Regional review on preparedness for switch from trivalent Oral Polio Vaccine (tOPV) to bivalent Oral Polio Vaccine (bOPV) in South East Asia Region (SEAR) countries was attended by the EPI programme managers of ten out of eleven member states of WHO’s SEAR. There was an active participation of experts from headquarters, US CDC, regional and country offices of WHO & UNICEF. Global and regional updates were provided on the polio eradication and endgame strategic plan implementation and this was followed by presentations on the current status of switch preparedness by each country. The detailed micro-plans with timelines and responsibilities for conducting the switch in the country were collectively reviewed. The technical experts offered potential solutions to overcome the challenges identified by the country teams.

This publication provides an overview of preparedness in each SEAR country to implement the switch in April 2016 with plans to overcome the potential challenges.

Regional Review on Preparedness for the Switch from tOPV to bOPV in the South-East Asia Region

24–25 February 2016
New Delhi, India
Regional Review on Preparedness for the Switch from tOPV to bOPV in the South-East Asia Region

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Acronyms

ANMs auxiliary nurse midwives
bOPV bivalent oral polio vaccine
CDC United States Centers for Disease Control and Prevention
cVDPV circulating vaccine-derived poliovirus
EPI expanded programme on immunization
GPEI Global Polio Eradication Initiative
IPV inactivated poliovirus vaccine
mOPV monovalent oral polio vaccine
SAGE Strategic Advisory Group of Experts on Immunization
SEAR South-East Asia Region
SIA supplementary immunization activity
tOPV trivalent oral polio vaccine
UNICEF United Nations Children’s Fund
VAPP vaccine-associated paralytic poliomyelitis
VDPV vaccine-derived poliovirus
WHO World Health Organization
WPV wild poliovirus
1. **Background**

Polio eradication is truly a monumental achievement of the World Health Organization (WHO) South-East Asia (SEA) Region. The journey towards polio eradication in the WHO SEA Region has been challenging. An estimated 250,000 polio cases were occurring annually in the Region prior to 1988, when the Forty-first World Health Assembly adopted a resolution to eradicate polio from the world. The eleven Member States of the Region (Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste) committed to achieving polio eradication. The Region, containing a quarter of the world's population, was certified polio-free on 27 March 2014, following three years of zero wild poliovirus (WPV) case detection in the presence of certification-standard surveillance.

Even as the remaining strains of wild poliovirus are being eradicated from the remaining polio-infected countries, the switch from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) will be a major step to combat circulating vaccine-derived polioviruses (cVDPVs) and vaccine-associated paralytic poliomyelitis (VAPP). Over 90% of cVDPV cases and approximately 30% of VAPP cases are due to the type 2 component of tOPV. Given the risk that the type 2 component of tOPV poses to a world free of WPV type 2, tOPV will be replaced with bOPV in both routine programmes and supplementary immunization activities (SIAs).

The Global Polio Eradication Initiative (GPEI) has initiated the global withdrawal of the type 2 component of OPV (OPV2) on the recommendation of the Strategic Advisory Group of Experts (SAGE) in October 2015. The SAGE defined a two-week window from 17 April to 1 May 2016 during which the switch from trivalent OPV to bivalent OPV (containing type 1 and 3 serotypes only) must happen in all countries/territories that are currently using OPV. This switch was endorsed by the Sixty-eighth World Health Assembly in 2015.
Execution of the switch demands very meticulous tracking and strong oversight during both the preparatory and implementation phases. This workshop was conducted to assess implementation and accomplishment of the planned activities required to meet the switch deadline. The workshop allowed technical experts and managers to identify challenges being faced in each country and to develop solutions to these barriers through a consultative process. The platform also allowed for mutual learning among countries.

2. Objectives

The objectives of the regional review workshop on preparedness for the switch from tOPV to bOPV were as follows:

- assess preparedness of countries for the globally synchronized switch from tOPV to bOPV during 17 April 2016 to 1 May 2016;
- support preparatory planning by reviewing the national switch plans;
- identify the challenges, risks, barriers as well as potential measures to mitigate anticipated challenges for an effective implementation of the switch.

3. Inaugural session

A two-day workshop on the regional review of switch preparedness was organized in New Delhi, India, on 24–25 February 2016. The workshop began with the inaugural address by Dr Arun B. Thapa, Director Programme Management, WHO Regional Office for South-East Asia. He lauded the collective efforts of all the developmental partners in bringing the Region to this unprecedented juncture in polio eradication.

