Polio eradication cross-border coordination plan 2024/2025

Lake Chad Basin and Sahel countries

World Health Organization
African Region

polio global eradication initiative

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Designed in Brazzaville, Congo

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Executive summary

The continued widespread transmission of the variant type 2 poliovirus across the Lake Chad Basin, the Sahel and broader West Africa presents a significant challenge to meeting global polio eradication deadlines. Seven countries at the core of the Lake Chad Basin and the Sahel act as engines of transmission with large outbreaks and significant transnational spread. These countries can be grouped into two distinct but overlapping core epidemiological blocks:

- **Lake Chad Basin countries:** Cameroon, Central African Republic, Chad, Niger, and Nigeria; and
- **Sahel countries:** Burkina Faso and Mali.

Polioviruses spread based on human movement patterns and interactions that often transcend national boundaries. The region's borders are highly diverse, including inaccessible and insecure areas. The frequent movement of populations, security issues, and gaps in immunization coverage and disease surveillance necessitate a strong, coordinated response across the two epidemiological blocks.

The response unfolds amid significant challenges in the Lake Chad Basin and Sahel region. Rapid population growth and harsh climatic conditions, including droughts and desertification, have exacerbated food insecurity, with 55 million people facing or expected to face food and nutrition insecurity in 2024. The situation is worsened by ongoing armed conflicts and violent extremism, leading to widespread displacement and a humanitarian crisis, where access to basic needs is severely limited. Economic difficulties, such as rising food prices and currency devaluation, further complicate the region's ability to recover.

In the past, these countries worked together successfully to end wild poliovirus outbreaks. This was partly achieved through the establishment of dedicated subregional coordination teams that were tasked with intensifying cross-border activities to detect and respond to poliovirus transmission, including in the Lake Chad Basin. These mechanisms succeeded and were disbanded once the transmission was interrupted. However, since then, variant type 2 poliovirus transmission has emerged and spread across the subregions.

This document outlines a plan for the subregions' cross-border coordination mechanisms and activities for the remainder of 2024 and 2025. The goal is to ensure effective multi-country collaboration to end the transmission of active poliovirus outbreaks in the subregions by the end of 2025 and to address any remaining risks by the end of 2026. Lessons learnt from prior efforts and insights from two technical meetings with countries, representatives from the Global Polio Eradication Initiative (GPEI) and wider partners, held in Brazzaville in July and August 2024, were drawn upon to inform this plan.

Each country in the block has submitted a comprehensive national plan covering relevant activities. Joint activities have been selected to effectively link countries and agreement has also been reached on synchronizing immunization responses.

The focus of this plan is to define and operationalize the necessary coordination mechanisms, including synchronizing and optimizing campaigns, deploying special interventions to reach border and mobile populations and enhancing data-sharing and surveillance activities to facilitate early detection and quick, effective responses.

High-level political commitments for cross-border polio eradication

To successfully coordinate and implement multi-country activities, this plan requires the same high-level political commitment and leadership that brought an end to wild poliovirus on the continent.

A virtual interministerial meeting with senior government leadership and Global Polio Eradication Initiative (GPEI) partners was held on 16 August 2024, during which the seven participating countries during which the seven participating countries demonstrated strong support for ten commitments for the interruption of variant poliovirus transmission:

1. Advocate for sustained whole-of-government commitment to make the interruption of variant poliovirus transmission a top health priority, and establish, reactivate or maintain:
   (a) a strong incident management system in each country that brings together the government and partners under one roof and under one system, led by a senior government official (National Incident Manager) with direct access to the senior government leadership, including the health minister;
   (b) an active strategic Interagency Coordination Committee on Immunization that meets at least every quarter; and
   (c) a multi-country coordination mechanism to coordinate cross-border activities and ensure effective collaboration and resource allocation.
2. Support the newly established coordination mechanism for the Lake Chad Basin countries in N'Djamena and the broader West Africa response coordination and support team in Burkina Faso.
3. Develop and implement national plans for cross-border coordination, incorporating key transnational population movement patterns involving at-risk populations.
4. Deliver synchronized polio vaccination campaigns across borders to reach all at-risk populations living across porous borders.
5. Enhance cross-border polio activities for reporting, detection, information-sharing, response coordination and social and behaviour change, focusing on highly mobile populations and those in hard-to-reach border areas.
6. Implement temporary recommendations from the International Health Regulations (IHR) concerning ongoing events and context involving transmission and international spread of poliovirus.
7. Enhance routine immunization, including reaching unvaccinated and under-vaccinated children with the oral poliovirus vaccine and two doses of the inactivated poliovirus vaccine (IPV).
8. Carry out joint innovative community engagement activities across borders continuously.
9. Enable regular vaccination and disease surveillance data sharing among all partners and neighbouring countries, using specialized tools such as geographic information system (GIS) technology.
10. Establish a monitoring and accountability framework that includes quarterly virtual and twice a year in-person ministerial dialogues to evaluate challenges, progress, and bottlenecks on polio eradication and essential immunization.

1. Introduction

The global polio programme aims to eradicate wild poliovirus transmission in endemic countries, stop variant poliovirus transmission and prevent new outbreaks in all countries by December 2028. The African Region has shown strong capability by ending indigenous wild poliovirus (WPV) transmission and stopping the WPV outbreak following importation.

In 2024, the Region developed the *Africa Regional Polio Eradication Action Plan 2024–2025*. This plan outlines a bold strategy to end polio outbreaks across the WHO African Region by moving beyond the standard response to more intensive efforts, similar to what it took to end wild polioviruses in the Region. The timeline to reach the goals is phased across epidemiological zones, with the aim to end all active variant poliovirus type 1 outbreaks by December 2024 and all active variant poliovirus type 2 outbreaks by December 2025.

