1. Introduction

Rift Valley Fever (RVF) is a life-threatening disease of domestic ruminants and humans, included in OIE list as a notifiable and transmissible disease of serious socioeconomic impacts and public health concerns [1]. The causative agent is Rift Valley Fever virus (RVFV) that belongs to the family Bunyaviridae, genus Phlebovirus [2]. It was first reported among livestock in Kenya in 1931; since then it has been reported as occurring in most African countries [3].

The first appearance of RVF virus in new geographical areas outside Africa was reported in Jazan region, southwest Saudi Arabia, in 2000, with 886 confirmed cases involving 124 deaths in humans [4]. The socioeconomic impact of the RVF epidemics has been higher especially to populations that were totally dependent on livestock as source of income. Studies quantifying the socioeconomic impact of RVF outbreaks are lacking.

In Kenya, during 2006/2007 outbreak, the total economic losses from livestock mortality and potential milk production were calculated at over US$9.3 million and US$77,000, respectively. The negative impacts not only affect livestock producers, but also extend to various stakeholders in the marketing chain including livestock traders due to unsold animals during quarantine, slaughterhouses casual laborers, and butchers who were affected by imposition of slaughter bans during outbreaks [5].

As there is no specific treatment for RVF, vaccination of susceptible animals in endemic and high risk areas with safe and cost-effective vaccine during nonepidemic periods remains the only effective method to build sufficient immunity that is able to prevent virus amplification in livestock, break the cycle of transmission, and eliminate the main source of human infection [6].

Although several adverse
effects have been associated with vaccination including injection site reactions, systemic and allergic reactions, residual pathogenicity, and genetic recombination [7], the numerous advantages and the benefits derived have promoted the use of vaccines rather than chemotherapy. Apart from the fact that vaccination is the only available method to prevent viral infections in the absence of broad spectrum antiviral, they are mostly environmentally friendly and contribute indirectly to preventing drug resistance and pharmaceutical residues in food [8]. Furthermore, they have significant impacts not only on reducing losses or improving health and production, but also on human health through increasing safe food supplies and preventing zoonotic diseases [9].

A successful vaccination program depends on a proper selection of vaccine, as well as careful handling practices (in accordance with manufacturer’s instruction). Vaccine type and timing should be done according to the epidemiological aspect of targeted disease. Generally, live attenuated vaccines are more preferable to inactivated ones, since only a single dose is required to provide a long-term immunity. The live attenuated vaccines are recommended in endemic zones and considered the primary available option for controlling the disease in high risk areas during interepizootic period or in an outbreak early warning phase, while inactivated vaccines are advisable in free low risk zones and free high risk areas [10]. However, during an outbreak time of RVF, vector control, public education, quarantine, and slaughter ban probably are the most effective measures against the disease.

Obviously, the commercial production of RVF vaccines tends to be the biggest challenge, as the cost of sustained vaccination campaigns against RVF is beyond the capacity of most countries suffering regular outbreaks. Additionally, outbreaks of RVF usually occurred at irregular intervals and most commonly following exceptionally heavy rains. These events have led to refusing the annual vaccination during long interepizootic periods which in turn both decreases the demand for vaccines and prevents the manufacturers from maintaining strategic stocks due to limited shelf-life.

It could be argued that reliable information about vaccination in endemic zones is scarce. With the exception of Saudi Arabia, South Africa, and Egypt, all affected countries had not practiced routine vaccination (Table 1). In Egypt control of RVF was based on alternation between live and inactivated vaccines concurrent with periodical vector control. Live vaccine has been used at intermittent periods, before, during, or after outbreaks, in unidentified manner which might be a significant factor in disease persistence and maintaining endemicity of RVF in Egypt [14]. In Jazan region, southwest of Saudi Arabia, has had the hardest hit by the disease in 2000. 65.6% of animal cases occurred in Jazan, 26.9% in Asir, and 7.5% in AlQuenfeda. The infection rate was 23%, 8.7%, and 2% in Jazan, Asir, and AlQuenfeda, respectively [15]. Various control measures since then have been in place including sustaining vaccination campaigns, vector control, and surveillance system. Amazingly, the inactivated vaccine was used during the first three weeks of the outbreak despite the risk of RVFV transmission within and between herds through the reuse of needles during vaccination campaign. The inactivated vaccine subsequently was replaced with live attenuated vaccine (Smithburn strain) which has been used as the gold standard vaccine for several years and seems to play a significant role in control, as long as no clinical disease in humans and animals has been reported yet [16].

