

Vaccines for Africa: a “limited market”?



African leaders are gathering in Addis Ababa, Ethiopia, this week for the first ever Ministerial Conference on Vaccines in Africa. The event brings together government officials, including ministers of finance, technical experts, and policymakers, with the goal of advancing the coverage of life-saving immunisations across the continent.

There are many examples of highly successful African vaccination campaigns on which to base ongoing efforts. The most obvious recent campaign might be that against meningitis A: a disease that affected a quarter of a million people in 1996, killing 25 000 of them. 20 years later, the disease is all but eliminated from Africa's so-called meningitis belt—the 26 affected countries spanning the continent from Senegal in the west to Ethiopia in the east. Since the introduction of a conjugate vaccine (PsA-TT; MenAfriVac) in 2010, incidence has plummeted in all countries that have introduced it. In 2014 there were zero cases in vaccinated individuals. Work is continuing to ensure that these enormous gains—the result of well funded and externally organised mass vaccination campaigns—can be sustained by countries via their routine immunisation programmes. A special satellite meeting convened by the Meningitis Vaccine Project ahead of the ministerial conference aims to encourage and shape such plans.

The meningitis A story is unique in that it began not with the mere scale-up and affordable supply of an existing vaccine, but with the creation of a low-cost, bespoke vaccine specifically for the region. Yet more conventional, long-running programmes have seen progress equally worth celebrating. As of Feb 3, Africa had gone 4 months without any circulating vaccine-derived cases of poliomyelitis or any positive environmental sample (and 18 months without a case of wild poliovirus)—the longest time in its history. One of the key aims of the ministerial conference this week is to reflect on the lessons that polio vaccination campaigns in Africa, particularly Nigeria, can offer to other health programmes such as those aiming to improve antenatal care, routine vaccination rates, screening for malnutrition, and health education. It would be a travesty if the tremendous efforts made in terms of political leadership, accountability, equitable access, and community engagement were to dry up as

polio's need for them recedes. This effort to build on polio's legacy is therefore a crucial one.

Further successes, highlighted in this journal, include the introduction into routine immunisation schedules of pentavalent rotavirus vaccine in Rwanda and *Haemophilus influenzae* type b (Hib) vaccine in Kenya. These vaccines have led to substantial reductions in hospital admissions for non-bloody diarrhoea and invasive Hib disease, respectively. The need for continued surveillance is nevertheless critical, since waning immunity and adverse effects (notably intussusception with rotavirus vaccine) are very real concerns.

Another particularly pressing concern is the alarming rise in an unusual strain of *Neisseria meningitidis* serogroup C in Africa over recent years. The unique clone is genetically distant from all other known C strains and only appeared in 2013, making it unlikely to have arisen as a result of serogroup replacement after meningitis A vaccination. 10 cases were confirmed in 2013, in Niger and Nigeria. However, numbers quickly rose to 48 confirmed cases in 2014, and 1196 in 2015. As many as 11 000 cases were suspected last year, of whom 800 died. A shortage of vaccine hampered control efforts, prompting a multiagency warning about the potential for a much larger outbreak this year and a plea to vaccine manufacturers to expand stockpiles to 5 million by 2016. As we enter the 2016 meningitis season, the latest figures up to January 24 show 16 confirmed cases of meningitis C (13 in Niger, two in Ghana, and one in Burkina Faso) and only 4.2 million doses of vaccine available for the whole season, most of it only from March. WHO experts cite a “limited market” for the vaccine as a reason for the shortfall.

Again, we seem to be one step behind the microbes. In the case of the unprecedented explosion of Ebola and Zika viruses, the pharmaceutical industry's failure to have a vaccine prepared could perhaps be understood. Yet in the case of *N meningitidis*, one serogroup of which caused very recent devastation and another of which is threatening to do the same, the industry's stance seems shortsighted at best, and irresponsible at worst.

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For the **Ministerial Conference on Vaccines in Africa** see <http://immunizationin africa2016.org/>

For the **multiagency warning about meningitis C in Africa** see <http://www.who.int/mediacentre/news/releases/2015/meningitis-africa/en/>