Hanging in the balance: the politics of global polio eradication in Pakistan.

Abstract

Poliomyelitis is reemerging in the public conscious after decades of obscurity. The Global Polio Eradication Initiative (GPEI) is the largest, most ambitious international public health program currently in operation. Since its inception in 1988 the GPEI has immunized 2.5 billion children across 200 countries, resulting in the reduction of worldwide polio cases by 99%. Despite this success the disease continue to circulate in Pakistan, inhibiting efforts to achieve worldwide eradication. A number of issues relating to both the national health infrastructure (NHI) and broader socio-political factors impede polio eradication in Pakistan, particularly in the Federally Administered Tribal Areas (FATA). Current literature is dominated by a narrow focus upon NHI problems. However a broader discussion of the non-NHI issues impeding vaccination is required, including recognition of the connection between the non-NHI problems and Western intervention in the region. This paper will address non-NHI issues impeding the GPEI in the FATA and border regions, arguing that polio eradication in Pakistan is not achievable in the current context of political instability, social opposition and inaccessibility within volatile areas. Unless these complex issues in the FATA and border regions are addressed, polio eradication in Pakistan will remain unachievable.
Hanging in the balance: the politics of global polio eradication in Pakistan.

“Pakistan risks being the country that prevents global polio eradication.”


Poliomyelitis is reemerging in the public conscious after decades of obscurity. The Global Polio Eradication Initiative (GPEI) is the largest, most ambitious international public health program currently in operation. Since its inception in 1988 the GPEI has immunized 2.5 billion children across 200 countries, resulting in the reduction of worldwide polio cases by 99%. The early success of the program contributed to the widespread decline of polio cases worldwide, consigning the disease to the annals of history in the public conscious. Despite these achievements and the investment of USD $8.2 billion over 23 years, polio remains endemic in Pakistan, Afghanistan and Nigeria. Much of the Middle East had been polio free since the 1990’s however the disease emerged in Syria in 2013 in the wake of the ongoing civil war. Despite large-scale public health and vaccination campaigns by the World Health Organization and international affiliates, polio has spread in Syria placing the Middle East region at risk of continuing transmission. Beyond Syria, import of the virus to Somalia, the Republic of Congo and Tajikistan led to outbreaks resulting in hundreds of cases of polio related paralysis in 2013. Should control of polio continue to decline it is estimated that the case rate of polio could rise to 200,000 over the next decade. Control and eradication of the disease is therefore essential, yet continues to evade the GPEI and world health authorities.

Pakistan has become a center of concern in recent years, witnessing a rise in polio cases in 2011 whilst cases in Afghanistan and Nigeria declined. In January 2014 4 cases of polio reported Pakistan, following 91 cases in 2013. Continued transmission of polio in Pakistan is a global health


3 Ibid


concern, evidenced by spread of the virus from Pakistan to China in 2011 and Egypt in 2013. The issues inhibiting the polio eradication program have implications beyond the GPEI, drawing into question the feasibility of other eradication programs worldwide. Sania Nishtar, Former Pakistani Federal Minister of Education & Training, Science and Technology and health development advocate, observed that problems impeding the eradication initiative in Pakistan were either due to weakness of the national health infrastructure or broader socio-political issues. This paper will adopt the framework suggested by Nishtar, dividing issues associated with the Pakistan PEI into problems related to the national health infrastructure (NHI) and those outside of the health-system of Pakistan (non-NHI). Conceptualization of problems within this framework allows for effective analysis of the cause and possible solutions to the complex and multifaceted issues impeding realization of the GPEI.