Dr Thapa commended the dedication exhibited in planning and preparing for the switch by all stakeholders and urged them to maintain the momentum to ensure implementation, monitoring and validation of the switch. He reminded participants that there is no room for complacency in these 52 days remaining before the switch and that the pace of activities will increase further leading up to the switch. With the hope that the Region is better positioned to handle the challenging task, he highlighted the need for containment activities post-switch and for review of outbreak response plans.
Dr Douglas James Noble, Regional Health Adviser, United Nations Children’s Fund Regional Office for South Asia (ROSA), Nepal, in his opening remarks, laid emphasis on the fact that the switch from tOPV to bOPV in itself is an activity that has never been undertaken before and requires a number of critical activities that must be completed in advance of the switch. This historical effort constitutes the fastest vaccine introduction globally, as introduction of bOPV as well as inactivated poliovirus vaccine (IPV) is being targeted along with switch plans.


Dr Sunil Bahl, Regional Adviser, Accelerated Disease Control, Immunization and Vaccine Development, WHO South-East Asia Region, presented the current status of polio eradication globally and in the South-East Asia Region.

Strong progress continues to be made towards each of the four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018 (the Endgame Plan). Afghanistan and Pakistan are the only two countries that remain endemic for poliomyelitis. Wild poliovirus transmission is at the lowest levels in history, with the fewest-ever reported cases from the fewest-ever affected countries in 2015.

During 2015, 74 cases of wild poliovirus type 1 (WPV1) were reported worldwide (54 in Pakistan and 20 in Afghanistan). Supplementary immunization activities to enhance coverage in inaccessible areas and meticulous tracking of missed children in Pakistan have resulted in a major decline in case numbers of WPV1 in Pakistan, which have gone down from 306 in 2014 to 54 in 2015. The eradication of polio globally now depends primarily on concentrating efforts in the localized geographical areas in these two countries.

The declaration of international spread of wild poliovirus as a Public Health Emergency of International Concern and the temporary recommendations promulgated under the International Health Regulations (IHR 2005) remain in effect. At its meeting on 10 November 2015, the IHR Emergency Committee recommended extending the temporary
recommendations to countries affected by vaccine-derived poliovirus outbreaks (previously, the recommendation had been limited to countries affected by wild poliovirus).

The Global Commission for Certification of Eradication of Poliomyelitis certified the global eradication of wild poliovirus type 2 (WPV2).

As part of the Polio Eradication and Endgame Strategic Plan (the Polio Endgame) 2013–2018, and as recommended by WHO, all 126 countries at the start of 2013 using only OPV were required to introduce at least one dose of the IPV into routine immunization schedules as part of preparations for the global withdrawal of type 2 containing OPV now confirmed for April 2016. The level of commitment from countries to meet this timeline has been exceptional. Almost all countries using only OPV at the start of 2013 had committed to introduce IPV before the end of 2015. However, the rapid scale-up of IPV production required has encountered multiple challenges, leading to a global shortage. The SAGE at its October 2015 meeting recommended that all countries must implement the globally synchronized switch from trivalent OPV to bivalent OPV in April 2016.

IPV’s primary value is in minimizing the occurrence of paralytic disease from any type 2 VDPV after the OPV switch in April 2016. The short-term risk of a cVDPV type 2 (cVDPV2) outbreak after the switch is higher in countries with low routine immunization coverage or a history of cVDPV2 or wild poliovirus outbreaks, as well as in countries sharing borders with higher risk countries. This risk has been reduced by boosting population immunity through ongoing high-quality tOPV campaigns before the switch to bOPV.

In tier 1 and 2 countries at risk of cVDPV2, should an outbreak of cVDPV2 occur after the switch, having IPV already introduced will enable a more effective and rapid outbreak response. This is due to IPV’s role in priming the immune system for a more rapid and robust response to OPV. IPV will also help to protect against paralytic polio and to boost immunity to polio infection. In the event of a VDPV2 being detected in any country after the switch, a global stockpile of monovalent type 2 OPV (mOPV2) and IPV will be available for outbreak response.
5. Polio endgame strategy and eradication in the South-East Asia Region

The South-East Asia Region has remained free of wild poliovirus for more than five years, with the last case reported on 13 January 2011. However, the risk of importation of wild poliovirus from currently infected countries remains. It is critical that all countries in the Region continue to take appropriate actions to maintain a polio-free status. These include: ensuring high population immunity against polio through routine and/or supplementary immunization activities; maintaining sensitive surveillance for polioviruses; and having updated outbreak response plans to manage any poliovirus detection.

Countries in the Region also remain at a risk of emergence of vaccine-derived polioviruses. In Myanmar, two cases due to a circulating vaccine-derived poliovirus type 2 were detected in 2015. An outbreak response was initiated in Myanmar that included conducting multiple large-scale vaccination campaigns, in addition to efforts to strengthen poliovirus surveillance and improve routine immunization coverage.