As of July 2024, the Region is on course to stop transmission of ongoing variant poliovirus type 1 outbreaks by December 2024 (data as of July 2024). This progress is encouraging, but it is tempered by the challenges posed by widespread circulation of the variant poliovirus type 2.

Across Africa, the transnational spread of polioviruses is one of the greatest challenges that countries face in their attempts to stop transmission. This is especially the case in the Lake Chad Basin countries and across West Africa. Border areas in the Lake Chad Basin are at high risk for poliovirus transmission due to factors such as insecurity and inadequate access to healthcare. The virus spreads easily across borders, which are often highly porous. These areas are often missed in planning unless both sides coordinate effectively to ensure comprehensive coverage.

In view of the goal to interrupt transmission of the poliovirus in the African Region by 2025, as outlined in the *Africa Regional Polio Eradication Action Plan 2024-2025*, and the current rate of cross-border transmission between countries, faster progress is urgently needed. This cross-border coordination plan aims to expedite progress by outlining the actions required to intensify cross-border efforts and improve poliovirus detection and response across the subregions.

1.1 Need for coordinated action

Based on the current epidemiology and subregional risk assessments, areas within the Lake Chad Basin and Sahel subregions are regarded as very high risk for transmission of the type 2 variant poliovirus. Between 2022 and 2024, 33 cases and 17 environmental isolates have been traced to other countries (data as of 4 August 2024). The surveillance performance varies, with many subnational areas in the region reporting below target thresholds. The detection of 67 orphan viruses across the subregions, particularly in Chad and Nigeria, between 2022 and 2024 highlights significant surveillance gaps (data as of 4 August 2024).

Populations move very frequently across borders in these subregions. Recognizing the high risk of poliovirus spread, in 2014, the International Health Regulations Emergency Committee declared the situation a public health emergency of international concern, recommending vaccination for international travellers. This approach is crucial for helping to stop continued transmission and move closer to a polio-free world.

However, given the current polio epidemiology and imminent deadlines, urgent progress on cross-border coordination is essential to get the programme on track. This includes establishing multi- country coordination mechanisms, implementing special strategies to map and reach populations on the move, and improving cross-country notification of polio detections to enable rapid and effective responses.

Discussions between countries, in which representatives agreed on these strategies to improve cross-border coordination, took place in late July and early August 2024 in Brazzaville, Republic of Congo, at the *GPEI cross-border coordination technical meetings for polio eradication* for each subregion. In these meetings, the establishment of coordination mechanisms was deliberated and the actions laid out in this plan were refined.

1.2 Existing cross-border coordination guidance

While there is no single strategy for best practices in cross-border coordination for polio, relevant guidelines exist.

To effectively address the spread of the poliovirus in hard-to-reach areas, the polio programme has developed techniques such as cross-border risk assessments, population mapping, coordinated surveillance with stakeholders and community-based case detection.[1] Gaps are addressed through environmental surveillance and ad-hoc case searches, with the support of tools like mobile data collection and geospatial information system mapping.

Recognizing the importance of integrating efforts to combat vaccine-preventable diseases across borders, the WHO South-East Asia and Western Pacific Regions have developed an implementation framework to enhance cross-border collaboration for all vaccine-preventable diseases.[2] The framework emphasizes the importance of involving multiple stakeholders, conducting joint risk assessments and utilizing regional data-sharing mechanisms to address the challenges posed by cross-border disease spread.

Given the critical importance of preparedness for crises that may have cross-border implications, it is essential for countries to assess and strengthen their readiness to manage such emergencies. In this context, the Organization for Security and Co-operation in Europe has developed and updated a self-assessment tool.[3] This tool enables nations to evaluate their level of preparedness, with a particular focus on addressing the unique challenges posed by emergencies that can transcend national borders.

Given the increasing complexity of global health emergencies, the Global Outbreak Alert and Response Network, coordinated by the World Health Organization (WHO), addresses key challenges through its handbook.[4] This resource outlines key strategies to enhance cross-border coordination, including conducting regular coordination calls, ensuring interoperability through shared systems for real-time data exchange and integrating partners within national response structures. These approaches aim to strengthen global health security by fostering collaboration across diverse stakeholders and regions.

1.3 Past cross-border coordination mechanisms

In the African Region, there have been several formal and informal structures that have played a role in managing cross-border polio eradication activities. For example, in the Horn of Africa, a coordination taskforce was set up in Nairobi between 2014 and 2016 with Djibouti, Eritrea, Ethiopia, Kenya, Somalia, South Sudan, Sudan, Uganda and Yemen.

In the Lake Chad Basin, a similar coordination mechanism was established from 2016 to 2018 for Cameroon, Central African Republic, Chad, Niger and Nigeria, operating from a central hub in N'Djamena.

High population movement, insecurity, and political fragmentation complicated efforts to implement a joint strategy across the subregions. They also underscored the importance of adaptable strategies that can navigate political complexities and engage multiple stakeholders effectively. In insecure areas, innovative solutions, such as leveraging local actors, were essential to improving vaccine coverage. A significant takeaway is that addressing cross-border transmission requires more than just vaccination campaigns.

The use of messaging applications, such as WhatsApp, has allowed real-time information sharing across borders. Close collaboration between surveillance and joint investigation teams enhanced the timeliness of detection. These strategies not only improved performance but also built local capacity. Importantly, the success of these mechanisms relied heavily on strong leadership from the government at all levels, with sustained support from partners. The centralized coordination teams had the full mandate to implement strategies effectively, allowing them to act swiftly and decisively in a complex operational environment.

