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Vaccines and Global Health: The Week in Review
8 November 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 and Global Health: 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 6,500 entries.*

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***Request an email version:** Vaccines and Global Health: The Week in Review is published as a single email summary, scheduled for release each Saturday evening before midnight (EDT in the U.S.). If you would like to receive the email version, please send your request to david.r.curry@centerforvaccineethicsandpolicy.org.*

POLIO [to 8 November 2014]
Public Health Emergency of International Concern (PHEIC)
GPEI Update: Polio this week - *As of 22 October 2014*
Global Polio Eradication Initiative
Editor's Excerpt and text bolding
Full report: http://www.polioeradication.org/Dataandmonitoring/Poliothisweek.aspx
:: Two new cases of circulating vaccine derived polio virus (cVDPV) have been reported in South Sudan, constituting an outbreak. Immunization activities are planned in November and December in order to stop the spread of cVDPV.
:: Immunization campaigns in Iraq in September reached 88% of children under 5. Around 20 million children were vaccinated across the Middle East in October. These activities are helping

to protect the gains made against the virus in the region, with no case reported for nearly 7 months.
:: In central Africa, it has been 6 months since the latest case of polio in Equatorial Guinea. In Cameroon, high level delegates from the World Health Organization, UNICEF and the Center for Disease Control and Prevention met with the Prime Minister and the Minister of Health in order to discuss the urgency of the outbreak response

Afghanistan

:: Six new wild poliovirus type 1 (WPV1) cases were reported in the past week in Afghanistan. Of these, 4 are from Kandahar province (2 in Kandahar district, and 1 in each of the previously uninfected districts of Shahwalikot and Arghandab); 1 is from the Bermel district of Paktika province, and 1 from the previously uninfected province of Ghazni, in Giro district. The most recent case had onset of paralysis on 4 October in Arghandab district, Kandahar province. The total number of WPV1 cases is now 18.
:: Given the growing outbreak in neighbouring Pakistan, Afghanistan is taking protective steps to limit any spread of the virus. Subnational Immunization Days (SNIDs) are scheduled across the south and east of Afghanistan 16-18 November using bivalent oral polio vaccine (OPV).

Nigeria

:: One new type 2 circulating vaccine-derived poliovirus (cVDPV2) case was reported in the past week in Bindawa district of Katsina province. The total number of cVDPV2 cases for 2014 is now 21. This cVDPV2 case had onset of paralysis on 12 September.

Pakistan

:: Fifteen new wild poliovirus type 1 (WPV1) cases were reported in the past week in Pakistan. Of these, 8 are from the Federally Administered Tribal Areas (FATA) (1 from South Waziristan, 1 from Frontier Region Bannu and 6 from Khyber Agency); 3 from Balochistan province (2 from Killa Abdullah district and 1 from Quetta); and 4 from Khyber Pakhtunkhwa (KP) province (3 from Peshawar district and 1 from Charsada district, previously uninfected in 2014). The most recent case had onset of paralysis on 20 October in South Waziristan. This brings the total number of WPV1 cases in 2014 to 235 compared to 56 in 2013 by this date.
:: Immunization activities are continuing with particular focus on known high-risk areas, in particular the newly opened areas of FATA. At exit and entry points of areas that are inaccessible during polio campaigns, 163 permanent vaccination points are being used to reach internally displaced families as they move in and out of the inaccessible area. Over 700,000 people have been vaccinated in the past few months at transit points and in host communities, including half a million children.

Horn of Africa

:: Two new cases of circulating vaccine derived poliovirus type 2 (cVDPV2) have been reported in South Sudan this week. Both are from Rubkona district of Unity province. The most recent onset of paralysis was on the 12 September.

West Africa

:: Even as polio programme staff across West Africa support efforts to control the Ebola outbreak affecting the region, efforts are being made in those countries not affected by Ebola to vaccinate children against polio. National Immunization Days (NIDs) are planned in Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Mauritania, Senegal and Togo starting 31 October and in Guinea Bissau starting on 8 November. Subnational Immunization Days (SNIDs) will also take place starting 31 October in Niger and Mali.

EBOLA/EVD [to 8 November 2014]
Public Health Emergency of International Concern (PHEIC); "Threat to international peace and security" (Security Council)

FINAL COMMUNIQUE: EXTRAORDINARY SESSION OF THE AUTHORITY OF ECOWAS HEADS OF STATE AND GOVERNMENT

ECOWAS **-** Economic Community of West African States
N°: 204/2014
6 NOVEMBER 2014 [Accra, Ghana]
[Excerpts; Editor's text bolding]

5. The Summit was deeply concerned by the negative impact of the Ebola Virus Disease on the economies of the countries directly affected, human security as well as the social and humanitarian situation in the region. It equally expressed concern regarding the threat to the regional integration process as well as regional peace and security posed by this epidemic.

6. The Authority expressed strong feelings at the loss of thousands of lives since the outbreak of the epidemic and reiterated solidarity and sympathy with the people of the affected countries, in particular Guinea, Liberia, Nigeria, Sierra Leone and Mali.

7. The Heads of State and Government reaffirmed their firm commitment to continue their joint and coordinated efforts in the determined fight against the Ebola Virus Disease. To that end, they commended the appropriate actions undertaken by Nigeria and Senegal, which enabled these two Member States to contain the epidemic. While also encouraging the other affected countries in their efforts to contain the epidemic, they expressed their hope that these countries will achieve the same success.

8. In the same vein, **with a view to ensuring the efficiency of all the efforts, the Authority appointed E. Faure Essozimna Gnassingbe President of the Togolese Republic to supervise the Ebola Virus Disease response and eradication process.**

9. Furthermore, after endorsing the Regional Integrated Operational Plan for Response to the Ebola Virus Disease and welcoming the relevance of the areas of intervention contained therein, the Heads of State and Government made the following specific decisions:

To the Member States

10. The Heads of State and Government call on all the Member States to urgently develop and implement guidelines on Ebola treatment and management in line with WHO standards. They also urge them to join ICAO and seek assistance from the ICAO/WHO Cooperation Arrangement for the Prevention of the Spread of Communicable Diseases through Air Travel (CAPSCA).

11. In addition, Authority urges the Member States to contribute military personnel and logistics to enhance response capacities, support the medical staff on the field and participate in the construction of additional treatment and isolation centres as well as ensure their security. It also encourages Member States to provide additional medical and voluntary staff to the affected countries.

12. The Summit commends the Member States that made contributions to the Regional Solidarity Fund to fight Ebola mainly Benin, Burkina Faso, Cote d'Ivoire, Mali, Niger, Nigeria, Senegal and Sierra Leone and urges the other countries to fulfill their commitment to the Fund.

13. The Heads of State and Government reiterate their unwavering commitment to the principles of free movement within the ECOWAS region and invite all the Member States to adhere to them, in particular by removing restriction and ban on the movement of persons and goods to and from the affected countries, while observing the appropriate health control at the borders.

14. The Authority urges the Member States to conduct extensive public education, communication and awareness on the Ebola Virus Disease with a view to preventing the stigmatisation of affected persons and stopping the transmission of the disease.

15. To better address sanitary crisis in the future, the Heads of State and Government consider that it is essential to ensure the strengthening of national health systems by improving upon their effectiveness and also by increasing the resources allocated them in the national budgets in accordance with the Abuja Declaration, which requires the allocation of 15% of the total budget.

To the ECOWAS Commission

16. The Heads of State and Government reiterate the need to strengthen the regional multi-sectoral coordination in the fight against the epidemic and underpin the important role of ECOWAS in that regard.

17. To that end, the Authority requests the Commission to take the necessary measures, in collaboration with of all the stakeholders and persons involved in the field, to mobilise adequate resources for the coordinated implementation of the Regional Operational Plan for Response to the Ebola Virus Disease.

18. The Authority directs the Commission to actively participate in the various actions undertaken to support the efforts of the Member States particularly in the planning, implementation and coordination of all United Nations Mission for Ebola Emergency Response (UNMEER) and African Union activities in the region. The Authority also instructs the Commission to create a consultation framework with the Mission for a short, medium and long-term response.

19. The Summit directs the Commission to support Member States to better coordinate their medical and humanitarian efforts on the field.

20. The Authority instructs the Commission to take all the necessary actions to set up a regional center for disease prevention and control in West Africa and enhance health research in West Africa. **It also encourages the Commission to be involved in the ongoing initiatives towards the development of vaccines.**

21. Authority requests the Commission to deepen the socio-economic and cultural assessment of the epidemic and take all necessary steps to provide the appropriate medium and long term response through a resolute action against poverty and ignorance, for sustainable growth and development.

22. *To the International Community,* the Heads of State and Government welcome the adoption of the United Nations Resolution 2177, which marks its unanimous determination to eradicate the Ebola Virus Disease.

23. In that regard, the Authority commends the show of international solidarity in support to the efforts of the affected countries. In particular, it welcomes the technical and financial support from all the ECOWAS bilateral and multilateral partners on the field.

24. In view of the continuing and increasing challenges of the Ebola Virus Disease, the Summit calls on all the partners to maintain the level of their commitment and support to the region, in particular by increasing their financial assistance to the affected Member States.

25. Similarly, the Summit invites private sector, civil society, regional and international humanitarian and development organizations to intensify efforts in technical, financial and institutional assistance to support treatment centers and other regular medical facilities in the affected countries, as well as public education, awareness and communication.

26. The Authority also invites all the relevant Partners to accelerate efforts for vaccines and adequate therapy against the virus as well as support the region in the development of research capacity. In addition, Authority calls on them to prioritise

the provision of vaccines at subsidized prices to the affected countries, and to the region.
27. The Heads of State and Government call on all the airlines and maritime companies to continue flight schedules to the affected countries or resume operations notably to transport health and humanitarian goods, drugs and equipment. They also call on partner countries to lift the restrictions on visa issuance to nationals of affected countries.
28. The Authority decides to remain seized of the situation of the epidemic in West Africa and directs the President of the Commission to ensure the implementation of adopted decisions and regularly provide updates on the epidemic…

WHO: Ebola Virus Disease (EVD)
Situation report - 5 November 2014 'WHO Roadmap'
HIGHLIGHTS
:: There have been 13,042 reported cases of Ebola, with 4818 reported deaths, up to the end of 2 November.
:: All districts in Liberia and Sierra Leone have been affected.
:: All 83 contacts of the health-care worker infected in Spain have completed 21-day follow-up
[Excerpt from Summary]
…At the country level, the weekly incidence appears to be stable in Guinea. In Sierra Leone the weekly incidence continues to rise, while in Liberia it appears to be declining. In all three countries, EVD transmission remains persistent and widespread, particularly in the capital cities. All administrative districts in Liberia and Sierra Leone have reported at least 1 confirmed or probable case of EVD since the outbreak began. Cases and deaths continue to be under-reported in this outbreak.
Of the countries with localized transmission, Mali and the United States of America continue to monitor potential contacts. In Spain, all 83 contacts of the health-care worker infected in Madrid have completed the 21-day follow-up period.

WHO welcomes approval of a second Ebola vaccine trial in Switzerland
Statement
6 November 2014
WHO welcomes approval by Swissmedic, the Swiss regulatory authority for therapeutic products, of a second Swiss trial of an experimental Ebola vaccine. The trial will be led by the University Hospitals of Geneva (HUG). If judged safe, larger scale trials will be taken to African countries as early as January 2015.
This trial approval means that the vaccine will be tested on approximately 115 volunteers in Geneva. The trial, which is receiving support from WHO, is the latest in a series of trials involving 2 different candidate Ebola vaccines that are ongoing in Switzerland, Mali, the United Kingdom, and the United States.
About the vaccine
The experimental VSV-ZEBOV vaccine has been developed by scientists at the Public Health Agency of Canada . It is based on the virus that causes vesicular stomatitis, a disease affecting animals. This virus has been weakened and genetically modified to express the glycoprotein of the Zaire Ebola virus (ZEBOV) so as to provoke an immune response against real Ebola viruses. The experimental vaccine will be tested on healthy volunteers, some of whom will be deployed as health care staff in the fight against the Ebola epidemic in West Africa. The trial will test the

safety of the vaccine and its ability to provoke an immune response. VSV-ZEBOV is also being tested on healthy volunteers in the USA (the first trial started 13 October) and trials are planned to start very soon in Germany, Gabon and Kenya.

Vaccine trials

The trial is the second one organised in Switzerland and coordinated by WHO. The first vaccine, "ChAd3" - Chimpanzee-Adenovirus ChAd3-ZEBOV – started trials in Lausanne at the end of October….

WHO: African regulators' meeting looking to expedite approval of vaccines and therapies for Ebola

November 2014

Aiming to make potential Ebola therapies and vaccines available as quickly as possible, the ninth African Vaccine Regulatory Forum (AVAREF), taking place in Pretoria, South Africa, from 3-7 November, will devote the first two days to agree on a collaborative mechanism for fast tracking approvals for clinical trials and registration of these products in the affected countries.

"As the President of Liberia has aptly put, the best cure for Ebola is stronger health systems," said Kees De Joncheere, WHO Director for Essential Medicines and Health products.

"It is crucial that we match the speed with which Ebola vaccines are being developed and tested with equal haste in making them available to populations once they are judged safe and effective," said Sarah Barber, WHO Representative in South Africa. "To do that, we need to agree on the design of clinical trials, and we need to collaborate across borders to fast-track scientific assessment, regulatory approval and roll-out."

The mechanism would cover:

:: Clear pathways and timelines for expedited ethical and regulatory review of clinical trial applications and approval of products;

:: Agreement on timelines and joint safety and efficacy assessments of the new products to fast-track national registration;

:: Endorsement of a panel of safety experts for expedited review of safety data of new products with relevant communication to National Regulatory Authorities (NRAs);

:: Technical assistance from the World Health Organization (WHO) to facilitate these processes.

Ebola, which has killed close to 5 000 people so far and crushed the already weakened health systems of Guinea, Liberia and Sierra Leone, had until recently received little attention from the pharmaceutical sector. The current outbreak, unprecedented in geographical scope and severity, has mobilised numerous private and public stakeholders to accelerate the development of vaccines to contain the outbreak and prevent other such crises in the future.

Three vaccines are currently undergoing human safety trials outside Africa. Once they are judged safe, further trials will take place in the countries affected by Ebola. The vaccines are being developed respectively by Glaxo-Smith-Kline with the US Government, Johnson & Johnson, and the Canadian Public Health Agency.

At the same time, partnerships between WHO and some member states are looking to the plasma of Ebola survivors, who have built antibodies to the virus, as a possible therapeutic option for people who are already infected. The plasma clinical trials will also need expedited review by ethics committees and regulators. If judged safe and effective, this therapy can be rolled out rapidly.

The Pretoria meeting will bring together public health officials, regulatory and industry experts from 25 African countries and international health stakeholders. The meeting has awakened broad interest among African governments because the accelerated mechanism fast

track process it will put in place could be used as a model for other countries to accelerate access to potentially useful therapies in emergency situations.

"As the President of Liberia has aptly put, the best cure for Ebola is stronger health systems," said Kees De Joncheere, WHO Director for Essential Medicines and Health products. "That wake-up call could turn things around for Africa and represent another step towards increasing access to and better regulation of health products,

AVAREF

AVAREF was founded in 2006 by WHO to support NRAs in making informed decisions concerning authorization of clinical trials, evaluation of product registration dossiers, and any other challenging issues related to vaccines evaluation. AVAREF provides African regulatory authorities charged with ensuring the safety of medical products and related research with expertise and opportunities for information sharing and capacity building. It also offers product developers the opportunity for joint review by regulatory authorities from multiple countries of clinical trial and marketing authorization applications for high priority vaccines to be used in African countries. While initially focused on vaccines, AVAREF is beginning to expand to cover medicines and diagnostics as well.

WHO Guidance: How to conduct safe and dignified burial of a patient who has died from suspected or confirmed Ebola virus disease

October 2014 :: 17 pages

WHO/EVD/Guidance/Burials/14.2

Download the full version in English

Overview

This protocol provides information on the safe management of dead bodies and burial of patients who died from suspected or confirmed Ebola virus disease.

These measures should be applied not only by medical personnel but by anyone involved in the management of dead bodies and burial of suspected or confirmed Ebola patients.

