Social and Behavior Change (SBC) Action Guide to Support Co-Administration of nOPV2 and bOPV in Response to cVDPV1, cVDPV2, and cVDPV3 Outbreaks

1. Background

Poliovirus continues to pose a serious threat to global health, particularly in regions with low immunization coverage and high population mobility. While circulating Vaccine-Derived Poliovirus type 2 (cVDPV2) has remained a persistent challenge, and cVDPV3 has re-emerged in multiple countries, cVDPV1 has also been detected in several high-risk geographies. In alignment with the latest recommendations from the Strategic Advisory Group of Experts (SAGE) and updated operational guidelines, the co-administration of novel oral polio vaccine type 2 (nOPV2) and bivalent oral polio vaccine (bOPV) is now advised for outbreak response to all three circulating strains—cVDPV1, cVDPV2, and cVDPV3. This strategy offers comprehensive protection in a single visit, maximizing coverage and minimizing operational complexity. Its success depends on strong public trust, clear communication, and active community participation.

2. Current Epidemiological Situation

Several countries in the African Region have reported new detections of cVDPV3, indicating sustained or expanding transmission. In Guinea, the virus was first detected in 2024, with four confirmed acute flaccid paralysis (AFP) cases and one environmental sample from the Kankan region. In early 2025, two additional cases emerged in Kouroussa and Kissidougou, extending the outbreak to the Faranah region. Chad has identified a new cVDPV3 isolate, genetically linked to a previously reported strain in Cameroon, suggesting a new emergence. Nigeria, already burdened with cVDPV2, has reported four cVDPV3 detections linked to a single index case. Cameroon confirmed an AFP case in June 2025, while Algeria detected a cVDPV3 isolate from an environmental sample in July 2024. These developments underscore the need for a regionally coordinated response and heightened vigilance.

3. Rationale for Co-Administration

The simultaneous use of nOPV2 and bOPV during immunization campaigns is a strategic response to the growing threat posed by multiple circulating vaccine-derived poliovirus strains namely cVDPV1, cVDPV2, and cVDPV3. Both vaccines are administered as oral drops, familiar to caregivers from routine immunization and previous polio campaigns, and do not involve injections. Co-administration ensures that children receive comprehensive protection against all currently circulating poliovirus types in a single visit, thereby maximizing coverage, reducing missed opportunities, and minimizing logistical challenges. This approach is endorsed by national and global health authorities, including the Strategic Advisory Group of Experts (SAGE), and has

been successfully implemented in various settings. However, given its novelty, clear and culturally sensitive communication is essential to help stakeholders and communities understand the rationale and safety of receiving two oral vaccines at once, and to prevent confusion, hesitancy, or resistance.

4. Importance of SBC (Advocacy, Communication, and Social Mobilization)

- Effective advocacy, communication, community engagement, and social mobilization are critical to the success of the co-administration strategy, especially now that it addresses outbreaks of cVDPV1, cVDPV2, and cVDPV3. Advocacy efforts must begin with engaging key influencers, i.e. medical professionals, traditional leaders, religious leaders, and community figures who can champion the campaign and reinforce public confidence. These stakeholders should be briefed on the current epidemiological situation, the rationale for co-administration, and the endorsement by global health authorities such as SAGE. Their role is essential in dispelling rumors, clarifying misconceptions, and addressing caregiver concerns.
- Community engagement is equally vital. Social mobilizers, influencers, trusted networks, and local media should be activated based on country-specific contexts and needs to raise awareness about the severity of polio, the benefits of co-administration, and the safety of the vaccines. Messaging must be culturally sensitive and tailored to local realities, emphasizing that both vaccines are oral drops one used at health centers and the other during campaigns and that no injections are involved. It should also clearly be clearly communicated that co-administration provides full protection against all currently circulating poliovirus strains.

- To support these efforts, vaccination teams and social mobilizers will receive training in Interpersonal Communication (IPC). This training will equip them to clearly explain the need for two vaccines and two finger marks, confidently address caregiver questions, and gather community feedback to improve campaign effectiveness. Building trust between vaccination teams and caregivers is essential to ensure high coverage, acceptance, and timely reporting of any concerns or misinformation.

5. Capacity Building for Frontline Workers

- To ensure effective delivery of the co-administration strategy targeting cVDPV1, cVDPV2, and cVDPV3, frontline workers including vaccinators, social mobilizers, and supervisors will undergo targeted training focused on clear communication, community engagement, and trust-building. This training will emphasize the rationale for administering two oral polio vaccines in a single visit and the importance of community reassurance.
- Orientation sessions for influencers and community leaders, including refusal resolution teams are essential, as many of them actively support social mobilization and serve as trusted sources of information within their communities. These sessions should equip

them with accurate, timely, and context-specific information to confidently respond to caregiver concerns, dispel rumors, and reinforce campaign messages.