In the Lake Chad Basin, security concerns and the difficulty of reaching remote populations, such as those living across the 1600 isolated islands on Lake Chad, made comprehensive coverage a complex task. This experience highlighted the importance of strong governmental ownership and leadership. However, the dissolution of the specialized task team without effective transfer of skills to local teams created gaps in capacity, demonstrating that success depends on building local expertise that can carry forward the work once external support diminishes. Additionally, the challenges of managing increasingly complex coordination meetings as more outbreaks emerged showed the need for streamlined communication and decision-making processes.

The successes in the Lake Chad Basin were partly due to the strong monitoring mechanisms as well as guidance and recommendations from technical advisory groups. The strategic use of data managers, such as GIS specialists, enabled data-driven decisions that were responsive to on-the-ground realities. Special interventions, such as those facilitated by wider partners, extended the reach of vaccination and surveillance into difficult-to-access areas. Ensuring strong government involvement and ownership of coordination committees were essential in securing long-term commitment and aligning these efforts with national health priorities.

These lessons highlight the importance of a formally established and empowered coordination task force that can tackle cross-cutting issues facing countries, provide innovative strategies, secure additional resources, implement organizational directives and enable country ownership in coordinating cross-border activities for polio eradication.

[1] GPEI. Guidelines for implementing polio surveillance in hard-to-reach areas and populations; 2020. (https://polioeradication.org/wp-content/uploads/2020/10/Guidelines-polio-surveillance-H2R-areas.pdf, accessed 12 November 2024).

[2] World Health Organization, Regional Office for South-East Asia. Implementation framework for cross-border collaboration for priority vaccine-preventable diseases surveillance and immunization; 2023. (https://iris.who.int/handle/10665/371603, accessed 12 November 2024).

[3] Organization for Security and Co-operation in Europe. Self-assessment tool for nations to increase preparedness for cross-border implications of crises; 2021. (https://www.osce.org/secretariat/104490, accessed 12 November 2024).

[4] World Health Organization. National outbreak response handbook by the Global Outbreak Alert and Response Network; 2024. (https://iris.who.int/handle/10665/377617, accessed 12 November 2024).

2. Goal and objectives

The goal of this plan is to:

> interrupt poliovirus transmission across the Lake Chad Basin and the Sahel by the end of 2025 and achieve certification of elimination by the end of 2028 through coordinated immunization strategies, strong surveillance and comprehensive coverage of all high-risk and underserved populations.

The objectives are to:

1. foster government ownership and leadership and enhance partner support;
2. establish and strengthen multi-country coordination mechanisms;
3. enhance cross-border surveillance and mapping of high-risk populations;
4. optimize cross-border immunization strategies and synchronize implementation; and
5. jointly address community resistance and advocacy challenges for populations living along common borders and high-risk mobile populations.

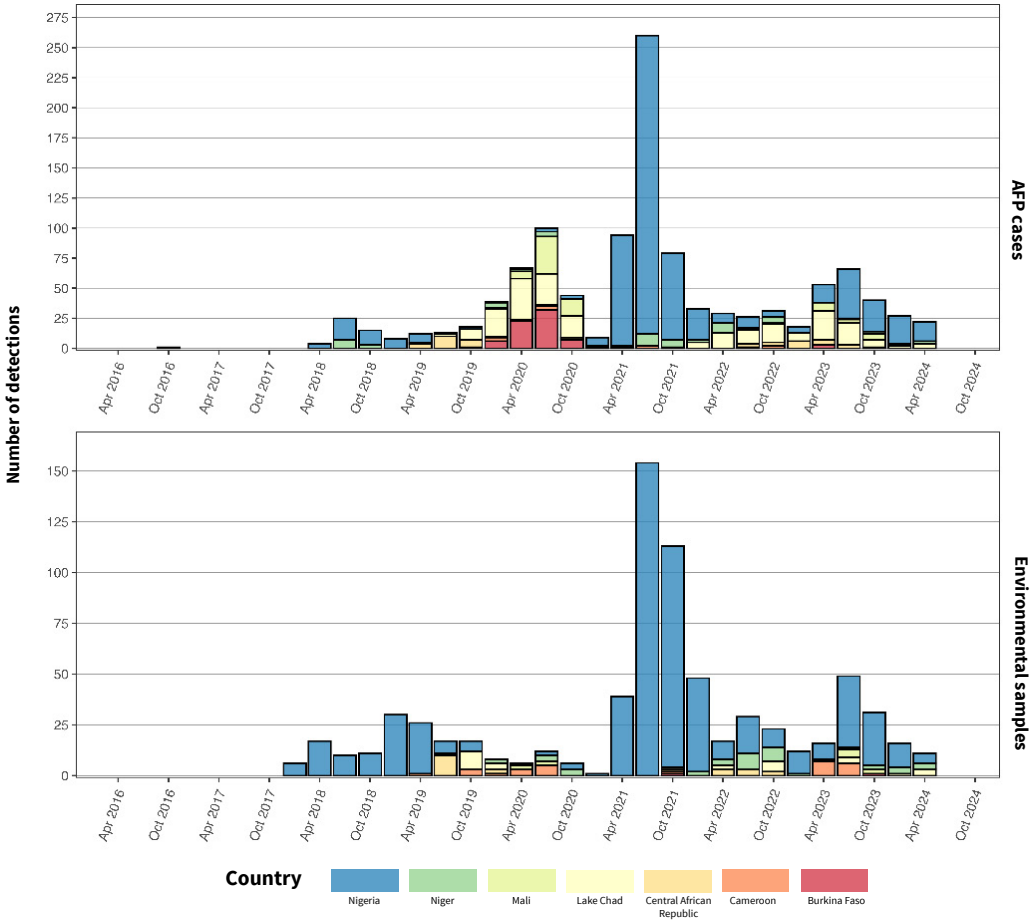
3. Cross-border context

This section explores the current context of the subregions for cross-border polio activities.

