks began in 2005 and 2006 respectively, and they have continued to be a mainstay of the group's offensive operations. Suicide attacks have been especially favored, both for their tactical benefits, and for the attention that they bring to the organization. The group has shown a willingness to attack hard targets, including the UN compound in Mogadishu. The group has also made heavy use of targeted assassinations, killing military personnel, politicians, and those who speak out against it. As one respondent in Banaadir remarked, "There is constant threat on anybody who speaks for justice, you may be assassinated in your own house and so nobody will speak."[238]

Stance on Aid and Vaccinations

Al-Shabaab has effectively blocked polio vaccination teams from a large segment of the population in south and central Somalia. The reasons underpinning this action are a complex blend of objections to international aid organizations, paranoid fears, centralization, and an increasingly vehement objection to the vaccine itself. However, the current opposition may be situationally grounded, with the group's actions being driven by its perception of vulnerability. If so, the group's stance on vaccinations is likely to be heavily influenced by its fortunes on the battlefield.

Al-Shabaab has historically had a contentious, yet working relationship with international NGOs operating in its territory. During the period that it governed Somalia, a Humanitarian Coordination Office was established to regulate aid organizations working in Somalia. Aid agencies working in Al-Shabaab territories were forced to pay a tax to the group to continue operating, though, at least initially, the organization did not significantly limit access. In at least one case, Al-Shabaab halted a WHO vaccination campaign in order to pressure the organization for more money.[239] One observer noted "Al-Shabaab sees itself as a 'government in waiting', and as such has a desire to provide

[235] Contested districts include Rab Dhuure, Baidoa, Buur Hakaba, Qansax Dheere, Afmadow, Badhaadhe, Kismaayo, Jowhar/Mahaday, Balcad/Warsheikh, Afgooye, Marka, and Wanla Weyne.
[236] Interview, Community Elder, Middle Shabelle
[237] Interview, Somali Journalist, Nairobi
[238] Interview, Community Leader, Banaadir
[239] Al-Shabab halts polio immunization activities in southwestern Somalia, Radio Bar-Kulan, Nairobi, in Somali 1600 gmt 5 Nov 11, Supplied by BBC Monitoring Africa – Political, November 5, 2011

services (or be credited with their provision) and control aid distribution."[240] Local commanders, often drawn from local clan groups, were often the most facilitating of aid activities. However, Al-Shabaab also viewed aid agencies with a strong degree of suspicion. Expulsions, based on accusations of espionage, were common.

This fear of espionage seems to have prompted the first steps by Al-Shabaab to limit vaccination efforts. Door-to-door vaccination drives were reportedly banned in some areas as early as 2008, though it does not appear a blanket ban came into place until 2010.[241] The earlier date coincides with a US airstrike that killed Aden Hashen Ayrow, a group leader. Ayrow's killing, coupled with other attempts to kill or apprehend Al-Shabaab and Al-Qaeda members in Al-Shabaab's territory, increased paranoia within the group. The door-to-door vaccine campaigns reportedly became seen as a major security threat to Al-Shabaab's commanders, and hence were banned by the group's leadership. However, the broad operational discretion enjoyed by local field commanders allowed, in some communities, for discrete door-to-door vaccine drives to occur. It is important to note that the group at this time was reportedly not anti-vaccine. It continued to allow the vaccine to be provided at health posts, and otherwise did not systematically agitate against the vaccine.

The group's defeat in the 2011 battle of Mogadishu seems to have had a strong, though indirect impact on the group's approach toward vaccination. First, the defeat severely weakened the group and made it less comfortable with taking risks, such as letting in (in its view) spies.[242] In part, this prompted the group to eject sixteen NGOs in 2011, including UNICEF and the WHO. In some cases, the group kidnapped or threatened officials associated with the polio vaccination program.[243] Second, after 2011 the group's centralization accelerated. District level commanders lost some, though not all of their ability to let in vaccination teams. Requests for access were increasingly referred up the chain of command for approval, and many were denied. Nonetheless, according to interviewees in Nairobi, in some locations district commanders continue to allow limited access.[244]

By 2013, Al-Shabaab's objections had shifted. Rather than opposing the method through which the vaccination campaign was conducted, it began to oppose the vaccine itself. The group engaged in a public messaging campaign to drive down demand for the vaccine by claiming it was part of a Western plot, and could well cause sterility or paralysis. While Islamic groups in other areas of the world commonly evince these rumors, it is unclear where in the organization the motivation for this stance emerged. Godane's effective purge of moderate members of the shura council may have given him the leeway to steer the group more towards international jihadist orthodoxy on vaccinations. Alternately, Al-Shabaab may be playing to its constituency, trumpeting rumors in order to discredit international actors in Somalia, and by default the entity that is most associated with them, the Federal Government of Somalia.