NHI related problems stem from a lack of funding and development in the Pakistani health system. In 2010 Pakistan recorded a health expenditure of 2.2% GDP, the third lowest total expenditure of 193 recorded countries. The percentage of Pakistan’s health expenditure has steadily declined from 3.3% in 1995, a year after the induction of the PEI, to the current rate of 2.2%. Funding inadequacies affect health care infrastructure across the entire country and are particularly problematic in remote and rural areas. An estimated 65% of the population does not have access to basic health facilities in remote regions, including along the Afghan-Pakistan border. Although the GPEI is well funded by international donors and affiliate organization, the ‘public infrastructure through which it is delivered is not’. As a result, the progress of the GPEI has been consistently hindered by the under development and under funding of the existing Pakistani health system. NHI related problems that have affected the GPEI include a lack of basic health care facilities, equipment and experience in public health policy and management. These issues are largely related to the implementation of government policy and inadequate investment in public and clinical health service development across Pakistan.

In recent years the problems facing the GPEI have become concentrated in political unstable regions along the Afghan-Pakistan border. Limited government influence, particularly in the

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12 Ibid.
14 Nishtar, “Pakistan, politics and polio”, 160.
Federally Administered Tribal Areas (FATA), has exacerbated NHI problems in the remote tribal communities. Issues including inaccessibility and religious, social and political opposition have further reduced polio vaccination coverage in volatile areas. These non-NHI problems stem from complex socio-political factors, involving both national and international actors. The non-NHI problems faced by the GPEI in Pakistan’s border regions are often overlooked in the current literature. Svea Closser, Assistant Professor of Sociology and Anthropology at Middlebury College, has observed that the optimism that dominates much of the literature regarding the GPEI is necessary to obtain continued support for the project. Closser argues that the continued optimism surrounding the Pakistan PEI prevents ‘objective analysis of the problems the project faces’ in Pakistan. Thus, an optimistic focus on easily solvable problems has led to an unrealistic understanding of the achievability of the Pakistani PEI within much of the literature and the wider media. This is representative of much of the current literature, which presents little discussion of the more complex and discouraging non-NHI problems within the border regions.

The impact of non-NHI problems on achieving vaccination cannot be underestimated. In 2012, 73% of polio cases in Pakistan occurred in the FATA. Only 25-33% of children in the FATA under the age of three received three or more doses of OPV during routine vaccination drives in 2011, well below the target of 80% required for population immunity. The Khyber Agency within the FATA - the only area known to harbor poliovirus type 3 worldwide - has been inaccessible to immunization teams since September 2009. The FATA have become a center of volatility and insecurity since the September 11 terrorist attacks and subsequent Western intervention in the region. This has been attributed to a number of factors including the influx of militant groups, power struggles between local tribes, increased influence of clerics and political Islam, and U.S. military operations in the area. The climate of instability within the region has

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15 Svea. Closser, “‘We can’t give up now’: global health optimism and polio eradication in Pakistan”, Medical Anthropology 31, (2012): 400
16 Ibid: 400.
19 Ibid: 491.
20 Ibid: 492.
thus been exacerbated by a multitude of factors outside of national government policy. As a result non-NHI problems are not easily solved through governmental action or GPEI policy.

This paper will address non-NHI issues in the FATA and border regions impeding the realization of polio eradication in Pakistan. As current literature is dominated by a narrow focus upon NHI problems a broader discussion of the non-NHI issues impeding vaccination is required, including recognition of the connection between the non-NHI problems and Western intervention in the region. This paper argues that polio eradication in Pakistan is not achievable in the current context of political instability in the FATA and border regions. A focus upon solving the NHI related problems in accessible areas is not sufficient to overcome the challenges of political instability, opposition and inaccessibility within volatile areas. Unless these complex issues in the FATA and border regions are addressed, polio eradication in Pakistan will remain unachievable.

