Center for Vaccine Ethics and Policy
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Vaccines: The Week in Review
25 May 2013
Center for Vaccine Ethics & Policy (CVEP)

This weekly summary targets news, events, announcements, articles and research in the global vaccine ethics and policy space and is aggregated from key governmental, NGO, international organization and industry sources, key peer-reviewed journals, and other media channels. This summary proceeds from the broad base of themes and issues monitored by the Center for Vaccine Ethics & Policy in its work: it is not intended to be exhaustive in its coverage. Vaccines: The Week in Review is also posted in pdf form and as a set of blog posts at http://centerforvaccineethicsandpolicy.wordpress.com/. This blog allows full-text searching of over 3,500 entries.

Comments and suggestions should be directed to
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UNICEF: Emergency measles vaccination campaign to protect 125,000 children in Central African Republic

UNICEF and its partners announced an emergency measles vaccination campaign in Bangui, the conflict-hit capital of the Central African Republic, after eight children tested positive for the disease in April. UNICEF said it is working with the Ministry of Health, WHO and NGO partners Merlin, IMC, ACF, PU-AMI and COOPI to reach 125, 000 children during the 22-26 May campaign. UNICEF noted that "recent fighting in the country has led to a breakdown of basic services and increased the risk of disease outbreaks in Bangui and across the country. This, along with poor living conditions, and a historically low vaccination rate for measles of 62 per cent, means that the lives of large numbers of children are now at risk from the disease."

UNICEF also said the campaign faces considerable challenges. "Secure humanitarian access to those in need remains difficult in CAR. Following the coup on 24 March 2013, the security situation continues to be tenuous as law and order have yet to be fully restored in the capital. Many regions remain difficult to reach because of violence and insecurity and will be even harder to access as the rainy season sets in. Despite this, UNICEF is working with partners on the ground to respond to the emergency that is either directly or indirectly affecting the entire population of 4.6 million." In preparation for the measles campaign, UNICEF said that 246,500 units of vaccine arrived in Bangui on 15 May, including 100,000 vaccines purchased by funds donated by the airline easyJet.

Full media release: http://www.unicef.org/media/media_69308.html

WHO: Global Alert and Response (GAR) – *Disease Outbreak News*

http://www.who.int/csr/don/2013_03_12/en/index.html

. Novel coronavirus infection - update (Middle East respiratory syndrome-coronavirus) – *update 23 May 2013*

Excerpt

23 May 2013 - The Ministry of Health in Saudi Arabia has notified WHO of an additional laboratory-confirmed case of infection with the Middle East respiratory syndrome coronavirus (MERS-CoV).

The fatal case was reported from Al-Qaseem region in the Central part of the country and is not related to the cluster of cases reported from Al-Ahsa region in the Eastern part of the country. The patient was a 63-year-old man with an underlying medical condition who was admitted to a hospital with acute respiratory distress on 15 May 2013 and died on 20 May 2013. Investigation into contacts of this case is ongoing.

The Saudi authorities are also continuing the investigation into the outbreak that began in a health care facility since the beginning of April 2013 in Al-Ahsa. To date, a total of 22 patients including 10 deaths have been reported from the outbreak.

Globally, from September 2012 to date, WHO has been informed of a total of 44 laboratory-confirmed cases of infection with MERS-CoV, including 22 deaths.

WHO has received reports of laboratory-confirmed cases from the following countries in the Middle East: Jordan, Qatar, Saudi Arabia, and the United Arab Emirates (UAE). France, Germany, Tunisia and the United Kingdom also reported laboratory-confirmed cases; they were either transferred for care of the disease or returned from Middle East and subsequently became ill. In France, Tunisia and the United Kingdom, there has been limited local transmission among close contacts who had not been to the Middle East but had been in close contact with the laboratory-confirmed or probable cases.

Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns.

Health care providers are advised to maintain vigilance. Recent travellers returning from the Middle East who develop SARI should be tested for MERS-CoV as advised in the current surveillance recommendations. Specimens from patients' lower respiratory tracts should be obtained for diagnosis where possible. Clinicians are reminded that MERS-CoV infection should be considered even with atypical signs and symptoms, such as diarrhoea, in patients who are immunocompromised…

http://www.who.int/csr/don/2013_05_23_ncov/en/index.html

. Wild poliovirus in the Horn of Africa – *22 May 2013*

Excerpt

22 May 2013 - The Horn of Africa is currently experiencing an outbreak of wild poliovirus type 1 (WPV1). A four-month-old girl near Dadaab, Kenya, developed symptoms of acute flaccid paralysis (AFP) on 30 April 2013. Two healthy contacts of the child tested positive for WPV1. They are the first laboratory confirmed cases in Kenya since July 2011. Investigation into this outbreak is ongoing. In addition, a case of WPV1 in Banadir, Somalia was confirmed on 9 May 2013.

In response to the outbreak, the first vaccination campaign, reaching 440 000 children began on 14 May 2013 in Somalia and a second round of vaccination is planned for 26 May 2013 in synchronization with the affected parts of Kenya.

The risk to neighbouring countries is deemed as very high, due to large-scale population movements across the Horn of Africa and persistent immunity gaps in some areas. Dadaab hosts a major refugee camp, housing nearly 500 000 persons from across the Horn of Africa.

An alert for enhanced surveillance for polio has been issued to all countries across the Horn of Africa, highlighting the need to conduct active searches for any suspected cases. All countries are urged to rapidly identify sub-national surveillance gaps and to take measures to fill the gaps.

In 2005, polio spread east across the African continent, and into Yemen and the Horn of Africa, resulting in over 700 cases. Since then, international outbreak responses have been adopted and new monovalent and bivalent oral polio vaccines have been developed, which can significantly reduce the severity and length of polio outbreaks.

Some areas of Somalia (south-central) are also affected by an outbreak due to circulating vaccine-derived poliovirus type 2 (cVDPV2), which has resulted in 18 cases in Somalia since 2009. In 2012, this strain spread to Dadaab, causing three cases.

WHO's International Travel and Health recommends that all travellers to and from polio-infected areas be fully vaccinated against polio…
http://www.who.int/csr/don/2013_05_22/en/index.html

Update: Polio this week - *As of 22 May 2013*

Global Polio Eradication Initiative
http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx
[Editor's extract and bolded text]

. A wild poliovirus type 1 (WPV1) case has been confirmed in Kenya, the first WPV in the country since July 2011, with onset of paralysis 30 April. The location is a refugee camp in the Dadaab area, close to the border with Somalia, where a child was paralysed by polio near the capital Mogadishu on 18 April. Outbreak response activities are being planned. See 'Horn of Africa' section for more.

Pakistan

. No new WPV cases were reported in the past week. The total number of WPV cases for 2013 remains eight. The most recent WPV case had onset of paralysis on 24 April (WPV1 from Federally Administered Tribal Areas – FATA).

. One new cVDPV2 case was reported in the past week (from North Waziristan, FATA), bringing the total number of cVDPV2 cases for 2013 to four. It is the most recent cVDPV2 case in the country and had onset of paralysis on 22 April.

. It is the second cVDPV2 case from North Waziristan, an area where immunizations have been suspended by local leaders since last June. To minimize the risk of a major outbreak in this area, it is critical that access to children is granted as quickly as possible. Immunizations in neighbouring high-risk areas are being intensified, to further boost population immunity levels in those areas and prevent further spread of this outbreak.

. Pakistan is also affected by transmission of WPV1, with eight cases this year (compared to 16 cases for the same period in 2012). Wild poliovirus type 3 (WPV3) has not been detected in the country in more than 12 months (since April 2012, from Khyber Agency, FATA).

. Confirmation of these latest cases underscores the risk which ongoing polio transmission (be it due to WPV or cVDPV) in the country continues to pose to children everywhere, and in particular to children living in areas where access has not been possible for extended periods of time.

. The security situation continues to be monitored closely, in consultation with law enforcement agencies. Immunization activities continue to be implemented, in some areas staggered or postponed, depending on the security situation at the local level.