- All trainees will be prepared to explain the rationale for administering two oral vaccines, address caregiver questions with empathy and clarity, and reinforce key messages around safety, urgency, and the endorsement of co-administration by global health authorities such as SAGE.
- Training will also include modules on Interpersonal Communication (IPC), emphasizing respectful dialogue, active listening, and culturally sensitive engagement. The importance of using two finger marks for verification, gathering community feedback, and maintaining professionalism throughout the campaign will be reinforced to ensure consistency and accountability in field operations.

6. Perception and Acceptance Assessments

Perception and acceptance assessments will be conducted among communities, caregivers, and frontline workers through focus group discussions (FGDs) and other participatory methods. Insights gathered from these engagements will inform the development of communication strategies, public messaging, and FAQs to ensure they are relevant, responsive, and grounded in community realities.

This assessment will:

- Generate evidence on knowledge gaps, concerns, and motivators related to the co-administration of nOPV2 and bOPV in response to cVDPV1, cVDPV2, and cVDPV3 outbreaks
- Enable audience segmentation to tailor messaging for specific groups (e.g., hesitant caregivers, skeptical community leaders, or under-informed health workers)
- Support the creation of culturally sensitive and context-specific communication materials
- Equip frontline workers with practical insights to strengthen their interpersonal communication and community engagement efforts

By anchoring SBC design in real-world perceptions, this intervention ensures that messaging is not only informative but also trusted and actionable.

7. Continued follow-up on field experiences and community Feedback

As part of the community feedback mechanism, rumor and misinformation tracking should be initiated from the outset of co-administration communications. Early detection of emerging concerns will enable timely adjustments to messaging, strategy, and field operations, ensuring that community trust is maintained throughout the campaign.

SBC strategies must remain dynamic and responsive to field realities. Establishing robust systems for ongoing documentation and analysis of field experiences and community feedback will:

- Facilitate real-time learning from community interactions, campaign implementation, and frontline worker experiences

- Enable adaptive messaging that responds to evolving concerns, rumors, and misinformation

- Provide a continuous feedback loop for monitoring and evaluation, helping measure the effectiveness of SBC interventions and refine them accordingly

This iterative learning approach ensures that SBC remains relevant, evidence-informed, and aligned with the evolving landscape of vaccine delivery—ultimately strengthening community engagement and campaign outcomes.

8. **Messaging Strategy**:

Key messages will be developed in consultation with government stakeholders, GPEI and implementing partners. These messages will highlight the following areas:

- **Purpose:** Clearly explain the rationale and public health importance of co-administering two oral polio vaccines nOPV2 and bOPV in response to outbreaks of cVDPV1, cVDPV2, and cVDPV3.

- **Safety:** Reassure caregivers and communities that co-administration is safe, endorsed by national and global health authorities (including SAGE), and has been successfully implemented in multiple settings.

- **Familiarity:** Emphasize that both vaccines are oral drops, consistent with what caregivers have seen in previous campaigns. These vaccines are not new—one is used at health centers and the other during polio campaigns. No injections are involved

- **Effectiveness / Benefit:** Highlight the added value of co-administration. Together, the two vaccines provide complete protection against all circulating poliovirus strains and offer double protection to children

- **Urgency and Risk:** Emphasize that poliovirus continues to circulate. This campaign provides a timely and critical opportunity to interrupt transmission

- **Clarity of Action:** Clearly communicate what caregivers are expected to do—allow their child to receive both oral vaccines, administered safely and simultaneously during the campaign visit, and ensure routine immunization is completed

9. Conclusion

The co-administration of nOPV2 and bOPV is a scientifically sound and urgently needed strategy to combat the growing threat of cVDPV1, cVDPV2, and cVDPV3. Its success depends on community trust, informed consent, and active participation. Through well-planned and effectively

executed SBC activities—supported by strong capacity building for frontline workers—we can ensure that every child in affected areas receives comprehensive protection against poliovirus. This campaign represents a critical opportunity to interrupt transmission and move closer to a polio-free future.

A Q&A annexure has been included to support field-level implementation. Like the main guide, it will be updated regularly based on country-level experiences, community feedback, and emerging operational needs.

Note on Document Adaptability: *This guide is intended as a living document. It will be periodically updated to reflect evolving country contexts, field-level experiences, and emerging programmatic priorities. Implementing teams are encouraged to share feedback, lessons learned, and contextual adaptations to strengthen its relevance and effectiveness across settings.*

Annexure: Frequently Asked Questions (FAQs)

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