

## Center for Vaccine Ethics and Policy

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### Vaccines and Global Health: The Week in Review 15 February 2014 Center for Vaccine Ethics & Policy (CVEP)

*This weekly summary targets news, events, announcements, articles and research in the vaccine and global health 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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**The United States joined 26 countries, the WHO, the Food and Agriculture Organization (FAO), and the World Organization for Animal Health (OIE) in committing to the goals of the Global Health Security Agenda “to accelerate progress toward a world safe and secure from the threat of infectious disease.”** Over the next five years the United States plans to work with at least 30 partner countries (containing at least 4 billion people) “to prevent, detect and effectively respond to infectious disease threats, whether naturally occurring or caused by accidental or intentional releases of dangerous pathogens.” Later this year, the White House will host an event bringing together nations who are committed to protecting the world from infectious disease threats to review progress and chart the way forward on building a global system for preventing, detecting, and responding to such threats. CDC Director Dr. Tom Frieden commented, “The United States and the world can and must do more to prevent, detect, and respond to outbreaks as early and as effectively as possible. CDC conducted two global health security demonstration projects last year in partnership with Vietnam and Uganda to strengthen laboratory systems, develop strong public health emergency operations centers, and create real-time data sharing in health emergencies. CDC is committed to replicate the successes in these two projects in ten additional countries this year.”

U.S. government departments including HHS, DoS, USDA, and DoD “will work closely with global partners to build countries’ global health security capacities in areas such as surveillance, detection and response in order to slow the spread of antimicrobial resistance, establish national biosecurity systems, reduce zoonotic disease transmission, increase routine immunization, establish and strengthen national infectious disease surveillance and laboratory systems, and develop public health electronic reporting systems and emergency operations centers.” Countries joining the United States to meet the Global Health Security goals at today’s

launch were Argentina, Australia, Canada, Chile, China, Ethiopia, Finland, France, Georgia, Germany, India, Indonesia, Italy, Japan, Kazakhstan, Mexico, Netherlands, Norway, Republic of Korea, Russian Federation, Saudi Arabia, South Africa, Turkey, Uganda, United Kingdom, and, Vietnam.

[www.globalhealth.gov/global-health-topics/global-health-security/index.html](http://www.globalhealth.gov/global-health-topics/global-health-security/index.html).

<http://www.hhs.gov/news/press/2014pres/02/20140213a.html>

**UNICEF Watch** [to 15 February 2014]

[http://www.unicef.org/media/media\\_67204.html](http://www.unicef.org/media/media_67204.html)

**UNICEF said that together with the Government of Guinea and other NGO partners, it vaccinating over 1.7 million children in Guinea amid a continuing measles outbreak.**

Yesterday, the Ministry of Health announced that there are over 1,300 new suspected cases and five child deaths since the beginning of 2014. UNICEF Representative in Guinea Dr. Mohamed Ag Ayoya commented, "In Guinea, where three out of five children are not fully vaccinated, measles can have a devastating impact as it spreads quickly and kills children. UNICEF has worked quickly to provide expertise, vaccines and other materials and stands ready to support the Government in any way we can."

[http://www.unicef.org/media/media\\_71996.html](http://www.unicef.org/media/media_71996.html)

**WHO: Humanitarian Health Action**

<http://www.who.int/hac/en/index.html>

**Medical supplies air-delivered to north-east Syria**

WHO started to deliver medicines, vaccine and medical supplies to north-east Syria this week by chartered flights from the capital Damasacus. WHO is providing medical supplies for more than 335 000 beneficiaries, including medicines for chronic and infectious diseases, skin diseases, as well as medical supplies needed to treat patients with injuries.

[Read the story on medical supplies to north-east Syria](#)

**Speech: WHO Director-General celebrates polio-free India**

Dr Margaret Chan, Director-General of the World Health Organization

Address at the "India celebrates triumph over polio" event; New Delhi, India

11 February 2014

*Excerpt*

...India has shown the world that there is no such thing as impossible. This is likely the greatest lesson, and the greatest inspiration for the rest of the world.

India's leadership in polio eradication is widely appreciated and warmly welcomed, especially among the 194 Member States of WHO. The country has shared its experiences, best practices, lessons learned, and expert staff with the remaining endemic countries.

The defeat of polio in India paves the way for certification of the entire South-East Asia region as polio-free, possibly at the end of March. When this happens, nearly 80% of the world's population will be living in countries that are certified polio-free.

The polio-free status of every country remains under threat as long as poliovirus is still circulating anywhere in the world. We still have some way to go. But India provides the decisive proof that eradication is feasible, technically and operationally.

India is fully aware of the need to safeguard its magnificent achievement. Immunization against polio remains high, and emergency preparedness and response plans are in place to respond urgently to any importations.

India will continue its role as a global leader as the Polio Endgame is implemented, including through the introduction of inactivated polio vaccine and the stepwise phasing out of oral polio vaccine.

Right now, the country is using the legacy of its polio success to intensify routine immunization, with a special emphasis on reaching underserved and marginalized populations. The elimination of measles will likely be the next permanent improvement for the health of India's people.

The 13 January news that India had now gone 3 years without a polio case made headlines around the world. This is a monumental achievement that fully deserves today's celebration.

*Full text of speech:* <http://www.who.int/dg/speeches/2014/india-polio-free/en/index.html>

### **[India] Vaccination must for visitors from polio-hit nations**

[The Hindu](#) | 9 February 2014

From March 1, polio vaccination will be mandatory for all international travellers coming to India from polio-infected countries.

The Health Ministry has also made OPV (oral polio vaccine) compulsory for those travelling from India to polio-endemic countries and countries with poliovirus circulation to prevent virus importation.

The polio-endemic countries are Afghanistan, Nigeria and Pakistan. Countries with poliovirus circulation are Ethiopia, Kenya, Somalia and Syria.

OPV vaccination certificates, valid for one year, will be issued by the government.

Resident nationals of the seven infected countries are required to receive an OPV dose, regardless of age and vaccination status, at least four weeks prior to departure for India. The vaccination certificate will have to be produced while applying for visa and during travel in India.

However, OPV is not mandatory for foreign nationals residing in the seven infected countries or India before their travel.

Travellers can contact local health authorities in their countries for vaccination and certificates.

Travellers from India to countries with poliovirus transmission should receive a dose of OPV at least four weeks prior to departure.

Each district has designated at least one centre where OPV vaccination will be given and certificate issued. The District Immunisation Officer is the designated official for issue of certificates.

### **Update: Polio this week - As of 12 February 2014**

Global Polio Eradication Initiative

Full report: <http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx>

*[Editor's extract and bolded text]*

:: Celebrating 3 years polio-free in India: on 11 February, dignitaries from around the world came together at a celebratory event in Delhi. The President of India, Shri Pranab Mukherjee, was joined in the celebrations by Prime Minister Dr Manmohan Singh, Union Health and Family Welfare Minister Ghulam Nabi Azad, Chairperson of the National Advisory Council Sonia Gandhi,

Leader of the Opposition Shushma Swaraj, WHO Director-General Dr Margaret Chan, Rotary International President Ron D Burton and other high-level representatives. The Regional Certification Commission (RCC) for the Southeast Asia Region is expected to convene at end-March and review data from the entire Region, to determine if it will be officially certified as polio-free.

:: In Afghanistan, an immunization response is ongoing to last week's reported case in Kabul. It was the first case in the province since 2002, and is linked to transmission in neighbouring Pakistan. Afghanistan continues to make strong progress towards polio eradication. This latest case in Kabul underscores the ongoing risk polio continues to pose to children everywhere.

### ***Afghanistan***

:: One new wild poliovirus type 1 (WPV1) case was reported in the past week. The total number of WPV1 cases remains 14 for 2013, but is now two for 2014. The most recent WPV1 case had onset of paralysis on 15 January 2014 from Badakhshan province, Northern Region.

### ***Nigeria***

:: One new cVDPV2 case was reported in the past week. The total number of cVDPV2 cases for 2013 is now 4. The most recent cVDPV case had onset of paralysis on 24 December (from Maiduguri, Borno).

:: An appropriate response to this most recent cVDPV2 case in Borno is now being planned. The cVDPV2 case is linked to previous transmission in Chad from 2013.

:: The persisting transmission of two separate strains of cVDPV2 (from AFP cases and from the environment) in northern Nigeria and in north-West Pakistan is of concern to the GPEI since the 'withdrawal' of type 2 OPV vaccine (the 'tOPV to bOPV switch'), planned for early 2016, will not be possible unless all persistent cVDPV2 transmission has been stopped.

### ***Pakistan***

:: Two new WPV1 cases were reported in the past week, both from North Waziristan in FATA (with onset of paralysis on 17 and 25 January 2014). The total number of cases for 2013 remains 93. The total number of cases in 2014 is now nine. The most recent case had onset of paralysis on 25 January 2014 (WPV1 from North Waziristan).

:: North Waziristan is the district with the largest number of children being paralyzed by poliovirus in the world (both wild- and VDPV2). Immunization activities have been suspended by local leaders since June 2012. It is critical that children in all areas are vaccinated and protected from poliovirus. 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.

:: The densely populated Peshawar valley is considered to be the main 'engine' of poliovirus transmission, alongside North Waziristan, due to large-scale population movements through Peshawar from across this region, and into other areas of Pakistan. The quality of operations must be urgently improved in Peshawar, and immunizations resumed in North Waziristan. However, at the same time, concerning trends have been noted in greater Karachi, Sindh and in Quetta, Balochistan. Environmental positives isolates from every major city of Punjab confirm widespread virus circulation.

:: In Quetta, genetic sequencing of a positive environmental sample collected on 28 December 2013 indicates that it is linked to virus last detected in Afghanistan in July 2012, suggesting undetected circulation. Subnational analyses of surveillance sensitivity and immunity profiles are ongoing in both countries to ascertain more clarity. This further underscores the risk ongoing transmission anywhere, including low-level transmission, poses to the polio eradication efforts of both countries.

### ***Horn of Africa***

:: The Horn of Africa Technical Advisory Group (TAG) convened last week in Nairobi, Kenya, to evaluate impact of current outbreak response activities. The TAG underscored that the initial response to the outbreak was appropriate, however expressed grave concern that gaps in SIA quality and surveillance remained in key infected areas of the region. Consequently, the group concluded there is a serious risk of the outbreak continuing and of further spread both within and beyond countries of the Horn of Africa. The group recommended that infected countries should focus efforts on high-risk and infected areas, by conducting high-quality SIAs no more than four weeks apart.

