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Vaccines and Global Health: The Week in Review
25 October 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.*

Editor's Note:
The gravity and complexity of the Ebola/EVD crisis continue to accelerate. We will strive to present a coherent, high-level digest of thre situation using official sources wherever possible, with a special focus on vaccines and other preventive strategies. Reading this issue you will encounter significant Ebola/EVD content throughout, including a number of editorials and analyses in Journal Watch below.
We continue to open the Week in Review with coverage of the two ongoing Public Health Emergencies of International Concern (PHEIC) – polio and Ebola/EVD.

POLIO [to 25 October 2014]

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
:: World Polio Week, starting on 23 October, provides an opportunity to recognize the progress made towards the global eradication of polio in 2014. This year is the first year with South East Asia certified as polio-free.
:: The Canadian Prime Minister Stephen Harper was awarded Rotary International's Polio Eradication Champion Award on 18 October in recognition of his efforts to achieve a polio free world. Canada has been a long standing supporter of the Global Polio Eradication Initiative since 1988.
:: Pakistan has reached 210 cases of paralysis caused by wild poliovirus in 2014. This is the highest number of cases on record by October in any year, and accounts for more than 85% of all cases worldwide.

Pakistan

:: Four new wild poliovirus type 1 (WPV1) cases were reported in the past week in Pakistan. Of these, 3 are from the Federally Administered Tribal Areas (FATA) (1 from South Waziristan and 2 from Khyber Agency); and 1 from Lakki Marwat district of Khyber Pakhtunkhwa (KP) province. The most recent case had onset of paralysis on 1 October. This brings the total number of WPV1 cases in 2014 to 210 compared to 46 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.

World Polio Day 2104

:: Ten million childhood disabilities prevented in campaign to end polio – UNICEF
NEW YORK, 23 October 2014 – Every day, a thousand or so children have been protected from disability during a 26-year global effort to eradicate polio. The worldwide campaign has immunised millions of previously-unreached children across the globe, UNICEF said on the eve of World Polio Day…
:: MMWR October 24, 2014 / Vol. 63 / No. 42
- World Polio Day — October 24, 2014
- Polio-Free Certification and Lessons Learned — South-East Asia Region, March 2014
:: Rotary marks World Polio Day 2014 with US$44.7 million in grants to fight polio in Africa, Asia and the Middle East
Oct 21, 2014, With the world "This Close"—99%—to eliminating polio from the planet, the effort is receiving an additional US$44.7 million boost from Rotary to support immunization activities, surveillance, and research spearheaded by the Global Polio Eradication Initiative.
:: IVAC - Celebrating Progress on World Polio Day

EBOLA/EVD [to 25 October 2014]

Washington Post
19 October 2014
Opinion
The long-term cure for Ebola: An investment in health systems

by Ellen Johnson-Sirleaf

The writer is president of Liberia.

As the Ebola nightmare continues in Liberia and as we battle to contain the epidemic, it is important to look beyond the immediate crisis. Many more lives will be lost before this dreadful outbreak is beaten, but to properly honor the memory of the victims we need to ask how it happened in the first place and, more pressingly, how we can prevent it from happening again.

After 30 years of brutal civil and political unrest, Liberia was a nation reborn. We transformed our country from a failed state into a stable democracy, rebuilding its infrastructure and its education and health systems, and enjoying one of the most promising growth records in Africa. Then Ebola swept in, threatening to tear apart that progress. It is a terrifying reminder of the destructive power of infectious disease, one all the more devastating given how far Liberia has come.

Without a doubt, part of the reason for this situation is that, with the exception of Doctors Without Borders, the initial international response to this emergency was markedly slow. This gave Ebola the time it needed to overwhelm our already-fragile health infrastructure.

President Obama has since committed to sending up to 4,000 military personnel to West Africa to set up much-needed health-care facilities and to train health-care workers, and last week he authorized the use of additional reserves, if needed. This will help our efforts to contain the outbreak, and we are truly thankful.

Similarly, a suitable vaccine and treatment for Ebola could have helped prevent this outbreak from getting out of control. And, indeed, efforts to fast-track the development of a promising candidate vaccine could potentially help to bring this all to a swifter end, even if initially there were only enough doses to vaccinate health workers on the front line.

But while these are very much welcome developments, they are nevertheless responses to an outbreak already out of control. After all, military field hospitals would not be needed if adequate health-care services were in place. And, as Uganda has demonstrated after several terrible outbreaks, the key to preventing a major outbreak is a health infrastructure robust enough to be able to respond quickly and effectively when cases first appear.

Medical staff in Uganda now have the training and means to recognize symptoms and isolate patients immediately, and they have access to appropriate equipment and protective clothing. Similarly, social mobilization networks are in place to get information out to the people to reduce the risk of spread, while laboratory facilities can confirm cases swiftly. It is a highly effective setup that was created with considerable help from the U.S. Centers for Disease Control and Prevention, but it relies wholly upon having strong health infrastructure.

In Liberia, a country that never before had an incidence of Ebola, we were utterly ill-equipped and unprepared. What is so tragic is that, until this outbreak, Liberia had made significant progress in building up its public health systems. With help from organizations such as Gavi, the Vaccine Alliance, we have reduced childhood mortality by two-thirds since 1990, thanks largely to expansive immunization programs.

Much of that good work has now been undermined. Having worked its way through the cracks in our fragile health infrastructure, Ebola has effectively brought health care to a halt in Liberia, as people avoid seeking medical attention. There is nowhere to go. So, with the malaria season setting in and routine immunization programs stopped, even when this outbreak is over we must prepare for other diseases to take hold.

Yet, with Ebola having claimed the lives of 96 of our health workers and infected more than 209 others, recovering is going to be hard. This is a huge hit for a country that had barely 50 doctors to care for a population of 4.4 million at the start of this outbreak.

More than ever, we will be reliant upon assistance from partners such as the United States and Britain, and global health organizations such as the World Health Organization, UNICEF and Gavi, to help rebuild our health systems, invest in health facilities, staff and equipment and restore immunization levels. And it's not just Liberia — any African nation with a fragile health system is potentially vulnerable to this terrible disease. After all, infectious disease knows no borders.

The United Nations has said it is going to take $1 billion to stop this outbreak. Of course, that's our immediate priority. But at the same time, countries like Liberia need long-term investment to build up our health systems to prevent outbreaks of this scale from ever happening again. We owe it to the thousands of citizens and health workers who have so far lost their lives to be prepared.

WHO: Ebola Virus Disease (EVD)
Situation report - 25 October 2014 'WHO Roadmap'
HIGHLIGHTS
:: There have been 10,141 EVD cases in eight affected countries since the outbreak began, with 4,922 deaths
:: Mali has reported its first confirmed case of EVD
:: A confirmed case has been reported in New York City, in the United States of America

WHO: Statement on the 3rd meeting of the IHR Emergency Committee regarding the 2014 Ebola outbreak in West Africa
WHO statement
23 October 2014
[Full text; Editor's text bolding]

The third meeting of the Emergency Committee convened by the WHO Director-General under the IHR 2005 regarding the 2014 Ebola virus disease (EVD, or "Ebola") outbreak in West Africa was conducted with members and advisors of the Emergency Committee on Wednesday, 22 October 2014, from 13:00 to 17:10 CET.

This meeting was convened in advance of the 3-month date of the expiration of the temporary recommendations issued on 8 August 2014 and their extension on 22 September 2014, owing to the increase in numbers of cases in Guinea, Liberia, and Sierra Leone, and the new exportation of cases resulting in limited transmission in Spain and United States of America.

Current situation

The current situation was reviewed. As of 22 October 2014, the number of total cases stands at 9936 total cases, with 4877 deaths. Cases continue to increase exponentially in Guinea, Liberia, and Sierra Leone; the situation in these countries remains of great concern. The key lessons learned to control the outbreak include the importance of leadership, community engagement, bringing in more partners, paying staff on time, and accountability. WHO, UN partners and the international community have scaled up their support in these three countries.

The outbreaks in Nigeria and Senegal were declared over as of 20 October and 17 October, respectively. The Committee welcomed this development and commended those involved in this achievement.

Cases have recently occurred in Spain and United States of America. The index cases in both of these countries originated in West Africa.

Update by IHR States Parties

After the overview summary, the following IHR States Parties provided an update on and assessment of the Ebola situation in their countries, including progress towards implementation of the Emergency Committee's Temporary Recommendations: Guinea, Liberia, Sierra Leone, Spain, and United States of America.

It was the unanimous view of the Committee that the event continues to constitute a Public Health Emergency of International Concern (PHEIC).

In light of States Parties' presentations and subsequent Committee discussions, several points and challenges were noted for the affected countries and other countries. The primary emphasis must continue to be stopping the transmission of Ebola within the 3 affected countries with intense transmission. This action is the most important step for preventing international spread. Specific attention, including through appropriate monitoring and follow-up of their health, should be paid to the needs of health care workers. This will also encourage more health care staff to assist in this outbreak.

The Committee reviewed the recommendations issued on 8 August and the comments published on 22 September, and provided the following additional advice to the Director-General for her consideration in addressing the Ebola outbreak in accordance with IHR (2005). All previous temporary recommendations remain in effect. Even though a few cases have occurred outside the 3 countries with intense transmission, the measures recommended appear to have been helpful in limiting further international spread. Additional recommendations follow below.

Recommendations for States with intense Ebola transmission (Guinea, Liberia, Sierra Leone)

Exit screening in Guinea, Liberia and Sierra Leone remains critical for reducing the exportation of Ebola cases. States should maintain and reinforce high-quality exit screening of all persons at international airports, seaport, and major land crossings, for unexplained febrile illness consistent with potential Ebola infection. The exit screening should consist of, at a minimum, a questionnaire, a temperature measurement and, if fever is discovered, an assessment of the risk that the fever is caused by Ebola virus disease (EVD). States should collect data from their exit screening processes, monitor their results, and share these with WHO on a regular basis and in a timely fashion. This will increase public confidence and provide important information to other States.

WHO and partners should provide additional support needed by States to further strengthen exit screening processes in a sustainable way.

Recommendations for all States

The Committee reiterated its recommendation that there should be no general ban on international travel or trade. A general travel ban is likely to cause economic hardship, and could consequently increase the uncontrolled migration of people from affected countries, raising the risk of international spread of Ebola. The Committee emphasized the importance of normalizing air travel and the movement of ships, including the handling of cargo and goods, to and from the affected areas, to reduce the isolation and economic hardship of the affected countries. Any necessary medical treatment should be available ashore for seafarers and passengers.

Previous recommendations regarding the travel of EVD cases and contacts should continue to be implemented.

A number of States have recently introduced entry screening measures. WHO encourages countries implementing such measures to share their experiences and lessons learned. Entry screening may have a limited effect in reducing international spread when added to exit screening, and its advantages and disadvantages should be carefully considered.

If entry screening is implemented, States should take into account the following considerations: it offers an opportunity for individual sensitization, but the resource demands may be significant, even if screening is targeted; and management systems must be in place to care for travellers and suspected cases in compliance with International Health Regulations (IHR) requirements.

A number of States without Ebola transmission have decided to or are considering cancelling international meetings and mass gatherings. Although the Committee does not recommend such cancellations, it recognizes that these are complex decisions that must be decided on a case-by-case basis. The Committee encourages States to use a risk-based approach to make these decisions. WHO has issued advice for countries hosting international meetings or mass gatherings, and will continue to provide guidance and support on this issue. The Committee agreed that there should not be a general ban on participation of competitors or delegations from countries with transmission of Ebola wishing to attend international events and mass gatherings but that the decision of participation must be made on a case by case basis by the hosting country. The temporary recommendations relating to travel should apply; additional health monitoring may be requested.

All countries should strengthen education and communication efforts to combat stigma, disproportionate fear, and inappropriate measures and reactions associated with Ebola. Such efforts may also encourage self-reporting and early presentation for diagnosis and care.