Horn of Africa

. One new WPV case was reported in the past week (WPV1 from a refugee camp in Dadaab, north-eastern Kenya), with onset of paralysis on 30 April. It is the first WPV in Kenya since July 2011, and it follows last week's confirmation of a WPV1 case from Somalia (onset of paralysis 18 April).
. The child is a four-month-old girl. Two healthy contacts of the child tested positive for WPV1. Dadaab hosts several large refugee camps, housing nearly 500,000 people from across the Horn of Africa, including from Somalia.
. An emergency outbreak response is being planned, to reach nearly 440,000 children aged less than 15 years across Dadaab, beginning on 26 May, using bivalent OPV. Further campaigns are planned across a wider area, including parts of Nairobi, on 9 June, followed by large-scale subnational immunization days (SNIDs) in late June.
. In Somalia, an outbreak response immunization activity was held last week (14-16 May), to reach 350,000 children across Banadir region (including Mogadishu), with further activities across Banadir and other regions planned for 26-29 May and again in early June.
. Immunization campaigns are also planned in other areas of the Horn of Africa, notably Ethiopia and Yemen, to urgently boost population immunity levels and minimize the risk of spread of the outbreak. Countries across the Horn of Africa are at significant risk, due to large-scale population movements and persistent immunity gaps in some areas. In 2005, polio spread across the African continent, and into Yemen and the Horn of Africa, resulting in over 700 cases. The adoption of international outbreak response guidelines and the development of new vaccines since then, have – when fully implemented – considerably reduced the severity and duration of such outbreaks.

Sixty-sixth World Health Assembly
20–28 May 2013
Geneva
Daily notes on proceedings - *Editor's Excerpts*

Notes: Monday, 20 May 2013

World Health Assembly opens with focus on the Post Millennium Development Goals Agenda
The Sixty-sixth World Health Assembly opened this morning with the election of Dr Shigeru Omi, Special Assistant for International Affairs, Ministry of Health, Labour and Welfare of Japan, as its new president. Five vice-presidents were also appointed from Angola, Haiti, Nepal, Oman, and Ukraine, representing their respective regions.

. Last 1,000 days for MDGs and the path forward

In his message, which was read by Mr Kassym-Jomart Tokayev, Director-General of the United Nations Office in Geneva, UN Secretary-General Ban Ki-moon drew attention to the positive effect the Millennium Development Goals (MDGs) have had on the global health agenda. He noted that the Health Assembly will discuss a number of MDG-related issues, such as implementation of the Global Vaccine Action Plan and recommendations from the UN Commission on life-saving commodities for women and children. He described the pressing challenge presented by the rise in noncommunicable diseases, highlighting the role of universal health coverage in ensuring equitable access to health services. He emphasized the continuing need for WHO to handle unforeseen global health events, such as newly emerging viruses.

Dr Omi observed that reform of WHO, the topic of tomorrow's plenary discussion, aims to make the Organization more relevant, more effective and more dynamic.

Watch the President's speech on video
Streaming wmv, 00:12:44

. Opening address of the WHO Director-General

In her opening address, WHO Director-General Dr Margaret Chan reiterated the importance of transparent reporting and vigilance in disease outbreaks, including recent cases of novel coronavirus and influenza H7N9, whilst at the same time maintaining the momentum made in addressing long-standing health issues such as tuberculosis, HIV, malaria; the emerging problem of noncommunicable diseases; and eradication of polio.

Dr Chan reiterated WHO's refusal to work with the tobacco industry. However, she did not exclude the opportunity for cooperation with the food and beverage industry to address noncommunicable diseases, while supporting existing safeguards which ensure no conflicts of interest.

Read the Director-General's address to the Sixty-sixth World Health Assembly
Watch the Director-General's address
Streaming wmv, 00:31:48

66th WHA - Notes: Wednesday, 22 May 2013

. Accelerating achievement of health-related MDGs: The Global Fund New Funding Model, implications for country level cooperation and WHO's support

Technical briefing

Dr Margaret Chan, Director-General of WHO, applauded the contribution made by the Global Fund to Fight AIDS, Tuberculosis and Malaria to progress towards the MDGs at today's lunchtime technical briefing on the Fund's New Funding Model. Dr Mark Dybul, Executive Director of the Global Fund, explained that the new approach builds on three core principles: working as a financing institution that partners with others to serve countries; providing predictability around resource availability; and creating a platform for broader public health support.

Ministers of Health from El Salvador, Myanmar and Zimbabwe, all of whom have made proposals using the new funding model, welcomed the changes enthusiastically and commended support provided by WHO and other technical partners. Other speakers praised the Fund's closer alignment with country plans and willingness to provide more support for health systems as well as its readiness to learn from experience and to increase transparency.
http://www.who.int/mediacentre/events/2013/wha66/journal/en/index3.html

66th WHA - Notes: Thursday, 23 May 2013

. Implementation of the International Health Regulations (2005)

Item 15.1 - documents A66/16 and A66/16 Add.1

Before the item was undertaken, delegates requested an update from the WHO Secretariat and the Kingdom of Saudi Arabia on the recent emergence of MERS-CoV (previously known as Novel Coronavirus). The Secretariat and the Saudi Ministry of Health provided background information and a history of the emergence and response to the virus to date. The WHO presentation is attached. The discussion of the item will restart tomorrow.

Global overview of an emerging novel coronavirus
pdf, 741kb
Saudi Arabia's response to novel coronavirus
pdf, 993kb
Implementation of the International Health Regulations (2005) (A66/16)
pdf, 178kb

Implementation of the International Health Regulations (2005) (A66/16 Add.1)
http://www.who.int/mediacentre/events/2013/wha66/journal/en/index2.html

66th WHA - Notes: Friday, 24 May 2013

. Implementation of the International Health Regulations (2005)

Item 15.1 - document A66/16 and A66/16 Add.1

The newly identified H7N9 and MERS-CoV outbreaks lent even greater relevance to discussions on the International Health Regulations. Delegates voiced widespread support for the IHR and acknowledgement of WHO's role in assisting countries. The Director-General told delegates that WHO was committed to supporting countries affected by MERS-CoV and to helping "unpack the barriers" standing in the way of the full implementation of the IHR. She added newly emerging diseases are not just a country problem but a global problem and WHO and the IHR can help bring together "the assets of the world" to fight such threats. The Secretariat stressed the need for countries to provide the necessary resources to ensure IHR work can continue in countries and at WHO. Delegates noted a report updating progress in taking forward 15 recommendations that seek to further improve the effectiveness of the regulations. Countries that have not yet met their IHR obligations and are requesting an extension to the deadline beyond 2014, will be required to inform the WHO Director-General and explain why they have not been able to put IHR in place.

Implementation of the International Health Regulations (2005) (A66/16)
pdf, 177kb
Addendum (A66/16 Add.1)
pdf, 81.8kb

. Pandemic influenza preparedness: sharing of influenza viruses and access to vaccine and other benefits

Item 15.2 - document A66/17

This is the first annual report of the pandemic influenza preparedness (PIP) framework which delegates were agreed to note. The report covers three main areas: virus sharing, benefit sharing, and governance.

It was noted that many countries still lack basic capacities. Laboratory and disease surveillance were highlighted by some countries. A similar concern was highlighted on the regulation and deployment of influenza vaccines during a pandemic.

Lengthy negotiations to conclude binding SMTA2s (Standard Material Transfer Agreement 2) are ongoing. Delegates called for an acceleration on the processes to enable agreements to be signed.

Delegates emphasized the need for transparency related to use of partnership contribution funds.

Pandemic Influenza Preparedness Framework 2013 biennial report (A66/17)
pdf, 204Kb

. Poliomyelitis: intensification of the global eradication initiative

Item 15.3 - document A66/18

The World Health Assembly acknowledged the progress achieved in the past year in bringing polio to its lowest ever levels, thanks to actions of Member States in placing polio eradication on an emergency footing. Delegates endorsed the new Polio Eradication and Endgame Strategic Plan 2013-2018 to secure a lasting polio-free world and urged for its full implementation and financing.

At the same time, the Assembly received stark warning of the ongoing risk the disease poses to children everywhere, with confirmation of a new polio outbreak in the Horn of Africa (Somalia and Kenya)

Noting the generous pledges made to support polio eradication at the Global Vaccine Summit, delegates urged donors to rapidly convert these pledges into contributions. The WHA pointed out that this funding was critical for accelerated implementation of the Plan, given the complexity and scale of introducing inactivated polio vaccine worldwide.

Delegates condemned the deadly attacks on health workers in Pakistan (in December 2012) and Nigeria (in February 2013), and called on all governments to ensure the safety and security of frontline health workers.