6. Regional status of preparedness for switch from tOPV to bOPV

Countries in the SEA Region are well prepared to withdraw the type 2 component of oral polio vaccine by switching from the trivalent OPV to bivalent OPV in April 2016. All countries in the Region, except Indonesia, have introduced inactivated polio vaccine in their expanded programme on immunization (EPI) programmes. Indonesia is likely to introduce IPV in July 2016. Countries in the Region are facing reduced IPV supplies due to inadequate availability of sufficient IPV.

National switch plans have been finalized in all countries by the Ministry of Health in close coordination and support from development partners, WHO and UNICEF. The National Switch Coordination Committee in each country is overseeing and coordinating the subnational and peripheral task force activities.
The procurement process of bOPV is ongoing in all countries of South-East Asia to ensure sufficient availability of bOPV by the time of the switch. Seven countries in the Region are procuring bOPV through UNICEF while the remaining four have plans for self-procurement. The bivalent oral polio vaccine is licensed for use in six countries of the Region while the remaining five countries will accept WHO prequalified bOPV. Available stocks have been taken into consideration while procuring additional tOPV to ensure that no stock-outs occur pre-switch, and there is minimal tOPV stock post-switch in all countries. National plans for tOPV withdrawal and disposal are well chalked out in all countries of the Region.

The national workshop for EPI managers has been successfully completed in Sri Lanka, Thailand and Timor-Leste, and plans are in place in the remaining countries. Training activities for health officials and frontline workers at the subnational level are on track and are likely to be completed prior to the switch in the Region.

The process for identifying independent monitors for the switch is in progress, and plans are well drafted to identify and train these monitors prior to the switch in all countries. Training materials for switch-related activities have been finalized in nine countries. These materials are being finalized in Bhutan and Myanmar.

Risk communication and crisis communication plans are in the advanced stages of preparation along with communication material development for health-care workers in all countries. Plans for developing the communication guides and training materials are expected to be completed in Bangladesh, Maldives and Myanmar well before the switch dates.

Switch validation committees have been constituted in all countries of South-East Asia to closely monitor the implementation and validation of the switch process.
### Table 1: Regional status of preparedness for switch from tOPV to bOPV

<table>
<thead>
<tr>
<th>Countries</th>
<th>National switch date declared</th>
<th>2nd tOPV inventory</th>
<th>bOPV licensed</th>
<th>bOPV supplies</th>
<th>Training Material</th>
<th>National workshop for EPI managers</th>
<th>Subnational workshop for EPI managers</th>
<th>Plan for training of frontline workers</th>
<th>Switch monitors identified</th>
<th>Communication plan/material developed</th>
<th>OPV withdrawal bOPV delivery plan developed</th>
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<tr>
<td>Bangladesh</td>
<td>23/04/2016</td>
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<td>Thailand</td>
<td>29/04/2016</td>
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<td>Yes</td>
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<td>Developed</td>
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<td>Timor-Leste</td>
<td>18/04/2016</td>
<td>Completed</td>
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<td>Completed</td>
<td>Available</td>
<td>No</td>
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Source: WHO South-East Asia Region, data as of February 2016.
7. **Global poliovirus containment activities: an update**

In 2015, there was some progress on efforts to contain poliovirus type 2, in line with the WHO Global Action Plan (GAP) to minimize poliovirus facility-associated risk after type-specific eradication of wild polioviruses and sequential cessation of oral polio vaccine use (GAP III). Countries in the Region have reported on the destruction or planned retention of wild polioviruses and vaccine-derived polioviruses. By the end of July 2016, three months after the switch, countries are expected to complete the second part of Phase I, and report on the destruction or planned retention of all Sabin type 2 poliovirus materials. Countries hosting poliovirus essential facilities (vaccine production, research and repositories) are also expected to certify these facilities against appropriate implementation of the containment requirements described in GAP III. It is crucial, in preparation of this global event, that countries meet the established deadlines to identify facilities holding wild or vaccine-derived poliovirus type 2, destroy all type 2 poliovirus materials and only where necessary, appropriately contain type 2 poliovirus in essential poliovirus facilities.

8. **Vaccine (IPV and OPV) supply situation: an update**

The global stock status of bOPV supplies is adequate to meet the needs of all 155 countries post-switch in April 2016. Sufficient quantities of tOPV are also available to boost the type 2 immunity in selected countries through supplementary immunization activities prior to the switch.

Stockpiles of monovalent OPV type 2 (mOPV2) are being maintained, and standard operating procedures being put in place to ensure a rapid and timely delivery of the vaccine to manage any unforeseen outbreak due to wild poliovirus type 2/vaccine-derived poliovirus type 2.