The Committee emphasized the importance of continued support by WHO and other national and international partners towards the effective implementation and monitoring of these recommendations.

Based on this advice and the information considered by the Committee, the Director-General accepted the Committee's assessment, and declared that the 2014 Ebola outbreak in Guinea, Liberia and Sierra Leone continued to constitute a Public Health Emergency of International Concern. The Director-General endorsed the Committee's advice and issued them as Temporary Recommendations under IHR (2005). The Director-General thanked the Committee members and advisors for their advice and requested their reassessment of this situation within 3 months or earlier should circumstances require.

WHO convenes industry leaders and key partners to discuss trials and production of Ebola vaccine

24 October 2014 -- WHO convened a high-level emergency meeting on 23 October to look at the many complex policy issues that surround access to Ebola vaccines. Ways to ensure the fair distribution and financing of these vaccines were discussed, as well as plans for the different phases of clinical trials to be performed concurrently rather than consecutively, partnerships for expediting clinical trials, and proposals for getting all development partners moving in tandem and at the same accelerated pace.

:: Full report: WHO high-level meeting on Ebola vaccines access and financing
23 October 2014 - 14 pages

:: Summary report of a WHO High-level Meeting on ebola vaccines access and financing
Ebola situation assessment - 23 October 2014

[Full text; Editor's text bolding]

Introduction

A high-level emergency meeting, convened by WHO at the request of several governments and representatives of the pharmaceutical industry, was held on 23 October to look at the many complex policy issues that surround eventual access to experimental Ebola vaccines.

Ways to ensure the fair distribution and financing of these vaccines were discussed in an atmosphere characterized by a high sense of urgency. This sense of urgency was conveyed in many ways – from plans for the different phases of clinical trials to be performed concurrently rather than consecutively, to suggested partnerships for expediting clinical trials, to proposals for getting all development partners moving in tandem and at the same accelerated pace.

More than 90 participants, including some of the world's leading scientists, came, on short notice, from national and university research institutions, also in Africa, government health agencies, ministries of health and foreign affairs, national security councils, and several offices of Prime Ministers and Presidents. Also represented were national and regional drug regulatory authorities, the MSF (Doctors Without Borders) medical charity, funding agencies and foundations, the GAVI alliance for childhood immunization, and development banks, including the African Development Bank, the European Investment Bank, and the World Bank Group.

Main conclusions reached

Impact of vaccines on further evolution of the epidemic

The meeting concluded that vaccines will have a significant impact on the further evolution of the epidemic in any scenario, from best-case to worst-case.

Financing of vaccine development, clinical trials, and vaccination campaigns

The meeting concluded that funding issues should not be allowed to dictate the vaccine agenda. The funds will be found.

Liability

The meeting concluded that neither affected countries nor industry should be left alone to bear the burden should lawsuits arise following possible adverse reactions to an Ebola vaccine. To respond to this potential problem, a proposal was made to establish a "club" of donors, in collaboration with the World Bank.

The timing and quantity of vaccine supplies

The meeting concluded that the timing and quantity of vaccine doses should not constrain the design of clinical trials. Industry confirmed that enough vaccine doses would be available.

GlaxoSmithKline's monthly production capacity for purified bulk vaccine was expected to rise from the current figure of 24,000 doses to 230,000 by April 2015, if they can be filled for release. NewLink's bulk vaccine manufacturing capacity for the Canadian vaccine was noted to vary, according to the dose selected, from 52,000 doses to 5.2 million doses anticipated for the first quarter of 2015.

Design of protocols for phase 2 and phase 3 clinical trials

The meeting concluded that randomized controlled clinical trials were the gold standard in terms of yielding reliable scientific data for the analysis and interpretation of efficacy. A stepped-wedge design could also yield useful and meaningful data during the special circumstances of the current epidemic.

Priority uses of vaccine when supplies are limited

The meeting concluded that health care workers, including medical staff, laboratory staff, burial teams, and facility cleaners, should have first call on vaccine doses while supplies remain limited. Vaccination of health care workers in the three countries was judged feasible during the first quarter of 2015.

Regulatory requirements

The meeting concluded that the licensure and authorization requirements of regulatory authorities should be streamlined and harmonized, enabling the rapid introduction of vaccines for clinical trials and general distribution, yet with no compromise of scientific standards. In order to deliver the number of doses on the schedules proposed by the manufacturers,

regulators must work closely with the manufacturers to find ways to overcome a number of regulatory hurdles.

Urgent measures to improve readiness for clinical trials and vaccines

The meeting concluded that two preparatory measures should be given the most urgent priority: community engagement and social mobilization to prepare populations to understand and accept clinical trials and vaccination campaigns, and the building of basic public health infrastructures, especially given the considerable logistical challenges facing health services in Guinea, Liberia, and Sierra Leone.

Coordination and alignment among multiple partners

The meeting concluded that a mechanism or framework must be urgently established, relying on WHO's convening and coordination powers, to get all partners working in tandem, according to a single agreed plan and aligned with industry's "critical paths" analysis.

Determination to finish the job

The meeting concluded that all efforts to develop, test, and approve Ebola vaccines must be followed through to completion at the current accelerated pace, even if dramatic changes in the epidemic's transmission dynamics meant that vaccines were no longer needed.

Meeting of the Ethics Working Group on Ebola Interventions

20 – 21 October 2014, Geneva, Switzerland

:: Summary of the Meeting pdf, 218kb

Excerpt

A 1 ½ day meeting was held to map out the ethical issues related to the design of trials to evaluate the safety and efficacy of candidate therapeutic agents for use in the current Ebola Virus Disease outbreak in West Africa. Ten members of the Ethics Working group were assisted by methodologists, statisticians, drug regulators, researchers, and ethics committee chairs/administrators to tease out the ethical issues associated with the different designs. The agenda and the LoP is attached/can be found here.

The meeting was informed by work done on this issues in prior Working Group meetings.

The Ethics Working Group reiterated that the focus on therapeutics at the meeting, did not supersede the requirement to focus efforts on bringing the epidemic under control with enhanced attention and resources for public health measures. Nor did it indicate that other forms of clinical, public health, anthropological, sociological or operational research is without merit in the current outbreak. Many of these types of research can be handled with well understood study designs and oversight mechanisms.

Six case studies on the different trial designs for therapeutics were used to illustrate the ethical dimensions related to their implementation in the context of the Ebola epidemic. The case studies allowed the regulators, researchers, ethics committee chairs/administrators and the representatives of pharmaceutical companies to discuss various aspects of the study designs, the advantages and disadvantages of each, and identify the issues that were relevant for consideration in an ethical analysis during their conduct in an outbreak situation in the affected countries. On day two of the meeting, the members of the Ethics working Group - through a deliberative process - reached consensus on some aspects and identified other aspects for further development through e-discussions.

The Final Meeting Report will summarize the areas of consensus reached by the group and outline a set of outstanding questions that require further attention.

:: Agenda pdf, 206kb

:: List of Participants pdf, 392kb

WHO: Ebola situation assessments
:: Mali confirms its first case of Ebola 24 October 2014
:: Nigeria is now free of Ebola virus transmission 20 October 2014

WHO IN ACTION
Liberia: New Ebola mobile lab speeds up diagnosis and improves care
20 October 2014

CDC/MMWR Watch [to 25 October 2014]
http://www.cdc.gov/media/index.html
Ebola Outbreak - 2014
:: CDC Announces Active Post-Arrival Monitoring for Travelers from Impacted Countries - Press Release WEDNESDAY, OCTOBER 22, 2014
:: CDC update on Ebola Response, 10-22-2014 - Media Advisory WEDNESDAY, OCTOBER 22, 2014
:: Innovative Response by Firestone Health Officials May Have Limited Ebola Spread in a Part of Liberia - Press Release TUESDAY, OCTOBER 21, 2014
:: CDC update on Ebola Response and PPE: 10-20-2014 - Transcript MONDAY, OCTOBER 20, 2014
:: Tightened Guidance for U.S. Healthcare Workers on Personal Protective Equipment for Ebola - Fact Sheet - Media StatementMONDAY, OCTOBER 20, 2014

MMWR October 24, 2014 / Vol. 63 / No. 42
:: Control of Ebola Virus Disease — Firestone District, Liberia, 2014

NIH Watch [to 25 October 2014]
:: Texas nurse free of Ebola virus; discharged from NIH Clinical Center
October 24, 2014 — NIH Clinical Center discharges Nina Pham who is free of Ebola virus disease.
:: NIH media briefing on discharge of Ebola patient from its Clinical Center Special Clinical Studies Unit
October 24, 2014 — NIH officials will brief reporters about the discharge of Nina Pham.
:: NIH begins early human clinical trial of VSV Ebola vaccine
October 22, 2014 — Researchers at NIAID are conducting the early phase trial to evaluate the vaccine, called VSV-ZEBOV.

European Medicines Agency Watch [to 25 October 2014]
http://www.ema.europa.eu/ema/
:: EMA ready to start assessment of Ebola vaccines and treatments as soon as data are made available
Rapid scientific advice to speed up development
22/10/2014
During the past months, the European Medicines Agency (EMA) has put in place a system to give the best possible scientific advice to companies that are currently developing possible vaccines and/or treatments to fight Ebola virus disease.

The Agency has also established a form of rolling review that allows experts to continuously assess incoming data and develop increasingly robust scientific opinions based on the additional data provided during the process. The initial review and subsequent updates will be shared with healthcare decision-makers in the most affected and other countries. This will enable them to take informed decisions on whether and how they want to use the vaccines/medicines in the current Ebola outbreak taking into account their specific situation.

"We are ready and keen to assess data as soon as companies start submitting them," explains EMA Executive Director Guido Rasi. "We have put in place regulatory processes that allow the best experts from across Europe to accelerate the assessment of data once we receive them."…

:: Speeding up development of Ebola treatments and vaccines

EMA encourages companies to apply for orphan designation

20/10/2014

The European Medicines Agency (EMA) encourages developers of treatments or vaccines against Ebola to apply for orphan designation. Medicines with recognised orphan status have access to a range of incentives to stimulate development and facilitate placing on the market. This includes free scientific advice from EMA, fee waivers and 10 years of market exclusivity once the medicine is authorised.

Applications for orphan designation of Ebola medicines will be treated as a priority and EMA has committed to fast-tracking their evaluation…

Industry Watch [to 25 October 2014]

Selected media releases and other selected content from industry.

:: Johnson & Johnson Announces Major Commitment to Speed Ebola Vaccine Development and Significantly Expand Production

NEW BRUNSWICK, N.J., Oct. 22, 2014 /PRNewswire/ -- Johnson & Johnson (NYSE: JNJ) today announced that it has made a commitment of up to $200 million to accelerate and significantly expand the production of an Ebola vaccine program in development at its Janssen Pharmaceutical Companies. The company is closely collaborating with the World Health Organization (WHO), the National Institute of Allergy and Infectious Diseases (NIAID), as well as other key stakeholders, governments, and public health authorities on the clinical testing, development, production and distribution of the vaccine regimen…

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 25 October 2014.

UNMEER site: Statements

:: WHO Key messages on the Ebola outbreak in West Africa (24 October 2014)

13 pages of "key messages" underscore the complexity of the EVD crisis.

:: Statement attributable to the Spokesman for the Secretary-General on contributions to the UN Ebola Multi-Partner Trust Fund (21 October 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 selected elements of interest from these reports. The full daily report is available as a pdf using the link provided by the report date.

24 October 2014

Human Rights

3. 43 people quarantined for EVD monitoring in western Liberia are reportedly threatening to break out of an isolation center because of a lack of food.

4. Work has commenced on an EVD holding facility at Freetown's largest prison. With almost 2,000 inmates, EVD could spread quickly among this vulnerable population. With support from UNDP, the correctional facility will refurbish two holding centres - one for women and one for men - that will house new inmates and keep them separate from the general population for 21 days. UNDP also handed over equipment like buckets, soap, blankets and mosquito nets that will help inmates and guards at Freetown's prison and all 17 prisons in Sierra Leone.