Twelve steps have been identified describing the different phases Burial Teams have to follow to ensure safe burials, starting from the moment the teams arrive in the village up to their

:: Read the note for media

WHO: Ebola situation assessments

:: New study sheds light on the importance of supportive care for Ebola patients 6 November 2014

WHO IN ACTION

:: Government of Senegal boosts Ebola awareness through SMS campaign

3 November 2014

Related News on Ebola

:: Statement from the Travel and Transport Task Force on Ebola virus disease outbreak in West Africa 7 November 2014

WHO does not recommend general bans on travel or trade

Leading international organizations and associations from the transport, trade and tourism sector stand firmly with WHO against general bans on travel and trade, as well as restrictions that include general quarantine of travellers from Ebola-affected countries.

The Travel and Transport Task Force, established in August 2014, calls for international cooperation of governments and the transport sector in following the recommendations of the International Health Regulations Emergency Committee on Ebola, convened by WHO.

WHO does not recommend general bans on travel or trade, or general quarantine of travellers arriving from Ebola-affected countries, as measures to contain the outbreak.

Such measures can create a false impression of control and may have a detrimental impact on the number of health care workers volunteering to assist Ebola control or prevention efforts in the affected countries. Such measures may also adversely reduce essential trade, including supplies of food, fuel and medical equipment to the affected countries, contributing to their humanitarian and economic hardship….

…About the Travel and Transport Task Force

Members of the Travel and Transport Task Force include the World Health Organization (WHO), the International Civil Aviation Organization (ICAO), the World Tourism Organization (UNWTO), Airports Council International (ACI), International Air Transport Association (IATA), World Travel and Tourism Council (WTTC) International Maritime Organization (IMO), the International Chamber of Shipping (ICS) and the Cruise Lines International Association (CLIA).

:: WHO welcomes strong commitment from Australia to beating Ebola

6 November 2014

WHO – African Region

:: **Dr Matshidiso Moeti of Botswana nominated new World Health Organization's Regional Director for Africa**

Cotonou, Benin, 5 November 2014 - Dr Matshidiso Moeti of the Republic of Botswana was today nominated to be the next World Health Organization's Regional Director for Africa. Health Ministers from the 47 Countries that constitute the WHO African Region nominated her at their annual meeting, which is taking place in Cotonou. Dr Moeti is scheduled to take up her new post on 1 February 2015, succeeding Dr Luis Sambo, whose mandate ends on 31 January 2015 after having served as the Regional Director for the past 10 years.

Speaking after her nomination, she pledged to work for and with every member state to address the health challenges facing the African Region. The Regional Director-elect noted that the Millennium Development Goals propelled the Region to a certain level of health. Dr Moeti also underscored the need to further work to enhance equity and human rights towards universal health care. "I commit myself and colleagues to build on what we have created so far and I am confident that we will ride on the positive things happening in the Region."

Dr Moeti's nomination is subject to confirmation by WHO's Executive Board in January 2015.

More News

:: Dr Sambo urges countries to accelerate the progress of implementation of the African Public Health Emergency Fund - 06 November 2014

:: African countries resolve to step up efforts to tackle vaccine preventable diseases - 05 November 2014

:: Dr Sambo proposes key actions to tackle Ebola - 05 November 2014

:: President Boni Yayi urges African leaders to strengthen health systems to contain epidemics - 03 November 2014

[Editor's Note: Selected elements in the speech below (bolded text) generated a number of opinion pieces and op-eds in major media channels including the Wall Street Journal (see Media Watch below)]

WHO Director-General addresses the Regional Committee for Africa

http://www.who.int/dg/speeches/2014/regional-committee-africa/en/

Dr Margaret Chan
Director-General of the World Health Organization
Address to the Regional Committee for Africa, Sixty-fourth Session
Cotonou, Republic of Benin
3 November 2014

[Full text]

Excellencies, honourable ministers, distinguished delegates, representatives of the African Union, Dr Sambo, ladies and gentlemen,

Many external experts and analysts believe that Africa is at a crossroads. As I speak to you, Africa shows the world two prominent public faces that are strikingly different.

One face shows Africa rising, undergoing an economic and social transformation that is unparalleled in any other region of the world, at any time in recent history.

This is the face that showcases Africa's abundant natural resources, its increasingly educated, peaceful, and healthy populations, and the region's resilience, creativity, and boundless energy. This is the face of beginnings: of prosperity, wellbeing, and a healthy future. But this bright future depends on whether governments make equity in the distribution of benefits an explicit policy goal.

As the latest Progress Panel and Report on Africa, headed by Kofi Annan, notes: "The ultimate measure of progress in Africa is not to be found in GDP numbers and growth rates, but in the wellbeing of people, and in prospects for enabling people to improve their lives."

As you all know, much of Africa's growth has been concentrated in sectors, such as mining and petroleum, that favour the elite but do little to improve living conditions and health status in the rural areas where most of the poor and sick reside.

All nations benefit from an Africa that is prosperous, stable, and fair. This view was underscored in September during an emergency session of the UN Security Council, which considered the Ebola outbreaks in West Africa as a threat to international security.

In Guinea, Liberia, and Sierra Leone, Ebola has set back hard-won political stability and economic recovery, and is reversing some striking recent gains in health outcomes.

Let me give you just one statistic to think about. In 2012, WHO estimated that 21 000 people, 95% of them children, died of malaria in the three West African countries combined. This figure was a marked improvement over the 34 000 malaria deaths estimated for 2000. This is just one of many positive trends that is now under threat.

Ladies and gentlemen,

The Ebola outbreak that is ravaging parts of West Africa is the most severe acute public health emergency seen in modern times. It has many unprecedented dimensions, including its heavy toll on frontline domestic medical staff.

I extend my deepest sympathy to the people of West Africa who have seen so many of their fellow countrymen fall ill and die. I extend my deepest sympathy to the families, the loved ones, the neighbours, and entire villages and communities.

I can tell you one thing: every one of these West Africans who died from Ebola was beloved. All of us must respect the compassion and courage of so many health workers who unselfishly risked their lives, and lost them. The three countries have lost some of their greatest humanitarian heroes.

In the midst of these alarming trends, two WHO arguments that have fallen on deaf ears for decades are now out there with consequences that all the world can see, every day, on prime-time TV news.

The first argument concerns the urgent need to strengthen long-neglected health systems, an argument long-championed by your RD [Regional Director].

When heads of state in non-affected countries talk about Ebola, they rightly attribute the outbreak's unprecedented severity to the "failure to put basic public health infrastructures in place."

Without fundamental public health infrastructures in place, no country is stable. No society is secure. No resilience exists to withstand the shocks that our 21st century societies are delivering with ever-greater frequency and force, whether from a changing climate or a runaway killer virus.

The second argument is this. Ebola emerged nearly four decades ago. Why are clinicians still empty-handed, with no vaccines and no cure?

Because Ebola has historically been confined to poor African nations. The R&D incentive is virtually non-existent. A profit-driven industry does not invest in products for markets that cannot pay. WHO has been trying to make this issue visible for ages. Now people can see for themselves.

Ladies and gentlemen,

I will leave it to an African medical correspondent to comment on the two faces of today's Africa.

He has written eloquently about how outbreaks of diseases, like Ebola, make Africa's neglected health systems and impoverished populations highly visible.

He cites the importance of the recent economic transformation to Africa's international reputation as a continent of hope. But he is quick to ask the related question. "What good does it do," he asks, "to cover the ceiling of your house with golden paint when the walls and foundation have cracks?"

I will end my Ebola comments here.

You have a heavy agenda to get through. You need to approve a regional strategic plan for immunization, with highly ambitious targets. Like the rest of the world, you will be transitioning from the Millennium Development Goals to a post-2015 development agenda.

Africa needs to seize this new agenda on its own terms. Frankly, this region has, in the past, suffered from some bad development advice.

Future solutions to Africa's problems must be uniquely African solutions. In the past, Africa has followed in line with the priorities and strategies defined by global health initiatives, and not always as defined by your own governments and perceived health needs. Now Africa needs to lead.

In April, African ministers of health, at their gathering in Luanda, endorsed universal health coverage as a means to achieve and sustain the health MDGs and recognized it as an essential part of the post-2015 development agenda. This is what I mean by leadership.

Among the items on your agenda is the nomination of your next regional director.

I thank Dr Luis Sambo for his years of dedication to WHO and to the health of the African people. I wish him every success as he opens a new chapter in his long career.

For this Regional Office, the next big challenge is to ensure that WHO reform is credible and efficient.

Thank you.

UNMEER [UN Mission for Ebola Emergency Response] @UNMEER #EbolaResponse

UNMEER's website is aggregating and presenting content from various sources including its own External Situation Reports, press releases, statements and what it titles "developments." We present a composite below from the week ending 8 November 2014.

UNMEER External Situation Reports

UNMEER External Situation Reports are issued daily (excepting Saturday) with content organized under these headings:

- *Highlights*
- *Key Political and Economic Developments*
- *Human Rights*
- *Medical*
- *Logistics*
- *Outreach and Education*
- *Resource Mobilisation*
- *Essential Services*
- *Upcoming Events*

The "*Week in Review"* will present highly-selected elements of interest from these reports. The full daily report is available as a pdf using the link provided by the report date.

7 November 2014

Highlights

Key Political and Economic Developments

1. UN Special Envoy on Ebola Dr. David Nabarro said the extraordinary global response over the past month has made him hopeful the outbreak could end in 2015, though he cautioned that the fight to contain the disease is not even a quarter done. In the past four weeks, the rate of EVD infections seems to be slowing in some parts of West Africa, he said. In other hotspots it appears to be expanding the way it was a month ago. Nabarro said there are five times more beds for treatment in the three most affected countries than there were two months ago, which is helping to reduce the number of cases, along with improving efforts to find infected people and trace their contacts. Nabarro pointed to two other positive signs: the extraordinary global response in the last month and the mobilization of local communities in the three countries as a result of massive media campaigns and house-to-house "sensitization efforts" involving traditional leaders.

Response Efforts and Health

5. The EVD outbreak has likely killed far more people than the 4,828 deaths reported by the World Health Organization, WHO's strategy chief Christopher Dye said Thursday, warning that thousands of fatalities were likely not accounted for. The likely explanation is that many people are burying the dead in secret, possibly to avoid having authorities interfere with burial customs like washing and touching the deceased, which is widely blamed for much of the transmission. The fact that WHO-reported numbers of cases and deaths are lower now than they were last week is due a different, more consistent manner of counting, Mr. Dye said. It does not imply a slowing down of the disease.

8. As part of the Rapid Response Team, UNICEF recently conducted rapid assessments of "hot spots" in Liberia – namely Grand Kru, Grand Bassa, Sinoe and Grand Cape Mount counties – focused on how to rapidly isolate and treat patients with symptoms of Ebola following clear infection control standards. The process involves working with County Health Teams, communities and partners to design local solutions including the setup of Community Care

Centers, providing technical assistance on water, sanitation and hygiene management, and advising on how to engage communities. Additional assessments in Gbarpolu and Bomi are underway.

Essential Services

16. Sierra Leone's Deputy Health Minister Madina Radman said the country's failure to clearly separate its EVD treatment units from regular health facilities had destroyed confidence in hospitals and clinics. "We are struggling to regain confidence in our health facilities because of this mistake", she said. "About 50 per cent of the deaths in the country are not Ebola but, because people fear to come to some of our healthcare facilities, they die needlessly due to other treatable diseases."

17. According to analysis by the ngo Action Contre la Faim and the University of Naples Federico II, in 2015 the EVD crisis will lead to an increase of people suffering from undernourishment in Guinea, Liberia and Sierra Leone. 5,3 to 5,7 million people are expected be undernourished in 2015 in the 3 most affected countries, compared to 5 million before the start of the epidemic.

6 November 2014

Key Political and Economic Developments

1. The International Finance Corporation (IFC), a member of the World Bank Group, announced a package of at least 450 million USD in commercial financing that will enable trade, investment, and employment in Guinea, Liberia and Sierra Leone. The private sector initiative will include 250 million USD in rapid response projects, and at least 200 million USD in investment projects to support post-epidemic economic recovery. It is part of the World Bank Group's effort to support the most affected countries during the Ebola Virus Disease (EVD) epidemic and prepare them for economic recovery.

3. The Obama administration will ask the US Congress for about 6.2 billion USD in emergency funding to combat the spread of EVD in West Africa and reduce risks for U.S. citizens. According to a statement from the US Office of Management and Budget, the money would be used to strengthen domestic public health systems, contain and mitigate the outbreak in West Africa, and speed up efforts to obtain vaccines. The request seeks 2.4 billion USD for domestic public health services. Another 2.1 billion USD is for the US State Department and its Agency for International Development, 112 million USD for the Pentagon and 1.5 billion USD to be put in a contingency fund.

Human Rights

7. Sierra Leone said Wednesday it was holding a journalist in a maximum security prison after a guest on his radio show criticised President Ernest Bai Koroma's handling of the Ebola outbreak. David Tam Baryoh, host of the weekly "Monologue" programme on the private radio station Citizen FM, was arrested on Tuesday and sent to Freetown's Pademba Road jail. Baryoh had interviewed an opposition party spokesman who criticised Koroma and his government's handling of the Ebola outbreak.

Response Efforts and Health

9. The International Federation of Red Cross and Red Crescent Societies (IFRC), the lead agency managing burials and cremations, estimates that of all EVD deaths, 87% (4,404 of 5,060 cumulative deaths) have been managed by a trained burial or cremation team. A limitation of this estimation is that a significant number of deaths and burials are not reported, and that is does not yet include burials managed by other organizations. WHO estimates there is a need for 528 trained burial teams in the three affected countries. Currently 140 trained teams are on the ground.

5 November 2014

Key Political and Economic Developments

1. World Bank President Jim Yong Kim on Tuesday urged Asian countries to send trained health workers to the West African countries hit by Ebola Virus Disease (EVD), warning the focus on stricter border control was not the solution. He welcomed efforts by South Korea, China and Japan to send medical personnel or equipment to combat the outbreak. Asia must send more medical teams to the three affected countries, he said, adding that just 30 medical teams from around the world have gone to assist in the countries so far.

4. Residents in Wonkifong, Guinea, approximately 90 km from Conakry demonstrated yesterday against the establishment of a new EVD treatment unit in their locality; security forces intervened to restore calm. Negotiations are underway to resolve the situation.

Response Efforts and Health

7. Australia is contracting a private company to staff and operate an EVD treatment unit in Sierra Leone, Prime Minister Tony Abbot has said. He said Australia would commit 17m USD to a 100-bed treatment unit being built by the UK. But he ruled out sending government health workers - most workers would be hired locally with international staff likely to include some Australians.

10. As of last week, 110 UNICEF-supported social and mental health workers had provided psychosocial, family tracing, reunification and reintegration support to 817 children affected by EVD in Liberia's ten most affected counties. In addition, UNICEF is working with the Liberian government to train EVD survivors to care for these children and be engaged in community mobilization activities.

Essential Services

18. FAO, WFP, governments and other partners are currently carrying out a Crops and Food security Assessment Mission (CFSAM) based on rapid joint assessments in the field in Guinea, Liberia and Sierra Leone. The mission will provide an analysis of the agricultural production, prices, markets, trades and stocks situation. The first outcomes should be available before 18 November 2014.

4 November 2014

Key Political and Economic Developments

4. Dr. Peter Salama, Global Ebola Emergency Coordinator for UNICEF, told reporters at UN Headquarters that the agency will be doubling its staff from 300 to 600 in the three most-affected countries - Guinea, Liberia and Sierra Leone - where children account for one-fifth of all Ebola cases. Dr. Salama also said an estimated 5 million children are affected and some 4,000 children have become orphaned from the current epidemic. UNICEF is reaching out to EVD survivors who are often willing to work on the frontlines of the disease response at the community level in local care centers with community health workers.

Human Rights

6. In Dandayah, in the Forécariah prefecture of Guinea, a group of contact tracers was chased away by residents under threat of death, despite appeals for calm by several officials including the mayor.

Resource Mobilisation

1. The African Union (AU) is seeking funding from some of the continent’s richest people, including several billionaires, to pay the costs for volunteer doctors and nurses fighting EVD in West Africa, it said yesterday. The bloc is seeking to raise $35 million in the first round and

eventually as much as $100m for the Business-to-Rescue Fund. A separate campaign to ask for contributions from citizens will follow.
Essential Services
11. The peak season for Lassa fever in West Africa is about to begin. The virus has been largely forgotten in the EVD crisis, and health workers are warning that they may not have the resources to deal with the disease if cases increase. The symptoms of Lassa are largely identical to EVD, posing an extra problem. All of the countries worst hit by EVD are home to Lassa fever.