Due to the technical challenges encountered in the rapid scale-up of IPV production required to meet the timelines, there is reduced availability of IPV from manufacturers. The supply constraints for IPV are global, affecting all countries irrespective of the procurement procedure. WHO and UNICEF are taking actions to liaise with the manufacturers concerned
to understand the reasons for the delays, minimize the consequences to the programme, and obtain assurances for future forecasted requirements. The concept of a fractional dose of IPV is also being evaluated at the global level. The evidence does exist that two doses of IPV generate equal and even greater immunogenicity than a single dose.
9. Country presentations

Bangladesh

Switch date: 23 April 2016

1. OPV inventory and supply adjustment

tOPV availability is adequate for the pre-switch period, and redistribution is ongoing at the national level to ensure minimal stocks post-switch. bOPV supplies are sufficient, and procurement order for the same has been completed. The country has introduced IPV in the EPI schedule. However, stock-outs of IPV are likely in the near future. Readjustment within the subnational level is a challenge that the country plans to mitigate by monitoring at the national and subnational levels on an ongoing basis.

2. Training

Training materials, guidelines and schedules have been developed, and defined timelines of all trainings are being met. The major challenge at the national level is competing priorities of the health system, which the country is overcoming by enhanced coordination with the programmes at the national and subnational levels.

3. Communication

Stakeholders from the private sector have been briefed on the switch. Meetings with different executive committees and media are planned at the national level to minimize the risk of dissemination of false information, apart from identifying a spokesperson at each level. The country has requested communication support from UNICEF ROSA.

4. Vaccine distribution and withdrawal

A few private clinics that provide tOPV vaccination also receive government EPI supplies, but withdrawal of tOPV in these clinics is still a challenge.
Orientation of the sector and a thorough monitoring of their service points are also planned as part of the switch preparation.

5. Monitoring and validation

Switch monitors have been identified and are being finalized. To overcome the challenge of private sector validation, a thorough monitoring of private service points using recruited monitors from other professional health bodies (e.g. private medical associations and paediatric associations) is planned. Adequate budgetary provisions are in place for ensuring smooth monitoring and validation of switch activities.
Bhutan

Switch date: 25 April 2016

1. OPV inventory and supply adjustment

The current tOPV stock is sufficient until the switch date, and a minimal balance is expected to remain afterwards. The first stock of bOPV has been received, and the procurement process for additional bOPV is ongoing. The country has introduced one dose of IPV in the EPI schedule; however, there is currently a stock-out of the vaccine.

2. Training

Training materials for independent switch monitors and all stakeholders are being developed. Health workers have been trained for the switch while IPV introduction and refresher trainings are planned for workers trained more than a month prior to the switch date. A thorough briefing of all staff involved in switch activities is proposed well in advance of the switch date. A checklist to monitor the quality and completeness of training is being developed.

3. Communication

Official notifications along with innovative use of mobile technology to reach all workers providing regular updates, reminders for tOPV and bOPV stock status and preparations for the switch are planned at the subnational level. Communication materials are being developed to ensure dissemination of appropriate messages regarding the switch to all key stakeholders. It is also proposed to support the Ministry of Health by briefing the media spokesperson regarding switch plans closer to the scheduled switch date.

4. Vaccine distribution and withdrawal

There are no private vaccination service providers. A checklist of the handover of all vials will be used at each level in the system. Switch monitors will be withdrawing tOPV for disposal by boiling at the central
level. A simultaneous preparation of a detailed destruction report is proposed.

5. Monitoring and validation

A standard checklist has been developed, and the monitoring plan is underway. Monitors will be deployed to identify health centres prior to the switch day. A request for an additional funding support of US$ 10,000 for travel expenses of switch monitors is being submitted to development partners (WHO/UNICEF).
Democratic People's Republic of Korea

Switch date: 18 April 2016

1. OPV inventory and supply adjustment

tOPV stocks are sufficient until the switch date and bOPV supplies are expected to be delivered on time. IPV was successfully introduced in the EPI schedule, however delivery of the vaccine has been delayed and IPV stock-out is likely in the near future.

2. Training

Training materials and guidelines as well as training plans for all workshops have been developed.

3. Communication

Simple key communication messages have been developed along with a communication plan. A national consultative meeting and stakeholders’ meeting have been completed. A conservative approach with regards to mass media engagement is being adopted with the EPI manager acting as the focal point for media as needed.

4. Vaccine distribution and withdrawal

There are no private vaccination service providers. The vaccine exchange plan has been developed and to ensure compliance, visits of national task force members are proposed. Appropriate measures to ensure adequate bOPV have been adopted. For tOPV destruction at the national level, boiling methodology is being considered, and signed certification of disposal to the National Switch Validation Committee will be made compulsory.
5. Monitoring and validation

Independent monitors were trained to ensure sufficient number of monitors in the field during switch activity. Supervisors will be responsible for cross-checking the completeness and quality of all monitoring documentation.
India

**Switch date: 25 April 2016**

1. **OPV inventory and supply adjustment**

IPV is being introduced in the EPI schedule in a phased manner in the country. Real-time inventory or a weekly web-based inventory of vaccines will be maintained for all states prior to the switch. All licenses for manufacturing as well as import of tOPV will be cancelled on 25 April 2016. tOPV stocks are sufficient until the switch date, and efforts to minimize the post-switch tOPV stocks have been made. The mechanism for the disposal of excess tOPV is by autoclaving. An accountability framework has been set up through the formation of task forces at the district, state and national levels.

