Pakistan and Polio

Dr. Sania Nishtar

The NEWS International
Wednesday, November 23, 2011

Governance

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At the recent meeting of heads of Commonwealth states, Australia put polio squarely on the table with a 54 million dollar promise. This adds to the existing pledges towards the disease eradication goal, which has collectively received more resources than any other global health intervention, to date. There is one problem though and Pakistan is in the dock once more—this time as a living threat to the global goal of eradicating a disease for the second time from the face of this planet. The weight of the allegations is mighty. After 23 years of commencing the World Health Organization-led Global Polio Eradication initiative, billions of dollars in investment, mobilization of 20 million health workers and a population wide intervention in 125 countries, vaccinating more than 2 billion children, there are only four countries in the world which continue to harbor the disease. Pakistan is the only country where cases have steadily increased since 2008. The country's progress, as labeled by the Independent Monitoring Board of the Global Polio Eradication Initiative, now lags far behind every other country in the world and there is every indication now that Pakistan will be the last remaining reservoir of Poliovirus transmission in the world. What is additionally worrying is that poliovirus has started spreading internationally from Pakistan, as was evidenced by the recent outbreak of the crippling childhood disease in the western province of China, which WHO has traced back to Pakistan.

In many ways the case of polio eradication defies the notion that political will combined with allocation of sufficient resources will tackle any problem. That is not a given. The importance of functioning systems become apparent, as failures manifest—just as in the case of the global financial crisis and more recently the middle eastern democratic movements. Pakistan has consistently accorded high priority to polio, declared it a national emergency and allocated resources at a time of severe financial crunch, when an ongoing war, a relentless insurgency and two consecutive years of unprecedented flooding had created many competing priorities for resource allocations. The weight behind the eradication drive led by WHO and supported by the international development community channeled in money despite the severely crowded out of fiscal space, internationally. This is evidenced by the recent innovative financing for polio by the Japanese government through a debt swap, the direct pledge for polio eradication in Pakistan by the Bill and Melinda Gates Foundation, and the consistent inflow from other spearheading agencies, WHO, UNICEF, CDC, USAID and Rotary International. The support to Pakistan has been unprecedented. Despite this, Pakistan, which was a global partner in eradicating Small pox in the 70s and quietly eliminated Dracunculiasis on its own later, is now becoming a global pariah, because of its inability to eradicate polio.

The dynamics underlying this are complex. There is cross border movement of nomadic populations across the vast and porous Pakistan-Afghanistan border, both sides of which are conflict-ridden. Vast swathes of Pakistan's Federally

Administered Tribal Areas, which constitute 12% of the country's territory and adjoining provinces, are plagued by an armed insurgency, where ongoing fighting severely limits access of vaccination teams. This is compounded by the tragic disinformation about polio vaccination. Misinformed religious factions challenge the writ of the state and campaign widely against polio on the mistaken notion that vaccination is forbidden in the religion, that it impacts on fertility and that it is part of a conspiratorial design against Muslims. Such indoctrination orchestrates refusals on part of parents to vaccinate children, even when the facility is being provided by the state at their door step. Population "mindsets" and "movements" in these polio-trouble spots do account for a majority of the new cases. But to discount the contribution of other important factors would be incorrect.

The 33 districts, which are labeled as high risk for polio and those that adjoin them, also include central Punjab and Karachi, Pakistan's coastal metropolis, where failure to vaccinate because of poor health systems functioning and poor performance of the vaccination teams has been widely recognized. Malpractices such as absenteeism in public facilities, ghost vaccination teams, well-institutionalized pilfering from the supply chain, crony managerial appointments, collusion in monitoring records and embezzlement at the field level are all well known. Concrete and commensurate action to institutionalize and compel accountability has just not been forthcoming to address these problems. These gaps in the governance of the Polio Eradication Program are an impediment to the effective translation of the National Emergency Plan for Polio Eradication into concrete action on ground and all the sensitization, awareness creation and commitment mobilization at the highest level, ultimately comes to a naught. The same is being observed during the recent outbreak of Dengue in Pakistan. Capacity of the public primary healthcare system, which anchors the field immunization process, has been deeply eroded over the decades. Lack of policy consistency across governments has not enabled successive reforms at this level to take root and the resulting ambiguities arising as a result of the de-tracking and re-tracking from the local government system, a reform introduced in 2000, is not helping either. There has been no attempt to harness the outreach of the private sector, which delivers the bulk of healthcare in the country.

These inefficiencies are not all. Other constraints are evidenced in eight hours of load shedding interrupting vaccine cold chain, volatility in fuel prices impacting mobility of vaccinators, and poor sanitation and high population density leading to diarheal diseases—still the third commonest cause of deaths in children in Pakistan—possibly interfering with vaccine absorption. Theories of vested interest at the administrative level to linger on with National Immunization Days—the key instrument of polio eradication—because of the incentives linked to them, also abound.

Then there is the elephant in the room. Pakistan has recently abolished its Ministry of Health, under the 18th Constitutional Amendment, under which there has been massive devolution of responsibilities from the federal to the provincial level in Pakistan's federating system. This has led to lack of responsibility for national actions in health, a fragmented health information architecture, and low human resource morale because of deployment uncertainty, all detrimental for the polio eradication drive.

The systemic malaise, which affects vaccination is evident not just in polio but also more generally with 47% children fully vaccinated, after 17 years of a relatively well funded program rolling. Polio is, therefore, also an insight into the country's institutional capacity and the ability of its systems to deliver on programmatic endpoints. This is unacceptable and may come to haunt us in the event of an outbreak of an emerging or reemerging infection, which may be lurking in our neighboring region to the east.

Pakistan needs to put its entire organizational shoulder to the Polio eradication wheel on an emergency basis and get actors involved that can deliver in emergencies, to tackle this problem with institutionalization of accountability as a key element. So long as a single child remains infected with polio, the global goal of eradication will not be met. While at it, we must also look inwards to put in place critically needed health system reforms, which will be vital for meeting any development target in Pakistan's mileu where social divides are widening at an alarming pace.

The author is the founder of Heartfile and the recently launched Sania Nishtar Health Fund. www.sanianishtar.info