Al-Shabaab's public messaging campaign against the vaccine was less a sign of strength, than of weakness. Messaging campaigns were primarily conducted in urban areas that have been under Al-Shabaab control for several years. The diversion of group resources to minimize demand for the vaccine is likely an implicit admission that Al-Shabaab's ideology and authority are only lightly accepted in these zones. Rural areas are far more problematic, comprising both the bulk of Al-

[240] Ashley Jackson and Abdi Aynte, Talking to the Other Side: Humanitarian Negotiations with Al-Shabaab in Somalia, Humanitarian Policy Group, Overseas Development Institute, Pp. 15
[241] Interview, WHO Personnel, Nairobi
[242] Ashley Jackson and Abdi Aynte, Talking to the Other Side: Humanitarian Negotiations with Al-Shabaab in Somalia, Humanitarian Policy Group, Overseas Development Institute, Pp. 16
[243] Somali militants threaten to kill WHO workers over polio vaccination, Radio Dalsan, Mogadishu, in Somali 1600 gmt 13 Feb 2013, supplied by BBC Monitoring Africa - Political
[244] Interview, Somalia Federal Government Health Official, Nairobi

Shabaab's operational space and containing the bulk of Somalia's population. As noted earlier, rural dwellers are far less likely to be able to access healthcare, are more suspicious of vaccination efforts, and are less likely to have been reached by the awareness campaigns. Al-Shabaab's messaging may play into and buttress a pre-existent suspicion. Additionally, Al-Shabaab can further hamper the ability of these populations to travel to nutrition and health posts to access the vaccine. The 600,000 to 800,000 children dwelling here present a potentially chronic pool for poliovirus infections, raising the risk that the diseases could easily reappear in Somalia's urban areas, and in neighboring countries.

Mitigation Strategies

Improving overall public healthcare by closing the urban rural healthcare divide and strengthening local ownership

Al-Shabaab is neither the root of Somalia's political conflict nor the most intractable long-term threat to achieving high levels of vaccination. As noted throughout the report, two key challenges threaten healthcare in Somalia: a lack of local ownership and a dramatic urban-rural divide in access to care. Urban dwellers are far more likely to have access to healthcare, information, and, in the current moment, accurate information on polio and on the polio vaccine. Unfortunately, urban dwellers currently constitute a minority of the population. Therefore, strategies need to be developed to first buttress the capacity of the Federal Government's service provision and second to provide information, healthcare services, and information to rural dwellers

1. Information, Attraction, Access: One strategy to appeal to rural dwellers could hinge on the aforementioned three elements. Identify an information strategy that can specifically target rural populations in each of the regions, including the targeting of key decision makers. This could include the dissemination of low price radios, telephones, and other technology devices. Ensure the countryside has equal access to information, to the degree possible, as urban dwellers do. Additionally, utilize these channels to increase demand for the polio vaccine. This may be a simple information campaign, or it could use outreach through the diaspora of urban residents to their rural relatives. Finally, enable rural dwellers to access vaccination services. If, as some research has indicated, travel for health services is often prohibitively expensive for rural residents, consider the funding of travel for those willing to make the journey.

2. Improving overall rural Healthcare Services: In order to deal with the urban-rural health care divide in the short and medium term, mobile health care units could be used to improve rural health care services. Remoteness and accessibility poses one of the biggest problems when it comes to rural health care services, therefore mobile units can be used to bring health care services to the people. In the long run, making health care more accessible for rural dwellers should be part of the countries general infrastructure and development strategy.

