

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

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THE RACE TO ERADICATION

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POLIO IN NIGERIA

THE RACE TO ERADICATION

*Jennifer G. Cooke and Farha Tahir*¹

Since 1988, the Global Polio Eradication Initiative (GPEI)—an international partnership of government and private institutions—has reduced the number of reported polio² cases worldwide by more than 99 percent (from 350,000 new cases in 1988³ to 627 in 2011⁴), successfully eliminating polio from much of the globe.

Yet Nigeria remains one of the most entrenched reservoirs of poliovirus in the world. Continued transmission in 7 of Nigeria’s northern states has led to reintroduction of the virus in at least 12 African countries previously declared polio free, repeatedly dashing hopes that global targets for eradication—first in 2000, then in 2005—could be met. Recurrent setbacks, including a resurgence of cases in 2011, have introduced an element of skepticism that the global campaign can ultimately be successful. A remarkably frank and hard-hitting evaluation from the GPEI Independent Monitoring Board expressed concerns in late 2011 that polio “will not be eradicated on the current trajectory. Important changes in style, commitment and accountability are essential.”⁵ And some public health experts express concern about the opportunity costs of continuing a campaign with a

¹ Jennifer Cooke and Farha Tahir are, respectively, director and research associate of the Africa Program at the Center for Strategic and International Studies (CSIS) in Washington, DC. The authors are grateful to CSIS Africa Program interns Joanna Francis and Kathryn Havranek for their research support; to Phillip Nieburg, senior associate with the CSIS Global Health Policy Center for his advice and input; and to the GPEI officials who spoke candidly about progress and challenges in Nigeria’s eradication campaign.

² Poliomyelitis (polio) is a contagious viral disease spread largely through fecal contamination of food or water, most often the result of poor sanitary conditions. In approximately 1 percent of cases, the virus leaves the intestinal tract and enters the bloodstream, attacking the nervous system and causing permanent paralysis. The vast majority of cases (up to 95 percent) are asymptomatic, however, making polio difficult to detect but easy to spread.

³ Centers for Disease Control and Prevention (CDC), “What Would Happen If We Stopped Vaccinations?” July 2010, <http://www.cdc.gov/vaccines/vac-gen/whatifstop.htm>.

⁴ Global Polio Eradication Initiative (GPEI), “Polio Eradication This Week,” 2011, <http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx>.

⁵ 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>.

price tag of \$1 billion annually to eradicate a disease that, however devastating, is not among the top 20 killers in the developing world.⁶

The Nigerian experience has underscored the complexity of the eradication endeavor and vividly demonstrates the fragility and reversibility of gains made to date. “Nigeria,” according to GPEI’s independent monitoring board, “is at risk of losing everything it had gained.”⁷ Now, with a new target date for global eradication set for the end of 2012, the stakes are extremely high: beyond the human costs of additional flare-ups, further postponement of the target date may undermine the sense of opportunity, urgency, and focus necessary to achieve eradication. Concern that this new target may be missed has spurred an urgent “now or never” push by GPEI members to apply the lessons of the last decade and ensure that Nigeria will be polio free by 2013.

Multiple factors have hampered eradication efforts in Nigeria’s northern states. Many are embedded in the country’s broader sociopolitical dynamics, the enduring chasm between government and the governed, and a decentralized governmental system that has often neglected service delivery to marginalized communities. Nonetheless, considerable progress has been made to overcome these challenges through the application of diplomatic pressures, incentives, new technologies, more comprehensive and culturally sensitive approaches, and renewed high-level political will.

Going forward, prospects for success in Nigeria in 2012 will hinge on two core questions: first, whether the high-level commitment to polio eradication currently expressed by the Nigerian federal government, the country’s state governors, and influential religious leaders, can be sustained in the face of multiple pressing challenges and potential political volatility; and second, whether this commitment can be translated consistently into effective local action among the northern communities most at risk. In the best of circumstances, these challenges are daunting. At the start of 2012, however, escalating attacks by the violent Boko Haram sect, which have left hundreds dead in Nigeria’s northern and middle belt states and created an atmosphere of pervasive fear and insecurity, threaten to undermine both political will and local accessibility, putting the Nigerian and global polio eradication campaign at risk.

Background on the Global Campaign

In 1988, the World Health Organization (WHO) committed itself to eradicating polio, launching GPEI, a public-private partnership led by WHO, Rotary International, the U.S. Centers for Disease Control and Prevention (CDC), and the UN Children’s Fund (UNICEF). The Bill and Melinda Gates Foundation is among the initiative’s most generous financial supporters, and polio has become a centerpiece of the foundation’s work. The initiative seeks to end polio worldwide through

⁶ For an outline of competing perspectives, see for example, Charles Kenny, “The Eradication Calculation,” *Foreign Policy*, January 17, 2011, http://www.foreignpolicy.com/articles/2012/01/17/the_eradication_calculation.

⁷ Independent Monitoring Board of the Global Polio Eradication Initiative, “Report, October 2011.”

routine immunization of at least 80 percent of children under one year old with a minimum of three doses of oral polio vaccine, supplementary vaccine doses for children under five, enhanced surveillance of and reporting on children under the age of 15, and more targeted campaigns for high-risk areas. The campaign has made dramatic progress against the virus, reducing polio-endemic countries from 125 in 1988 to only 3 as of January 2012: Afghanistan, Nigeria, and Pakistan. The most recent country to halt transmission was India, which on January 12, 2012, celebrated one full year with no new reported cases.

