

**Polio Eradication and Accountability:
A Case study of Nigeria and the GPEI¹**
Annex to the IAP reflections report 2021

Background

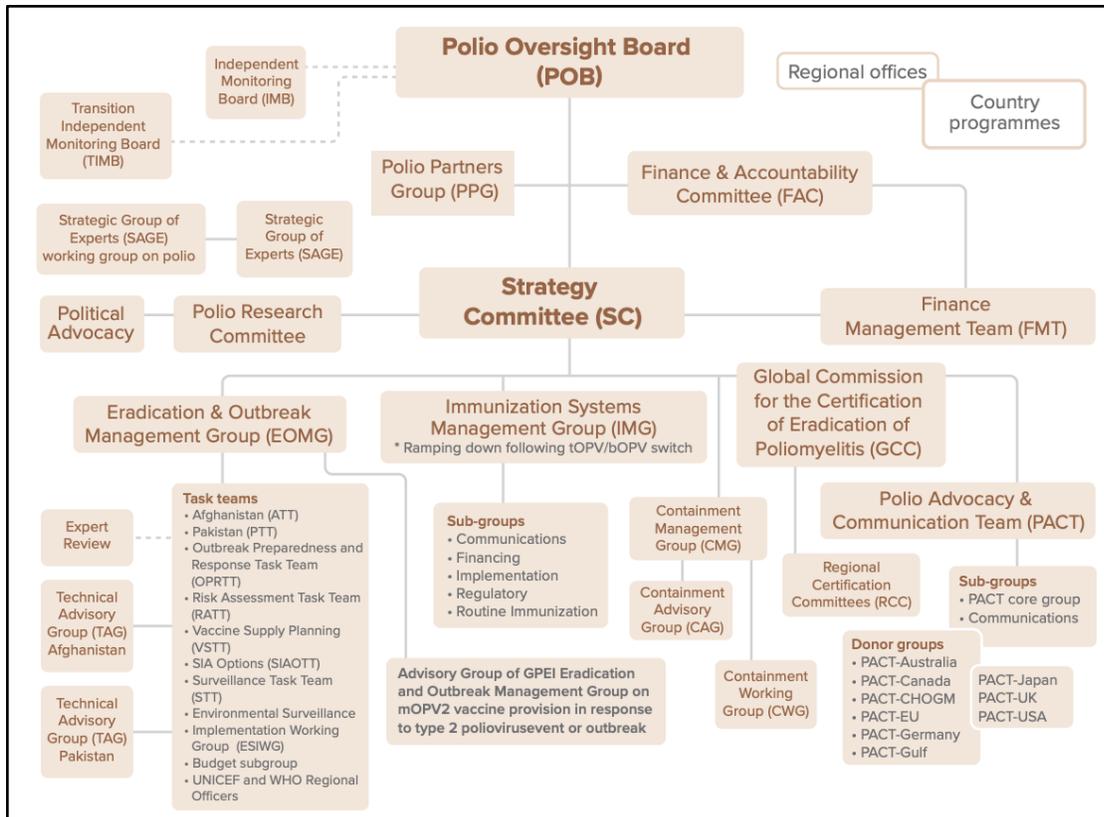
In 1988, the World Health Assembly adopted a resolution for the eradication of polio worldwide and the Global Polio Eradication Initiative (GPEI)—a partnership between national governments, WHO, Rotary International, the United States CDC, and UNICEF, and later joined by the Bill & Melinda Gates Foundation (BMGF) and Gavi, the Vaccine Alliance—was launched (WHA, 1988). By 2012, reported cases of polio had declined by more than 99 percent and transmission had been interrupted in all but three countries—Afghanistan, Pakistan, and Nigeria. In May 2012, the World Health Assembly declared the completion of polio eradication a programmatic emergency for global public health (WHA, 2012).

In 2012, Nigeria had 122 cases of wild polio virus (WPV) in 60 districts, an increase from 62 cases in 2011 (Moturi et al., 2014; WER, 2013). The country was a reservoir for the reintroduction of WPV into previously polio-free countries—between 2003-2013, WPV was reintroduced into 26 previously polio-free countries from northern Nigeria (WER, 2015). Challenges confronting Nigeria’s polio eradication program included insecurity in the highest risk states (in the north), anti-polio vaccine views, insufficient implementation of supplementary immunization activities in some locations, little coordination between national and global partners, and a lack of accountability (WER, 2013; Desmarais, 2016).