3.1 Epidemiological overview

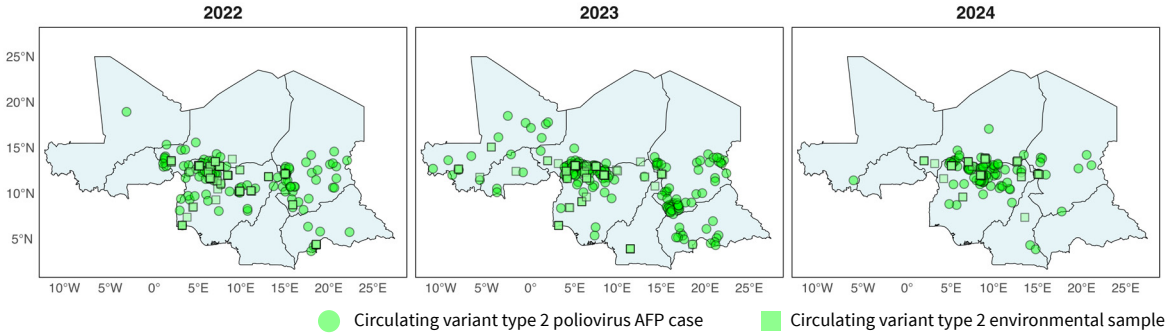
The seven countries are critical for the elimination of circulating variant polioviruses in the African Region. They act as core engines of transmission and lie at the centre of population movement corridors that have spread polio across central, western, northern and eastern Africa. Subnational areas in Nigeria and Chad have been classified as core reservoirs with persistent transmission for ≥24 months. Fig. 1 below shows the epidemiological curve for variant poliovirus type 2 outbreaks in the seven countries since the global withdrawal of trivalent oral polio vaccine (tOPV) in 2016.

Fig. 1. Epidemic curves of variant poliovirus type 2 cases and environmental surveillance detections in the seven Lake Chad Basin and Sahel countries, 2016–2024



Since January 2016, 1154 cases and 873 environmental surveillance isolates were reported from the seven countries. The spread of the type 2 variant peaked in 2021 with 443 cases and 350 isolates reported in that year alone with Nigeria accounting for 420 (95%) cases and 345 (99%) environmental surveillance detections (Fig. 1 and Fig. 2).

Fig. 2. Map of poliovirus detections in the Lake Chad Basin and Sahel subregions, 2022–2024



This widespread transmission was primarily driven by low immunization rates and immunity gaps in a considerable cohort of young children. Essential health service delivery was significantly disrupted by the COVID-19 pandemic. Routine immunization gaps, coupled with global vaccine supply challenges and weaknesses in polio surveillance have contributed to the spread, including in the Lake Chad Basin and Sahel countries.

Since 2021, transmission has declined, however, circulation has not been successfully interrupted. Recurrent spillover from these core reservoirs have led to frequent resurgence in countries previously free of polioviruses. In Nigeria, from August 2023 to August 2024, the number of cases has more than tripled compared to the previous 12 months. The same situation was observed in other countries over the last five years.

3.2 Outbreak response

Between July 2023 and June 2024, the seven countries have implemented between two to four national or subnational rounds each: Chad implemented two rounds, Nigeria implemented four rounds, and the remaining countries implemented three rounds. Almost 96 million children were vaccinated at least one time during this period and at least 295 million novel oral poliovirus vaccine type 2 (nOPV2) doses were administered (data as of 5 August 2024).

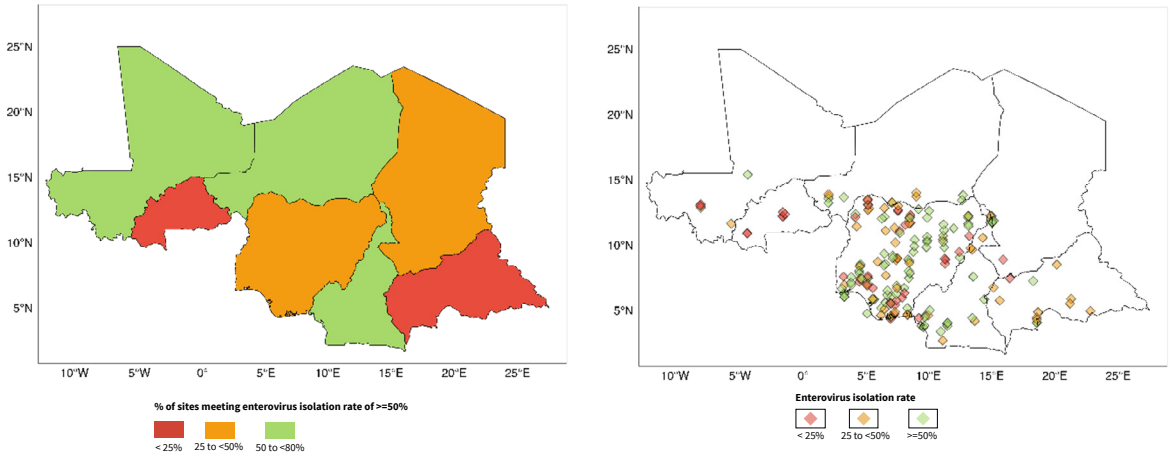
These large-scale immunization activities resulted in enhanced population immunity across the subregions. However, despite the substantial reduction in risk across the wider population, transmission has persisted in subnational core reservoirs and high-risk geographies, and many of these geographies have at-risk transnational populations. Delays in conducting campaigns, inadequate cross-border coordination and quality of campaigns, especially in areas facing insecurity or hard-to-reach areas, have contributed to the persistent transmission.