2. **Training**

Training materials and plans for all levels are in place. A national workshop for the switch conducted during the IPV workshop will be supplemented with a second workshop. The challenge being posed by the enormous amount of human resources to be trained in this short time is being managed by formulating detailed training plans and a training feedback mechanism. Catch-up sessions will also be planned for any absentees. State-level trainings will include communication and risk management issues.

3. **Communication**

To make the concept of switch simple and well understood, discussions have been held with all stakeholders. The designated defined roles of all individuals during the switch have been clearly spelt out. A spokesperson kit has been formulated specifically for any media queries. The Ministry of Health and Family Welfare, Government of India, is closely coordinating with professional entities, including the Indian Medical Association and the Indian Association of Paediatrics so that uniform and appropriate messages
are delivered to all professionals in the health-care system, especially to those in the private sector.

4. **Vaccine distribution and withdrawal**

The public sector’s vaccine availability of bOPV and tOPV is well planned and supervised at all levels. Listing and mapping of private OPV supply chain is in process. The guidelines issued by the national regulator to withdraw the license of tOPV manufactures post-switch shall facilitate tOPV withdrawal at the national and subnational levels.

5. **Monitoring and validation**

Independent monitors have been identified and well trained for the upcoming switch. The National Coordination Committee for Polio Eradication and the National Switch Validation Committee have been well constituted. Certain geographical areas such as the north-east and conflict areas pose a challenge for effective monitoring. Local independent monitors will be deployed in these areas to support monitoring activities. To prevent auxiliary nurse midwives (ANMs) from retaining any tOPV vials, a certification mechanism for ANMs is being put into action.
Indonesia

Switch date: 4 April 2016

1. OPV inventory and supply adjustment

tOPV stocks are adequate until the switch, and any excess will be utilized during the National Immunization Days planned prior to the switch. The bivalent oral polio vaccine has been ordered and availability has been confirmed. IPV licensing is under process, and introduction of IPV in the EPI schedule is planned post-switch during July 2016.

2. Training

Guidelines have been disseminated, and all trainings and workshops are being held as per timelines. Training completeness in the private sector is to be verified, and a review meeting will be held to evaluate the completeness of all public sector trainings. The country has a need for technical assistance to ensure well-trained independent switch monitors.

3. Communication

Communication plans and materials have been developed and disseminated. The private sector is in the loop, and further advocacy meetings are planned, along with religious leaders. Religious boards have been engaged and have issued a Fatwa on polio and routine immunization. The media has been made aware of the polio endgame activities, and the Director of Surveillance and Health Quarantine has been identified as the spokesperson in case of any query.

4. Vaccine distribution and withdrawal

The tOPV withdrawal and bOPV delivery plan has been developed. Enlisting of tOPV suppliers to the private sector and private vaccination service providers is ongoing. For easy identification, colour coding of vial caps is being employed: tOPV-silver cap and bOPV-red cap. The majority of the tOPV disposal will be done at the district level.
5. Monitoring and validation

Independent monitors have been recruited and placed in selected high-risk provinces. Trainings are planned for all monitors. The National Certification Committee will also be actively carrying out monitoring to strengthen ongoing activities. The National Committee of Experts on Polio Eradication will be responsible for switch validation.

The National Task Force for Polio Eradication has been established. Provinces and districts also have task forces. It has been unanimously decided among the national and provincial levels to begin the switch activity on 4 April as Indonesia is an archipelago of islands and this poses geographical challenge to ensure global synchronization of switch within a two-week period by 1 May 2016.
Maldives

Switch date: 18 April 2016

1. OPV inventory and supply adjustment

Procurement order for tOPV has been completed in view of a stock-out being expected before the switch, while supplies are also being adjusted and redistributed. Supplies for bOPV are sufficient. IPV has been introduced in the national EPI schedule.

2. Training

Training kits and plans have been drafted, and workshops and trainings at all levels are either completed or in progress. There is a felt need of technical assistance to strengthen the capacities of health professionals at the vaccine delivery sites with regards to switch implementation.

3. Communication

Communication plans and materials are being developed. Orientation of all medical professional bodies and private practitioners are either completed or planned. Media briefings have been held, along with plans of a joint press release on the switch date. To mitigate risk of incoherent communication, the Ministry of Health shall identify a media spokesperson. A national operation room with phone lines is also being set up to address public concerns.

