

# Polio eradication cross-border coordination plan 2024 – 2025:

Lake Chad Basin and  
Sahel countries



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# Executive summary

The continued widespread transmission of the poliovirus across the Lake Chad Basin, the Sahel and broader West Africa presents a significant challenge to meeting global polio eradication deadlines. The seven countries at the core of the Lake Chad basin and the Sahel pose a unique challenge as engines of transmission. These countries have experienced large outbreaks of the variant poliovirus type 2 and have been the source of a considerable amount of transnational spread.

Among these countries, there are two distinct and 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 immunisation coverage and disease surveillance necessitate a strong, coordinated response across the two epidemiological blocks.

The poliovirus outbreak response is unfolding 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 subregion.

This document outlines a plan for the subregion's 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 subregion 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 link countries effectively, and agreement has also been reached on synchronizing immunization responses.

The focus of this plan is to define and operationalize the necessary coordination mechanisms. This includes synchronising and optimising 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

This plan requires high-level political commitment and leadership, similar to what enabled the end of wild poliovirus on the continent, to coordinate and implement multi-country activities. A virtual interministerial meeting with senior government leadership and Global Polio Eradication Initiative (GPEI) partners was held on 16 August 2024. During the meeting, the seven participating countries demonstrated strong support for ten commitments for the interruption of variant poliovirus transmission:

1. Make the interruption of variant poliovirus transmission a top health priority and advocate for sustained whole-of-government political commitment 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 senior government official (National Incident Manager) with direct access to the senior government leadership, including the Minister of Health; and
  - b) An active strategic Interagency Coordination Committee on Immunisation that meets at least every quarter.
2. Support the establishment and active participation in multi-country coordination mechanisms to coordinate cross-border activities and ensure effective collaboration and resource allocation.
  - a) A specific coordination mechanism for the Lake Chad Basin countries is to be established in N'Djamena and a 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 corridors involving at-risk populations;
4. Ensure synchronised polio vaccination campaigns across borders to enable coverage of all at-risk populations living across common borders;
5. Enhance cross-border polio activities for reporting, detection, information-sharing, response coordination, community engagement 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 immunisation, 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.

# Introduction

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

## Need for coordinated action

Based on the current epidemiology and subregional risk assessments, there are areas within the Lake Chad Basin and Sahel subregion that are currently 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 subregion, 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 sub-regions. 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 back 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 a rapid and effective response.

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.

## Existing cross-border coordination guidance

While there is no single strategy for best practices in cross-border coordination for polio, however, relevant guidelines do 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.<sup>1</sup> 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 vaccine-preventable diseases.<sup>2</sup> The framework emphasises the importance of involving multiple stakeholders, conducting joint risk assessments, and utilising 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.<sup>3</sup> 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 Organisation (WHO), addresses key challenges through its handbook.<sup>4</sup> 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.

## 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.

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<sup>1</sup> GPEI. Guidelines for Implementing Polio Surveillance in Hard-to-Reach Areas and Populations. Geneva: World Health Organization; c. 2018. Available at: <https://polioeradication.org/wp-content/uploads/2020/10/Guidelines-polio-surveillance-H2R-areas.pdf>.

<sup>2</sup> World Health Organization, Regional Office for South-East Asia. *Implementation Framework for Cross-Border Collaboration for Priority Vaccine Preventable Diseases Surveillance and Immunization*. New Delhi: WHO Regional Office for South-East Asia; 2023. Available at: <https://apps.who.int/iris/handle/10665/365395>.

<sup>3</sup> Organization for Security and Co-operation in Europe. (2021, June 8). *Self-Assessment Tool for Nations to Increase Preparedness for Cross-Border Implications of Crises*. Organization for Security and Co-operation in Europe. Available at: <https://www.osce.org/secretariat/104490>

<sup>4</sup> World Health Organization. (2024). National outbreak response handbook by the Global Outbreak Alert and Response Network. World Health Organization. <https://iris.who.int/handle/10665/377617>.

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.

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

The use of messaging applications, such as WhatsApp, has aided real-time information sharing across borders. Deep collaboration between surveillance teams and joint investigation are critical to enhancing 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 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 sustainable 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 occurred 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 highlighted the importance of a formally established and empowered coordination task force that tackles cross-cutting issues facing countries, provides innovative strategies, secures additional resources, implements organizational directives, and enables country ownership in coordinating cross-border activities for polio eradication.