GPEI has set the end of 2012 as the new target for ending global transmission. With a cost of close to \$1 billion per year and previous targets twice postponed, the effort has reached a make-or-break moment. One GPEI official confided that for the global campaign to succeed, the initiative will need a big victory this year, with real risk that if the 2012 target is missed, the program will likely stop or need dramatic rethinking. The Strategic Advisory Group of Experts on Immunization echoed this sentiment in November 2011, declaring:

unequivocally that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health... Failure would not only rapidly lead to a major resurgence of the disease with thousands of children crippled for life or killed every year, but would also be seen as the most expensive public health failure in history. It would have a disastrous effect on overall global immunization efforts and primary health care by seriously undermining their credibility with donors and stakeholders.⁸

GPEI members are cautiously optimistic that countries where polio has recently been reintroduced can succeed in halting transmission once again. Afghanistan has mounted what is considered a strong program, with polio cases largely restricted to 13 high-conflict areas where accessibility is limited.⁹ Pakistan and Nigeria are seen as the most pressing and vexing challenge countries in the year ahead. Of these two, Nigeria takes on particular strategic importance, both because the costs of failure are in some ways more dire than in Pakistan and because at present it appears to be the more likely candidate for eradication.

The World Health Assembly has repeatedly identified Nigeria as the single biggest risk to global polio eradication. It is the only endemic country with ongoing transmission of both wild poliovirus (WPV) types 1 and 3. (Afghanistan had no WPV type 3 in 2011, and Pakistan's last reported case was in June 2011.) Nigeria also has relatively high levels of vaccine-derived poliovirus type 2 (oral

⁸ Quoted in World Health Organization (WHO) Executive Board, "Poliomyelitis: Intensification of the global eradication initiative: Report by the Secretariat," December 1, 2011, http://apps.who.int/gb/ebwha/pdf_files/EB130/B130_19-en.pdf. The Advisory Group's report was published in January 2012; see WHO, "Meeting of the Strategic Advisory Group of Experts on Immunization, November 2011—Conclusions and Recommendations," *Weekly Epidemiological Record* 87, no. 1 (January 6, 2012), <http://www.who.int/wer/2012/wer8701.pdf>.

⁹ Independent Monitoring Board of the Global Polio Eradication Initiative, "Report, October 2011."

polio vaccine contains a weakened live virus that in rare instances can mutate back into a form that can paralyze.) The high levels of vaccine-derived virus in Nigeria are of particular concern, since they are considered an indication of very low population immunity, and such outbreaks are generally seen as an achievable early target for polio control programs. Further, retransmission of WPV from Nigeria has resulted in a greater number of polio outbreaks in neighboring countries than retransmission from India or Pakistan—and with more enduring impact. Although the oral polio vaccine has higher per-dose efficacy among sub-Saharan African populations than among Asian populations (and a significantly lower level of vaccine coverage is required to stop polio transmission),¹⁰ the surveillance capacities and health systems in those countries most vulnerable to Nigeria’s exportation of the virus—Niger, Chad, and Sudan, for example—are far weaker than those of Pakistan and Afghanistan’s neighbors.

GPEI and the Nigerian Context

How is it that Nigeria continues to confound polio eradication efforts, even as other African countries, with fewer resources than Nigeria, have successfully interrupted transmission? A first explanation is Nigeria’s sheer size: with a population of 155 million and 36 states (some with populations equaling those of neighboring African countries), the challenges of poverty, corruption, weak institutions, social conflict, and political volatility are magnified, and mounting a “national” endeavor of any kind becomes especially daunting.

A second explanation is Nigeria’s diversity. The population comprises more than 250 ethnic groups, roughly evenly divided between Muslims and Christians, with a small minority observing traditional religions. Though there is considerable overlap, the northern region is predominantly Muslim, with the Hausa and Fulani the majority ethnic groups; and the south is predominantly Christian. North and south were administered separately under colonial rule, and rivalry between northern and southern elites has been an enduring feature of Nigerian political life.

Third, the country’s federalized system—encompassing a national government, state governments, and local government authorities (LGAs), which rose in number from 310 in 1989 to 774 in 1999—produces considerable variability in capacities and priorities, and the multiple tiers of government complicate the delineation of responsibilities, funding flows, and accountability.

Finally, GPEI launched its eradication efforts in Nigeria in 1996, a time when the country was in deep economic and political crisis, making the factors mentioned above particularly acute. By 1996, the country had seen 10 military coups and was under the rule of General Sani Abacha, whose corrupt and brutal government oversaw continued corrosion of state institutions, heavy-handed suppression of civil society and public political discourse, and further decline in state services and standards of living. The economy was stagnating as revenues from Nigeria’s petroleum sector had declined precipitously since the boom years of the 1970s, leaving in their wake a system of

¹⁰ GPEI, “GPEI: Strategic Plan 2010–2012,” p. 26, <http://www.polioeradication.org/content/publications/gpei.strategicplan.2010-2012.eng.may.2010.pdf>.

patronage and corruption that pervaded government at every level. Successive leaders' failure to invest in non-oil sectors of the economy over time had led to the collapse of agricultural and manufacturing capacities, the traditional economic mainstays of the country's northern states. The country's economic decline in the 1990s thus led to disproportionate impoverishment in the north and a deepening economic gap between north and south.