Poliomyelitis: intensification of the global eradication initiative (A66/18)
pdf, 146kb
http://www.who.int/mediacentre/events/2013/wha66/journal/en/index1.html

66th WHA - Notes: Saturday, 25 May 2013
. Global Vaccine Action Plan
Item 16.1 - document A66/19

Member States reiterated their support to the Global Vaccine Action Plan (GVAP) to prevent millions of deaths by 2020 through more equitable access to vaccines for people in all communities, and for the proposed Framework for Monitoring, Evaluation and Accountability (which is linked to the Commission on Information and Accountability for Women's and Children's Health).

Delegates also supported the independent review process to assess and report progress and acknowledged the leadership demonstrated by the Strategic Advisory Group of Experts on immunization (SAGE) in this process. Speakers highlighted the need to mobilize greater resources to support low- and middle-income countries to implement the Plan and monitor impact; ensure that support to countries to implement the Plan includes a strong focus on strengthening routine immunization; and to facilitate vaccine technology transfer.

Global Vaccine Action Plan (A66/19)
pdf, 205kb
http://www.who.int/mediacentre/events/2013/wha66/journal/en/index.html

Speech and Response: *Harnessing the power of science and the private sector: a 21st century model for international development*
Dr Seth Berkley, CEO of the GAVI Alliance
Inaugural Lecture: Wellcome Trust - Cambridge Centre for Global Research University of Cambridge
2nd May 2013
Slides:
http://www.thrive.cam.ac.uk/thrive/Seth%20Berkley%20GAVI%20Cambridge%20Final%20slides.pdf
Video:
http://www.thrive.cam.ac.uk/thrive/GAVI%20CEO%20lecture%20in%20Cambridge%20(02052013)%20-%20%20540p.mp4

Video HD:
http://www.thrive.cam.ac.uk/thrive/GAVI%20CEO%20lecture%20in%20Cambridge%20(02052013)%20-%20high%20definition%20720p.mp4

"The world-leading flu expert, Professor Derek Smith (Director of the WHO Collaborating Centre for Modelling, Evolution and Control of Emerging Infectious Diseases at the University of Cambridge, and Co-PI for the WT-CCGHR) gave a great presentation in response to Dr Berkley's lecture, and that talk is also available on the video recording."
http://www.thrive.cam.ac.uk/

GAVI Coverage: Excerpt

"…In the lecture Dr Berkley explained how GAVI operates and why this is critical to ensuring it has a lasting impact. As a 21st Century development organisation, GAVI is an inclusive and diverse partnership bringing together the World Health Organization, UNICEF, and recipient and donor countries together with NGOs, vaccine manufacturers, technical research institutes and individuals with skills and commitment to immunise children.

"In the GAVI model, developing countries lead vaccine uptake and co-finance the cost of the vaccines they receive to ensure immunisation programmes are sustainable after GAVI support ends. With a Board structure drawn from a diverse range of sectors, GAVI seeks to inject private sector innovation into public health issues…"
http://www.gavialliance.org/library/news/gavi-features/2013/gavi-as-a-model-of-21st-century-development/#sthash.i5vwCgxh.dpuf

PATH CEO Steve Davis announced a pledge "…to work with partners to save the lives of two million children affected by pneumonia and diarrhea by the end of 2015." Mr. Davis said "PATH is in the business of providing the world—particularly many of the poorest parts of the world—with a set of tools so good health can be in reach of everyone. And we're here today to discuss these tools, and how PATH is thinking and acting differently to deploy them."
Webcast of the event
http://www.path.org/news/an130524-breakfast-webcast.php

IVI: Strategic Plan 2013-2017 Chart
pdf
VISION: Developing countries free of suffering from infectious disease
MISSION: Discover, develop, and deliver safe, effective, and affordable vaccines for the world's developing nations
GOALS: To ensure continued success in both vaccine sciences and public health, IVI's new strategic plan for 2013-2017 will focus its efforts around the following four goals:
. Accelerate the development and introduction of safe and effective vaccines (cholera, typhoid, dengue and other EDD);
. Discover and pursue proof of concept for new vaccine candidates, with a particular focus on new vaccines against enteric and diarrheal diseases;
. Advance science driving new achievements in vaccinology, specifically through conducting further research in vaccine-enhancing technology and understanding how the immune system works in response to vaccination;

. Contribute to building vaccine technology and systems capacity in developing countries. The chart includes specific goal level indictors.

The **Weekly Epidemiological Record (WER) for 24 May 2013**, vol. 88, 21 (pp. 217–224) includes:
- Building rotavirus laboratory capacity to support the Global Rotavirus Surveillance Network
- WHO Task Force on Immunization: call for nominations
http://www.who.int/entity/wer/2013/wer8821.pdf

WHO - Humanitarian Health Action
http://www.who.int/hac/en/index.html
-No new relevant updates published

UN Watch to 25 May 2013
Selected meetings, press releases, and press conferences relevant to immunization, vaccines, infectious diseases, etc. http://www.un.org/en/unpress/
-No new relevant content.

Reports/Research/Analysis/ Conferences/Meetings/Book Watch
Vaccines: The Week in Review has expanded its coverage of new reports, books, research and analysis published independent of the journal channel covered in Journal Watch below. Our interests span immunization and vaccines, as well as global public health, health governance, and associated themes. If you would like to suggest content to be included in this service, please contact David Curry at: david.r.curry@centerforvaccineethicsandpolicy.org

Meeting: ACIP (ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES)
June 19 - 20, 2013
Centers for Disease Control and Prevention
Atlanta, Georgia
Meeting Agenda/Draft at 21 May 2013:
http://www.cdc.gov/vaccines/acip/meetings/downloads/agenda-archive/agenda-2013-06.pdf
Agenda topics:
- Japanese Encephalitis Vaccine
- General Recommendations on Immunization
- Pertussis Vaccines
- Human Papillomavirus (HPV) Vaccine
- Rotavirus Vaccines: Update on Intussusception
- The Role of Retail Pharmacies/Pharmacists in Vaccine Delivery in the United States
- Vaccine Supply
- Herpes Zoster Vaccine
- Influenza

Meeting: "Cooperation Among First-to-Introduce Countries for Dengue Vaccines 2013 Meeting"
Dengue Vaccine Initiative (DVI); Hosted by the Ministry of Health of Brazil
April 9-11, 2013
Brasilia, Brazil

The meeting had three main objectives: 1) For developers to present status and timelines of dengue vaccine candidates under development; 2) For countries to present epidemiology data and points to consider for dengue vaccine introduction; and 3) For first-to-introduce countries to find mechanisms for collaboration in preparing introduction of dengue vaccines. Participating countries included Colombia, Indonesia, Mexico, Thailand, Malaysia and the Philippines, in addition to Brazil.

The meeting led to the identification of several areas for collaboration between countries and DVI: surveillance, regulatory pathways, modeling, strategic demand forecasting, financing, and communications. Specific examples of follow-on collaborations were: 1) In collaboration with WHO and WHO regional offices, to standardize dengue surveillance; 2) To implement regulatory support activities such as access to knowledge and literature on dengue and dengue vaccines, facilitation of inter-agency collaborations for evaluation of dengue vaccines, National Regulatory Agency and National Immunization Technical Advisory Group coordination; 3) The application of a computer model to design the potentially most effective immunization strategies; 4) The preparation of demand forecasts that can take into account the potential limited supply; 5) The identification of resources to support the costs of the vaccine and its distribution; and 6) The development of accurate and informative communication messages to prepare communities for vaccine introduction.

The countries will meet again in October in Thailand to discuss collaborative activities to be undertaken in preparation for a dengue vaccine introduction. The meeting will be held in conjunction with the Third International Conference on Dengue and Dengue Haemorrhagic Fever, "Global Dengue: Challenges and Promises", which meets in Bangkok from the 21st to the 23rd of October.

Agenda and slide presentations: http://www.denguevaccines.org/news-events/cooperation-among-first-introduce-countries-dengue-vaccines-2013-meeting

Journal Watch

Vaccines: The Week in Review continues its weekly scanning of key peer-reviewed journals to identify and cite articles, commentary and editorials, books reviews and other content supporting our focus on vaccine ethics and policy. ***Journal Watch*** **is not intended to be exhaustive, but indicative of themes and issues the Center is actively tracking.** We selectively provide full text of some editorial and comment articles that are specifically relevant to our work. Successful access to some of the links provided may require subscription or other access arrangement unique to the publisher.