Changing public opinion on healthcare and vaccinations

Interviews in Somalia indicated that attitudes on healthcare and vaccinations are malleable. This is beneficial, in that it shows there is a rapid rebound in demand for vaccinations in areas that have been under Al-Shabaab control. However, the pendulum can also swing the other way. Multiple interviewees noted that prior to this awareness campaign they had not been exposed to an information campaign in a number of years. Many remarked that this lack of information not only depressed demand for the vaccine, it also made the work of the current effort all the more difficult. When not confronted with a dangerous disease people tend to forget the importance of vaccination. Therefore, it should not be taken for granted that Somali's perceptions on polio will remain conducive to polio vaccination campaigns. Extremist rhetoric, rumors from the diaspora, and a dissipating sense of urgency around the disease can re-craft the social operating environment in Somalia. Access to technology – radio, mobile phones, etc. – allows information to spread quickly, both hindering and helping vaccination efforts.

The following strategies may be followed:

3. Assessment of Public Opinion on Community Level: Determining the public opinion on community level will be necessary in order to review and reassess current communication strategies and campaigns for different regions. It is a prerequisite for all the other information strategies listed below.

4. Radio Strategy: Sponsor a continuing series of radio programs around public health broadly. Polio issues will be prominently featured, but not exclusively. Programmes will achieve better uptake if they are interactive, via call-ins, debates, etc. The benefit of a radio strategy is that it has broad penetration in both rural and urban areas.

5. Mobile Health Information Strategy: Craft Mobile Health programs for Somalia that enable individuals to easily get information on various diseases as well as on the closest healthcare facility. Reverse SMS efforts could be used to push out information and health alerts to mobile users in Somalia. Given the percentage of mobile phone uptake in Somalia, this strategy has the potential for a high degree of effectiveness.

6. Internet Strategy: Develop a Somali language web presence that raises awareness of polio, and seeks to disabuse rumors. Make it active, and craft it in such a way that it continually draws in users. Ensure it is mobile accessible.

7. Direct Engagement Strategy: In order to reach people directly without media, one could engage clan as well as religious leaders to help change their opinion, and through them the opinion of their followers. In addition to the media strategy, it will be key to understand and cover the whole spectrum of information diffusion and opinion formation in Somalia. The use of community leaders and harnessing the power of oral tradition – Somalia has a famous history for poetry – could also be another option for awareness raising in more remote areas.

Overcoming political and security issues

The key barrier to achieving effective vaccination levels in the short term is political and related to security. Al-Shabaab presents the key impediment at present. The group's opposition to door-to-door vaccination campaigns, its vehement dislike of international aid organizations, and its increasing centralization and conservatism all present long term challenges to vaccination campaigns. While it is tempting to view these trends as indicative of an increased Salafist influence within Somalia, in all likelihood they are primarily rooted in Somali culture and Al-Shabaab's violent history.

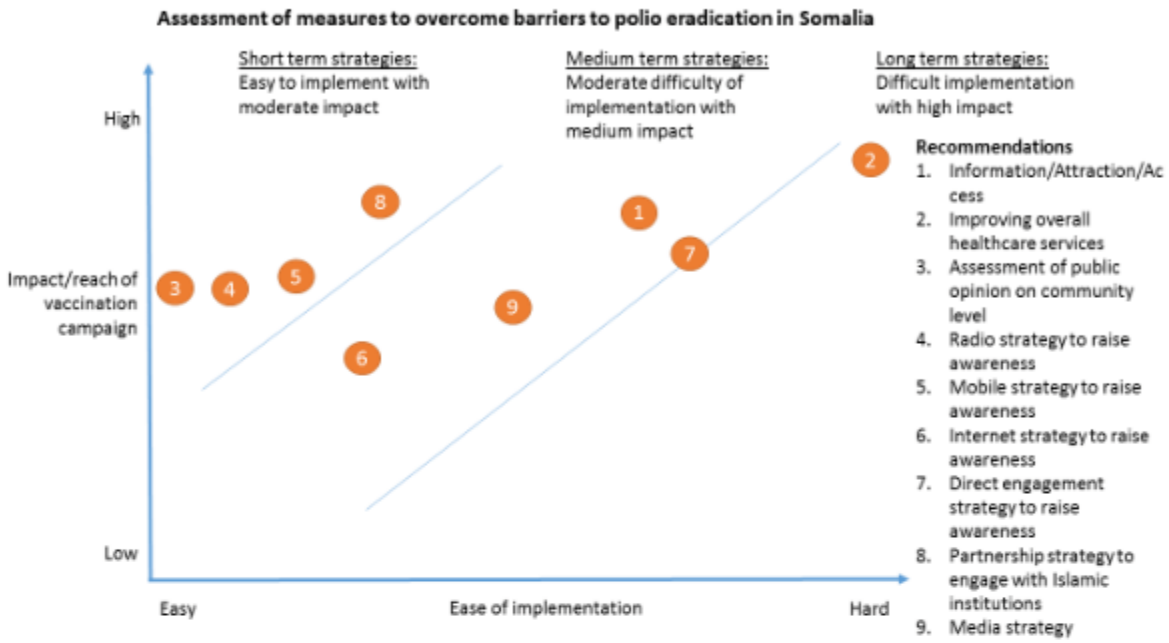
Given Al-Shabaab's military capacity, it is not advisable to simply wait the group out. Rather, strategies to bring them on board with public health efforts are key. In part this may involve a reliance on increased outreach to religious authorities and communities in Al-Shabaab areas, intended to put public pressure on the group to change its stance on the vaccine.

