



# **International Coordination Group on Vaccine Provision for Epidemic Meningitis**

## **Report of the Annual Meeting**

**Geneva**

**18 September 2018**

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## List of abbreviations

AFRO	WHO Regional Office for Africa
EYE	Eliminate Yellow Fever Epidemics
Gavi	Gavi, the Vaccine Alliance
GTFCC	Global Task Force on Cholera Control
ICG	International Coordinating Group
IFRC	International Federation of Red Cross and Red Crescent Societies
MSF	Médecins sans Frontières
SD	Supply Division of UNICEF
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## Executive summary

The annual meetings of the International Coordinating Group (ICG) on Vaccine Provision for epidemic meningitis, cholera and yellow fever were held back-to-back from 18–20 September in Geneva. The aims of the meeting of the ICG on Vaccine Provision for Epidemic Meningitis, held on 18 September, were for partners and stakeholders to: review relevant epidemic response activities and lessons learned during 2017–2018; discuss the anticipated stockpile size, composition and funding for the period 2019–2020; and exchange information with the extended group of ICG partners and stakeholders, including vaccine manufacturers.

After the opening remarks, all participants were updated on the epidemiological situation and vaccine shipments from the ICG meningitis stockpile. UNICEF-SD gave its update on vaccine procurement and anticipated needs for the coming years. This was followed by the strategic decision by participants on the size of the stockpile for 2020/2021. In the afternoon, WHO HQ gave an overview of the "Defeating Meningitis by 2030" strategy, which was introduced at the World Health Assembly in May 2018. Gavi presented an update on its supply and demand roadmap, including its meningitis vaccine investment case, and progress on market shaping activities. Vaccine manufacturers gave their production forecasts for the period 2018–2022. Finally, the ICG Secretariat presented the results of the recent external evaluation of the ICG mechanism, and its proposals for its Governance and Oversight Committee and new ICG Mechanism Accountability Framework.

There was a decrease in meningitis transmission in the meningitis belt in 2018 compared with the previous year. Serogroup C *Neisseria meningitidis* and *Streptococcus pneumoniae* were the most common causative pathogens detected. Four requests were made for emergency vaccines and two of these, from Fiji and Nigeria, were approved for a total of 412,830 doses.

Major themes to come out of the meeting included the need to enhance engagement with vaccine suppliers to both increase the supply offer and ensure reliability of supply. Participants discussed the use of four-year tenders for vaccine supply, and whether they have improved vaccine availability. There is a need to identify and evaluate ways of alleviating bottlenecks in the procurement and delivery process. To this end, it was agreed that ICG and UNICEF Supply Division (SD) will establish a working group on delivery lead times and to identify and evaluate bottlenecks in the procurement and delivery process. The working group will also evaluate whether the use of four-year tenders has improved vaccine availability.

The ICG members agreed that a stockpile of five million doses of C-containing vaccine should be available at the beginning on each start of the epidemic season in January. Out of the five million doses, at least three million should be CW-containing. Vaccine supply remains a challenge, and the stockpile remains well below the size requested by the ICG. All possible efforts are required to expand the stockpile beyond the current 3.5 million doses to ensure that it meets future needs.

Efforts are underway to implement the recommendations of the external review of the ICG, which was presented to the ICG Secretariat in October 2017. The ICG has established its new Governance and Oversight Committee and is beginning to implement the ICG Accountability Framework which sets out the actions and responsibilities of the ICG and each partner, including individual country governments, at each stage of the ICG process. Going forward, performance indicators will be assigned to the ICG and partners to which they will be accountable.

## 1. Introduction

Meningococcal meningitis is primarily caused by *Neisseria meningitidis* (Nm). Globally, six serogroups are implicated in epidemics, and all except B and Y have a widespread distribution in Africa. Although meningococcal meningitis epidemics can occur elsewhere, the majority of cases are found during the dry season from December to June in the “meningitis belt”, a region encompassing 26 African countries home to around 450 million people which spans the Sahel biogeographic zone. Outbreaks involving *Streptococcus pneumonia* and *Haemophilus influenzae* type b are also occasionally detected.

In 1996 more than 200,000 meningococcal meningitis cases and 20,000 deaths caused by Nm serogroup A occurred across the meningitis belt. The International Coordinating Group on Vaccine Provision (ICG) was established the following year as an emergency mechanism to respond to outbreaks of epidemic meningitis. ICG groups and emergency vaccine stockpiles were established for meningitis yellow fever and cholera in 1997, 2001 and 2013 respectively. In addition to vaccines, the ICG for meningitis maintains a stockpile of antibiotics for treatment of cases.