:: An assessment of outbreak response activities in Ethiopia indicates significant ongoing vaccination coverage gaps in key areas, notably in parts of Somali region of the country. All efforts must be made to fill these vaccination coverage gaps as urgently as possible, which are threatening the regional outbreak response efforts.

The **Weekly Epidemiological Report (WER) for 14 February 2014**, vol. 89, 7 (pp. 53–60) includes:

:: Global Advisory Committee on Vaccine Safety, 11–12 December 2013  
<http://www.who.int/entity/wer/2014/wer8907.pdf?ua=1>

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

[http://www.who.int/csr/don/2013\\_03\\_12/en/index.html](http://www.who.int/csr/don/2013_03_12/en/index.html)

:: **Human infection with avian influenza A(H7N9) virus – update** [14 February 2014](#)

The National Health and Family Planning Commission (NHFPC) of China and the Centre for Health Protection (CHP), Hong Kong, SAR, China has notified WHO of a total of eight additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus, including one death...So far, there is no evidence of sustained human-to-human transmission...

While the recent report of avian influenza A(H7N9) virus detection in live poultry exported from mainland China to Hong Kong SAR shows the potential for the virus to spread through movement of live poultry, at this time there is no indication that international spread of avian influenza A(H7N9) has occurred. However as the virus infection does not cause signs of disease in poultry, continued surveillance is needed.

Should human cases from affected areas travel internationally, their infection may be detected in another country during or after arrival. If this were to occur, community level spread is unlikely as the virus does not have the ability to transmit easily among human. Until the virus adapts itself for efficient human-to-human transmission, the risk of ongoing international spread of H7N9 virus by travellers is low. The overall risk assessment has not changed.

Further sporadic human cases of avian influenza A(H7N9) infection are expected in affected and possibly neighbouring areas, especially given expected increases in the trade and transport of poultry associated with the Lunar New Year...

:: Human infection with avian influenza A(H7N9) virus – update [11 February 2014](#)

:: Human infection with avian influenza A(H7N9) virus – update [10 February 2014](#)

[*Editor's Note: See Journal Watch* below for "Possible pandemic threat from new reassortment of influenza A(H7N9) virus in China" *Eurosurveillance*, Volume 19, Issue 6, 13 February 2014, <http://www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationId=11678> ]

**GAVI Watch** [to 15 February 2014]

<http://www.gavialliance.org/library/news/press-releases/>

*No new content identified.*

**CDC/MMWR Watch** [to 15 February 2014]

[http://www.cdc.gov/mmwr/mmwr\\_wk.html](http://www.cdc.gov/mmwr/mmwr_wk.html)

**MMWR – February 14, 2014 / Vol. 63 / No. 6**

*No new relevant content.*

**European Medicines Agency Watch [to 15 February 2014]**

<http://www.ema.europa.eu/ema/>

*No new relevant content.*

**UN Watch** [to 15 February 2014]

Selected meetings, press releases, and press conferences relevant to immunization, vaccines, infectious diseases, global health, etc. <http://www.un.org/en/unpress/>

*No new relevant content.*

**World Bank/IMF Watch** [to 15 February 2014]

Selected media releases and other selected content relevant to immunization, vaccines, infectious diseases, global health, etc. <http://www.worldbank.org/en/news/all>

*No new relevant content.*

### **Reports/Research/Analysis/Commentary/Conferences/Meetings/Book Watch**

*Vaccines and Global Health: 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](mailto:david.r.curry@centerforvaccineethicsandpolicy.org)

### **Commentary: *Science for the Poor – Making Vaccines to Combat Poverty***

[Peter Hotez, M.D, Ph.D.](#)

[The Huffington Post](#) | 11 February 2014

Is it possible to vaccinate against poverty?

According to the World Bank, an estimated [2.4 billion people live on less than \\$2 per day](#), while 1.2 billion live on less than \$1.25 per day -- a group often referred to as "the bottom billion". We now know that almost all of the bottom billion and many of those living on less than \$2 per day remain trapped in poverty because they are chronically debilitated by a group of afflictions known as the [neglected tropical diseases](#), or 'NTDs'.

NTDs are long-lasting parasitic and related infections such as ascariasis, trichuriasis, hookworm, schistosomiasis, lymphatic filariasis, onchocerciasis, trachoma, Chagas disease, and leishmaniasis. The major point is that these NTDs can actually cause poverty either because they make people too sick to go to work and limit agricultural productivity, or because they strike children at vulnerable times, thereby stunting their physical and intellectual development. NTDs also disproportionately affect pregnant women, making them ill and causing them to produce low birth weight or premature infants.

Beyond their staggering public health impact, the economic losses from NTDs are also impressive: our studies with collaborators at Johns Hopkins University show that Chagas disease results in more than \$7 billion lost annually, mostly in the Western Hemisphere. There are similar data available for many other NTDs.

Remember, the NTDs are not rare conditions -- virtually every single person living in extreme poverty is infected with at least one of these conditions.

Science can offer a lot to prevent these infections, thereby making poor people well enough to go back to work, children healthy and intellectually vibrant, and improving pregnancy outcomes. One approach now underway is annual mass treatment with a package of essential medicines that targets several NTDs at once, and costs only 50 cents per person. Although not a true vaccine, the World Health Organization uses the term "preventive chemotherapy" to describe this approach because when used over a period of time, together with other supportive measures, it is actually leading to the elimination of lymphatic filariasis and trachoma, and in some cases [even river blindness](#) in dozens of impoverished countries. In collaboration with several international organizations we organized a Global Network for NTDs that is raising awareness about the opportunity for these low-cost preventive chemotherapy approaches.

For other NTDs, however, we need new technologies. In 2011 the Sabin Vaccine Institute allied with Texas Children's Hospital and Baylor College of Medicine to expand its development portfolio of new and novel vaccines to combat NTDs. The result is the expansion of a unique non-profit product development partnership that is located in Houston's Texas Medical Center -- a medical city of 100,000 people -- to transition discoveries from the bench to the clinic and produce the next generation 'antipoverty vaccines', i.e. vaccines that would not only improve health but simultaneously also lift people out of poverty. For example, hookworm infection affects more than 400 million people in Africa, Asia, and the Americas, where it is a leading cause of anemia and childhood malnutrition, and has been shown to reduce future wage earnings. Our product development partnership, through activities led by [Dr. Maria Elena Bottazzi](#), has developed, transitioned, and produced a prototype hookworm vaccine undergoing clinical trials in Brazil, and will soon undergo [additional testing in Gabon](#) through a so-called HOOKVAC consortium of European and African partners. We are also working to evaluate and modify the vaccine so it [targets additional parasitic infections](#) such as ascariasis and trichuriasis.

Finally, a new schistosomiasis vaccine is under development and will soon begin clinical trials. Nor is poverty exclusive to developing countries or failed nations. Today, almost two million families in the United States live on less than \$2 per day and poverty is rampant in southern states such as Texas and others along the Gulf Coast. We found that NTDs are also [widespread among these impoverished Americans](#). For example 300,000 people in the United States suffer from Chagas disease, a cause of heart disease transmitted by kissing bugs -- our group, which includes a consortium of Mexican institutions, is now working to develop one of the first Chagas disease vaccines for clinical trials.

Dr. Albert Sabin, whose name and legacy our Institute honors once said, "A scientist who is a human being cannot rest while knowledge which might reduce suffering rests on the shelf." Our

[Sabin Vaccine Institute and Texas Children's Hospital Center for Vaccine Development](#) is one of six major international product development partnerships currently pioneering vaccine development in the non-profit sector. Together we are making the vaccines for diseases that affect millions if not billions but only those living in extreme poverty.

Almost thirty years ago I graduated from New York's Rockefeller University, whose motto is *Scientia pro bono humani generis* - science for the benefit of humanity. Developing a new generation of antipoverty vaccines is a true expression of that concept.

*Peter Hotez, M.D., Ph.D. is president of the Sabin Vaccine Institute and the founding dean of the National School of Tropical Medicine at Baylor College of Medicine, where he is also Professor of Pediatrics and Texas Children's Hospital Endowed Chair of Tropical Pediatrics. Prof. Hotez is also the Fellow on Disease and Poverty at the James A. Baker Institute for Public Policy at Rice University. He is the author of Forgotten People, Forgotten Diseases (ASM Press).*

### **Report: Accelerating HPV Vaccine Uptake – Urgency for Action to Prevent Cancer**

[U.S.] President's Cancer Panel (PCP): February 2014

<http://deainfo.nci.nih.gov/advisory/pcp/annualReports/HPV/index.htm#sthash.LfsA4o48.dpbs>

#### *Overview*

Human papillomaviruses (HPV) cause most cases of cervical cancer and large proportions of vaginal, vulvar, anal, penile, and oropharyngeal cancers. HPV also causes genital warts and recurrent respiratory papillomatosis. HPV vaccines could dramatically reduce the incidence of HPV-associated cancers and other conditions among both females and males, but uptake of the vaccines has fallen short of target levels. The President's Cancer Panel finds underuse of HPV vaccines a serious but correctable threat to progress against cancer. In this report, the Panel presents four goals to increase HPV vaccine uptake: three of these focus on the United States and the fourth addresses ways the United States can help to increase global uptake of the vaccines. Several high-priority research questions related to HPV and HPV vaccines also are identified .

#### *Excerpts from Executive Summary*

#### ...PART 2: URGENCY FOR ACTION

HPV vaccine uptake has not kept pace with that of other adolescent vaccines and has stalled in the past few years. In 2012, only about one-third of 13- to 17-year-old girls received all three recommended doses. These levels fall considerably short of the U.S. Department of Health and Human Services Healthy People 2020 goal of having 80 percent of 13- to 15-year-old girls fully vaccinated against HPV. Immunization rates for U.S. boys are even lower than for girls. Less than 7 percent of boys ages 13 to 17 completed the series in 2012. This low rate is in large part because the ACIP recommendation for routine vaccination of boys was not made until 2011. However, it is even lower than what was observed for girls in 2007—the first year following the recommendation for females—suggesting that concerted efforts are needed to promote HPV vaccination of males.

The Centers for Disease Control and Prevention (CDC) estimates that increasing HPV vaccination rates from current levels to 80 percent would prevent an additional 53,000 future cervical cancer cases in the United States among girls who now are 12 years old or younger over the course of their lifetimes. Thousands of cases of other HPV-associated cancers in the U.S. also likely would be prevented within the same timeframe. A growing proportion of these cancers—most notably, oropharyngeal cancers—will occur in males, who currently are vaccinated at very low rates.