3.3 Surveillance performance

Acute flaccid paralysis (AFP) surveillance quality across the seven countries, while meeting global standards at the national level, has remained varied at the subnational level (Fig. 3). Performance gaps are especially notable along the common borders of Niger–Nigeria, Burkina Faso–Mali–Niger, Cameroon–Nigeria and Central African Republic–Chad. Similarly, while there has substantial expansion of the environmental surveillance network, there are still gaps in site quality, including in areas with high transnational populations (Fig. 4). Focused action is needed to address gaps and ensure high quality surveillance at all levels.

Fig. 3. AFP surveillance performance at district level, July 2023–June 2024

Fig. 4. Environmental surveillance performance at site level, July 2023–June 2024



3.4 Special populations

Reaching and vaccinating special populations across Burkina Faso, Cameroon, Central African Republic, Chad, Mali, Niger, and Nigeria is a significant challenge. These groups, estimated to be between 100 and 115 million people, include mobile populations, displaced persons, underserved urban communities, border populations and island inhabitants. Vaccinating these populations requires tailored vaccination strategies, mobile and community-based approaches, cross-border coordination and a commitment to reaching remote and underserved groups.

Forcibly displaced populations, estimated to be between eight to nine million people, live in overcrowded and unstable conditions, often in temporary shelters or camps. An estimated 80 million people across the seven countries are thought to live in urban slums. Both populations face barriers to vaccination. This includes poor infrastructure, overcrowding, and inadequate sanitation. Systematically including these populations in vaccination plans and ensuring high quality microplanning are crucial. These populations also experience mistrust of authorities and misinformation about vaccines. Tailored community engagement strategies are vital to reducing resistance and increasing demand for vaccination.

An estimated seven million people living along the common borders regularly engage in cross-border movements for trade, social activities and migration. Island populations in Lake Chad, estimated around 400 000 people, live in transient and seasonal settlements. Vaccination efforts are further complicated by limited accessibility and security concerns. Innovative solutions, such as mobile teams and close intercountry collaboration, are needed.

4. Coordination mechanisms

Establishing coordination teams and communication channels between health authorities and partners in neighbouring countries at both the national and local levels is crucial to effective coordination. This facilitates the timely sharing of surveillance data and health alerts, enabling joint rapid responses to polio cases that may arise near borders. A strong commitment from political leaders, including health ministers and heads of state and government, is essential for success.

4.1 Subregional mechanisms

To enhance coordination and increase technical support to countries, two coordination mechanisms are proposed:

- **Lake Chad Basin coordination mechanism for polio eradication:** Based in N'Djamena, this mechanism will be established for Cameroon, Central African Republic, Chad, Niger, and Nigeria.
- **West Africa coordination mechanism for polio eradication:** Based in Burkina Faso, this mechanism will support a coordinated approach across West Africa, including the Sahel countries of Burkina Faso and Mali.

Considering that poliovirus outbreaks are now ongoing across the whole continent of Africa, both mechanisms will operate under the existing GPEI Regional Outbreak Response Group, thus ensuring an overall alignment in response activities across the region.

4.2 Local mechanisms

4.2.1 District health and border focal points

Each country is to appoint district health level and/or border focal point in key locations to support local coordination. The local focal point's role is to serve as the main contact for cross-border communication, ensuring timely data sharing on polio cases and immunization coverage, which includes the following tasks:

1. monitor and report polio trends, contribute to joint risk assessments and ensure quality data collection aligned with regional standards;
2. support synchronized immunization campaigns, implement special interventions at border crossings, and target mobile and high-risk border populations;
3. engage local leaders, influencers, and community members to promote vaccination and ensure consistent communication strategies;
4. organize training focused on cross-border coordination, such as protocols for cross-border data sharing, surveillance methods, and synchronized immunization efforts, ensuring that health workers are prepared for cross-border challenges;
5. participate in risk assessments, help update microplans based on population movements, and adapt plans to emerging needs;
6. conduct synchronized planning at the lowest level between the local technical teams, partners, and local administration or information sharing, where joint planning is not feasible;
7. strengthen information sharing monthly at the local level, using an agreed monitoring template, through phone, email, and regular meetings;
8. strengthen the documentation and implementation of action points from coordination meetings;

9. participate in joint training sessions between local focal points at regular intervals for coordination of disease surveillance, reporting, and vaccination campaign implementation between countries;
10. document activities and share weekly, biweekly, or monthly reports, depending on outbreak intensity.

4.3 Key players and stakeholders

Identifying local stakeholders and actors can enhance support for cross-border coordination. Many of these agencies and organizations have specialized knowledge on mobile populations and are active in areas inaccessible to GPEI. They can also provide insights into intercountry demographic and geopolitical dynamics. This may include other government divisions, United Nations agencies, the Red Cross and Red Crescent Societies, CORE Group, peacekeeping forces and other nongovernmental organizations (NGOs).

To map and track special populations, especially across dynamic borders in the conflict zones, the United Nations Office for Coordination of Humanitarian Affairs (UNOCHA) produces maps and local situational analyzes; and the Office of the United Nations High Commissioner for Refugees (UNHCR) collects rich data on population numbers and movement; and the Centre for Humanitarian Dialogue analyzes different groups and actors in conflict-affected settings.

The International Organization for Migration (IOM) helps to reach populations with medical interventions at borders. For example, at some border control posts in Niger, the IOM, health workers, and security forces work together to screen mobile populations for possible vaccine-preventable diseases, including for suspected AFP cases. Other activities include population mobility mapping, community event-based surveillance, reporting and information sharing, mobility sensitive risk communication and community engagement, social and behaviour change strategies and joint simulation exercises.

Cross-referencing mobility data for special populations with polio case distribution provides valuable insights for governments to identify areas requiring joint actions. It also helps partners avoid duplicating efforts and ensures that data is used in a complementary manner, thereby maximizing the impact of interventions.