4. Vaccine distribution and withdrawal

Plans to operationalize push and pull mechanisms for the switch have been developed. The private sector undertakings procure the required vaccine supplies from the government set-up. Disposal of tOPV is planned at the centre by incineration or autoclaving for which a certification will be issued by the Validation Committee. Certain atolls with access issues will have vaccine transported via airplanes and sea vessels. The online system of
stock management (as well as physical counting at all levels will be used for validation).

5. Monitoring and validation

Independent switch monitors have been identified and training of monitors is planned. A National Validation Committee has been established. One hundred per cent vaccine storage points will be targeted for monitoring.
Myanmar

Switch date: 29 April 2016

1. OPV inventory and supply adjustment

Procurement order for tOPV is in progress to mitigate the risk of vaccine stock-out. Sufficient doses of bOPV have been procured along with funds for additional bOPV orders. The initial allocation of IPV has not been sufficient to cover current needs, and a request has been raised to development partners for supporting vaccine supplies.

2. Training

Training materials for national and subnational workshops have been developed. Detailed switch activities to be implemented with timelines have been developed. All advocacy, training and logistics activities will take place within March 2016. Supervisors will be reinforcing switch training concepts immediately prior to the switch to ensure better implementation.

3. Communication

Information, education and communication (IEC) materials and other communication products are being developed. Communication messages that are being drafted for the media and those that are being drafted for health workers will be strategically different. Advocacy meetings and media briefings are also planned.

4. Vaccine distribution and withdrawal

There are no identified private suppliers or service providers in the country. Development of standard operating procedure for distribution is in progress, disposal microplans are being finalized and shall be shared with the central management team. All excess tOPV will be labelled and brought to be destroyed by incineration. The ongoing outbreak of cVDPV response entails intensive SIAs in using of tOPV, and this shall ensure minimal stocks of tOPV post-switch.
5. Monitoring and validation

Identification of monitors and development of the sampling plan and data collection forms is in progress. Public health trainees may also be deployed as the workforce for switch implementation.
Nepal

Switch date: 17 April 2016

1. OPV inventory and supply adjustment

Procurement order for tOPV as per stocks has been completed to maintain sufficient stocks until the switch date. Adequate bOPV stocks have also been procured. IPV was introduced into routine immunization in September 2014.

2. Training

Switch plans and standardized training materials have been disseminated at all levels. While initial trainings were already conducted during the recent workshop, under the measles and rubella vaccination campaign, the earthquake-affected districts have trainings scheduled in March.

3. Communication

Communication materials have been developed and disseminated, and IEC materials are being adapted. A talk show by the Honourable Minister and Central Health Director on the day of the switch to deliver key messages to the media and public has been planned. Meetings with all committees, officials and organizations at the centre are planned and on track.

4. Vaccine distribution and withdrawal

OPV procured by the private sector is supplied through the government supply chain mechanism. Any leftover vaccines are returned to the district vaccine store. The existing supply chain management system will be used for distribution of bOPV and recall of tOPV. Furthermore, a tOPV recall box with key messages pasted on it is going to be utilized.
5. Monitoring and validation

External monitors are in the process of being selected, and their training and deployment are to be planned. The role of the Validation Committee and monitors has been detailed clearly. The private sector delivering immunization services has been mapped in local microplans and communicated to local health authorities.
Sri Lanka

Switch date: 30 April 2016

1. **OPV inventory and supply adjustment**

   No tOPV stock-outs are expected as tOPV supply adjustments are meticulously planned. Procured bOPV stocks are to be delivered by early April 2016. IPV was introduced in the country and a stock-out of the same is expected.

2. **Training**

   Training materials and guidelines for health-care workers are to be finalized along with training dates. Trainings at all levels have been planned and are on track.

3. **Communication**

   A communication plan and media briefing kit have been developed. Initial communication has already been made to private hospitals. Provincial and regional directors are to be briefed along with media briefing.

4. **Vaccine distribution and withdrawal**

   A tOPV withdrawal and bOPV delivery plan has been developed. The private sector tOPV stock is provided by the government and there are no separate private sector tOPV suppliers. bOPV stocks will be stored in a separate cold room at the national level. From district to health areas, the vaccine supply will be on exchange basis. The collected tOPV will be stored out of the cold chain and labelled for destruction by incineration. Stock exchange formats will be used for the same. Collection plans are to be developed.
5. Monitoring and validation

Documents for monitoring are under preparation. The plan is to include specialists, such as microbiologists, paediatricians, provincial consultant community physicians and regional epidemiologist in the supervisory and validation team as field monitors.
Thailand

Switch date: 29 April 2016

1. OPV inventory and supply adjustment

tOPV inventory is currently ongoing whereas bOPV supplies are confirmed and expected well in time. IPV introduction is ongoing along with single dose vial procurement procedures.

