International Coordinating Group on Vaccine Provision for Cholera Control

Annual meeting

12 - 13 July 2016

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Abbreviations

CERF	Central Emergency Response Funds
DRC	Democratic Republic of Congo
EPI	Expanded Programme on Immunization
Gavi	The Global vaccine alliance
OCV	Oral Cholera Vaccine
ICG	International Coordinating Group on Vaccine Provision for Epidemic Cholera Control
IFRC	International Federation of Red Cross and Red Crescent
M	Million
MOH	Ministry of Health
MSF	Medecins sans Frontiers
PQ	Prequalified
PQT	WHO's Prequalification team
SAGE	Scientific Advisory Group of Experts for immunization
SD	(UNICEF) Supply Division
RF	Revolving Fund
UNICEF	United Nation Children's Emergency Fund
WASH	Water, Sanitation, and Hygiene
WCO	WHO Country Office
WHO	World Health Organization

Executive summary

On 12 and 13 July, the International Coordinating Group (ICG) for cholera vaccine provision (OCV) held its annual meeting to review the epidemic season, vaccine procurement and supply and define the vaccine needs for 2017 stockpile. The executive members of the ICG are the following organizations: International Federation of Red Cross and Red Crescent (IFRC), Medecins sans Frontiers (MSF), United Nation Children's Emergency Fund (UNICEF) and the World Health Organization (WHO). Discussion focused on the OCV ICG mechanism, including ICG process indicators, vaccine supply projections, role of the ICG for OCV in the coming years, reimbursement from Global Vaccine Alliance (Gavi) non-eligible countries. On the second day the focus of the discussion was on the vaccine demand and projected supply from the OCV vaccine manufacturers.

The stockpile consists of 2 million doses for the 2016 epidemic season. In 2015, a total of 3,142,671 Oral Cholera Vaccines (OCV) were requested, of which 1,654,345 doses were released to respond to six requests for vaccines. In 2016, a total of 1,065,693 OCV were requested, of which 1,065,785 doses were released to respond to six requests for vaccines. The average time between the ICG approving the request up to the vaccine arriving in the country was 14.4 days, which is longer than the seven days the ICG strives for. On average the vaccination started 9.5 days after reception of the vaccine within the country.

The main challenges identified by the ICG during the meeting include:

1. Delays in shipping and arrival of the vaccines after the ICG approval of the request (section 2)
2. Delay in the starting the vaccination campaign after arrival of the vaccine (Section 2)
3. Forecasting for outbreaks remains complicated (Section 3)
4. Reimbursement from Gavi non-eligible countries in to the Revolving Fund (Section 6)
5. Under reporting of cholera cases (Section 8)
6. Indicators used for review by Gavi are routine immunization focussed and not on outbreak response (Section 8)

The meeting concluded that there is good news in terms of supply: in the near future there will be a substantial increase of vaccine production capacity, however a stockpile will always remain necessary. A better understanding on the time line with manufacturers exists as well as a better supply forecast. In the next year a discussion on the future role of the ICG will be needed; once there is no shortage there might no longer be a need for the ICG. A discussion on the revolving fund is needed and the mechanism for reimbursement by Gavi non-eligible countries. The Zambia example where response with a one-dose reactive campaign was received as important for facilitating response and rapidly controlling an outbreak.

The ICG Members reached consensus that the forecast for 2017 will be two Million doses of OCV at a continuous level.

1 Epidemiological update

Preliminary figures from 2015 show a total of 163,000 cases reported. From all countries reporting cholera cases, the majority of cases were detected in Afghanistan and Haiti. There is no significant decline in the number of reported cholera cases; still a high number of cases were reported also in Mozambique, Somalia and Democratic Republic of Congo (DRC) as well as long, country wide outbreaks occurred in Tanzania and Kenya. In Haiti the 40,000 cases reported are considered an underestimation of the real number of cases, as most areas are quite remote and are either underreporting or not reporting at all. The under-reporting was also considered significant in South Asian countries where Bangladesh reported zero cases and India reported 889 cases and 4 deaths.

Country (year)	**Cases**	**Deaths**
DRC (2015)	19,125	271
DRC (2016)	10,229	216
Haiti	43,487	494
Iraq (suspected cases)	4,016	?
India	889	4
Kenya (2014 – 2016)	15,242	239
Somalia (2016)	9139	441
Tanzania (2015 – 2016)	21,696	341
Zambia (2016)	948	9

Table 1: overview of reported cholera cases

Annex I provides a graphic overview of the worldwide distribution of Cholera in 2015, by Country.