# Goal and objectives

The goal of this plan is to:

- Achieve the interruption of poliovirus transmission across the Lake Chad Basin and the Sahel by the end of 2025 and the certification of elimination by the end of 2028 through enhanced and coordinated immunisation strategies, ensuring robust surveillance systems 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. Optimise cross-border immunisation strategies and synchronise implementation;
5. Jointly address community engagement and advocacy challenges facing populations living along common borders and high-risk mobile populations.



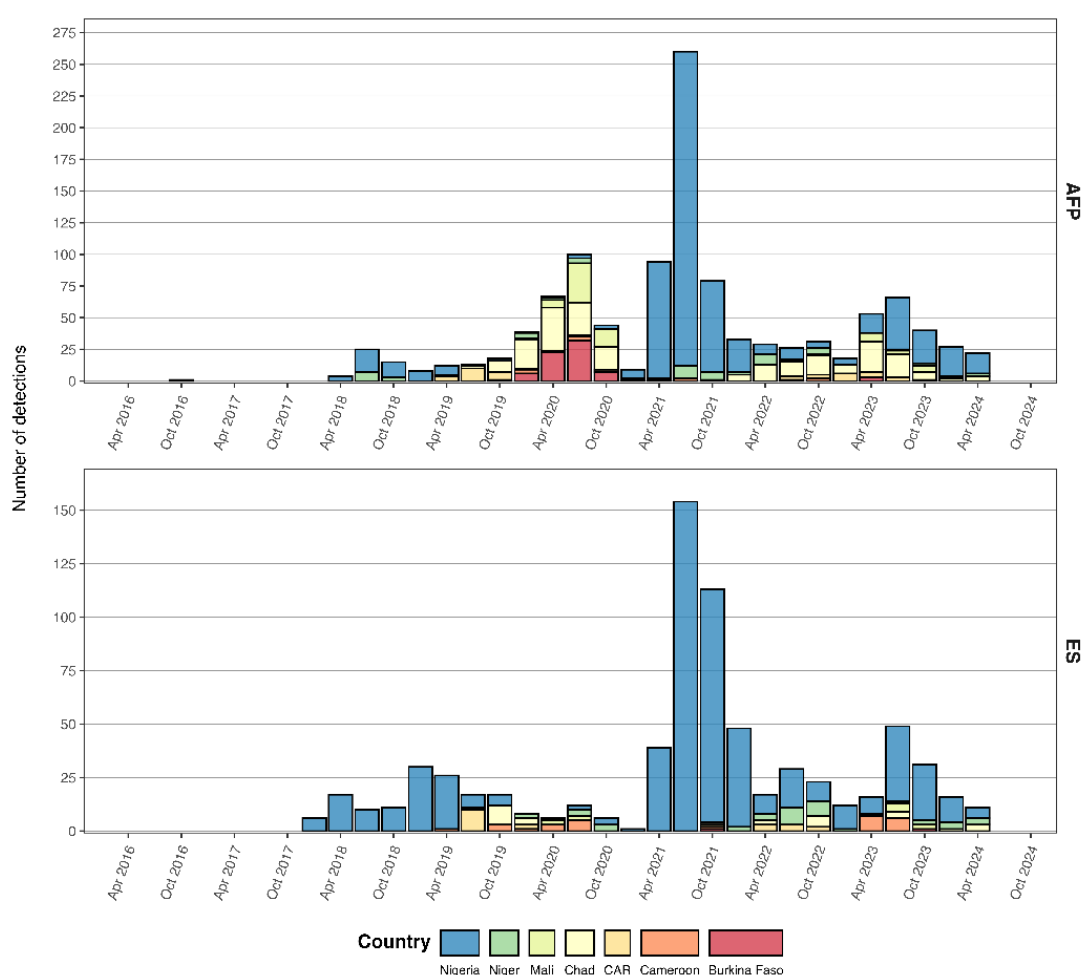
# Cross-border context

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

## Epidemiological overview

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

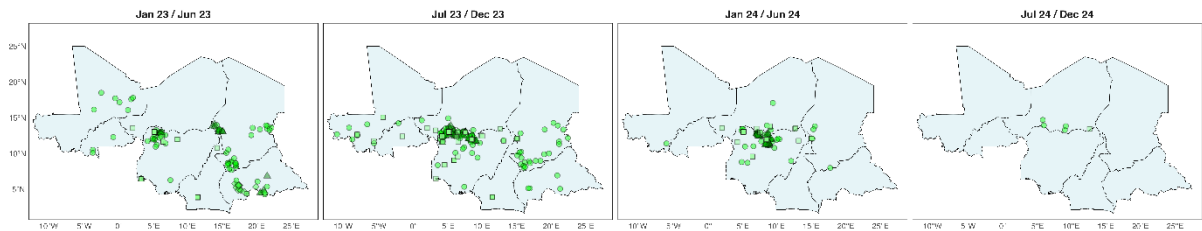
**Fig. 1. Epidemic curves of variant poliovirus type 2 cases and environmental surveillance detections in the seven Lake Chad Basin and Sahel countries, 2016 – 2024**