Medical

7. Guinea has started paying compensation to the families of health workers who have died of EVD. Eight families have already been paid a USD 10,000 lump sum. The families of 42 victims, including doctors, nurses, drivers and porters, have been identified to receive compensation.

Outreach and Education

18. Reportedly more than half the beds in treatment centers in Monrovia, Liberia, remain empty because of the government's order that the bodies of all suspected EVD victims be cremated. Cremation violates Liberians' values and cultural practices leading to the sick often being kept at home and buried in secret, increasing the risk of more infections.

Resource Mobilisation

23. Billionaire Paul Allen will contribute at least USD 100 million to help stop EVD.

23 October 2014

Highlights

Many WHO staff, including Assistant Director General for Health Systems and Innovation, Dr Marie-Paule Kieny, are volunteering to test experimental EVD vaccines.

Medical

6. The WHO reported that meeting the overall EVD crisis response target of isolating 70 per cent of EVD cases by 1 December, and 100 per cent of cases by 1 January, requires effective case identification, isolation and treatment. In terms of case identification, WHO estimates that 28 laboratories are required across the three most affected countries. At present, 12 laboratories are operational (three in Guinea, five in Liberia, and four in Sierra Leone). Up to 20 000 contact tracing staff may also be needed. In regard to case isolation and treatment, the WHO estimates that 4388 beds are required in 50 Ebola treatment units (ETUs) across the three most affected countries. At present, 1126 (25 per cent) are in place. In addition, there remains

a gap in the availability of foreign medical teams to manage and staff ETUs - there are firm commitments from teams for 30 of the planned 50 ETUs.

22 October 2014

Medical

7. France's Atomic Energy Commission reported that a new device similar to a simple pregnancy home-test could allow doctors to diagnose a patient with suspected EVD in under 15 minutes. Trials have validated the technique and prototype kits should be available in affected countries by the end of October for a clinical trial.

9. The European Commission confirmed that under its Humanitarian Aid Regulation medical evacuations of international workers can be covered up to 100 per cent of their cost, and recalled that other elements such as existing insurance coverage will need to be taken into account to determine the exact percentage on a case by case basis.

21 October 2014

Human Rights

6. A UNICEF survey of 1,400 households across Sierra Leone found that EVD survivors face high levels of stigma, shame, and discrimination from communities, undermining their ability to rebuild their lives. About 96 per cent of households in the study reported some discriminatory attitudes toward people with suspected or confirmed EVD, and 76 per cent said they would not welcome someone who was infected with EVD back into their community, even if that person has recovered. Children are particularly vulnerable, especially when they or their parents have to be isolated for treatment.

Medical

12. The Director General of the World Health Organization, Dr. Margaret Chan, says the agency will be transparent about its handling of the Ebola outbreak, following an internal report that details failures in containing the virus.

Outreach and Education

16. The FAO has opened an online discussion, until 10 November 2014, on EVD and food security and nutrition in West Africa. Comments can be sent via email to FSN-moderator@fao.org or uploaded directly, upon registration to the FSN Forum in West Africa (register here).

Essential Services

18. A rapid assessment survey in Sierra Leone conducted by the FAO found that 47 per cent of farmers have had their work "considerably disrupted" by the EVD outbreak.

19. Médecins Sans Frontières has decided to temporarily suspend its pediatric and maternal medical activities at its Gondama hospital (located near Bo, Sierra Leone), because of the strain of responding to EVD in the country.

20. During the Ebola crisis, securing continuity of access to anti-retroviral drugs and essential HIV prevention interventions is critical to reduce morbidity and mortality of people living with HIV and to prevent new infections. The UNAIDS Inter Agency Task Team is advocating for a minimum HIV service package as part of efforts to restore public health services during this EVD outbreak.

20 October 2014

Key Political and Economic Developments

2. Liberia's President, Ms. Ellen Johnson Sirleaf, has made an impassioned plea for all nations to commit to the fight against Ebola ahead of a meeting of EU foreign ministers today. She said a generation of Africans were at risk of "being lost to economic catastrophe" because of the epidemic, warning that the "time for talking or theorising is over".

4. Food prices have risen by an average of 24 per cent across Guinea, Liberia and Sierra Leone

forcing some families to reduce their intake to one meal a day. The FAO and WFP said that decisions by these three governments to quarantine districts and restrict movements to contain the spread of EVD have also impacted markets and reduced food security.

Medical

9. Médecins Sans Frontières (MSF) will work in collaboration with key partners in the affected countries, including the WHO, in order to implement fast-tracked clinical trials for some of the new treatments for Ebola at existing treatment sites. Experimental treatments are currently being selected and trial designs are being developed to ensure that disruption to patient care is minimal, that medical and research ethics are respected, and that sound scientific data is produced. MSF does not usually engage in research and trials for drug development, but faced with this massive outbreak, it is taking exceptional measures.

Essential Services

33. The WFP has begun food distribution on the outskirts of Freetown, Sierra Leone, to 265,000 people. This is the biggest one-off food distribution in the country since the start of the EVD outbreak.

34. UNICEF signed a project cooperation agreement valued at over USD 1 million with Save the Children for the provision of health, nutrition and WASH interventions Liberia.

35. The Ministry of Agriculture in Guinea, FAO and the WFP have initiated a rapid assessment of the impact of the EVD outbreak on agriculture and food security.

19 October 2014

Summary of Key Gaps and Needs

13. Safe and dignified burials are also of critical importance as they are responsible for a very significant number of new infections. We are aiming at 70 per cent of safe burials by 1 December. Recruiting, training and remunerating safe burial teams is vital, as well as community outreach and education. The US Centers for Disease Control (CDC) has observed in Liberia that It is becoming increasingly apparent that people are not going to ETCs due to the fear of cremation.

UNMEER site: Press Releases

:: WFP And World Bank Scale Up Government Logistical Capacity In Response To Ebola (21 October 2014)

UNMEER site: Developments

:: Mali confirms its first case of Ebola

24 October 2014 - Mali's Ministry of Health has confirmed the country's first case of Ebola virus disease. The Ministry received positive laboratory results, from PCR testing, on Thursday and informed WHO immediately. In line with standard procedures, samples are being sent to a WHO-approved laboratory for further testing and diagnostic work.

:: In town hall, Ban cites UN efforts against Ebola threat

24 October 2014 - New York The United Nations is moving rapidly to deploy resources and personnel to stem the outbreak of the Ebola virus disease in West Africa and to ensure that UN staffers are protected, Secretary-General Ban Ki-moon said Friday in a town hall meeting attended by hundreds of UN staffers here and, by video, around the world.

:: Why I am volunteering to test the Ebola vaccine

21 October 2014 - Ebola is not a West African problem, it is a problem for mankind. To that end I strongly feel that the world should stand in solidarity with West Africa and be part of the development and testing of Ebola vaccines.

:: In Sierra Leone, getting back to school – on the airwaves
21 October 2014 - Freetown, Sierra Leone With schools closed throughout the country as a result of the Ebola epidemic, Sierra Leone is bringing the classroom into students' homes through the use of educational radio broadcasts.

:: UN Women mourns loss of Sierra Leone colleague to Ebola
20 October 2014 - New York UN Women is deeply saddened by the passing away of our colleague Mr. Edmond Bangura-Sesay on Saturday, 18 October, after testing positive for the Ebola virus. Mr. Bangura-Sesay served with great dedication since 2005 as the driver for the UN Women Office in Sierra Leone.

:: Pregnant in the shadow of Ebola: Deteriorating health systems endanger women
20 October 2014 - MONROVIA, Liberia Thirty-six year old Comfort Fayiah, in Monrovia, Liberia, never imagined her pregnancy would end the way it did – with her giving birth on the side of the road, in a heavy downpour, to twins.

UNFPA United Nations Population Fund
http://www.unfpa.org/public/
20 October 2014 - Dispatch
Pregnant in the shadow of Ebola: Deteriorating health systems endanger women
MONROVIA, Liberia – Thirty-six year old Comfort Fayiah, in Monrovia, Liberia, never imagined her pregnancy would end the way it did – with her giving birth on the side of the road, in a heavy downpour, to twins. Throughout the three countries worst affected by the Ebola crisis, many women are refusing to seek care from health centres, and some overwhelmed, undersupplied health facilities are turning away those who arrive.

UN Women
http://www.unwomen.org/
UN Women mourns loss of Sierra Leone colleague to Ebola
Date : October 20, 2014
UN Women is deeply saddened by the passing away of our colleague Mr. Edmond Bangura-Sesay on Saturday, 18 October, after testing positive for the Ebola virus. Mr. Bangura-Sesay served with great dedication since 2005 as the driver for the UN Women Office in Sierra Leone.

DFID
https://www.gov.uk/government/organisations/department-for-international-development
Selected Releases
:: UK secures €1 billion European Ebola commitment
24 October 2014 DFID and Number 10 Press release
The Prime Minister, David Cameron, has secured a €1 billion (£800 million) funding pledge at the European Council meetings in Brussels, following a call for European leaders to do more to fight the disease in West Africa.

As part of the commitment, the UK has boosted its own response to the Ebola crisis in West Africa by £80 million, bringing its total contribution to more than £200 million.

The Prime Minister wrote to the President of the European Council, Herman Van Rompuy, and fellow leaders last week to warn of the need to act fast to contain and defeat this deadly virus, stating that "if we do not significantly step up our collective response now, the loss of life and damage to the political, economic and social fabric of the region will be substantial and the threat posed to our citizens will also grow."…

:: Tenth British aid flight delivers medicines for Ebola treatment facilities in Sierra Leone
23 October 2014 DFID Press release

:: Better global disability data needed to ensure no one is left behind
23 October 2014 DFID Press release
The international community needs to do more to stop people with disabilities being left behind, International Development Minster Lynne Featherstone said today.

Development Minister Lynne Featherstone has called for better data collection on disability prevalence in order to improve support for those affected in developing countries.
Speaking at the Disability Data Conference today in London (23 October 2014), Ms Featherstone, alongside co-hosts Akiko Ito, Chief of the Secretariat for the UN's Convention on the Rights of Persons with Disabilities and Director of the Leonard Cheshire Disability Research Centre, called on international development donors, civil society organisations and academics to strengthen the quality of information they collect about disability by using a single method of data collection….

MSF/Médecins Sans Frontières

:: MSF aims to start drug trials in Ebola clinics next month
Reuters | 22 October 2014

The medical charity Medecins Sans Frontieres (MSF) intends to start trials of experimental Ebola drugs in its treatment centers in West Africa next month, as it steps up measures to tackle the worst outbreak of the disease on record. Bertrand Draguez, medical director of MSF Belgium, said academics and the World Health Organization (WHO) were currently assessing which drugs to include in the tests. Meanwhile, a team of experts in West Africa was assessing which treatments should be tested in which MSF clinic, he said.

:: Ebola: MSF Urges Immediate Action on Vaccines and Treatments for Frontline Workers
October 24, 2014
[Excerpts]

Geneva—Following a high-level meeting on access and funding for Ebola vaccines convened yesterday by World Health Organization (WHO), Doctors Without Borders/Médecins Sans Frontières (MSF) has urged that plans to get forthcoming Ebola vaccines and treatments to frontline workers must be rapidly implemented. Significant investment and incentives are needed now to accelerate these steps.

"The message we heard from WHO that the people fighting the epidemic will be among the first to test Ebola vaccines and treatments is exactly the one we needed to hear," said Dr. Bertrand Draguez, medical director for MSF. "Now urgent action is needed to get those promises delivered in West Africa as soon as possible. This needs to be followed by massive roll out of vaccines to the general population once their efficacy is proven."

"It crucial that people from Ministries of Health, aid agencies, and communities who are holding the response to the epidemic together, and ensuring access to essential health care, are protected," Dr. Draguez added. "Resources everywhere are stretched to almost breaking point; everyone is at capacity, but it is extremely hard for the people treating and sustaining the response to do it with absolutely no safety net. Safe and effective treatments and vaccines could offer just that."