The President's Cancer Panel finds underuse of HPV vaccines a serious but correctable threat to progress against cancer. Organized, mutually reinforcing efforts could have synergistic impact on HPV vaccine uptake. The Panel presents four goals to increase HPV vaccine uptake; three goals focus on increasing uptake in the United States ([Part 3](#)), and the fourth addresses ways the United States can help increase global uptake of the vaccines ([Part 4](#)). Several high-priority research areas also are identified ([Part 5](#)). All recommendations and some of the stakeholders responsible for implementing them are summarized in [Appendix B](#).

The Panel urges all stakeholders—including federal and state governments, healthcare professionals, nongovernment organizations with a focus on public health, and parents, caregivers, adolescents, and other members of the public—to contribute to efforts to achieve this goal and protect millions of men and women around the world from the burden of avoidable cancers and other diseases and conditions in the coming years...

#### ...[PART 4: INCREASING GLOBAL HPV VACCINATION](#)

The burden of HPV-associated cancers extends beyond the borders of the United States, affecting populations in every country. Patterns of HPV-associated cancers differ by region. Cervical cancer is the most common HPV-associated cancer globally. In less developed regions, the large majority of HPV-attributed cancers are cervical cancers. In the United States and other more developed regions, other sites account for a significant proportion of HPV-associated cancers.

While the prevalence of HPV infections and distribution of HPV types vary by region, research has found consistently that HPV16 and HPV18, the cancer-causing strains HPV vaccines protect against, are responsible for at least two-thirds of cervical cancer cases in populations around the world. This provides a strong indication that HPV vaccines will be effective virtually everywhere.

As with cervical cancer screening programs, HPV vaccination programs have been implemented primarily in high-resource areas. Some of the most successful vaccination programs are in Australia, the United Kingdom, and parts of Canada. The U.S. can learn from successful HPV vaccination programs in these and other countries that in some cases have already led to measurable public health benefits.

Addressing the global burden of HPV-associated cancers requires implementation of HPV vaccination programs in low- and middle-income countries, where the majority of HPV-associated cancer cases occur.

#### :: [GOAL 4: PROMOTE GLOBAL HPV VACCINE UPTAKE](#)

The World Health Organization recommends that HPV vaccines be introduced into national immunization programs where prevention of cervical cancer is a public health priority and vaccine introduction is feasible and sustainable. The Panel recommends that the United States collaborate with global partners to support HPV vaccine uptake and other cancer prevention and control activities worldwide.

[Objective 4.1: The United States should continue its collaboration with and support of GAVI to facilitate HPV vaccine introduction and uptake in low-income countries.](#)

[Objective 4.2: The United States should continue to support global efforts to develop comprehensive cancer control plans and cancer registries in low- and middle-income countries.](#)

**Four U.S.-based national medical associations** — the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and American College of Obstetricians and Gynecologists (ACOG) — together with the Immunization Action Coalition and the CDC **issued a call urging physicians across the U.S. to educate their patients about the human papillomavirus (HPV) vaccine,**

**and to strongly recommend HPV vaccination.”** In the "Dear Colleague" letter issued today, medical and public health organizations “emphasize to physicians that strong health provider recommendations are critical to increasing the HPV vaccination rate and preventing HPV-associated cancers. Despite more than seven years of vaccine monitoring showing overwhelming evidence of HPV vaccine safety and effectiveness, vaccination rates are not improving while rates for other adolescent vaccines are...”

Feb. 12, 2014 <http://www.prnewswire.com/news-releases/leading-medical-and-public-health-organizations-join-efforts-urging-physicians-to-strongly-recommend-human-papillomavirus-hpv-vaccination-245185081.html>

### ***Journal Watch***

*Vaccines and Global Health: 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](mailto:david.r.curry@centerforvaccineethicsandpolicy.org)*

### **The American Journal of Bioethics**

Volume 14, Issue 2, 2014

[http://www.tandfonline.com/toc/uajb20/current#.Uv\\_UyrQt6F9](http://www.tandfonline.com/toc/uajb20/current#.Uv_UyrQt6F9)

#### **Connecting Health Systems Research Ethics to a Broader Health Equity Agenda**

Bridget Pratta

pages 1-3

DOI: 10.1080/15265161.2014.881213

[No abstract]

#### **Ethical Review of Health Systems Research in Low- and Middle-Income Countries: A Conceptual Exploration**

Adnan A. Hydera, Abbas Rattania, Carleigh Krubinera, Abdulgafoor M. Bachania & Nhan T. Tranb

DOI:

10.1080/15265161.2013.868950

pages 28-37

[http://www.tandfonline.com/doi/abs/10.1080/15265161.2013.868950#.Uv\\_VlrQt6F8](http://www.tandfonline.com/doi/abs/10.1080/15265161.2013.868950#.Uv_VlrQt6F8)

#### *Abstract*

Given that health systems research (HSR) involves different aims, approaches, and methodologies as compared to more traditional clinical trials, the ethical issues present in HSR may be unique or particularly nuanced. This article outlines eight pertinent ethical issues that are particularly salient in HSR and argues that the ethical review process should be better tailored to ensure more efficient and appropriate oversight of HSR with adequate human protections, especially in low- and middle-income countries. The eight ethical areas we discuss include the nature of intervention, types of research subjects, units of intervention and

observation, informed consent, controls and comparisons, risk assessment, inclusion of vulnerable groups, and benefits of research. HSR involving human participants is necessary to ensure health systems strengthening and quality of care and to guide public policy intelligently. Health systems researchers must carefully define their intent and goals and openly clarify the values that may influence the premises and design of protocols. As new types of population-level research activities become more commonplace, it is critical that institutional review board (IRB) and research ethics committee (REC) review processes evolve to evaluate these research protocols in ways that address the nuanced features of these studies.

**[Vulnerability as a Concept for Health Systems Research](#)**

[Margaret Meek Lange](#)

pages 41-43

**[Ethical Review of Health Systems Research in Low- and Middle-Income Countries: Research–Treatment Distinction and Intercultural Issues](#)**

[Shivam Gupta](#)

pages 44-46

**American Journal of Infection Control**

Vol 42 | No. 2 | February 2014 | Pages 93-214

<http://www.ajicjournal.org/current>

[Reviewed earlier; No relevant content]

**American Journal of Preventive Medicine**

Vol 46 | No. 3 | March 2014 | Pages 219-330

<http://www.ajpmonline.org/current>

[No relevant content]

**American Journal of Public Health**

Volume 104, Issue 3 (March 2014)

<http://ajph.aphapublications.org/toc/ajph/current>

[No relevant content]

**American Journal of Tropical Medicine and Hygiene**

February 2014; 90 (2)

<http://www.ajtmh.org/content/current>

[Reviewed earlier]

**Annals of Internal Medicine**

4 February 2014, Vol. 160. No. 3

<http://annals.org/issue.aspx>

[Reviewed earlier]

**BMC Public Health**

(Accessed 15 February 2014)

<http://www.biomedcentral.com/bmcpublichealth/content>

**Research article**

**[No difference in sexual behavior of adolescent girls following Human Papilloma Virus vaccination: a case study two districts in Uganda; Nakasongola and Luwero](#)**

Judith Caroline Aujo, Sabrina Bakeera-Kitaka, Sarah Kiguli, Florence Mirembe BMC Public Health 2014, 14:155 (12 February 2014)

*Abstract* (provisional)

Background

Vaccination against Human Papilloma Virus (HPV) before sexual debut has been recommended by WHO as a primary prevention strategy against cervical cancer. In Uganda, vaccination against HPV started as a demonstration project among young girls in Nakasongola; and Ibanda districts. Studies have suggested that vaccination against HPV could result in risky sexual behavior and increase the risk of early sexual debut.

This study was done to compare the sexual behavior of HPV vaccinated and non vaccinated adolescent girls in two neighboring districts in Uganda; and to assess whether HPV vaccination had any influence on sexual behavior of vaccinated adolescent girls.

Methods

This was an unmatched comparative study, which used both qualitative and quantitative study methods. It was carried out among 400 primary school girls aged 12 to 15 years in the districts of Nakasongola (vaccinated) and Luwero (non vaccinated). Quantitative data was collected using a questionnaire while qualitative data was obtained using focus group discussions and key informant interviews. The main outcome measure was the number of sexually active girls in each group.

Results

Of the 400 girls, 8 volunteered information that they were sexually active, 5(2.5%) from Luwero (non vaccinated) and 3 (1.5%) from Nakasongola (vaccinated), but there was no statistically significant difference between the 2 groups. HPV vaccination was not significantly associated with being sexually active.

Conclusion

There was no significant difference in sexual behavior between vaccinated and non vaccinated girls.

**Research article**

**[Measuring underreporting and under-ascertainment in infectious disease datasets: a comparison of methods](#)**

Cheryl L Gibbons, Marie-Josée J Mangan, Dietrich Plass, Arie H Havelaar, Russell John Brooke, Piotr Kramarz, Karen L Peterson, Anke L Stuurman, Alessandro Cassini, Eric M Fèvre and Mirjam EE Kretzschmar

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BMC Public Health 2014, 14:147 doi:10.1186/1471-2458-14-147

Published: 11 February 2014

*Abstract* (provisional)

Background

Efficient and reliable surveillance and notification systems are vital for monitoring public health and disease outbreaks. However, most surveillance and notification systems are affected by a degree of underestimation (UE) and therefore uncertainty surrounds the 'true' incidence of disease affecting morbidity and mortality rates. Surveillance systems fail to capture cases at two distinct levels of the surveillance pyramid: from the community since not all cases seek

healthcare (under-ascertainment), and at the healthcare-level, representing a failure to adequately report symptomatic cases that have sought medical advice (underreporting). There are several methods to estimate the extent of under-ascertainment and underreporting.

#### Methods

Within the context of the ECDC-funded Burden of Communicable Diseases in Europe (BCoDE)-project, an extensive literature review was conducted to identify studies that estimate ascertainment or reporting rates for salmonellosis and campylobacteriosis in European Union Member States (MS) plus European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland and four other OECD countries (USA, Canada, Australia and Japan). Multiplication factors (MFs), a measure of the magnitude of underestimation, were taken directly from the literature or derived (where the proportion of underestimated, under-ascertained, or underreported cases was known) and compared for the two pathogens.

#### Results

MFs varied between and within diseases and countries, representing a need to carefully select the most appropriate MFs and methods for calculating them. The most appropriate MFs are often disease-, country-, age-, and sex-specific.