If you would like to suggest other journal titles to include in this service, please contact David Curry at: david.r.curry@centerforvaccineethicsandpolicy.org

American Journal of Infection Control

Vol 41 | No. 5 | May 2013 | Pages 389-480
http://www.ajicjournal.org/current
[Reviewed earlier]

American Journal of Public Health
Volume 103, Issue 6 (June 2013)
http://ajph.aphapublications.org/toc/ajph/current
[Reviewed earlier]

Annals of Internal Medicine
21 May 2013, Vol. 158. No. 10
http://www.annals.org/content/current
[No relevant content]

BMC Public Health
(Accessed 25 May 2013)
http://www.biomedcentral.com/bmcpublichealth/content
Research article
Using HPV vaccination for promotion of an adolescent package of care: opportunity and perspectives
Catherine MacPhail, Emilie Venables, Helen Rees and Sinead Delany-Moretlwe
Abstract (provisional)
Background
Adolescents are a difficult population to access for preventive health care, particularly in less resourced countries. Evidence from developed countries indicates that the HPV vaccine schedule may be a useful platform from which to deliver other adolescent health care services. We conducted a qualitative cross sectional study to assess the potential for using the HPV vaccine in the South African public health care system as an opportunity for integrated health care services for adolescents.
Methods
Parents, young adolescents, community members and key informants participated in interviews and focus group discussions about feasibility and acceptability, particularly the use of the HPV vaccination as the basis for an integrated adolescent package of care. Health care providers in both provinces participated in focus group discussions and completed a pairwise ranking exercise to compare and prioritise interventions for inclusion in an adolescent package of care.
Results
Participants were in favour of integration and showed preference for detailed information about the HPV vaccine, general health information and specific sexual and reproductive health information. Among health care workers, results differed markedly by location. In North West, prioritisation was given to information, screening and referral for tobacco and alcohol abuse, and screening for hearing and vision. In Gauteng integration with referral for male circumcision, and information, screening and referral for child abuse were ranked most highly.
Conclusions
There is generally support for the delivery of adolescent preventive health services. Despite national priorities to address adolescent health needs, our data suggest that national policies

might not always be appropriate for vastly different local situations. While decisions about interventions to include have traditionally been made at country level, our results suggest that local context needs to be taken account of. We suggest low resource strategies for ensuring that national policies are introduced at local level in a manner that addresses local priorities, context and resource availability.
http://www.biomedcentral.com/1471-2458/13/493/abstract
The complete article is available as a provisional PDF. The fully formatted PDF and HTML versions are in production.

British Medical Bulletin
Volume 105 Issue 1 March 2013
http://bmb.oxfordjournals.org/content/current
[Reviewed earlier]

British Medical Journal
25 May 2013 (Vol 346, Issue 7909)
http://www.bmj.com/content/346/7909
[No relevant content]

Bulletin of the World Health Organization
Volume 91, Number 5, May 2013, 313-388
http://www.who.int/bulletin/volumes/91/5/en/index.html
[Reviewed earlier]

Clinical Therapeutics
Vol 35 | No. 5 | May 2013 | Pages 541-744
http://www.clinicaltherapeutics.com/current
[No relevant content]

Cost Effectiveness and Resource Allocation
(Accessed 25 May 2013)
http://www.resource-allocation.com/
[No new relevant content]

Current Opinion in Infectious Diseases.
June 2013 - Volume 26 - Issue 3 pp: v-v,213-293
http://journals.lww.com/co-infectiousdiseases/pages/currenttoc.aspx
[Reviewed earlier]

Development in Practice
Volume 23, Issue 3, 2013

http://www.tandfonline.com/toc/cdip20/current
[Reviewed earlier; No relevant content]

Emerging Infectious Diseases
Volume 19, Number 6—June 2013
http://www.cdc.gov/ncidod/EID/index.htm

Perspective

Prospects for Emerging Infections in East and Southeast Asia 10 Years after Severe Acute Respiratory Syndrome

P. Horby et al.
http://wwwnc.cdc.gov/eid/article/19/6/pdfs/12-1783.pdf

Abstract
It is 10 years since severe acute respiratory syndrome (SARS) emerged, and East and Southeast Asia retain a reputation as a hot spot of emerging infectious diseases. The region is certainly a hot spot of socioeconomic and environmental change, and although some changes (e.g., urbanization and agricultural intensification) may reduce the probability of emerging infectious diseases, the effect of any individual emergence event may be increased by the greater concentration and connectivity of livestock, persons, and products. The region is now better able to detect and respond to emerging infectious diseases than it was a decade ago, but the tools and methods to produce sufficiently refined assessments of the risks of disease emergence are still lacking. Given the continued scale and pace of change in East and Southeast Asia, it is vital that capabilities for predicting, identifying, and controlling biologic threats do not stagnate as the memory of SARS fades.

Perspective

Public Health Lessons from Severe Acute Respiratory Syndrome a Decade Later

J. P. Koplan et al.
http://wwwnc.cdc.gov/eid/article/19/6/pdfs/12-1426.pdf

Abstract
The outbreak of severe acute respiratory syndrome in 2002–2003 exacted considerable human and economic costs from countries involved. It also exposed major weaknesses in several of these countries in coping with an outbreak of a newly emerged infectious disease. In the 10 years since the outbreak, in addition to the increase in knowledge of the biology and epidemiology of this disease, a major lesson learned is the value of having a national public health institute that is prepared to control disease outbreaks and designed to coordinate a national response and assist localities in their responses.

Letter

Wild Poliovirus Importation, Central African Republic

Excerpt
To the Editor: Since the Global Polio Eradication Initiative was launched in 1988, indigenous transmission of wild poliovirus (WPV) has been interrupted in all countries except Afghanistan, Pakistan, and Nigeria (1). However, during 2003–2011, outbreaks resulting from importation of WPV occurred in 29 previously polio-free countries in Africa, including Central African Republic (CAR) (1–3). In 2011, 350 WPV cases were reported from 12 countries in Africa, a 47% decrease from the 657 cases reported by 12 countries in Africa in 2010 (1).
In CAR, the last case of poliomyelitis caused by indigenous transmission of wild poliovirus was reported in 2000, but importation of WPV type 1 has been reported (4). We describe the importation of WPV1 and WPV3 into CAR during successive events in 2008, 2009, and 2011…

http://wwwnc.cdc.gov/eid/article/19/6/pdfs/12-1821.pdf

Eurosurveillance
Volume 18, Issue 21, 23 May 2013
http://www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationId=11678
Rapid communications
Ongoing outbreak of rubella among young male adults in Poland: increased risk of congenital rubella infections
by I Paradowska-Stankiewicz, MP Czarkowski, T Derrough, P Stefanoff
Detection on four continents of dengue fever cases related to an ongoing outbreak in Luanda, Angola, March to May 2013
by E Schwartz, E Meltzer, M Mendelson, A Tooke, F Steiner, P Gautret, B Friedrich-Jaenicke, M Libman, H Bin, A Wilder-Smith, DJ Gubler, DO Freedman, P Parola

Forum for Development Studies
Volume 40, Issue 2, 2013
http://www.tandfonline.com/toc/sfds20/current
[No relevant content]

Global Health Governance
Volume VI, Issue 1: Fall 2012
– December 31, 2012
[Reviewed earlier]

Globalization and Health
[Accessed 25 May 2013]
http://www.globalizationandhealth.com/
[No new relevant content]

Health Affairs
May 2013; Volume 32, Issue 5
http://content.healthaffairs.org/content/current
Theme: *Tackling The Cost Conundrum*
[No specific relevant content on vaccines/immunization]

Health and Human Rights
Vol 14, No 2 (2012)
http://hhrjournal.org/index.php/hhr
[Reviewed earlier]

Health Economics, Policy and Law

Volume 8 - Issue 02 - April 2013
http://journals.cambridge.org/action/displayIssue?jid=HEP&tab=currentissue
[Reviewed earlier]

Health Policy and Planning
Volume 28 Issue 3 May 2013
http://heapol.oxfordjournals.org/content/current
[Reviewed earlier]