5. Cross-border activities

5.1 Map special populations

To enhance cross-border coordination for polio eradication, it is essential to implement strategies for mapping and tracking mobile and hard-to-reach border populations, especially before major response rounds. Table 1. below presents the core actions and strategies for mapping and tracking special populations across borders. Close collaboration with local governments and relevant actors and regular periodic updates (such as in-between campaigns) are essential.

Table 1. Actions for mapping and tracking special populations

Activity	Details	Output
Map and track special population movements and locations	• Map official and non-official border crossings. • Map seasonal and irregular movement patterns and estimating population flow averages. • Profile villages/settlements, special populations, security, points of interest and access on both sides of the border. • Map areas more easily accessible from neighbouring districts or countries. • Identify organizations at border entry and exit points (immigration, port health services, police, humanitarian NGOs). • Use historical data, local knowledge and predictive modelling to anticipate future movements. • Identify and map key congregation points, such as water points and livestock markets, for mobile and hard-to-reach populations. • Collaborate with teams already engaged in mapping special populations, such as those working in animal and livestock health. • Collect data during vaccination campaigns to refine population maps and plans. • Employ satellite imagery and GIS technology to create detailed maps. Utilize drones for aerial surveys in remote and inaccessible areas to gather images and data. • In hard-to-reach or insecure border areas, collect and analyze health seeking behaviour data and map healthcare providers (formal and	• Maps for movement patterns, border crossings and local actors/resources produced • Mechanism for special population tracking data-sharing established between countries • Network of informants formed for high-risk groups • Incoming traveller register developed

Table 1. cont'd...

	informal), key community actors, NGOs, humanitarian agencies, and the Medical Corp of the military if required in special situations. • Establish a network of informants at the community level to gather valuable local knowledge and real-time updates on population movements. • Establish a data-sharing mechanism with neighbouring focal points for cross-border population tracking. • Coordinate with relevant organizations to register, track and perform other surveillance or immunization activities for incoming travellers, as well as for inclusion in future vaccination campaigns.	
Risk assessments	• Develop and apply indicators to assess risks, identify gaps and rank priority groups or locations for poliovirus transmission among special populations.	• Risk assessment indicator framework developed • Risk assessments conducted
Microplans	• Conduct microplan validation exercises that include special population settlements in vaccination campaign planning.	• Special population microplans validated and available at the district level
In-between round activities	• Count and vaccinate missed children in border areas and among special populations. • Engage and mobilize special populations. • Train health workers and volunteers in border areas. • Collect and analyze data to refine strategies. • Update maps, risk assessments and plans. • Initiate or intensify integration with other mass immunization programmes such as the Periodic Intensification of Routine Immunization, the Big Catch-Up, GAVI's Zero-Dose Immunization Programme and routine immunization.	• Targeted immunization for missed children • Microplans and risk mapping updated • Community engagement and mobilization • Training and capacity building for health workers enhanced • Data collected and analysis of coverage conducted

5.2 Synchronize response

To effectively stop the transmission of variant poliovirus type 2 in the Lake Chad Basin and Sahel subregions, synchronized activities are essential to maximize resource use. The key steps are shown in Table 2.

Table 2. Synchronized activities for polio eradication

Activity	Details
Decentralized microplanning	• Identify all targeted children in border settlements and plan resources accordingly, involving local leaders, security officials, and NGOs. • Communicate the importance of immunization to protect children within settlements as well as those crossing borders. • Complete this planning one month in advance of campaigns to ensure resource mobilization.
Joint supervision	• Conduct joint supervision of campaigns, beginning with collaborative meetings of health area heads and technical teams from bordering districts.
Standardized tools	• Use similar tools at borders to streamline record-keeping, data exchange, and analysis.
Joint evaluation	• Conduct joint evaluations two weeks post-campaign in border districts, analyzing performance and planning improvements. Focus to be given to identifying missed villages and populations. Organize mop-up to reach unvaccinated children.

For the remainder of 2024, there will be three synchronized campaigns, based on risk assessments, projected vaccine supply and budget availability. Table 3 shows the proposed supplementary immunization activities (SIAs) nOPV2.

Table 3. Proposed synchronized campaigns for the Lake Chad Basin for 2024–2025.

Location	Scope	Date
Central African Republic, Chad and Nigeria	Subnational	26–29 September 2024
Burkina Faso, Cameroon, Mali, Niger, and Nigeria	National	25–28 October 2024
Cameroon, Central African Republic, Chad, Niger and Nigeria	National	22–25 November 2024

5.3 Optimize cross-border immunization and response

To implement cross-border polio immunization activities, several dimensions should be considered. These dimensions include collaboration by various government services responsible for territorial administration, promoting transparency and fostering government ownership and leadership. Coordination between the technical services of the health ministry and other relevant ministries, particularly those dealing with population issues, is vital. Effective cross-border activities also require coordination between organizations at the central level and, most importantly, between entities in border districts and catchment areas.

The process begins with establishing dialogue among authorities responsible for territorial administration to secure clearance for technical teams. Once a consensus is reached on the modality of collaboration, the central services of the health ministry, using platforms like One Health, can connect all key players, most of whom operate at district level. Table 4 outlines specific actions and strategies for optimizing polio vaccination and response among special populations.

Table 4. Actions for optimizing vaccination among special populations, including border communities

Activity	Details	Output
Special vaccination teams	• Track nomadic pastoralists and other seasonal migrants and deploy special vaccination teams to reach and vaccinate them; adjust plans based on real-time information from community informants and other sources.	• Special vaccination teams established and deployed
Transit vaccination points	• Establish transit vaccination points at key locations such as border crossings, markets and major travel routes to vaccinate children on the move. • Position multiple vaccination teams on both sides of the border, varying in number and based on daily needs, to manage the influx of travellers. Increase the number of teams during high influx periods, such as during population displacement due to natural disasters or insecurity. • Consider expanded age-group vaccination that includes children over the age of five, based on case data, especially in high-risk areas and among populations with low routine immunization coverage. • Implement a 'handshake' policy where the two sides of the border agree on area coverage responsibilities, recognizing that borders populations may live and have social connections on both sides.	• Transit vaccination points established • Border coordination policy agreed

Table 4. cont'd...