#### Conclusions

When routine data are used to make decisions on resource allocation or to estimate epidemiological parameters in populations, it becomes important to understand when, where and to what extent these data represent the true picture of disease, and in some instances (such as priority setting) it is necessary to adjust for underestimation. MFs can be used to adjust notification and surveillance data to provide more realistic estimates of incidence.

### **British Medical Bulletin**

Volume 108 Issue 1 December 2013

<http://bmb.oxfordjournals.org/content/current>

[Reviewed earlier]

### **British Medical Journal**

15 February 2014 (Vol 348, Issue 7945)

<http://www.bmj.com/content/348/7945>

[No relevant content]

### **Bulletin of the World Health Organization**

Volume 92, Number 2, February 2014, 77-152

<http://www.who.int/bulletin/volumes/92/2/en/index.html>

[Reviewed earlier]

### **Clinical Therapeutics**

Vol 36 | No. 1 | 01 January 2014 | Pages 1-150

<http://www.clinicaltherapeutics.com/current>

[Reviewed earlier]

### **Cost Effectiveness and Resource Allocation**

(Accessed 15 February 2014)

<http://www.resource-allocation.com/>

[No new relevant content]

### **Current Opinion in Infectious Diseases**

February 2014 - Volume 27 - Issue 1 pp: v-vi,1-114

<http://journals.lww.com/co-infectiousdiseases/pages/currenttoc.aspx>

[Reviewed earlier; No relevant content]

### **Developing World Bioethics**

December 2013 Volume 13, Issue 3 Pages ii-ii, 105-170

<http://onlinelibrary.wiley.com/doi/10.1111/dewb.2013.13.issue-3/issuetoc>

[Reviewed earlier]

### **Development in Practice**

Volume 23, Issue 8, 2013

<http://www.tandfonline.com/toc/cdip20/current>

[Reviewed earlier; No relevant content]

### **Emerging Infectious Diseases**

Volume 20, Number 2—February 2014

<http://www.cdc.gov/ncidod/EID/index.htm>

[Reviewed earlier; No relevant content]

### **The European Journal of Public Health**

Volume 24 Issue 1 February 2014

<http://eurpub.oxfordjournals.org/content/current>

[Reviewed earlier; No relevant content]

### **Eurosurveillance**

Volume 19, Issue 6, 13 February 2014

<http://www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationId=11678>

#### ***Rapid communications***

#### **Possible pandemic threat from new reassortment of influenza A(H7N9) virus in China**

Z Meng<sup>1</sup>, R Han<sup>2</sup>, Y Hu<sup>1</sup>, Z Yuan<sup>1</sup>, S Jiang<sup>1</sup>, X Zhang<sup>1,3</sup>, J Xu<sup>1,3</sup>

#### ***Abstract***

Avian influenza A(H7N9) virus re-emerged in China in December 2013, after a decrease in the number of new cases during the preceding six months. Reassortment between influenza A(H7N9) and local H9N2 strains has spread from China's south-east coast to other regions. Three new reassortments of A(H7N9) virus were identified by phylogenetic analysis: between

A(H7N9) and Zhejiang-derived strains, Guangdong/Hong Kong-derived strains or Hunan-derived A(H9N2) strains. Our findings suggest there is a possible risk that a pandemic could develop.

### **Forum for Development Studies**

Volume 40, Issue 3, 2013

<http://www.tandfonline.com/toc/sfds20/current>

[Reviewed earlier; No relevant content]

### **Globalization and Health**

[Accessed 15 February 2014]

<http://www.globalizationandhealth.com/>

#### ***Research***

#### **[Health systems performance assessment in low-income countries: learning from international experiences](#)**

Christine Kirunga Tashobya, Valéria Campos da Silveira, Freddie Ssengooba, Juliet Nabyonga-Orem, Jean Macq and Bart Criel

#### **[Author Affiliations](#)**

. Globalization and Health 2014, 10:5 doi:10.1186/1744-8603-10-5

Published: 13 February 2014

#### ***Abstract*** (provisional)

##### **Background**

The study aimed at developing a set of attributes for a 'good' health system performance assessment (HSPA) framework from literature and experiences in different contexts and using the attributes for a structured approach to lesson learning for low-income countries (LICs).

##### **Methods**

Literature review to identify relevant attributes for a HSPA framework; attribute validation for LICs in general, and for Uganda in particular, via a high-level Ugandan expert group; and, finally, review of a selection of existing HSPA frameworks using these attributes.

##### **Results**

Literature review yielded six key attributes for a HSPA framework: an inclusive development process; its embedding in the health system's conceptual model; its relation to the prevailing policy and organizational set-up and societal context; the presence of a concrete purpose, constitutive dimensions and indicators; an adequate institutional set-up; and, its capacity to provide mechanisms for eliciting change in the health system. The expert group contextualized these attributes and added one on the adaptability of the framework.

Lessons learnt from the review of a selection of HSPA frameworks using the attributes include: it is possible and beneficial to involve a range of stakeholders during the process of development of a framework; it is important to make HSPA frameworks explicit; policy context can be effectively reflected in the framework; there are marked differences between the structure and content of frameworks in high-income countries, and low- and middle-income countries; champions can contribute to put HSPA high on the agenda; and mechanisms for eliciting change in the health system should be developed alongside the framework.

##### **Conclusion**

It is possible for LICs to learn from literature and the experience of HSPA in other contexts, including HICs. In this study a structured approach to lesson learning included the development of a list of attributes for a 'good' HSPA framework. The attributes thus derived can be utilized by

LICs like Uganda seeking to develop/adjust their HSPA frameworks as guidelines or a check list, while taking due consideration of the specific context. The review of frameworks from varied contexts, highlighted varied experiences which provide lessons for LICs.

### **Global Health Governance**

Summer 2013

<http://blogs.shu.edu/ghg/category/complete-issues/summer-2013/>

[No new relevant content]

### **Global Health: Science and Practice (GHSP)**

November 2013 | Volume 1 | Issue 3

<http://www.ghspjournal.org/content/current>

[Reviewed earlier]

### **Global Public Health**

Volume 8, Issue 10, 2013

<http://www.tandfonline.com/toc/rgph20/current#.Uq0DgeKy-F9>

[Reviewed earlier]

### **Health Affairs**

February 2014; Volume 33, Issue 2

<http://content.healthaffairs.org/content/current>

*Theme: Early Evidence, Future Promise Of Connected Health*

[Reviewed earlier]

### **Health and Human Rights**

Volume 15, Issue 2

<http://www.hhrjournal.org/>

[Reviewed earlier]

### **Health Economics, Policy and Law**

Volume 9 - Issue 01 - January 2014

<http://journals.cambridge.org/action/displayIssue?jid=HEP&tab=currentissue>

[Reviewed earlier; No relevant content]

### **Health Policy and Planning**

Volume 29 Issue 1 January 2014

<http://heapol.oxfordjournals.org/content/current>

[Reviewed earlier]

**Human Vaccines & Immunotherapeutics** (formerly Human Vaccines)

March 2014 Volume 10, Issue 3

<http://www.landesbioscience.com/journals/vaccines/toc/volume/10/issue/3/>

[No relevant content]

**Infectious Agents and Cancer**

<http://www.infectagentscancer.com/content>

[Accessed 15 February 2014]

[No new relevant content]

**Infectious Diseases of Poverty**

<http://www.idpjournal.com/content>

[Accessed 15 February 2014]

[No new relevant content]

**International Journal of Epidemiology**

Volume 42 Issue 6 December 2013

<http://ije.oxfordjournals.org/content/current>

[Reviewed earlier]

**International Journal of Infectious Diseases**

Vol 17 | No. 12 | December 2013

<http://www.ijidonline.com/current>

[Reviewed earlier; No relevant content]

**JAMA**

February 12, 2014, Vol 311, No. 6

<http://jama.jamanetwork.com/issue.aspx>

**Association of Varying Number of Doses of Quadrivalent Human Papillomavirus Vaccine With Incidence of Condyloma**

Eva Herweijer, MSc<sup>1</sup>; Amy Leval, PhD<sup>2,3</sup>; Alexander Ploner, PhD<sup>1</sup>; Sandra Eloranta, PhD<sup>1</sup>; Julia Fridman Simard, ScD<sup>4</sup>; Joakim Dillner, MD<sup>1</sup>; Eva Netterlid, PhD<sup>5,6,7</sup>; Pär Sparén, PhD<sup>1</sup>; Lisen Arnheim-Dahlström, PhD<sup>1</sup>

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JAMA. 2014;311(6):597-603. doi:10.1001/jama.2014.95.

<http://jama.jamanetwork.com/article.aspx?articleid=1829685>

*ABSTRACT*

Importance

Determining vaccine dose-level protection is essential to minimize program costs and increase mass vaccination program feasibility. Currently, a 3-dose vaccination schedule is recommended for both the quadrivalent and bivalent human papillomavirus (HPV) vaccines. Although the primary goal of HPV vaccination programs is to prevent cervical cancer, condyloma related to

HPV types 6 and 11 is also prevented with the quadrivalent vaccine and represents the earliest measurable preventable disease outcome for the HPV vaccine.

#### Objective

To examine the association between quadrivalent HPV vaccination and first occurrence of condyloma in relation to vaccine dose in a population-based setting.

#### Design, Setting, and Participants

An open cohort of all females aged 10 to 24 years living in Sweden (n = 1 045 165) was followed up between 2006 and 2010 for HPV vaccination and first occurrence of condyloma using the Swedish nationwide population-based health data registers.

**Main Outcomes and Measures** Incidence rate ratios (IRRs) and incidence rate differences (IRDs) of condyloma were estimated using Poisson regression with vaccine dose as a time-dependent exposure, adjusting for attained age and parental education, and stratified on age at first vaccination. To account for prevalent infections, models included a buffer period of delayed case counting.

#### Results

A total of 20 383 incident cases of condyloma were identified during follow-up, including 322 cases after receipt of at least 1 dose of the vaccine. For individuals aged 10 to 16 years at first vaccination, receipt of 3 doses was associated with an IRR of 0.18 (95% CI, 0.15-0.22) for condyloma, whereas receipt of 2 doses was associated with an IRR of 0.29 (95% CI, 0.21-0.40). One dose was associated with an IRR of 0.31 (95% CI, 0.20-0.49), which corresponds to an IRD of 384 cases (95% CI, 305-464) per 100 000 person-years, compared with no vaccination. The corresponding IRDs for 2 doses were 400 cases (95% CI, 346-454) and for 3 doses, 459 cases (95% CI, 437-482). The number of prevented cases between 3 and 2 doses was 59 (95% CI, 2-117) per 100 000 person-years.