Human Vaccines & Immunotherapeutics (formerly Human Vaccines)
Volume 9, Issue 5 May 2013
http://www.landesbioscience.com/journals/vaccines/toc/volume/9/issue/5/
[Reviewed earlier]

Infectious Diseases of Poverty
http://www.idpjournal.com/content
[Accessed 25 May 2013]
[No new relevant content]

International Journal of Epidemiology
Volume 42 Issue 2 April 2013
http://ije.oxfordjournals.org/content/current
[Reviewed earlier]

International Journal of Infectious Diseases
Vol 17 | No. 7 | July 2013
http://www.ijidonline.com/current
[Reviewed earlier]

JAMA
May 22, 2013, Vol 309, No. 20
http://jama.ama-assn.org/current.dtl
[No relevant content]

JAMA Pediatrics
May 2013, Vol 167, No. 5
http://archpedi.jamanetwork.com/issue.aspx
[Reviewed earlier; No relevant content]

Journal of Community Health

Volume 38, Issue 3, June 2013
http://link.springer.com/journal/10900/38/3/page/1
[Reviewed earlier]

Journal of Health Organization and Management
Volume 27 issue 3
http://www.emeraldinsight.com/journals.htm?issn=1477-7266&show=latest
[Reviewed earlier; No relevant content]

Journal of Infectious Diseases
Volume 207 Issue 12 June 15, 2013
http://jid.oxfordjournals.org/content/current
[Reviewed earlier; No relevant content]

Journal of Global Infectious Diseases (JGID)
April-June 2013 Volume 5 | Issue 2 Page Nos. 43-90
http://www.jgid.org/currentissue.asp?sabs=n
[No relevant content]

Journal of Medical Ethics
June 2013, Volume 39, Issue 6
http://jme.bmj.com/content/current
Brief report
Comprehension of a simplified assent form in a vaccine trial for adolescents
Sonia Lee, Bill G Kapogiannis, Patricia M Flynn, Bret J Rudy, James Bethel, Sushma Ahmad, Diane Tucker, Sue Ellen Abdalian, Dannie Hoffman, Craig M Wilson, Coleen K Cunningham, Adolescent Medicine Trials Network for HIV/AIDS Interventions (ATN
Abstract
Introduction
Future HIV vaccine efficacy trials with adolescents will need to ensure that participants comprehend study concepts in order to confer true informed assent. A Hepatitis B vaccine trial with adolescents offers valuable opportunity to test youth understanding of vaccine trial requirements in general.
Methods
Youth reviewed a simplified assent form with study investigators and then completed a comprehension questionnaire. Once enrolled, all youth were tested for HIV and confirmed to be HIV-negative.
Results
123 youth completed the questionnaire (mean age=15 years; 63% male; 70% Hispanic). Overall, only 69 (56%) youth answered all six questions correctly.
Conclusions
Youth enrolled in a Hepatitis B vaccine trial demonstrated variable comprehension of the study design and various methodological concepts, such as treatment group masking.
http://jme.bmj.com/content/39/6/410.abstract

Journal of Medical Microbiology
June 2013; 62 (Pt 6)
http://jmm.sgmjournals.org/content/current
[Reviewed earlier; No relevant content]

Journal of the Pediatric Infectious Diseases Society (JPIDS)
Volume 2 Issue 2 June 2013
http://jpids.oxfordjournals.org/content/current
Measles Outbreak Associated With International Travel, Indiana, 2011
J Ped Infect Dis (2013) 2(2): 110-118 doi:10.1093/jpids/pis132
Melissa G. Collier, Angela Cierzniewski, Thomas Duszynski, Cheryl Munson, Mona Wenger, Brad Beard, Ryan Gentry, Joan Duwve, Preeta K. Kutty, and Pamela Pontones
Abstract
Background
Endemic measles was declared eliminated in the United States in 2000, but imported measles cases continue to cause outbreaks. On June 20, 2011, 5 epidemiologically linked measles cases were reported to the Indiana State Department of Health. We investigated to identify additional cases and to prevent further spread.
Methods
Case findings and contact investigations during the June 3, 2011–August 13, 2011 outbreak identified measles cases, exposed persons, and exposure settings. Laboratory confirmation included measles serology and reverse-transcription polymerase chain reaction. Control measures included evaluating measles immune status and providing post-exposure prophylaxis, isolation, and quarantine.
Results
Fourteen confirmed measles illnesses were identified (10 [71%] females; median age, 11.5 years [range, 15 months–27 years]). The source patient was an unvaccinated US resident who recently traveled from Indonesia. Twelve patients were unvaccinated members of the source patient's extended family. Two hospitalizations and no deaths were reported. Among 868 exposed persons identified through contact investigation, 644 (74%) had documented measles immunity, 153 (18%) were lost to follow-up, and 71 (8%) lacked evidence of immunity.
Conclusions
Misdiagnosis of measles in an unvaccinated patient with recent travel history to a measles-endemic region resulted in the second largest measles outbreak in the United States during 2011. Clinicians should consider measles among patients presenting with febrile rash illness and history of recent travel, and clinicians should promptly report suspected illnesses. Early identification of infectious patients, rapid public health investigation, and maintenance of high vaccine coverage are critical for the prevention and control of measles outbreaks.
http://jpids.oxfordjournals.org/content/2/2/110.abstract

Journal of Pediatrics
Vol 162 | No. 6 | June 2013 | Pages 1087-1298
http://www.jpeds.com/
Generalists' role in vaccine safety reporting

Thomas R. Welch, MD
Every pediatrician involved in the day-to-day process of administering vaccines is aware of how fraught with complexity it has become. On one hand, many pediatricians have seen in their professional lifetimes the virtual disappearance of once-feared childhood disorders. On the other hand, unwarranted concerns about vaccine safety are leaving more and more children unprotected.
http://www.jpeds.com/article/S0022-3476%2813%2900440-X/preview

Comprehensive Assessment of Serious Adverse Events Following Immunization by Health Care Providers

S. Elizabeth Williams, Kathryn M. Edwards, MD, Roger P. Baxter, MD, Philip S. LaRussa, MD, Neal A. Halsey, MD, Cornelia L. Dekker, MD, Claudia Vellozzi, MD, MPH, Colin D. Marchant, MD, Peter D. Donofrio, MD, Tyler E. Reimschisel, MD, Melvin Berger, MD, Jane F. Gidudu, MD, Nicola P. Klein, MD, PhD

Abstract

Many events occurring after vaccination have been attributed to vaccines, when in fact the association was often due to chance.1 However, as with any medical intervention, there are times when adverse events are caused by immunizations.2 Distinguishing which events are causally related to vaccine, rather than coincidental events, is a challenge for the pediatrician and a major focus of vaccine safety science. Consider a child who presents with aseptic meningitis after immunization. Because of the temporal relationship, one may suspect the immunizations as the cause, yet subsequent isolation of enterovirus from cerebrospinal fluid implicates the enteroviral infection instead.3 The term adverse event following immunization (AEFI) is defined as any untoward event that occurs after immunization, regardless of causal association.4 AEFI is the preferred notation to describe such clinical events because the term is free from implications regarding causal relationship and favors an open mind about the role of immunizations. AEFIs are a common part of routine clinical practice. The Clinical Immunization Safety Assessment (CISA) network has reviewed many individual cases of AEFIs and found that when a comprehensive investigation for alternative etiologies of the AEFI is completed, other causes for the event can often be identified. Yet, such comprehensive evaluations are rarely performed.8 We describe a stepwise approach to the comprehensive assessment of serious AEFIs by health care providers. The main objective is to highlight the important role that health care providers play in this effort by actively evaluating for the most likely causes of serious events when they occur after immunization.
http://www.jpeds.com/article/S0022-3476%2813%2900062-0/preview

Journal of Virology
June 2013, volume 87, issue 11
http://jvi.asm.org/content/current
[Reviewed earlier; No relevant content]

The Lancet
May 25, 2013 Volume 381 Number 9880 p1789 - 1876
http://www.thelancet.com/journals/lancet/issue/current

Book: Polio revisited
Review by Paul Offit
Preview

Contrary to the signature opening of the television series Star Trek, Gareth Williams, professor of medicine at Bristol University in the UK, has decided to boldly go where many men and women have gone before. Like Richard Carter in Breakthrough, or Tony Gould in A Summer Plague, or Aaron Klein in Trial by Fury, or John Paul in A History of Poliomyelitis, or Naomi Rogers in Dirt and Disease, or Jane Smith in Patenting the Sun, or John Wilson in Margin of Safety, or Nina Seavey in A Paralyzing Fear, or, most notably, David Oshinsky in his Pulitzer-Prize-winning, Polio: An American Story, Williams has written a book about polio and the polio vaccine.