GPEI arrived in Nigeria at a time when the country's health system was in crisis. Structural reforms introduced in the late 1980s and early 1990s to rationalize public spending offered some improvement at the macroeconomic level, but they had calamitous effects on public service delivery, particularly in education and health.

As part of the reforms, responsibility for primary health care services was transferred to local governments, which had little capacity, resources, or will to take up the task. The country's national Expanded Program on Immunization (EPI), which during the 1980s had made some progress in increasing the exceptionally low national immunization coverage rate (from 5 to 10 percent in the early 1980s to near 50 percent in 1990), was likewise devolved to state government responsibility.¹¹ Local governments were expected to purchase their own vaccines, which had previously been provided to them gratis by the federal government. This led to a dramatic reduction in availability, as LGAs failed to budget for vaccine procurement, and the system of routine immunization essentially collapsed.¹² By 1993, overall immunization coverage rates had declined to an estimated 30 percent.¹³ General Abacha brought EPI back under federal control, creating a parastatal body renamed the National Program on Immunization (NPI), but the institution was largely ineffective. Abacha's wife was implicated in multiple corruption scandals involving vaccine procurement,¹⁴ and the director of NPI from 1996 to 2005, a political appointee with personal ties to both the Abacha and Olusegun Obasanjo leadership, was accused of gross incompetence and corruption.

With Abacha's death in 1998, the country made the precarious transition to civilian democratic rule. While the country has made important strides in governance, macroeconomic management, and efforts to curb corruption, decades of political turmoil have left an enduring legacy that continues to frustrate health, education, and development interventions.

¹¹ Anthropologist Elisha Renne of the University of Michigan has published a particularly comprehensive exploration that examines a range of historical, cultural, and political factors from health administration under British colonial rule to the outbreak of vaccine-derived polio virus in 2005–2009. See Elisha P. Renne, *The Politics of Polio in Northern Nigeria* (Bloomington: Indiana University Press, 2010).

¹² Claire Magone, "Nigeria: Public Health Relations," in *Humanitarian Negotiations Revealed: The MSF Experience*, ed. Claire Magone et al. (London: Hurst & Co., 2011), <http://www.msf-crash.org/livres/en/nigeria-public-health-relations>.

¹³ Renne, *The Politics of Polio in Northern Nigeria*.

¹⁴ Ngozi Okonjo-Iweala, "Corruption: Myths and Realities in a Developing Country Context" (second annual Richard Sabot Memorial Lecture, Center for Global Development, Washington, D.C., June 20, 2007), http://www.cgdev.org/files/1423131_file_Sabot_2007_Okonjo_Iweala.pdf.

The Challenge in the North

For all its political and economic challenges, Nigeria made significant progress on polio from 1996 to 2001, with dramatic expansion of coverage through National and Subnational Immunization Days, a significant drop in reported cases, and increasing optimism that the 2005 global eradication target might be met. Progress was especially strong in the country's south, where public investments (under the country's colonial administrators, as well as postindependence governments) in education, infrastructure, and health were far higher, and where higher population immunity, better logistic support and access, and greater health personnel capacity facilitated the initiative's work. Polio transmission was successfully halted in southern Nigeria in 2005. But as the campaign intensified its efforts, it met increasing resistance in the country's north.

Many explanations have been put forward to account for the breakdown of eradication efforts in northern Nigeria. The country's economic decline since independence has hit the north particularly hard, with public- and private-sector investment largely focused on the south. Per capita public expenditure on health in the north was less than half that in the country's south in 2003, with local government authorities and households carrying a far greater proportional burden.¹⁵ Development indicators remain exceptionally low in many northern states, and health services are less developed than in much of the south. These factors have not only created logistical challenges in vaccine coverage but have also contributed to marginalization and isolation from the country's south and the broader world. Olusegun Obasanjo's accession to the presidency in 1999 made him Nigeria's first democratically elected president since 1978 and the first Nigerian Christian and southerner to lead the federal government since his own tenure as military ruler from 1976 to 1979. The shift in power from northern to southern political elites fueled a further sense of political marginalization.

The north's relative isolation has to some extent fostered distrust and suspicion of external—particularly Western—interventions. As the polio campaign intensified, a host of rumors sprang up, some fueled by local imams, that the immunization effort was a Western ploy to control or eliminate Muslim populations in the north by causing sterility or spreading the HIV virus. The fact that the vaccine was provided free of charge and distributed by government health workers to even the most remote communities heightened suspicions, as parents wondered why medicine and medical services for far more common and deadly illnesses like malaria, cholera, and diarrheal disease, were neither free nor readily accessible.¹⁶

While wariness of vaccine initiatives is not uncommon in the developing world, fears in Nigeria were compounded in the aftermath of a controversial drug trial in the pivotal northern city of

¹⁵ Olanrewaju Olaniyan and Akanni O. Lawanson, "Health Expenditure and Health Status in Northern and Southern Nigeria: A Comparative Analysis Using NHA Framework" (paper presented at the 2010 CSAE conference, St. Catherine College, University of Oxford, Oxford, UK, March 2010), 7, <http://www.csae.ox.ac.uk/conferences/2010-EDiA/papers/451-Lawanson.pdf>.

¹⁶ U.S. Embassy, Abuja, "October Sitrep on Nigerian Polio Eradication Efforts," cable, October 29, 2008, <http://wikileaks.ch/cable/2008/10/08ABUJA2129.html#>.