#### Conclusions and Relevance

Although maximum reduction in condyloma risk was seen after receipt of 3 doses of quadrivalent HPV vaccine, receipt of 2 vaccine doses was also associated with a considerable reduction in condyloma risk. The implications of these findings for the relationship between number of vaccine doses and cervical cancer risk require further investigation. Human papillomavirus (HPV) types 16 and 18, two HPV types included in the prophylactic HPV vaccines, are implicated in multiple cancer outcomes, including cervical cancer.<sup>1,2</sup> The quadrivalent HPV vaccine also protects against HPV types 6 and 11, which cause about 90% of condylomas, also referred to as genital warts.<sup>3</sup> Condyloma is the first HPV-related disease end point that can be measured after quadrivalent HPV vaccination because of its short incubation time of between 1 and 6 months.<sup>4- 6</sup>

Between 2007 and 2011, Sweden had a partially subsidized, opportunistic HPV vaccination program for girls aged 13 to 17 years. Vaccine coverage within this target group was about 25% in 2010.<sup>7</sup> Ninety-nine percent of girls vaccinated received the quadrivalent vaccine. In 2012, a school-based vaccination program was launched for girls aged 10 to 12 years, with a catch-up program for girls aged 13 to 18 years, all free of charge.

Both the bivalent and quadrivalent vaccines currently have a 3-dose schedule, which is associated with increased cost and other program feasibility issues.<sup>8,9</sup> Dose efficacy has been widely discussed as a fundamental factor in decisions regarding vaccination strategies.<sup>8,10,11</sup> The overall protective effects of HPV vaccination programs and requisite efforts appropriate for ensuring complete 3-dose vaccinations are unclear. Small clinical trials have reported measures of vaccine efficacy with less than 3 doses.<sup>8,12,13</sup>

In contrast to vaccine efficacy trials, population-based studies can examine reduction in disease end points and are more likely to reflect the vaccinated population.<sup>14,15</sup> Population-

based studies measuring HPV-related diseases provide essential complementary information to studies of vaccine dose efficacy, which primarily assess nondisease end points such as immune response or are designed so that efficacy comparisons cannot be made between multiple dose levels. Registry data in Sweden include unique information on vaccination dose dates for the entire population. The aim of this study was to assess the association between quadrivalent HPV vaccination and condyloma per vaccine dose among young females in a population-based setting.

### **[Legislative Challenges to School Immunization Mandates, 2009-2012](#)**

Saad B. Omer, PhD1; Diane Peterson, BS2; Eileen A. Curran, MPH1; Alan Hinman, MD3; Walter A. Orenstein, MD4

#### **[Author Affiliations](#)**

JAMA. 2014;311(6):620-621. doi:10.1001/jama.2013.282869.

School immunization mandates, implemented through state-level legislation, have played an important role in maintaining high immunization coverage in the United States. Immunization mandates permit exemptions that vary from state to state in terms of type of exemption (eg, religious, personal belief, medical), and administrative ease of obtaining these exemptions. Certain types of exemptions (especially personal belief exemptions) and the ease of obtaining them are predictive of high rates of vaccine exemptions and increased disease risk among exemptors themselves and in the communities in which they reside.<sup>1,2</sup>

### **JAMA Pediatrics**

February 2014, Vol 168, No. 2

<http://archpedi.jamanetwork.com/issue.aspx>

[Reviewed earlier]

### **Journal of Community Health**

Volume 39, Issue 1, February 2014

<http://link.springer.com/journal/10900/39/1/page/1>

[Reviewed earlier]

### **Journal of Health Organization and Management**

Volume 27 issue 6 - Latest Issue

<http://www.emeraldinsight.com/journals.htm?issn=1477-7266&show=latest>

[Reviewed earlier; No relevant content]

### **Journal of Infectious Diseases**

Volume 209 Issue 5 March 1, 2014

<http://jid.oxfordjournals.org/content/current>

### **Young Gay Men and the Quadrivalent Human Papillomavirus Vaccine—Much to Gain (and Lose)**

[Ross D. Cranston](#)

Department of Medicine, University of Pittsburgh, Pennsylvania

<http://jid.oxfordjournals.org/content/209/5/635.extract>

*Extract*

Human papillomavirus (HPV) is the world's most common viral sexually transmitted infection [1, 2]. Approximately 40 HPV types infect anogenital squamous epithelium and can be broadly divided into low-risk (eg, HPV 6, 11) and high-risk (eg, HPV 16, 18) phenotypes based on their historical association with cervical cancer. This relationship also holds true for other anogenital (anal, vulvar, vaginal) and oropharyngeal malignancies. Although most HPV infections are asymptomatic, when symptoms do occur, they often reflect the presence of warts, dysplasia, or frank malignancy.

Anogenital HPV infection is mostly transient in both sexes, with persistent high-risk HPV infection associated with the development of squamous-cell cancers [3, 4]. HPV prevalence data vary by gender, with men being more likely to have higher-level detection over a wider age range than women, whose prevalence decreases from a peak in their early 20s [3, 5]. However, it is men who have sex with men (MSM) who have the highest rates of anogenital HPV infection and also HPV-associated malignancy, particularly HPV 16-associated anal cancer [6, 7].

HPV vaccination has been shown to be safe and effective in preventing the acquisition of anogenital HPV infection and the development of dysplasia [8–10]. The challenge ahead is to ensure that vaccinations are available to those at risk in a manner that optimizes their efficacy. There are 2 licensed HPV vaccines: a bivalent vaccine directed against HPV 16 and 18 (Cervarix, GlaxoSmithKline, London, UK) licensed for females aged 9–25 years, and a quadrivalent HPV vaccine (qHPV) directed against HPV 6, 11, 16, and 18 (Gardasil, Merck, Whitehouse Station, NJ) licensed for females and males ages 9–26 years. Both vaccines' indications include prevention of...

### **Early Acquisition of Anogenital Human Papillomavirus Among Teenage Men Who Have Sex With Men**

[Huachun Zou](#)<sup>1</sup>, [Sepehr N. Tabrizi](#)<sup>2,3,4</sup>, [Andrew E. Grulich](#)<sup>5</sup>, [Suzanne M. Garland](#)<sup>2,3,4</sup>, [Jane S. Hocking](#)<sup>6</sup>, [Catriona S. Bradshaw](#)<sup>1,7,8</sup>, [Andrea Morrow](#)<sup>7</sup>, [Garrett Prestage](#)<sup>5,9</sup>, [Alyssa M. Cornell](#)<sup>3,4</sup>, [Christopher K. Fairley](#)<sup>1,7,9,a</sup> and [Marcus Y. Chen](#)<sup>1,7,9,a</sup>

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<http://jid.oxfordjournals.org/content/209/5/642.abstract>

#### *Abstract*

**Background.** Anogenital human papillomavirus (HPV) is common among men who have sex with men (MSM) and causes anal cancer. This study examined the determinants of initial anogenital HPV infection among teenage MSM.

**Methods.** Two hundred MSM aged 16 to 20 years were recruited via community and other sources. Men were tested for HPV DNA from the anus and penis.

**Results.** The proportion of men with anal HPV of any type increased from 10.0% in men reporting no prior receptive anal sex to 47.3% in men reporting  $\geq 4$  receptive anal sex partners ( $P < .001$ ). A similar pattern was also seen with HPV type 16 ( $P = .044$ ). The proportion of men

with penile HPV increased from 3.7% in men reporting no prior insertive anal sex to 14.8% in men reporting  $\geq 4$  insertive anal sex partners ( $P = .014$ ). Overall, 39.0% (95% confidence interval (CI), 32.2%–46.1%) of men had at least 1 HPV type: 23.0% (95% CI, 17.4%–29.5%) had a vaccine-preventable type (6, 11, 16 or 18).

Conclusions. Early and high per partner transmission of HPV occurred between men soon after their first sexual experiences. HPV vaccination needs to commence early for maximal prevention of HPV among MSM.

### **Journal of Global Ethics**

Volume 9, Issue 3, 2013

[http://www.tandfonline.com/toc/rjge20/current#.UqNh2OKy\\_Kc](http://www.tandfonline.com/toc/rjge20/current#.UqNh2OKy_Kc)

[Reviewed earlier; No relevant content]

### **Journal of Global Infectious Diseases (JGID)**

October-December 2013 Volume 5 | Issue 4 Page Nos. 125-186

<http://www.jgid.org/currentissue.asp?sabs=n>

[No relevant content]

### **Journal of Medical Ethics**

March 2014, Volume 40, Issue 3

<http://jme.bmj.com/content/current>

[No relevant content]

### **Journal of Medical Microbiology**

February 2014; 63 (Pt 2)

<http://jmm.sgmjournals.org/content/current>

[No relevant content]

### **Journal of the Pediatric Infectious Diseases Society (JPIDS)**

Volume 2 Issue 4 December 2013

<http://jpids.oxfordjournals.org/content/current>

[Reviewed earlier]

### **Journal of Pediatrics**

Vol 164 | No. 2 | February 2014 | Pages 223-430

<http://www.jpeds.com/current>

[Reviewed earlier; No relevant content]

### **Journal of Public Health Policy**

Volume 35, Issue 1 (February 2014)

<http://www.palgrave-journals.com/jphp/journal/v35/n1/index.html>

### ***Special Section: Preventing Addictions***

[Reviewed earlier; No relevant content]

### **Journal of the Royal Society – Interface**

April 6, 2014; 11 (93)

<http://rsif.royalsocietypublishing.org/content/current>

[No relevant content]

### **Journal of Virology**

March 2014, volume 88, issue 5

<http://jvi.asm.org/content/current>

[Reviewed earlier; No relevant content]

### **The Lancet**

Feb 15, 2014 Volume 383 Number 9917 p575 – 668 e12 - 14

<http://www.thelancet.com/journals/lancet/issue/current>

#### ***Editorial***

#### **Protecting children in conflict**

[The Lancet](#)

[Preview](#) |

The UN Convention on the Rights of the Child states that children have rights to protection, health, education, and fair treatment. For the children killed, tortured, raped, and abused in conflicts, these rights are far beyond reach.

Last week, a [report](#) of the UN Secretary-General on the situation of children and armed conflict in Syria detailed grave violations against children, committed by all parties. More than 10 000 children are estimated to have been killed since March, 2011, many more injured, and countless psychologically affected. The document contains reports of the imprisonment, torture, and murder of children, and their exposure to unthinkable cruelties. Sexual violence is used to harm, humiliate, and intimidate young victims and those forced to witness. Children have been recruited into warfare, abducted for ransom, and used as human shields. They have lost families, homes, schools, and health care.