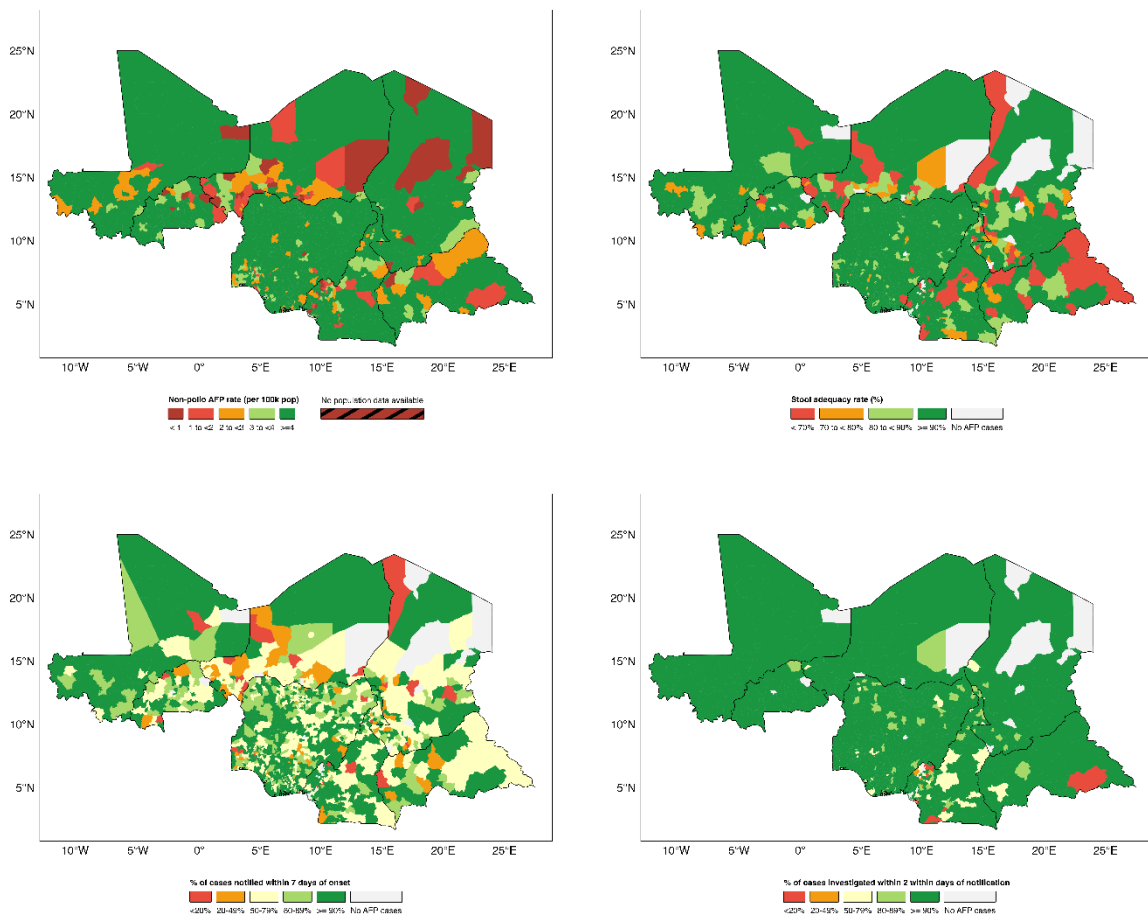
Since January 2016, 1,154 cases and 873 environmental surveillance isolates were reported from the seven countries. The spread of the type 2 variant peaked in 2021 with 443 cases and 350 isolates reported in that year alone with Nigeria accounting for 420 (94.8%) cases and 345 (98.5%) of the environmental surveillance detections (Fig. 1 and Fig. 2).