Kano. In the midst of a major meningitis outbreak in 1996, the Pfizer pharmaceutical company launched a clinical trial of the antibiotic trovafloxin to compare its effectiveness against a standard anti-meningitis drug. Eleven of the children participating in the trials died, and Pfizer was accused of administering the trial without fully informed parental consent.¹⁷ The Pfizer trial controversy sparked major street demonstrations in Kano and spurred demands for greater accountability.¹⁸ The deaths and the subsequent controversy over responsibility and compensation had a profound and enduring impact on already suspicious northern populations.

The scale of resistance to polio immunization changed dramatically in July 2003, when the leadership of a prominent Muslim umbrella group, Jama'atul Nasril Islam, and Nigeria's Supreme Council for Shari'a questioned the vaccine's safety and encouraged a boycott. The council's then-president publicly claimed that "there were strong reasons to believe that the polio immunization vaccine was contaminated with anti-fertility drugs, contaminated with certain virus that cause HIV/AIDS, contaminated with Simian virus that are likely to cause cancers."¹⁹

Local political, community, and religious leaders fueled the rumors, encouraging followers to boycott. Ibrahim Shekarau, then-governor of Kano state, suspended the administration of the vaccine pending an investigation of its safety. Bauchi, Kaduna, and Zamfara state governments soon followed suit. Some observers suspect that northern political leaders took up the call for resistance less because of community safety concerns than as a means of pushing back and "demonizing" the federal "southern" government.²⁰

As reports on the boycott spread, parents began actively refusing vaccination when health workers came to their homes, 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 health workers would place on a vaccinated child.²¹

¹⁷ Jacqui Wise, "Pfizer accused of testing new drug without ethical approval," *British Medical Journal* 332, no. 7280 (January 2001):194, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1119465/>.

¹⁸ Joe Stephens, "Pfizer Reaches Settlement Agreement in Notorious Nigerian Drug Trial," *Washington Post*, April 4, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/04/03/AR2009040301877.html>.

¹⁹ *BBC News*, "Polio in Nigeria Threatens Region," October 27, 2003, <http://news.bbc.co.uk/2/hi/africa/3216329.stm>.

²⁰ U.S. Embassy, Abuja, "The State of Play: Polio Eradication Initiative," cable, June 24, 2004, <http://wikileaks.ch/cable/2004/06/04ABUJA1132.html>. Polio was not the only issue in which resistance against the federal government was manifest. At the same time as the boycott, northern leaders were seeking to extend Shari'a to criminal law in the north, a move that was understood both as a response to popular frustration with the breakdown of security and governance and also as a way to fundamentally challenge the federal "Christian" leadership in Abuja.

²¹ Associated Press, "Rumors cause resistance to vaccines in Nigeria," *MSNBC*, September 25, 2006, http://www.msnbc.msn.com/id/15005238/ns/health-infectious_diseases/t/rumors-cause-resistance-vaccines-nigeria/.

Turning the Corner

The 2003 boycott dealt a severe blow to global eradication efforts: the subsequent resurgence of polio in Nigeria was directly linked to the reinfection of an estimated 20 countries, accounting for 80 percent of the world's paralytic cases, and cost the international community more than \$500 million.²²

GPEI, the United Nations, and the U.S. government scrambled to resolve the crisis, mounting a multifaceted diplomatic effort to end the formal boycott.²³ This included high-level outreach to senior Nigerian political and religious leaders, engagement by GPEI with the Organization of the Islamic Conference (OIC) to elevate the issue and urge member states to accelerate eradication efforts, interventions with African Union leadership to put pressure on Nigeria, and ultimately the shipment of polio vaccine produced in Muslim-majority Indonesia to assuage suspicions of Western anti-Muslim conspiracies.

WHO reportedly made it an explicit goal to ensure that Saudi Arabia understood the possibility of polio transmission during the annual Hajj pilgrimage and conveyed to the governor of Kano that pilgrims to Saudi Arabia might be prohibited from the Hajj if they refused vaccination.²⁴ Saudi Arabia required that visitors from Nigeria, Pakistan, Afghanistan, and India present a polio vaccine certificate and additionally receive an oral dose of vaccine on entering the country.

Cumulatively, these external diplomatic efforts at pressure and persuasion helped bolster efforts from within the Nigerian Health Ministry, and the northern Nigerian boycott formally ended in 2004. Within a year, many of the same religious and political leaders who had questioned the safety of the vaccine came to champion polio immunization. In 2004, both the governor and the emir of Kano participated in national immunization drives (Governor Shekarau allowed President Obasanjo to publicly administer the drops to his one-year-old daughter), and in 2006, a newly appointed sultan of Sokoto, considered the spiritual leader of Nigeria's Muslim community, became a vigorous proponent of polio immunization among local religious and traditional leaders.

Yet, the boycott's consequences continued to be felt in Nigeria for years. Confirmed cases of wild polio virus rose from 202 in 2002 to 1,122 in 2006 (see appendix on page 16), with cases spilling over into neighboring countries and well beyond. At the World Health Assembly in Geneva in May 2008, member states singled out Nigeria as posing a high risk to international health and urged it to intensify eradication efforts. They made clear that continued polio transmission was damaging Nigeria's status in the global community.

²² 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.

²³ This international mobilization is described in Judith Kaufmann and Harley Feldbaum, "Diplomacy and the Polio Immunization Boycott in Northern Nigeria," *Health Affairs* 28, no. 4 (July/August 2009): 1091–1101.

²⁴ *Ibid.*, 1097.