2. Training

All trainings and meetings have been completed at all levels. Refresher materials in the form of videos to refresh pharmacists and EPI managers are being developed. Supervisors will be responsible to encourage viewing of training videos by health workers. A high-level consultancy with ministerial officials is scheduled to activate switch monitoring.

3. Communication

Meetings with vaccine suppliers and private hospitals/clinics have been completed to ensure adequate oral polio vaccine supply prior to the switch and post-switch. Outbreaks in neighbouring countries pose a threat to Thailand that can be minimized by cross-border collaboration and timely information sharing.

4. Vaccine distribution and withdrawal

The guidelines for tOPV recall and disposal have been discussed with all suppliers. Private clinics providing tOPV have been enlisted to recall tOPV from the private sector. Pull exchange will be used to withdraw tOPV. Incineration will be the preferred method of tOPV destruction. Certification mechanisms are also being established to ensure complete withdrawal from the private sector.
5. Monitoring and validation

Switch monitors have been identified while the monitoring plan is being developed. To minimize delays in dissemination of aggregate information, web-based reporting is going to be utilized.
Timor-Leste

Switch date: 18 April 2016

1. **OPV inventory and supply adjustment**
   
   No tOPV stock-out prior to the switch is expected. The availability of bOPV is ensured to be sufficient during the switch and post-switch.

2. **Training**
   
   Training materials for all workshops have been developed, and trainings are in progress as per timelines. Health workers will also be sensitized a few weeks prior to the switch.

3. **Communication**
   
   A communication plan and key communication materials have been developed while other materials such as stickers, pamphlets, are underway.

4. **Vaccine distribution and withdrawal**
   
   A tOPV withdrawal and bOPV delivery plan has been developed. The plan is to keep tOPV out of cold chain by the use of stickers/labels. Formats for recording unused tOPV withdrawal have been printed, and disposal is planned by incineration at the central level. Distribution of bOPV to district and peripheral vaccine delivery sites in the field will be through the push mechanism.

5. **Monitoring and validation**
   
   Switch monitors are in the process of being identified. Independent monitors will be trained during the second week of March 2016. Stickers are planned to be pasted on every vaccine refrigerator on the switch date declaring – “NO tOPV IN THIS REFRIGERATOR” along with signs of the cold chain handler, institution head and national monitor who visits it. Strict monitoring protocols will be followed to ensure 0% tOPV in the cold chain post-switch.
10. Conclusions

The regional review of switch preparedness in February 2016 ensured a common understanding of the relevance of the timely completion of switch planning, and establishing active and direct links with different agencies involved in the global switch.

Countries revised their switch plans during the workshop, developed microplans and were equipped with the tools to be fully prepared for implementation of the switch in their respective country circumstances.

All countries in the Region are on track and progressing well to implement the switch on the designated date of each country.

The meticulous planning and thorough preparation for the switch in the Region is evident, and for “on-the-ground” success of switch implementation, close monitoring and supervision is essential in the near future. For effective monitoring, high-risk sites have been identified and measures to ensure timely completion of tasks by independent monitors are in place at the national and subnational levels.
Annexes
Annex 1

Opening remarks and welcome address by Dr Arun B. Thapa, Director Programme Management, WHO Regional Office for South-East Asia

Welcome participants from the ministries of health from 10 Member States (all except Democratic People’s Republic of Korea are attending).

Welcome colleagues from WHO and UNICEF country offices of all 11 countries as well as from UNICEF ROSA and East Asia Pacific Regional Office regions.

Welcome facilitators from WHO and UNICEF headquarters, UNICEF supply division, CDC Atlanta, Task Force for Global Health, Atlanta and Emory University.

You are all aware that the Global Polio Eradication and Endgame Strategic Plan 2013–2018 requires a phased removal of all oral polio vaccines (OPVs) in all OPV-using countries to eliminate the risks of vaccine-associated paralytic polio (VAPP) and vaccine-derived polioviruses (VDPVs).

Given that the wild poliovirus type 2 has been eradicated globally in 1999 and the risk that the type 2 component of trivalent OPV poses to a world free of polio, it is proposed to switch from the trivalent OPV (tOPV) to bivalent OPV (containing type 1 and 3 serotypes only). The switch has been endorsed by the World Health Assembly 2015 and is confirmed to be conducted in April 2016, following a decision of the Strategic Advisory Group of Experts (SAGE) in October 2015. The SAGE has defined a two-week window from 17 April to 1 May 2016 during which the switch from tOPV to bOPV must happen in all 156 countries/territories that are currently using OPV.

All 11 countries in the South-East Asia Region of WHO use OPV in their programme and are, therefore, expected to implement the globally synchronized tOPV to bOPV switch in April 2016. In preparation of the switch, a number of activities have to be completed in each country. These include establishment of management structures, licensure and
procurement of bOPV for use after the switch, conducting inventories of tOPV and adjusting procurement of tOPV supplies prior to the switch, developing and implementing training and communication plans in preparation of the switch, establishing mechanisms for monitoring and validation of switch and having protocols for recall, destruction and validation of tOPV in each country.