Links to Global Accountability

Nigeria’s attempts to interrupt the transmission of polio are tied to efforts by global actors to achieve polio elimination in the remaining endemic countries—these efforts include global-level accountability mechanisms. GPEI has an internal Polio Oversight Board (POB), under which sits the GPEI Polio Partners’ Group and the Financial & Accountability (FAC) Committee. Parallel to the GPEI structure but essential to its accountability operations are two independent review panels: 1) the Independent Monitoring Board (IMB) established in 2010 at the request of the Executive Board of WHO and the World Health Assembly (WHA) to monitor the implementation and impact of the first GPEI Strategic Plan 2010– 2012 against milestones and targets, and 2) a Transition Independent Monitoring Board established in 2017 to monitor the progress on transitioning polio infrastructure to support both health security and health systems as the remaining countries move towards elimination. Both Boards are provided financial and human resources to carry out coordination, alignment, and oversight activities at country-level.

¹ This case was developed by Global Health Insights based on a narrative literature review with input from IAP.



Source: Crowley et al., 2018

The IMB’s initial relationship with Nigeria was to monitor whether the country—which at the time fell under the category of a “polio endemic, but making progress” country—was on track to achieve the goals it set for itself in its national strategic plan, tying Nigeria’s progress to the larger set of GPEI goals: mainly to see 2 out of 4 of the then-polio endemic countries (Nigeria, Afghanistan, Pakistan, and India) on track to achieve cessation of transmission (IMB, 2011).

Moving Forward on Accountability for Polio Elimination in Nigeria

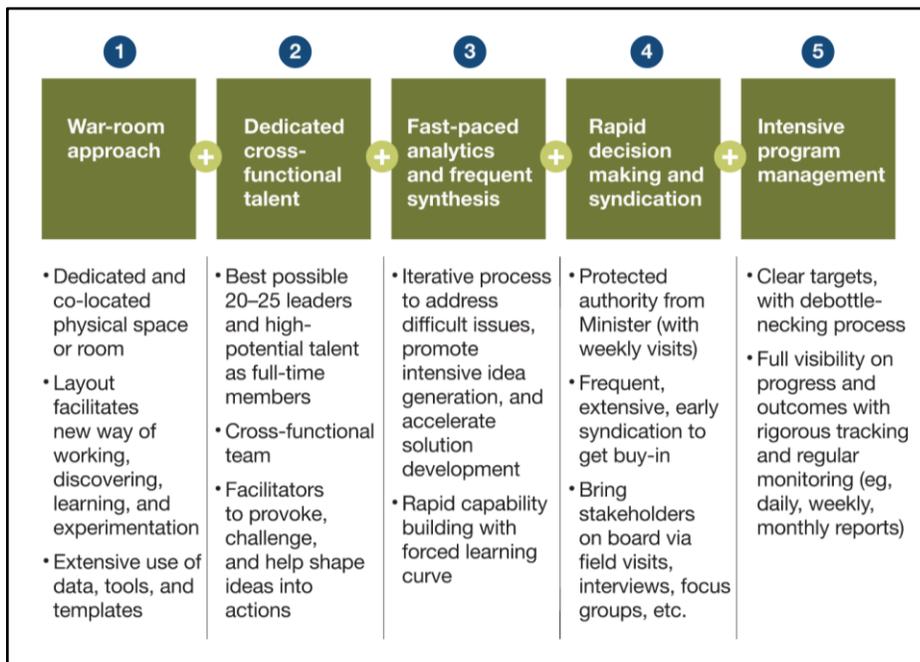
In its first report following its establishment in December 2010, IMB strongly urged Nigeria—which was seen to have made strong progress over the previous two years, with robust plans in place—to commit to becoming the second country, alongside India, to achieve cessation of transmission and identified gaps in vaccination and surveillance quality, waning political commitment during the election season, and slow implementation as potential barriers to achieving the end of transmission by 2011 (IMB, 2011). Meeting with Ministry of Health representatives, IMB supported Ministry of Health representatives to co-identify gaps and co-create solutions which were then incorporated into recommendations of the March 2011 Expert Review Committee meeting.