3 November 2014
Human Rights
6. According to a survey by UNICEF, 96 percent of Ebola survivors in Sierra Leone have experienced some sort of discrimination. More than three-quarters of respondents told UNICEF they would not welcome back an Ebola survivor into their community.
Essential Services
20. Women are no longer giving birth in health facilities due to EVD. Contraception distributions have also dropped by 70 per cent leading to fears of a high rate of new teenage pregnancies and a doubling of severe acute malnutrition of children under five with mothers struggling to earn money for food. Indeed, new data on severe acute malnutrition admissions in Liberia for the month of September 2014 revealed that a total of 325 severely malnourished children under the age of five were admitted to UNICEF-supported integrated management of acute malnutrition treatment sites.
21. MSF has begun distributing antimalarial medicines in Monrovia, Liberia, a crucial medical intervention in a city where the basic health care system has collapsed in recent months. Malaria is endemic in Liberia but due to the incredible demand of the EVD outbreak on the medical system, basic health care such as malaria treatment is now very difficult to find in Monrovia. MSF's program will prevent new malaria cases and minimize the number of people with malaria at EVD treatment units. US philanthropist Bill Gates on Sunday announced he will donate over USD 500 million to fight malaria.

2 November 2014 | Weekly Situational Analysis
6. EVD survivors and health workers in the affected countries regularly report being shunned by their communities. While some EVD survivors have been branded as witches for surviving the disease, members of burial teams have faced calls for eviction from their homes. The latter is all the more worrying as a study by the Yale School of Public Health this week found that the greatest impact in terms of the EVD response would come from ensuring safe burials: if transmission via burial practices were eliminated, it is assessed that the secondary infection rate would drop below one per EVD case.

UNMEER site: Press Releases
:: WFP Continues Scaling Up Ebola Response With Partners:"Together We Must Do More" (6 November 2014)

UNICEF [to 8 November 2014]
http://www.unicef.org/media/media_71724.html
:: Massive UNICEF shipments of supplies to fight Ebola reach 3,000MT mark
GENEVA/COPENHAGEN/NEW YORK, 7 November 2014 – UNICEF has sent almost 3,000 metric tonnes of life-saving supplies including protective equipment and essential medicine in the past

three months to fight the spread of Ebola in Guinea, Liberia and Sierra Leone. The children's agency is among the largest source of supplies in the Ebola response.

CDC/MMWR Watch [to 8 November 2014]
http://www.cdc.gov/media/index.html
:: CDC Increasing Supply of Ebola-specific Personal Protective Equipment for U.S. Hospitals - Press Release - Friday, November 7, 2014
:: Chikungunya outbreak progresses in Caribbean, Central and South America - Press Release - Thursday, November 6, 2014
:: Millions of US women are not getting screened for cervical cancer - Press Release - Wednesday, November 5, 2014

MMWR November 7, 2014 / Vol. 63 / No. 44::
- Declines in Pneumonia Hospitalizations of Children Aged <2 Years Associated with the Use of Pneumococcal Conjugate Vaccines — Tennessee, 1998–2012
-. Establishment of a Community Care Center for Isolation and Management of Ebola Patients — Bomi County, Liberia, October 2014

Obama seeks $6.2 billion for Ebola fight

By Associated Press November 5

WASHINGTON — President Barack Obama on Wednesday asked Congress for $6.2 billion in emergency funds to confront Ebola at its source in West Africa and to secure the United States against any possible spread.

Of the total, $2 billion would be apportioned to the United States Agency for International Development and $2.4 billion would go to the Department of Health and Human Services, the White House said. More than $1.5 billion would be for a contingency fund to deal with any unanticipated developments like a flare-up in West Africa or a need to vaccinate U.S. health care workers.

The Ebola money is the first request from Obama in the aftermath of an election that ushered in a Republican-controlled Congress, which is being seen as a repudiation of the president. The Ebola crisis has received bipartisan attention amid concerns over the potential of the disease to spread into the United States.

The White House is asking for prompt action, meaning it wants approval during the current lame duck session, while Democrats are still in control of the Senate. It wants the money on an "emergency" basis, meaning it should be added to the deficit. Republicans, if they agree the money is needed, may press for spending cuts elsewhere in the budget…

US officials unveil plan to test Ebola drugs

By Associated Press November 5

NEW ORLEANS — The quest for an Ebola treatment is picking up speed. Federal officials have unveiled a plan to test multiple drugs at once, in an umbrella study with a single comparison group to give fast answers on what works.

"This is novel for us" and is an approach pioneered by cancer researchers, said Dr. Luciana Borio, head of the U.S. Food and Drug Administration's Ebola response. "We need to learn what helps and what hurts" and speed treatments to patients, she said.

She outlined the plan Wednesday at an American Society of Tropical Medicine and Hygiene conference in New Orleans. Thousands of scientists have crowded into day and late-night sessions on Ebola, which has killed 5,000 West Africans this year.

There is no treatment for Ebola, but several experimental ones such as ZMapp have been tried on a few patients, and scientists are eyeing some others that were developed for different conditions but may also fight Ebola.

"There's this tremendous urge to want to give people these experimental therapies" but it's crucial to make sure they don't do harm, said the FDA's Dr. Edward Cox.

Everyone in the umbrella study would get supportive care, such as intravenous fluids, then be assigned to receive one of several drugs or be in a comparison group. That's needed because without one, there's no way to know if any problems or deaths are from the drug or the disease, Cox said.

Instead of waiting until a certain number of patients are treated to look at results, as is usually done, researchers will monitor results as they come in, pairing each person on a drug with someone from the comparison group to see if a pattern can be detected.

The National Institutes of Health developed this "learn as you go" plan "to allow a winner to be declared very early," Cox said.

He said the FDA could not name the drugs being considered, but said a meeting next week with various companies should crystallize the plans.

Thousands break Ebola quarantine to find food [Sierra Leone]
Associated Press | 4 November 2014
By SARAH DiLORENZO

DAKAR, Senegal (AP) — Thousands of people in Sierra Leone are being forced to violate Ebola quarantines to find food because deliveries are not reaching them, aid agencies said. Large swaths of the West African country have been sealed off to prevent the spread of Ebola, and within those areas many people have been ordered to stay in their homes.

The government, with help from the U.N.'s World Food Program, is tasked with delivering food and other services to those people. But there are many "nooks and crannies" in the country that are being missed, Jeanne Kamara, Christian Aid's Sierra Leone representative, said Tuesday…

…While public health authorities have said heavy restrictions may be necessary to bring under control an Ebola outbreak unlike any other, the Disasters Emergency Committee, an umbrella organization for aid organizations, warned on Monday that they were cutting off food to thousands of people.

"The quarantine of Kenema, the third largest town in Sierra Leone, is having a devastating impact on trade — travel is restricted so trucks carrying food cannot freely drive around," the committee said in a statement. "Food is becoming scarce, which has led to prices increasing beyond the reach of ordinary people."

Because services are not reaching them, people who are being monitored for signs of Ebola — and should be staying at home — are venturing out to markets to look for food, potentially contaminating many others, said Kamara of Christian Aid…

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WHO & Regionals [to 8 November 2014]
:: GIN October 2014 pdf, 2.21Mb 4 November 2014

:: Global Alert and Response (GAR) - Disease Outbreak News (DONs)
Middle East respiratory syndrome coronavirus (MERS-CoV) – Saudi Arabia 7 November 2014

:: Weekly Epidemiological Record (WER) for 7 November 2014, vol. 89, 45 (pp. 505–508) includes:
- Report of the 7th Meeting of the WHO working group on polymerase chain reaction protocols for detection and subtyping of influenza viruses, Geneva, June 2014
http://www.who.int/entity/wer/2014/wer8945.pdf?ua=1

:: PPP launched to improve prevention of women's cancers and quality of cancer registries in Latin America and the Caribbean
04 NOVEMBER 2014,
- PAHO (Pan American Health Organization) Foundation and International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) combine efforts to improve breast and cervical cancer prevention and control.
- The partnership aims to improve understanding and practices among primary health care providers and patients for breast cancer screening and early detection as well as increase capacity of cancer registries in the region.
- Three-year joint project is receiving $600,000 funding from IFPMA as well as in-kind contributions such as communications and infrastructure supplies.

New York, 4 November 2014 – The PAHO (Pan American Health Organization) Foundation and the International Federation of Pharmaceutical Manufacturers & Associations (IFPMA) announced today a partnership to jointly build regional capacity to fight woman's cancers in Latin America and the Caribbean. The three-year collaboration will allow the first phase of a $5M initiative to focus on women's cancers in selected countries in Latin America and the Caribbean. …

GAVI Watch [to 8 November 2014]
http://www.gavialliance.org/library/news/press-releases/
:: Pentavalent vaccine introductions represent historic milestone for immunisation in India
01 November 2014
Rollouts in Madhya Pradesh and Rajasthan start two-phase process which will add 5-in-1 vaccine to routine immunisation programmes in every Indian state.

IVI Watch [to 8 November 2014]
http://www.ivi.org/web/www/home
:: EDCTP-TDR Clinical Research and Development Fellowships
IVI is pleased to announce its participation as a host organization for the EDCTP-TDR Clinical Research and Development Fellowships. EDCTP and the World Health Organization's TDR have a partnership to support junior to mid-career researchers and clinical staff from low- and middle-income countries (LMICs) to develop new skills in clinical research and development through fellowship placements in pharmaceutical companies, PDPs and other relevant host organizations for up to two years. IVI has agreed to host two fellowship placements. Selected fellows will be placed at the institute for a minimum of six months and up to a maximum of 24 months. The Call for Proposals is currently open and the application deadline is 30 January

2015, 16:00 (GMT). For more information about the fellowships and how to apply, please visit: http://www.edctp.org/calls-and-grants/calls-for-proposals-overview/edctp-tdr-clinical-research-and-development-fellowships/

PATH Watch [to 8 November 2014]
http://www.path.org/news/
:: Announcement | November 03, 2014
PATH to collaborate with GlaxoSmithKline to develop a test critical to malaria care
New diagnostics for a common enzyme deficiency will bolster malaria elimination efforts

BMGF - Gates Foundation Watch [to 8 November 2014]
http://www.gatesfoundation.org/Media-Center/Press-Releases
:: Gates Foundation Commits More than $500 Million to Tackle The Burden of Infectious Disease in Developing Countries
[Excerpt]

NEW ORLEANS (November 2, 2014) – Calling the Ebola epidemic a "critical moment in the history of global health," Bill Gates, Co-chair of the Bill & Melinda Gates Foundation, today urged greater investment in scientific innovation to ensure that the world stays ahead of rapidly evolving disease threats such as drug-resistant malaria and dengue fever.

Addressing the 63rd annual meeting of the American Society of Tropical Medicine and Hygiene, Gates announced that the foundation is committing more than $500 million in 2014 to reduce the burden of malaria, pneumonia, diarrheal diseases, and an array of parasitic infections that are leading causes of death and disability in developing countries. Gates also announced that the foundation has boosted its annual funding for malaria by 30 percent, and he laid out a vision for how malaria can be eradicated by the middle of the 21st century. Gates said important lessons from the Ebola epidemic must guide the world's response to all infectious diseases, particularly the need to strengthen health systems in developing countries, improve infectious disease surveillance systems and sustain investments in the R&D pipeline.

"The Ebola epidemic has shown, once again, that in today's interconnected world, health challenges anywhere create health challenges everywhere – and the best way to overcome those challenges is to dedicate ourselves to the great cause of reducing the global burden of infectious disease," Gates said in his prepared remarks.

On September 10, the foundation announced a $50 million commitment to support the scale up of efforts to contain the Ebola outbreak in West Africa. This funding – which is in addition to the more than $500 million announced today – will support emergency response efforts for Ebola, including capacity building and the establishment of Emergency Operations Centers in affected countries. The foundation is also supporting research on Ebola interventions, including rapid diagnostics, vaccines and ZMapp, an experimental Ebola treatment.

:: GAIA Vaccine Foundation's Story-Telling Cloth gets "Innovation" Award For West African-Style "Social Media" Cervical Cancer Prevention Campaign

PROVIDENCE, R.I., Nov. 6, 2014 /PRNewswire/ -- The Bill and Melinda Gates Foundation awarded $100,000 to GAIA Vaccine Foundation to test whether dissemination of a printed cloth that tells the story of HPV and cervical cancer, coupled with a media campaign led by influential women musicians, will improve HPV knowledge and incite women to be screened for cervical cancer and (when vaccine is available) to vaccinate their daughters against HPV in West Africa.. Cervical cancer is one of the most common and lethal cancers (67% mortality) among women

in Africa, with rates that are approximately 5 fold higher than in the US. Nine out of ten (87%) cervical cancer deaths occur in less developed regions of the world, like Mali. This exceptionally high rate of cervical cancer is almost entirely due to lack of knowledge about HPV, since at least in Mali, cervical cancer screens are free and available at every health center.

Gates Foundation is funding the innovative idea that story-telling 'Pagnes', a traditional cloth worn by most women in West Africa, can motivate women to be screened for cancer while making use of fashion to disseminate cervical cancer education…

Industry Watch [to 8 November 2014]

Selected media releases and other selected content from industry.

:: The New England Journal of Medicine Publishes Results of Final Landmark Phase III Efficacy Clinical Study of Sanofi Pasteur's Dengue Vaccine Candidate

- Study successfully met primary objective and confirms high efficacy against severe dengue and hospitalization
- Sanofi Pasteur intends to file for registration in several endemic countries in 2015 -
- Dengue vaccine candidate would address an urgent unmet medical need in tropical and sub-tropical regions of the world

3 November 2014

[Excerpt]

…Sanofi Pasteur's phase III efficacy clinical study program for its dengue vaccine candidate was conducted in over 31,000 participants across 10 endemic countries in Asia2 and Latin America. Sanofi Pasteur will file for registration of its vaccine candidate and, subject to regulatory approval, the world's first dengue vaccine could be available in the second half of 2015.

"We plan to submit the vaccine for licensure in 2015 in endemic countries where dengue is a public health priority," said Olivier Charmeil, President and CEO of Sanofi Pasteur. "We are committed to supporting countries' ambitions to significantly impact the human and economic burden of dengue through comprehensive vaccination programs. Our goal is to help meet the WHO's objectives to reduce dengue mortality by 50% and morbidity by 25% by 2020."…

… Sanofi Pasteur is already producing the vaccine in a newly dedicated production facility in Neuville-sur-Saône, France, which will be capable of providing timely supply of large quantities of vaccines to meet the global public health demand…

:: Sanofi Pasteur Announces FDA Approval of Updated Prescribing Information for Fluzone High-Dose Vaccine for Adults 65 and Older

Includes New Data Showing Fluzone High-Dose Vaccine More Efficacious Than Standard-Dose Fluzone Vaccine -

SWIFTWATER, Pa., Nov. 3, 2014 /PRNewswire/ -- Sanofi Pasteur, the vaccines division of Sanofi today announced that the U.S. Food and Drug Administration (FDA) has approved the supplemental biologics license application (sBLA) for Fluzone® High-Dose (Influenza Vaccine) to include efficacy data in the Prescribing Information. These data demonstrate that Fluzone High-Dose vaccine provided improved protection against influenza ("the flu") compared to standard-dose Fluzone vaccine (trivalent intramuscular formulation) in adults 65 years of age and older.

The Prescribing Information for Fluzone High-Dose vaccine now includes data from a large-scale, multi-center efficacy and safety trial published in the August 14, 2014, issue of The New England Journal of Medicine (DOI: 10.1056/NEJMoa1315727).[i]…

NIH Watch [to 8 November 2014]
http://www.nih.gov/news/index.html
No new digest content identified.

FDA Watch [to 8 November 2014]
http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/default.htm
No new digest content identified.

European Medicines Agency Watch [to 8 November 2014]
http://www.ema.europa.eu/ema/
No new digest content identified.

European Vaccine Initiative [to 8 November 2014]
http://www.euvaccine.eu/news-events
No new digest content identified.

Global Fund Watch [to 8 November 2014]
http://www.theglobalfund.org/en/mediacenter/announcements/
No new digest content identified.