Vaccination campaigns were conducted in Iraq, Malawi, South Sudan, Zambia and Haiti. In the latter, Water, Sanitation, and Hygiene (WASH) interventions have been implemented.

Often it is easier to mobilize OCV for outbreak response or humanitarian crisis than it is for control of endemic cholera. In humanitarian crisis situations, it is well known that through preventive vaccination campaigns, outbreaks can be controlled. However, in endemic situations, showing the benefits of vaccination to prevent deaths is challenging since WASH activities are implemented at the same time.

Country experience - Iraq

In Iraq, using OCV was originally not part of the cholera preparedness and response plan. For both the Ministry of Health (MOH) and the WHO Country Office (WCO) time was needed before they accepted to implement OCV campaigns. Delays were encountered in the vaccine

arrival as the Iraqi National Regulatory Authority (NRA) was, from the start, not included in the discussions with the MOH and the vaccine was not licensed in the country.

Lessons learned from the campaign in Iraq include: 1) the department of Expanded Programme on Immunization (EPI) played a critical role in the implementation of the OCV campaign activities including social mobilization, cold-chain management and transportation; 2) the intensive social mobilization activities created high demand; 3) the availability of operational funds contributed to the timely implementation and higher coverage; and 4) OCV has become one of the cholera preparedness and response interventions.

Country experience - Zambia

Under the leadership of the MOH, a clear sharing of the responsibilities was defined; MSF focused on vaccination and the Monitoring & Evaluation. The MOH focussed on the standard response including surveillance, case management, WASH, and sensitisation. As a good collaboration existed between the partners, the arrival of the vaccine was well prepared and vaccination started the day after arrival of the vaccine. To ensure coverage of the adult male population, the areas where they usually gather were targeted. As not enough vaccines were available, a one dose OCV strategy was implemented providing a high protection for a short term.

MSF is currently trying to gather evidence that one dose is sufficient to stop an outbreak. This is part of their efforts to be more efficient in responding to outbreaks/emergencies. The study first started in 2015 in Juba and is extended to other areas, including to Zambia for this outbreak.. The preliminary findings showed significant effectiveness of 1 dose regimen, close to the two dose regimen, which could possibly provide a significant change in future cholera outbreak response.

2 ICG response and Performance

The number of doses indicated below for 2015 and 2016 include only vaccines shipped for humanitarian and outbreak response.

A total of 3,142,671 OCV were requested from **June to October 2015** of which 1,654,345 doses were shipped, as can be seen in table 2 below.

Country	Date	Vaccines requested	Approval (total/partial/ refused	Quantity shipped
# 6 Nepal	2 June	459,132	Not approved	0
#7 Tanzania	23 June	164,582	Approved	254,590
# 8 South Sudan	3 July	104,430	Not approved	0
#9 South Sudan	7 July	639,466	Partially approved	270,340
#10 South Sudan	22 July	66,755	Approved	66,780

Country	Date	Vaccines requested	Approval (total/partial/ refused	Quantity shipped
#11 Cameroon	23 July	116,344	Approved	116,375
#12 Iraq	4 October	510,000	Approved	510,020
Total		**3,142,671**		**1,654,345**

Table 2 – Vaccines requested and shipped for reporting period 2015

A total of 1,065,693 OCV were requested from **January to March 2016** of which 1,065,785 doses were shipped, as can be seen in table 3 below.

Country	Date	Vaccines requested	Approval (total/partial/ refused	Quantity shipped
#1 Niger	12 Jan	195,132	Approved	195,160
#2 Malawi	23 Jan	160,000	Approved	160,020
#3 Malawi	24 Feb	40,000	Approved	40,005
#4 Zambia	24 March	598,131	Approved	598,150
#5 South Sudan	22 March	72,430	Approved	72,450
Total		**1,065,693**		**1,065,785***

* difference is due to packaging

Table 3 - Vaccines requested and shipped for reporting period 2016

The main reasons for refusal of requested vaccines include:

- South Sudan # 8 : The Monitoring and Evaluation was not clearly defined
- Nepal # 6 - revised request: There was no evidence of increased risk for cholera post-earthquake, nor was there evidence of strong partner's involvement. The request for a loan was not approved either as there was a shortage of vaccine.

The average time between the ICG approving the request up to the vaccine arriving in the country was 14.4 days, which is longer than the seven days the ICG strives for (see Annex II). These delays have implications at country level for the launching of the vaccination campaign. The average time between the vaccine arriving in the country to the start of the vaccination