I am aware that national switch plans have been developed by all countries outlining the various activities, timelines and responsibilities to accomplish the above tasks. In consideration of the fact that the switch has to be synchronized globally, during the two-week period defined by SAGE, and that this is an activity that has never been conducted before, and that there is no flexibility in delaying the switch due to noncompletion of preparatory activities for the switch, it is critical that a detailed assessment of all preparatory activities is undertaken in advance of the actual switch date. This is what is proposed to be done during this workshop.

I am aware that the regional offices of WHO and UNICEF have been working closely with the Ministry of Health colleagues in all countries of the Region to provide support for the preparatory activities for the switch, and have also been closely tracking and monitoring switch-related activities. Overall, we in WHO are extremely pleased with the progress made so far. I am especially pleased to see that management structures have been established for switch monitoring in all countries; IPV has been introduced in 10 of the 11 countries of the Region and that bOPV is either licensed in all countries or will be accepted from WHO prequalified manufacturers; and that plans for training, communication, monitoring, also vaccine exchange, are all in place.

However, the next two months are going to be critical for the switch.

The pace of some activities might have to be increased as we get closer to the switch date. There will be a need for greater attention to the micro-details of all activities and subactivities pertaining to the switch. There is no room for any complacency from now until the switch. It is important to identify any risks/barriers/challenges now so that solutions can be identified collectively over the next two days while we are in this meeting. Management structures at all levels will have to be activated and the urgency and importance associated with the switch activities will have to be emphasized to all those involved with this process.
We are holding this workshop two months in advance of the switch to give time to countries and to us to take actions to overcome the barriers that the switch process may be facing.

While we will be restricting our discussions to the switch process during the two days of the meeting here, I would also like to bring to your attention to two important related issues. These include the containment of the polioviruses and the outbreak response plans.

Containment is a complex area of work but extremely critical. It includes containing not only wild polioviruses of type 2 but also Sabin viruses of type 2, and there are very strict timelines attached to this process. If not completed appropriately as per guidelines outlined in the Global Action Plan III, we run a risk of introducing type 2 polioviruses in communities, post-switch, and this could have some serious consequences due to reduced type 2 immunity.

It will also be critical to update the outbreak response plans in countries so that we are in a state of appropriate preparedness to handle any outbreaks that may emerge post-switch. I understand that guidelines for updating these plans have been circulated recently and all tier 1 and 2 countries (India, Indonesia, Myanmar and Timor-Leste) must update their plans by 31 March 2016. Other countries are also encouraged to update their plans as soon as possible.

So there is a heavy schedule of work ahead of us. But I am confident that with the collective efforts of all of you sitting in this room, we shall be able to complete this task as successfully as many other tasks in the past, including polio eradication in the Region.

I am looking forward to very useful deliberations during the two days of this meeting and I am hoping that we will be better positioned to handle the challenging task at the end of the day tomorrow.

Best wishes to all of you.

Thank you.
Annex 2

Agenda

- Objectives and overview of the programme
- Global and Regional Polio eradication and endgame strategy: An update
- Global IPV and OPV supply situation: An update
- Global/Regional poliovirus containment activities: An update
- Current status of preparedness for the switch by individual countries
- Looking ahead – Planning for the final phase before the switch – Introduction to group work
- Group work by individual country teams on developing micro-plans, challenges/risks and potential solutions in the following five thematic areas in each country: -
  - inventory and OPV supply adjustment
  - trainings
  - communication
  - vaccine distribution, exchange & tOPV disposal
  - monitoring and validation
- Presentations by individual country teams of the micro plans for switch implementation including the probable solutions to challenges anticipated
- Summarizing challenges/risks and potential solutions by thematic area
  - inventory and OPV supply adjustment
  - trainings
  - communication
  - vaccine distribution, exchange & tOPV disposal
  - monitoring and validation
Annex 3

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Regional review on preparedness for switch from trivalent Oral Polio Vaccine (tOPV) to bivalent Oral Polio Vaccine (bOPV) in South East Asia Region (SEAR) countries was attended by the EPI programme managers of ten out of eleven member states of WHO's SEAR. There was an active participation of experts from headquarters, US CDC, regional and country offices of WHO & UNICEF. Global and regional updates were provided on the polio eradication and endgame strategic plan implementation and this was followed by presentations on the current status of switch preparedness by each country. The detailed micro-plans with timelines and responsibilities for conducting the switch in the country were collectively reviewed. The technical experts offered potential solutions to overcome the challenges identified by the country teams.

This publication provides an overview of preparedness in each SEAR country to implement the switch in April 2016 with plans to overcome the potential challenges.