Reports/Research/Analysis/Commentary/Conferences/Meetings/Book Watch/Tenders

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

IOM/NRC Meeting: Research Priorities to Inform Public Health and Medical Practice for Domestic Ebola Virus Disease (EVD): A Workshop
November 3, 2014

An ad hoc committee, under the auspices of the Institute of Medicine in collaboration with the National Research Council will organize a one-day workshop that will explore potential research priorities arising as a result of the emergence of Ebola Virus Disease (EVD), a hemorrhagic disease caused by a filovirus, in the United States. The workshop will focus primarily on basic science and environmental health research issues of specific concern to affected and potentially affected U.S. communities. The workshop will help inform future research that could be conducted under real-world conditions (i.e., during an event) that would provide public health officials and the general public with additional accurate information about virus transmission, mitigation of health risks, and appropriate measures to prevent the spread of disease. Specific topics that may be discussed include:
:: Routes of transmission and persistence of the virus to inform public health practice.

- Examine characteristics and properties of the virus that influence the stability and viability of EVD in order to continue to inform public health efforts, handling of potentially infectious materials, and protection of at-risk responders.
- Assess methods of viral inactivation and alternative solutions for effective disinfection of contaminated surfaces.
- Explore considerations regarding the real-world use of personal protective equipment (PPE) among non-traditional workers or others that may be exposed to infected individuals or contaminated materials, including real-time training and education.

:: Strategies to address issues of concern to healthcare workers and the general public, including the use of PPE and personal protective behaviors to prevent spread and reduce exposure.

The committee will develop the agenda for the workshop session, select and invite speakers and discussants, and moderate the discussions. An individually authored brief workshop summary based on the presentations and discussions held during the workshop will be prepared by a designated rapporteur in accordance with institutional guidelines.

NFID: Addressing the Challenges of Serogroup B Meningococcal Disease Outbreaks on College Campuses

Monday, November 17, 2014 at 12:00 PM ET

Register Online

NFID experts, Carol J. Baker, MD and William Schaffner, MD will present highlights of the NFID report, "Addressing the Challenges of Serogroup B Meningococcal Disease Outbreaks on College Campuses," examining the public health response to recent college outbreaks and strategies for appropriate and streamlined future public health responses. The discussion will be timely, based on the recent FDA approval of the first meningococcal B vaccine in the US.

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

The American Journal of Bioethics

Volume 14, Issue 12, 2014

http://www.tandfonline.com/toc/uajb20/current

[Target Article: this article is accompanies by seven articles providing analysis and comment]

Shared Vulnerabilities in Research

Eric Chwanga*

DOI:10.1080/15265161.2014.964872

pages 3-11
Published online: 04 Nov 2014
Abstract
The U.S. Code of Federal Regulations governing federally funded research on human subjects assumes that harmful research is sometimes morally justifiable because the beneficiaries of that research share a particular vulnerability with its subjects. In this article, I argue against this assumption, which occurs in every subpart of the Code of Federal Regulations that deals with specific vulnerable populations (pregnant women, fetuses, neonates, prisoners, and children). I argue that shared vulnerability is no exception to the general principle that harming one person in order to benefit another is no more justifiable if the two people have traits in common. Further, shared vulnerability is not a reasonable proxy for any morally relevant desideratum of research, in particular the desire to benefit the worst off, the desire to avoid exploitation, and the desire to use vulnerable populations in research only when necessary.

American Journal of Infection Control
Volume 42, Issue 11, p1141-1254 November 2014
http://www.ajicjournal.org/current
[New issue; No relevant content[

American Journal of Preventive Medicine
Volume 47, Issue 5, p531-688 November 2014
http://www.ajpmonline.org/current
Assessing Immunization Interventions in the Women, Infants, and Children (WIC) Program
Tracy N. Thomas, MPH, MSc, Maureen S. Kolasa, MPH, Fan Zhang, PhD, Abigail M. Shefer, MD
National Center for Immunization and Respiratory Disease, CDC, Atlanta, Georgia
Published Online: September 13, 2014
DOI: http://dx.doi.org/10.1016/j.amepre.2014.06.017
Abstract
Background
Vaccination promotion strategies are recommended in Women, Infants, and Children (WIC) settings for eligible children at risk for under-immunization due to their low-income status.
Purpose
To determine coverage levels of WIC and non-WIC participants and assess effectiveness of immunization intervention strategies.
Methods
The 2007–2011 National Immunization Surveys were used to analyze vaccination histories and WIC participation among children aged 24–35 months. Grantee data on immunization activities in WIC settings were collected from the 2010 WIC Linkage Annual Report Survey. Coverage by WIC eligibility and participation status and grantee-specific coverage by intervention strategy were determined at 24 months for select antigens. Data were collected 2007–2011 and analyzed in 2013.
Results
Of 13,183 age-eligible children, 5,699 (61%, weighted) had participated in WIC, of which 3,404 (62%, weighted) were current participants. In 2011, differences in four or more doses of the diphtheria, tetanus toxoid, and acellular pertussis (DTaP) vaccine by WIC participation status

were observed: 86% (ineligible); 84% (current); 77% (previous); and 69% (never-eligible). Children in WIC exposed to an immunization intervention strategy had higher coverage levels than WIC-eligible children who never participated, with differences as great as 15% (DTaP).
Conclusions
Children who never participated in WIC, but were eligible, had the lowest vaccination coverage. Current WIC participants had vaccination coverage comparable to more affluent children, and higher coverage than previous WIC participants.

American Journal of Public Health
Volume 104, Issue 11 (November 2014)
http://ajph.aphapublications.org/toc/ajph/current
[Reviewed earlier]

American Journal of Tropical Medicine and Hygiene
November 2014; 91 (5)
http://www.ajtmh.org/content/current

Global Health Research in Narrative: A Qualitative Look at the FICRS-F Experience
Benjamin Bearnot, Alexandra Coria, Brian Scott Barnett, Eva H. Clark, Matthew G. Gartland, Devan Jaganath, Emily Mendenhall, Lillian Seu, Ayaba G. Worjoloh, Catherine Lem Carothers, Sten H. Vermund and Douglas C. Heimburger*
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Abstract.
For American professional and graduate health sciences trainees, a mentored fellowship in a low- or middle-income country (LMIC) can be a transformative experience of personal growth and scientific discovery. We invited 86 American trainees in the Fogarty International Clinical Research Scholars and Fellows Program and Fulbright–Fogarty Fellowship 2011–2012 cohorts to contribute personal essays about formative experiences from their fellowships. Nine trainees contributed essays that were analyzed using an inductive approach. The most frequently addressed themes were the strong continuity of research and infrastructure at Fogarty fellowship sites, the time-limited nature of this international fellowship experience, and the ways in which this fellowship period was important for shaping future career planning. Trainees also addressed interaction with host communities vis-à-vis engagement in project implementation. These qualitative essays have contributed insights on how a 1-year mentored LMIC-based research training experience can influence professional development, complementing conventional evaluations. Full text of the essays is available at http://fogartyscholars.org/.

Short-Term Global Health Education Programs Abroad: Disease Patterns Observed in Haitian Migrant Worker Communities Around La Romana, Dominican Republic
Brian J. Ferrara, Elizabeth Townsley, Christopher R. MacKay, Henry C. Lin and Lawrence C. Loh*

Author Affiliations
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Abstract.
The possibility of encountering rare tropical disease presentations is commonly described as a benefit derived by developed world medical trainees participating in clinical service-oriented short-term global health experiences in the developing world. This study describes the health status of a population served by a short-term experience conducted by a North American institute, and the results of a retrospective review are used to identify commonly encountered diseases and discuss their potential educational value. Descriptive analysis was conducted on 1,024 encounter records collected over four unique 1-week-long trips by a North American institution serving Haitian migrant workers in La Romana, Dominican Republic. The top five diagnoses seen in the clinic were gastroesophageal reflux disease (GERD), hypertension (HTN), upper respiratory infections, otitis media, and fungal skin infection. On occasion, diagnoses unique to an indigent tropical population were encountered (e.g., dehydration, malnutrition, parasites, and infections.). These findings suggest a similarity between frequently encountered diagnoses on a short-term clinical service trip in Dominican Republic and primary care presentations in developed world settings, which challenges the assumption that short-term service experiences provide exposure to rare tropical disease presentations. These findings also represent additional data that can be used to better understand the health and healthcare planning among this vulnerable population of Haitian migrant workers.

Epidemiology of Sexually Transmitted Infections in Rural Southwestern Haiti: The Grand'Anse Women's Health Study

Kathleen A. Jobe, Robert F. Downey*, Donna Hammar, Lori Van Slyke and Terri A. Schmidt
Author Affiliations
University of Washington, Division of Emergency Medicine, Seattle, Washington; Seattle–King County Disaster Team, Seattle, Washington; Sysmex America, Inc., Laboratory Application Services, San Diego, California; Providence Health and Services, North Coast Urgent Care Clinics, Seaside, Oregon; MultiCare Health System, Department of Social Work, Tacoma, Washington; Oregon Health & Science University, Department of Emergency Medicine, Portland, Oregon
Abstract.
The study attempts to define socioeconomic, clinical, and laboratory correlates in vaginitis and other sexually transmitted infections in rural southwestern Haiti. A convenience sample of subjects recruited from a rural women's health clinic and attending an established clinic at the Haitian Health Foundation (HHF) clinic was studied. A standardized history and physical examination, including speculum examination, and collection of blood, urine, and vaginal swabs were obtained from the women at the rural clinic. Additional vaginal swab samples only for Nucleic Acid Amplification Test (NAAT) testing were obtained from women at the HHF clinic in Jérémie. Laboratory results from Leon subjects were positive for Gardnerella vaginalis in 41% (41 of 100), Trichomonas vaginalis in 13.5% (14 of 104), Candida sp. in 9% (9 of 100), Mycoplasma genitalium in 6.7% (7 of 104), Chlamydia trachomatis in 1.9% (2 of 104), and Neisseria gonorrhea in 1% (1 of 104) of patients. Human immunodeficiency virus (HIV)

antibody tests were negative in 100% (103 of 103) of patients, and syphilis antibody testing was positive for treponemal antibodies in 7.7% (8 of 104) patients. For subjects from the HHF, 19.9% were positive for T. vaginalis, 11.9% were positive for C. trachomatis, 10.1% were positive for M. genitalium, and 4.1% were positive for N. gonorrhea. Infections with G. vaginalis, T. vaginalis, and Candida were the most common. N. gonorrhea, C. trachomatis, Candida sp., T. vaginalis, and M. genitalium infections were associated with younger age (less than 31 years old).

Cholera at the Crossroads: The Association Between Endemic Cholera and National Access to Improved Water Sources and Sanitation

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Author Affiliations

Division of Foodborne, Waterborne and Environmental Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia

Abstract.

We evaluated World Health Organization (WHO) national water and sanitation coverage levels and the infant mortality rate as predictors of endemic cholera in the 5-year period following water and sanitation coverage estimates using logistic regression, receiver operator characteristic curves, and different definitions of endemicity. Each was a significant predictors of endemic cholera at $P < 0.001$. Using a value of 250 for annual cases reported in 3 of 5 years, a national water access level of 71% has 65% sensitivity and 65% specificity in predicting endemic cholera, a sanitation access level of 39% has 63% sensitivity and 62% specificity, and an infant mortality rate of 65/1,000 has 67% sensitivity and 69% specificity. Our findings reveal the tradeoff between sensitivity and specificity for these predictors of endemic cholera and highlight the substantial uncertainty in the data. More accurate global surveillance data will enable more precise characterization of the benefits of improved water and sanitation.

Annals of Internal Medicine

4 November 2014, Vol. 161. No. 9

http://annals.org/issue.aspx

Ideas and Opinions | 4 November 2014

Toward Tuberculosis Elimination in Low-Incidence Countries: Reflections From a Global Consultation

Knut Lönnroth, MD, PhD, MSc; Giovanni Battista Migliori, MD; and Mario Raviglione, MD

Article and Author Information

Ann Intern Med. 2014;161(9):670-671. doi:10.7326/M14-1888

In July 2014, participants from 36 countries and experts in the field met to discuss a global framework for eliminating tuberculosis in low-incidence countries. This commentary discusses the framework for elimination, which will require high-level political commitment, strong public health programs, social justice, international solidarity, and investment in research…

BMC Health Services Research

(Accessed 8 November 2014)

http://www.biomedcentral.com/bmchealthservres/content

Research article

Frontline health workers as brokers: provider perceptions, experiences and mitigating strategies to improve access to essential medicines in South Africa

Bvudzai Priscilla Magadzire1*, Ashwin Budden2, Kim Ward13, Roger Jeffery4 and David Sanders1
Author Affiliations
BMC Health Services Research 2014, 14:520 doi:10.1186/s12913-014-0520-6
Published: 5 November 2014
Abstract (provisional)
Background
Front-line health providers have a unique role as brokers (patient advocates) between the health system and patients in ensuring access to medicines (ATM). ATM is a fundamental component of health systems. This paper examines in a South African context supply- and demand- ATM barriers from the provider perspective using a five dimensional framework: availability (fit between existing resources and clients? needs); accessibility (fit between physical location of healthcare and location of clients); accommodation (fit between the organisation of services and clients? practical circumstances); acceptability (fit between clients? and providers? mutual expectations and appropriateness of care) and affordability (fit between cost of care and ability to pay).
Methods
This cross-sectional, qualitative study uses semi-structured interviews with nurses, pharmacy personnel and doctors. Thirty-six providers were purposively recruited from six public sector Community Health Centres in two districts in the Eastern Cape Province representing both rural and urban settings. Content analysis combined structured coding and grounded theory approaches. Finally, the five dimensional framework was applied to illustrate the interconnected facets of the issue.
Results
Factors perceived to affect ATM were identified. Availability of medicines was hampered by logistical bottlenecks in the medicines supply chain; poor public transport networks affected accessibility. Organization of disease programmes meshed poorly with the needs of patients with comorbidities and circular migrants who move between provinces searching for economic opportunities, proximity to services such as social grants and shopping centres influenced where patients obtain medicines. Acceptability was affected by, for example, HIV related stigma leading patients to seek distant services. Travel costs exacerbated by the interplay of several ATM barriers influenced affordability. Providers play a brokerage role by adopting flexible prescribing and dispensing for `stable? patients and aligning clinic and social grant appointments to minimise clients? routine costs. Occasionally they reported assisting patients with transport money.
Conclusion
All five ATM barriers are important and they interact in complex ways. Context-sensitive responses which minimise treatment interruption are needed. While broad-based changes encompassing all disease programmes to improve ATM are needed, a beginning could be to assess the appropriateness, feasibility and sustainability of existing brokerage mechanisms.
Research article
Cost-effectiveness analysis in Developing Nations: A cross sectional survey about Exposure, Interest and Barriers
Jackson Musuuza, Mendel E Singer, Anna Mandalakas and Achilles Katamba
Author Affiliations
BMC Health Services Research 2014, 14:539 doi:10.1186/s12913-014-0539-8
Published: 4 November 2014
Abstract (provisional)

Background
Cost effectiveness analysis (CEA) is a useful tool for allocation of constrained resources, yet CEA methodologies are rarely taught or implemented in developing nations. We aimed to assess exposure to, and interest in CEA, and identify barriers to implementation in Uganda.
Methods
A cross-sectional survey was carried out in Uganda using a newly developed self-administered questionnaire (via online and paper based approaches), targeting the main health care actors as identified by a previous study.
Results
Overall, there was a 68% response rate, with a 92% (69/75) response rate among the paper-based respondents compared to a 40% (26/65) rate with the online respondents. Seventy eight percent (74/95) of the respondents had no exposure to CEA. None of those with a master of medicine degree had any CEA exposure, and 80% of technical officers, who are directly involved in policy formulation, had no CEA exposure. Barriers to CEA identified by more than 50% of the participants were: lack of information technology (IT) infrastructure (hardware and software); lack of local experts in the field of CEA; lack of or limited local data; limited CEA training in schools; equity or ethical issues; and lack of training grants incorporating CEA. 93% reported a lot of interest in learning to conduct CEA, and over 95% felt CEA was important for clinical decision making and policy formulation.
Conclusions
Among health care actors in Uganda, there is very limited exposure to, but substantial interest in conducting CEA and including it in clinical decision making and health care policy formation. Capacity to undertake CEA needs to be built through incorporation into medical training and use of regional approaches.