Signs of Promise

Some observers consider the World Health Assembly's admonition, coming from developed and developing countries alike, to have been an important turning point in Nigeria's national and regional response. Senior Nigerian leaders were reportedly humiliated and embarrassed about the country's role in "reinfected the world" and vowed to redouble efforts to halt polio's spread.²⁵

By the end of that year, Nigeria had demonstrated renewed determination to forge a more strategic and tailored approach to eradication, designed at once to better engage at the community level and to sustain and encourage political will among federal, state, and local leadership.

Greater National Leadership

Since 2008, national authorities have reaffirmed their commitment to halting polio, stepping up efforts to raise awareness and shouldering a greater proportion of the initiative's costs. The late President Umaru Yar'Adua, who succeeded President Obasanjo in 2007, was outspoken in his commitment to polio eradication and had, as governor of the northern state of Katsina, been a proponent of the campaign even in the midst of the northern-based boycott.²⁶ Yar'Adua was succeeded by President Goodluck Jonathan in 2010, who has similarly expressed strong commitment to eradication efforts. President Jonathan pledged an additional \$60 million in federal funds to the polio eradication effort over the next two years at the October 2011 Commonwealth Heads of Government Meeting.

Nigeria's federal health leadership has also won praise for its strategic vision and commitment to the polio campaign and for drawing on key internal and external players to bolster efforts and sustain domestic momentum. Minister of State for Health Mohammed Pate, selected in October 2011 by President Jonathan to lead a special task force on polio, is considered a particularly promising appointment. Pate was previously head of the National Primary Health Care Development Agency, which merged with the National Program on Immunization, and has been credited with bringing greater levels of accountability and efficiency to the agency, as well as for maintaining a strong institutional focus on polio. Under Pate's leadership, the newly formed task force will oversee and coordinate the national campaign, with a special emphasis on monitoring progress by individual states and LGAs and ensuring accountability for lags and poor performance.

A number of communication campaigns have been launched at the national level to raise popular awareness and public support for polio eradication. These include, for example, the launch of the Polio-Free Torch Campaign, a partnership among the federal government, the Nigerian Olympic Committee, and GPEI to highlight the country's ambition to be polio free by the 2012 Summer

²⁵ U.S. Embassy, Abuja, "Nigeria: Encouraging Political Support for Polio Eradication," cable, August 11, 2008, <http://wikileaks.ch/cable/2008/08/08ABUJA1591.html>.

²⁶ Rotary International, "Nigerian president declares commitment to polio eradication," July 28, 2008, http://www.rotary.org/en/MediaAndNews/News/Pages/080729_news_yaradua.aspx.

Olympics. “Polio-Free” ambassadors in each state will join Nigerian Olympic athletes as the Polio-Free torch travels state-to-state to engage governors, LGA chairmen, and opinion leaders, urging local religious and community leaders to participate in the campaign and encouraging parents to allow health workers into their homes.²⁷

Increased State-Level Commitment

State governments likewise have become more energized and supportive of the campaign, although commitment has been more variable over time. In 2009, Nigerian state governors signed the Abuja Commitments to Polio Eradication, a pledge to ensure vaccination of all children under five in their respective states, to allocate additional funding for eradication efforts, and to provide regular progress updates to the federal government.²⁸ Though initially successful, the governors’ focus began to drift in 2010, particularly as campaigning and political maneuvering in the run-up to the 2011 elections got underway.

In October 2011, Bill Gates of the Bill and Melinda Gates Foundation travelled to Abuja to re-galvanize state-level commitment by announcing the creation of the Governors’ Immunization Leadership Challenge. Aimed at incentivizing continued commitment, the initiative promises a \$500,000 grant from the foundation in recognition of “those Executive Governors whose states pass a pre-defined threshold to improve routine immunization coverage and end polio.” The grant must be used toward key health priorities, but it can also be supplemented with matching funds up to \$250,000 for additional health projects in the recipient’s state.²⁹

Engaging Communities

A core lesson of the boycott was that polio programming was not effectively connecting with local populations and was thus failing to mitigate fears and build confidence in the vaccine effort. Since the boycott’s end, the campaign has intensified efforts to reach marginalized communities with information on the importance of vaccination and to respond directly to their expressed concerns.

Examples of these interventions include outreach to children in Qur’anic schools; a series of community dialogues undertaken in partnership with the Federation of Muslim Women Association of Nigeria (FOMWAN), local health workers, and traditional leaders; and the use of *majigi* films—locally produced dramas that include facts about polio.

²⁷ Polio Free Nigeria, “About the Polio Free Torch Campaign,” 2011, <http://www.poliofreenigeria.com/about%20pft.html>.

²⁸ GPEI, “Abuja Commitments to Polio Eradication in Nigeria: A communiqué following the meeting of governors with Mr. Bill Gates, 02 February 2009,” http://www.polioeradication.org/content/publications/AbujaCommitments_04Feb2009.pdf.

²⁹ Bill & Melinda Gates Foundation, “To Help Nigeria Stop Polio, Bill Gates Launches ‘Governors’ Immunization Leadership Challenge,” press release, October 4, 2011, <http://www.gatesfoundation.org/press-releases/Pages/governors-immunization-leadership-challenge-111004.aspx>.

The National Program of Immunization has launched Immunization Plus Days,³⁰ a vaccination campaign that seeks to integrate lessons about immunization to school-age children and engage them in identifying other children in their area to be vaccinated. These efforts in some instances have been linked with incentives for parents, including provision of vitamin A, de-worming tablets, and antimalarial bed nets.³¹ 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.