The issue of inaccessibility cuts to the core of the problems facing the GPEI as it directly prevents vaccination in vulnerable communities. In 2012, 6-23% of children living in the FATA were inaccessible to vaccination teams, resulting in between 64,000-257,000 children not receiving OPV. Inaccessibility is a complex issue resulting from a number of social, political, religious and administrative factors, and exacerbated by a lack of government control. Regions can become inaccessible due to security concerns, opposition by community leaders, or deterioration of road and transportation infrastructure. In particular, areas of insecurity are often prime locations for poliovirus circulation as vaccination teams consistently miss isolated communities. According to Abid et al., ‘impeded access to the target populations [in the FATA] has been primarily related to governance lapses or security-related challenges in the program catchment area’. UN regulations have resulted in physically accessible areas being administratively inaccessible to GPEI teams. Closser observes that ‘a lack of security clearance prevents WHO or UNICEF employees from traveling to insecure districts, leaving district health departments without supervision or surveillance’. Furthermore security concerns often ‘dwarf the threat of polio’, resulting in less commitment for eradication in the face of larger security threats. The risk to polio eradication

26 N. Abid et al., ‘Pakistan’s fight against poliomyelitis’: s9.
27 Svea Closser, ‘Fighting polio in Pakistan’: 149.
28 Ibid:149.
staff, both management and field workers is real. As of May 2014 40 polio workers associated with the GPEI or its affiliates have been killed, either by targeted assassination or suicide attacks.\(^{29}\)

Seven or eight doses of OPV administered in multiple vaccination drives are required to obtain effective immunity against polio. This is a major issue in areas where accessibility is compromised by political or security concerns. O’Reilly et al estimate that 40% of children under 3 in the FATA and border regions are unprotected against the predominant form of polio.\(^{30}\) This statistic is a reflection of the inadequate multiple vaccination coverage in the FATA due to the changing nature of accessibility in the region. Although vaccination teams may gain access to a previously isolated community, the window of opportunity is often short.\(^{31}\) Insecurity can result in access being impossible at short notice making planning and implementing campaigns difficult within many regions of the FATA.\(^{32}\) It is therefore difficult to guarantee that children in the tribal areas will receive the required dosage of OPV despite being accessible for one or two scheduled vaccination drives.\(^{33}\) As a result, reports celebrating access to previously inaccessible regions are often overly optimistic as they do not consider the requirement of multiple doses and continued access.

The problem of inaccessibility is also a concern for polio surveillance and data collection. Surveillance is as essential component of the GPEI, as it allows teams to track the progress of the eradication program and identify problem areas.\(^{34}\) As discussed previously, under-reporting or non-compliance by unaccountable individuals may impact the accuracy of data reported by field workers.\(^{35}\) This can be particularly problematic in tribal areas where security concerns deter workers from completing house-visits and vaccination drives. Accessibility must be taken into account when considering the accuracy of data produced from the national surveillance system. The


\(^{31}\) Abid, et al., “Pakistan’s fight against poliomyelitis”:


\(^{34}\) David Heymann & Larry Brilliant, “Surveillance in eradication and elimination of infectious diseases: a progression through the years”, Vaccine 29 (2011): 141.

\(^{35}\) Closser, “Chainsg polio in Pakistan”:101-104.
established system of surveillance is widely considered to be extensive and sensitive.\textsuperscript{36} However, surveillance is conducted by trained WHO staff who, as UN employees, are regularly denied access to insecure areas. Thus the accuracy and coverage of surveillance systems in the FATA may be hindered by continuing inaccessibility and instability of the region. Little of the existing literature, either produced by academics, government or non-government agencies, gives an indication as to the impact of inaccessibility on the surveillance of polio in the tribal regions.

Religious and political opposition to polio vaccination has been a roadblock to effective community engagement in remote tribal areas. Rumors that the OPV was ‘unclean’ under Islamic law, contained HIV, or was a western plot to sterilize the Muslim population were introduced by extreme clerics in Nigeria in 2004.\textsuperscript{37} Such fears spread to Pakistan, where extreme religious leaders and militant groups adopted and perpetuated the theories. Prayer leaders in the Peshawar district of the FATA claimed that the GPEI was ‘a U.S. program to cut the Muslim population’, and therefore displeased Allah.\textsuperscript{38} Polio eradication in Pakistan has become an issue of religious interpretation, hindering acceptance of vaccination in some communities. The influence of anti-polio religious clerics upon public perception of the program is a concern. An estimated 200,000 children have missed polio vaccinations as a result of refusals in the years prior to 2012.\textsuperscript{39} In 2011 14,645 children were not vaccinated in southern tribal areas as families refused the OPV due to religious and social concerns.\textsuperscript{40} Such refusals add an extra layer of complexity within the context of accessibility, resulting in children being missed even when vaccination teams can access an area. Garnering public support and confidence in the GPEI is essential to obtaining effective vaccination coverage, but is being continuously undermined by factors outside of the GPEI’s control.