Tragically, similar reports have surfaced from other nations gripped by conflict. Brutality against children in the Central African Republic is said to be at unprecedented levels; children are being beheaded and maimed amid widespread sexual violence, and an estimated 6000 are associated with armed groups. For children who escape conflict, the psychological scars from witnessing horrific events endure. In South Sudan, orphaned and displaced children will struggle to find their emotional needs met in a country battered by decades of civil war, many living in camps where their security and health are threatened. Children born as refugees might not have birth certificates, crucial to ensure they can access their rights.

By committing atrocities to children, fighters destroy their nation's future. Damage to children's health, education, and psychological wellbeing will delay a country's recovery; without decisive action, a generation in every war zone could become the lasting casualties. Better protection of children is paramount. The Syrian Government has legislated greater child protection, but violations threaten to continue while war lasts. During the conflicts and the

aftermath, international communities must seek to heal emotional wounds and safeguard children's rights.

### ***Comment***

#### **Protecting health: the global challenge for capitalism**

[Richard Horton](#) [a](#), [Selina Lo](#) [a](#)

<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2962712-9/fulltext>

The quest to secure economic growth, after a financial crisis that raised serious questions about capitalism's ability to protect and sustain the wellbeing of populations in rich and poor countries alike, is the overriding political priority for many governments today. And those prospects for growth seem good. The World Bank reported in January, 2014, that "advanced economies are turning the corner" and that "developing countries [will] regain strength after two weak years".<sup>1</sup> Specifically, global growth is expected to be 3·2% in 2014, rising to 3·5% by 2016. In high-income countries, growth is predicted to be 2·2% in 2014, rising to 2·4% in 2016. And for developing countries, the expectations are little short of spectacular: projected growth of 5·3% in 2014, rising to 5·7% in 2016. By 2015 it is projected that sub-Saharan Africa will host seven of the world's fastest growing economies. The World Bank concludes that the world is "finally emerging from the global financial crisis".

This change in economic fortune should be good news for health. It will mean more resources to invest not only in the health sector, but also in related sectors that shape and influence health, such as education and housing. However, there are disparities between regions. The World Bank<sup>1</sup> estimates that China can expect growth of 7·7% in 2014. Sub-Saharan Africa's growth will likely be 6·4%, excluding South Africa. South Asia should come in at 5·7%, with India at 6·2%. But Latin America and the Middle East are expected to deliver dismal 2·9% and 2·8% growth rates, respectively. Meanwhile, some countries will do less well than their neighbours. Pakistan, 3·4% growth. South Africa, 2·7%. Brazil, 2·4%. Egypt, 2·3%. Central and eastern Europe, 2·1%. Iran, 1%. These between-country disparities will be compounded by within-country inequalities. The World Bank has less to say on this issue. But the lack of inclusive growth within a nation—that is, the exclusion of sectors of the population from the overall benefits of economic growth which should include improved health—will deepen inequality in ways that headline gross domestic product figures fail to reveal.

Economic growth alone will not deliver good health to the most vulnerable sectors of society without addressing the intertwined global factors that challenge or destroy healthy lives. Beyond the economy, recent extreme weather events experienced across most parts of the world are tentative (and incompletely understood) signs that the effects of climate change are already with us. The effect that climate has on the agriculture sector and food security, and the likely impact on nutrition and health outcomes, requires further deep evaluation and cooperation between disciplines. The worsening conflict in Syria, and the continued violence in Iraq, Afghanistan, South Sudan, and the Central African Republic, show the frightening ability of violence to damage health and wellbeing, not only directly, but also indirectly through the social chaos violence inevitably causes. Recent episodes of civil strife in Turkey, Thailand, and Brazil prove that despite considerable health gains, the political systems within which those health gains have taken place are fragile and unstable—lessons that all societies need to relearn, no matter how secure they feel today.

These challenges can be addressed only by reaching beyond the health sector. This might seem an obvious notion but its common understanding and application in global policy debate is weak. Decisions made in different political domains rarely have health at the core of their thinking.

One great gap in thinking about the future of health and wellbeing are the arrangements we put in place to organise our international institutions and policies to sustain the fortunes of societies. These arrangements are inherently political, as Ole Petter Ottersen and his colleagues argue in the final report of The Lancet—University of Oslo Commission on Global Governance for Health.<sup>2</sup> They are about power. They are about elites. And they are about a rigid consensus among these powerful elites that prevents most attempts to question the norms on which political decisions are made. Yet elites are only as powerful as the systems that support the status quo. And global systems, such as those in trade, investment, or security, should (but do not always) have mechanisms for civil society participation and links with international norms that already exist to protect health.

The Commission addresses seven political domains that shape health and contribute to inequity within populations: finance, intellectual property, trade and investment treaties, food, corporate activity, migration, and armed conflict. It examines the obstacles to effective global governance for health. And finally, it proposes mechanisms to improve the accountability of all those who influence health through these different sectors. Proposals that could better articulate a way in which civil society engages in global policy, together with ideas for how international institutions could be mandated to produce health equity impact assessments, are worthy of consideration and debate.

The Commission includes contributors from 13 countries, including India, Brazil, Thailand, Tanzania, Ghana, Namibia, South Africa, and the occupied Palestinian territory. They have provided an opportunity to pause and reflect on a problem of emerging and serious importance. The era after the Millennium Development Goals is one that will be substantially more complex than today. The link between poverty and sustainability is not simple. Exclusive anti-poverty measures will not solve some of the biggest health threats people face. Solutions will require specific input from different regions, countries, and individuals—and a more critical understanding than has hitherto been displayed by policy makers of the determinants of human survival and wellbeing. Success will demand courage and flexibility to challenge the consensus that so inhibits the changes needed to bring about greater equity. This Commission can, we hope, be a contribution to this need for greater critical understanding and challenge.

We would like to thank all of the Commissioners for their contributions to this project—and especially Professor Ole Petter Ottersen for leading this work—and are grateful for the support of the Commission from the Norwegian Agency for Development Cooperation, the Norwegian Ministry of Foreign Affairs, the Norwegian Ministry of Education and Research, the Board of the University of Oslo, the University of Oslo's Institute of Health and Society and Centre for Development and the Environment, and the Harvard Global Health Institute.

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<sup>1</sup> The World Bank. Global economic prospects: coping with policy normalization in high-income countries. Washington, DC: The World Bank, 2014.

<sup>2</sup> Ottersen OP, Dasgupta J, Blouin C, et al. The political origins of health inequity: prospects for change. Lancet 2014. published online Feb 11. [http://dx.doi.org/10.1016/S0140-6736\(13\)62407-1](http://dx.doi.org/10.1016/S0140-6736(13)62407-1).

#### **The Lancet Commissions**

##### ***-University of Oslo Commission on Global Governance for Health***

##### **The political origins of health inequity: prospects for change**

Ole Petter Ottersen, Jashodhara Dasgupta, Chantal Blouin, Paulo Buss, Virasakdi Chongsuvatwong, Julio Frenk, Sakiko Fukuda-Parr, Bience P Gawanas, Rita Giacaman, John Gyapong, Jennifer Leaning, Michael Marmot, Desmond McNeill, Gertrude I Mongella, Nkosana

Moyo, Sigrun Møgedal, Ayanda Ntsaluba, Gorik Ooms, Espen Bjertness, Ann Louise Lie, Suerie Moon, Sidsel Roalkvam, Kristin I Sandberg, Inger B Scheel

[Full Text](#) | [PDF](#)

### *Executive summary*

Despite large gains in health over the past few decades, the distribution of health risks worldwide remains extremely and unacceptably uneven. Although the health sector has a crucial role in addressing health inequalities, its efforts often come into conflict with powerful global actors in pursuit of other interests such as protection of national security, safeguarding of sovereignty, or economic goals.

This is the starting point of The Lancet—University of Oslo Commission on Global Governance for Health. With globalisation, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power: states, transnational corporations, civil society, and others. The decisions, policies, and actions of such actors are, in turn, founded on global social norms. Their actions are not designed to harm health, but can have negative side-effects that create health inequities. The norms, policies, and practices that arise from global political interaction across all sectors that affect health are what we call global political determinants of health.

The Commission argues that global political determinants that unfavourably affect the health of some groups of people relative to others are unfair, and that at least some harms could be avoided by improving how global governance works. There is an urgent need to understand how public health can be better protected and promoted in the realm of global governance, but this issue is a complex and politically sensitive one. Global governance processes involve the distribution of economic, intellectual, normative, and political resources, and to assess their effect on health requires an analysis of power.

This report examines power disparities and dynamics across a range of policy areas that affect health and that require improved global governance: economic crises and austerity measures, knowledge and intellectual property, foreign investment treaties, food security, transnational corporate activity, irregular migration, and violent conflict. The case analyses show that in the contemporary global governance landscape, power asymmetries between actors with conflicting interests shape political determinants of health.

### *Key messages*

:: The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions

:: Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities

:: Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas

:: There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health

:: State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health

:: Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet

**The Lancet Global Health**

Feb 2014 Volume 2 Number 2 e58 – 116

<http://www.thelancet.com/journals/langlo/issue/current>

[Reviewed earlier]

**The Lancet Infectious Diseases**

Feb 2014 Volume 14 Number 2 p87 – 172

<http://www.thelancet.com/journals/laninf/issue/current>

[Reviewed earlier]

**Medical Decision Making (MDM)**

February 2014; 34 (2)

<http://mdm.sagepub.com/content/current>

[No relevant content]

**The Milbank Quarterly**

*A Multidisciplinary Journal of Population Health and Health Policy*

December 2013 Volume 91, Issue 4 Pages 659–868

[http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)1468-0009/currentissue](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1468-0009/currentissue)

[Reviewed earlier; No relevant content]

**Nature**

Volume 506 Number 7487 pp131-260 13 February 2014

[http://www.nature.com/nature/current\\_issue.html](http://www.nature.com/nature/current_issue.html)

[No relevant content]

**Nature Immunology**

February 2014, Volume 15 No 2 pp111-205

<http://www.nature.com/ni/journal/v15/n2/index.html>

[No relevant content]

**Nature Medicine**

February 2014, Volume 20 No 2

<http://www.nature.com/nm/index.html>

[No relevant content]

**Nature Reviews Immunology**

February 2014 Vol 14 No 2

<http://www.nature.com/nri/journal/v14/n2/index.html>

[No relevant content]

### **New England Journal of Medicine**

February 13, 2014 Vol. 370 No. 7

<http://www.nejm.org/toc/nejm/medical-journal>

[No relevant content]

### **OMICS: A Journal of Integrative Biology**

January 2014, 18(1)