Some states have introduced an additional element of coercion. In mid-2011, Kano state joined Kwara and Niger states in threatening to fine or imprison parents who refuse to immunize their children and to prosecute public health workers who fail to report refusals.³² Prosecution, according to the Kano state Health Ministry, would fall under existing law that forbids parents from barring access to health care for their children. It is unclear how effective this strategy has been.

The Challenges Ahead

Encouraging rhetoric from senior leaders and grand gestures to raise awareness about polio are not lacking in Nigeria—nor have these efforts been for naught. In fact, the shift in commitment since 2008 has brought impressive results. Reported cases of wild poliovirus have fallen precipitously in the last four years, from 798 in 2008 to 388 in 2009 to 21 in 2010. The number of WPV cases increased in 2011, but the absolute number—58—remains relatively low.

The challenge of polio, however, is that unless transmission is interrupted entirely, dramatic flare-ups and reversals remain a strong possibility. This explains the variability in case counts between years, as well as the uncertain prospects for eradication's success.

Reaching the Chronically Neglected

The urgent need in the coming year, according to GPEI representatives, is to identify and reach those isolated clusters of children in communities that immunization efforts to date have consistently missed. Evidence suggests that rather than randomly missing some children each year, the vaccine campaign is missing some of the same children and families year after year. The campaign will focus on identifying where these children reside and why they are not getting vaccinated.

³⁰ Christine Jaulmes, "Children Take the Lead in Northern Nigeria's Immunization Drive," UNICEF, March 5, 2007, http://www.unicef.org/immunization/nigeria_38545.html.

³¹ *IRIN News*, "Nigeria: Vitamin A Handouts Boost Polio Eradication Efforts," June 14, 2010, <http://www.irinnews.org/report.aspx?reportid=89470>.

³² *IRIN News*, "Nigeria: Jail Threat for Polio Vaccination Refuseniks," August 11, 2011, <http://www.irinnews.org/report.aspx?ReportId=93480>.

The initiative has stepped up efforts to strengthen micro-plans—the detailed, tailored strategies that drill down to the individual home level to ensure all children are vaccinated. The program is increasingly incorporating global positioning system (GPS) and geographic information system (GIS) technology to track the movement of vaccination teams and identify areas, communities, or even individual homes that have been missed.

While GPEI members are cautiously optimistic that they can reach these neglected communities, three main areas of concern persist.

Politics and Security in the North

First, there is the real possibility of continued community resistance. For all the improvements in communication, geographic coverage, and engagement with communities and local leaders, some localized areas remain chronic nonparticipants. Safety concerns and lingering suspicions that were fuelled during the boycott may persist.

Further, there is some evidence that communities may seize on the eradication campaign's urgency as leverage against local and state governments. In December 2011, a local community in northern Jigawa state threatened to boycott future polio immunization exercises unless the government completes a health clinic that has been left unfinished for the past 15 years. A village spokesman declared that “our decision is predicated on the fact that Immunization is being carried out to prevent selected diseases, but the most important health needs of the people have been abandon [sic] by the government.”³³

There remains some risk that north-south and state-federal battles may play out once again in the public health arena. The April 2011 presidential elections that brought President Jonathan back to office were deeply divisive. Northern frustrations with the ruling party and perceptions that it was “the north's turn” to rule led to mass protests in the north and postelection violence that left 800 dead. As yet, there is no evidence that politics have impinged on the polio campaign, and GPEI representatives are so far confident that polio eradication is no longer seen as a federally imposed priority but has been embraced as a valid goal at the state level as well.

A resurgence of extreme anti-Western, antiestablishment ideologies, particularly the violent terror group Boko Haram, is of deep concern, particularly if the group succeeds in expanding its currently limited sphere of influence among northern communities. Boko Haram has been carrying out almost daily attacks on government offices and civilians in parts of the northeast, significantly affecting regional security, and creating potential accessibility challenges for health workers attempting to vaccinate. The group has expanded its targets from local attacks in the remote northeastern states to major attacks in the Nigerian capital of Abuja, where it bombed the headquarters of both the United Nations and the Federal Police Force and, in January 2012, synchronized attacks in the northern city of Kano that killed more than 160 people. In early

³³ *Afrique en ligne*, “Nigeria: Polio faces another setback in Nigeria,” December 5, 2011, <http://www.afriquejet.com/health-polio-Immunization-2011120528857.html>.

December the group 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—the NPI offices may have been targeted simply because they are government facilities—but at the very least, the attack is an indication that child health interventions are fair game in the group’s violent political agenda.

Boko Haram challenges the legitimacy of not only the state apparatus, but also the traditional religious hierarchy within northern Nigeria, which they see as corrupted by the political system. Should this and similar ideologies gain traction, northern Nigeria may see a further fracturing of traditional and religious authorities, and interventions and exhortations by key leaders like the sultan of Sokoto or emir of Kano may eventually have diminishing impact.