Currently, two main types of vaccines with different development techniques are available for immunization against RVF, including live attenuated vaccines and inactivated vaccines [17]. Attenuation of live vaccines was accomplished by in vitro passage through a series of cell cultures so as to produce a version of a virus attenuated to such a level unable to cause disease in animals, together with inducing a rapid onset of long lasting immune response similar to that of natural infection. Inactivation was obtained by growing the virus in culture media before treatment with heat or chemicals such as Formalin to destroy the ability of viruses to replicate [18]. Although inactivated vaccines are biologically safer, are more stable, and have no residual viruses or risk of reversion as attenuated vaccines [19], they are still known to be less protective and to need high antigenic mass and strong adjuvant to stimulate the immune system. Moreover, they continued to be associated with slow onset of immunity, local reactogenicity and residue, risk of incomplete inactivation, and hazards to personnel, as well as not being very efficient without multiple injections [20].

To date, there is no licensed vaccines against RVF available to immunize humans, while various strains for live-stock are now licensed and commercially produced including Smithburn vaccine, Formalin-Inactivated vaccine, and Clone13. These vaccines are produced by three different laboratories: Onderstepoort Biological Products limited (OBP) in South Africa, Kenya Veterinary Vaccine Producing Institute (KEVEVAPI), and Egypt’s Veterinary Serum and Vaccine Research Institute (EVSVRI) (Table 2).

**Table 1: Vaccination program in Africa and Arabian Peninsula [11].**

| Country     | Type of vaccine          | Vaccine schedule            | Historical outbreaks  |
|-------------|--------------------------|-----------------------------|-----------------------|
| Saudi Arabia| Live attenuated (Smithburn strain) | Annual vaccination          | 2000                  |
| South Africa| Live attenuated (Clone13) | Annual vaccination (high risk zones) | 1950, 1974, 1981, 1996, 1999, 2010 |
| Egypt       | Inactivated vaccine      | Biannual vaccination        | 1977, 1993, 1996, 2003 |
| Kenya and Tanzania | Live attenuated (Smithburn strain) | At outbreak warning       | 1931, 1936, 1968, 1978, 1997, 1951, 2006 |

**Aims of the Study.** This paper specifically aims to:

1. summarize commercially available RVF vaccines for veterinary use in Africa and Arabian peninsula,
2. highlight the safety-efficacy profile and drawbacks of these vaccines according to previous safety-efficacy trails.
Table 2: Commercially available vaccines against RVF [12].

| Commercial vaccine name               | Vaccine type   | Form       | Company                                | Adjuvant          | Packing                           | Instructed dose                     | Use in pregnant animals |
|----------------------------------------|----------------|------------|----------------------------------------|-------------------|-----------------------------------|-------------------------------------|------------------------|
| Rift Valley Fever (inactivated)        | Inactivated    | Liquid     | Onderstepoort Biological Products      | Aluminum hydroxide| Available in bottles of 100 mL    | Sheep and goats 1 mL s/c            | Yes                    |
| Rift Valley Fever (live)               | Live attenuated| Freeze-dried| Onderstepoort Biological Products      | No                | Available in bottles of 100 doses  | Cattle, sheep, and goats 1 mL s/c    | No                     |
| RVF Clone13                            | Live attenuated| Freeze-dried| Onderstepoort Biological Products      | No                | Available in bottles of 100 doses  | Cattle, sheep, and goats 1 mL s/c    | Yes                    |
| Rift Valley inactivated vaccine        | Inactivated (Zagazig H501 strain) | Liquid | Veterinary Serum and Vaccine Research Institute | Aluminum hydroxide | Available in bottles of 100 doses  | Sheep and goats 1 mL s/c            | Yes                    |
| RIFTVAX™                               | Live attenuated Smithburn strain | Freeze-dried | Kenya Veterinary Vaccine Producing Institute | No                | Available in bottles of 100 doses  | Cattle 2 mL s/c                   | No                     |
2. Method of Data Collection

A systematic review was conducted by searching Google Scholar (https://scholar.google.com/) and the National Library of Medicine's Medline database through PubMed (http://www.ncbi.nlm.nih.gov/sites/entrez/) up to March 15, 2016. The search terms “RVF” and “vaccine” were combined using the operators “AND” and “OR” to identify the original research articles describing the safety and efficacy profile of commercial veterinary vaccines against RVF. A total of 2691 articles were identified by searching Google Scholar and PubMed (2510, 109), respectively. The identified studies were screened on the basis of original research and its relevance to the aim of this review; in addition the full article should be published in English-language. Studies that did not meet inclusion criteria were excluded.