Staff who should be prioritized to test the vaccines include health care workers, community workers, and people who support the Ebola response such as hygiene personnel, ambulance drivers, health promoters, contact tracers, and people in charge of funerals. Medical staff providing care for other diseases than Ebola should also be prioritized to receive test vaccines. While the focus of the WHO meeting was on Ebola vaccines, new treatments and diagnostics for the disease are also urgently needed to allow people treating the epidemic to do their jobs effectively and efficiently.

"The rapid development and deployment of safe and effective experimental treatments is also critical," said Dr. Draguez. "Today, doctors and nurses involved in the struggle against Ebola are getting more and more frustrated as they have no treatment for patients with a disease that kills up to 80 percent of them."…

…Large-scale investment in all front-running vaccines, drugs, and diagnostics is vital and sufficient resources for clinical trials and post-trial access need to be mobilized by donors now. The scientific data generated for each product under clinical trials should be published in real time, and a pooled bank of samples should be established to facilitate open research. But the lack of approved Ebola products to this point highlights a key issue that must be urgently addressed; the lack of sufficient investment and incentives to develop them.

"Appropriate incentives that give industry a reason to develop these vital tools for Ebola are needed now—government and donors must line up to help here," Dr. Balasegaram said. "We need researchers and developers to conduct clinical trials in parallel with scaling up production supply, which we know has its inherent risks. Governments and donors must help incentivize this risk, and the path to regulation in getting approved, safe and effective vaccines and treatments on the ground in West Africa needs to be a smooth one."

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WHO & Regionals [to 25 October 2014]

:: Improved data reveals higher global burden of tuberculosis

22 October 2014 -- Recent intensive efforts to improve collection and reporting of data are shedding new light on the epidemic, revealing almost half a million more cases than previously estimated. WHO's "Global tuberculosis report 2014" shows that 9 million people developed TB in 2013, and 1.5 million died, including 360 000 people who were HIV positive.

- Read the note for the media
- Read the Global tuberculosis report 2014
- Tuberculosis – WHO Fact Sheet 22 October 2014

:: Global Alert and Response (GAR) - Disease outbreak news

- Middle East respiratory syndrome coronavirus (MERS-CoV) – Turkey 24 October 2014
- Chikungunya – France 23 October 2014

:: The Weekly Epidemiological Record (WER) 24 October 2014, vol. 89, 43 (pp. 465–492) includes:

- Human papillomavirus vaccines: WHO position paper, October 2014
http://www.who.int/entity/wer/2014/wer8943.pdf?ua=1

In an updated position paper published today, WHO revised the number of doses recommended for human papillomavirus (HPV) vaccines for different age groups:

> *Vaccination schedule: Following a review of the evidence demonstrating that post-vaccination antibody GMCs were shown to be non-inferior, and recognizing cost-saving and programmatic advantages, WHO has changed its previous recommendation of a 3-dose schedule to a 2-dose schedule, with increased flexibility in the interval between doses which may facilitate vaccine uptake.*

WHO reiterates its recommendation that HPV vaccines should be included in national immunization programmes, provided that: prevention of cervical cancer and other HPV-related diseases constitutes a public health priority; vaccine introduction is programmatically feasible; sustainable financing can be secured; and the cost-effectiveness of vaccination strategies in the country or region is considered.

:: EURO - Crown Princess Mary of Denmark underlines importance of universal vaccination in address to Tajik medical students
24-10-2014

Today, on World Polio Day, as part of her visit to Tajikistan to draw attention to maternal and child health issues throughout the WHO European Region, HRH Crown Princess Mary of Denmark underlined that access to immunization at every stage of life is the right of every individual.

CDC- MMWR October 24, 2014 / Vol. 63 / No. 42
:: Influenza Outbreak in a Vaccinated Population — USS Ardent, February 2014
:: History and Evolution of the Advisory Committee on Immunization Practices — United States, 1964–2014

EVI Watch (European Vaccine Initiative) [to 25 October 2014]
http://www.euvaccine.eu/
:: EVI support leads to scientific breakthrough
24 October 2014

With funding from Irish Aid via the EVI InnoMalVac project, Simon Draper's group - working closely with Professor Matt Higgins' group - at the University of Oxford, Biochemistry Department have solved the structure of RH5 bound to basigin and the neutralisation of monoclonal antibodies. A paper was published in Nature on 17 August fully acknowledging EVI and the InnoMalVac project. Access to the structure is now paving the way forward to design improved vaccines against RH5, as well as the other RH malaria proteins.
:: EDUFLUVAC Annual Meeting 2014
21 October 2014
The first EDUFLUVAC annual meeting successfully took place at the Riviera Hotel in Carcavelos, Portugal on 15-16 October 2014

FDA Watch [to 25 October 2014]
http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/default.htm
No new digest content identified.

GAVI Watch [to 25 October 2014]
http://www.gavialliance.org/library/news/press-releases/
No new digest content identified.

Global Fund Watch [to 25 October 2014]
http://www.theglobalfund.org/en/mediacenter/announcements/
No new digest content identified.

BMGF - Gates Foundation Watch [to 25 October 2014]
http://www.gatesfoundation.org/Media-Center/Press-Releases
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

Developing Country Vaccine Manufacturers Network - DCVMN 15th Annual General Meeting
27-29 October 2014
New Delhi, India
…"*Vaccines, our shared responsibility"* is the theme of this year's gathering and we hope to inspire continuous advancements by sharing new knowledge, new technologies, and the benefits derived from our joint efforts. The programme proposes plenary sessions with speakers from around the world, representing different viewpoints from government, industry, civil society and academia. Our members and partners have cordially agreed to serve as facilitators of discussions, fostering the spirit of international cooperation….

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 11, 2014
http://www.tandfonline.com/toc/uajb20/current
[Reviewed earlier]

American Journal of Infection Control
Volume 42, Issue 10 , Supplement, S189-S296 October 2014
http://www.ajicjournal.org/issue/S0196-6553%2814%29X0013-1
[Reviewed earlier]

American Journal of Preventive Medicine
Volume 47, Issue 4, p375-530, e7-e10 October 2014
http://www.ajpmonline.org/current
[Reviewed earlier]

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
October 2014; 91 (4)
http://www.ajtmh.org/content/current
[Reviewed earlier]

Annals of Internal Medicine
21 October 2014, Vol. 161. No. 8
http://annals.org/issue.aspx
[New issue; No relevant content]

BMC Health Services Research
(Accessed 25 October 2014)
http://www.biomedcentral.com/bmchealthservres/content
[No new relevant content]

BMC Infectious Diseases
(Accessed 25 October 2014)
http://www.biomedcentral.com/bmcinfectdis/content
[No new relevant content]

BMC Medical Ethics

(Accessed 25 October 2014)
http://www.biomedcentral.com/bmcmedethics/content

Research article

Attitude towards informed consent practice in a developing country: a community-based assessment of the role of educational status

Kenneth Amaechi Agu, Emmanuel Ikechukwu Obi, Boniface Ikenna Eze and Wilfred Okwudili Okenwa
Author Affiliations

BMC Medical Ethics 2014, 15:77 doi:10.1186/1472-6939-15-77
Published: 22 October 2014

Abstract (provisional)

Background

It has been reported by some studies that the desire to be involved in decisions concerning one's healthcare especially with regard to obtaining informed consent is related to educational status. The purpose of this study, therefore, is to assess the influence of educational status on attitude towards informed consent practice in three south-eastern Nigerian communities.

Methods

Responses from consenting adult participants from three randomly selected communities in Enugu State, southeast Nigeria were obtained using self- / interviewer-administered questionnaire.

Results

There were 2545 respondents (1508 males and 1037 females) with an age range of 18 to 65 years. More than 70% were aged 40 years and below and 28.4% were married. More than 70% of the respondents irrespective of educational status will not leave all decisions about their healthcare to the doctor. A lower proportion of those with no formal education (18.5%) will leave this entire decision-making process in the hands of the doctor compared to those with tertiary education (21.9%). On being informed of all that could go wrong with a procedure, 61.5% of those with no formal education would consider the doctor unsafe and incompetent while 64.2% of those with tertiary education would feel confident about the doctor. More than 85% of those with tertiary education would prefer consent to be obtained by the doctor who will carry out the procedure as against 33.8% of those with no formal education. Approximately 70% of those who had tertiary education indicated that informed consent was necessary for procedures on children, while the greater number of those with primary (64.4%) and no formal education (76.4%) indicated that informed consent was not necessary for procedures on children. Inability to understand the information was the most frequent specific response among those without formal education on why they would leave all the decisions to the doctor.

Conclusion

The study showed that knowledge of the informed consent practice increased with level of educational attainment but most of the participants irrespective of educational status would want to be involved in decisions about their healthcare. This knowledge will be helpful to healthcare providers in obtaining informed consent.

BMC Public Health

(Accessed 25 October 2014)
http://www.biomedcentral.com/bmcpublichealth/content

Research article

Herpes zoster vaccine (HZV): utilization and coverage 2009 - 2013, Alberta, Canada

Xianfang C Liu, Kimberley A Simmonds, Margaret L Russell and Lawrence W Svenson
Author Affiliations
BMC Public Health 2014, 14:1098 doi:10.1186/1471-2458-14-1098
Published: 23 October 2014
Abstract (provisional)
Background
Herpes zoster vaccine (HZV) is not publicly funded in the province of Alberta, Canada. We estimated vaccine coverage among those aged 60 years or older for 2013, as well as vaccine utilization rates per hundred thousand population over the period 2009 - 2013. We explored for factors associated with HZV dispensing rates.
Methods
We used administrative data from the Alberta Pharmaceutical Information Network (PIN) database to identify unique persons for whom HZV had been dispensed from community pharmacies over 2009 - 2013. PIN data were also used to estimate the pharmacy/population ratios for rural and urban Alberta over the period. Denominators for rates were estimated using mid-year population estimates from the Alberta Health Care Insurance Plan Registry. Income quintile data were estimated from the 2006 Census of Canada. Crude, age, sex, geographic (rural vs. urban), income-quintile and year specific rates of HZV vaccine dispensing were estimated per 100,000 population. Rates were adjusted for pharmacy/population ratio. Vaccine coverage for persons aged 60 years or older was estimated using counts of all unique persons for whom the vaccine was dispensed over the period in the numerator and a 2013 mid- year population denominator.
Results
HZV dispensing rates rose annually from 2009 - 2013. Vaccine coverage was estimated to be 8.4% among persons aged 60 years or older. Rates of dispensing were highest for persons aged 60-69 years and were higher for females than males and for persons from higher compared to lower income quintiles. Dispensing rates were lower for rural than for urban residents. About 2% of vaccine was dispensed for persons aged less than 50 years.