	• Allow monitors, evaluators and supervisors from both sides to locally coordinate on vaccinations and to ensure that no household is missed and to share information if any missed area is found. • Preposition vaccines and other supplies at borders and implement local strategies to enable close cross-border collaboration.	
Campaign quality and synchronization	• Focus on improving the quality of SIAs in regions with high population movement or hard-to-reach border areas, by optimizing team selection, supervision and reaching persistently missed populations. • Strengthen data collection and monitoring systems to track vaccination coverage, identify gaps, and adjust strategies in real-time to ensure all populations are reached. • Ensure synchronization of campaigns across borders to minimize missed populations.	• Quality improvement plans targeting border and mobile populations developed • Data collection and monitoring systems strengthened • Mass campaigns synchronized
High-level advocacy	• Develop a joint communication plan and emphasize the need for health ministries of neighbouring countries to coordinate communication activities (including, if possible, joint press releases on launch of joint campaigns in multiple countries at the same time). • Mobilize heads of government engagement to support cross-border activities and request the collaboration of all relevant ministries. • Obtain the relevant ministry approval to allow health workers from different countries to work together at the local level to ensure that no child is missed. • Incentivize the launch of synchronized campaigns by the authorities of the border states, regions and provinces, where feasible. • Call on the ministries responsible for the implementation of the One Health approach to strengthen their support for the cross-border activities.	• Joint communication plan developed • Heads of government engagement on polio and immunization completed • Health workers of neighbouring countries allowed to work together and operate in each other's territories • Launch of synchronized campaigns from border territories organized • All relevant activities by NGOs integrated and NGOs provided significant support fully included in planning process • Joint mapping of cross-border religious and community leaders

Table 4. cont'd...

	• Urge NGOs operating in public health emergencies to integrate relevant messages and routine immunization interventions in their action. • Develop joint cross-border community engagement activities and messages involving traditional influencers, religious, nomadic and clan or tribe leaders to gain community trust and support for surveillance and vaccination, before, during, after and outside of polio campaigns and other routine immunization activities.	conducted • Joint information, educational, and communication products (letters, audio, and video) that engage religious and community leaders are produced and disseminated
Capacity building	• Provide specialized training for local focal points on techniques for reaching and vaccinating at risk populations, including the use of mobile and/or special teams and transit points vaccination teams. • Conduct, in the border territories, a series of stakeholder capacity-building trainings on interpersonal communication and social mobilization activities.	• Capacity-building trainings are provided • Stakeholders in border areas are trained on interpersonal communication and social mobilization activities
Local risk assessments	• Perform local risk assessments to identify high-risk areas and populations, using community informants and local data to tailor immunization strategies and prioritize interventions in mobile and hard-to-reach border groups.	• Regularly reviewed priority list of interventions, populations and locations
Community engagement and social mobilization activities	• Develop social mapping of border districts (such as languages, leaders, NGOs, associations, communities, and communication channels. • Set up cross-border community engagement units involving authorities, community and religious leaders, nomads, refugees, migrants, and leaders of internally displaced persons, for social mobilization and community engagement in relation to polio interventions. • Develop and implement a joint, cross-border communication plan, integrating perception, social and behavioural surveys, and lessons learnt. • Identify female champions and influencers in border areas for social mobilization and immunization activities.	• Social mapping of cross-border districts • Terms of reference for community animation units • Joint cross-border communication plan • Mapping of female champions and influencers

Table 4. cont'd...

Consistent and unified messaging	• Develop joint and harmonized message packages for routine immunization and polio cross-border response. • Co-creation of communication tools and materials adapted to the local context for border communities.	• Harmonized message banks, communication and advocacy materials for polio and routine immunization for cross-border activities
Integrated vaccination campaigns	• Where feasible, coordinate with other vaccination campaigns to simultaneously administer polio vaccines to special populations, such as using the established trust in veterinary services to reach pastoralist and nomadic populations.	• Integrated campaigns
Supporting routine immunization planning and assessments	• Support vaccine-preventable disease departments in the development of focused routine immunization strengthening plans for border areas and mobile populations. • Contribute to the scale-up facility-based and outreach microplans at border areas and special groups to strengthen routine immunization by defining movement patterns of the mobile populations. • Support the assessment of the functionality of all health facilities in border areas or those visited by mobile populations to ensure the provision of cold chain and other resources for immunization service delivery.	• Routine immunization strengthening plan supported
Security support	• Where feasible, identify local security officers who know the local context and security forces. • Create a security plan to support cross-border activities.	• Security plan developed • Support from local security experts obtained

5.4 Cross-border surveillance

In areas where traditional AFP surveillance is not always possible, additional strategies, supervision and feedback loops are crucial to detect circulating polioviruses. Extending surveillance-related performance tracking beyond traditional indicators, regular assessments, quarterly reviews, and risk analyzes by subregional teams is imperative to the timely identification of challenges and mitigation planning. Table 5 below outlines supplemental surveillance strategies that help to address cross-border risks.