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

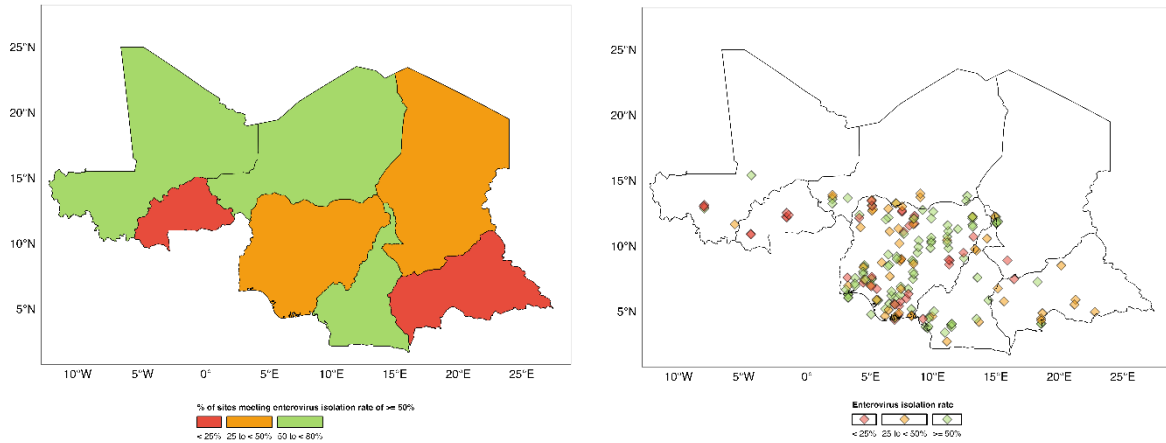
**Fig. 2. Map of poliovirus detections in the Lake Chad Basin and Sahel subregion, 2022-2024**



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



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



Since 2021, transmission has declined, however, circulation was not successfully interrupted especially in the core reservoirs of transmission. Recurrent spill over from these core reservoirs have led to frequent resurgence. 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 of the last five years.

## Outbreak response

Between July 2023 and June 2024, the seven countries have each implemented between two to four national or subnational rounds; Chad implemented two rounds. Nigeria implemented four rounds. The remaining countries each implemented three rounds. Almost 96 million children were vaccinated at least one time during this period and at least 295 million nOPV2 doses were administered (data as of 5 August 2024). These large-scale immunisation activities resulted in enhanced population immunity across the subregion. However, despite the success in ensuring 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.

## 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 been 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.

## Special populations

Reaching and vaccinating special populations across Burkina Faso, Cameroon, Central African Republic, Chad, Mali, Niger, and Nigeria are significant challenges. 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 mobile and community-based approaches, cross-border coordination, and a commitment to reaching remote and underserved groups. Their circumstances require tailored vaccination strategies.

Forcibly displaced populations, estimated to be between 8 to 9 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 improving coverage.

An estimated 7 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.

# 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 Ministers of Health and Heads of State and Government, is essential for success.

## 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.

## Local mechanisms

### 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:

1. Serve as the main contact for cross-border communication, ensuring timely data sharing on polio cases and immunization coverage;
2. Monitor and report polio trends, contribute to joint risk assessments and ensure quality data collection aligned with regional standards;
3. Support synchronized immunisation campaigns, implement special interventions at border crossings, and target mobile and high-risk border populations;
4. Engage local leaders, influencers, and community members to promote vaccination and ensure consistent communication strategies;
5. Organize training focused on cross-border coordination, such as protocols for cross-border data sharing, surveillance methods, and synchronised immunisation efforts, ensuring that health workers are prepared for cross-border challenges;
6. Participate in risk assessments, help update microplans based on population movements, and adapt plans to emerging needs;
7. Conduct synchronised planning at the lowest level between the local technical teams, partners, and local administration or information sharing, where joint planning is not feasible;
8. Strengthen information sharing monthly at the local level, using an agreed monitoring template, through phone, email, and regular meetings;
9. Strengthen the documentation and implementations of action points from coordination meetings;
10. Participate in joint training sessions between local focal points at regular intervals for coordination of disease surveillance, reporting, and vaccination campaign implementation between countries;
11. Document activities and share weekly, biweekly, or monthly reports, depending on outbreak intensity.

## Key players and stakeholders

Identifying local stakeholders and actors can enhance support for cross-border coordination. Many of these agencies and organisations have specialised 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 organisations (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 analyses; 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 analyses different groups and actors in conflict-affected settings.

The International Organisation 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 AFP. 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 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.