BMC Research Notes
(Accessed 25 October 2014)
http://www.biomedcentral.com/bmcresnotes/content
[No new relevant content]

British Medical Journal
25 October 2014 (vol 349, issue 7980)
http://www.bmj.com/content/349/7980
Research
Re-evaluating cost effectiveness of universal meningitis vaccination (Bexsero) in England: modelling study
BMJ 2014; 349 doi: http://dx.doi.org/10.1136/bmj.g5725 (Published 09 October 2014) Cite this as: BMJ 2014;349:g5725
Hannah Christensen, research associate1,
Caroline L Trotter, senior lecturer2,
Matthew Hickman, professor of public health and epidemiology1,
W John Edmunds, professor of infectious disease modelling3

Author affiliations
Accepted 22 August 2014
Abstract
Objective To use mathematical and economic models to predict the epidemiological and economic impact of vaccination with Bexsero, designed to protect against group B meningococcal disease, to help inform vaccine policy in the United Kingdom.
Design: Modelling study.
Setting: England.
Population: People aged 0-99.
Interventions: Incremental impact of introductory vaccine strategies simulated with a transmission dynamic model of meningococcal infection and vaccination including potential herd effects. Model parameters included recent evidence on the vaccine characteristics, disease burden, costs of care, litigation costs, and loss of quality of life from disease, including impacts on family and network members. The health impact of vaccination was assessed through cases averted and quality adjusted life years (QALYs) gained.
Main outcome measures: Cases averted and cost per QALY gained through vaccination; programmes were deemed cost effective against a willingness to pay of £20 000 (€25 420, $32 677) per QALY gained from an NHS and personal and social services perspective.
Results In the short term, case reduction is greatest with routine infant immunisation (26.3% of cases averted in the first five years). This strategy could be cost effective at £3 (€3.8, $4.9) a vaccine dose, given several favourable assumptions and the use of a quality of life adjustment factor. If the vaccine can disrupt meningococcal transmission more cases are prevented in the long term with an infant and adolescent combined programme (51.8% after 30 years), which could be cost effective at £4 a vaccine dose. Assuming the vaccine reduces acquisition by 30%, adolescent vaccination alone is the most favourable strategy economically, but takes more than 20 years to substantially reduce the number of cases.
Conclusions: Routine infant vaccination is the most effective short term strategy and could be cost effective with a low vaccine price. Critically, if the vaccine reduces carriage acquisition in teenagers, the combination of infant and adolescent vaccination could result in substantial long term reductions in cases and be cost effective with competitive vaccine pricing.

Bulletin of the World Health Organization
Volume 92, Number 10, October 2014, 697-772
http://www.who.int/bulletin/volumes/92/10/en/
[Reviewed earlier]

Clinical Infectious Diseases (CID)
Volume 59 Issue 9 November 1, 2014
http://cid.oxfordjournals.org/content/current
[Reviewed earlier]

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

Integrated Partnerships and the Transformation of Pharmaceutical Research and Development
Kenneth I. Kaitin
p1346–1348
Published online: October 6, 2014
Preview
From where will the life-saving and life-improving medicines of tomorrow come? It is a fair question. There is ample evidence to suggest that the extant model of drug development is yielding too few products, at too high a cost, to sustain the growth of the research-based pharmaceutical industry, long the dominant source of these medicines.[1] Moreover, intense global price pressure, competition from generics, increasing regulatory demands, and expiring patents on many top-selling drugs have created a stifling environment for drug developers.

Cost Effectiveness and Resource Allocation
(Accessed 25 October 2014)
http://www.resource-allocation.com/
[No new relevant content]

Current Opinion in Infectious Diseases
October 2014 - Volume 27 - Issue 5 pp: v-vi,403-469
http://journals.lww.com/co-infectiousdiseases/pages/currenttoc.aspx
[Reviewed earlier]

Developing World Bioethics
August 2014 Volume 14, Issue 2 Pages ii–viii, 59–110
http://onlinelibrary.wiley.com/doi/10.1111/dewb.2014.14.issue-2/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/
[New issue; No relevant content]

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

Epidemiology and Infection
Volume 142 - Issue 10 - October 2014
http://journals.cambridge.org/action/displayIssue?jid=HYG&tab=currentissue
[Reviewed earlier]

The European Journal of Public Health
Volume 24 Issue 5 October 2014
http://eurpub.oxfordjournals.org/content/current
[Reviewed earlier]

Eurosurveillance
Volume 19, Issue 41, 16 October 2014
http://www.eurosurveillance.org/Public/Articles/Archives.aspx?PublicationId=11678
[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 25 October 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 25 October 2014]
http://www.globalizationandhealth.com/
[No new relevant content]

Health Affairs
October 2014; Volume 33, Issue 10

http://content.healthaffairs.org/content/current
Theme: Specialty Pharmaceutical Spending & Policy
[No relevant content]

Health and Human Rights
Volume 16, Issue 2 December 2014
http://www.hhrjournal.org/
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

Acceptability of conditions in a community-led cash transfer programme for orphaned and vulnerable children in Zimbabwe

Morten Skovdal1,2, Laura Robertson3, Phyllis Mushati4, Lovemore Dumba5, Lorraine Sherr6, Constance Nyamukapa3,4 and Simon Gregson3,4
Author Affiliations
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Accepted July 8, 2013.
Abstract

Evidence suggests that a regular and reliable transfer of cash to households with orphaned and vulnerable children has a strong and positive effect on child outcomes. However, conditional cash transfers are considered by some as particularly intrusive and the question on whether or not to apply conditions to cash transfers is an issue of controversy. Contributing to policy debates on the appropriateness of conditions, this article sets out to investigate the overall buy-in of conditions by different stakeholders and to identify pathways that contribute to an acceptability of conditions.

The article draws on data from a cluster-randomized trial of a community-led cash transfer programme in Manicaland, eastern Zimbabwe. An endpoint survey distributed to 5167 households assessed community members' acceptance of conditions and 35 in-depth interviews and 3 focus groups with a total of 58 adults and 4 youth examined local perceptions of conditions. The study found a significant and widespread acceptance of conditions primarily because they were seen as fair and a proxy for good parenting or guardianship. In a socio-

economic context where child grants are not considered a citizen entitlement, community members and cash transfer recipients valued the conditions associated with these grants. The community members interpreted the fulfilment of the conditions as a proxy for achievement and merit, enabling them to participate rather than sit back as passive recipients of aid.

Although conditions have a paternalistic undertone and engender the sceptics' view of conditions being pernicious and even abominable, it is important to recognize that community members, when given the opportunity to participate in programme design and implementation, can take advantage of conditions and appropriate them in a way that helps them manage change and overcome the social divisiveness or conflict that otherwise may arise when some people are identified to benefit and others not.

Health and access to care for undocumented migrants living in the European Union: a scoping review

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Accepted July 11, 2013.

Abstract

Background

Literature on health and access to care of undocumented migrants in the European Union (EU) is limited and heterogeneous in focus and quality. Authors conducted a scoping review to identify the extent, nature and distribution of existing primary research (1990–2012), thus clarifying what is known, key gaps, and potential next steps.

Methods

Authors used Arksey and O'Malley's six-stage scoping framework, with Levac, Colquhoun and O'Brien's revisions, to review identified sources. Findings were summarized thematically: (i) physical, mental and social health issues, (ii) access and barriers to care, (iii) vulnerable groups and (iv) policy and rights.

Results

Fifty-four sources were included of 598 identified, with 93% (50/54) published during 2005–2012. EU member states from Eastern Europe were under-represented, particularly in single-country studies. Most study designs (52%) were qualitative. Sampling descriptions were generally poor, and sampling purposeful, with only four studies using any randomization. Demographic descriptions were far from uniform and only two studies focused on undocumented children and youth. Most (80%) included findings on health-care access, with obstacles reported at primary, secondary and tertiary levels. Major access barriers included fear, lack of awareness of rights, socioeconomics. Mental disorders appeared widespread, while obstetric needs and injuries were key reasons for seeking care. Pregnant women, children and detainees appeared most vulnerable. While EU policy supports health-care access for undocumented migrants, practices remain haphazard, with studies reporting differing interpretation and implementation of rights at regional, institutional and individual levels.

Conclusions

This scoping review is an initial attempt to describe available primary evidence on health and access to care for undocumented migrants in the European Union. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers,

researchers and policy makers, and reduced ambiguities in health-care rights and obligations for undocumented migrants.

Does the distribution of healthcare utilization match needs in Africa?

Igna Bonfrer1,*, Ellen van de Poel1, Michael Grimm2,3 and Eddy Van Doorslaer1,4
Author Affiliations
1Institute of Health Policy & Management, Erasmus University Rotterdam, Burgemeester Oudlaan 50, 3000 DR Rotterdam, The Netherlands, 2Department of Economics, University of Passau, Innstrasse 29, 94032, Passau, Germany, 3International Institute of Social Studies, Erasmus University Rotterdam, Kortenaerkade 12, 2518 AX, The Hague, The Netherlands and 4Erasmus School of Economics, Erasmus University Rotterdam, Burgemeester Oudlaan 50, 3000 DR Rotterdam, The Netherlands
Accepted September 9, 2013.
Abstract
An equitable distribution of healthcare use, distributed according to people's needs instead of ability to pay, is an important goal featuring on many health policy agendas worldwide. However, relatively little is known about the extent to which this principle is violated across socio-economic groups in Sub-Saharan Africa (SSA). We examine cross-country comparative micro-data from 18 SSA countries and find that considerable inequalities in healthcare use exist and vary across countries. For almost all countries studied, healthcare utilization is considerably higher among the rich. When decomposing these inequalities we find that wealth is the single most important driver. In 12 of the 18 countries wealth is responsible for more than half of total inequality in the use of care, and in 8 countries wealth even explains more of the inequality than need, education, employment, marital status and urbanicity together. For the richer countries, notably Mauritius, Namibia, South Africa and Swaziland, the contribution of wealth is typically less important. As the bulk of inequality is not related to need for care and poor people use less care because they do not have the ability to pay, healthcare utilization in these countries is to a large extent unfairly distributed. The weak average relationship between need for and use of health care and the potential reporting heterogeneity in self-reported health across socio-economic groups imply that our findings are likely to even underestimate actual inequities in health care. At a macro level, we find that a better match of needs and use is realized in those countries with better governance and more physicians. Given the absence of social health insurance in most of these countries, policies that aim to reduce inequities in access to and use of health care must include an enhanced capacity of the poor to generate income.

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[Reviewed earlier]

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Volume 6 Issue 3 September 2014
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Volume 210 Issue 10 November 15, 2014

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Vol 16, No 10 (2014): October
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The Lancet
Oct 25, 2014 Volume 384 Number 9953 p1477 - 1548
http://www.thelancet.com/journals/lancet/issue/current
Editorial
National armies for global health?
The Lancet

October, 2014, has seen unprecedented deployment of both US and British military personnel to support the efforts in west Africa against the Ebola crisis. Up to 4000 US troops could be deployed in Liberia as part of Operation United Assistance. The British Army commenced Operation Gritrock with the departure of a medical team on Oct 16 to Sierra Leone. "This unit has been the Vanguard medical regiment for the past 20 months which means we are on high readiness to deploy at short notice to anywhere in the world", said Lieutenant Colonel Alison McCourt from 22 Field Hospital in Aldershot. This capacity to rapidly assemble highly trained personnel experienced in operating in extreme and dangerous conditions is just one factor that makes the military well suited to respond in such humanitarian crises, along with resources, expertise in logistics, transportation, and command and control.

Although countries like the UK and Australia contribute to humanitarian missions, by far the bulk of global support comes from the USA. Involvement of US military personnel in global health activities has increased substantially during the past decade, according to a report published on Oct 8 by the Center for Strategic and International Studies. The report, entitled Global Health Engagement: Sharpening a Key Tool for the Department of Defense, highlights the key role that the military health system could play in "the nation's health, diplomacy and development goals", but also criticises previous activities in global health engagement carried out by the US Department of Defense (DoD).

Much of this criticism focuses on the poor coordination of DoD efforts alongside other civilian agencies, which still provide the vast majority of humanitarian global aid. Before the Ebola effort, DoD spending on global health engagement was estimated at US$600 million, compared with $9 billion from civilian agencies. The report describes an ad-hoc short-term focus, and accuses the DoD's global health efforts of poor appreciation of local cultural norms, little high-level oversight, and failure to properly assess effectiveness. However, the report acknowledges that since 2010, when a mandate for "promoting global health" was introduced into the US National Security Strategy, substantial developments have occurred in internal organisation, quality control, and inter-agency coordination. Specific examples include the formation of the new military position of DoD's global health engagement coordinator and efforts to undertake extensive outreach to civilian agencies.

The DoD has also released a report which discusses the increasing demands on the DoD to provide humanitarian assistance as a consequence of climate change. The report 2014 Climate

Change Adaptation Roadmap describes climate change as a "threat multiplier", with the potential to exacerbate existing challenges to US national security. This is the first report from the DoD that acknowledges that climate change-related global extreme weather events are already creating unstable conditions that affect national security, creating demands for more frequent disaster relief because of hunger, poverty, conflict, and population displacement.