In 2011, after Nigeria had significant setbacks and rising case numbers, the IMB again re-engaged Nigeria. The Board noted that although the plan put in place by the Government of Nigeria was strong and well-constructed and more human resources had been brought on board to scale up the response, the country was nevertheless on the brink of becoming the source of global transmission. Working with the Government, IMB helped them identify poor financial commitment to social mobilization and community engagement, alongside major gaps in surveillance, as areas in need of input (IMB, 2012).

An Emergency Plan for Polio Eradication

Alongside these efforts, in 2012, the Federal Government of Nigeria created an emergency operations centre (EOC) in Abuja for polio eradication and launched a national emergency plan. The plan included oversight from senior levels of government (with the direct involvement of the President through a Presidential Task Force), new program management and strategies, increased human resources, and establishment of a National Accountability Framework (Nasir et al., 2016). Programmatically, the plan included strengthened surveillance, improved quality of supplementary immunization activities at national and subnational levels, strategies to reach underserved populations, and improved routine immunization (Nasir et al., 2016; WER, 2013). The EOC was a centralized command-and-control unit for planning and management in which leaders of involved national and global organizations were all located in the same place and met regularly to prepare and implement strategies (Desmarais, 2016). EOCs were also established in high-risk states in northern Nigeria (Desmarais, 2016).

The polio EOCs were founded on five components to ensure focus on the highest-priority problems, operational effectiveness, and accountability:



Source: Desmarais, 2016

Responding enthusiastically to Nigeria’s establishment of the EOCs, the IMB further recommended a continual live audiovisual feed broadcast online from the country, enabling global polio experts and the IMB to observe and provide input at any time (IMB, 2012). This support aided the country in starting a positive upward trend toward polio eradication.

“The Emergency Operations Centre concept has been vital in creating and sustaining a cohesive ‘emergency’ culture within the polio endemic countries. However, the concept alone is not enough to have an impact. It must operate consistently and be implemented in a highly skilled and authoritative way. The establishment of such a centre made an immediate impact in Nigeria because of two key factors. Firstly, a Cabinet Minister, who had the credibility and authority to convene sub-national leaders and take decisions, led a strong secretariat of the multi-stakeholder task force. Secondly, the positioning of the Emergency Operations Centre within the Nigerian governance structure enabled remedial actions to be taken immediately when they were escalated up the chain of accountability. If the Emergency Operations Centre is operated and managed in a purely technocratic manner, with ineffective connection to the highest-level decision makers, then the Programme in the country will never reach a pinnacle of performance.” IMB, 16th Report, October 2018

Accountability in Nigeria’s Emergency Plan for Polio Eradication

The emergency plan’s National Accountability Framework was based on the following principles: 1) promoting individual accountability at every level; 2) providing rewards for strong performance (e.g. public recognition, meetings with senior leaders, award certificates, media mentions, training, etc.); 3) ensuring consequences for weak performance (e.g. documentation and sanctions such as warnings, withholding of allowances, disengagement from the program); 4) using evidence-based decision-making; 5) conducting monthly independent assessments; 6) ensuring feedback loops between wards, local government areas (LGAs), states, Core Group, and the Presidential Task Force (NPHCDA, 2013). The framework specified all responsible actors and immunization activities, ensured the identification of any missed tasks, allowed continuous improvement in immunization activities, and overall held administrations in LGAs accountable to the President for polio eradication activities and performance.

LGA High Risk Operational Plans and key performance indicators that were measured and regularly updated—together this information was fed into a dashboard that informed progress (NPHCDA, 2013). Each organization contributed staff for the collection, analysis and reporting of relevant data (Desmarais, 2016). Additionally, local staff provided by the National Primary Health Care Development Agency (NPHCDA) collected data at the level of LGAs and wards. The intensive data collection and program management approach meant the EOCs could identify issues quickly and address particular challenges (Desmarais, 2016).