The PEI has also become a politically charged issue in recent years, linked to American presence in the region and drone strikes along the Pakistan-Afghan border. The involvement of Dr. Shakil Afridi, a Pakistani PEI-associated doctor, in the US-led assassination of Osama Bin Laden has been a major source of contention within Pakistan. The doctor’s association with vaccination

\textsuperscript{36}T. Hovi \textit{et al.}, “Role of environmental polio surveillance in global polio eradication and beyond”, \textit{Epidemiology and Infection} 140 vol.1 (2012): 1.
\textsuperscript{37}Abid, N., \textit{et al.}, “Pakistan’s fight against poliomyelitis”: s7
\textsuperscript{39}Ashfaq Yusufzai, “Pakistan: Polio vaccination – one hurdle down, one more to go”, \textit{Inter-Press Service News Agency} November 3 2009, \url{http://www.ipsnews.net/2009/11/pakistan-polio-vaccination-one-hurdle-down-one-more-to-go/} [Accessed 29/10/12].
drives and Western NGO’s has created widespread suspicion of both international and national staff involved in Western run aid programs.\textsuperscript{41} The case of Dr. Afridi has further entrenched suspicion of the GPEI within extreme groups. Hafiz Gul Bahadur, a Pakistani Taliban commander, claimed that Dr. Afridi is just one example ‘of spying on mujahedeen for the U.S. during the polio vaccination campaign’.\textsuperscript{42} Furthermore Sami ul-Haq, one of Pakistan’s most influential clerics, retracted his support for the program, declaring that the PEI is a cover for American spy infiltration into Pakistan.\textsuperscript{43} Ul-Haq has questioned the very basis for Western interest in polio eradication, claiming that the PEI is a means of keeping Pakistani’s alive ‘just to kill them by drones’.\textsuperscript{44}

The theorized connection between the PEI and US drone strikes has been adopted by extremist groups such as the Taliban, al Qaeda and Punjabi who occupy isolated regions along the Afghan-Pakistan border. In June 2012 Hafiz Gul Bahadur banned polio immunization drives in the North Waziristan region of the FATA.\textsuperscript{45} The ban resulted in up to 161,000 children being inaccessible to vaccination teams prior to a scheduled immunization drive in the area. Bahadur claimed that the ban was in protest to CIA activity in tribal areas and would not be lifted until the U.S. ceased drone strikes in North Waziristan. As the GPEI has no affiliation with the CIA or connection with continuing drone strikes in the area, this is a difficult political problem for the program to overcome. Previously the GPEI has engaged Taliban leaders to allow free passage of vaccinators to communities within the tribal areas.\textsuperscript{46} However political events outside of the GPEI’s control undermine trust and perpetuate suspicion of the program.

It is important to note that community support for polio immunization is strong in some regions of the FATA. In September 2012 elders of the Union Council Kankola of Peshawar district, a region on the FATA border, expressed concern over a lack of immunization drives occurring in the area.\textsuperscript{47} This concern is evidence of the support for polio eradication by leaders in the volatile border provinces. Opposition to the GPEI by community’s leaders is not the general trend within the region. Support of elders for the GPEI is an essential element in broader community engagement and has become increasingly important in recent years. The involvement of Imams in