The stated aims of the DoD have moved from just protecting the health of US forces and US citizens from security threats to "partnering with other nations to achieve security cooperation and build partner capacity". But this concept reflects the challenges posed by placing military personnel in sites of public health emergencies: the goals of deployments are in support of military strategy rather than as a purely humanitarian action. The use of the military for humanitarian operations is not militarily, politically, or legally neutral. Peacekeeping with combat troops has often proved to be a complicated arrangement and at times at odds with humanitarian needs and sometimes a precursor to hostility.

The 2007 UN Oslo Guidelines clearly state that military assets should only be used as a last resort in situations where "there is no comparable civilian alternative…to meet a critical humanitarian need"—a position reinforced by AJP-9, NATO's doctrine on civil military cooperation. This situation is clearly the case with the Ebola epidemic, the scale and severity of which has outstripped the capacity of the humanitarian global health community. But should this involvement challenge the current position on military involvement in humanitarian catastrophes or prompt us to strengthen civilian global health systems?

As the DoD has recognised, the security of one nation's citizens is inextricably linked to others through both global health and climate change. Therefore, the military seem set to play a greater part in global civilian health in the future. The question is what should this role look like in the 21st century?

Comment

Polio endgame management: focusing on performance with or without inactivated poliovirus vaccine

Kimberly M Thompson

Preview |

In The Lancet, Jacob John and colleagues1 report results from a randomised trial of 450 children from Vellore, India, aged 1–4 years that assessed the effects of giving a dose of inactivated poliovirus vaccine (IPV) to children previously immunised with five or more doses of oral poliovirus vaccine (OPV) at least 6 months before the study. The results confirm that an extra dose of IPV in this population increases serum antibodies.2 The study goes further to show that the IPV dose boosts individual intestinal immunity in OPV-vaccinated children, at least for a short period of time.

Effect of a single inactivated poliovirus vaccine dose on intestinal immunity against poliovirus in children previously given oral vaccine: an open-label, randomised controlled trial

Jacob John MD a *, Sidhartha Giri MD a *, Arun S Karthikeyan MSc a, Miren Iturriza-Gomara PhD a b, Prof Jayaprakash Muliyil DrPH a, Prof Asha Abraham PhD a, Prof Nicholas C Grassly DPhil a c Prof Gagandeep Kang PhD a

Summary

Background

Intestinal immunity induced by oral poliovirus vaccine (OPV) is imperfect and wanes with time, permitting transmission of infection by immunised children. Inactivated poliovirus vaccine (IPV) does not induce an intestinal mucosal immune response, but could boost protection in children

who are mucosally primed through previous exposure to OPV. We aimed to assess the effect of IPV on intestinal immunity in children previously vaccinated with OPV.
Methods
We did an open-label, randomised controlled trial in children aged 1—4 years from Chinnallapuram, Vellore, India, who were healthy, had not received IPV before, and had had their last dose of OPV at least 6 months before enrolment. Children were randomly assigned (1:1) to receive 0·5 mL IPV intramuscularly (containing 40, 8, and 32 D antigen units for serotypes 1, 2, and 3) or no vaccine. The randomisation sequence was computer generated with a blocked randomisation procedure with block sizes of ten by an independent statistician. The laboratory staff did blinded assessments. The primary outcome was the proportion of children shedding poliovirus 7 days after a challenge dose of serotype 1 and 3 bivalent OPV (bOPV). A second dose of bOPV was given to children in the no vaccine group to assess intestinal immunity resulting from the first dose. A per-protocol analysis was planned for all children who provided a stool sample at 7 days after bOPV challenge. This trial is registered with Clinical Trials Registry of India, number CTRI/2012/09/003005.
Findings
Between Aug 19, 2013, and Sept 13, 2013, 450 children were enrolled and randomly assigned into study groups. 225 children received IPV and 225 no vaccine. 222 children in the no vaccine group and 224 children in the IPV group had stool samples available for primary analysis 7 days after bOPV challenge. In the IPV group, 27 (12%) children shed serotype 1 poliovirus and 17 (8%) shed serotype 3 poliovirus compared with 43 (19%) and 57 (26%) in the no vaccine group (risk ratio 0·62, 95% CI 0·40—0·97, p=0·0375; 0·30, 0·18—0·49, p<0·0001). No adverse events were related to the study interventions.
Interpretation
The substantial boost in intestinal immunity conferred by a supplementary dose of IPV given to children younger than 5 years who had previously received OPV shows a potential role for this vaccine in immunisation activities to accelerate eradication and prevent outbreaks of poliomyelitis.
Funding
Bill & Melinda Gates Foundation.

Effectiveness of maternal pertussis vaccination in England: an observational study

Gayatri Amirthalingam MFPH a, Nick Andrews PhD b, Helen Campbell MSc a, Sonia Ribeiro BA a, Edna Kara MBBS a, Katherine Donegan PhD d, Norman K Fry PhD c, Prof Elizabeth Miller FRCPath a, Mary Ramsay FFPH a

Summary
Background
In October, 2012, a pertussis vaccination programme for pregnant women was introduced in response to an outbreak across England. We aimed to assess the vaccine effectiveness and the overall effect of the vaccine programme in preventing pertussis in infants.
Methods
We undertook an analysis of laboratory-confirmed cases and hospital admissions for pertussis in infants between Jan 1, 2008, and Sept 30, 2013, using data submitted to Public Health England as part of its enhanced surveillance of pertussis in England, to investigate the effect of the vaccination programme. We calculated vaccine effectiveness by comparing vaccination status for mothers in confirmed cases with estimates of vaccine coverage for the national population of pregnant women, based on data from the Clinical Practice Research Datalink.
Findings

The monthly total of confirmed cases peaked in October, 2012 (1565 cases), and subsequently fell across all age groups. For the first 9 months of 2013 compared with the same period in 2012, the greatest proportionate fall in confirmed cases (328 cases in 2012 vs 72 cases in 2013, −78%, 95% CI −72 to −83) and in hospitalisation admissions (440 admissions in 2012 vs 140 admissions in 2013, −68%, −61 to −74) occurred in infants younger than 3 months, although the incidence remained highest in this age group. Infants younger than 3 months were also the only age group in which there were fewer cases in 2013 than in 2011 (118 cases in 2011 vs 72 cases in 2013), before the resurgence. 26 684 women included in the Clinical Practice Research Datalink had a livebirth between Oct 1, 2012 and Sept 3, 2013; the average vaccine coverage before delivery based on this cohort was 64%. Vaccine effectiveness based on 82 confirmed cases in infants born from Oct 1, 2012, and younger than 3 months at onset was 91% (95% CI 84 to 95). Vaccine effectiveness was 90% (95% CI 82 to 95) when the analysis was restricted to cases in children younger than 2 months.

Interpretation

Our assessment of the programme of pertussis vaccination in pregnancy in England is consistent with high vaccine effectiveness. This effectiveness probably results from protection of infants by both passive antibodies and reduced maternal exposure, and will provide valuable information to international policy makers.

Funding

Public Health England.

Series

Homelessness

The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations

Seena Fazel, John R Geddes, Margot Kushel

Preview | Summary

Homelessness

Health interventions for people who are homeless

Stephen W Hwang, Tom Burns

Preview | Summary

The Lancet Global Health

Nov 2014 Volume 2 Number 11 e616 – 671

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

Editorial

Polio: is the end in sight?

Zoë Mullan

Preview /

World Polio Day, on October 24, is an annual opportunity to revitalise attention and efforts towards the global eradication of this now rare but still fatal and devastatingly disabling infectious disease. 2014 has not felt like a good year for infectious disease control, yet just 3 months from now, a major date in the Polio Eradication and Endgame Strategic Plan 2013–18 will be reached. The first objective of the plan, launched in April last year, was "to stop all [wild poliovirus] transmission by the end of 2014".

Comment

Inactivated polio vaccine launch in Nepal: a public health milestone

Andreas Hasman, Hendrikus C J Raaijmakers, Douglas J Noble

Preview |
On Sept 18, 2014, as part of the Global Polio Eradication Initiative (GPEI), Nepal became the first GAVI-supported country in the world to introduce one dose of inactivated poliomyelitis vaccine (IPV) into routine immunisation schedules at 14 weeks. The launch at Tribhuvan University Teaching Hospital, Kathmandu, is a significant step, but there are challenges ahead.

Estimation of daily risk of neonatal death, including the day of birth, in 186 countries in 2013: a vital-registration and modelling-based study
Shefali Oza, Simon N Cousens, Joy E Lawn
Preview | Summary | Full Text | PDF

Effectiveness of a rural sanitation programme on diarrhoea, soil-transmitted helminth infection, and child malnutrition in Odisha, India: a cluster-randomised trial
Thomas Clasen, Sophie Boisson, Parimita Routray, Belen Torondel, Melissa Bell, Oliver Cumming, Jeroen Ensink, Matthew Freeman, Marion Jenkins, Mitsunori Odagiri, Subhajyoti Ray, Antara Sinha, Mrutyunjay Suar, Wolf-Peter Schmidt
Preview | Summary | Full Text | PDF

Effect of antenatal multiple micronutrient supplementation on anthropometry and blood pressure in mid-childhood in Nepal: follow-up of a double-blind randomised controlled trial
Delan Devakumar, Shiva Shankar Chaube, Jonathan C K Wells, Naomi M Saville, Jon G Ayres, Dharma S Manandhar, Anthony Costello, David Osrin
Preview | Summary | Full Text | PDF

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Oct 2014 Volume 14 Number 10 p899 - 1022
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Volume 18, Issue 8, October 2014
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October 2014; 34 (7)
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September 2014 Volume 92, Issue 3 Pages 407–631
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Volume 514 Number 7523 pp403-528 23 October 2014
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October 2014, Volume 20 No 10 pp1079-1217
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[Reviewed earlier]

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October 2014 Vol 14 No 10
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[Reviewed earlier]

New England Journal of Medicine
October 23, 2014 Vol. 371 No. 17
http://www.nejm.org/toc/nejm/medical-journal
Perspective
Doing Today's Work Superbly Well — Treating Ebola with Current Tools
François Lamontagne, M.D., Christophe Clément, M.D., Thomas Fletcher, M.R.C.P., Shevin T. Jacob, M.D., M.P.H., William A. Fischer, II, M.D., and Robert A. Fowler, M.D.C.M., M.S.(Epi)
N Engl J Med 2014; 371:1565-1566
October 23, 2014
DOI: 10.1056/NEJMp1411310

The Ebola outbreak that is ravaging West Africa is a daily staple of the lay press and of scholarly medical publications. Ebola evokes fear among both the public and clinicians. It also evokes a sort of therapeutic nihilism — after all, if there is no treatment, what can be done? And without an Ebola-specific antiviral medication, of what use are infectious-disease clinicians? Without oxygen, let alone mechanical ventilators, how can acute and critical care clinicians possibly contribute?