<http://online.liebertpub.com/toc/omi/17/12>

[No relevant content]

### **The Pediatric Infectious Disease Journal**

February 2014 - Volume 33 - Issue 2 pp: 121-231,e29-e66

<http://journals.lww.com/pidj/pages/currenttoc.aspx>

[Reviewed earlier]

### **Pediatrics**

February 2014, VOLUME 133 / ISSUE 2

<http://pediatrics.aappublications.org/current.shtml>

[Reviewed earlier; No relevant content]

### **Pharmaceutics**

Volume 6, Issue 1 (March 2014), Pages 1-

<http://www.mdpi.com/1999-4923/6/1>

[No relevant content]

### **Pharmacoeconomics**

Volume 32, Issue 2, February 2014

<http://link.springer.com/journal/40273/32/2/page/1>

[Reviewed earlier; No relevant content]

### **PLoS One**

[Accessed 15 February 2014]

<http://www.plosone.org/>

#### **Research Article**

#### **Quantifying the Decisional Satisfaction to Accept or Reject the Human Papillomavirus (HPV) Vaccine: A Preference for Cervical Cancer Prevention**

Diane M. Harper mail, Billy B. Irons, Natalie M. Alexander, Johanna C. Comes, Melissa S. Smith, Melinda A. Heutinck, Sandra M. Handley, Debra A. Ahern

Published: February 14, 2014

DOI: 10.1371/journal.pone.0088493

<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0088493>

## *Abstract*

### Objective

Only a portion of the US population is willing to consider HPV vaccination to date. The primary aim of this study is to determine the decisional satisfaction associated with HPV vaccination.

### Study Design

This is a prospective survey conducted at an urban college where women 18–26 years old completed a decisional satisfaction survey about their HPV vaccine experience.

### Results

Regardless of the decision to accept or reject HPV vaccination, the decisional satisfaction was very high (mean 5-item score = 21.2 (SD 3.8)). Women without HPV vaccination were decisionally neutral significantly more often than those already vaccinated; 22% were decisionally neutral for the option to accept HPV vaccination at that visit. Cervical cancer prevention was preferred significantly more often than genital wart prevention in all analyses.

### Conclusions

Targeting those who are decisionally neutral about HPV vaccination may result in a higher uptake of HPV vaccination.

## ***Research Article***

### **Essential Medicines Are More Available than Other Medicines around the Globe**

Yaser T. Bazargani, Margaret Ewen, Anthonius de Boer, Hubert G. M. Leufkens, Aukje K. Mantel-Teeuwisse mail

Published: February 12, 2014

DOI: 10.1371/journal.pone.0087576

<http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0087576>

## *Abstract*

### Background

The World Health Organization (WHO) promotes the development of national Essential Medicines Lists (EMLs) in order to improve the availability and use of medicines considered essential within health care systems. However, despite over 3 decades of international efforts, studies show an inconsistent pattern in the availability of essential medicines. We evaluated and compared the availability of essential medicines, and medicines not included in national EMLs, at global and regional levels.

### Methods

Medicine availability in the public and private sector were calculated based on data obtained from national and provincial facility-based surveys undertaken in 23 countries using the WHO/HAI methodology. The medicines were grouped according to their inclusion ('essential') or exclusion (termed 'non-essential') in each country's EML current at the time of the survey. Availability was calculated for originator brands, generics and any product type (originator brands or generics) and compared between the two groups. Results were aggregated by WHO regions, World Bank country income groups, a wealth inequality measure, and therapeutic groups.

### Findings

Across all sectors and any product type, the median availability of essential medicines was suboptimal at 61.5% (IQR 20.6%–86.7%) but significantly higher than non-essential medicines at 27.3% (IQR 3.6%–70.0%). The median availability of essential medicines was 40.0% in the public sector and 78.1% in the private sector; compared to 6.6% and 57.1% for non-essential medicines respectively. A reverse trend between national income level categories and the availability of essential medicines was identified in the public sector.

### Interpretation

EMLs have influenced the provision of medicines and have resulted in higher availability of essential medicines compared to non-essential medicines particularly in the public sector and in low and lower middle income countries. However, the availability of essential medicines, especially in the public sector does not ensure equitable access.

## **PLoS Medicine**

(Accessed 15 February 2014)

<http://www.plosmedicine.org/>

[No new relevant content]

## **PLoS Neglected Tropical Diseases**

January 2014

<http://www.plosntds.org/article/browseIssue.action>

### **[Mass Vaccination with a New, Less Expensive Oral Cholera Vaccine Using Public Health Infrastructure in India: The Odisha Model](#)**

Shantanu K. Kar, Binod Sah mail, Bikash Patnaik, Yang Hee Kim, Anna S. Kerketta, Sunheang Shin, Shyam Bandhu Rath, Mohammad Ali, Vittal Mogasale, Hemant K. Khuntia, Anuj Bhattachan, Young Ae You, Mahesh K. Puri, Thomas F. Wierzba

<http://www.plosntds.org/article/info:doi/10.1371/journal.pntd.0002629#close>

#### *Abstract*

##### Introduction

The substantial morbidity and mortality associated with recent cholera outbreaks in Haiti and Zimbabwe, as well as with cholera endemicity in countries throughout Asia and Africa, make a compelling case for supplementary cholera control measures in addition to existing interventions. Clinical trials conducted in Kolkata, India, have led to World Health Organization (WHO)-prequalification of Shanchol, an oral cholera vaccine (OCV) with a demonstrated 65% efficacy at 5 years post-vaccination. However, before this vaccine is widely used in endemic areas or in areas at risk of outbreaks, as recommended by the WHO, policymakers will require empirical evidence on its implementation and delivery costs in public health programs. The objective of the present report is to describe the organization, vaccine coverage, and delivery costs of mass vaccination with a new, less expensive OCV (Shanchol) using existing public health infrastructure in Odisha, India, as a model.

##### Methods

All healthy, non-pregnant residents aged 1 year and above residing in selected villages of the Satyabadi block (Puri district, Odisha, India) were invited to participate in a mass vaccination campaign using two doses of OCV. Prior to the campaign, a de jure census, micro-planning for vaccination and social mobilization activities were implemented. Vaccine coverage for each dose was ascertained as a percentage of the censused population. The direct vaccine delivery costs were estimated by reviewing project expenditure records and by interviewing key personnel.

##### Results

The mass vaccination was conducted during May and June, 2011, in two phases. In each phase, two vaccine doses were given 14 days apart. Sixty-two vaccination booths, staffed by 395 health workers/volunteers, were established in the community. For the censused population, 31,552 persons (61% of the target population) received the first dose and 23,751 (46%) of these completed their second dose, with a drop-out rate of 25% between the two doses. Higher coverage was observed among females and among 6–17 year-olds. Vaccine cost

at market price (about US\$1.85/dose) was the costliest item. The vaccine delivery cost was \$0.49 per dose or \$1.13 per fully vaccinated person.

#### Discussion

This is the first undertaken project to collect empirical evidence on the use of Shanchol within a mass vaccination campaign using existing public health program resources. Our findings suggest that mass vaccination is feasible but requires detailed micro-planning. The vaccine and delivery cost is affordable for resource poor countries. Given that the vaccine is now WHO pre-qualified, evidence from this study should encourage oral cholera vaccine use in countries where cholera remains a public health problem.

#### *Author Summary*

Cholera – an acute life-threatening diarrheal illness – continues to disrupt public health in resource poor countries. The devastating outbreaks in Haiti and Zimbabwe – to name just two of many occurrences – calls for the use of available oral cholera vaccines as an additional tool in the arsenal of cholera control measures. An oral cholera vaccine (Shanchol) has been licensed in India since 2009; however, there has only been limited use of this vaccine in government public health programs. A vaccination campaign using 2 doses of Shanchol was conducted in Odisha, India, during May and June, 2011, where 31,552 persons (61% of the target population) received the first dose and 23,751 of them completed their second dose. The vaccine delivery cost was \$0.49 per dose. Through our findings and experience, we discuss the organization of the cholera vaccination campaign in Odisha, the challenges met for conducting the campaign and the strategies designed to overcome those challenges, and the delivery costs incurred in the use of this vaccine, the first of its kind, in a public health setting. We believe that evidence from this study is of significant interest and use to policymakers from countries where cholera remains a public health problem.

### **PNAS - Proceedings of the National Academy of Sciences of the United States of America**

<http://www.pnas.org/content/early/>

(Accessed 15 February 2014)

[Website unavailable for review]

### **Pneumonia**

Vol 2 (2013)

<https://pneumonia.org.au/index.php/pneumonia/issue/current>

[Reviewed earlier]

### **Public Health Ethics**

Volume 6 Issue 3 November 2013

<http://phe.oxfordjournals.org/content/current>

[Reviewed earlier]

### **Qualitative Health Research**

February 2014; 24 (2)

<http://qhr.sagepub.com/content/current>

Special Issue: Communication  
[No relevant content]

**Revista Panamericana de Salud Pública/Pan American Journal of Public Health  
(RPSP/PAJPH)**

[December 2013](#) Vol. 34, No. 6

[http://www.paho.org/journal/index.php?option=com\\_content&view=article&id=134&Itemid=230&lang=en](http://www.paho.org/journal/index.php?option=com_content&view=article&id=134&Itemid=230&lang=en)

[Reviewed earlier]

**Risk Analysis**

January 2014 Volume 34, Issue 1 Pages 1–201

<http://onlinelibrary.wiley.com/doi/10.1111/risa.2014.34.issue-1/issuetoc>

[Reviewed earlier; No relevant content]

**Science**

14 February 2014 vol 343, issue 6172, pages 701-808

<http://www.sciencemag.org/current.dtl>

[No relevant content]

**Science Translational Medicine**

12 February 2014 vol 6, issue 223

<http://stm.sciencemag.org/content/current>

[No relevant content]

**Social Science & Medicine**

Volume 106, [In Progress](#) (April 2014)

<http://www.sciencedirect.com/science/journal/02779536/104>

[No relevant content]

**Vaccine**

Volume 32, Issue 11, Pages 1227-1322 (5 March 2014)

<http://www.sciencedirect.com/science/journal/0264410X/32>

**[Yellow fever vaccine-associated adverse events following extensive immunization in Argentina](#)**

Original Research Article

Pages 1266-1272

Cristián Biscayart, María Eugenia Pérez Carrega, Sandra Sagradini, Ángela Gentile, Daniel Stecher, Tomás Orduna, Silvia Bentancourt, Salvador García Jiménez, Luis Pedro Flynn, Gabriel Pirán Arce, María Andrea Uboldi, Laura Bugna, María Alejandra Morales, Clara Digilio, Cintia Fabbri, Delia Enría, Máximo Diosque, Carla Vizzotti

*Abstract*

As a consequence of YF outbreaks that hit Brazil, Argentina, and Paraguay in 2008–2009, a significant demand for YF vaccination was subsequently observed in Argentina, a country where the usual vaccine recommendations are restricted to provinces that border Brazil, Paraguay, and Bolivia. The goal of this paper is to describe the adverse events following immunization (AEFI) against YF in Argentina during the outbreak in the northeastern province of Misiones, which occurred from January 2008 to January 2009. During this time, a total of nine cases were reported, almost two million doses of vaccine were administered, and a total of 165 AEFI were reported from different provinces. Case study analyses were performed using two AEFI classifications. Forty-nine events were classified as related to the YF vaccine (24 serious and 1 fatal case), and 12 events were classified as inconclusive. As the use of the YF 17D vaccine can be a challenge to health systems of countries with different endemicity patterns, a careful clinical and epidemiological evaluation should be performed before its prescription to minimize serious adverse events.