The ICG brings together four founding agencies: The International Federation of Red Cross and Red Crescent Societies, Médecins Sans Frontières (MSF), the United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO). It also consults with extended partners including technical experts and vaccine suppliers. Gavi, the Vaccine Alliance, is the principal funder of the three vaccine stockpiles.

### **The ICG’s objectives are:**

- To provide equitable vaccine allocation through careful and objective assessment of risk, based on epidemiological and operational criteria
- To rapidly deliver vaccines in response to infectious disease outbreaks.
- To coordinate the deployment of limited quantities of vaccines and other essential medicines.
- To minimize wastage of vaccines and other supplies.
- To advocate for readily-available, low-cost vaccines and medicines.
- To work with manufacturers through UNICEF and WHO to guarantee availability of vaccine emergency stock supplies at the global level.
- To follow standard operating procedures and establish financial mechanisms to purchase emergency vaccine supplies and ensure the sustainability of stocks.

The 2018 annual meeting of the ICG on Vaccine Provision for epidemic meningitis was held on 18 September in Geneva. Participants included representatives of the World Health Organization (WHO) headquarters (HQ), including ICG Secretariat, the WHO Regional Office for Africa (AFRO), United Nations Children’s Fund (UNICEF), with participants both from HQ and the Supply Division (SD), Médecins sans Frontières, the International Federation of Red Cross and Red Crescent Societies (IFRC) and Gavi, the Vaccine Alliance. Representatives from vaccine manufacturers were also in attendance.

The primary objectives of the meeting were to review relevant epidemic response activities and lessons learned during 2017–2018; discuss the anticipated stockpile size, composition and funding for the period 2019–2020; and exchange information with the extended group of ICG partners and stakeholders, including vaccine manufacturers.

The 2018 annual meeting follows on from that of the previous year, held on 13–14 July 2017. Important action points from the 2017 meeting included convening a WHO-led technical consultation to consider when the response to pneumococcal outbreaks should include emergency vaccination and emphasising the role of UNICEF-SD in engaging with manufacturers to improve delivery times. Most importantly, it was agreed that the ICG's performance indicators should be reviewed and revised to reflect respective organizational responsibilities following the completion of the external evaluation of the ICG which was commissioned in June 2017 and whose conclusions were presented to the ICG Secretariat in October 2017.

## 2. Epidemiological update 2018

The epidemiological situation in 2018 was relatively quiet, despite the expectation of an expansion of Nm-C in Nigeria and Niger. In the meningitis belt there was remaining Nm-C activity in Nigeria and Niger following from the previous epidemic season, in addition to cases attributed to Nm-W and *Streptococcus pneumoniae* in Ghana. From 1 January to 1 July (epidemic weeks 1–26) there were 3,186 suspected cases and 206 deaths reported across five epidemic districts in **Nigeria**; mostly concentrated in Zamfara state and attributed to Nm-C. In **Niger** there were 1,335 suspected cases and 99 deaths, mostly Nm-C and Nm-X, in one epidemic district. In the same period, **Ghana** reported 802 cases and 58 deaths in six epidemic districts caused by *Streptococcus pneumoniae* and Nm-W. In **South Sudan** there was a limited outbreak in 2018 in which one district crossed the epidemic threshold. A total of 292 suspected cases and 41 deaths were reported in epidemic weeks 1–26. During epidemic weeks 3–9, 13 samples were collected from suspected cases and tested at the National Public Health Laboratory in Juba. Six of these were found to have been contaminated with *Streptococcus agalactiae* while the others were negative. Although *Streptococcus pneumoniae* was suspected as the causative pathogen, only one sample could be confirmed. Among confirmed cases in the meningitis belt overall up to 24 April 2018, 34% of cases were caused by *Streptococcus pneumoniae* while 25% were Nm-C and 24% Nm-X. These proportions differed by country, however.

Notable meningitis outbreaks occurred outside the meningitis belt in 2018. In **Liberia** a cluster of cases was detected in Lofa County, with 8 cases and 5 deaths from 5–21 January 2018. The pathogen was isolated from an oral swab and cardiac fluid sample and was identified as Nm-W using PCR. In **Fiji**, 87 cases and 5 deaths were reported from 1 January to 1 July (epidemic weeks 1–26), with the majority of cases in the country's Central and Western divisions. Of these, 27 were laboratory confirmed, and Nm-C was found to be the dominant pathogen (accounting for around 70% of cases) with some cases of Nm-B. Although this represents a notable increase in incidence compared with previous years, this event was considered non-acute.

Major challenges for meningitis control highlighted in 2018 (similar to previous years) included rapid dispersal and spread of infection, particularly in Nigeria, and limited laboratory capacity for case confirmation.

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