Managerial Capacity and Accountability

A second source of deep concern is the capacity, competence, and commitment of LGAs. The LGAs are admittedly only one component of a larger, often dysfunctional system, in which resource flows, accountability, and feedback systems are often weak and opaque. But they are the most important interface between the health system and the communities at risk. As the 2009 GPEI Independent Evaluation Team for Nigeria concluded, “the ‘war’ against polio in Nigeria will be won or lost at the local government level.”³⁴

Unfortunately, LGAs have long been considered a weak link in Nigeria’s governance structure. There is considerable variation among LGAs, but for the vast majority, the overall record on service delivery, financial management and transparency, accountability, and competence has been extremely poor. In polio vaccine efforts, these weaknesses have manifested themselves in highly variable commitment; the breakdown of basic logistics management in areas such as cold-chain management or provision of basic supplies, diversion of resources or delayed release of required LGA funding; deployment of substandard vaccination teams (some have been accused of skimming off allocated funding by using untrained family members or young middle schoolers to deliver the vaccines); and lack of evaluation, monitoring, and accountability.

In partnership with the federal government, a strategic focus of GPEI in 2012 will be “ensuring that all LGA chairpersons are engaged and accountable for SIA [Supplementary Immunization Activity] performance in the 85 high-risk and very high-risk LGAs that have...persistent virus transmission.”³⁵ The newly created presidential task force is slated to track and make publicly available data on progress in these high-risk LGAs to ensure accountability.

Meanwhile, GPEI has mobilized to make technical assistance and advice readily available to program implementers. For example, in December 2011, the U.S. CDC activated the Emergency Operations Center to support polio eradication. The center draws on expertise from across the

³⁴ Independent Evaluation Team for Nigeria, “Report on Barriers to Polio Eradication in Nigeria, October 2009,” http://www.polioeradication.org/content/general/Polio_Evaluation_NIE.pdf.

³⁵ GPEI, “GPEI: Strategic Plan 2010–2012.”

CDC community to provide scientific and management advice to country-level efforts during disasters or public health emergencies. CDC is also recruiting “STOP Polio” teams—volunteers with public health experience who bring added capacities in logistics, communications, and data management to supplement local workers. WHO will deploy small teams to work alongside key Nigerian LGAs to help bolster managerial capacity and strengthen accountability and feedback mechanisms. A number of these teams will be drawn from India, where an intense and systematic emphasis on accountability was considered key to the national program’s ultimate success. A similar six-month deployment in 2010 by a two-person WHO-India team to Kebbi state in northern Nigeria is credited with helping dramatically reduce transmission.³⁶

Accountability must work both ways, and as important as ensuring LGA accountability for performance will be ensuring that state and federal governments are attuned and responsive to the needs of LGAs. Careful monitoring of LGA performance, and swift intervention by state governments and the global community when necessary, will be essential to overcome inherent LGA weaknesses.

Maintaining the Focus of Senior Leadership

Finally, a third source of concern is the durability of high-level political will, commitment, and action to follow through on promises made in recent years. Nigeria’s political context is complex and volatile, with multiple competing demands, intense rivalries, and major political challenges that, if unchecked, could threaten the country’s security, national cohesion, and democracy. This is not a context that encourages long-term commitment, particularly in delivering services to marginalized, impoverished communities that have little political clout. Exhortation by external donors and the embarrassment of being singled out by the World Health Assembly have galvanized senior-level leaders, but there are no guarantees that their commitment will be sustained over time.

The contentious 2011 national election and its violent aftermath led to a significant lag in momentum and attention to polio, and other challenges loom—most immediately, for example, escalating attacks by Boko Haram and nation-wide mass protests over the controversial removal of fuel subsidies—that may similarly undercut the leadership’s focus. Sustained political commitment will be especially problematic if the 2012 target is not met, and the longer the campaign goes on, the greater the possibility of waning commitment and the onset of “polio fatigue.” Even if the zero case target is met, the government will need to maintain a high level of immunization coverage for a considerable time after the last polio case is reported. Maintaining the sense of urgency and focus will require strategically targeted high-level interventions by GPEI members, the United Nations, and especially Nigeria’s developing-country peers.

The Organization of the Islamic Conference, the Economic Community of West African States (ECOWAS), and the African Union all have important roles to play in conveying the significance of Nigeria’s progress in eradication. U.S. president Barack Obama, reaching out to the global Muslim

³⁶ Not-for-attribution interview with GPEI official, December 22, 2011.

community in his 2009 Cairo speech, announced a new global effort in partnership with the OIC to eradicate polio.³⁷ In September 2011, African ministers of health urged remaining polio-infected countries to declare outbreaks or retransmission as “national public health emergencies.”³⁸ In January 2012, the WHO Executive Board is expected to discuss a resolution that calls for the completion of polio eradication as a “programmatically emergency for global public health.” It is hoped that this kind of high-level exhortation, encouragement, and pressure will sustain the focus and commitment needed for the global campaign to be successful.