BMC Infectious Diseases
(Accessed 8 November 2014)
http://www.biomedcentral.com/bmcinfectdis/content
[No new relevant content]

BMC Medical Ethics
(Accessed 8 November 2014)
http://www.biomedcentral.com/bmcmedethics/content
[No new relevant content]

BMC Public Health
(Accessed 8 November 2014)
http://www.biomedcentral.com/bmcpublichealth/content
[No new relevant content]

BMC Research Notes
(Accessed 8 November 2014)
http://www.biomedcentral.com/bmcresnotes/content

Hepatitis B vaccination status and Needle-stick and Sharps-related Injuries among medical school students in Nepal: a cross-sectional study

Suraj Bhattarai, Smriti KC, Pranil MS Pradhan, Sami Lama and Suman Rijal
Author Affiliations

BMC Research Notes 2014, 7:774 doi:10.1186/1756-0500-7-774
Published: 3 November 2014

Abstract (provisional)

Background

Hepatitis B is a dreadful infectious disease and a major global health problem. Health-care workers including clinical students are more vulnerable to such infections and non-sterile occupational exposures as their daily activities are closely related to patient's blood and body fluids.

Methods

A descriptive cross sectional study was conducted at B.P. Koirala Institute of Health Sciences (BPKIHS), Dharan, Nepal from July till October 2012. All medical, dental and nursing students were surveyed for their Hepatitis B vaccination status and only those students in clinical rotations were surveyed for the prevalence and pattern of Needle-stick and Sharps-related Injuries (NSSIs) using a pre-tested, semi-structured, self-administered questionnaire. Descriptive and inferential statistics was used to analyze the data.

Results

Majority (86.5%) of students were vaccinated against Hepatitis B of which 83.7% had completed full doses. Among non-vaccinated students, 43.2% reported the main reason for non-vaccination as lack of vaccination programs. Out of 210 respondents from clinical rotations, 90 students (42.8%) reported at least one injury. Among those injured, two students reported exposure to Human immunodeficiency virus (HIV) positive cases and four to Hepatitis B virus (HBV) positive cases. Most of the injuries (44%) occurred during Internal Medicine posting and the most common sharp involved (56.3%) was Hypodermic needle. Most injuries (35.6%) occurred while manipulating needle into patients. Following exposure, only 11.4% took Post exposure prophylaxis and 19.54% went for a Post-exposure serology test.

Conclusions

Needle-stick and Sharps-related Injuries occur frequently among health care workers including trainee students keeping them at high risk for acquiring dreadful infections like HBV, HCV and HIV. They need to be protected from unwarranted hazards by adopting routine Hepatitis B vaccination programs and by reinforcing education regarding universal precautions.

British Medical Journal

08 November 2014(vol 349, issue 7982)
http://www.bmj.com/content/349/7982

[New issue; No relevant content]

Bulletin of the World Health Organization

Volume 92, Number 11, November 2014, 773-848
http://www.who.int/bulletin/volumes/92/11/en/

[Reviewed earlier]

Clinical Infectious Diseases (CID)
Volume 59 Issue 10 November 15, 2014
http://cid.oxfordjournals.org/content/current
Impact of Repeated Vaccination on Vaccine Effectiveness Against Influenza A(H3N2) and B During 8 Seasons
Huong Q. McLean, Mark G. Thompson, Maria E. Sundaram, Jennifer K. Meece, David L. McClure, Thomas C. Friedrich, and Edward A. Belongia
Clin Infect Dis. (2014) 59 (10): 1375-1385 doi:10.1093/cid/ciu680
Abstract
OPEN ACCESS
The effect of prior influenza vaccination history on vaccine effectiveness was assessed in a community cohort over 8 seasons. Current- and previous-season vaccination generated similar levels of protection; vaccine-induced protection was greatest for individuals with no recent vaccination history.

Clinical Therapeutics
Volume 36, Issue 10, p1295-1482 October 2014
http://www.clinicaltherapeutics.com/current
[Reviewed earlier]

Complexity
November/December 2014 Volume 20, Issue 2 Pages fmi–fmi, 1–81
http://onlinelibrary.wiley.com/doi/10.1002/cplx.v20.2/issuetoc
The Simply complex
Exponential growth in Ebola outbreak since May 14, 2014
Allen G. Hunt*
Article first published online: 18 OCT 2014
DOI: 10.1002/cplx.21615
Excerpt
Contrary to general opinion, the current Ebola outbreak in West Africa followed an exponential growth curve starting already in mid-May. The death toll followed an exponential growth curve with almost the same time constant, allowing direct calculation of the mortality of the outbreak. This value remained steady at about 72%, contrary to the estimate of the World Health Organization of slightly above 50%. Until the last 2 weeks, the projected date at which the number of infected individuals would reach 100,000 had remained steady at January 19. Updated statistics from September 6 advanced that date by at least a month. Estimates suggest that over 20,000 already have been infected, exceeding the number that the WHO has declared could be the eventual outcome…

Cost Effectiveness and Resource Allocation
(Accessed 8 November 2014)
http://www.resource-allocation.com/
[No new relevant content]

Current Opinion in Infectious Diseases
December 2014 - Volume 27 - Issue 6 pp: v-v,471-572
http://journals.lww.com/co-infectiousdiseases/pages/currenttoc.aspx
[Reviewed earlier]

Developing World Bioethics
December 2014 Volume 14, Issue 3 Pages ii–iii, 111–167
http://onlinelibrary.wiley.com/doi/10.1111/dewb.2014.14.issue-3/issuetoc
[Reviewed earlier]

Development in Practice
Volume 24, Issue 7, 2014
http://www.tandfonline.com/toc/cdip20/current
[Reviewed earlier]

Emerging Infectious Diseases
Volume 20, Number 11—November 2014
http://wwwnc.cdc.gov/eid/
[Reviewed earlier]

Epidemics
Volume 9, In Progress (December 2014)
http://www.sciencedirect.com/science/journal/17554365
[Reviewed earlier]

Epidemiology and Infection
Volume 142 - Issue 12 - December 2014
http://journals.cambridge.org/action/displayIssue?jid=HYG&tab=currentissue
Review Articles
Pneumococcal and meningococcal infection
A review of the evidence to inform pneumococcal vaccine recommendations for risk groups aged 2 years and older
A. STEENSa1a2 c1, D. F. VESTRHEIMa1, I. S. AABERGEa1, B. S. WIKLUNDa1,
J. STORSAETERa1, M. A. RIISE BERGSAKERa1, K. RØNNINGa1 and E. FURUSETHa1
a1 Division of Infectious Disease Control, Norwegian Institute of Public Health, Oslo, Norway
a2 European Programme for Intervention Epidemiology Training (EPIET), European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden
SUMMARY
For decades, vaccination with the 23-valent polysaccharide pneumococcal vaccine (PPV23) has been available for risk groups aged ≥2 years to prevent invasive pneumococcal disease (IPD). Recently, a 13-valent pneumococcal conjugated vaccine (PCV13) has been licensed for use in all age groups. PCV13 may induce better protection than PPV23 because of different immunogenic properties. This called for a revision of vaccine recommendations for risk groups. We therefore

reviewed literature on risk groups for IPD, and effectiveness and safety of pneumococcal vaccines and supplemented that with information from public health institutes, expert consultations and data on IPD epidemiology. We included 187 articles. We discuss the implications of the heterogenic vulnerability for IPD within and between risk groups, large indirect effects of childhood immunization, and limited knowledge on additional clinical benefits of PCV13 in combination with PPV23 for the Norwegian recommendations. These are now stepwise and consider the need for vaccination, choice of pneumococcal vaccines, and re-vaccination interval by risk group.

Original Papers

Pneumococcal and meningococcal infection

The effect of distance on observed mortality, childhood pneumonia and vaccine efficacy in rural Gambia

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a2 Department of Disease Control, London School of Hygiene & Tropical Medicine, London, UK

a3 Medical Research Council Tropical Epidemiology Group, Department of Infectious Disease Epidemiology, London School of Hygiene & Tropical Medicine, London, UK

SUMMARY

We investigated whether straight-line distance from residential compounds to healthcare facilities influenced mortality, the incidence of pneumonia and vaccine efficacy against pneumonia in rural Gambia. Clinical surveillance for pneumonia was conducted on 6938 children living in the catchment areas of the two largest healthcare facilities. Deaths were monitored by three-monthly home visits. Children living >5 km from the two largest healthcare facilities had a 2·78 [95% confidence interval (CI) 1·74–4·43] times higher risk of all-cause mortality compared to children living within 2 km of these facilities. The observed rate of clinical and radiological pneumonia was lower in children living >5 km from these facilities compared to those living within 2 km [rate ratios 0·65 (95% CI 0·57–0·73) and 0·74 (95% CI 0·55–0·98), respectively]. There was no association between distance and estimated pneumococcal vaccine efficacy. Geographical access to healthcare services is an important determinant of survival and pneumonia in children in rural Gambia.

Short Reports

Hepatitis

Hepatitis B vaccination for healthcare personnel in American Samoa: pre-implementation survey for policy decision

K. N. LYa1 c1, H. ROBERTSa1, R. E. WILLIAMSa1, Y. MASUNU-FALEAFAGAa2, J. DROBENIUCa1, S. KAMILIa1 and E. H. TESHALEa1

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a2 American Samoa Immunization Program, American Samoa Department of Health, Pago Pago, American Samoa

SUMMARY

American Samoa does not have a hepatitis B vaccination policy for healthcare personnel (HCP). Consequently, hepatitis B has remained a health threat to HCP. In this study, we performed a cross-sectional study and examined demographic and risk information and hepatitis B vaccination, testing, and serostatus in hospital employees in American Samoa. Of 604 hospital employees, 231 (38·2%) participated, and of these, 158 (68·4%) were HCP. Of HCP participants, 1·9% had chronic hepatitis B infection, 36·1% were susceptible, and 60·8% were immune. Nearly half of HCP participants reported history of needlestick injury. Overall,

participants' knowledge of their hepatitis B infection and vaccination status was low. These data support the adoption of a hepatitis B vaccination policy for HCP by American Samoa, as currently recommended by the World Health Organization and the US Centers for Disease Control and Prevention. Adherence to the policy could be monitored as a way to measure protection.

The European Journal of Public Health
Volume 24, Issue suppl 2, 01 October 2014
http://eurpub.oxfordjournals.org/content/24/suppl_2
Supplement: 7th European Public Health Conference
Introduction to Glasgow 2014

We are delighted to introduce this supplement to the European Journal of Public Health which contains the abstracts of papers to be presented at the 7th European Public Health Conference. It includes abstracts for the main part of the conference: plenary sessions; oral sessions (including workshops); pitch sessions; and poster walks.

For Glasgow 2014, we have received a new record in abstracts and workshops: 1025 single abstracts and 75 workshops from 68 countries worldwide. This new record posed an extra challenge to the International Scientific Committee, responsible for the reviewing of the abstracts. The International Scientific Committee of the Glasgow 2014 conference consisted of 59 experts from 20 countries and was chaired by Martin McKee from the UK. We are extremely grateful to them for the hard work this involved. The members of the International Scientific …

Eurosurveillance
Volume 19, Issue 44, 06 November 2014
http://www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationId=11678
[New issue; No relevant content]

Global Health: Science and Practice (GHSP)
August 2014 | Volume 2 | Issue 3
http://www.ghspjournal.org/content/current
[Reviewed earlier]

Global Health Governance
[Accessed 8 November 2014]
http://blogs.shu.edu/ghg/category/complete-issues/summer-2013/
[No new relevant content]

Global Public Health
Volume 9, Supplement 1, 2014
http://www.tandfonline.com/toc/rgph20/.Uq0DgeKy-F9#.U4onnCjDU1w
This Special Supplement is dedicated to all the Afghan and international health workers who sacrificed their lives during the rebuilding of the Afghan health system.
[Reviewed earlier]

Globalization and Health
[Accessed 8 November 2014]
http://www.globalizationandhealth.com/
[No new relevant content]

Health Affairs
November 2014; Volume 33, Issue 11
http://content.healthaffairs.org/content/current
Collaborating For Community Health
[No specific relevant content]

Health and Human Rights
Volume 16, Issue 2 December 2014
http://www.hhrjournal.org/volume-16-issue-2/
Papers in Press: Special Issue on Health Rights Litigation
[Reviewed earlier]

Health Economics, Policy and Law
Volume 9 - Issue 04 - October 2014
http://journals.cambridge.org/action/displayIssue?jid=HEP&tab=currentissue
[Reviewed earlier]

Health Policy and Planning
Volume 29 Issue 7 October 2014
http://heapol.oxfordjournals.org/content/current
[Reviewed earlier]

Health Research Policy and Systems
http://www.health-policy-systems.com/content
[Accessed 8 November 2014]
[No new relevant content]

Human Vaccines & Immunotherapeutics (formerly Human Vaccines)
September 2014 Volume 10, Issue 9
http://www.landesbioscience.com/journals/vaccines/toc/volume/10/issue/9/
[Reviewed earlier]

Infectious Agents and Cancer
[Accessed 8 November 2014]

http://www.infectagentscancer.com/content
[No new relevant content]

Infectious Diseases of Poverty
[Accessed 8 November 2014]
http://www.idpjournal.com/content
Research Article

Multinational corporations and infectious disease: Embracing human rights management techniques

Kendyl Salcito, Burton H Singer, Mitchell G Weiss, Mirko S Winkler, Gary R Krieger, Mark Wielga and Jürg Utzinger
Author Affiliations
Infectious Diseases of Poverty 2014, 3:39 doi:10.1186/2049-9957-3-39
Published: 3 November 2014
*Abstract (*provisional)
Background
Global health institutions have called for governments, international organisations and health practitioners to employ a human rights-based approach to infectious diseases. The motivation for a human rights approach is clear: poverty and inequality create conditions for infectious diseases to thrive, and the diseases, in turn, interact with social-ecological systems to promulgate poverty, inequity and indignity. Governments and intergovernmental organisations should be concerned with the control and elimination of these diseases, as widespread infections delay economic growth and contribute to higher healthcare costs and slower processes for realising universal human rights. These social determinants and economic outcomes associated with infectious diseases should interest multinational companies, partly because they have bearing on corporate productivity and, increasingly, because new global norms impose on companies a responsibility to respect human rights, including the right to health.
Methods
We reviewed historical and recent developments at the interface of infectious diseases, human rights and multinational corporations. Our investigation was supplemented with field-level insights at corporate capital projects that were developed in areas of high endemicity of infectious diseases, which embraced rights-based disease control strategies.
Results
Experience and literature provide a longstanding business case and an emerging social responsibility case for corporations to apply a human rights approach to health programmes at global operations. Indeed, in an increasingly globalised and interconnected world, multinational corporations have an interest, and an important role to play, in advancing rights-based control strategies for infectious diseases.
Conclusions
There are new opportunities for governments and international health agencies to enlist corporate business actors in disease control and elimination strategies. Guidance offered by the United Nations in 2011 that is widely embraced by companies, governments and civil society provides a roadmap for engaging business enterprises in rights-based disease management strategies to mitigate disease transmission rates and improve human welfare outcomes.

International Health
Volume 6 Issue 3 September 2014
http://inthealth.oxfordjournals.org/content/6/3.toc
[Reviewed earlier]

International Journal of Epidemiology
Volume 43 Issue 5 October 2014
http://ije.oxfordjournals.org/content/current
[Reviewed earlier]

International Journal of Infectious Diseases
Volume 28, p8 November 2014
http://www.ijidonline.com/current
[Reviewed earlier]

JAMA
November 5, 2014, Vol 312, No. 17
http://jama.jamanetwork.com/issue.aspx
[New issue; No relevant content]

JAMA Pediatrics
November 2014, Vol 168, No. 11
http://archpedi.jamanetwork.com/issue.aspx
Viewpoint | November 2014
Global Child HealthA Call to Collaborative Action for Academic Health Centers
Parminder S. Suchdev, MD, MPH1,2,3; Robert F. Breiman, MD3,4; Barbara J. Stoll, MD1,2
[+] Author Affiliations
JAMA Pediatr. 2014;168(11):983-984. doi:10.1001/jamapediatrics.2014.1566.
This Viewpoint calls for collaborative action in order for academic health centers to improve global child health.
Despite substantial progress toward achieving the Millennium Development Goals of maternal and child survival, challenges persist, including tackling factors beyond survival such as improving quality of life and long-term physical and cognitive development. The web of health determinants have evolved and include food security, climate change, urbanization, and noncommunicable diseases. These 21st century realities underscore an urgent need to engage a wide array of disciplines to catalyze new ways to implement sustainable solutions for the health of the planet.1
Viewpoint | November 2014
Social Impact Bonds - Behavioral Health Opportunities
Eric Trupin, PhD1; Nicholas Weiss, MD1; Suzanne E. U. Kerns, PhD1
[+] Author Affiliations
JAMA Pediatr. 2014;168(11):985-986. doi:10.1001/jamapediatrics.2014.1157.
The past 2 decades have seen remarkable growth in the development of cost-beneficial, evidence-based programs in pediatric health, behavioral health, youth juvenile justice, and child

welfare. Despite the economic and system constraints that have slowed broad dissemination, research-proven approaches have exceptional potential to improve population-level well-being while simultaneously protecting society from the burdensome costs of failing to treat the problems they target.