Sustaining Progress

Nigeria’s emergency action plan suffered some early setbacks which required further commitments and continued engagement. For example, in February 2013, 13 health workers were killed in different events in Borno and Kano, resulting in the suspension of and cancellation of follow-up rounds. That year, IMB quarterly reviews drew attention to Nigeria’s flatlining progress and supported the country in becoming accountable for improving geographic consistency and LGA response, extending accountability for polio elimination downstream, ensuring that the distraction of elections did not interfere with implementation, and recommending that the country’s Expert Review Committee ensured area-specific LGA plans were put in place (IMB, 2013).

As a consequence, over the next two years, Nigeria saw progressive reductions in the incidence of WPV1 cases (WER, 2015) and the last WPV3 case was reported in Nigeria in November 2012 (WER, 2013). Successes were due to improved quality of supplementary immunization activities nationwide, more effective strategies to address hard to reach communities and reduce non-compliance and refusal of vaccines, and enforcement of the accountability framework (NPHCDA, 2013; WER, 2014). However, surveillance gaps remained, and there was continued transmission of vaccine-derived poliovirus type 2 due to insufficient routine vaccination coverage (WER, 2014).

Due to this progress, IMB began to highlight the EOCs as a best practice for emulation by the other polio endemic countries, welcomed the development and institutionalization of EOCs down to state level, recognized Nigeria's success at leveraging polio infrastructure to quickly and efficiently responding to the nascent Ebola outbreak in the country, and praised its accountability framework for setting clear standards for individuals' performance (IMB, 2014). By 2015, Nigeria was able to be removed from the list of polio endemic countries, having been free from cases for more than a year.

Responding to Setbacks

Nevertheless, the IMB felt that certain states fell far short of agreements and, thus, to keep the country accountable to an emergency mode it was necessary to categorize Nigeria as “not nearly there” when it came to polio elimination (IMB, 2014). Their concern was not unfounded. After two years of no detection of WPV cases, in August and September 2016, two vaccine-derived and four WPV1 cases were reported in Borno in northeastern Nigeria, an area plagued by insurgency and insecurity since 2013. Genetic sequencing linked the WPV1 cases to cases last reported in Borno in 2011, suggesting that there had been unreported transmission of WPV1 since that time (WER, 2017), while the vaccine-derived cases were estimated to have been circulating for at least two years (IMB, 2016).

The IMB expressed concern about waning political commitment at both federal and state levels with the polio task force failing to meet frequently, and election activities distracting from efforts to secure public trust (IMB, 2016). The review team noted that the Presidential Task Force had not met in the first half of 2016 and that political commitment and programmatic success at the national level masked issues at the state level—in particular, related to financial commitment and programmatic resilience—highlighting Borno State as a clear example (IMB, 2016).

A comprehensive response was conducted by Nigeria's EOC, GPEI partners, and health ministries in four other countries in the Lake Chad Basin (WER, 2017), with coordination of response extended through 2018 in recognition of the potential that Nigeria's setback extending to other countries in the region (IMB, 2017). Additionally, while IMB review found Nigeria's response to the 2016 outbreak to be strong, it was concerned about the accessibility of much of Borno State, weaknesses in the quality of the programme at lower levels, and response fatigue (IMB, 2017). As importantly, it was worried about sustaining financial commitments for both polio and routine immunization more broadly at the national and state levels, especially as the country was beginning its journey to transition out of Gavi funding by 2020/21 (IMB, 2017).

In 2016 and 2017, both the IMB and Nigerian government saw that a major key to success in the country's polio response would be “unlocking Borno” which, in turn, involved not simply public health commitments but political ones: engaging the security forces and military, establishing Joint Civilian Taskforces, and tying political commitment to polio expressly to political commitments made by the President with respect to regional security (IMB, 2017). In the words of the IMB, “in moving forward over the next six months, the military could assist in a decisive big breakthrough by allowing the shifting of the emphasis to the humanitarian ethos of the Polio Programme saying, “We need to get to these locations, can you get us there?” (IMB, 2017).