Conclusion

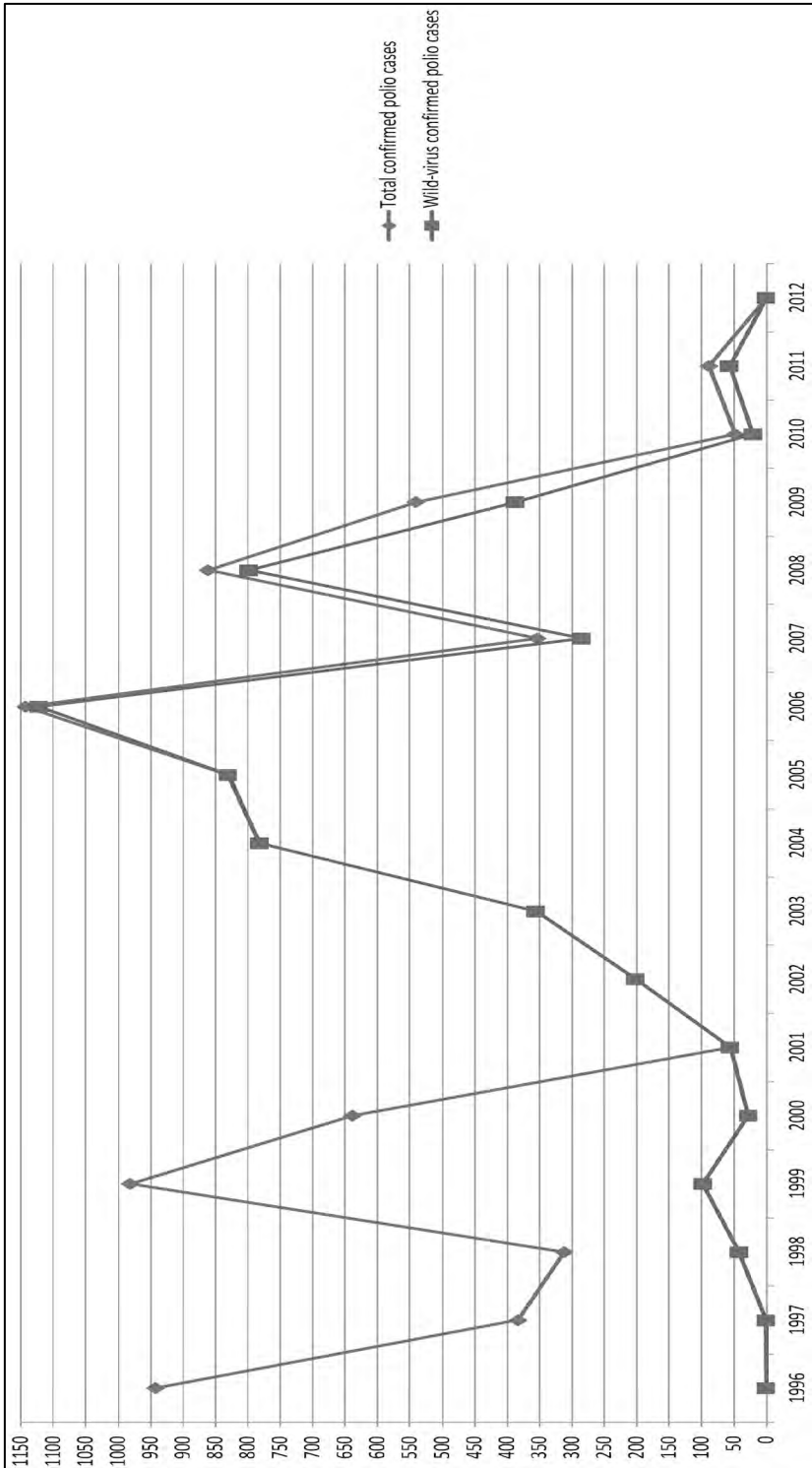
Nigeria’s polio eradication campaign has reached a critical juncture. National and international initiatives have resulted in substantial progress in recent years, but many of the factors that have frustrated previous efforts persist: challenges of scale, diversity, governance, and underdevelopment. These challenges confound many health and development efforts in Nigeria and are particularly vexing in implementing a sustained, focused, national preventive health campaign around a disease that is of greater and more immediate perceived priority for national leaders and external donors than it is for the communities the campaign aims to assist. Major uncertainties loom for Nigeria in 2012. Worsening security and a government under increasing strain add to the concern that commitment to the eradication campaign may be lost in the coming year. Continued attacks by Boko Haram may undercut GPEI’s plans for a surge in managerial capacity as external teams (as well as domestic vaccinators) may be reluctant to deploy into areas that are vulnerable to violence. Failure to meet the 2012 target may lead to a fundamental rethink of the polio strategy and a turn to a much longer-term approach with greater emphasis on control and routine immunization.

Nonetheless, there is an opportunity in the coming year to capitalize on the momentum and renewed political will within Nigeria. Strategic diplomatic engagement, new approaches to ensure expanded coverage and community buy-in, and greater monitoring and support for program implementers have brought Nigeria within striking distance of success. In 2012, using GPS technologies and skillful communication to hone in on chronically missed families; bringing in “surge” logistic, managerial, and reporting capacity to strengthen local government authorities; and finding bold and innovative ways to keep polio eradication on the Nigerian and global agenda may ultimately lead to success. Reaching the 2012 target is not the end of the road, as vaccinations will need to continue well into the future. But achieving the target may serve as powerful motivator to sustain the required effort and consolidate the gains made to date.

³⁷ Barack Obama, “Remarks by the President on a New Beginning” (speech given at Cairo University, Cairo, Egypt, June 4, 2009), <http://www.whitehouse.gov/the-press-office/remarks-president-cairo-university-6-04-09>.

³⁸ WHO Regional Committee for Africa, “Resolution: Poliomyelitis Eradication in the African Region,” Yamoussoukrou, Côte d’Ivoire, September 1, 2011.

Appendix. Number of Polio Cases in Nigeria, 1996-2012



Year	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	942	383	312	981	638	56	202	355	782	831	1143	353	861	541	48	89	0
WPV	0	1	42	98	28	56	202	355	782	830	1122	285	798	388	21	58	0

Source: WHO, "Polio Case Count," http://apps.who.int/immunization_monitoring/en/diseases/poliomyelitis/afpextract.cfm.



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