The Lancet Infectious Diseases
Jun 2013 Volume 13 Number 6 p465 - 558
http://www.thelancet.com/journals/laninf/issue/current

Editorial

A proportionate response to H7N9

The Lancet Infectious Diseases

Preview

Since Chinese authorities first reported on March 31, 2013, the emergence of a new form of influenza A virus—H7N9—causing human disease, there has been speculation as to whether this virus will be the agent of the next influenza pandemic. The H1N1 pandemic of 2009–10 was milder and caused far fewer deaths than were predicted when that virus first emerged. As a consequence, there is understandable scepticism when health authorities warn that the next pandemic might be just around the corner. However, given the severity of illness caused by H7N9 and its high case-fatality rate, a way must be found between vigilance and fear-mongering.

Comment

AS03-adjuvanted influenza vaccine in elderly people

Julie E Ledgerwood

Preview

The best available method for prevention of influenza is vaccination. However, the effectiveness of inactivated trivalent influenza vaccine (TIV) is variable, generally reaching 60% in the overall population when vaccine strains and outbreak strains are well matched.1 Even with available licensed vaccines, up to 15% of the world's population become infected with influenza every year, with as many as 5 million cases of severe illness and 500 000 deaths.2 In developed countries, most influenza deaths occur in elderly people, and, depending on the endpoint assessed, TIV effectiveness is as low as 9% in this population.

Articles

AS03-adjuvanted versus non-adjuvanted inactivated trivalent influenza vaccine against seasonal influenza in elderly people: a phase 3 randomised trial

Janet E McElhaney, Jiri Beran, Jeanne-Marie Devaster, Meral Esen, Odile Launay, Geert Leroux-Roels, Guillermo M Ruiz-Palacios, Gerrit A van Essen, Adrian Caplanusi, Carine Claeys, Christelle Durand, Xavier Duval, Mohamed El Idrissi, Ann R Falsey, Gregory Feldman, Sharon E Frey, Florence Galtier, Shinn-Jang Hwang, Bruce L Innis, Martina Kovac, Peter Kremsner, Shelly McNeil, Andrzej Nowakowski, Jan Hendrik Richardus, Andrew Trofa, Lidia Oostvogels, for the Influence65 study group

http://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2813%2970046-X/abstract

Summary

Background

We aimed to compare AS03-adjuvanted inactivated trivalent influenza vaccine (TIV) with non-adjuvanted TIV for seasonal influenza prevention in elderly people.
Methods
We did a randomised trial in 15 countries worldwide during the 2008—09 (year 1) and 2009—10 (year 2) influenza seasons. Eligible participants aged at least 65 years who were not in hospital or bedridden and were without acute illness were randomly assigned (1:1) to receive either AS03-adjuvanted TIV or non-adjuvanted TIV. Randomisation was done in an internet-based system, with a blocking scheme and stratification by age (65—74 years and 75 years or older). Participants were scheduled to receive one vaccine in each year, and remained in the same group in years 1 and 2. Unmasked personnel prepared and gave the vaccines, but participants and individuals assessing any study endpoint were masked. The coprimary objectives were to assess the relative efficacy of the vaccines and lot-to-lot consistency of the AS03-adjuvanted TIV (to be reported elsewhere). For the first objective, the primary endpoint was relative efficacy of the vaccines for prevention of influenza A (excluding A H1N1 pdm09) or B, or both, that was confirmed by PCR analysis in year 1 (lower limit of two-sided 95% CI had to be greater than zero to establish superiority). From Nov 15, to April 30, in both years, participants were monitored by telephone or site contact and home visits every week or 2 weeks to identify cases of influenza-like illness. After onset of suspected cases, we obtained nasal and throat swabs to identify influenza RNA with real-time PCR. Efficacy analyses were done per protocol. This trial is registered with ClinicalTrials.gov, number NCT00753272.
Findings
We enrolled 43 802 participants, of whom 21 893 were assigned to and received the AS03-adjuvanted TIV and 21 802 the non-adjuvanted TIV in year 1. In the year 1 efficacy cohort, fewer participants given AS03-adjuvanted than non-adjuvanted TIV were infected with influenza A or B, or both (274 [1·27%, 95% CI 1·12—1·43] of 21 573 vs 310 [1·44%, 1·29—1·61] of 21 482; relative efficacy 12·11%, 95% CI −3·40 to 25·29; superiority not established). Fewer participants in the year 1 efficacy cohort given AS03-adjuvanted TIV than non-adjuvanted TIV were infected with influenza A (224 [1·04%, 95% CI 0·91—1·18] vs 270 [1·26, 1·11—1·41]; relative efficacy 17·53%, 95% CI 1·55—30·92) and influenza A H3N2 (170 [0·79, 0·67—0·92] vs 205 [0·95, 0·83—1·09]; post-hoc analysis relative efficacy 22·0%, 95% CI 5·68—35·49).
Interpretation
AS03-adjuvanted TIV has a higher efficacy for prevention of some subtypes of influenza than does a non-adjuvanted TIV. Future influenza vaccine studies in elderly people should be based on subtype or lineage-specific endpoints.
Funding
GlaxoSmithKline Biologicals SA.

Medical Decision Making (MDM)
May 2013; 33 (4)
http://mdm.sagepub.com/content/current
[Reviewed earlier]

The Milbank Quarterly
A Multidisciplinary Journal of Population Health and Health Policy
March 2013 Volume 91, Issue 1 Pages 1–218
http://onlinelibrary.wiley.com/doi/10.1111/milq.2013.91.issue-1/issuetoc

[Reviewed earlier]

Nature
Volume 497 Number 7450 pp409-530 23 May 2013
http://www.nature.com/nature/current_issue.html
[No relevant content]

Nature Immunology
May 2013, Volume 14 No 5 pp415-522
http://www.nature.com/ni/journal/v14/n5/index.html
[Reviewed earlier]

Nature Medicine
May 2013, Volume 19 No 5 pp507-651
http://www.nature.com/nm/journal/v19/n5/index.html
[Reviewed earlier; No relevant content]

Nature Reviews Immunology
May 2013 Vol 13 No 5
http://www.nature.com/nri/journal/v13/n5/index.html
[Reviewed earlier; No relevant content]

New England Journal of Medicine
May 23, 2013 Vol. 368 No. 21
http://www.nejm.org/toc/nejm/medical-journal
[No relevant content]

OMICS: A Journal of Integrative Biology
May 2013, 17(5)
http://online.liebertpub.com/toc/omi/17/5
[Reviewed earlier; No relevant content]

Revista Panamericana de Salud Pública/Pan American Journal of Public Health (RPSP/PAJPH)
April 2013 Vol. 33, No. 4
http://www.paho.org/journal/index.php?option=com_content&task=view&id=123&Itemid=223
[No relevant content]

The Pediatric Infectious Disease Journal
June 2013 - Volume 32 - Issue 6 pp: A15-A16,585-707,e227-e264

http://journals.lww.com/pidj/pages/currenttoc.aspx
[No relevant content]

Pediatrics
May 2013, VOLUME 131 / ISSUE 5
http://pediatrics.aappublications.org/current.shtml
[Reviewed earlier]

Pharmaceutics
Volume 5, Issue 2 (June 2013), Pages 220-
http://www.mdpi.com/1999-4923/5/2
[Reviewed earlier; No relevant content]

Pharmacoeconomics
Volume 31, Issue 5, May 2013
http://link.springer.com/journal/40273/31/5/page/1
[No relevant content]

PLoS One
[Accessed 25 May 2013]
http://www.plosone.org/
Influenza Mortality in the United States, 2009 Pandemic: Burden, Timing and Age Distribution
Ann M. Nguyen, Andrew Noymer Research Article | published 22 May 2013 | PLOS ONE
10.1371/journal.pone.0064198
Abstract
Background
In April 2009, the most recent pandemic of influenza A began. We present the first estimates of pandemic mortality based on the newly-released final data on deaths in 2009 and 2010 in the United States.
Methods
We obtained data on influenza and pneumonia deaths from the National Center for Health Statistics (NCHS). Age- and sex-specific death rates, and age-standardized death rates, were calculated. Using negative binomial Serfling-type methods, excess mortality was calculated separately by sex and age groups.
Results
In many age groups, observed pneumonia and influenza cause-specific mortality rates in October and November 2009 broke month-specific records since 1959 when the current series of detailed US mortality data began. Compared to the typical pattern of seasonal flu deaths, the 2009 pandemic age-specific mortality, as well as influenza-attributable (excess) mortality, skewed much younger. We estimate 2,634 excess pneumonia and influenza deaths in 2009–10; the excess death rate in 2009 was 0.79 per 100,000.
Conclusions

Pandemic influenza mortality skews younger than seasonal influenza. This can be explained by a protective effect due to antigenic cycling. When older cohorts have been previously exposed to a similar antigen, immune memory results in lower death rates at older ages. Age-targeted vaccination of younger people should be considered in future pandemics.