# Cross-border activities

## 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
<b>Mapping and tracking special population movements and locations</b>	<ul style="list-style-type: none"> <li>• Mapping official and non-official border crossings.</li> <li>• Mapping seasonal and irregular movement patterns and estimating population flow averages.</li> <li>• Profiling villages/settlements, special populations, security, points of interest and access on both sides of the border.</li> <li>• Mapping areas more easily accessible from neighbouring districts or countries.</li> <li>• Identifying organizations at border entry and exit points (immigration, port health services, police, humanitarian NGOs).</li> <li>• Use historical data, local knowledge and predictive modelling to anticipate future movements.</li> </ul>	<ul style="list-style-type: none"> <li>• Maps for movement patterns, border crossings and local actors/resources produced.</li> <li>• Mechanism for special population tracking data-sharing established between countries.</li> <li>• Network of informants formed for high-risk groups.</li> </ul>

	<ul style="list-style-type: none"> <li>• Identify and map key congregation points, such as water points and livestock markets, for mobile and hard-to-reach populations.</li> <li>• Collaborate with teams already engaged in mapping special populations, such as those working in animal and livestock health.</li> <li>• Collect data during vaccination campaigns to refine population maps and plans.</li> <li>• Employ satellite imagery and GIS technology to create detailed maps. Utilise drones for aerial surveys in remote and inaccessible areas to gather images and data.</li> <li>• In hard-to-reach or insecure border areas, collect and analyse healthcare seeking behaviour data of the local populations to help map healthcare providers (formal and informal) and facilities, key community actors, NGOs, humanitarian agencies, and the Medical Corp of the military if required in special situations.</li> <li>• Establish a network of informants at the community level to gather valuable local knowledge and real-time updates on population movements.</li> <li>• Establish a data-sharing mechanism with neighbouring focal points for cross-border population tracking.</li> <li>• Coordinate with relevant organisations to register, track and perform other surveillance or immunisation activities for incoming travellers, as well as for inclusion in future vaccination campaigns.</li> </ul>	<ul style="list-style-type: none"> <li>• Incoming traveller register developed.</li> </ul>
<b>Risk assessments</b>	<ul style="list-style-type: none"> <li>• Develop and apply indicators to assess risks, identify gaps, and rank priority groups or locations to detect and respond to poliovirus transmission among special populations.</li> </ul>	<ul style="list-style-type: none"> <li>• Risk assessment indicator framework developed.</li> <li>• Risk assessments conducted.</li> </ul>
<b>Microplans</b>	<ul style="list-style-type: none"> <li>• Conduct microplan validation exercises to include special population settlements in vaccination campaign planning.</li> </ul>	<ul style="list-style-type: none"> <li>• Special population microplans validated and available at the district level.</li> </ul>
<b>In-between round activities</b>	<ul style="list-style-type: none"> <li>• Count and vaccinate missed children in border areas and among special populations.</li> <li>• Engage and mobilise special populations.</li> <li>• Train health workers and volunteers in border areas.</li> <li>• Collect and analyse data to refine strategies.</li> <li>• Update maps, risk assessments and plans.</li> <li>• Initiate, intensify and strengthen integration with other mass immunisation programmes such as the Periodic Intensification of Routine Immunisation, the Big Catch-Up, GAVI's Zero-Dose Immunisation Programme and integration with other antigens.</li> </ul>	<ul style="list-style-type: none"> <li>• Targeted immunisation for missed children conducted.</li> <li>• Microplans and risk mapping updated.</li> <li>• Community engagement and mobilization.</li> <li>• Training and capacity building for health workers enhanced.</li> <li>• Data collected and analysis of coverage conducted.</li> </ul>

## Synchronise response

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

**Table 2. Synchronised activities for polio eradication**

Activity	Details
<b>Decentralised microplanning</b>	<ul style="list-style-type: none"> <li>Identify all targeted children in border settlements and plan resources accordingly, involving local leaders, security officials, and NGOs.</li> <li>Communicate the importance of immunisation to protect children within settlements as well as those crossing borders.</li> <li>Complete this planning one month in advance of campaigns to ensure resource mobilization.</li> </ul>
<b>Joint supervision</b>	<ul style="list-style-type: none"> <li>Conduct joint supervision of campaigns, beginning with collaborative meetings of health area heads and technical teams from bordering districts.</li> </ul>
<b>Standardised tools</b>	<ul style="list-style-type: none"> <li>Use similar tools at borders to streamline record-keeping, data exchange, and analysis.</li> </ul>
<b>Joint evaluation</b>	<ul style="list-style-type: none"> <li>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. Organise mop-up to reach unvaccinated children.</li> </ul>

