International Coordination Group for Oral Cholera Vaccine Provision

Report of the Annual Meeting

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Table of contents

List of abbreviations iv
Executive summary v
1. Epidemiological update 2016–2017 1
2. ICG response and performance 3
3. Vaccine supply, procurement and forecasting 4
4. Evaluation of the ICG 5
4.1 GAVI request for observer status 6
4.2 SAGE recommendations 6
5. Discussion 6
6. Action points 7
Annex 1. Agenda 9
Annex 2. List of participants 11

List of tables

Table 1. Cholera outbreaks 2016–2017 in AFRO, EMRO and PAHO 1
Table 2. Summary of requests received, responses and performance, 2016 3
Table 3. Summary of requests received, responses and performance, 2017 3
Table 4. Average days of ICG performance indicators 4

List of figures

Figure 1. Timeline for the ICG evaluation process 6

List of abbreviations

AFRO	WHO Regional Office for Africa
CFR	Confirmed fatality rate
EMRO	WHO Regional Office for the Eastern Mediterranean
GAVI	Gavi, the Vaccine Alliance
GTFCC	Global Task Force on Cholera Control
ICG	International Coordinating Group
MoU	Memorandum of understanding
MSF	Médecins sans Frontières
OCV	Oral cholera vaccine
PQ	Prequalification
SD	Supply Division of UNICEF
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization

Executive summary

The International Coordinating Group (ICG) on Oral Cholera Vaccine Provision held its annual meeting in Geneva from 11 to 12 July 2017. The aim of the meeting was for partners and stakeholders to: review relevant epidemic response activities and lessons learned during 2016 and 2017; discuss the anticipated stockpile size, composition and funding for the period 2018–2020; and exchange information with the extended group of ICG partners and stakeholders, including vaccine manufacturers.

Participants included representatives of the World Health Organization (WHO) headquarters (HQ), including ICG Secretariat, the WHO Regional Office for Africa (AFRO), the WHO Regional Office for the Eastern Mediterranean (EMRO), the Pan American Health Organization (PAHO), United Nations Children's Fund (UNICEF), with participants both from HQ and the Supply Division (SD), Médecins sans Frontières (MSF), and the International Federation of Red Cross and Red Crescent Societies (IFRC). Other participants included representatives of the Gavi, the Vaccine Alliance (GAVI), and a team of Hera consultants, which has been commissioned to evaluate the ICG.

Representatives of vaccine manufacturers also attended the second day of the meeting to present their plans for current and future vaccine production and supply.

Vaccine requests
Five requests were received from four countries during 2016, followed by eight requests from five countries in 2017. One request from South Sudan was withdrawn and one from Malawi was refused.

Vaccine responses
Between August 2016 and July 2017, a total of 8 541 656 doses of vaccine were requested and 5 134 750 were released.

As of 12 July 2017, the overall oral cholera vaccine (OCV) emergency stockpile comprises approximately 2.6 million doses.

1. Epidemiological update 2016–2017

The ICG secretariat, presented the current state of oral cholera vaccine (OCV) supply and demand.

While supply has been improving rapidly, it is still overtaken during large-scale demand, as has been the case most recently with Haiti, Malawi, South Sudan and Yemen. Although EU Biologics has confirmed it will improve supply with the introduction of plastic tube production, this is still under consideration by the prequalification (PQ) team. The ICG Secretariat now has two main suppliers, Shantha Biotechnics and EU Biologics, but more suppliers are needed, especially for more vaccine supplies.

In terms of demand, more countries are expressing interest in introducing OCV, but the lack of multi-year or long-term plans in most countries impedes the ability to effectively and confidently forecast for the medium-term. In terms of procurement, it has been agreed that there is a single stockpile with a guaranteed availability of a minimum of 2 million doses for use in an emergency. As far as shipments are concerned, there have been some delays due to in-country regulatory approvals and delivery logistics.

Table 1 shows suspected and confirmed cases, and deaths, during cholera outbreaks in 2016–2017.

Table 1. Cholera outbreaks 2016–2017 in AFRO, EMRO and PAHO

Country	Suspected/confirmed cases	Deaths (among confirmed cases)	Confirmed fatality rate (%)	Comment
Democratic Republic of Congo	43 073	1 200	2.83	Ethnic conflict led to population displacement Suspected cases in 20/26 provinces
Haiti	7 503	84	0.84*	(2017 figure. 2016 was 41 421
Kenya	581	7	1.2	10 counties reporting cases 19% cases laboratory confirmed
Somalia	54 994	808	1.5	Cases reported in 48 districts in 16 regions
Sudan	21 781	418	1.9	15/18 states affected
Yemen	300 000	1600	0.6	Suspected cases in 20/22 governorates

* In institutions.

By June 2017, the total number of reported cholera cases was 64 664 with 1465 deaths since the beginning of 2017 and an overall confirmed fatality rate (CFR) of 2.3%. A considerable number of cases and deaths have been reported in the Democratic Republic of Congo, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Sudan, the United Republic of Tanzania, and Zimbabwe.

In the **Democratic Republic of Congo**, the cumulative caseload for 2016–2017 is 43 073 cases, with 1220 deaths. Suspected cases have been reported in 20 of the country's 26 provinces. In 2016, there were 29 352 suspected cases and 817 deaths. A further 13 721 suspected cases were estimated by June 2017 with 403 deaths. During 2017, ethnic conflict has led to population displacement and resulted in a high number of suspected cholera cases. The epidemic continues to spread.

Cholera has been reported in 10 of **Kenya**'s counties, with five managing to control the outbreak. By 1 June 2017, a total of 581 cases had been reported with seven deaths. Of these, 19% were laboratory-confirmed cases. The understanding of the dynamics of the epidemic in the capital is hampered by insufficient information, as is the proper assessment of the risk of a major outbreak.

In **Somalia**, increased rainfall in early 2016 led to flooding and displacement, which in turn facilitated outbreaks of several diseases, including cholera and typhoid. In January 2017, the number of cases of cholera continued to rise in the south because of flood-related contaminated water sources, and in the central region because of the scarcity of water. A cumulative total of 53 015 cases and 795 deaths have been reported since the first week of the outbreak. One million people have been vaccinated, with the number of reported cases and deaths beginning to decrease.

In **Sudan**'s Blue Nile state, an outbreak that began in August 2016 had, by April 2017, spread rapidly throughout the country, with 15 out of 18 states affected. The White Nile is host to a large south Sudanese refugee population and has experienced the highest number of cases so far. By June 2017, there were 21 781 suspected cases and 418 deaths. The response has been limited, compounded by both an underfunded health system and inadequate water, sanitation and hygiene (WASH) facilities.