Journal of Community Health
Volume 39, Issue 6, December 2014
http://link.springer.com/journal/10900/39/6/page/1
Smallpox Inoculation (Variolation) in East Africa with Special Reference to the Practice Among the Boran and Gabra of Northern Kenya
Pascal James Imperato, Gavin H. Imperato
Pages 1053-106

Journal of Epidemiology & Community Health
December 2014, Volume 68, Issue 12
http://jech.bmj.com/content/current
[Reviewed earlier]

Journal of Global Ethics
Volume 10, Issue 2, 2014
http://www.tandfonline.com/toc/rjge20/.U2V-Elf4L0I#.VAJEj2N4WF8
Tenth Anniversary Forum: The Future of Global Ethics
[Reviewed earlier]

Journal of Global Infectious Diseases (JGID)
July-September 2014 Volume 6 | Issue 3 Page Nos. 93-137
http://www.jgid.org/currentissue.asp?sabs=n
[Reviewed earlier]

Journal of Health Care for the Poor and Underserved (JHCPU)
Volume 25, Number 3, August 2014
http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu.25.3.html
[Reviewed earlier]

Journal of Health Organization and Management
Issue 6 – December 2014
http://link.springer.com/journal/10903/16/6/page/1
Special Focus: Mental Health and Wellness

Journal of Immigrant and Minority Health

Volume 16, Issue 5, October 2014
http://link.springer.com/journal/10903/16/5/page/1
[Reviewed earlier]

Journal of Immigrant & Refugee Studies
Volume 12, Issue 4, 2014
http://www.tandfonline.com/toc/wimm20/current#.VFWeF8l4WF9
Special Issue: New Forms of Intolerance in European Political Life

Journal of Infectious Diseases
Volume 210 Issue 10 November 15, 2014
http://jid.oxfordjournals.org/content/current
[Reviewed earlier]

The Journal of Law, Medicine & Ethics
Fall 2014 Volume 42, Issue 3 Pages 280–401
http://onlinelibrary.wiley.com/doi/10.1111/jlme.2014.42.issue-3/issuetoc
Special Issue: SYMPOSIUM: Concussions and Sports
[Reviewed earlier]

Journal of Medical Ethics
November 2014, Volume 40, Issue 11
http://jme.bmj.com/content/current
[Reviewed earlier]

Journal of Medical Internet Research
Vol 16, No 11 (2014): November
http://www.jmir.org/2014/11
[New issue; No relevant content]

Journal of Medical Microbiology
November 2014; 63 (Pt 11)
http://jmm.sgmjournals.org/content/current
[Reviewed earlier]

Journal of the Pediatric Infectious Diseases Society (JPIDS)
Volume 3 Issue 3 September 2014
http://jpids.oxfordjournals.org/content/current
[Reviewed earlier]

Journal of Pediatrics
Volume 165, Issue 5, p879-1072 November 2014
http://www.jpeds.com/current

Vaccine promotion messages may not encourage vaccination

Helen Campbell, MSc
Public Health England
Helen Bedford, PhD
UCL Institute of Child Health, London, United Kingdom
DOI: http://dx.doi.org/10.1016/j.jpeds.2014.08.017

Commentary

Vaccination resistance and distrust emerged early and have coexisted ever since. Parents may be selective about, defer, or immunize despite having concerns.[1] There is no clear evidence of increasing immunization hesitancy, however. In the United Kingdom, for example, vaccination is at its highest level, including MMR coverage. Setting aside practical barriers to vaccination, no distinct division exists between those choosing or declining vaccines.[1] Multiple factors influence this decision and evidence for interventions reducing vaccine refusal or hesitancy is limited.[2] In the study by Nyhan et al, none of the four MMR-related messages increased parental intent to vaccinate, although details of their children's age (and thus MMR relevance) were missing. The study suggested that some interventions, although better informing, may increase safety concerns and reduce intent to vaccinate. In reality, multilayered (as opposed to single fact) information provision is more typical, with individual access determined by personal need. Health professionals are key,[3] and the resultant interactive process can better direct to appropriate resources and allows tailored discussion. What is clearly needed, however, is adequate premarket testing with outcome measures that capture impact on knowledge and on intended behavior.

Journal of Public Health Policy
Volume 35, Issue 4 (November 2014)
http://www.palgrave-journals.com/jphp/journal/v35/n4/index.html

Editorial

A proposal to rethink how we track tuberculosis spread around the world

Phyllis Freeman[a] and Anthony Robbins[a]
aCo-Editors
Journal of Public Health Policy (2014) 35, 423–424. doi:10.1057/jphp.2014.36; published online 11 September 2014

We are pleased to publish in this issue an article that lays out a novel and promising global strategy for tuberculosis (TB).[1] Becerra and Swaminathan start with children, who within the global epidemic remain largely invisible. They explain why it is useful to think of children with TB as 'sentinels' – as well as a neglected population that urgently needs quality attention. Every year about 1 million children get sick with TB. Children are exposed to TB, mostly in homes shared with others who cough the mycobacterium into the air. Each child is a sentinel, helping detect the infecting cases, and creating an opportunity for preventive treatment for some, treatment of active disease for many others. But it will not be easy.

Becerra and Swaminathan identify key difficulties:

- the very nature of pediatric TB;
- the inadequacy of diagnostic tools;
- lack of data for good disease burden estimates; and

- failure, in most of world, to field contact investigations.

The plight of children signals a continuing failure of two decades of global TB policy – focused on Directly Observed Therapy with a set regime of 'first line drugs' (effective in the absence of drug resistance) – for all but the most affluent countries. If the world were to adopt additional tools used commonly in wealthier nations, contact investigation followed by use of existing diagnostic tools, and drug sensitivity testing to learn about the infecting organisms, it should be possible to set quantitative treatment and prevention targets among children exposed at home to multidrug-resistant TB, country by country. The article describes the strategy in detail. These authors are not satisfied with their ambitious proposal for case finding and preventive treatment. They have organized a science-advocacy network to take action – the Sentinel Project on Pediatric Drug-Resistant Tuberculosis. Their activities warrant following (sentinel-project.org).

Those in developing countries seem more aware of today's dilemma for improving response to TB than those in more affluent settings. An Indian colleague writes: 'It is disheartening to see that whenever the problem of TB is discussed among experts, it gets largely confined to multidrug resistant TB and HIV induced TB, as if the regular form is already under control'.2 His comment may reflect the difference between richer countries, where TB spread has nearly been halted compared with countries with fewer resources, where prevalence is high in the general population and epidemic spread persists. For richer countries two exceptions require special attention: continuing vulnerability for people infected with drug-resistant strains and for those with compromised immune systems.

To mount more urgent and informed global support, this article provides a crucial link between 'business as usual' in TB action, and a future where attention to children can protect many in danger and lead to a more comprehensive and effective set of programs worldwide.

Commentary: A targets framework: Dismantling the invisibility trap for children with drug-resistant tuberculosis

Open
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bNational Institute for Research in Tuberculosis, Chennai, India
The online version of this article is available Open Access

Abstract

Tuberculosis (TB) is an airborne infectious disease that is both preventable and curable, yet it kills more than a million people every year. Children are highly vulnerable, but often invisible casualties. Drug-resistant forms of TB are on the rise globally, and children are as vulnerable as adults but less likely to be counted as cases of drug-resistant disease if they become sick. Four factors make children with drug-resistant TB 'invisible': first, the nature of the disease in children; second, deficiencies in existing diagnostic tools; third, overreliance on these tools; and fourth, our collective failure to deploy one effective tool for finding and treating children – contact investigation. We describe a nascent science-advocacy network – the Sentinel Project on Pediatric Drug-Resistant Tuberculosis – whose goal is to end child deaths from this disease. Provisional annual targets, focused on children exposed at home to multidrug-resistant TB, to be updated every year, constitute a framework to focus attention and collective actions at the community, national, and global levels. The targets in two age groups, under 5 and 5–14 years old, tell us the number of: (i) children who require complete evaluation for TB disease and infection; (ii) children who require treatment for TB disease; and (iii) children who would benefit from preventive therapy.

Building capacities of elected national representatives to interpret and to use evidence for health-related policy decisions: A case study from Botswana
Open
Anne Cockcrofta, Mokgweetsi Masisib, Lehana Thabanec, and Neil Anderssond,e
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eCIET/PRAM, Department of Family Medicine, McGill University, Montreal, Canada
The online version of this article is available Open Access
Abstract
Elected national representatives make decisions to fund health programmes, but may lack skills to interpret evidence on health-related topics. In 2011, we surveyed the 61 members of Botswana's Parliament about their use of epidemiological evidence, then provided two half-days of training about using evidence. We included the importance of counter-factual evidence, the number needed to treat, and unit costs of interventions. A further session in 2012 covered evidence about the HIV epidemic in Botswana and planning the best mix of interventions to reduce new HIV infections. The 27 respondents reported they lacked good quality, timely evidence, and had difficulty interpreting and using evidence. Thirty-six, including seven ministers, attended one or both trainings. They participated actively and their evaluation was positive. Our experience in Botswana could potentially be extended to other countries in the region to support evidence-based efforts to tackle the HIV epidemic.

Journal of the Royal Society – Interface
December 6, 2014; 11 (101)
http://rsif.royalsocietypublishing.org/content/current
[No new relevant content]

Journal of Virology
November 2014, volume 88, issue 21
http://jvi.asm.org/content/current
[Reviewed earlier]

The Lancet
Nov 08, 2014 Volume 384 Number 9955 p1641 – 1720 e52 - 56
http://www.thelancet.com/journals/lancet/issue/current
Editorial
The medium and the message of Ebola
The Lancet
…Social media during a health crisis has the potential to bring experts together in a transparent and democratic forum with global participation to generate a mass of new and potentially helpful ideas. Scaling up the positive and constructive discussion of an informed Twitter discussion could remove boundaries between scientists, health professionals, and policy

makers, creating a new diverse community that gives everyone a voice and an opportunity to contribute. To create the conditions to defeat Ebola, we need more of that kind of global engagement, knowledge, and commitment.

A new Lancet Commission on Essential Medicines

The Lancet

Preview /

Access to essential medicines globally is a highly charged political issue that is often about trade, poliies, and protest. Essential medicines are crucial if countries are to achieve universal health coverage, and access will be a major goal for the post-2015 development era.

Special Report

The WHO AFRO Regional Director candidates

Udani Samarasekera

Preview /

The *Lancet* asked the candidates for one of the most important jobs in Africa five questions ahead of the meeting that will decide who will be nominated for the position. Udani Samarasekera reports.

The Lancet Global Health

Nov 2014 Volume 2 Number 11 e616 – 671

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

[Reviewed earlier]

The Lancet Infectious Diseases

Nov 2014 Volume 14 Number 11 p1023 - 1162

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

[Reviewed earlier]

Maternal and Child Health Journal

Volume 18, Issue 9, November 2014

http://link.springer.com/journal/10995/18/9/page/1

[Reviewed earlier]

Medical Decision Making (MDM)

November 2014; 34 (8)

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

[New issue; No relevant content]

The Milbank Quarterly

A Multidisciplinary Journal of Population Health and Health Policy

September 2014 Volume 92, Issue 3 Pages 407–631

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

[Reviewed earlier]

Nature
Volume 515 Number 7525 pp7-156
http://www.nature.com/nature/current_issue.html
Nature | News
Sharing

Models overestimate Ebola cases

Rate of infection in Liberia seems to plateau, raising questions over the usefulness of models in an outbreak.

Declan Butler
04 November 2014

The reality of the Ebola outbreak is not reflected by model projections of high case numbers. The Ebola outbreak in West Africa has infected at least 13,567 people and killed 4,951, according to figures released on 31 October by the World Health Organization (WHO). Now, in a rare encouraging sign, the number of new cases in Liberia seems to be flattening after months of exponential growth. Scientists say it is too soon to declare that the disease is in retreat: case data are often unreliable, and Ebola can be quick to resurge. But it is clear that mathematical models have failed to accurately project the outbreak's course.

Researchers are now struggling to understand whether reports of empty beds at treatment centres and declining burial numbers are signs that fewer people are developing Ebola, or whether cases and deaths are going unrecorded. In Liberia's capital, Monrovia, just 80 of 250 beds were filled at the Médecins Sans Frontières (MSF) centre last week. But Fasil Tezera, who heads MSF's Liberia mission, is cautious: "The present epidemic is unpredictable," he says. Epidemiologists normally use mathematical models to estimate the trajectory of an outbreak, and to estimate where and how to direct scarce medical resources. But for the current crisis, on-the-ground data contradict the projections of published models, says Neil Ferguson, an epidemiologist at Imperial College London, and a member of the WHO's multidisciplinary Ebola Response Team.

On 7 October, for example, modeller Alessandro Vespignani of Northeastern University in Boston, Massachusetts, and his collaborators predicted that Liberia would see 6,900–34,400 cases by 24 October, and 9,400–47,000 by 31 October. But the WHO put the number of reported cases in the country at just 6,535 as of 25 October.

Vespignani says that his model was a worst-case scenario, in which exponential growth of cases continued and containment measures were ineffective. But he and other modellers are also handicapped by incomplete and unreliable data on Ebola epidemiology, especially in the hardest-hit areas. And they have little empirical data on how disease-control measures quantitatively affect Ebola transmission, says ecologist Nick Golding, who studies the spatial distribution of disease at the University of Oxford, UK. Models "are fitted to pretty poor-quality data on case counts, and essentially no data on interventions", he says, making it difficult to generate accurate projections.

Two more-complex models published last month attempted to tease out the effects of various control measures. But their outcomes also do not square with the most recent Liberia data (J. A. Lewnard et al. Lancet Infect. Dis. http://doi.org/wn9; 2014, and A. Pandeyet al. Science http://doi.org/wts; 2014). That does not surprise Alison Galvani, an epidemiologist at Yale University in New Haven, Connecticut, and an author of both studies. "Epidemics are moving targets," she says, adding that her model projections are at best a preliminary outline for public-health intervention. Because the model projections can be easily misunderstood, Ferguson says that modellers "really need to think carefully about what we really know about

Ebola transmission and the impact of different interventions, and do our best to communicate the many uncertainties".

In the meantime, Bruce Aylward, a WHO assistant director-general who is coordinating the agency's Ebola efforts, is "terrified" that any plateau in new cases will be misinterpreted as meaning that the problem is going away. There is still a need to greatly increase the resources available to treat infected people and prevent new cases, Aylward says.

But if the slowing rate of infection in Liberia is confirmed, it could suggest that even moderate levels of public-health intervention can pay off, says Golding. For the current Ebola outbreak, the average number of new cases spawned by an infected individual — 1.2–2.2 — is much lower than that of many other communicable diseases, such as measles (which can spread to between 12 and 18 people per case). As Ebola prevention measures push down this figure, the disease becomes easier to control; when it dips below 1, virus spread stops completely.
Until the West African outbreak is extinguished, there is a real risk that the disease will resurge in areas where it has been stamped out — or even cover new ground. A stark reminder of this came in the past two weeks: a two-year-old girl with Ebola travelled hundreds of kilometres from Guinea to Mali on a bus — raising concerns that the many people she came into contact with could spark outbreaks in Mali.

Nature Medicine
November 2014, Volume 20 No 11 pp1219-1353
http://www.nature.com/nm/journal/v20/n11/index.html
Nature Medicine | Editorial
Course correction [Ebola]
Nature Medicine 20, 1219 (2014)
doi:10.1038/nm.3756
Published online
06 November 2014

The international response to the ongoing Ebola epidemic has in many respects been more reactive than proactive. But there are changes that, if made, may shift the balance toward future readiness.

The projections are appalling. At the time of this writing, the World Health Organization (WHO) stated that the number of new Ebola virus disease cases could reach 10,000 per week before the end of the year. The three most heavily afflicted nations—Guinea, Liberia and Sierra Leone—remain woefully underequipped to stem the tide of infection. Severe shortages in medical personnel, protective gear, treatment beds and burial teams hinder almost every aspect of the effort. Cases of transmission were also reported in the US and Spain.