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

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

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

## Optimise cross-border immunisation and response

To implement cross-border polio immunisation activities, several dimensions should be considered. These dimensions include the collaboration by government services responsible for territorial administration, promoting transparency and fostering government ownership and leadership. Coordination between the technical services of the ministry of health 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 need for collaboration, the central services of the Ministry of Health, using platforms like One Health, can connect all key players, most of whom operate at the district and health area levels. The following table outlines specific actions and strategies for optimising polio vaccination and response among special populations:

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

Activities	Details	Output
<b>Special vaccination teams</b>	<ul style="list-style-type: none"> <li>Track nomadic pastoralists and seasonal migrants and deploy special vaccination teams that can reach and vaccinate them; adjust plans based on real-time information from community informants and other sources.</li> </ul>	<ul style="list-style-type: none"> <li>Special vaccination teams established and deployed.</li> </ul>
<b>Transit vaccination points</b>	<ul style="list-style-type: none"> <li>Establish transit vaccination points at key transit locations such as border crossings, markets, and major travel routes to vaccinate children on the move.</li> <li>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 deportations or displacement due to natural disasters or insecurity.</li> <li>Consider expanded age-group vaccination that includes children over the age of five, based on data, especially in high-risk areas and among populations with low routine immunisation coverage.</li> <li>Implement a 'handshake' policy where the two sides of the border agree on area coverage responsibilities, recognizing that border populations may live and have social connections on both sides.</li> <li>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.</li> <li>Preposition vaccines and other supplies at borders and allow for cross-border collaboration.</li> </ul>	<ul style="list-style-type: none"> <li>Transit vaccination points established.</li> <li>Border coordination policy agreed.</li> </ul>
<b>Campaign quality and synchronisation</b>	<ul style="list-style-type: none"> <li>Focus on improving the quality of SIAs in regions with high population movement or hard-to-reach border areas, by optimising team selection, supervision and reaching persistently missed populations.</li> <li>Strengthen data collection and monitoring systems to track vaccination coverage, identify gaps, and adjust strategies in real-time to ensure all populations are reached.</li> <li>Ensure synchronisation of campaigns across borders to minimise missed populations.</li> </ul>	<ul style="list-style-type: none"> <li>Quality improvement plans targeting border and mobile populations developed.</li> <li>Data collection and monitoring systems strengthened.</li> <li>Mass campaigns synchronised.</li> </ul>

<b>High-level advocacy</b>	<ul style="list-style-type: none"> <li>• Develop a joint communication plan. Emphasise the need for Ministers of Health of neighbouring countries to coordinate communication activities (including, if possible, joint press releases, launch of joint campaigns in multiple countries at the same time, etc.)</li> <li>• Mobilise heads of government engagement to support cross-border activities and request the collaboration of all relevant ministries.</li> <li>• Obtain the relevant ministers' support to allow health workers to work together at the local level to ensure that no child is missed.</li> <li>• Incentivise the launch of synchronised campaigns by the authorities of the border states, regions, provinces, where feasible.</li> <li>• Call on the ministries responsible for the implementation of the One Health approach to strengthen their support for the cross-border activities.</li> <li>• Urge NGOs operating in public health emergencies to integrate relevant messages and routine immunisation interventions in their action.</li> <li>• Develop joint cross-border community engagement activities/messages involving traditional influencers, religious, nomadic and clan/tribe leaders to gain community trust and support for surveillance and vaccination, before, during, after and outside of polio campaigns and other routine immunisation activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Joint communication plan developed.</li> <li>• Heads of government engagement on polio and immunisation completed.</li> <li>• Health workers of neighbouring countries are allowed to work together and operate in each other's territories.</li> <li>• Launch of synchronised campaigns from border territories organized.</li> <li>• All relevant activities by NGOs integrated and NGOs provided significant support fully included in planning process.</li> <li>• Joint mapping of cross-border religious and community leaders conducted.</li> <li>• Joint information, educational, and communication products (letters, audio, and video...) that engage religious and community leaders are produced and disseminated.</li> </ul>
<b>Capacity building</b>	<ul style="list-style-type: none"> <li>• Provide specialised 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.</li> <li>• Conduct, in the border territories, a series of stakeholder capacity-building trainings on interpersonal communication and social mobilisation activities</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity-building trainings are provided.</li> <li>• Stakeholders in border areas are trained on interpersonal communication and social mobilisation activities.</li> </ul>
<b>Local risk assessments</b>	<ul style="list-style-type: none"> <li>• Perform local risk assessments to identify high-risk areas and populations, using community informants and local data to tailor immunisation strategies and prioritise interventions in mobile and hard-to-reach border groups.</li> </ul>	<ul style="list-style-type: none"> <li>• Regularly reviewed priority list of interventions, populations and locations.</li> </ul>
<b>Community engagement and social</b>	<ul style="list-style-type: none"> <li>• Develop social mapping of border districts (such as languages, leaders, NGOs, associations, communities, and communication channels, etc.).</li> </ul>	<ul style="list-style-type: none"> <li>• Social mapping of cross-border districts.</li> </ul>