### **[The economic burden of sixteen measles outbreaks on United States public health departments in 2011](#)**

Original Research Article

Pages 1311-1317

Ismael R. Ortega-Sanchez, Maya Vijayaraghavan, Albert E. Barskey, Gregory S. Wallace

#### *Abstract*

##### Background

Despite vaccination efforts and documentation of elimination of indigenous measles in 2000, the United States (US) experienced a marked increase in imported cases and outbreaks of measles in 2011. Due to the high infectiousness and potential severity of measles, these outbreaks require a vigorous response from public health institutions. The effort and resources required to respond to these outbreaks are likely to impose a significant economic burden on these institutions.

##### Objective

To estimate the economic burden of measles outbreaks (defined as  $\geq 3$  epidemiologically linked cases) on the local and state public health institutions in the US in 2011.

##### Methods

From the perspective of local and state public health institutions, we estimated personnel time and resources allocated to measles outbreak response in local and state public health departments, and estimated the corresponding costs associated with these outbreaks in the US in 2011. We used cost and resource utilization data from previous studies on measles outbreaks in the US and, relying on outbreak size classification based on a case-day index, we estimated costs incurred by local and state public health institutions.

##### Results

In 2011, the US experienced 16 outbreaks with 107 confirmed cases. The average duration of an outbreak was 22 days (range: 5–68). The total estimated number of identified contacts to measles cases ranged from 8936 to 17,450, requiring from 42,635 to 83,133 personnel hours. Overall, the total economic burden on local and state public health institutions that dealt with measles outbreaks during 2011 ranged from an estimated \$2.7 million to \$5.3 million US dollars.

##### Conclusion

Investigating and responding to measles outbreaks imposes a significant economic burden on local and state health institutions. Such impact is compounded by the duration of the outbreak and the number of potentially susceptible contacts.

## **Vaccine**

Volume 32, Issue 10, Pages 1131-1226 (26 February 2014)

<http://www.sciencedirect.com/science/journal/0264410X/32/10>

### **Increased measles–mumps–rubella (MMR) vaccine uptake in the context of a targeted immunisation campaign during a measles outbreak in a vaccine-reluctant community in England**

Original Research Article

Pages 1147-1152

Arnaud Le Menach, Naomi Boxall, Gayatri Amirthalingam, Liz Maddock, Sooria Balasegaram, Miranda Mindlin

#### *Abstract*

##### Background

Following a measles outbreak in a vaccine-rejecting community between April and September 2011 in South-East England, local health agencies implemented a two-pronged measles–mumps–rubella (MMR) immunisation campaign from August to October offered at the local general practice where most cases were registered. The campaign included (a) accelerated vaccination of children earlier than scheduled (1st dose at 6–11 months, or 2nd dose at 18–39 months), (b) catch-up of those aged over 18 months who had had no MMR immunisations or were late for second MMR. We investigated the impact of the outbreak and campaign on the number of MMR doses given.

##### Materials and methods

In January 2012, we collected information on MMR vaccination for children registered at the practice aged 6 months–16 years on 1 August 2011, through the child health information system. We counted the number of MMR doses administered in 2011 and compared it to 2008–2010 data. We estimated the proportion vaccinated among the children eligible for the accelerated and catch-up campaign.

##### Results

The local practice administered 257 MMR doses in 2011, a 114% increase on the average for 2008–2010. Among children eligible for earlier MMR vaccination 5/26 (19%) received a first dose, and 34/57 (60%) a second dose. Among children eligible for catch-up, 20/329 (6%) received their first MMR and 39/121 (32%) their second. Of 1538 children, the proportion completely unimmunised for MMR declined by 3 percentage-points after the outbreak.

##### Discussion

Uptake of MMR vaccination significantly increased during the outbreak following the immunisation campaign. Those amenable to MMR vaccination seem to have benefited from the campaign more than those with no previous vaccinations. Future evaluations should address what made a few parents change their mind and have their children vaccinated for the first time during the outbreak.

## **Vaccine: Development and Therapy**

(Accessed 15 February 2014)

<http://www.dovepress.com/vaccine-development-and-therapy-journal>

[No new relevant content]

## **Vaccines — Open Access Journal**

(Accessed 15 February 2014)

<http://www.mdpi.com/journal/vaccines>

### **Review**

## **[Towards New Broader Spectrum Pneumococcal Vaccines: The Future of Pneumococcal Disease Prevention](#)**

by [Lucia H. Lee](#), [Xin-Xing Gu](#) and [Moon H. Nahm](#)

Vaccines 2014, 2(1), 112-128; doi:[10.3390/vaccines2010112](https://doi.org/10.3390/vaccines2010112) - published online 14 February 2014

Abstract: Seven-valent pneumococcal conjugate vaccine (PCV7) introduction and routine pediatric use has substantially reduced the burden of Streptococcus pneumoniae disease worldwide. However, a significant amount of disease burden, due to serotypes not contained in PCV7, still exists globally. A newly recognized serotype, 6C, was until recently, identified and reported as serotype 6A. This review summarizes the serotype epidemiology of pneumococcal disease pre- and post-introduction of PCV7, available post-marketing surveillance data following the introduction of higher valency pneumococcal vaccines (PCV10, PCV13) and future prospects for the development of new pneumococcal vaccines.

### **Value in Health**

Vol 17 | No. 1 | January – February 2014 | Pages 1-140

<http://www.valueinhealthjournal.com/current>

[Reviewed earlier; No relevant content]

## **[From Google Scholar & other sources: Selected Journal Articles, Newsletters, Dissertations, Theses, Commentary](#)**

### **[\[PDF\] Trends in the types and quality of childhood immunisation research output from Africa 1970-2010: mapping the evidence base](#)**

S Machingaidze, GD Hussey, CS Wiysonge - BMC Health Services Research, 2014

Abstract

Background: Over the past four decades, extraordinary progress has been made in establishing and improving childhood immunization programmes around Africa. In order to ensure effective and sustainable positive growth of these childhood immunisations programmes, the development, adaptation and implementation of all interventions (programme activities, new vaccines, new strategies and policies) should be informed by the best available local evidence.

Methods: An assessment of the peer-reviewed literature on childhood immunization research published in English from 1970 to 2010 was conducted in PubMed and Africa-Wide databases. All study types were eligible for inclusion. A standard form was used to extract information from all studies identified as relevant and entered into a Microsoft Access database for analysis.

Results: Our initial search yielded 5,436 articles from the two databases, from which 848 full text articles were identified as relevant. Among studies classified as clinical research (417), 40% were clinical trials, 24% were burden of disease/epidemiology and 36% were other clinical studies. Among studies classified as operational research (431), 77% related to programme management, 18% were policy related and 5% were related to vaccine financing. Studies were conducted in 48 African countries with six countries (South Africa, The Gambia, Nigeria, Senegal, Guinea-Bissau and Kenya) accounting for 56% of the total research output. Studies

were published in 152 different journals with impact factors ranging from 0.192 to 53.29; with a median impact factor of 3.572.

Conclusion: A similar proportion of clinical versus operational research output was found. However, an uneven distribution across Africa was observed with only six countries accounting for over half of the research output. The research conducted was of moderate to high quality, with 62% being published in journals with 2010 impact factors greater than two. Urgent attention should be given to the development of research capacity in low performing countries around Africa, with increased focus on the process of turning immunisations programme research evidence into policy and practice, as well as increased focus on issues relating to vaccine financing and sustainability in Africa.

### **Media/Policy Watch**

This section is intended 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 in 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 15 February 2014*

#### **Inside the world's largest polio reservoir**

*The city of Peshawar, in northwestern Pakistan, is a hotspot for the crippling virus.*

[Arisla Jawaid](#) Last updated: 08 Feb 2014 14:43

Peshawar, Pakistan - Almost 60 years after Jonas Salk developed a vaccine for the polio virus, the crippling disease remains endemic in just three countries: Afghanistan, Pakistan, and Nigeria.

Of those, only Pakistan saw an increase in the number of cases reported last year, from 58 cases in 2012 to 93 in 2013. More than 90 percent of these were found to be genetically linked to a strain of the virus emanating from the northwestern city of Peshawar.

According to a [statement](#) released by the World Health Organization (WHO), all environmental sewage samples collected over the past six months in Peshawar have tested positive for the presence of poliovirus, making the urban centre of approximately four million the world's "largest poliovirus reservoir", or source of infection...

### **The Atlantic**

<http://www.theatlantic.com/magazine/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**BBC**

<http://www.bbc.co.uk/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Brookings**

<http://www.brookings.edu/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Council on Foreign Relations**

<http://www.cfr.org/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Economist**

<http://www.economist.com/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Financial Times**

<http://www.ft.com>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Forbes**

<http://www.forbes.com/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Foreign Affairs**

<http://www.foreignaffairs.com/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**Foreign Policy**

<http://www.foreignpolicy.com/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**The Guardian**

<http://www.guardiannews.com/>

*Accessed 15 February 2014*

[No new, unique, relevant content]

**The Huffington Post**

<http://www.huffingtonpost.com/>

*Accessed 15 February 2014*

[Science for the Poor: Making Vaccines to Combat Poverty](#)  
[Peter Hotez, M.D, Ph.D. Become a fan](#)  
Founding Dean, National School of Tropical Medicine

**Le Monde**

<http://www.lemonde.fr/>  
Accessed 15 February 2014  
[No new, unique, relevant content]

**New Yorker**

<http://www.newyorker.com/>  
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