Of 2619 screened reports, 31 articles were finally selected on the basis of inclusion criteria to describe Smithburn vaccine (12 articles), inactivated vaccine (9 articles), and Clone13 (10 articles). Additional studies were obtained through citation tracking of review and original articles.

2.1. Smithburn Vaccine. Smithburn Vaccine Strain was derived from the virulent Entebbe strain, isolated from mosquitoes in Uganda and developed by serial passages in mouse brains to be able to induce immunity in ewes and their offspring after subcutaneous inoculation [21], currently produced in OBP and KEVEVAPI in freeze-dried form. The recommended dose is 1 mL of the reconstituted vaccine administered via subcutaneous route for the immunization of sheep and goats for OBP vaccine whereas cattle received 2 mL of RIFTVAX™ vaccine compared with 1 mL of Rift Valley Fever (Live) produced at OBP. According to manufacturer’s instructions, the vaccine can cause abortion or fetal malformation in a small percentage of animals, particularly sheep, as well as a slight febrile reaction that may occur on the second to fourth day following inoculation. Accordingly, the use should be restricted to nonpregnant animals above six months of age before or at the mating season so as to ensure maternal antibodies and to avoid abortion as well [22]. Despite these adverse outcomes, it has been widely used for many years as the major prevention measure as a cost-effective vaccine in most endemic zones, since the first introduction of the virus [23]. Likewise, in Jazan region, Saudi Arabia, it has been used as the gold standard vaccine for several years as a prevention measure, since 2000 outbreak. It has also been proved through serological surveys to be effective and highly beneficial in controlling infections, as no notable clinical signs in animals have been reported yet [24]. Published efficacy studies conducted in the same region in sheep and goats reported that the vaccine was highly immunogenic and able to induce long lasting antibodies, irrespective of variations among vaccine batches. The level of herd immunity induced by Smithburn Strain Vaccine significantly declined with elapse of years. The percentage of IgG positive animals declined from 95% to 66.7% after one year, and it would decline to zero after six years and eleven months [25]. This decline could be as the consequence of low sensitivity of ELISA test over time. The IgG sandwich ELISA was more sensitive and highly accurate in yearly diagnosis of infection or vaccination with RVF [26]. On the contrary, some safety and potency concerns associated with Smithburn vaccine. The vaccine neither was able to produce proper protective antibodies in all animal species particularly cows, nor was safe in immunocompromised animals and pregnant ones during gestation period leading to high rate of abortion [27]. Larger efficacy and safety study conducted to investigate antibody response to Smithburn vaccine in cattle reported that twenty-eight cows out of 120 pregnant cows and buffalos aborted within three days after vaccination. Moreover, the isolation of the virus from aborted fetus has proved in utero transmission of the vaccine virus [27]. Furthermore, the vaccine virus not only caused abortion and death of fetus at parturition, but also caused harmful changes in internal organs and propagated inside hepatic cells in a manner similar to natural infection [28].

2.2. Formalin-Inactivated Vaccine. The lyophilized vaccine containing 2% Human Serum Albumin was first prepared in African green Monkeys Kidney cell and proved to be safe, immunogenic, and highly resistant to thermal deterioration [29]. Commercially produced from OBP and EVSVRI, the virus strain was adapted for growth in baby hamster Kidney (BHK-21) cell, with aluminum hydroxide gel adjuvant for immunization of cattle, sheep, and goats, irrespective of the age and stage of pregnancy [12]. A safe version of inactivated vaccines with minor side effects named TSI-GSD 200 was developed in USA by using a new master seed of the Entebbe strain. The vaccine is neither licensed for use in human nor commercially available but has been used to protect personnel who either work in laboratories with RVFV or would be exposed to RVF infection, after receiving three doses on days 0, 7, and 28, to provide good long immunity with neutralizing antibody titers (1:140) [30]. The safety and efficacy profile of inactivated vaccines have been further investigated in several trials. The immunization of susceptible cattle, sheep, and goats with inactivated vaccine would induce higher neutralizing antibodies persisting for 9 month in cattle with evidence of protections against RVFV in pregnant ewes [31]. A comparative study conducted to assess the response in cattle to live and inactivated RVF vaccines revealed that a booster dose of inactivated vaccine after 3 months of the first vaccination was safe and able to evoke a good response sufficient to protect cattle against RVF for at least 1 year [32]. Further studies were conducted to evaluate the inactivated OBP vaccine as it is extremely difficult to maintain low temperatures during vaccine transportation. The vaccine was stored in different temperatures (4°C, 25°C) with alternation between 4°C and 25°C for a week. It was suggested that the vaccine was stable, well tolerated with mild or limited adverse reactions, and not adversely affected by variation in temperature during transportation and that induced long-term neutralizing antibodies may persist for 21 months after booster dose at any age and any stage of pregnancy [33, 34].