<b>mobilisation activities</b>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Develop a joint, cross-border communication plan, integrating perception, social and behavioural surveys, lessons learnt, etc.</li> <li>• Identify women champions and influencers in border areas for social mobilisation and immunisation activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Terms of reference for community animation units.</li> <li>• Joint cross-border communication plan.</li> <li>• Mapping of women champions and influencers.</li> </ul>
<b>Consistent and unified messaging</b>	<ul style="list-style-type: none"> <li>• Develop joint and harmonised message packages for routine immunisation and polio cross-border response.</li> <li>• Co-creation of communication tools and materials adapted to the local context of border communities.</li> </ul>	<ul style="list-style-type: none"> <li>• Harmonized message banks, communication and advocacy materials for polio and routine immunisation for cross-border activities.</li> </ul>
<b>Integrated vaccination campaigns</b>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated campaigns.</li> </ul>
<b>Supporting routine immunisation planning and assessments</b>	<ul style="list-style-type: none"> <li>• Support vaccine-preventable disease departments in the development of a focused routine immunisation strengthening plan for border areas and mobile populations.</li> <li>• Contribute to the scale-up facility-based and outreach micro plans at border areas and special groups to strengthen routine immunisation by defining movement patterns of the mobile populations.</li> <li>• 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 immunisation service delivery.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine immunisation strengthening plan supported.</li> </ul>
<b>Security support</b>	<ul style="list-style-type: none"> <li>• Where feasible, identify local security officers who know the local context and security forces.</li> <li>• Create a security plan to support cross-border activities.</li> </ul>	<ul style="list-style-type: none"> <li>• Security plan developed.</li> <li>• Support from local security experts obtained.</li> </ul>

## 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 analyses 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**

Activities	Details	Output or indicator
<b>Context mapping and profiling</b>	<ul style="list-style-type: none"> <li>• Identify, map, and profile high-risk, hard-to-reach border areas and special populations.</li> <li>• Map all official and unofficial entry points and the services operating at them.</li> <li>• Identify point of interest around the cross-border areas that bring the community together.</li> <li>• Assess access to health services and surveillance network capacity for these groups.</li> <li>• Map healthcare providers and facilities.</li> <li>• Collect healthcare seeking behaviour data.</li> <li>• Develop and regularly update specialised surveillance plans and strategies.</li> <li>• Coordinate mapping activities with ministries of health and wider partners.</li> <li>• Record acute flaccid paralysis cases from special populations.</li> <li>• Conduct specialised training and capacity building for border surveillance officers to collect and analyse data to update plans.</li> </ul>	<ul style="list-style-type: none"> <li>• Documented mapping and profiling.</li> <li>• List of surveillance officers trained.</li> <li>• Updated surveillance plans.</li> <li>• New variable added to data collection tools to record acute flaccid paralysis cases from border areas and among special populations.</li> </ul>
<b>Adjust surveillance network (active and passive surveillance)</b>	<ul style="list-style-type: none"> <li>• Adapt the surveillance network based on healthcare seeking behaviour, demographics, and access. Factor in significant population changes and address disruptions due to population movements.</li> <li>• Conduct sensitization of surveillance actors – clinicians, surveillance focal persons, community informants.</li> </ul>	<ul style="list-style-type: none"> <li>• Biannual update of the surveillance network adapting to population changes or other disruptions with documented evidence of changes from the previous one and reasons.</li> </ul>
<b>Ad hoc active search for acute flaccid paralysis cases</b>	<ul style="list-style-type: none"> <li>• 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).</li> <li>• Adjust the surveillance network, sensitise the health care providers, assess impact and implement improvements as needed.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of unreported acute flaccid paralysis cases detected (by facilities and communities), investigated and taken on the line list or the excluded line list</li> <li>• Document network adjustments and/or sensitization done</li> <li>• Impact assessment of surveillance adjustments e.g using non-polio AFP rate.</li> </ul>
<b>Community-based surveillance</b>	<ul style="list-style-type: none"> <li>• Initiate or strengthen community-based surveillance in border areas focusing on security-compromised regions and high-risk populations.</li> </ul>	<ul style="list-style-type: none"> <li>• Number and proportion of acute flaccid paralysis cases reported by community-based surveillance increased.</li> </ul>
<b>Acute flaccid paralysis</b>	<ul style="list-style-type: none"> <li>• Conduct contact sampling for all cases in official entries at border areas, such as health facilities in proximity to these borders,</li> </ul>	<ul style="list-style-type: none"> <li>• Data analysis of contact samples and cost benefit analysis</li> </ul>