Multiple cases of vaccine-derived polio continued in Nigeria throughout 2017-2018. The IMB, however, praised the increased willingness of Nigeria's polio stakeholders to engage and question data, innovate in response to bottlenecks, and delegate and invest at LGA levels. They also highlighted numerous successes by Joint Civilian Taskforces—critical accountability structures enabling a more transparent relationship to

military engagement in the polio response in the north. Surveillance in the northern parts of the country was still seen to be in need of improvement and data required further disaggregation in order to better target intervention (IMB, 2018). The team also saw routine immunization as a critical area of investment. Most importantly, the IMB again held the government to account over declining investment in the National Polio Programme as a response to absence of the WPV cases, as well as the fact that the Presidential Task Force—while meeting more frequently and consistently—was not chaired by the President himself (IMB, 2018). The tension between the absence of WPV cases in the country and the willingness to sustain an emergency response with adequate funding, personal and political commitment was also felt at global levels, where GPEI itself was proposing a budgetary reduction of between 15-20 percent to Nigeria (IMB, 2018) and a global review commissioned by the IMB urged the Initiative to recommit and re-engage donors to ensure that—irrespective of global case numbers—polio remained a global health emergency (Crowley et al, 2018). Linking Nigeria’s accountability efforts to the GPEI, the IMB stated that “advocacy is needed from the top leadership of the GPEI and from donor governments to the highest level of the Nigerian government” (IMB, 2018).

Success in Interrupting the Transmission of WPV in Nigeria

By 2019, Nigeria’s commitment was strongly commended by IMB. Not only were Health Ministers and programme officers part of the IMB delegation to the 17th IMB meeting of that year, but Nigerian legislators and Chairmen of the legislative Health Committees also attended, in spite of the fact that they came from differing political parties (IMB, 2019). No new WPV had been detected in more than three years. The National Polio Programme had carried out a comprehensive review and gap analysis tied to eliminating vaccine-derived illness. Recognizing that many of the remaining challenges were tied to low levels of routine vaccination, the Nigerian government declared the essential immunization levels a national emergency in 2017 and established a National Routine Immunisation Emergency Coordinating Centre, supporting in turn the transition from Gavi to domestic funding (IMB, 2019).

Finally, in August 2020, Nigeria was declared free from wild polio. While vaccine-derived polio is still a challenge, polio programme implementation and accountability infrastructure has, in turn, been leveraged throughout 2020 to support Nigeria’s COVID-19 response.

“Two years ago, the IMB advised the Nigeria Polio Programme to focus on resilience. How, as it was heading towards a winning trajectory, would it put in place those systems that would allow it to withstand the surprises that pop up? The serious vaccine-derived poliovirus outbreak is an example of Nigeria’s Polio Programme not yet having the required level of resilience measures in place. The Emergency Operations Centre has a crucial role in further strengthening resilience to create a no surprises culture in the Nigeria Polio Programme. This must be a top priority for the Nigeria government, especially through: better quality campaigns, transformational change in essential immunisation coverage, constructing modern environmental sanitation systems, securing the right level of funding.” IMB, 17th Report, November 2019

Lessons on Accountability: The Case of Nigeria and the IMB

1. Achieving progress on accountability was an iterative process requiring trust and confidence on all sides. IMB carried out quarterly visits to Nigeria, enabling the IMB to continually increase its knowledge of conditions on the ground, revisiting the same stakeholders again and again.
2. By tracking progress in real time, the government and the IMB were able to course correct rapidly and flexibly and innovate to address program bottlenecks and accountability issues, as these evolved and changed over each year.

3. The IMB review missions encouraged an inclusive approach, widening and deepening the contribution and participation of all relevant stakeholder groups from the President and National Assembly to local government officials to citizens on the ground in the affected states.
4. GPEI and its partners ensured that both the IMB and subsequent work on coordination, alignment, and oversight with the Government of Nigeria was sufficiently resourced.
5. IMB insisted on full transparency and openness. Together, the Government of Nigeria, IMB, and GPEI created a space for frank and substantive discussions by instituting ‘Chatham House rules’ (i.e. what is said in this room, stays in this room). It used hard-hitting, sometimes harsh, language in its quarterly reports, but never deviated from its commitment to seeing Nigeria succeed.

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