2.3. Clone13 Vaccine. Although, Formalin-Inactivated vaccine and live attenuated Smithburn vaccine are widely used in control, both of them were accompanied by significant
Table 3: Safety and efficacy profile of commercial vaccines against RFV [13].

| Commercial vaccine name | Safety profile | Persistence duration of antibodies | Cost |
|-------------------------|----------------|------------------------------------|------|
| Rift Valley Fever (live) | Cause abortion in pregnant ewes, Cause teratogenic effects, Cause significant level of viraemia, Risk of reversion to virulence | Long-term immunity, Single dose | Low price |
| RVF Clone13 | Safe in pregnancy, Very low viraemia, Risk of genetic reassortment, Restricted to endemic zones | Short shelf-life, Single dose, Long-term immunity | Low price |
| Rift Valley Fever (inactivated) | Safe in pregnancy, Can be used during outbreaks, Can be used in low risk zones | Booster dose is required, Annual revaccination, Not practical in routine vaccination | High cost |

Concerns. The first one requires multiple doses for protection, and the second has a risk of causing abortion and fetal malformation in pregnant animals [35]. Drawbacks of these vaccines stressed the need for alternative vaccines in terms of safety and efficacy. Consequently, a massive progress and several initiatives have been done for the evolution of modern vaccines. Recent studies have shown that RFV virus vaccines containing deletions of the NSs and NSm genes are highly attenuated, confer protective immunity with no detectable viremia, and could be useful in control of RFV virus in endemic regions, as well as allowing for DIVA [36]. The commercial OBP vaccine named (RVF Clone13) has recently been registered, marketed in a form of freeze-dried live attenuated virus (Clone13 strain), and extensively used in South Africa [37]. Clone13 is a naturally attenuated isolate of RFV virus with a large deletion in the S segment. It was cloned by plaque purification of nonfatal human case isolate (74HB59 strain), obtained during 1974 RFV outbreak in Central African Republic, and proved to be highly immunogenic leading to long-term immunity as well [38]. Published efficacy and safety studies of Clone13 vaccine have shown that the vaccine protects animals properly without inducing undesirable clinical signs, such as abortion in pregnant ewes, pyrexia, or fetal malformation in their offspring [39]. Recent efficacy and safety studies conducted in sheep and goats in Senegal stipulated that the vaccine was safe at stages of pregnancy and did not induce adverse effects. Additionally, more than 70% of the vaccinated sheep and goats showed that long-term seroconversion persisted for 1 year after vaccination [40]. However, some safety studies raised concerns about the possibility of genetic reassortant between S segment in Clone13 vaccine and virulent strains in field [41]. Furthermore, in a more recent study, it was reported that the vaccine virus is able to cross the ovine placental barrier and spread to the fetus resulting in malformations and stillbirths [42]. Remarkably, the vaccine has the potential to be used as DIVA vaccine for RFV, but the accompanying diagnostic tests are not yet commercially available [43].

Although the currently available commercial vaccines have made great contributions to RFV control over the past 80 years, they are associated with some safety and efficacy concerns, including, but not limited to, risk of abortion, pyrexia, fetal malformation, teratogenic effects, viraemia, risk of reassortment, short shelf-life, revaccination, and risk of incomplete inactivation in killed vaccines (Table 3). The gap in the safety and immunity explains the need for new promising candidates currently under development, such as subunit vaccines, virus vector, and replicons [44, 45]. The most prominent among these candidates is a recombinant Capripoxvirus (CPV) vaccine which was developed to protect against RFV as well as against sheep poxvoir infection. Promising results have been reported in Preclinical Stage trials including safety in pregnant ewes and offspring, stability of the vaccine, and its potential for DIVA [46].

3. Conclusion

To sum up, the study has come out with some important results which can be summarized as follows.

First, commercial vaccines currently available in the market are lacking safety and DIVA.

Second, live attenuated Smithburn was reported to cause abortion and fetal malformation in pregnant ewes.

Third, Formalin-Inactivated vaccine requires multiple doses or annual revaccination to provide protection which renders the vaccine not recommended in endemic zones.

Fourth, the safety of Clone13 during the first trimester of gestation remains controversial as it has been reported that the vaccine causes malformations and stillbirths.

Fifth, drawbacks of currently available vaccines stress the need for developing and bringing vaccine candidates to markets in near future to fill the gap in safety and immunogenicity.

Finally, validated serological test for DIVA should be considered in future researches.

Competing Interests

The author declares that they have no competing interests.
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