One thing is clear: the international community was not prepared to respond to this outbreak. Less clear is how, with limited resources, to stop the current epidemic. But several broad areas stand out as particularly important for efforts to stem Ebola's spread and improve preparedness for future outbreaks.

One is our sense of urgency. In hindsight, the inability of the world to put forward an agile response to this particular outbreak is not surprising. The first infections occurred in a region unfamiliar with Ebola, at the junction of three nations suffering from civil unrest, crippling poverty and deficient healthcare systems. These and other factors enabled the initiation of multiple chains of transmission, allowing this pathogen to reach, for the first time, densely populated areas. In terms of dynamics and scale, this outbreak may be outside anything ever modeled or anticipated by any relief agency. That said, the Ebola virus is a known pathogen.

Unlike the viruses that caused the first outbreaks of sudden acute respiratory syndrome (SARS) or Middle East respiratory syndrome (MERS), the world has been aware of the existence of the Ebola virus and its lethality since its first detection in 1976. So, the fact that no country had a large stockpile of clinically tested vaccine or therapy for Ebola may be interpreted to indicate a lack of a sense of urgency. At the very least, it suggests a lack of prioritization of this pathogen, which is not endemic outside of Africa. If this outbreak teaches us one thing, it's that our assumptions regarding which pathogens the world needs to worry most about need to change.

But changing assumptions is only a start. Acting on them requires coordination and money. Governments around the world have dedicated funds to tackle the Ebola challenge, but funding remains far short of what is needed now—the UN estimated $1 billion will be necessary to contain the current epidemic—and in the future. In terms of the current outbreak, on 16 October the UN announced that though it has received $20 million in pledges from various governments for its Ebola trust fund, only $100,000 has come in thus far. Encouragingly, there has been an outpouring of financial contributions from wealthy individuals and private organizations, the most recent being $25 million from Mark Zuckerberg and his wife Priscilla Chan to the Centers for Disease Control and Prevention (CDC) Foundation. But whether money will arrive as fast as is needed to quell the still escalating epidemic is unclear.

And where should we allocate funds? In terms of responding to the current outbreak, money should flow towards efforts to mobilize the expertise and equipment to build clinics, administer treatment and safely bury the dead. More complicated are decisions about where to spend to enable preparedness for future outbreaks. Some experts, including Francis Collins, director of the US National Institutes of Health (NIH), have blamed cuts in research funding for the lack of clinically tested Ebola vaccines and therapeutics. Yet prior to this outbreak, US and Canadian government research agencies had discovered candidate Ebola vaccines, and US and Canadian biotechnology companies had formed around candidate Ebola therapeutics. The bottleneck in each case was clinical testing, approval and stockpiling rather than the basic discovery research.

Although agencies such as the US Biomedical Advanced Research and Development Authority (BARDA) were set up for the purpose of efficiently taking candidate vaccines and drugs relevant to public health through advanced development and stockpiling, by many accounts BARDA is underfunded, forcing prioritization of pathogens such as influenza over those that were perceived in the past to be more distant threats, such as Ebola. The first BARDA funding for a medical countermeasure against any viral hemorrhagic fever was awarded only in September 2014, to Mapp Biopharmaceutical for advanced development of their antibody-based Ebola therapy. Encouragingly, agencies such as the NIH Vaccine Research Center—with the mission of taking vaccines all the way through advanced development—have initiated clinical testing of candidate Ebola vaccines. And in August 2014, the Wellcome Trust created the Ebola research funding initiative, which commits some funds specifically to clinical studies that could be conducted during the current epidemic. But greater throughput in clinical testing may be one thing needed to stop belated prioritization of infectious agents. So, in a setting of limited funding, allocating more towards advanced development and stockpiling may be advisable.

Another area demanding committed spending is regular and rigorous training of healthcare workers in the use of personal protective gear. Encouragingly, the CDC set up a training course for clinicians on their way to West Africa to treat infected patients, but the transmission of the Ebola virus between infected patients and nurses in hospitals in Dallas and Madrid indicate that even healthcare workers working in 'routine' settings need a deeper understanding of up-to-date guidelines for protecting themselves and others while treating patients with various infectious diseases. Right now it is unclear which institutions will ensure the implementation of

such preparedness procedures, at least in the US, as the CDC lacks authority over local and state health agencies in this regard.

Global efforts must be engaged to halt the Ebola epidemic. But when it is over, it is essential that the international community take stock of what this horrific crisis taught us and prioritize these lessons in the long term.

Nature Reviews Immunology
November 2014 Vol 14 No 11
http://www.nature.com/nri/journal/v14/n11/index.html
[New issue; No relevant content]

New England Journal of Medicine
November 6, 2014 Vol. 371 No. 19
http://www.nejm.org/toc/nejm/medical-journal
Perspective
History of Medicine
Ebola in a Stew of Fear
Gregg Mitman, Ph.D.
N Engl J Med 2014; 371:1763-1765
November 6, 2014
DOI: 10.1056/NEJMp1411244

The Pediatric Infectious Disease Journal
November 2014 - Volume 33 - Issue 11 pp: 1103-1209,e273-e315
http://journals.lww.com/pidj/pages/currenttoc.aspx
[New issue; No relevant content]

Pediatrics
November 2014, VOLUME 134 / ISSUE 5
http://pediatrics.aappublications.org/current.shtml
[New issue; No relevant content]

Pharmaceutics
Volume 6, Issue 4 (December 2014), Pages 543-
http://www.mdpi.com/1999-4923/6/4
[Reviewed earlier]

Pharmacoeconomics
Volume 32, Issue 11, November 2014
http://link.springer.com/journal/40273/32/11/page/1
[Reviewed earlier]

PLoS One
[Accessed 8 November 2014]
http://www.plosone.org/
Research Article
Incidence of Rotavirus and Circulating Genotypes in Northeast Brazil during 7 Years of National Rotavirus Vaccination
Ricardo Q. Gurgel, Alberto De Juan Alvarez, Alda Rodrigues, Robergson R. Ribeiro, Sílvio S. Dolabella, Natanael L. Da Mota, Victor S. Santos, Miren Iturriza-Gomara, Nigel A. Cunliffe, Luis E. Cuevas mail
Published: October 31, 2014
DOI: 10.1371/journal.pone.0110217
Abstract
Background and Aims
Rotavirus causes severe diarrhoea and Brazil introduced the Rotarix G1P[8] vaccine in 2006. We aimed to describe changes in rotavirus incidence and diarrhoea epidemiology before and after vaccine introduction.
Methods
Design: (i) hospital-based survey of children with diarrhoea (2006–2012); (ii) diarrhea-mortality and hospitalization surveillance (1999–2012).
Setting
(i) Aracaju and (ii) state and national level.
Results
1841 children were enrolled and 231 (12.5%) had rotavirus. Rotavirus was less frequent from January-June than from July-December (9.4% versus 20.9%, $p<0.01$), but the seasonal variation was less defined after 2009. Very few rotavirus cases (8–3.9%) were detected in 2011, with an increase in 2012 (13–18.5%). In 2006, unvaccinated children were more likely to have rotavirus, but thereafter unvaccinated and vaccinated children had equally low incidence. Older children and those with rotavirus were more likely to have severe diarrhea episodes. The most frequent genotype from 2006 to 2010 was G2P[4]; except in 2009, when most cases were G1P[8]. Very few G2P[4] were detected from 2011 and 50% cases in 2012 were G8P[4]. Diarrhoea-hospitalizations decreased nationally from 89,934 (2003) to 53,705 (2012; 40.3% reduction) and in the state from 1729 to 748 (56.7% reduction). Diarrhoea-deaths decreased nationally from 4368 in 1999 to 697 in 2012 (84% reduction, $p<0.001$) and in the state from 132 to 18 (86% reduction). These changes were much larger after vaccine introduction.
Conclusions
The vaccine was associated with substantial reductions in rotavirus incidence and diarrhoea-hospitalizations and deaths. The G2P[4] genotype predominance disappeared over time and may be replaced by other heterotypic genotypes.
Research Article
Effect of Pneumococcal Conjugate Vaccination in Uruguay, a Middle-Income Country
Gabriela García Gabarrot, Mariana López Vega, Gabriel Pérez Giffoni, Silvia Hernández, Pablo Cardinal, Viviana Félix, Jean Marc Gabastou, Teresa Camou mail, the Uruguayan SIREVA II Group
Published: November 06, 2014
DOI: 10.1371/journal.pone.011233
Abstract
Background

In 2008, a 7-valent pneumococcal conjugate vaccine (PCV7) was introduced into the routine childhood immunization program in Uruguay, with a 2+1 schedule. In 2010, PCV13 replaced PCV7, and the same 2+1 schedule was used. The effect of these pneumococcal vaccines on the incidence of invasive pneumococcal infections (IPD) and on serotype distribution was analyzed retrospectively, based on passive national laboratory surveillance.
Methods
Data from 1,887 IPD isolates from 5 years before and 5 years after PCV7 introduction (7 before and 3 after PCV13 introduction) was examined to assess the incidence rate per 100,000 age-specific population of all IPD, PCV7-serotypes, and PCV13-serotypes associated IPD among children <2 years and 2 to 4 years old, and patients ≥5 years old. Trends of frequency for each serotype were also analyzed.
Results
Comparison of pre-vaccination (2003–2007) and post-vaccination (2008–2012) periods showed a significant decrease in IPD incidence among children <2 years old (IR 68.7 to IR 29.6, $p<0.001$) and children 2 to 4 years ($p<0.04$). IPD caused by serotypes in PCV7 was reduced by 95.6% and IPD caused by 6 serotypes added in PCV13 was reduced by 83.9% in children <5 years old. Indirect effects of both conjugate vaccines were observed among patients ≥5 years old one year after the introduction of each vaccine, in 2010 for PCV7 and in 2012 for PCV13. Nevertheless, for reasons that still need to be explained, perhaps due to ascertainment bias, total IPD in this group increased after 2007. In 2012, the relative frequency of vaccine serotypes among vaccinated and unvaccinated population declined, except for serotype 3. Non vaccine serotypes with increasing frequency were identified, in rank order: 12F, 8, 24F, 22F, 24A, 15C, 9N, 10A and 33.
Conclusion
Consecutive immunization with PCV7 and PCV13 has significantly reduced IPD in children <5 years of age in Uruguay.

Research Article

Global Systematic Review of the Cost-Effectiveness of Indigenous Health Interventions

Blake J. Angell mail, Janani Muhunthan, Michelle Irving, Sandra Eades, Stephen Jan Published: November 05, 2014
DOI: 10.1371/journal.pone.011124

Abstract

Background
Indigenous populations around the world have consistently been shown to bear a greater burden of disease, death and disability than their non-Indigenous counterparts. Despite this, little is known about what constitutes cost-effective interventions in these groups. The objective of this paper was to assess the global cost-effectiveness literature in Indigenous health to identify characteristics of successful and unsuccessful interventions and highlight areas for further research.
Methods and Findings
A systematic review of the published literature was carried out. MEDLINE, PSYCINFO, ECONLIT, EMBASE and CINAHL were searched with terms to identify cost-effectiveness evaluations of interventions in Indigenous populations around the world. The WHO definition was followed in identifying Indigenous populations. 19 studies reporting on 27 interventions were included in the review. The majority of studies came from high-income nations with only two studies of interventions in low and middle-income nations. 22 of the 27 interventions included in the analysis were found to be cost-effective or cost-saving by the respective studies. There were

only two studies that focused on Indigenous communities in urban areas, neither of which was found to be cost-effective. There was little attention paid to Indigenous conceptions of health in included studies. Of the 27 included studies, 23 were interventions that specifically targeted Indigenous populations. Outreach programs were shown to be consistently cost-effective.
Conclusion
The comprehensive review found only a small number of studies examining the cost-effectiveness of interventions into Indigenous communities around the world. Given the persistent disparities in health outcomes faced by these populations and commitments from governments around the world to improving these outcomes, it is an area where the health economics and public health fields can play an important role in improving the health of millions of people.

PLoS Medicine
(Accessed 8 November 2014)
http://www.plosmedicine.org/
[No new relevant content]

PLoS Neglected Tropical Diseases
(Accessed 8 November 2014)
http://www.plosntds.org/
[No new relevant content]

PNAS - Proceedings of the National Academy of Sciences of the United States of America
(Accessed 8 November 2014)
http://www.pnas.org/content/early/
Probabilistic cognition in two indigenous Mayan groups
Laura Fontanaria, Michel Gonzalezb, Giorgio Vallortigarac, and Vittorio Girottoa,1
Author Affiliations
Edited by Philip N. Johnson-Laird, Emeritus Princeton University, Princeton, NJ, and approved October 3, 2014 (received for review June 6, 2014)
Significance
Correct probabilistic evaluations are one of the hallmarks of rationality. Is the human ability to make them dependent on formal education, or does it emerge regardless of instruction and culture? This paper shows that preliterate and prenumerate Mayan adults are able to solve a variety of probabilistic problems. These individuals correctly use prior and posterior information, proportions and elementary combinatorial procedures to predict the occurrence of random outcomes. And they perform like Mayan school children and Western controls. The finding that adults with no formal education are able to make suitable predictions indicates that, regardless of schooling and culture, the human mind possesses a basic probabilistic knowledge.
Abstract
Is there a sense of chance shared by all individuals, regardless of their schooling or culture? To test whether the ability to make correct probabilistic evaluations depends on educational and cultural guidance, we investigated probabilistic cognition in preliterate and prenumerate Kaqchikel and K'iche', two indigenous Mayan groups, living in remote areas of Guatemala.

Although the tested individuals had no formal education, they performed correctly in tasks in which they had to consider prior and posterior information, proportions and combinations of possibilities. Their performance was indistinguishable from that of Mayan school children and Western controls. Our results provide evidence for the universal nature of probabilistic cognition.

Pneumonia
Vol 5 (2014)
https://pneumonia.org.au/index.php/pneumonia/issue/current
Special Issue "Pneumonia Diagnosis"
[Reviewed earlier]

Public Health Ethics
Volume 7 Issue 2 July 2014
http://phe.oxfordjournals.org/content/current
[Reviewed earlier]

Qualitative Health Research
December 2014; 24 (12*)*
http://qhr.sagepub.com/content/current
Special Issue: Concepts in Promoting Health
[New issue; No relevant content]

Revista Panamericana de Salud Pública/Pan American Journal of Public Health (RPSP/PAJPH)
September 2014 Vol. 36, No. 3
http://www.paho.org/journal/index.php?option=com_content&view=article&id=151&Itemid=266&lang=en
Infant feeding practices in the Peruvian Amazon: implications for programs to improve feeding [Prácticas de alimentación de lactantes en la Amazonia peruana: implicaciones para los programas de mejora de la alimentación]
Gwenyth Lee, Maribel Paredes Olortegui, Sylvia Rengifo Pinedo, Ramya Ambikapathi, Pablo Peñataro Yori, Margaret Kosek, and Laura E. Caulfield
Desigualdad e inequidad en la utilización de servicios médicos según grupos etarios en Chile, 2000–2011 **[Inequality and inequity in the use of medical services in Chile, by age group, 2000–2011]**
Alejandra Chovar Vera, Felipe Vásquez Lavín y Guillermo Paraje
INFORMES ESPECIALES / SPECIAL REPORTS
El camino hacia la erradicación de la poliomielitis a través de la Organización Panamericana de la Salud **[The road to polio eradication via the Pan American Health Organization]**
Miguel Armando Mosquera Gordillo, Natalia Barón Cano
y Rosa Ballester Añón

Risk Analysis
September 2014 Volume 34, Issue 9 Pages 1581–1774
http://onlinelibrary.wiley.com/doi/10.1111/risa.2014.34.issue-9/issuetoc
[New issue; No relevant content]

Science
7 November 2014 vol 346, issue 6210, pages 669-784
http://www.sciencemag.org/current.dtl
In Depth
Infectious Diseases
Delays hinder Ebola genomics
Gretchen Vogel
As the Ebola epidemic sweeps through West Africa, scientists lack key genetic data to answer a question that has provoked much worried speculation: Is the virus becoming more transmissible or more deadly, or acquiring changes that would let it evade diagnostic tests or vaccines? Thousands of blood samples from Ebola patients have been sitting in refrigerators in Africa and Europe, untouched. And, as Science went to press, the few groups that have new sequence data have not made them public. Researchers are eager for a close-up look at how the virus may be evolving. Besides answering questions about its virulence, genomic data could reveal details about the epidemic, including hotspots of transmission and how often the virus has escaped from its animal reservoir to humans. But faced with the all-consuming public health response to the epidemic, bureaucratic obstacles, and chaotic record keeping, scientists have had to wait.