<b>contact sampling</b>	especially in regions with poor surveillance or suspected virus transmission.	of the results (after 6 months).
<b>Targeted healthy children stool surveys</b>	<ul style="list-style-type: none"> <li>In close coordination with the lab expected to process the 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.</li> </ul>	<ul style="list-style-type: none"> <li>With support of AFRO, develop a specific protocol for this activity.</li> <li>Identification of newly infected administrative regions.</li> </ul>
<b>Environmental surveillance in access-compromised areas</b>	<ul style="list-style-type: none"> <li>Enhance environmental surveillance in areas with large cross border populations</li> <li>Set up ad hoc environmental sites in hard-to-reach, security-compromised, or newly accessible areas, and IDP camps for a limited time.</li> </ul>	<ul style="list-style-type: none"> <li>Performance of ad hoc environmental surveillance sites.</li> <li>Number of outbreaks detected via ad hoc environmental surveillance.</li> </ul>
<b>Innovation</b>	<ul style="list-style-type: none"> <li>Collect geolocation data for acute flaccid paralysis cases, active surveillance and supervisory visits.</li> <li>Mapping of catchment areas of environmental surveillance sites using GIS.</li> <li>Facilitate case reporting and coordination via text messaging or with internet-based messaging applications, such as WhatsApp</li> <li>Assess journey of stool specimens from collection to laboratory.</li> </ul>	<ul style="list-style-type: none"> <li>Track and document the number of new ideas implemented, discontinued projects, implementation speed, impact and lessons learnt.</li> </ul>
<b>Stool sample collection and transport</b>	<ul style="list-style-type: none"> <li>Ensure early communication between sender, logistician, and laboratory workers in access-compromised and hard-to-reach areas.</li> <li>Communicate feedback on the quality of stool specimens and results to the original informer to maintain the integrity and reliability of the surveillance system.</li> </ul>	<ul style="list-style-type: none"> <li>Disaggregated analysis of the timeliness of detection in border areas.</li> <li>Number of stool sample results available at the lowest administrative level.</li> </ul>
<b>Special monitoring and evaluation activities</b>	<ul style="list-style-type: none"> <li>Conduct monitoring and evaluation in border areas with access challenges and high-risk populations.</li> <li>Identify hidden surveillance gaps, validate reported cases, and perform data quality checks.</li> <li>Assess silent areas, group specific data analysis (by area and population group) and conduct targeted surveillance reviews.</li> </ul>	<ul style="list-style-type: none"> <li>Number of cases validated by secondary/tertiary supervisors.</li> <li>Proportion of cases with updated critical data after validation.</li> <li>Number of targeted surveillance reviews and silent areas assessed.</li> </ul>
<b>Cross notification of AFP cases between countries</b>	<ul style="list-style-type: none"> <li>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).</li> <li>Involve concerned subregional and regional surveillance offices in disputed cross-notified cases.</li> </ul>	<ul style="list-style-type: none"> <li>Reported AFP cases from another country assigned EPID number within 48 hours.</li> <li>Electronic copy of case investigation form shared.</li> </ul>

# Resource and support requirements

The newly established cross-border coordination 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 CoreGroup, IOM, and UNCHR to support these activities.

Timely communication of these needs to the WHO Regional Office for Africa (AFRO) 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.

## Joint risk assessments

To support the prioritization of activities, AFRO 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 this subregion. 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.

## Vaccine supply

The novel oral polio vaccine (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. Prioritisation of vaccines and response activities will be based on a needs assessment to ensure efficient allocation and effective implementation.