International Coordinating Group (ICG) on Vaccine Provision for Cholera, Meningitis, and Yellow Fever: Report of the Annual Meeting

23-24 September 2020

World Health Organization

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Contents

Abbreviations and acronyms

CFR	Case fatality rate
DCGI	Drugs Controller General of India
DRC	Democratic Republic of the Congo
EMA	European Medicines Agency
EVD	Ebola virus disease
EYE	Eliminate Yellow Fever Epidemics
FDA	Food and Drug Administration of the United States
Gavi	Gavi, the Vaccine Alliance
GOC	Governance Oversight Committee
GTFCC	Global Task Force on Cholera Control
Hib	*Haemophilus influenzae* type b
HSS	Health system strengthening
ICG	International Coordinating Group on Vaccine Provision
IFRC	International Federation of Red Cross and Red Crescent Societies
KPI	Key performance indicator
MSF	Médecins sans Frontières
Nm	*Neisseria meningitidis*
OCV	Oral cholera vaccine
PCCS	Post-campaign coverage surveys
PPE	Personal protective equipment
PQ	Prequalification
RT-PCR	Reverse transcription polymerase chain reaction
SAGE	Strategic Advisory Group of Experts on Immunization
SD	Supply Division of UNICEF
SIIPL	Serum Institute of India
SOP	Standard operating procedure
UNICEF	United Nations Children's Fund
UNICEF SD	Supply Division of UNICEF
VIS	Vaccine Investment Strategy
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WHO-OSL	WHO Operation Support and Logistics

Introduction

The 2020 annual meeting of the International Coordinating Group (ICG) on Vaccine Provision for Cholera, Meningitis and Yellow Fever was held online from 23 to 24 September 2020. The meeting was chaired by Dr Olivier Ronveaux on day 1 and by Dr Laurence Cibrelus on day 2. The agenda of the meeting and the list of participants are attached as Annex 1 and Annex 2, respectively.

The ICG has four founding members – the International Federation of Red Cross and Red Crescent Societies (IFRC), Médecins Sans Frontières (MSF), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), with the latter being the host agency for the ICG Secretariat. Staff from these member organizations were present at the meeting, together with staff from Gavi the Vaccine Alliance, which finances the vaccine stockpile, and UNICEF Supply Division which is the main procurement agency. Although vaccine manufacturers have attended ICG annual meetings in the past, they were not present at the 2020 meeting owing to the shorter and combined agenda which dealt with issues related to three vaccine stockpiles plus EVD vaccine stockpile. It was agreed that the vaccine manufacturers will be updated later about the meeting decisions which needs their attention and further action.

Objectives of the meeting

The objectives of the meeting were:

- to review the epidemiological situation in 2019-2020
- to review the outbreaks and campaigns supported by the ICG during 2019-2020
- to discuss the vaccine demand forecast
- to review the ICG coordination mechanisms.

Epidemiological situation in 2019-2020

Meningitis
Katya Fernandez

A comparison of the meningitis epidemic seasons of 2019 and 2020 in Africa's meningitis belt showed a decline in suspected cases from 13 692 cases in 2019 to 9975 cases reported by 20 countries in 2020. The case fatality rate (CFR) similarly fell from 5.7% to 5.4% over the same period. In fact, the number of cases has been decreasing over the past three years. From September 2019 to September 2020 the main meningitis pathogens identified were *Streptococcus pneumoniae*, NmC, NmX, NmW and Hib. *S. pneumoniae* was the leading pathogen, accounting for 32.7% of samples collected in 2019 and 46.3% in 2020. NmC accounted for 32.6% of pathogens collected in 2019 but just 5.3% in 2020. No NmA has been identified since 2017.

Two countries – Benin and Ghana – experienced meningitis epidemics in 2020 (caused by NmC in Benin and by *S. Pneumoniae* and NmX/NmW in Ghana). In Benin the epidemic threshold was reached in week 52 of 2019 in Banikoara in the north of the country. There

were 83 cases and 13 deaths. Surveillance, reporting, case management and laboratory confirmation were strengthened, and the initial response vaccinated some 900 people in the affected area in the first week of 2020. The doses used were from the national stock (originally set up for vaccination of Muslim pilgrims) and this helped to slow the outbreak. A reactive mass vaccination campaign in late January and early February, using ACYW conjugate vaccine released by ICG, covered 226 101 persons aged 1–29 years (coverage over 95%). The main challenge was the single-dose vaccine size in an area with limited cold chain capacity.

In Ghana, two districts in the Upper West region crossed the epidemic threshold in weeks 3 and 9 of 2020. Again, surveillance, reporting, case management and laboratory confirmation were strengthened. A total of 137 cases and 18 deaths were recorded in the region, with the main pathogens being *S. pneumoniae* (42%) and NmX (23.6%). However, no reactive vaccination campaign followed as there is as yet no policy for reactive vaccination of pneumococcal outbreaks; vaccination in pneumococcal outbreaks is currently being reviewed by the Strategic Advisory Group of Experts on Immunization (SAGE).

Cholera

Malika Bouhenia

In 2019 Africa reported the lowest numbers of reported cases of cholera in the present century and the Americas reported the lowest number since 2010. However, 93% of the 2019 total of 923 037 cholera cases were reported in Yemen. 2019 also saw some 1911 cholera deaths. Despite Africa's reduction in numbers, the CFR is higher in Africa than in other regions. During the period from September 2019 to September 2020, 16 countries reported outbreaks with a total of more than 450 000 cases and over 900 deaths. Of these, more than 25 000 cases and 370 deaths were reported from the Democratic Republic of the Congo (DRC), while 400 000 cases and 280 deaths were reported from Yemen. The remaining 14 countries together reported nearly 30 000 cases and 400 deaths.