Social Science & Medicine
Volume 120, In Progress (November 2014)
http://www.sciencedirect.com/science/journal/02779536/118
[Reviewed earlier]

Tropical Medicine and Health
Vol. 42(2014) No. 4
https://www.jstage.jst.go.jp/browse/tmh/42/4/_contents
[No relevant content]

Tropical Medicine & International Health
November 2014 Volume 19, Issue 11 Pages 1293–1390
http://onlinelibrary.wiley.com/doi/10.1111/tmi.2014.19.issue-11/issuetoc
[Reviewed earlier]

Vaccine
Volume 32, Issue 49, Pages 6591-6724 (20 November 20
http://www.sciencedirect.com/science/journal/0264410X/32/49
Conference report

International meeting on influenza vaccine effectiveness, 3–4 December 2012, Geneva, Switzerland
Pages 6591-6595
Kathryn E. Lafond, John S. Tam, Joseph S. Bresee, Marc-Alain Widdowson
Abstract
On December 3–4 2012, the World Health Organization convened a meeting of influenza vaccine effectiveness (VE) experts from over 25 countries in Geneva, Switzerland, to review recent developments in the global influenza vaccine landscape and evaluate approaches to determining the effectiveness of influenza vaccine products among target populations. Vaccine manufacturers from Thailand, Vietnam, India, and Brazil shared recent advances illustrating the expansion of influenza vaccine production worldwide. Randomized controlled trials are underway in several low and middle-income countries including India, Thailand, Bangladesh, and South Africa, to fill knowledge gaps in target populations such as children and pregnant women. National and international networks in the United States, Canada, Europe, Latin America and Australia are conducting multi-site observational studies with shared methodologies to generate national influenza VE estimates and pool data for regional estimates. Standardized VE estimation methods are key to generating point estimates that are comparable internationally and across different settings.
Review
Vaccine administration in children with chronic kidney disease
Review Article
Pages 6601-6606
Susanna Esposito, Maria Vincenza Mastrolia, Elisabetta Prada, Carlo Pietrasanta, Nicola Principi
Highlights
:: Children with chronic kidney disease are at a higher risk for infectious disease morbidities.
:: Innate and acquired immune systems are damaged in children with chronic kidney disease.
:: Children with chronic kidney disease should complete immunization schedules.
:: Vaccination coverage in children with chronic kidney disease is lower than desired.
:: Close contacts of children with chronic kidney disease should complete age-appropriate vaccination schedules.
The budget impact of controlling wastage with smaller vials: A data driven model of session sizes in Bangladesh, India (Uttar Pradesh), Mozambique, and Uganda
Original Research Article
Pages 6643-6648
Wanfei Yang, Monika Parisi, Betsy J. Lahue, Md. Jasim Uddin, David Bishai
Highlights
:: This model was the first to generate data-driven wastage rates as an output.
:: Scenarios were modeled based on arrival distributions derived from field data.
:: Vaccine wastage is estimated for IPV in Bangladesh, India, Mozambique, and Uganda.
:: Switching to smaller vials can reduce wastage, but it does not guarantee lower costs.
:: Our model can be adapted to different vaccines prices and dose schedules.
Mapping vaccine hesitancy—Country-specific characteristics of a global phenomenon
Original Research Article
Pages 6649-6654
Eve Dubé, Dominique Gagnon, Emily Nickels, Stanley Jeram, Melanie Schuster
Abstract

The term vaccine hesitancy refers to delay in acceptance or refusal of vaccines despite the availability of vaccination services. Different factors influence vaccine hesitancy and these are context-specific, varying across time and place and with different vaccines. Factors such as complacency, convenience and confidence are involved. Acceptance of vaccines may be decreasing and several explanations for this trend have been proposed. The WHO Strategic Advisory Group of Experts (SAGE) on Immunization has recognized the global importance of vaccine hesitancy and recommended an interview study with immunization managers (IMs) to better understand the range of vaccine hesitancy determinants that are encountered in different settings. Interviews with IMs in 13 selected countries were conducted between September and December 2013 and various factors that discourage vaccine acceptance were identified. Vaccine hesitancy was not defined consistently by the IMs and most interpreted the term as meaning vaccine refusal. Although vaccine hesitancy existed in all 13 countries, some IMs considered its impact on immunization programmes to be a minor problem. The causes of vaccine hesitancy varied in the different countries and were context-specific, indicating a need to strengthen the capacity of national programmes to identify the locally relevant causal factors and to develop adapted strategies to address them.

Vaccine: Development and Therapy
(Accessed 8 November 2014)
http://www.dovepress.com/vaccine-development-and-therapy-journal
[No new relevant content]

Vaccines — Open Access Journal
(Accessed 8 November 2014)
http://www.mdpi.com/journal/vaccines
[No new relevant content]

Value in Health
Volume 17, Issue 7 November 2014
http://www.valueinhealthjournal.com/current
[Reviewed earlier]

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

MIT - Thesis
Estimating network structure and propagation dynamics for an infectious disease: towards effective vaccine allocation
Kim, Louis Y. (Louis Yongchul)
Citable URI: http://hdl.handle.net/1721.1/91397
Department: Massachusetts Institute of Technology. Operations Research Center.
Date Issued: 2014
Abstract:

In the event of a pandemic influenza outbreak, such as the 2009-2010 H1N1 "Swine Flu" episode, it is crucial to effectively allocate limited resources in order to minimize the casualties. Design of effective resource allocation strategies requires good understanding of the underlying contact network and of the propagation dynamics. In this thesis we develop a parameter estimation method that learns the network structure, among a family of graphs, and disease dynamics from the recorded infection curve, assuming that the disease dynamics follow an SIR process. We apply the method to data collected during the 2009-2010 H1N1 epidemic and show that the best-fit model, among a scale-free network and a small-world network, indicates the scale-free network. Given the knowledge of the network structure we evaluate different vaccination strategies. As a benchmark, we allow the vaccination decisions to depend on the state of the epidemic and we show that random vaccination (which is the current practice), does not efficiently halt the spread of influenza. Instead, we propose vaccine allocation strategies that exploit the underlying network structure and provide a reduction in the number of infections by over 6 times compared to the current practice. In addition, more realistic scenario involves random encounters between agents. To test this hypothesis, we introduced a dynamic network formation on top of the static network model. We apply the estimation method to the dynamic network model and show a small improvement in estimating the infection dynamics of the 2009-2010 H1N1 influenza.

The Journal of Adolescent Health
Volume 55, Issue 5, p595-720 November 2014
http://www.jahonline.org/current
Article in Press

A Randomized Intervention of Reminder Letter for Human Papillomavirus Vaccine Series Completion

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DOI: http://dx.doi.org/10.1016/j.jadohealth.2014.08.014
Abstract
Purpose
Completion rate for the three-dose series of the human papillomavirus (HPV) vaccine has generally been low. This study evaluated the effectiveness of a reminder letter intervention on HPV vaccine three-dose series completion.
Methods
Female members of Kaiser Permanente Southern California Health Plan who received at least one dose, but not more than two doses, of the HPV vaccine by February 13, 2013, and who were between ages 9 and 26 years at the time of first HPV vaccination were included. Eighty percent of these females were randomized to receive the reminder letter, and 20% were randomized to receive standard of care (control). The reminder letters were mailed quarterly to those who had not completed the series. The proportion of series completion at the end of the 12-month evaluation period was compared using chi-square test.
Results
A total of 9,760 females were included in the intervention group and 2,445 in the control group. HPV vaccine series completion was 56.4% in the intervention group and 46.6% in the control groups ($p < .001$). The effect of the intervention appeared to be stronger in girls aged 9–

17 years compared with young women aged 18–26 years at the first dose and in blacks compared with whites.
Conclusions
Reminder letters scheduled quarterly were effective to enhance HPV vaccine series completion among those who initiated the vaccine. However, a large gap in series completion remained despite the intervention. Future studies should address other barriers to series completion, including those at the providers and the health care system level.

Special Focus Newsletters

RotaFlash November 7, 2014

Ethiopia perseveres to deliver rotavirus vaccines to all regions

Government, NGOs, religious leaders, and communities collaborate to overcome challenges in first year of rollout

November 7, 2014, marks one year since Ethiopia's national launch of rotavirus vaccines. In the past year, Ethiopia has shown remarkable commitment to immunization through simultaneously introducing vaccines against rotavirus and Meningitis A while also containing a polio outbreak in the eastern Somali region. With the August 2014 launch of rotavirus vaccines in the Somali region, Ethiopia has delivered these lifesaving interventions to all regions of the country. Although much work remains to be done, the Ethiopian Ministry of Health (MoH) and partners continue to persevere for access and delivery of vaccines through innovative means.

Somali region of Ethiopia introduces rotavirus vaccines following polio outbreak

At the time of the national launch of rotavirus vaccines in November 2013, the Ethiopian government was in the midst of containing a polio outbreak that had spread from neighboring countries into the Somali region of Ethiopia. This had been the first wild poliovirus case in Ethiopia since 2008, and the MoH, with the help of partners including UNICEF and WHO, responded quickly to conduct polio vaccination campaigns. With many health workers and resources in the Somali region occupied with these campaigns, the MoH decided in consultation with the Somali Regional Health Bureau and MoH immunization partners that it was necessary to postpone the region's introduction of rotavirus vaccines to enable full focus on the polio outbreak…

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 8 November 2014
Opinion
Ebola in West Africa is a wake-up call What the Ebola crisis tells us about our failing drug development system.
Last updated: 06 Nov 2014 10:30
Els Torreele - *Els Torreele is the director of the Access to Medicines Initiative of the Open Society Foundations.*
Piero Olliaro - *Piero Olliaro is the head of intervention and implementation research at the Special Program for Research and Training in Tropical Diseases, World Health Organization, and Newton-Abraham Visiting Professor at the Center for Tropical Medicine at the University of Oxford.*

Eight months into the world's worst Ebola outbreak, we have lost 5,000 lives and expect to see more infections and deaths in the coming months. The reason is simple: We have no drug to cure Ebola, or vaccine to prevent it.

It didn't have to be this way. If medicines were actually developed to respond to health needs, we would already have effective vaccines and drugs to prevent and control this deadly disease. Instead, health workers can only provide supportive care, and watch as 70 percent of patients die.

Many have lamented the lack of Ebola drugs and vaccines as a "market failure". Because Ebola outbreaks have historically been sporadic and only affected a few people, drug companies have not seen a big enough market to invest in it, even if a great deal of government funding has gone into supporting early research.

But this market explanation is only part of a larger reality. Our current system for developing new medicines is by design ill-suited to address the world's health needs.

Ebola is only the most recent illustration of how this system fails us. There is a dearth of drugs and vaccines for many infectious diseases. We have come to accept that drug companies will not invest in diseases that primarily affect the poor, such as the so-called "neglected" tropical diseases, leaving millions of people without cure for what are essentially treatable diseases. But are we ready to accept that, despite all scientific and technological progress, we lack medicines for global threats like multi-drug resistant tuberculosis, and have no effective antibiotics to protect us against the "superbugs" menacing even the best-equipped hospitals? Instead of generating much-needed medicines, our current system gives companies incentives to make blockbuster drugs that generate billions in sales, even if they are redundant from a medical perspective: Some 70 percent of "new" medicines developed, provide no added therapeutic value over what we already have. When new drugs do present a medical breakthrough, they are priced at levels that strain even wealthy health systems, let alone individual patients. A case is point is Gilead's new $1,000 per pill hepatitis C drug, Sovaldi, which remains largely inaccessible for the majority of hepatitis C patients worldwide.

The Ebola crisis shows how our system also fails in response to epidemic outbreaks, which are by definition infrequent and unexpected. We need to invest in research in between outbreaks to have drug and vaccine candidates ready to be tested as soon as the next one hits. While several Ebola drug and vaccine candidates have existed for some time, neither the public institutions that funded and conducted the early-stage research, nor the drug companies who would develop and manufacture them, prioritised these candidates. This was especially so, once the US government no longer saw Ebola as a potential bioterrorism threat.

We urgently need to design an alternative system to conduct, prioritise, and finance medicine development where the primary payback is improved global health, not shareholder profits. This

includes mechanisms that will allow drugs and vaccines to be developed but then held on our shelves until needed. This can only be achieved if we have strong public health leadership that views medicines as public goods, not commodities to generate profit.

Thankfully, a publicly supported response to Ebola is emerging, with several drug and vaccine trials about to start in West Africa. Instead of doing business as usual, relying largely on pharmaceutical companies to develop proprietary products, we can pilot a different paradigm of collective action under public leadership.

We need public leadership to promote open-source medicine development. Currently, knowledge of both the virus and its drug and vaccine candidates is limited and dispersed among individual researchers or companies. Pooling all available knowledge from previous and new studies into an open access database would not only limit duplication and accelerate research, but also allow crowdsourcing - asking the best scientific brains in the world to come together with new ideas and solutions.

We also need public leadership to provide rules and methodologies that facilitate the testing and registration of the medicines we need, and ensure their timely access and affordability. This will require creative and public-interest-focused management of patents and ownership issues that takes into consideration the significant public investments made in different stages of research and the public health need being addressed. It would ensure immediate and affordable access to medicines for all who need them.

The outbreak of Ebola in West Africa has been a wake-up call. It questions the effectiveness of our emergency preparedness and highlights the need for strengthening our health system. But, it should not stop there. We must seize this moment to rethink our drug and vaccine research and development system, aspiring for one that can respond to such a crisis because it is propelled by global need - not corporate greed.

The Atlantic
http://www.theatlantic.com/magazine/
Accessed 8 November 2014
[No new, unique, relevant content]

BBC
http://www.bbc.co.uk/
Accessed 8 November 2014
[No new, unique, relevant content]

Brookings
http://www.brookings.edu/
Accessed 8 November 2014
[No new, unique, relevant content]

Council on Foreign Relations
http://www.cfr.org/
Accessed 8 November 2014
[No new, unique, relevant content]

The Economist
http://www.economist.com/
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[No new, unique, relevant content]

Financial Times
http://www.ft.com
Accessed 8 November 2014
[No new, unique, relevant content]

Forbes
http://www.forbes.com/
Accessed 8 November 2014
[No new, unique, relevant content]

Foreign Affairs
http://www.foreignaffairs.com/
Accessed 8 November 2014
[No new, unique, relevant content]

Foreign Policy
http://www.foreignpolicy.com/
Accessed 8 November 2014
Journey to the Center of an Epidemic-- From New York to Brussels to Dakar to Monrovia: Day One of the trip to see Ebola-ravaged Liberia, up close and personal.
by Laurie Garrett
3 November 2014
The journey to Liberia tests the mettle of any American wanting to help the nation in its Ebola crisis. The trek really begins with fears about how the Samaritan will be received once he or she returns from the epidemic, facing quarantines and stigma. And the first leg lands the traveler in a political and cultural climate in steamy West Africa marked by resilience in the face of genuine threat…

The Guardian
http://www.guardiannews.com/
Accessed 8 November 2014
[No new, unique, relevant content]

The Huffington Post
http://www.huffingtonpost.com/
Accessed 8 November 2014
[No new, unique, relevant content]

Le Monde
Accessed 8 November 2014
http://www.lemonde.fr/
[No new, unique, relevant content]

New Yorker
http://www.newyorker.com/
Accessed 8 November 2014

[No new, unique, relevant content]

New York Times
http://www.nytimes.com/
Accessed 8 November 2014
[No new, unique, relevant content]

Wall Street Journal
http://online.wsj.com/home-page?_wsjregion=na,us&_homepage=/home/us
Accessed 8 November 2014
Review & Outlook
WHO Is Responsible?
4 November 2014
Margaret Chan blames everyone else for her agency's Ebola failures.
If trust in public institutions is at a modern ebb, one reason is that their leaders fail so often but then blame someone else for their misadventures. Witness the portrait of unaccountability that is Margaret Chan, the director-general of the World Health amid the Ebola crisis….

Washington Post
http://www.washingtonpost.com/
Accessed 8 November 2014
[No new, unique, relevant content]

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Support is also provided by a growing list of individuals who use this membership service to support their roles in public health, clinical practice, government, NGOs and other international institutions, academia and research organizations, and industry.

* * * *