PLoS Medicine
(Accessed 25 May 2013)
http://www.plosmedicine.org/
Integrating Global and National Knowledge to Select Medicines for Children: The Ghana National Drugs Programme
David Sinclair, Martha Gyansa-Lutterodt, Brian Asare, Augustina Koduah, Edith Andrews, Paul Garner
Summary Points
- This paper reports the experience of the Ghana National Drugs Programme as they reviewed the international evidence base for five priority paediatric medicines.
- Applying the global recommendations to Ghana was not straightforward for any of the five medicines, regardless of the presence of high quality evidence of important clinical benefits.
- Four main factors generated debate and uncertainty in the committee: (1) effect unproven in African settings; (2) control group in trials not consistent with current practice; (3) little evidence on cost and cost effectiveness; and (4) limited supply chain.
- This project demonstrates why global recommendations should be presented alongside transparent descriptions of the evidence base, allowing policy groups to identify where, when, and how the interventions have been evaluated, and any factors limiting applicability.
- As many policy questions are relevant across sub-Saharan Africa, and policy makers are likely to encounter similar problems, we encourage regional collaboration on health technology assessment, and sharing of information and resources.

PLoS Neglected Tropical Diseases
April 2013
http://www.plosntds.org/article/browseIssue.action
[No new relevant content]

PNAS - Proceedings of the National Academy of Sciences of the United States of America
(Accessed 25 May 2013)
http://www.pnas.org/content/early/recent
[No new relevant content]

Public Health Ethics
Volume 6 Issue 1 April 2013
http://phe.oxfordjournals.org/content/current
[Reviewed earlier]

Qualitative Health Research
July 2013; 23 (7)
http://qhr.sagepub.com/content/current
[No relevant content]

Risk Analysis
May 2013 Volume 33, Issue 5 Pages 751–944
http://onlinelibrary.wiley.com/doi/10.1111/risa.2013.33.issue-5/issuetoc
[Reviewed earlier; No relevant content]

Science
24 May 2013 vol 340, issue 6135, pages 893-1004
http://www.sciencemag.org/current.dtl
[No relevant content]

Science Translational Medicine
22 May 2013 vol 5, issue 186
http://stm.sciencemag.org/content/current
[No relevant content]

Social Science & Medicine
Volume 85, Pages 1-112 (May 2013)
http://www.sciencedirect.com/science/journal/02779536/85
[No relevant content]

Vaccine
Volume 31, Issue 21, Pages 2481-2538 (17 May 2013)
http://www.sciencedirect.com/science/journal/0264410X
[Reviewed earlier]

Vaccine: Development and Therapy
(Accessed 25 May 2013)
http://www.dovepress.com/vaccine-development-and-therapy-journal
[No new relevant content]

Value in Health
Vol 16 | No. 3 | May 2013
http://www.valueinhealthjournal.com/current
[Reviewed earlier]

From Google Scholar & other sources: Selected Journal Articles, Dissertations, Theses, Commentary

Liability for Failure to Vaccinate
By Art Caplan
Bill of Health, Harvard Law Petrie-Flom Center
http://blogs.law.harvard.edu/billofhealth/2013/05/23/liability-for-failure-to-vaccinate/
Posted on May 23, 2013

Safety and Immunogenicity of a Recombinant Tetravalent Dengue Vaccine in 9-16-Year-Olds: A Randomized, Controlled, Phase II Trial in Latin America
LÁ Villar, DM Rivera-Medina, JL Arredondo-García… - The Pediatric Infectious …, 2013
Background. The dengue virus is a member of the Flavivirus (FV) genus, which also includes the yellow fever virus. Dengue disease is caused by any one of four dengue virus serotypesand is a serious public health concern in Latin America. This study evaluated the ...

[HTML] **In pursuit of an HIV vaccine: an interview with Andrew McMichael**
AJ McMichael - BMC Biology, 2013
Andrew McMichael qualified in Medicine before doing a PhD in Immunology with Ita Askonas and Alan Williamson in the 1970s. His research during this time and later work done in his group has made a major contribution to our understanding of T-cell-mediated ...

Vaccination Errors Reported to the Vaccine Adverse Event Reporting System 2000-2011
https://cste.confex.com/cste/2013/webprogram/Paper1777.html
2013 CSTE Annual Conference, 2013
Wednesday, June 12, 2013: 2:22 PM
Ballroom B (Pasadena Convention Center)
Beth Hibbs , Pedro Moro , Paige Lewis , Elaine Miller , Karen Broder , Claudia Vellozzi , Centers for Disease Control and Prevention, Atlanta, GA
BACKGROUND: Medication errors are an important public health problem and the subgroup of vaccination errors is relatively understudied. We characterized vaccination error reports to the Vaccine Adverse Event Reporting System (VAERS), a U.S. passive surveillance system for vaccine adverse events (AEs).
METHODS: Signs and symptoms of AEs described in VAERS reports and reported medical errors are coded using the Medical Dictionary for Regulatory Activities (MedDRA). We searched VAERS for U.S. reports of vaccination errors from 2000-2011 using 39 MedDRA medical error coding terms and categorized them into 11 error groups. We performed manual review of selected reports and available medical records.
RESULTS: Of the 255,528 reports received by VAERS from 2000-2011, we identified 13,137 (5.1%) vaccination error reports. The number of annual vaccination error reports increased from 10 reports in 2000 to 1,396 in 2011, peaking at 2,696 in 2008. Of the vaccination error reports, 8813 (67%) reported the error without any AE while 4,324 (32.9%) documented an AE. Among these reports the most common AEs were injection site erythema (n=583, 13.5%), fever (n=495, 11.4%) and injection site pain (n=468, 10.8%). The most common vaccination error reported was inappropriate schedule (i.e. wrong age, wrong schedule) (n=3,886, 29.6%), most often described for pediatric rotavirus vaccines (n=620, 16%). The second most common vaccination error was wrong vaccine administered (n=2,693, 20.5%). In a random sample of

100 reports of wrong vaccine administered, the most common mix-ups involved similar or related vaccines (i.e. Varicella and Zoster, pediatric DTaP and adult Tdap) in vaccination settings that served both children and adults. We identified an unexpected vaccination error: 25 reports of rotavirus vaccine eye splashes affecting mainly healthcare providers (16 associated with ocular symptoms). Cluster reports occurring in multiple individuals (range 2-500 persons) at the same vaccination location and date were noted 208 times; the most common error for clusters was expired drug administered.
CONCLUSIONS: Although VAERS data have limitations of passive surveillance, the data show that potentially preventable vaccination errors have occurred since 2000 in individuals and in clusters. The most common vaccination errors, inappropriate schedule and wrong vaccine, as well as unexpected rotavirus eye splashes, may be prevented with education or packaging changes. Even though most vaccination errors are not temporally associated with an adverse health event, errors potentially could cause adverse events, incur additional costs, inconvenience patients and impact confidence in vaccination programs. Prevention strategies should be considered and evaluated.

