**Guidance Note: How to handle and dispose of tOPV found after 1 May 2016**

After the completion of the globally coordinated switch from trivalent OPV (tOPV) to bivalent OPV (bOPV) on 1 May 2016, countries are expected to continue on-site checks for tOPV in or outside of the vaccine cold chain during regular supervisory visits. The discovery of tOPV in the cold chain after the country has validated the tOPV-bOPV switch poses a transmission risk for polio virus type 2 and it should be thoroughly investigated.

All parties conducting field visits should also take the opportunity to check for the presence of tOPV vials in or outside of the cold chain and take corrective action as described below.

If tOPV is found, the following steps should be taken:

1. **Immediately remove the tOPV vials from the cold chain (open or closed), if applicable**
   a. Confirm with the person in charge or the health worker responsible if any tOPV has been used since the switch date, and explore why the tOPV had not been removed

2. **Place all tOPV vials in a clearly marked container or bag so it can be moved to destruction. Clearly write on and/or label the bag: ‘DO NOT USE. tOPV for destruction’. Record the number of vials and doses in the bag**

3. **Immediately inform appropriate authorities**
   a. The National Immunization Program
   b. The National Switch Validation Committee, if still active, or the Polio National Certification Committee

4. **Inactivate and destroy tOPV residual stocks** *
   a. **Inactivation by:** autoclaving, boiling, chemical inactivation (bleach), encapsulation or incineration
   b. **Disposal by:** transporting to waste facility or burying

5. **Depending on the number of vials, the following processes are recommended**
   a. If the tOPV is found at a health centre and the amount is:
      i. **Less than 20 vials:** inactivation and disposal can take place at the site using one of the recommended methods for disposal
      ii. **More than 20 vials:** properly labelled tOPV should be sent to higher level for proper inactivation and disposal
   b. If the tOPV is found at a district or higher level, it is recommended that the tOPV should be disposed of following the same process as during the 2016 national switch or by another method listed above that is currently available at that level.

Additional supervisory or monitoring visits to check for tOPV should be conducted in the district or in the area where the site is located to ensure that no other sites have tOPV in the cold chain.

If possible, investigate whether this health centre had been included in the original monitoring exercise and, if so, further investigation within the same zone of responsibility of those monitors should be conducted.

If tOPV is found at additional sites, more extensive checks may be needed. Additional efforts to properly inform health workers on the importance of no longer using tOPV should be also conducted.

*http://www.who.int/immunization/diseases/poliomyelitis/endeaftive2/oral_polio_vaccine/monitoring/en/*