We have traveled several times to West Africa and done primary patient care in treatment centers and hospitals in Guinea (Conakry and Guéckédou), Sierra Leone (Kenema, Bo, and Daru), and Liberia (Monrovia, Bong, and Foya). Before each trip, as we prepared to go to the front lines of Ebola medical care as part of World Health Organization and Médecins sans Frontières clinical teams, we, too, felt a certain unease about treating a highly transmissible infection for which there is no vaccine, no specific therapy, and a high mortality rate. Yet we also appreciated that most viral illnesses, and certainly most critical illnesses, have no specific therapy. And after spending much of the past 5 months treating patients with Ebola virus disease (EVD), we are convinced that it's possible to save many more patients. Our optimism is fueled by the observation that supportive care is also specific care for EVD — and in all likelihood reduces mortality. Unfortunately, many patients in West Africa continue to die for lack of the opportunity to receive such basic care…

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October 2014 - Volume 33 - Issue 10 pp: 997-1101,e247-e272
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Volume 6, Issue 3 (September 2014), Pages 354-
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PLoS Neglected Tropical Diseases
(Accessed 25 October 2014)
http://www.plosntds.org/
A One Health Framework for the Evaluation of Rabies Control Programmes: A Case Study from Colombo City, Sri Lanka
Barbara Häsler, Elly Hiby, Will Gilbert, Nalinika Obeyesekere, Houda Bennani, Jonathan Rushton
Research Article | published 23 Oct 2014 | PLOS Neglected Tropical Diseases
10.1371/journal.pntd.0003270

Abstract

Background

One Health addresses complex challenges to promote the health of all species and the environment by integrating relevant sciences at systems level. Its application to zoonotic diseases is recommended, but few coherent frameworks exist that combine approaches from multiple disciplines. Rabies requires an interdisciplinary approach for effective and efficient management.

Methodology/Principal Findings

A framework is proposed to assess the value of rabies interventions holistically. The economic assessment compares additional monetary and non-monetary costs and benefits of an intervention taking into account epidemiological, animal welfare, societal impact and cost data. It is complemented by an ethical assessment. The framework is applied to Colombo City, Sri Lanka, where modified dog rabies intervention measures were implemented in 2007. The two options included for analysis were the control measures in place until 2006 ("baseline scenario") and the new comprehensive intervention measures ("intervention") for a four-year duration. Differences in control cost; monetary human health costs after exposure; Disability-Adjusted Life Years (DALYs) lost due to human rabies deaths and the psychological burden following a bite; negative impact on animal welfare; epidemiological indicators; social acceptance of dogs; and ethical considerations were estimated using a mixed method approach including primary and secondary data. Over the four years analysed, the intervention cost US $1.03 million more than the baseline scenario in 2011 prices (adjusted for inflation) and caused a reduction in dog rabies cases; 738 DALYs averted; an increase in acceptability among non-dog owners; a perception of positive changes in society including a decrease in the number of roaming dogs; and a net reduction in the impact on animal welfare from intermediate-high to low-intermediate.

Conclusions

The findings illustrate the multiple outcomes relevant to stakeholders and allow greater understanding of the value of the implemented rabies control measures, thereby providing a solid foundation for informed decision-making and sustainable control.

Author Summary

Successful rabies control generates benefits in terms of improved human and animal health and well-being and safer environments. A key requirement of successful and sustainable rabies control is empowering policy makers to make decisions in an efficient manner; essential to this is the availability of evidence supporting the design and implementation of the most cost-effective strategies. Because there are many, at times differing, stakeholder interests and priorities in the control of zoonotic diseases, it is important to assess intervention strategies in a holistic way. This paper describes how different methods and data from multiple disciplines can be integrated in a One Health framework to provide decision-makers with relevant information, and applies it to a case study of rabies control in Colombo City, Sri Lanka. In Colombo City, a new comprehensive intervention was initiated in 2007 based on vaccination, sterilisation, education, and dog managed zones. Results showed that for the four year time period considered, the new measures overall cost approximately US $ 1 million more than the previous programme, but achieved a reduction in dog rabies cases and human distress due to dog bites, reduced animal suffering and stimulated a perception of positive changes in society. All these achievements have a value that can be compared against the monetary cost of the programme to judge its overall worth.

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Vol 5 (2014)
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October 2014; 24 (10)
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Vol. 42(2014) No. 3
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North American Journal of Medical Sciences
2014 | Volume : 6 | Issue : 10 |
Thimerosal-containing hepatitis b vaccination and the risk for diagnosed specific delays in development in the united states: A case-control study in the vaccine safety Datalink
David A Geier1, Janet K Kern2, Brian S Hooker3, Paul G King4, Lisa K Sykes4, Mark R Geier1
1 Institute of Chronic Illnesses, Inc, Silver Spring, Maryland, USA
2 Institute of Chronic Illnesses, Inc, Silver Spring, Maryland; Department of Psychiatry, University of Texas Southwestern Medical Center, Dallas, Texas, USA

3 Biology Department, Simpson University, Redding, California, USA
4 CoMeD, Inc, Silver Spring, Maryland, USA
DOI: 10.4103/1947-2714.143284
Page : 519-531
Abstract
Background: Within the first 3 years of life, the brain develops rapidly. Its development is characterized by critical developmental periods for speech, vision, hearing, language, balance, etc.; and alteration in any of the processes occurring in those critical periods can lead to specific delays in development.
Aims: The present study evaluated the potential toxic effects of organic-mercury exposure from Thimerosal (49.55% mercury by weight) in childhood vaccines and its hypothesized possible relationship with specific delays in development.
Materials and Methods: A hypothesis testing case-control study was undertaken to evaluate the relationship between exposure to Thimerosal-containing hepatitis B vaccines administered at specific intervals in the first 6 months among cases diagnosed with specific delays in development and controls born between 1991-2000, utilizing data in the Vaccine Safety Datalink database.
Results: Cases were significantly more likely than controls to have received increased organic-mercury from Thimerosal-containing hepatitis B vaccine administered in the first, second, and sixth month of life.
Conclusion: Though routine childhood vaccination may be an important public health tool to reduce the morbidity and mortality associated with infectious diseases, the present study supports an association between increasing organic-mercury exposure from Thimerosal-containing childhood vaccines and the subsequent risk of specific delays in development among males and females.

Ethics & Behavior
Volume 24, Issue 6, 2014
http://www.tandfonline.com/toc/hebh20/current#.VEvAPBZ4WF8
Peruvian Female Sex Workers' Ethical Perspectives on Their Participation in an HPV Vaccine Clinical Trial
Brandon Browna*, Mariam Davtyana & Celia B. Fisherb
DOI: 10.1080/10508422.2014.950269 Accepted author version posted online: 14 Aug 2014
Summary:
We examined FSW's evaluation of social and health risks and benefits, informed consent, incentives, fair treatment, and post-trial care following their participation in an HPV vaccine phase IV clinical trial (Sunflower Study), in which all 200 participants received quadrivalent HPV vaccine and 92% completed all 3 vaccine doses. Sixteen FSWs aged 23-29 years from Lima, Peru were administered semi-structured interviews to assess perceptions of study participation.
Broad themes emerging from content analysis included respect, concerns about privacy protections, absence of stigma, access to healthcare, and abandonment. Most participants reported that staff treated them with empathy, fairness, and dignity, participation provided protection from cancer and an opportunity to privately receive quality sexual health care, they were well prepared by consent procedures, participation was voluntary, and incentives were appropriate. Of note, one participant responded, "If nothing else, they always treated me as a human". Some participants experienced feelings of desertion when the study ended.

Participants were generally content with all aspects of the study and emphasized its protective and non-coercive attributes. Balancing fear and trust was the most notable broad theme. Participants expressed gratitude for the professional treatment despite normalized stigma regarding their FSW status. Researchers may also need to develop navigation plans to properly transition participants out of research projects once studies have ended to reduce feelings of abandonment. Additional research on perceptions of clinical trial participation is needed to ensure ethical treatment of research participants

Special Focus Newsletters

Dengue Vaccine Imitative Newsletter – October 2014

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.

AFP

At least four months to contain Ebola: Red Cross chief

22 October 2014

Beijing (AFP) - The Ebola epidemic will take at least four months to contain even if all necessary steps are taken, the global head of the Red Cross said Wednesday, warning of "the price for inaction"…

…Elhadj As Sy, chief of the International Federation of Red Cross and Red Crescent Societies, listed a range of measures which would help bring Ebola under control, including "good isolation, good treatment of cases which are confirmed, good, safe and dignified burials of deceased people".

"It will be possible, as it was possible in the past, to contain this epidemic within four to six months" if the response is adequate, he added.

"I think that is our best prospect and we our doing everything possible to mobilise our resources and our capacities to do so."

Speaking at an Asia-Pacific IFRC conference, he added: "There is always a price for inaction."…

Al Jazeera

http://www.aljazeera.com/Services/Search/?q=vaccine

Accessed 25 October 2014

US West Africans facing Ebola stigma

24 Oct 2014
Discrimination on the rise in New York City as locals gossip about those who have lost entire families 7,000km away.

The Atlantic
http://www.theatlantic.com/magazine/
Accessed 25 October 2014
The Psychology of Anti-Vaxers: How Story Trumps Science
An anecdote from a friend can hold more weight than a recommendation from a doctor.
Vanessa Wamsley Oct 19 2014, 8:00 AM ET

BBC
http://www.bbc.co.uk/
Millions of Ebola vaccine doses for 2015
24 October 2014 Last updated at 13:57 BST [Video segment]
Millions of doses of an Ebola vaccine will be produced by the end of 2015, the World Health Organization has announced.
And vaccines could be offered to health workers on the frontline in West Africa as soon as December 2014.
Dr Marie Paule Kieny, a WHO assistant director-general, said: "While we hope that the massive response, which has been put in place will have an impact on the epidemic, it is still prudent to prepare to have as much vaccine available if they are proven effective.

Brookings
http://www.brookings.edu/
Accessed 25 October 2014
[No new, unique, relevant content]

Council on Foreign Relations
http://www.cfr.org/
Accessed 25 October 2014
Backgrounder
Ebola Virus
by Danielle Renwick October 24, 2014
Officials say Ebola may have already claimed fifteen thousand lives in West Africa—and the toll is rising.
News Release
Updated Vaccine-Preventable Outbreaks Map Shows Attacks on Vaccinators Drive Polio Outbreaks
October 23, 2014
CFR's Global Health program has expanded its "Vaccine-Preventable Outbreaks Map," adding new data showing how a hostile climate for vaccinators thwarts the eradication of preventable illnesses such as polio.
Op-Ed
Vaccine Ignorance -- Deadly and Contagious
by Laurie Garrett, Maxine Builder October 23, 2014

In the absence of credible, strong political leadership, paranoia about disease can go viral. Laurie Garrett and Maxine Builder explain how false fears and suspicions are the enemies when it comes to disease prevention in this op-ed for the Los Angeles Times.

Economist
http://www.economist.com/
Ebola and big data - Waiting on hold
Mobile-phone records would help combat the Ebola epidemic. But getting to look at them has proved hard
Oct 25th 2014

Financial Times
http://www.ft.com
Accessed 25 October 2014

Forbes
http://www.forbes.com/
Pharma & Healthcare 10/23/2014 @ 11:44PM 3,091 views
Head of GSK Ebola Vaccine Research: "Can We Even Consider Doing A Trial?"

GlaxoSmithKline is considered by many a leading contender for delivering an Ebola vaccine at scale. Recent quotes by the Head of Ebola vaccine research for GSK, however, are sobering and indicate the enormous challenges ahead in the race to deliver a safe and effective vaccine in the quantities needed for the unprecedented outbreak in West Africa.

"The thing that is going to have the biggest impact is what is happening to the trajectory of the epidemic curve. If you progress the current trends 2 months into the future are we still in an environment where you can even consider doing a trial?" Dr. Ripley Ballou – Head of Ebola Vaccine Research, GSK (via ScienceInsider here)

At the GSK vaccine research facility outside of Brussels, they are working to squeeze 10 years of trial activity into 12 months. The hope is to have 20,000 doses ready to be tested by health workers early next year.

"At the same time we have to be able to manufacture the vaccine at doses that would be consistent with general use, and that's going to take well into 2016 to be able to do that. I don't think this [vaccine] can be seen as the primary answer to this particular outbreak. If it does work then to be able to be prepared so that we don't have to go through this again in five years, or whenever the next epidemic is going to break out." Dr. Ripley Ballou – Head of Ebola Vaccine Research, GSK (BBC News Health – here)

Earlier today, ScienceInsider published results (here) from leaked documents used in discussions with the World Health Organization (WHO), government officials and vaccine manufacturers.