The following Strategies may be of utility.

8. Partnership Strategy: First, continue funding of NGOs operating in Al-Shabaab territories, while working to identify Islamic NGOs which can help to develop health care facilities in Al-Shabaab territory. Al-Shabaab messaging has claimed that the poliovirus vaccine is manufactured in Christian countries. One means of countering this perception is through either messaging or, if the vaccine is indeed coming from Christian countries, identifying an Islamic source for the vaccine.

9. Media Strategy: Engage with Salafist/conservative clerics to open up a discussion on polio and vaccinations in Somalia. The goal would be to shift attitudes amongst Somali Al-Shabaab members and those living in Al-Shabaab territories on polio vaccination efforts. Potential media channels would include radio, TV, and Internet. It may be difficult to eliminate the spying concerns for some militants, but engaging on the issue of whether vaccinations are safe should be possible. This is also a potential avenue for diaspora engagement.

In the graph below, the various strategies laid out have been prioritized according to their likely impact on the polio eradication campaign, as well as on their feasibility. Feasibility was assessed along three criteria: cost, time and risk. In particular, the issue of risk is pertinent for those interventions seeking to have impact in Al-Shabaab controlled regions.



Areas for Future Analysis

Whereas this report provides an initial analysis for strategic understanding of key considerations for strategic purposes, any intervention selected must be predicated on an up-to-date and nuanced basis of information.

There are a number of avenues for future analysis that emerge from this report. In particular, it should be noted that there remains a lack of community-based information on perceptions in Somalia, particularly in areas difficult to access.

By necessity, the rapid assessment, upon which the report was based, was constrained in its sample size, and in the economic and geographic diversity of interviewees. While there was a strong consensus amongst interviewees on some specific findings – such as recent shifts in knowledge of polio, increased societal acceptance of the vaccine, and increasing access to healthcare – it is important to test these findings with a larger pool of respondents, in both urban and rural locales. Possible areas for follow on research include:

- Community-level surveys focused on perceptions of polio, vaccinations, and access to healthcare. These would be conducted in rural areas of south, central, and northern Somalia.

- Community-level surveys in ethnically Somali areas in Kenya and Ethiopia, as well as the refugee camps in the border regions, focused on perceptions of polio, vaccinations, and access to healthcare. The aim would be to identify whether there is regional applicability to the findings in this report.

- A survey of religious leaders in Somalia, aimed at identifying perceptions of polio, views on the vaccine and the vaccination process, and viewpoints on Al-Shabaab's anti-vaccine stance. A secondary goal could be to identify potential participants for pro-polio vaccine messaging activities.

- Professional surveys amongst Somali medical personnel to identify their views of the polio vaccination process. A key goal will be to identify whether health worker concerns uncovered in this study are common throughout Somalia, and whether any vaccination implementation partners have been successful in minimizing activities of concern.

The one area where work has been on-going is to map in greater detail the local leadership structure of Al-Shabaab and determine individual views on polio and the vaccination campaign. This has proved challenging and has raised security concerns for interviewers. In part, this is a reflection of the centralization of decision-making within Al-Shabaab and the erosion of local latitude amongst commanders on the ground, as outlined in the report.