There are concerns at both under-reporting from some countries and a low proportion of laboratory confirmation in others, leading to suspected over-reporting of cholera in those places. Countries not reporting cholera cases included Bangladesh (outside Cox's Bazaar), India and Philippines. However, campaigns were completed in DRC, Sudan and Uganda between October 2019 and July 2020. Campaigns were postponed in Bangladesh (part of Cox's Bazar), Mozambique and South Sudan because of COVID-19 and security issues. It was also felt there had been missed opportunities to vaccinate in Burundi, Kenya and Nigeria since there were outbreaks but no requests were received by the ICG. In Cameroon, following emerging outbreaks in different parts of the country, the ICG approved the use of oral cholera vaccine (OCV) to conduct reactive vaccination campaigns in Extreme North, North, Littoral, South and Southwest regions, which also required ICG approvals for changing the strategy to vaccinate in different areas as originally intended, making immediate use of the existing vaccine stocks available in the country at the moment.

Some 38 million doses of cholera vaccine were requested through GTFCC and ICG in 2019, with around 17 million being approved by the ICG. For 2020 the corresponding figures were 22 million doses requested and 19 million approved. During the period September 2019 to September 2020, 22.3 million doses were requested from the ICG, 9.2 million were approved and 5.8 million were administered. Normally most requests come to the ICG, although in

2020 requests have so far been submitted equally to the ICG and the Global Task Force on Cholera Control (GTFCC).

Action points

- ICG should further emphasize its vaccine stockpile to susceptible countries as outbreaks still occur without requests to the ICG.
- Efforts must be made to shorten the time to implementation (which currently ranges from 1 to 4 months).
- Countries to be encouraged to strengthen surveillance and report cholera cases to WHO.

Yellow fever

Jennifer Horton

Yellow fever cases and outbreaks over the past year have had a wide geographical scope and are typically detected in areas where people are involved in forestry, agriculture or herding. Viral transmission in border areas and mobile populations brings a risk of spread among localized high-risk groups and across international borders.

From the Americas, the majority of reported cases were from Brazil. However, numbers reported were far fewer in the past year (down from 1400 in 2018/19 to just 18 in the most recent period 2019/2020). Sporadic cases were also documented from Bolivia, Peru and Venezuela. In Africa, yellow fever cases were confirmed in several high-risk countries across the region. Outbreaks were documented in Ethiopia, Nigeria, South Sudan and Uganda, while there were outbreak potential cases from Chad, the Democratic Republic of Congo (DRC) and Mali.

Endemic areas in West African countries had previously benefited from the campaigns through the Yellow Fever Initiative in 2006–2014. The success of these activities is evidenced by the absence of yellow fever outbreaks in these countries from 2015 onwards. Nonetheless, there have been occasional sporadic cases in some of these countries in the past year. These are not unusual events in endemic areas, but it is a concern when population immunity levels are suboptimal as this represents a re-emerging epidemic risk. Additionally, three countries reported in 2019 that they had lower vaccination coverage though routine immunization than they achieved in prior years, suggesting a potentially growing immunity gap.

There have been four requests to the ICG for yellow fever vaccine since the last annual meeting in September 2019, all of which have been from countries in Africa. The recent requests from 2020 (year to date) have been noteworthy for the impact of COVID-19 on delaying investigations and responses. On the positive side, rapid outbreak responses have been implemented in some instances. Rapid implementation using in-country vaccine may have interrupted transmission in Ethiopia (2020) and Bauchi State, Nigeria (2019).

In two of the four applications to ICG, the ICG members suggested revisions to the reactive campaigns as follows: recommendation of a more focused response in Ethiopia; and recommendation and approval of a broader response in South Sudan and Uganda (addition of

one district with adjacent boundaries). Both suggestions were agreed by the countries concerned.

Regarding implementation, there have been delays of up to six months before confirmation of an outbreak and/or approvals by the ICG. In Bauchi, Nigeria, an initial response in the local government area with the epicentre of the outbreak was mounted using vaccine already in the country. However, the larger response lagged some months behind and occurred in a fragmented fashion secondary to the very small administrative units in two states. The initial response was suboptimal, partly due to the short lead time for organizing central support. In Uganda, delayed disbursement of funds from the government to the district slowed implementation, while refugee groups proved more mobile than anticipated.

Overall, the ICG requests for vaccine have included improved quality, including aspects of the epidemiological overviews and rationale for response, indicating improved capacity at country level. Initial entomological observations have been shared and detailed studies are pending. An outstanding area for improvement is after-action reporting, including post-campaign coverage surveys (PCCS). The campaign reports and PCCS have frequently been partial or delayed.

Practical guidance is being developed on PCCS adaptation for the short timelines and constraints of the outbreak response context. Work is ongoing with countries and regions to ensure full reporting of implementation. As it was an action point from last year's annual meeting, a revised ICG application form package with supporting guide, FAQs and annexes has been developed. This form will give an option for more environmental details. However, WHO's current vaccination survey methodology does not fit easily with reactive campaigns aimed at local administrative levels.

Action points for Yellow Fever

- Development of operational guidance for the PCCS in resource-limited settings and that can be applied in reactive campaigns.
- Roll-out of the updated ICG request form package.

COVID-19 impact on outbreak detection and response

Mohammad Salim Reza

Several disease prevention and outbreak response campaigns had been slowed or delayed due to the COVID-19 pandemic. For instance, there was uncertainty as to whether the reduction