



International Coordination Group for Oral Cholera Vaccine Provision

Report of the Annual Meeting

Geneva

11–12 July 2017

© World Health Organization 2017

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. International Coordination Group for Oral Cholera Vaccine Provision. Report of the annual meeting, Geneva, 11–12 July 2017. Geneva: meeting report: World Health Organization; 2017 (WHO/WHE/IHM/2017.13). Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

This publication contains the report of the meeting of International Coordination Group for Oral Cholera Vaccine Provision and does not necessarily represent the decisions or policies of WHO.

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 |
| Haiti | 7 503 | 84 | 0.84* | Suspected cases in 20/26 provinces (2017 figure. 2016 was 41 421) |
| Kenya | 581 | 7 | 1.2 | 10 counties reporting cases |
| Somalia | 54 994 | 808 | 1.5 | 19% cases laboratory confirmed |
| Sudan | 21 781 | 418 | 1.9 | Cases reported in 48 districts in 16 regions |
| Yemen | 300 000 | 1600 | 0.6 | 15/18 states affected |
| | | | | 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.

预览已结束，完整报告链接和二维码如下：

https://www.yunbaogao.cn/report/index/report?reportId=5_26055