Possible Factors Contributing to Vaccine Hesitancy Among Parents of Two Year Old Children in Georgia, 2010-2012

https://cste.confex.com/cste/2013/webprogram/Paper1613.html
2013 CSTE Annual Conference, 2013
Tuesday, June 11, 2013: 11:15 AM
Ballroom F (Pasadena Convention Center)
Rebecca M Willis , Georgia Department of Public Health, Atlanta, GA
Jessica Tuttle , Georgia Department of Public Health, Atlanta, GA
BACKGROUND:
Since 1997, the Georgia Immunization Office has conducted the annual Georgia Immunization Study (GIS) – a retrospective cohort study to determine the statewide and regional immunization coverage rates for 24 month old children born in the state of Georgia. In 2010, data collection was expanded to include reasons for incomplete immunization. This study aims to assess the contribution of vaccine hesitancy to inadequate immunization in Georgia.
METHODS:
We analyzed data from the Georgia Registry of Immunization Transactions and Services (GRITS), which provided information on approximately 7,000 children who received immunizations during 2010-2012. We assessed the proportion of children who were inadequately immunized (4:3:1:3:3:1:4 level), analyzed the reasons listed for inadequate immunization, and used descriptive statistics to characterize demographic or other factors that may contribute to vaccine hesitancy - measured as parent choosing delayed schedule or refusing any vaccines.
RESULTS:
During 2010-2012, a total of 462 (6.5%) two-year-olds were inadequately immunized by the end of the data collection period. During this time, there were a total of 261 (56.5%) reasons for inadequate immunization related to vaccine hesitancy, the most-frequently cited reason being "parent chose a delayed schedule" (141; 30.5%). The racial/ ethnic breakdown of the inadequately immunized subsample was: white, non-Hispanic (215; 46.5%), black, non-Hispanic (166; 35.9%) and Hispanic (28; 6.1%), similar to the overall eligible sample. The white, non-Hispanic children were inadequately immunized due primarily to a parent refusing one or more vaccines (48; 16.9%) versus children of black and Hispanic mothers (18; 5.0% and 5; 8.3%, respectively). Parents of children enrolled in WIC less often refused one or more

vaccines when compared to parents of children not enrolled in WIC (10% versus 21%) (2011). Parents of children whose mother was 25-34 years old at the time of birth more often chose a delayed immunization schedule for their child than both the under 25 year and 35+ years age groups (79; 35.1% versus 51; 27.4% and 11; 21.6%, respectively).
CONCLUSIONS:
Inadequate immunization may be attributed, in part, to vaccine hesitancy in more than 2.5% of the cohort of two year olds in Georgia during 2010-2012. Inadequately immunized children differ by race/ethnicity, maternal age, and maternal WIC enrollment. Healthcare providers should take into account these differences to target vaccine education and improve vaccine coverage in Georgia.

Media/Policy Watch

Beginning in June 2012, *Vaccines: The Week in Review* expanded to alert readers to substantive news, analysis and opinion from the general media on vaccines, immunization, global; public health and related themes. *Media Watch* is not intended to be exhaustive, but indicative of themes and issues CVEP is actively tracking. This section will grow from an initial base of newspapers, magazines and blog sources, and is segregated from *Journal Watch* above which scans the peer-reviewed journal ecology.

We acknowledge the Western/Northern bias in this initial selection of titles and invite suggestions for expanded coverage. We are conservative in our outlook of adding news sources which largely report on primary content we are already covering above. Many electronic media sources have tiered, fee-based subscription models for access. We will provide full-text where content is published without restriction, but most publications require registration and some subscription level.

Al Jazeera
http://www.aljazeera.com/Services/Search/?q=vaccine
Accessed 25 May 2013
[No new, unique, relevant content]

The Atlantic
http://www.theatlantic.com/magazine/
Accessed 25 May 2013
[No new, unique, relevant content]

BBC
http://www.bbc.co.uk/
Accessed 25 May 2013
[No new, unique, relevant content]

Brookings
http://www.brookings.edu/
Accessed 25 May 2013
[No new, unique, relevant content]

Economist

http://www.economist.com/
Accessed 25 May 2013
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Books
Resistant
Why a century-old battle over vaccination continues to rage.
by Michael Specter May 30, 2013
http://www.newyorker.com/arts/critics/books/2011/05/30/110530crbo_books_specter

BOOK review about the battle over vaccination. Smallpox claimed the lives of tens of thousands of French soldiers during the Franco-Prussian War, yet the Prussians lost fewer than five hundred men. That was because Prussia vaccinated its entire Army against the virus, and France did not. By the end…

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Wall Street Journal
http://online.wsj.com/home-page
May 20, 2013, 4:02 a.m. ET
Polio-Vaccine Team Attacked in Pakistan
Associated Press
KHAR, Pakistan—Officials say gunmen have killed a policeman guarding a polio-vaccination team in northwestern Pakistan.
Local government administrator Faramosh Khan says the gunmen attacked on Monday in the town of Mamound in the Bajur tribal area, just as the team started a vaccination drive.
No one has claimed responsibility for the shooting, but suspicion will likely fall on Islamic militants suspected in similar attacks.
Jehanzeb Dawar, a senior regional health official, said a total of 624 teams are taking part in the latest push in Bajur to vaccinate more than 220,000 children. The teams relaunched the drive after taking a couple of months off because of past attacks on vaccination teams in the country.
It's unclear whether the campaign will continue after Monday's attack.
http://online.wsj.com/article/SB10001424127887324787004578494402823401718.html

Washington Post
http://www.washingtonpost.com/
Accessed 25 May 2013
WHO: Competition, rules dispute mar efforts to combat new Mideast virus that has killed 22
By Associated Press, Published: May 23
GENEVA — International efforts to combat a new pneumonia-like virus that has now killed 22 people are being slowed by unclear rules and competition for the potentially profitable rights to disease samples, the head of the World Health Organization warned Thursday.
Dr. Margaret Chan, in a blunt warning to the U.N. agency's annual global assembly, portrayed a previously little-known flap over who owns a sample of the virus as a global game-changer that could put people's lives at risk. The virus, which first emerged in Saudi Arabia where most cases have arisen, is called MERS for Middle East respiratory syndrome.
"Please, I'm very strong on this point, and I want you to excuse me," she said. "Tell your scientists in your country, because you're the boss. You're the national authority. Why would

your scientists send specimens out to other laboratories on a bilateral manner and allow other people to take intellectual property rights on a new disease?"

The controversy stems from a sample taken by Saudi microbiologist Ali Mohamed Zaki that he mailed last year to virologist Ron Fouchier at the Erasmus Medical Center in the Netherlands.

Fouchier tested, sequenced and identified it last September as a new virus. Then his private medical center patented how it synthesized the germ and required other researchers who wanted samples to first sign an agreement that could trigger a payment.

Saudi Arabia, which had the first case, said the patenting delayed its development of diagnostic kits and blood tests. "There was a lag of three months where we were not aware of the discovery of the virus," Deputy Health Minister Ziad Memish told the Geneva assembly. He said the sample was sent to the Dutch lab without official permission.

So far there is no blood test for detecting infection in communities. Memish said that patients need to be isolated because in some cases, diarrhea or vomiting may help spread the germ.

Dr. Keiji Fukuda, WHO's assistant director-general for health security, said his agency also has been "struggling with diagnostics" because of property rights concerns and ill-defined international rules for sharing such materials.

Chan railed against any arrangement that could prevent rapid sharing of information or that would enable individual scientists or private labs to profit.

WHO officials say the delays involve blood and other tests though a few other facilities in Canada, Britain and Germany have samples.

Fouchier, however, said the agreements between individual countries are similar to those within WHO's networks.

"There are no restrictions to the use of the virus for research and public health purposes. There are only restrictions for commercial exploitation and forwarding virus to third parties," he wrote in an email, responding to questions from The Associated Press.

Any delays claimed by WHO are a misconception, he said.

"After the first identification of the virus, diagnostic tests were developed in collaboration with several public health laboratories, and these tests were distributed free of charge to everyone around the world who asked for them," Fouchier added. "We have not denied access to the virus to any research and public health laboratory with the appropriate facilities to handle this virus safely."

The World Health Assembly, the decision-making body of WHO, meets from May 20-28.

Indonesia has previously refused to share samples of the bird flu virus that has been seen in Southeast Asia for several years. That country claimed vaccines made from those samples would be too expensive for developing countries to afford. That dispute led to a protracted series of negotiations with WHO and others to ensure poor nations would have access to vaccines in a global epidemic…

http://www.washingtonpost.com/world/europe/un-22-deaths-worldwide-from-44-cases-of-new-coronavirus/2013/05/23/6eb63bb6-c3b4-11e2-9642-a56177f1cdf7_story.html

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