\begin{footnotesize}
\begin{itemize}
\item[41] McNeil, “C.I.A. vaccine ruse” \textit{The New York Times}
\item[44] Ibid.
\item[45] Walsh, “Taliban block vaccinations in Pakistan”, \textit{Daily Telegraph}
\end{itemize}
\end{footnotesize}
the education of local communities and the promotion of immunization is a major tactic being used to counteract misconceptions about the OPV. However the impact of religious and political opposition by extreme clerics and groups such as the Taliban cannot be underestimated. In September 2012 President Karzai appealed directly to the Taliban to ‘not hinder polio drives in villages because it will risk the lives of children’. Such a direct appeal highlights the power the Taliban holds in certain regions of FATA, and the little control either the government or the GPEI has to enforce immunization in such areas.

The national health infrastructure related problems are diverse and complex, but not insurmountable. As they stem from issues of funding and development of health programs, NHI problems can be addressed through appropriate policy reform and human resource management. Resolving larger issues such as a lack of basic health infrastructure requires a greater level of investment and commitment by government. Increasing access to sanitation, clinical health facilities and public health programs is a long-term project, but is achievable through policy reform and prioritization of health in the national framework. As such, NHI related problems could be addressed through effective government policy and investment in public health management.

Unlike NHI related issues, non-NHI problems within the FATA and border regions cannot simply be addressed through government policy and team development. The non-NHI problems inhibiting the PEI stem from continued conflict, instability and volatility within Pakistan and the region. The unstable political environment of the FATA is a result of a complex history of tribal, social and religious division, armed conflict and limited government control. Such issues cannot be readily addressed through government policy or social programs. Understanding the underlying causes which have contributed to the problems of inaccessibility and social and religious opposition is critical to creating realistic guidelines to achieving eradication. Although many academic and government papers recognize the complexity of non-NHI roadblocks, few address the underlying issues creating such problems. As a result suggested solutions, such as quick response units that are deployed when areas become accessible, are often not sustainable or effective in the long term.

An overarching theme that has emerged is the impact of Western intervention within the region. In particular, the U.S. led War On Terror and associated operations within Afghanistan have increased social and political instability within the Pakistani border area. The PEI’s cooperation

48 “In Pakistan, religious leaders fight polio”, UNICEF television http://www.youtube.com/watch?v=S60Q_U7GKTE [Accessed 28/09/12]
with extreme clerics and militant groups is an essential factor required to guarantee continuing access to at-risk children. However, U.S. actions in Afghanistan and Pakistan have undermined trust in the Western-led GPEI and perpetuated suspicion of both national and international aid workers. Despite the GPEI having no connection with U.S. military policy in the region, the program is heavily impacted by the actions of the western nation. This was highlighted during the political and social fallout following the US assassination of Osama Bin Laden and continuing drone strikes. Both operations significantly undermined trust of Western NGOs in the country, particularly those associated with vaccination and public health. Due to the GPEI’s independence it has little power to influence U.S. policies that have detrimental impacts upon the eradication program as a whole. In addition, the program’s reliance on funding from the United States government inhibits the GPEI from openly criticizing US policy. Thus the negative impact of western intervention upon polio eradication in Pakistan is significant, but not widely recognized or addressed.

Lack of critical analysis of the cause of non-NHI problems perpetuates unrealistic expectations as to the achievability of the eradication program in Pakistan. Greater discussion of broader socio-political problems within the border region is required, including recognition of the major impact of US activity in Afghanistan and the Pakistan border. Ultimately it is not the policies of the Pakistani government that have caused the greatest risk to polio eradication, but those of foreign powers. Whether the underlying issues contributing to instability within the Afghan-Pakistan border region can be resolved remains in question. Until stability is achieved, polio eradication in Pakistan and worldwide hangs in the balance.
News articles


Videos
“In Pakistan, religious leaders fight polio”, UNICEF television
http://www.youtube.com/watch?v=S60O_U7GKTE

Government and international agency publications


Secondary Sources


Closser, Svea. “‘We can’t give up now’: global health optimism and polio eradication in Pakistan”, *Medical Anthropology* 31, (2012): 385-403.