Table 5. Actions to enhance cross-border surveillance

Activity	Details	Output or Indicator
Context mapping and profiling	• Identify, map and profile high-risk, hard-to-reach border areas and special populations. • Map all official and unofficial entry points and the services operating at them. • Identify point of interest around the cross-border areas that bring the community together. • Assess access to health services and surveillance network capacity for these groups. • Map healthcare providers and facilities. • Collect healthcare seeking behaviour data. • Develop and regularly update specialized surveillance plans and strategies. • Coordinate mapping activities with ministries of health and wider partners. • Record acute flaccid paralysis cases from special populations. • Conduct specialized training and capacity building for border surveillance officers, including to collect and analyze data for updating plans.	• Documented mapping and profiling • List of surveillance officers trained • Updated surveillance plans • New variable added to data collection tools to record acute flaccid paralysis cases from border areas and among special populations
Adjust surveillance network (active and passive surveillance)	• Adapt the surveillance network based on healthcare seeking behaviour, demographics and access. Factor in significant population changes and address disruptions due to population movements. • Conduct sensitization of surveillance actors – clinicians, surveillance focal persons, community informants.	• Biannual update of the surveillance network adapting to population changes or other disruptions with documented evidence of changes from the previous one and reasons
Ad hoc active search for acute flaccid paralysis cases	• Conduct ad hoc searches to identify unreported acute flaccid paralysis cases through health records review and community interviews – document on the line list or excluding line list (according to guidelines). • Adjust the surveillance network, sensitize healthcare providers, assess impact and implement improvements as needed.	• Number of unreported acute flaccid paralysis cases detected (by facilities and communities), investigated and taken on the line list or the excluded line list

Table 5. cont'd...

		• Document network adjustments and/or sensitization done • Impact assessment of surveillance adjustments e.g. using non-polio AFP rate
Community-based surveillance	• Initiate or strengthen community-based surveillance in border areas focusing on security-compromised regions and high-risk populations.	• Number and proportion of acute flaccid paralysis cases reported by community-based surveillance increased
Acute flaccid paralysis contact sampling	• Conduct contact sampling for all cases in official entries at border areas, such as health facilities in proximity to these borders, especially in regions with poor surveillance or suspected virus transmission.	• Data analysis of contact samples and cost benefit analysis of the results (after 6 months)
Targeted healthy children stool surveys	• In close coordination with the laboratory expected to process stools, conduct stool surveys in high-risk areas with suspected poliovirus transmission but no reported cases as a screening tool, with a focus on mobile populations and border areas.	• With support from the WHO Regional Office for Africa, develop a specific protocol for this activity • Identification of newly infected administrative regions
Environmental surveillance in access-compromised areas	• Enhance environmental surveillance in areas with large cross border populations • Set up ad hoc environmental sites in hard-to-reach, security-compromised, or newly accessible areas and internally displaced persons camps for a limited time.	• Enhanced performance of environmental surveillance sites • Number of positive samples detected via ad hoc environmental surveillance
Innovation	• Collect geolocation data for acute flaccid paralysis cases, active surveillance and supervisory visits. • Map catchment areas of environmental surveillance sites using GIS. • Facilitate case reporting and coordination via text messaging or with internet-based messaging applications, such as WhatsApp.	• Track and document the number of new ideas implemented, discontinued projects, implementation speed, impact and lessons learnt

Table 5. cont'd...

	• Assess journey of stool specimens from collection to laboratory.	
Stool sample collection and transport	• Ensure early communication between sender, logistician, and laboratory workers in access-compromised and hard-to-reach areas. • Communicate feedback on the quality of stool specimens and results to the original informer to maintain the integrity and reliability of the surveillance system.	• Disaggregated analysis of the timeliness of detection in border areas • Number of stool sample results available at the lowest administrative level
Special monitoring and evaluation activities	• Conduct monitoring and evaluation in border areas with access challenges and high-risk populations. • Identify hidden surveillance gaps, validate reported cases, and perform data quality checks. • Assess silent areas, group specific data analysis (by area and population group) and conduct targeted surveillance reviews.	• Number of cases validated by secondary and tertiary supervisors • Proportion of cases with updated critical data after validation • Number of targeted surveillance reviews and silent areas assessed
Cross notification of AFP cases between countries	• Assign epidemiological investigation disease (EPID) numbers to cross-notified cases (between countries) based on travel history preceding the date of onset of paralysis (according to guidelines). • Involve concerned subregional and regional surveillance offices in disputed cross-notified.	• Reported AFP cases from another country assigned EPID number within 48 hours • Electronic copy of case investigation form shared

6. Resource and support requirements

The newly established cross-border coordination mechanisms should work with countries to conduct an objective assessment of their needs and requirements for cross-border activities. They should leverage existing resources from the government, GPEI and broader partners including NGOs working on polio-related activities such as the CORE Group, IOM, and UNCHR to support these activities.

Timely communication of these needs to the WHO Regional Office for Africa is essential. To ensure effective campaign implementation, countries should receive resources and funding for operational costs and campaigns at least four weeks before the campaign start date.

6.1 Joint risk assessments

To support the prioritization of activities, WHO Regional Office for Africa conducts regular risk assessments. These assessments evaluate current epidemiology, population immunity, and the historical risks of different epidemiological zones, including for West and Central Africa, thereby providing a predictive model of risk for these subregions. These models will be shared regularly with countries to help countries determine risk profiles, including for border areas, enabling the prioritization of areas and activities for cross-border efforts.

6.2 Vaccine supply

Currently, nOPV2 is the only vaccine used in the Region for variant type 2 response. It was initially supplied by one global supplier, BioFarma, in Indonesia. In July 2024, WHO added Biological E's nOPV2 to its list of prequalified products, which is expected to enhance supply stability moving forward. Countries should coordinate with their national regulatory authorities to prepare for the introduction of the new supplier.

Countries should objectively assess their vaccine needs to prevent wastage and stockouts. Prioritization of vaccines and response activities will be based on a needs assessment to ensure efficient allocation and effective implementation.

The WHO Regional Office for Africa

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Africa is one of the six regional offices throughout the world, each with its own programme geared to the particular health conditions of the Member States it serves.

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