Included in those documents was this GSK chart outlining a possible timeline for delivering 230,000 vaccines by April 2015 and then scaling to 1 million by December 2015.

Some of the other challenges referenced in their findings include:
:: Producing a vaccine in such large quantities ("fill capacity") and the effect this would have on other vaccines currently in production (rotavirus, measles, mumps and rubella)
:: Liability relief from regulators for producers and distributors of several vaccine candidates used in multiple human trials
:: Costs estimated at $73 million for 27 million does of the vaccine and another $78 million for the actual vaccine campaigns

:: Safe and secure transport and storage (with needed refrigeration throughout the delivery chain)

Unfortunately, modeling and forecasting the effects of a successful vaccine like the one that GSK and others are working on are less than encouraging. At least one study suggests that while a successful vaccine may reduce the mortality rate of those infected, it will do little to slow the transmission.

"The hypothetical mass application of a novel pharmaceutical like the one administered to two American aid workers had a much smaller impact on the course of the epidemic itself. While certainly lessening the burden of mortality of those infected (in the most optimistic scenario modeled, reducing the case-fatality rate from 50% to 12.5%), the downstream effects of such an intervention are relatively minor, as there is no suggestion that any candidate treatments have a substantial impact on transmission."

"These results also suggest that the epidemic has progressed beyond the point wherein it will be readily and swiftly addressed by conventional public health strategies. The forecasts for both Liberia and Sierra Leone in the absence of any major effort to contain the epidemic paint a bleak picture of its future progress, which suggests that we are in the opening phase of the epidemic, rather than near its peak." Modeling the Impact of Interventions on an Epidemic of Ebola in Sierra Leone and Liberia (Public Library of Science here)

A more accurate forecast of Ebola's endgame for this outbreak could well be what happened with the 2003 SARS outbreak in China. How to Shut Down A Country and Kill a Disease was written yesterday by Laurie Garrett – a senior fellow for global health at the Council on Foreign Relations and a Pulitzer Prize winning science writer. Based on her own first hand experience with SARS in China, she concluded with this assessment:

If the world cannot manage to muster promised monies and mobilize far more personnel and equipment to confront the epidemic, the governments of Sierra Leone, Guinea, and Liberia may be compelled to implement strategies as severe as China's SARS endgame, dragging thousands into isolation without respect for their rights or civil liberties, and even at gunpoint. The world must not compel such hellish action. The less odious, more humane alternative of building quality treatment centers on a scale to actually absorb thousands of needy patients and provide meaningful care that improves survival and thus lures Ebola sufferers out of hiding could still work today. It is hugely expensive, and it demands thousands of skilled health workers and support staff from all over the world. But in the absence of ample aid, three nations that nobly came back from the horrors of civil war into their dawns of democracy may be forced backward into an Ebola authoritarian horror.

Foreign Affairs
http://www.foreignaffairs.com/
Accessed 25 October 2014
The Poor and the Sick
What Cholera and Ebola Have in Common
By Fran Quigley
October 19, 2014

The two deadliest outbreaks of this century can be traced to one thing: poverty. Cholera exploded in the Haitian countryside in October 2010, infecting more than 600,000 people and killing 8,600. Ebola surfaced this March in Guinea and has since spread to Liberia and Sierra Leone. As of mid-October, more than 8,000 have been infected and 4,000 have died, almost exclusively in West Africa.

At first glance, the two outbreaks couldn't be less similar. Cholera moves quickly but it is a nineteenth-century disease, easily thwarted by modern water treatment systems and health care. It ravaged Haiti, but it has not spread beyond the developing world. Ebola, on the other hand, moves slowly and is not as easily treated. Further, it has reached the United States, earning it near-obsessive attention in U.S. news. As Greg Gonsalves, co-director of the Yale Global Health Justice Partnership wrote this month in Quartz, "Exotic infections for Americans, often from far away places, often Africa, strike fear into their hearts, but only once the pathogens have cleared customs." Ebola has cleared customs in a way Haitian cholera never has…

Foreign Policy
http://www.foreignpolicy.com/
Accessed 25 October 2014
[No new, unique, relevant content]

The Guardian
http://www.guardiannews.com/
Accessed 25 October 2014
Ebola outbreak prompts food scarcity and threat of social conflict
Fears are growing that the economic impact of the Ebola crisis could lead to unrest and political crises in west African countries
23 October 2014
Farmers in Liberia are too frightened to work together in their fields, fertilisers and seeds are stuck on the other side of closed borders, markets are almost empty, people have less money because jobs that involve physical contact with others are disappearing, and prices for everything from cassava to palm oil are rising.
It's a devastating chain reaction sparked by an unprecedented outbreak of disease in one of the world's poorest countries. Beyond the high mortality rate and human suffering, aid agencies fear the fabric of a society that endured a brutal civil conflict may be ruined.
Ten months after the Ebola outbreak started in Guinea, evidence is mounting that the crisis may be reversing more than a decade of fitful progress in west Africa…
Follow Britain's example on Ebola, David Cameron tells world leaders
UN chief Ban Ki-moon berates international community for contributing only $100,000 into his $1bn global fighting fund
17 October 2014
Britain has called on world leaders to "wake up" to the crisis posed by the Ebola outbreak and to follow the example of the UK, US and France in providing medical and financial support to countries in West Africa. As the UN secretary general, Ban Ki-moon, chided the international community for paying just $100,000 into his $1bn trust fund to fight Ebola, David Cameron called on other countries to "act in a similar way" to Britain, the US and France…
Funding the fight against Ebola: how much is needed and where will it go?
17 October 2014
The cogs of international aid are finally turning – here's how the money is being coordinated and what it's being spent on.
The Ebola crisis has exposed failings in the ability of leading global institutions to respond to an admittedly unprecedented health emergency. As world leaders chide one another for failing to dedicate enough funds to fighting the virus in west Africa, and the consequences of neglecting health systems in some of the world's poorest countries become ever more obvious,

the cogs of international aid are beginning to turn. But the money is only dribbling in slowly, and there are concerns that the virus is already out of control in Liberia, Sierra Leone and Guinea…

The Huffington Post
http://www.huffingtonpost.com/
Accessed 25 October 2014
Ebola: Learning From Past Mistakes
Philippe Douste-Blazy
Under-Secretary General of the United Nations; Chair, UNITAID
22 October 2014
…Ebola casts a harsh spotlight on global health politics and on almost 50 years of health development assistance in Africa. Of course, spectacular progress has been made in recent years in the field of healthcare. Infant mortality has fallen by over 50% in the last 20 years. Nevertheless, what the current Ebola crisis teaches us is the importance of primary healthcare, which is the bedrock of public health. This does not mean spectacular measures but putting in place the solid foundations without which it is impossible to sustainably raise the health level of a population. For decades, unfortunately, the slow and gradual implementation of robust primary health systems has been sacrificed in favor of quicker and more visible results…

Le Monde
Accessed 25 October 2014
http://www.lemonde.fr/
[No new, unique, relevant content]

NPR
Ebola Is Keeping Kids From Getting Vaccinated In Liberia
NPR Blog | 23 October 2014
…There are a lot of those sicknesses in Liberia. Even before Ebola, more than 7 percent of children here died before reaching age 5. Many of these deaths are from preventable diseases, says Adolphus Clarke, who helps manage the government's immunization program. …The numbers tell a tragic story. Before Ebola, 97 percent of babies were getting their routine vaccinations. Now the figure is 27 percent. That almost certainly means more children will die, Clarke says….There are already ominous reports from places hit hard by Ebola, says UNICEF's Sheldon Yett. "We've already had cases of measles in Lofa country which was the original epicenter of the disease in Liberia," he says. "So that's already happening."

New Yorker
http://www.newyorker.com/
Accessed 25 October 2014
[No new, unique, relevant content]

New York Times
http://www.nytimes.com/
Accessed 25 October 2014
New Protocol on Quarantines Seen as Barrier to Volunteers
By DAVID W. CHEN and LIZ ROBBINS
October 25, 2014

Requirements for isolating people who had contact with Ebola patients, like those announced in the New York area, could dissuade health workers from serving at the front lines of the epidemic….
Cuomo, Shifting Policy, Opens Rift With de Blasio
New York Ebola Patient's Fiancée Shares His Altruism
Anxiety on Ebola From Bellevue to Brooklyn

Wall Street Journal
http://online.wsj.com/home-page?_wsjregion=na,us&_homepage=/home/us
Accessed 25 October 2014
Oct 23, 2014
Ebola
Should Pharma be Indemnified for Ebola Vaccines? Take our Reader Poll
Ed Silverman

In response to the call to quickly develop Ebola vaccines, drug makers would like indemnity from governments or multilateral agencies for the widespread use of their new products in Africa. And the issue is expected to be discussed today at a World Health Organization meeting in Geneva that will include representatives from countries affected by the virus, the pharmaceutical industry, regulators and funding organizations, according to Reuters.

"I think it is reasonable that there should be some level of indemnification because the vaccine is essentially being used in an emergency situation before we've all had the chance to confirm its absolute profile," GlaxoSmithKline chief executive Andrew Witty tells BBC radio, according to Reuters. "That's a situation where we would look for some kind of indemnification."

In his view, indemnification would help compensate for the risk that involves fast tracking the supply of novel vaccines in just months instead of years. Witty notes that the WHO has asked drug makers to fast track their efforts. As Reuters notes, drug makers have been leery of investing in Ebola since the commercial opportunity is small, and that any losses or claims represent an added hurdle.

"This is an unprecedented pace of development," says Witty. "We are literally doing in maybe five or six months would normally take five or six years. I've already ordered five production lines to allow us to expand production."

Glaxo currently has the most advanced vaccine and doses are expected to be available later this year. Another vaccine is being developed by NewLink Genetics have begun and Johnson & Johnson expects to begin testing a vaccine in January, Reuters adds.

Drug makers are not the only ones who believe indemnification is warranted. Brian Greenwood, a professor of clinical tropical medicine at the London School of Hygiene and Tropical Medicine, tells Reuters that "there would have to be some sort of guarantee."

The meeting in Geneva will look at ways to streamline the development process for vaccines and to ensure there are adequate financial resources available, according to the news service. Europe, for instance, is expected to announce $250 million in funding to develop new Ebola vaccines, as well as drugs and diagnostic tests.

After initial criticism this past summer in some quarters for failing to have previously invested in products to combat Ebola, some drug makers are clearly responding. And rightly so, given that the outbreak may have devastating consequences for infected areas. The effort, of course, also requires investment and the risks of distributing products under such circumstances are clear…

Washington Post
http://www.washingtonpost.com/
Accessed 25 October 2014
Opinions
Michael Gerson: The world is in denial about Ebola's true threat

It is such a relief about that Ebola thing. The threat of a U.S. outbreak turned out to be overhyped. A military operation is underway to help those poor Liberians. An Ebola czar (what is his name again?) has been appointed to coordinate the U.S. government response. The growth of the disease in Africa, by some reports, seems to have slowed. On to the next crisis.

Except that this impression of control is an illusion, and a particularly dangerous one. The Ebola virus has multiplied in a medium of denial. There was the initial denial that a rural disease, causing isolated outbreaks that burned out quickly, could become a sustained, urban killer. There is the (understandable) denial of patients in West Africa, who convince themselves that they have flu or malaria (the symptoms are similar to Ebola) and remain in communities. And there is the form of denial now practiced by Western governments — a misguided belief that an incremental response can get ahead of an exponentially growing threat…

* * * *

Support for this service is provided by its governing institutions – Department of Medical Ethics, NYU Medical School; The Wistar Institute Vaccine Center and the Children's Hospital of Philadelphia Vaccine Education Center. Additional support is provided by the PATH Vaccine Development Program; the International Vaccine Institute (IVI); the Bill & Melinda Gates Foundation; industry resource members Janssen, Pfizer, and *Sanofi Pasteur U.S. (list in formation), and the Developing Countries Vaccine Manufacturers Network (DCVMN).*

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.

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